—Psychological Adjustment in the

Work Context

Only study guide for

IOP2604

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Table of Contents

LEARNING UNIT 1: The work context and psychological well-being

1.1 Purpose of learning unit 1

Work in some shape or form is an integral part of human life and of people's self-esteem, personal identity and general well-being. As a central life interest, work may even be more significant to many people than other important life roles, like family and religion, because for many of us, work provides the necessary means for supporting these life roles. Work has attributes and represents activities that give meaning to life and that structure time. Work helps people to develop, thus enabling them to create income, products and services that are valuable to and needed by their dependants and the community at large. People's experiences of work, working, work organisations and management contain positive and/or negative feedback that are important to the general well-being of individuals, groups and the community at large. While most people would rather work than not, “bad work” is arguably as detrimental as being unemployed. The impairment of work performance (or work dysfunctions) or not being able to adapt to the requirements of working is a consequence of not only the individual's intrinsic attributes and possible physical and emotional problems, but also the interaction between employees and various aspects of the work environment. The positive or negative attributes of workplaces, including the level of employee well-being, can also make work organisations healthy or unhealthy with all the consequences for individuals, organisations and the community at large.

1.2 Learning outcomes

Conceptualise employee well-being through the following:

- Explain psychological adjustment and maladjustment.
- Discuss the meaning of employment and unemployment.
- Compare the different models with regard to psychological well-being.

1.3 Key concepts

The following key concepts are defined in the glossary tool on myUnisa and are relevant to learning unit 1:

- well-being
- psychological adjustment
- psychological maladjustment
- positive psychology
- applied neurosciences
- amygdala
- central nervous system (CNS)
- prefrontal cortex (PFC)
- anterior cingualte cortex (ACC)
- triune brain
- hippocampus
- hypothalamus
- motivational schemata
- HPA-axis

- epinephrine (adrenalin)
- norepinephrine (noradrenalin)
- cortisol
- dopamine
- African psychology

1.4 Well-being at work

Psychological adjustment or psychological health is one part of well-being. To conceptualise psychological adjustment and maladjustment, you first need to have a holistic understanding of well-being. You also need to understand the impact of work on psychological adjustment as well as the impact of unemployment. Please read sections 1.4.1 to 1.4.2 below.

1.4.1 The definition well-being, psychological adjustment and maladjustment

Many concepts are used to denote a person's health status, that is, being healthy or ill, and may refer to health or illness as assessed by others or perceived by the person, or may denote certain contexts. Consider the physical, emotional and social aspects of health (Bergh 2011):

- Health, wellness or well-being as umbrella concepts refer to a fairly comprehensive state of being healthy or, if so specified, to a general state of illness, and may include the physical, emotional and social aspects of health or illness.
- Psychological health, wellness or well-being equate to the above description, but emphasise psychological or emotional health in a positive sense. Psychological health is also referred to as subjective well-being, which may include a person's subjective feelings and perceptions about his or her own state of health, and may include emotional and social aspects.
- In general, psychological adjustment or normality refers to thinking, emotions and behaviours that indicate that people cope adequately with tasks and demands in the various life roles, and manage in situations where they can be expected to manage, in certain circumstances and at certain stages of life. This definition is reminiscent of the generally accepted idea of maturity, which includes aspects like responsibility, independence and decision making. Note, however, that these definitions – of adjustment and maturity – may include some physical and psychological unhealthiness, since very few people are totally healthy in all or even some areas of human functioning even if they are generally regarded as mature.
- In contrast, maladjustment or abnormality refers to impairment in thinking, emotions, perceptions, social and even physical behaviours, which render people unable to function effectively in tasks or situations they can be expected to cope with, in certain circumstances, at certain stages of life and in various life roles. Maladjusted behaviours are mostly recognised by their intensity and frequency and the detrimental effects they have for the person or other people in various life roles, such as in private relationships and at work. In many cases, abnormal or seriously disturbed behaviours, resulting from genetic or environmental influences, render people totally helpless and incapacitated, and in need of intensive treatment or care at the appropriate institutions. However, not all psychologically disturbed people are helpless. Many are able at times or in certain circumstances (e.g. with medication) to function adequately, at work for instance, and to maintain relationships with others. Many distressed people may only experience temporary disabling symptoms resulting from certain life stressors, may still function in most or all life roles, and may still have the coping resources to recuperate quite quickly.

The distinctions between normality (being psychologically healthy) and abnormality (being psychologically unhealthy) may seem to be general and vague. Except for quite extreme and well-defined conditions, the difference between psychological adjustment and maladjustment is not easily determined, and may be influenced by many factors, one being the various approaches to normality and abnormality and the criteria that apply (Bergh 2011).

Psychological or mental health refers to people's psychic or psychological well-being. As a blanket term, it includes adjustment (normality) and maladjustment (abnormality or psychopathology). This bipolar meaning implies the availability of norms to describe the well-adjusted or healthy personality and behaviour, but also their opposites – psychological disorders and impaired behaviour. Most psychological disciplines, such as the study of personality and the various areas of Industrial and Organisational Psychology emphasise criteria for healthy adjustment (Bergh 2011).

Please read the definition and importance of well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 221–223.

1.4.2 The impact of work and unemployment on psychological adjustment

The meaning of work can perhaps be best understood by considering the serious consequences for the individual when a long or meaningful interaction and involvement with work or a work situation is severed. Job loss and possible unemployment can be defined as a process of exclusion, through which the individual is defined as a "non-member" of society and the society of workers, with severe consequences for the person, his or her family and society. One form of chosen or compulsory non-work status is retirement, which, if not planned and managed well, may well be described as a process of dying as a result of boredom.

Unemployment affects an individual's sense of self, sense of worth and sense of belonging. It produces high levels of stress, which can be difficult to regulate if the individual experiences a loss of control over their ability to create a meaningful life and provide for their families. The impact on an individual's psychological well-being can be devastating and can lead to psychological disorders such as depression, anxiety, drug and substance abuse, to mention only a few (Bergh 2011).

On the other hand, there are individuals with high levels of resilience who navigate unemployment in a healthy manner and use it as an opportunity to flourish. These individuals often redesign and reconstruct their life goals and end up building satisfying new careers.

Work holds the following advantages to employees (Bergh 2011):

- It is a context from which one draws social support and community feelings.
- It is a source of material rewards necessary for satisfying physical and social needs.
- It may provide a sense of mastery or self-efficiency.
- It is a way of making life predictable.
- It may provide a sense of self-worth through occupational prestige and fulfilment of a culturally valued "breadwinner" role.
- It is a source of social identity, a sense of belonging in the social structure.
- It imparts more meaning to a person's life activities.

- It contributes to the development of problem-solving abilities and general coping powers that increase the ability to adjust successfully to the environment and to life's demands.

Work can, however, also have disadvantages or negative influences and may then contribute to psychological maladjustment through the following factors:

- Unfavourable working circumstances may overwhelm a person, thereby undermining his or her sense of mastery and self-worth (Bergh 2011).
- The work may be demeaning if, for example, the person under-achieves or lacks training or competencies, thereby undermining his or her sense of self-worth and development.
- Overloading may prevent people from completing tasks and from developing problem-solving abilities and coping powers.
- Demanding obedience to unfair authority and amorality (e.g. dishonesty in business) may undermine a person's sense of authority and identity.
- Exhausting work may leave people with little energy to pursue psychological rewards after work.
- Requiring a person to do meaningless tasks gives rise to feelings of cynicism and alienation.
- Some work environments encourage excessive competitiveness and hostility towards others.
- A job that fails to provide adequate material rewards creates chronic financial strain for the individual.

1.5 Self-assessment

Please complete the self-assessment questions entitled “Well-being at work (1.5)” on myUnisa.

1.6 Models for understanding psychological adjustment

There are many models through which psychological adjustment and maladjustment can be understood. Each of these models or lenses helps us to understand psychological adjustment and maladjustment from a different angle. Considering different perspectives enable us to see well-being in a more integrated whole and helps us to appreciate and understand the complexity involved in psychological adjustment and maladjustment.

1.6.1 The disease model

In the disciplines of abnormal psychology and clinical psychology and therapeutic practices, and sometimes in other psychological and human resources management practices, there is a trend towards a negative or pathogenic emphasis in the description of criteria for psychological maladjustment, the classification and description of psychological problems and disorders, the assessment and treatment of these problems (Bergh 2011).

While this is true, you must remember that the negative emphasis represents the study and practice areas of these fields. In most of these fields, too, there is a well-founded body of knowledge of what health and adjustment are, that facilitates the possible study, treatment and management of maladjustment in order to promote a state of positive health and adjustment. This is much the same as with medical doctors who know when a person is healthy, but must attend to symptoms of illness in various ways to restore health. The pathogenic approach, which is apparent in the theory and practices of

certain psychology disciplines such as clinical psychology, psychopathology and therapeutic psychology, originated and is still imbedded in a medical and psychiatric view of illness or disease and its treatment (Bergh 2011).

Please read the disease model in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 223–224.

Please complete the self-assessment questions entitled "The disease model (1.6.2)" on myUnisa.

1.6.2 The positive psychology models

There has recently been a tendency in positive psychology and associated with growth and health psychology, to move away from a negative emphasis on illness, abnormal behaviour or psychopathology towards the positive and health, and towards human strengths and origins or sources of health, which will allow for growth and actualisation of potential (Berg 2011).

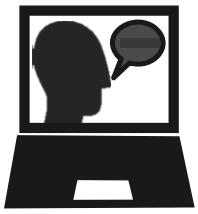
There are various theories in positive psychology that emphasises this positive approach to well-being. In this section, will learn more about the following models:

- the mental health continuum model
- the broaden-and-build model of positive emotions
- the PERMA model of well-being
- meaning models
- a hierarchical model of general psychological well-being

The mental health continuum model

Please read about the mental health continuum model in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Wissing, M, Potgieter, J, Guse, T, Khumalo, T & Nel, L. (2014). *Towards flourishing: contextualising positive psychology*. Pretoria: Van Schaik, chapter 6, 141–146.



Please participate in discussion forum 3, topic 1.

Please complete the self-assessment questions entitled “The mental health continuum model” on myUnisa.

The broaden-and-build model of positive emotions

Please read about the broaden-and-build model of positive emotions in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

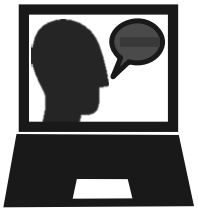
Wissing, M, Potgieter, J, Guse, T, Khumalo, T & Nel, L. (2014). *Towards flourishing: contextualising positive psychology.* Pretoria: Van Schaik, chapter 6, 147–151.

You can watch a video clip where Barbara Frederickson explains the broaden-and-build theory. You can access the link from additional resources on myUnisa.

https://www.youtube.com/watch?v=3DPYlyLUWmY

You can watch a video clip on an exercise to broaden and build positive emotions. You can access the link from additional resources.

https://www.youtube.com/watch?v=sv2h6ERirL8



Please participate in discussion forum 4, topic 1 to 5.

Please complete the self-assessment questions entitled
“The broaden-and-build model of positive emotions” on myUnisa.

The PERMA model

Please read about the PERMS model of well-being in source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Wissing, M, Potgieter, J, Guse, T, Khumalo, T & Nel, L. (2014). *Towards flourishing: Contextualising positive psychology.* Pretoria: Van Schaik, chapter 6, 151–153.

Quietly reflect on the questions in activity box 6.6 in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

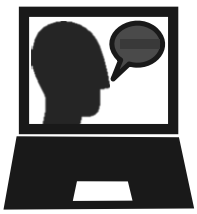
Wissing, M, Potgieter, J, Guse, T, Khumalo, T & Nel, L. (2014). *Towards flourishing: contextualising positive psychology.* Pretoria: Van Schaik, chapter 6, 153.

Please complete the self-assessment questions entitled “The PERMA model” on myUnisa.

The meaning models

Please read about the meaning models in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Wissing, M, Potgieter, J, Guse, T, Khumalo, T & Nel, L. (2014). *Towards flourishing: contextualising positive psychology.* Pretoria: Van Schaik, chapter 6, 153–165.



Please participate in discussion forum 5, topic 1 to 3.

Please complete the self-assessment questions entitled “The meaning model” on myUnisa.

General psychological well-being: A hierarchical model

Please read about the hierarchical model of general psychological well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Wissing, M, Potgieter, J, Guse, T, Khumalo, T & Nel, L. (2014). *Towards flourishing: contextualising positive psychology.* Pretoria: Van Schaik, chapter 6, 165–168.

Please complete the self-assessment questions entitled "A hierarchical model of psychological well-being" on myUnisa.

1.6.3 The applied neurosciences model

Please read about the neuroscience of well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *The neuroscience of well-being*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

1.6.4 African psychology

African psychology is often misunderstood as a focus on only the indigenous psychology of Africans. African psychology, however, includes indigenous African psychology, the needs and experiences of the modern African living in a post-colonial or post-apartheid Africa, as well as the psychology of multi-racial Africans "for whom the land of Africa is their original place of birth and upbringing … In this way, African Psychology is not a psychology of polarization. Rather, its aim is to promote the achievement of human synthesis in a race-less society" (Nwoye, 2015, p. 112–113).

Please read the following section in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

And so, what is African Psychology (see page 103–105)?

Nwoye, A. (2015). What is African Psychology the psychology of? *Theory and Psychology,* 25(1), 96–116.

Please complete the self-assessment questions entitled “What is African psychology?” on myUnisa.

Please read the following section in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Sources of differences between African and Western psychologies (see page 106–107).

Nwoye, A. (2015). What is African Psychology the psychology of? *Theory and Psychology,* 25(1), 96–116.

Please read the following section in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

African psychology: debate about its subject matter (see page 108–109)

Nwoye, A. (2015). What is African Psychology the psychology of? *Theory and Psychology,* 25(1), 96–116.

Please complete the self-assessment questions entitled “African psychology-debate about its subject matter” on myUnisa.

Please read the following section in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

What is African in African psychology? (see page 109–112)

Nwoye, A. (2015). What is African Psychology the psychology of? *Theory and Psychology,* 25(1), 96–116.

Please complete the self-assessment questions entitled “What is African in African psychology” on myUnisa.

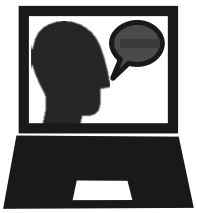
Please read the following section in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

What is African psychology is not? (see page 109–112)

Nwoye, A. (2015). What is African Psychology the psychology of? *Theory and Psychology,* 25(1), 96–116.

Please complete the self-assessment questions entitled "What is African psychology not" on myUnisa.

1.7 Critical reflection: Dicsussion forum



Please participate in discussion forum 6, topic 1 to 4.

1.8 Summary

Psychological adjustment can also be referred to as psychological well-being or psychological health. As you have seen, psychological well-being or psychological adjustment can be viewed and understood from many different lenses. The lense or combination of lenses we use in practice will be determined by the needs and context of the environment in which we would like to make a difference. The different models or lenses are not only different from each other, but in some aspects they overlap and compliment each other. Rather than choosing one view, we should endeavour to integrate the various views and understand the limitations and strengths of each.

LEARNING UNIT 2: Causal factors or aetiology of maladjustment

2.1 Purpose of learning unit 2

The purpose of learning unit 2 is to give you the knowledge to recognise and describe the forces inside and outside the organisation, which may cause or influence psychological adjustment and maladjustment. Through this learning unit, we would like to foster an appreciation for the complexity of causation in psychological adjustment as well as the role of stress.

2.2 Learning outcomes

Explain the causal factors or aetiology of occupational maladjustment through the following:

- Explain the complexity of causation in psychological maladjustment.
- A classification of various types of causal factors is identified and explained.
- Identifying various types of causal factors by examples and applying case studies is demonstrated.
- Stress as an explanatory approach and causal factor in psychological adjustment and health is explained.

2.3 Key concepts

The following key concepts are defined in the glossary tool on myUnisa and are relevant to learning unit 2:

- causation
- necessary cause
- sufficient cause
- contributory cause
- diathesis
- moderating factors
- self-efficacy
- locus of control
- optimism
- coping

2.4 The complexity of causation in psychological well-being

The assessment and identification of the cause-effect relationship in psychological behaviours are not straightforward. Before identifying causes and consequences, or making vague generalisations about all people and circumstances, it is necessary to consider all the factors within people and all the factors in their context of functioning that may be relevant (Bergh 2011).

As you might have observed in various contexts (e.g. your country, organisation, work group, marriage and friendship group) the problems are not always what they appear to be.

A reported or observed problem is often only a symptom or evidence of other, underlying problems, which are not easily detected or reported. A problem person in a workplace, for example, may be merely the "symptom-bearer" of the real problem, and this is perhaps why interventions, such as training, therapy or organisational transformations, may be misdirected in that they do not address the real causes and problems. Causation refers to the underlying reasons for, or origins of human behaviours and not only to the relationship. Causation, and the differences and similarities between people, are mostly explained by genetic and/or environmental determination. Relationships between human behaviours and influencing factors, as in statistical or correlation research, explain only the associations – some significant, some insignificant – between those variables, and we cannot necessarily infer causation of behaviours from them. We cannot, for example, assume that the manifestation of depression in an employee's behaviour is the result of genetic factors, because we know that the person's sister also tends to be depressed sometimes! Too many other factors like environmental events, may influence the onset of depression (Bergh 2011).

Single and multiple determination constitute another issue that often complicates explanations and identification of maladjusted behaviours, and may play a significant role in incorrect diagnoses or labelling. According to the general rules of genetics, people inherit their physical appearance and behaviours (phenotype) more or less equally from each parent's genes. Phenotype is further determined by dominant, recessive or multiple gene combinations from both parents, while specific features, especially certain physical and psychological illnesses, may be transmitted by sex-linked genes and gene mutations or deviations. The same rules can be inferred for environmental influences. Except for the influence of environmental factors on genetic potential, single or multiple environmental factors will have a more or less dominant influence on the origin and maintenance of people's cognitive, social and psychological behaviours. Coupled to the aspect of single and multiple causation of maladjusted behaviours are the following factors (Bergh 2011):

- A **necessary causal** factor refers to conditions or influences that must be present for the onset of a certain psychological disorder. Examples are certain genetic influences, which cause certain physical diseases. Necessary causes are not, however, always clearly evident in psychological disorders and work dysfunctions, and they may not be solely responsible for the manifestation of an illness or maladjustment, because other factors may also contribute. As with psychological disorders, it is also difficult to establish a necessary cause in the onset of work dysfunctions. It is possible to reason that any psychological disorder (e.g. according to the DSM classification) will cause some form of work dysfunction. While this argument has merits, such causes are very broad and generalised. People with severe symptoms of certain psychological conditions (e.g. obsessive-compulsive symptoms) may still be quite effective in performing certain tasks, because the nature of the tasks requires (and masks) such attributes (Bergh 2011).
- A **sufficient cause** is one that will definitely bring about a certain psychological disorder. Thus, work loss, unemployment or any other traumatic event may be a sufficient cause for depression or anxiety-based disorders. Sufficient causes may not, however, be necessary causes, as anxiety and depression may also be caused by many other genetic and environmental factors. A traumatic event might therefore not be the real cause of the problem, but only the triggering mechanism (Bergh 2011).
- **Contributory causes** refer to all the factors that may play a role in increasing the chances that a disorder will develop, although these factors may not be necessary or sufficient causes of the problem. So, for example, a manager who habitually works long hours may suffer psychological burnout: In this case, the working hours constitute a contributory cause. Related to the concept of contributory causes is the concept of diathesis, which refers to factors which may create a predisposition to or the "right conditions" for a psychological disorder to develop. Diathesis may include early influences or contributory influences, which may, however, not necessarily be sufficient to cause the onset of a problem. It may often be an unexpected event shortly before

the onset of a problem that combines with the diathesis to cause the problem. Thus, an employee with a genetic and psychological predisposition to depression (e.g. loss of parents early in life) may become seriously depressed when his wife dies or he loses his job (Bergh 2011).

Linked with the notions of predisposition and diathesis are the moderating influencing factors, which may determine the onset of psychological problems or stress reactions, or which may increase or decrease the seriousness or impact of manifested problems. The following are moderating factors (Bergh 2011):

- The importance of stressors, the number of demands and the duration and proximity of stressors may influence a person's psychological health or illness. Examples are the death of a close member of the family, the day before an examination, job loss, cut in salaries, threats of downsizing and labour unrest (Bergh 2011).
- People's stress appraisal or perception of daily hassles and life events as having meaning, that is, as being irrelevant, relevant or threatening, is an important influence on their reactions or coping behaviours (Bergh 2011).
- People's stress tolerance and internal and external sources of adjustment will also determine how they react to stressors. In this regard, it is particularly important to note how people perceive the stress factors (positive or negative), their internal stress coping techniques (e.g. problem-solving behaviours) and external coping resources in the environment (e.g. social support) (Bergh 2011).

With regard to coping resources, internal personality dispositions, like personal hardiness, optimism, internal locus of control, stamina, self-efficacy, sense of coherence, learnt resourcefulness and self-actualisation serve as moderating, protection or resiliency factors in the relationship between stress, health and illness (Bergh 2011). These dispositions, which are observable in certain traits and behaviours, have in common that people perceive themselves as being in control, or as being meaningfully involved, and determine whether they see events and change positively as a challenge or negatively as a threat. External coping resources include a person's own physical resources, but refer especially to the social support (physical goods, advice, love, empathy) he or she gets from family, friends and colleagues. In contrast, in the disease-prone personality type, certain underlying personality factors appear to be related to or predispose the individual to particular illnesses. Various meta-analyses of disease processes like asthma, headaches, stomach ulcers, cardiac diseases and arthritis indicate that negative emotions like depression, anger, proneness to hostility and negativity are linked to these diseases (Bergh 2011).

Other features in causation are whether causal factors occur early in people's lives or just before the onset of psychological problems. Related to this distinction are factors which have a stress impact over long periods of time (chronic stress), for example a mother's daily hassles with children, drivers' frustrations in traffic jams, or working unhappily for a very long time. Then there are factors which occur seldom but which present an immediate and intense impact and may cause acute stress problems, such as the sudden death of a spouse, divorce and natural disasters (Bergh 2011).

This discussion of the characteristics of causation underlines how important it is for professionals to have the competency to accurately assess the causes of maladjustment. Too often interventions are based on symptoms only, without addressing the real causes.

2.5 Outside forces of work-related well-being

Please read about outside forces of work related well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 228.

2.6 Organisational forces of work-related well-being

Organisational forces of work-related well-being can be understood by looking at the balance between work demands and resources within the social context the individual needs to function in.

Please read about organisational forces of work related well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 228–230.

Psychosocial factors in the work environment:

Employees have important social and interpersonal needs, such as the needs for social support, nurturance, inclusion, belonging or relatedness and to be liked or loved. Apart from employees' individual attributes, employee relationships and general work or labour relations are prominent factors in psychological adjustment and the performance of employees and the organisation (Bergh 2011).

The importance of psychosocial factors lies in the fact that individual employees, with all their unique attributes, usually do tasks in organisations in one or more work or task groups. Many criteria for and symptoms of psychological adjustment are related to relationship problems. In a previous section, I pointed out that problems of bonding or attachment behaviours during earlier development phases may present possible explanations for adult relationship problems. However, differences and conflicts between attributes of individual employees and groups may also cause stress for many employees. Similarly, conflicts between individual employees and groups about work-related issues such as jobs, positions, tasks, responsibilities, decision-making powers, resources, employee benefits and general working conditions are important stress factors, which may relate to many physical and psychological ailments. In transforming societies and companies with multi-cultural work forces, as in South Africa, relationship problems are often quite evident. This issue is recognised in the creation of activities to enhance “cultural learning” between individuals and groups in organisations. Relationship problems may be caused by one or more of the following specific influencing factors (Bergh 2011):

- Incompatibilities of personality (individual differences) may be a constant source of frustration and conflict if they are not managed efficiently. It is for this reason that selection and placement procedures must also consider personality and personal factors in certain contexts, for instance male and female, age groups and the composition of work groups. This does not imply

discrimination relating to any factor, but the rational accommodation of individual differences to be fair to individuals and the organisation. It may also imply the effective management of diversity in groups.

- Different expectations of the employer and employee, for example about work standards and policies, may also result in problems. In fact, this factor necessitates the ongoing revision or rewriting of social contracts stipulating the mutual overt expectations between employees and employers and even other stakeholders.
- Relationships represent an important psychosocial factor in the work situation, and their influence may be seen in the type of interactions between individuals and groups and in the type of social support employees create for themselves or which are encouraged by employers. An important ingredient of effective health promotion in, for instance, EAPs, is the type and quality of social support systems to encourage and maintain changes in health behaviours following certain interventions.
- Supervision represents the buffer between employees and management, which will qualify the type of communication, relationship and trust between employer and employees, as well as between employees and groups. The flexibility of supervision in organisations may represent one of the most important factors in employees' subjective work experience.
- Isolation from colleagues and other groups falls under the social aspects of work design. People are social beings and need inclusion, love and belonging. It is therefore incumbent on employers to ensure that jobs are designed in such a way as to ensure the necessary social contact. Social isolation and deprivation result in psychological uncertainty, anxiety, fear and inefficiency of cognitive, emotional and social skills. In this regard, however, overexposure to social contact is illustrated in the psychological burnout syndrome. In some jobs, burnout may manifest as lack of interpersonal concern and in various ways in contact with people, especially where interpersonal contact is a major part of the job.

Please complete the self-assessment questions entitled “Forces of organisational well-being” on myUnisa.

2.7 Moderators of work-related well-being

Individuals react differently to inside and outside forces of work-related well-being. Some individuals may flourish regardless of an adverse force, while another individual may experience psychological maladjustment or unwellness when confronted by the same force. It is therefore important to acknowledge that the individual also plays a moderating role in work-related well-being.

Please read about the moderators of work-related well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 230–231.

Please complete the self-assessment questions entitled “Moderators of organisational well-being” on myUnisa.

2.8 Stress and physical health as a causal factor of work-related well-being

Stress has a large and pervasive influence on work-related well-being. Section 1.6.3 discusses stress, anxiety and psychophysiology in great detail. Please read through this section again before continuing.

Impact of HIV/AIDS in South Africa:

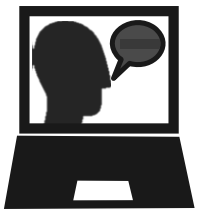
South Africa is experiencing the largest HIV/AIDS epidemic in the world. The slow destruction brought about by HIV/AIDS is going to affect the country adversely in the 21st century by diminishing the future skills pool. People from all walks of life are affected. Loss of professionals, like engineers, doctors, managers, teachers, and lawyers affects service and delivery (Bergh 2011).

Whilst the HIV/AIDS epidemic is affecting people of working age mostly, the number of orphans is also increasing and many of them are leaving school to take care of their younger siblings. The social grants they receive from the government partly make this possible (Rasool & Botha 2011). According to the UN, South Africa is the country with the largest number of HIV infections in the world. The HIV prevalence rate for adults aged 15 to 49 year is at 17,3% (http://www.unicef.org/esaro/5482_HIV_AIDS.html).

It is essential that the business community responds to the threat presented to both economic and societal sustainability by HIV/AIDS. By 2010, a total of 5,5 million people will have died from AIDS in South Africa. The International Labour Organisation (International Labour Conference 2008 as cited in Douglas & Sutherland 2009) points out that the epidemic disproportionately affects people during their most productive years. Douglas and Sutherland (2009) indicate that the sustainability of the market is also at stake; when people get sick they cease to be economically productive and the little disposable income they have is spent on healthcare, with very little left to be spent on products and services. Consequently, the private sector suffers the dual effects of an under-skilled workforce as well as a dwindling market. The business community is uniquely positioned to use its influence, resources, and leadership to challenge stigma, promote prevention, and facilitate treatment. Business has to respond, and a response will demand effective leadership of planned, comprehensive, organisational change initiatives that address HIV/AIDS in the workplace. Many studies have been carried out from the perspectives of medicine and economics.

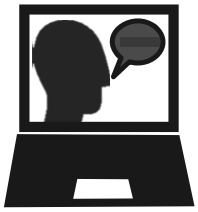
Rispel and Nieuwoudt (2012) conclude that the country’s more recent approach to dealing with the HIV epidemic provides a good example of intersectoral action to overcome the challenges of HIV. This approach includes good government leadership and stewardship; establishment of intersectoral structures and action that unite different stakeholders towards a common purpose; increasing resource allocation to combat the epidemic; capacity building within and outside government; addressing structural drivers (e.g. tackling the pharmaceutical industry to reduce the price of antiretroviral medicines); confronting harmful social norms and individual behaviours (e.g. promoting condom use); and genuine community participation and involvement of people living with HIV/AIDS. The results are evident

from a stabilising epidemic, increasing life expectancy, a vast reduction in mother-to-child-transmission, and a reduction in stigma and discrimination.



Please participate in discussion forum 7, topic 1.

2.9 Critical reflection: Discussion forum



Please participate in discussion forum 7, topic 2 and 3.

2.10 Summary

The cause of psyhcological adjustment or maladjustment is never a simple matter. It is usually a combination of factors inside and outside the organisation as well as the individual's response to these factors. When you are trying to understand why an employee, team or organisation is psychologically well or unwell, it is important to take note of all the factors and influences at play and how they are operating together to result in wellness or dysfunction.

LEARNING UNIT 3: Criteria and classification systems of psychological adjustment and maladjustment

3.1 Purpose of learning unit 3

The purpose of this learning unit is to introduce you to the various classification systems and criteria used for recognising possible disorders and work dysfunctions or symptoms of these, in general and in the work context.

3.2 Learning outcomes

To discuss different classification systems, psychological disorders and work dysfunctions – a classification of psychological disorders and work dysfunctions are provided.

3.3 Key concepts

The following key concepts are defined in the **Glossary** tool on myUnisa and are relevant to learning unit 3:

- physical functioning
- cognitive functioning
- emotional functioning
- social or interpersonal functioning
- moral functioning
- occupational functioning
- DSM 5
- work dysfunction
- mental disorder

3.3.1. General criteria for psychological adjustment

Criteria for mental health refer to standards or characteristics against human behaviour, which are evaluated in order to determine adjustment or maladjustment or to make a specific psychodiagnosis. The criteria for mental health are based on the psychological theory and research and address all areas of human functioning, that is physical, cognitive, psychological, social and moral, and include social and occupational life roles (Bergh 2011).

We prefer to classify the specific factors as physical, cognitive, psychological or emotional, social or interpersonal, moral, work and integrative criteria. Sufficient self-evaluation, openness to experience, contact with reality or appropriateness of responses apply in all these domains and can be related to the well-adjusted person's ability to live a meaningful and integrated life. We also contend that maladjusted behaviours may be distinguished from well-adjusted behaviours by their intensity and the frequency and impairment of people's functioning in their life roles (Bergh 2011).

- **Physical functioning**

Well-adjusted individuals are physically active, healthy and fit. This gives them enough energy and stamina to cope effectively with stress and other physical demands. Such people experience normal physical desires and have the freedom to control and satisfy them. They are realistically aware of their somatic and physical functioning and are able and willing to improve on possible unhealthy physical habits and behaviours (Bergh 2011).

- **Cognitive functioning**

Cognitive abilities are appropriately and optimally used, without undue influence from the emotions. Well-adjusted people experience their world objectively and rationally, whilst also being disciplined yet lenient in thinking and reasoning. Their cognitive appraisals, assessments and judgments of themselves, others and situations are realistic and optimistic, giving them insight into the meaning of life and the solution of problems (Bergh 2011).

- **Emotional functioning**

Well-adjusted people are open, aware and sensitive to their own and other peoples' emotions, feelings and needs, which they can accommodate and verbalise appropriately. They take responsibility for their emotions, which leads to emotional independence, and do not make undue emotional demands, for example, for support and acceptance, on other people and in relationships. A balanced emotional life leads to self-insight and knowledge, which helps these people to form a realistic self-image, with sufficient self-esteem, self-respect and self-acceptance. Emotional maturity and responsibility allow people to accept and understand other people's emotions. These qualities decrease anxiety and lead to eustress, or a positive, pleasant, and facilitating form of stress in which life's demands are appraised as challenges rather than as threats. Such people can experience the fullness of life as they explore and grow, rather than procrastinate or stagnate. An emotionally balanced life is further recognised by sufficient spontaneity and emotionality and adequate feelings of safety, without undue or unrealistic anxiety, fear and other emotional expressions (Bergh 2011).

- **Social or interpersonal functioning**

Based on their own self-acceptance, well-adjusted people show optimistic and unconditional acceptance of and respect towards others, and a preference for quality, in terms of depth and richness, in interpersonal relationships. Their relationships are characterised by responsible, spontaneous, natural and open, genuine behaviour guided by their own feelings. However, these people are also sensitive and considerate in their love of and loyalty to others, although not unduly insecure in attachments. They do not manipulate to get personal or secondary gains at a cost to other parties. Caring behaviours have more or less the following qualities (Bergh 2011):

  - Respect refers to recognition, esteem and regard for the human dignity of other people and their right as free individuals and to unconditional positive care and warmth.
  - Empathy is the ability to be consciously aware of and to feel and understand another person's meaning and deepest feelings from within that person's frame of reference and to communicate this accurately.
  - Honesty (transparency) indicates congruence between what is said and done and the true meaning of communication, without hiding behind various forms of defence mechanisms or facades.
  - Concreteness means that the person makes specific and factual statements rather than vague and general ones.

- **Moral functioning**

Well-adjusted people have a set of integrated values which assist them to decide between right and wrong in the various life roles, and to take responsibility for those decisions. Such moral character reflects some of the following (Bergh 2011):

- commitment to spiritual values
- honesty or congruency, the ability to be oneself, to refrain from hiding behind defence mechanisms and to know oneself so that one can learn to know others
- responsibility, which implies conduct that will benefit both oneself and others

- **Occupational functioning**

Psychologically well-adjusted people are sufficiently involved in their work. All their physical, cognitive, emotional, interpersonal and moral attributes contribute to providing the necessary competencies for successful work performance. More specifically, optimal work performance requires purposefulness, productivity, responsibility, motivation, lenience, initiative, concentration, creativity and optimal time management. People who perform their work best are focused on the immediate demands of the work, but can use past experiences without undue defensiveness and can cope with change. Well-adjusted employees assess and experience their roles in organisations realistically, and are cooperative and lenient towards diverse types of people and their contributions and opinions (Bergh 2011).

- **Personality and behaviour integration**

This category refers to the harmonious overall effect of well-adjusted behaviours from all the previous categories. I would say that well-adjusted people have a global sense of being in control in good and bad times and across time and situations. The following attributes refer to this psychological integration or maturity, which characterises good psychological adjustment and health (Bergh 2011):

- autonomy, which implies the ability to act effectively by means of internal powers (such as needs) without the unnecessary domination of external influences
- sufficient ability to integrate various aspects of the self and the environment
- sufficient self-evaluation to know one's capabilities to do certain things
- sufficient contact with reality
- the ability to learn from experience
- effectiveness, that is instrumental, purposeful behaviour according to set life goals and other objectives in order to realise potential and objectives
- efficiency – the realistic use of energy, acknowledging one's potential and limitations
- appropriateness of behaviour and responses to environmental stimuli, according to or as determined by age.
- flexibility: the ability to use alternative methods and reasoning in applicable and conflict situations; the ability to be open up to and learn from experience
- independence from previous physical and social environments, when needed
- living in the present, which implies the ability to participate wholeheartedly and joyfully in activities of life without unduly acting on the past or entertaining fantasies of the future
- self-confidence, which refers to the individual's confidence in herself as a person, her self-esteem and the validity of her decisions and actions
- self-knowledge, the consciousness that one lives and responds in one's environment and the experience and acceptance of every emotion

- intentionality, the ability to live intentionally because of the aforementioned skills, in other words, to fulfil the requirements of life within the context and in terms of the level of development

3.3.2 General criteria for psychological maladjustment

Although the criteria for adjustment may apply to maladjusted behaviour as a type of opposite, some criteria refer specifically to psychological disorders. This is also the purpose of the DSM, namely to specify diagnostic criteria for particular categories and types of psychological disorders (Bergh 2011). These will be discussed in learning unit 4. Below are general criteria for psychological maladjustment (Bergh 2011):

- Personal disintegration entails the unrealistic needs and constant dysfunction or impairment of abilities. The criteria for maladjustment include more specific criteria, namely feelings of personal inadequacy, lack of self-confidence and feelings of inferiority, poor self-concept, immaturity, general personality disintegration and little self-control.
- Group disintegration is evident from inefficient functioning in the community, and can include social unacceptability, the lack of social skills and social indifference.
- Disorientation refers to unrealistic and inappropriate responses to environmental stimuli and the integration of such behaviour with previous experiences, with the present and with the future.
- Subjective or psychological pain includes symptoms such as discomfort, stress, conflict and unhappiness.
- Irrationality or unpredictability refers to illogical and bizarre behaviour such as incoherent speech, delusions and hallucinations.
- Certain illness or conditions require medical and psychiatric treatment when they impair a person's functioning in occupational and other social roles.

3.3.3 General criteria for work (dys)function

Most of the above criteria are also applicable to the assessment of adjustment or maladjustment of employees. With regard to the impairment of work performance, more general criteria are applicable, within which more specific criteria can be set (Bergh 2011):

- **attitudes towards and observations of one's own personality (self)**, which include positive or negative observation of one's self-image, attitudes towards one's own personality and an understanding of one's identity
- **satisfaction or dissatisfaction with personal growth**, development and self-actualisation, and a low or high level of contentment with life
- levels or **feelings of mastery and efficiency**, which include features such as development, self-actualisation, efficient performance, the exploitation of abilities and the achievement of predetermined objectives

- **integration**, which refers to individuals' ability to realistically assimilate and handle influences from the environment and the spheres in which they act
- **autonomy**, which implies the ability to act effectively by means of internal powers (such as needs) without the unnecessary domination of external influences
- **observation of reality**, which implies the accurate assessment of the external environment, in relation to internal psychological needs
- **interpersonal and social efficiency**, which refers to the establishment of good interpersonal relationships or hostility towards others, as well as the ability to socialise as opposed to social withdrawal
- **general welfare**, which refers to emotional conditions, stress reactions, levels of self-esteem and occupational contentment
- **affective conditions**, which include emotional manifestations such as manic-depressiveness, anxiety, fear, and other emotional reactions
- **physiological conditions**, which refer to physiological responses to a situation, for instance blood pressure and heart rate
- **specific pathological conditions**, both physical and psychological, such as schizophrenia, neuroses and brain damage syndromes
- **adjustment and adaptability**, in other words the ability to meet the demands of the environment in terms of personal capabilities, as opposed to alienation and despair
- **specific criteria**, which include standards defined by the organisation such as satisfactory quantity and quality of production, attendance or absence, personnel turnover, and job satisfaction or dissatisfaction

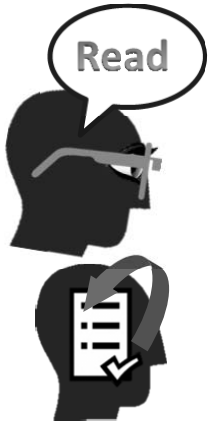
Obviously not all of these criteria are behaviour specific, and the diagnostician has to convert the general characteristics into observable and appropriate behaviour for every person. This is why people who make interactional or behavioural analyses are concerned with the meaning of the behaviour, rather than with the category or symptom attributed to the individual.

Please complete the self-assessment questions entitled “General criteria for psychological adjustment and work dysfunction” on myUnisa.

3.4 Classifications systems for understanding psychological maladjustment

Psychological maladjustment has been classified by the clinical psychology discipline into various psychological disorders in the DSM 5. Lowman (1993) and Sperry (1996) and Campbell and Cellini's (1981) have developed various classification systems for work dysfunctions with the focus on work performance and career development. Guenole (2014) challenges industrial psychologists to recognise the prevalence and impact of maladaptive personality at work. They argue that instead of profiling personality maladaptiveness into categories, a more appropriate approach for the work context would be to look at a maladaptive trait model. Section 3.4 will discuss these systems in more detail.

3.4.1 DSM 5



Please read about the DSM 5 in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *The purpose and structure of the DSM 5*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

Please complete the self-assessment questions entitled "DSM 5" on myUnisa.

3.4.2 Maladaptive personality at work: Alternative DSM-5 model for personality disorders

Please read the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Guenole, N. (2014). Maladaptive personality at work: exploring the darkness. *Industrial and Organisational Psychology,* 7, 85–97.

Please complete the self-assessment questions entitled "Maladaptive personality at work: exploring the darkness" on myUnisa.

3.4.3 Classification system for work dysfunctions

Though the DSM can be put to good use for occupational problems, in contrast to psychopathology, the field of occupational mental health or work adjustment does not yet have an accepted or well-known classification system. Classifications by Lowman (1993) and Sperry (1996) are very useful, particularly because they try to establish the relationships between psychological disorders (DSM) and work dysfunctions. As a matter of fact, one aspect of Lowman's classification is that it sets out to establish whether performance impairment is caused by psychopathology or work-related problems. Such assessment is crucial to intervention design.

Campbell and Cellini's (1981) classification for work dysfunctions is integrative and based on many career development theories and research, and can even accommodate certain aspects of Lowman and Sperry's classifications. Although the DSM does provide a fairly applicable basis for diagnosing some work dysfunctions, many problems still arise. Many employees experience symptoms of psychological disorders which may impair work performance; however, many employees' symptoms do not develop into diagnosable clinical disorders or even severe work dysfunctions (Bergh 2011).

The following classification system is based on an integration of Lowman, Sperry and Campbell and Celini's work and is divided into two sections, namely employee or individual problems and collective or organisational problems (Bergh 2011):

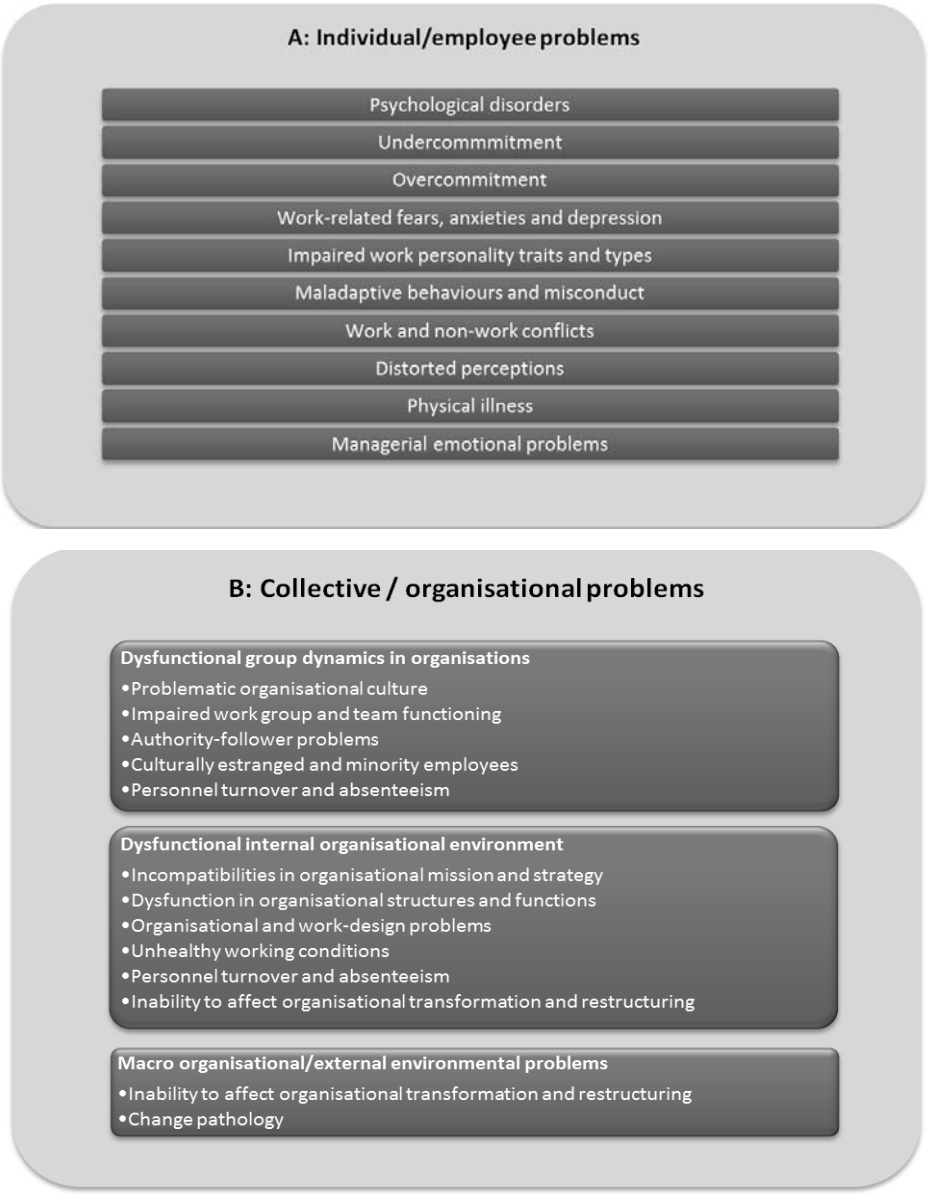
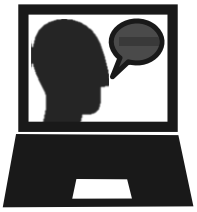


Figure 3.1: Integrated classification of work dysfunction (Bergh 2011)

Please complete the self-assessment questions entitled "Integrated classification system of work dysfunctions" on myUnisa.

3.5 Critical reflection: Discussion forum



Please participate in discussion forum 8, topic 1 to 3.

3.6 Summary

Classification systems are helpful in that it helps us to diagnose and plan interventions in organisations, but mostly because it gives the practitioner a sense of control and orientation. It can, however, also be limiting as psychological disorders and work dysfunctions never present themselves neatly in a categorised package. Psychological disorders and work dysfunctions (employee and organisational) are often a result of a complex dynamic of organisational, personal and environmental factors. The practitioner responsible for well-being needs to understand the various ways in which these factors impact on each other. A strict following of categories and classifications creates a risk that practitioners may end up designing interventions for symptoms instead of uncovering and dealing with the real issues that underlie the symptoms.

LEARNING UNIT 4: Psychological disorders and work dysfunctions

4.1 Purpose of learning unit 4

The purpose of this learning unit is to discuss the psychological disorders most relevant to the work context. The aim is further to discuss specific types of work dysfunctions and help students understand the impact of these on behaviour, work performance and work relationships.

4.2 Learning outcomes

To discuss different classification systems, psychological disorders and work dysfunctions:

- The main diagnostic characteristics of the different types of psychological disorders are described.
- The different types of psychological disorders and work dysfunctions are recognised and described.
- The influence of the symptoms on the impairment of employees, performance, career development and organisational functioning are discussed.
- The relationship between employee work dysfunctions and psychological disorders is explained.

4.3 Key concepts

The following key concepts are defined in the **Glossary** tool on myUnisa and are relevant to learning unit 4:

- comorbidity
- eco-system
- major depressive disorder
- bipolar disorder
- anxiety disorders
- personality disorders
- obsessive compulsive disorders
- trauma

4.4 Psychological disorders according to the DSM 5

Section 3.4.1 discussed the structure and purpose of the DSM 5. In this section we will look at the DSM 5 disorders most relevant to the work context. The discussions will focus on the main characteristics of the disorders and their impact on the work context. Please note that no student may use this information to diagnose any individual. Diagnoses of mental disorders may only be done by registered clinical psychologists. The purpose of these discussions is to sensitise students to the impact that mental disorders have in the workplace.

4.4.1 Bipolar and related disorder

Please read about bipolar disorder in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

4.4.2 Depressive disorders

Please read about depressive disorder in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

4.4.3 Anxiety disorders

Please read about anxiety disorder in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

4.4.4 Obsessive compulsive and related disorders

Please read about obsessive compulsive disorder in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

4.4.5 Trauma-related and stressor-related disorders

Please read about trauma-related and stressor-related disorders in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work disorders*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

4.4.6 Substance-related and addictive disorders

Please read the documents below. Download the documents from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

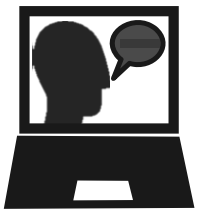
Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 241–242.

4.4.7 Personality disorders

Please read about personality disorder in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Psychological disorders and work*. Psychological adjustment in the work context course notes. Pretoria: Unisa.

4.4.8 The effects of mental disorders in the workplace



Please participate in discussion forum 9, topic 1.

Please read about the physical, psychological and behavioural effects of (un)well-being and work outcomes in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 231–232.

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=aX7jnVXXG5o&index=29&list=PL8dPuuaLjXtOPRKzVLY0jJY-uHOH9KVU6

Depressive and bipolar disorder: Crash Course Psychology #30

https://www.youtube.com/watch?v=ZwMlHkWKDwM&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

4.5 Work dysfunctions

In section 3.4.3, an integrated classification system for work dysfunctions were provided. The most relevant forms of individual and organisational work dysfunctions will be discussed here. Please note that these dysfunctions or occupational challenges relate indirectly to various categories of the integrated classification system for work dysfunctions. For the purpose of this module, it is not necessary for the student to attribute a particular dysfunction to the categories discussed in 3.4.3.

4.5.1 Burnout

Please read the section "Preventing stress and burnout, and promoting well-being" in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 232–234.

4.5.2 Career development challenges

Please read about career development and well-being in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Venter, J. (2016). *Career development and well-being*. Psychological adjustment in the work context course notes. Pretoria: Unisa

4.5.3 Absenteeism

Please read the section "Absenteeism" in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 1, 235–236.

4.5.4 Presenteeism

Please read the section "Presenteeism" in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 236–237.

4.5.5 Theft

Please read the section "Theft" in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational Psychology*. New York: Routledge, chapter 13, 237–238.

4.5.6 Sexual harassment

Please read the section "Sexual harassment" in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

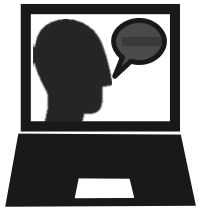
Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 238–239.

4.5.7 Bullying

Please read the section "Bullying" in the source below. Download the document from the e-reserves. Please refer to Tutorial Letter 101 for instructions on how to download the files.

Rothman, I & Cooper, L. (2015). *Work and organizational psychology*. New York: Routledge, chapter 13, 239–240.

4.6 Critical reflection: Discussion forums



Please participate in discussion forum 9, topic 2.

4.7 Summary

Mental disorders and work dysfunctions affect not only individual performance at work, but also impacts on team performance, innovation and creativity and on the quality of relationships with colleagues and customers. It is important to remember that emotional, behavioural and physical problems at work cannot merely be categorised by ticking the boxes of a particular work dysfunction or mental illness. Such a narrow-minded approach would inevitably lead to bias and unfair discrimination. Rather, the wellness practitioner should be curious to understand the contextual, psycho-social, organisational, cultural and uniquely individual factors around the behaviours, experiences and emotions of employees and managers. It is important to maintain an eco-systemic view of psychological adjustment.

LEARNING UNIT 5: Creating healthy organisations

5.1 Purpose of learning unit 5

The purpose of this learning unit is to help the student gain insight and knowledge in the methods that can be used to create healthy or positive organisations. This learning unit also explains how to deal with an organisation that is unhealthy or toxic. Whereas learning unit 3 and 4 focused on the possible psychological maladjustments (individual and organisational), learning unit 5 focuses on the flourishing organisation, and the building blocks and processes involved in positive organisations.

5.2 Learning outcomes

To discuss strategies and methods of occupational health promotion:

- Aspects related to the planning and implementation of employee and organisational health initiatives are explained.
- Types of health promotion programmes and service delivery systems are differentiated and explained.
- The various levels of intervention in health promotion activities are identified and described.
- The importance, use and abuse of ethical issues in occupational health promotion are critically evaluated and illustrated.
- An understanding of the implications of change in the modern workplace by also giving examples is demonstrated.

5.3 Key concepts

The following key concepts are defined in the **Glossary** tool on myUnisa and are relevant to learning unit 5:

- positive institutions
- psychological capital
- self-determination
- appreciative inquiry
- authentic leadership
- autonomy coaching
- flourishing
- intrinsic task characteristics
- organisational citizenship behaviour
- positive leadership
- psychological availability

5.4 Employee assistance programmes

The purpose of both EAPs and HPPs is to improve occupational health, although there are some differences in their service delivery. Some groups, like unionists, claim that both types of programmes are management-driven and social control mechanisms and frustrate union aspirations and activities. Employers, on the other hand, claim that initiatives such as EAPs and HPPs provide a means of employee development. To avoid negative connotations, unions prefer to refer to EAPs as member assistance programmes (MAPs), in which the interests of union members and employees are emphasised. If both EAPs and HPPs are comprehensive health improvement programmes, what are the differences between the two types of programmes (Bergh 2011)?

- Traditionally HPPs emphasise primary prevention and include various educational and screening activities to change employee behaviours and improve corporate practices that are conducive to employee and organisational health, and to reduce health-related risks and employee health problems that may impact on employee work performance and organisational productivity, (Bergh 2011).
- HPPs also emphasise the types of programmes or programme technologies that subscribe to the basic objective or philosophy employees should adopt to maintain new and more positive health behaviours and life styles. HPPs may promote good health by influencing employee attitudes and behaviours through training in health-related issues and designing work environments optimally. From a problem prevention perspective and a health promotion view, HPPs may typically include activities such as stress management training, AIDS education, nutrition and exercise programmes (e.g. weight control), and blood pressure and cholesterol screening. This is in support of and is supported by positive human resource attitudes to and regard for employees, and the usual human resource functions, including various training programmes (Bergh 2011).
- The purpose of EAPs, on the other hand, is tertiary prevention or identifying and treating, curing or managing existing problems, such as substance abuse, psychological and physical illness and other personal problems that affect employee work performance and organisational productivity. The idea is to improve the troubled employee's chances of recuperating and remaining employed. These programmes are typically job-based programmes in which employers provide troubled employees with the necessary counselling and other services and facilities to overcome their problems (Bergh 2011).
- Modern EAPs provide employees with multiple internal and external services covering many issues and problems in their personal and work lives. From a curative and prevention perspective, EAPs typically include various treatment programmes, for instance for substance abuse, and injuries and illness as a result of pollution and toxic substances. Other activities, which often relate to policies and procedures, are programme policies and procedures, negotiation procedures and grievance handling, education on and training in the use of the EAP and supervisory consultation (Bergh 2011).

It is, however, not always easy to differentiate clearly between types of services offered by EAPs and HPPs. I believe that an unnecessary and confusing differentiation is often made between curative, preventive and promotional activities. If these three types of activities are directed at improving occupational health and psychological adjustment, they all really refer to health promotion! This point is supported by difficulties in defining or differentiating between healthy and unhealthy behaviours or conditions, and in evaluating programme effectiveness in each instance. Furthermore, modern EAPs may

also include health improvement activities on more than one level, for instance prevention, cure and promotion (Bergh 2011). Similarly, HPPs may also offer curative services. In practice, therefore, these two approaches may be represented by separate activities and services in one employee well-being programme. Both approaches have the objective of health improvement, HPPs through early prevention and interventions through health-related training and information, and EAPs through treating presenting problems as early as possible. HPP activities may be less concerned about confidentiality and more profit-oriented and strive to keep all parties well informed so that they use their services optimally. EAPs, on the other hand, may be more aware of confidentiality because troubled employees who are referred and treated through in-house or contracted services want to keep their work record clean. EAP services are also less concerned about cost effectiveness and profits, especially if they are provided as in-house services (Bergh 2011).

EAPs probably provide the best current example of comprehensive health promotion programmes in the workplace which, as part of employee well-being initiatives, aim to provide employees and even their relatives and management with multiple health and counselling services to deal more effectively with personal, social and work-related problems. EAPs may include very specific health-related services and facilities in and outside organisations. They may also provide other macro-services, which deal with employees in the context of their external environments and broader community programmes (Bergh 2011).

It becomes obvious that effective work-site health promotion involves not only employee health, but also the health of organisations and society at large. It is therefore also essential that all parties should be involved in the planning, design, implementation and maintenance of health promotion initiatives. More and more companies are providing health promotion services, either internally or with other companies and external providers, which gives more employees access to diverse facilities. As comprehensive health promotion facilities, EAPs are quite diversified and may mean different things to different people. You may find differences in the type of services and therefore the type of professionals and clients in different EAPs. Some functions in organisations, for instance specific training programmes, may be related to certain health-promoting services which EAPs provide. In fact, as observed elsewhere, all functions in organisations should contribute to the optimal psychological adjustment of employees and their health in general (Bergh 2011).

5.4.1 Types of EAP programmes

During the planning and design of health promotion programmes, an important decision is what types of services will be offered and for whom services will be provided. EAPs or HPPs may be full-service programmes or limited service or utilisation programmes, a combination of the latter programmes or a referral and information service programme only (Bergh 2011).

Full-service programmes have some of the following attributes: comprehensive facilities, services and activities for health and employee assistance; provision of services for all types of problems; internal and external services aimed at cure, prevention and promotion, which are available to all employees, their dependants and retired employees; programmes that are community health oriented, with few or no costs involved for participants, unlimited usage, round-the-clock availability and referrals by various persons, but voluntary and confidential; as well as available follow-up services; training for supervisors, professionals and orientation for employees (Bergh 2011).

Limited service programmes may offer only certain internal and/or external services – offered as managerial tools to provide some services only or to obtain certain outcomes – and include substance

abuse treatment, disciplinary methods – possibly free of charge for some services only –, referrals mostly by supervisors, services that may be for employees only or are aimed at problem solving and productivity improvement. Information and referral services are services through which employees are referred to external services and no follow-up inquiries are made (Bergh 2011).

In-house programmes

In-house programmes are used in many types of organisations. These programmes are generally attached to the HR department of an organisation as a separate section or to the health and well-being functions of the organisation. Such programmes are best suited to large, centralised organisations. In-house EAPs have the advantages of a centralised location and management, quicker and more direct service to clients, quick and direct availability of necessary information and staff and professionals who know and have quick access to the organisation's culture and possible transformations and changes. Disadvantages are related to ethical issues, like confidentiality and the fact that EAP counsellors are known to many employees, which may influence the trust relationships in organisations (Bergh 2011).

In-house EAP practitioners and counsellors and their clients may experience some of the same organisational stressors, for example poor business performances and downsizing, which may influence the counselling relationship, commitment and objectivity. If employees and management are in disagreement on issues, this may also reflect negatively on the EAP, especially if the EAP is viewed as a managerial control over employees. The fact that EAP managers or coordinators also tend to form part of management and of their acceptance of certain managerial values, like profit making, which favour the organisation, may also jeopardise their EAP roles in participation and management. In-house programmes are also non-profit programmes and therefore expensive for the employer, while limited budgets may necessitate a limited and labour-intensive programme and a small number of EAP staff, which might result in multiple roles for EAP counsellors and cause slow service delivery to employees (Bergh 2011).

External or contract-based models

In these types of programmes the management of an EAP may be shared with external parties or an outside party may provide management and professional fee-based services. Such models are practical for small companies or geographically decentralised organisations that want to offer health promotion services to all employees. A big advantage for the organisation is that the contracting EAP firm or consultant must function as an independent business with all the associated responsibilities: staffing, budgeting, managing, marketing, training of staff, maintaining client and financial records and keeping the EAP or HPP viable and competitive in the market. Contracted EAP services vary in nature, but may consist of a package of services on different need levels on a price per capita basis and an annual fee per employee, regardless of employees' use of the services. Services may include all the usual EAP health-related services and activities, additional health-related services, and services like management and staff assistance programmes, including organisational development, management counselling, staff training, assessment services and EAP effectiveness training for managers in order to assess the programmes and do quality and cost control on contracted EAP services (Bergh 2011).

Contracted programmes may be more expensive than in-house programmes, but may provide a very broad service. Some programmes, however, provide very specific services and are not always closely attuned to the needs and culture of an organisation. These factors may influence the visibility and credibility of an EAP, but contracted services may have confidentiality advantages. For instance, services may be offered away from the work site by counsellors and practitioners not known to employees. Larger external providers of EAP and HPP services may also be able to offer qualified health practitioners,

counsellors and coordinators (managers) more integration and specialisation, as well as more variety with regard to their own development and the type of work they do (Bergh 2011).

Contracted EAP services may be more expensive than in-house programmes, but many organisations view EAPs and HPPs as profit enhancing. Companies are tending more and more to use health-care providers for the profits they deliver, whilst external providers of health care themselves are becoming bigger and more sophisticated. However, the costs involved in using external EAP or HPP contractors and their being distanced from the employee and organisation are factors that will re-energise the use of smaller in-house health-care and health promotion facilities (Bergh 2011).

Union-based EAP or HPP models

Because of resistance to corporate and in-house EAPs and in deference to union members, EAPs are sometimes referred to as member assistance programmes (MAPS). In many cases, unions form part of the EAP management. MAPS and EAPs offer similar types of services, but differ in their underlying policies and political philosophy. An important feature of MAPS is union opposition to EAPs (Bergh 2011):

- Unions believe that corporate or business management uses EAPs to enhance its own profits, while demanding more work for less pay from employees, and also to counter unionisation.
- Union management of EAPs may have advantages, such as negotiating and catering for more on-site health and other services. It may also demand that EAP services be provided on a non-profit basis and emphasise health care as an employee right, and a compulsory responsibility of management. Such attitudes, even if health professionals support them, may influence health-care relationships negatively, and are also very expensive to employers.

Depending on the vitality and membership strength of unions, MAPS may be very small or very large. However, because of the often ambiguous nature of unions in many societies or the dwindling political and financial power of unions, MAPS tend not to be used, are very small or have been terminated. In South Africa, however, unions are often an important part of EAP management (Bergh 2011).

Combined or blended EAP and HPP models

In many instances, EAP and HPP services are provided and managed by various combinations of in-house, union-based and externally contracted services. Companies may provide some in-house services for parts of the work force and use contracting services for more decentralised sections. In other cases, employees may benefit from internal, external and union-based services. Some companies may provide in-house services, while also contracting their own services out to other companies. Although blended models offer the advantage of more services, they may pose problems in integrating services and management, often due to differing policies and competition (Bergh 2011).

A special example of combined health promotion services is the use of consortiums in which a number of companies share facilities, services, staff and management. Although this option is attractive because duplication of many aspects can be avoided, it also poses problems due to lack of integration, opposition, differences in policies and competition between companies. The emergence of external health service providers, which are mostly profit-based, also makes consortiums more unlikely (Bergh 2011).

5.4.2 Needs analysis

For effective health promotion in organisations, it is essential to determine the outcomes or the types of services which are needed. This is best achieved by accurate organisational diagnostic assessments to establish the health promotion needs of the organisation, specific groups, individual employees and even related social or community needs. The assessment of health promotion needs by various methods may focus on the following (Bergh 2011):

- health mission statements and related values and goals
- existing occupational health promotion structure
- budget and other restraints on health promotion
- employee and organisational health needs and priorities
- roles of HR functions in health promotion
- policies on health promotion
- existing interventions and health promotion activities
- recruitment and referral procedures for staff and clients
- types of problems, for example sickness, absence or other problems
- perceptions about the nature of work in the organisation
- existing and expected training needs with regard to health promotion.

Health promotion in organisations must be aimed at achieving certain outcomes with various types of employees, problems or objectives. Levels of health promotion interventions can be considered from various perspectives, of which the following represent some of the approaches or issues. Another way to establish the needs for health promotion in organisations and how to intervene is to assess possible causes of presenting problems and the types of presenting problems. Table 5.1 lists some problems and activities handled in EAP's in general. This also emphasises the need for effective and accurate assessment techniques in organisations, not only to diagnose problems but also to identify individual and organisational performance gaps, which might indicate possible problems (Bergh 2011).

Lists such as the one in table 5.1 tend to verify the fact that EAPs might still tend to give more weight to the management of the physical well-being of employees. If we know the types of needs in organisations, planning can be done purposefully with regard to the type of programmes, activities, facilities and qualified professionals required to address such needs (Bergh 2011).

Problems and activities handled in EAPs in general
Health status assessments, report systems
Physical fitness/exercise deficiencies
Smoking
Alcohol and drug abuse
Nutrition
Medical self-care
Sexually transmitted diseases and AIDS education
Blood pressure and cholesterol
Health and safety
Non-work events, e.g. accidents
Weight control
Stress management
Psychological or mental health problems
Family-related and marriage problems
Cross-cultural counselling
Legal and financial problems
A medical aid scheme
Attitudinal problems, e.g. work performance, lateness
Maternity benefits
Career counselling services
Therapeutic and social work services
Problems and activities handled in EAPs in general

Table 5.1: Problems and activities handled in EAPs in general (Bergh 2011)

Another approach is to determine the type of intervention (activities, services, facilities, etc) which is necessary for an organisation to address behaviour change.

Behaviour change	Activities	Expected outcomes
Awareness	Health promotion activities, training information, e.g. newsletters, films	Change/improve attitudes/ intentions
Motivation	Assessments, specific training, orientation, self-development	Changed/improved commitment/ involvement
Behaviour change	Competency/knowledge-based training to change smoking, stress, fitness, nutrition behaviours, etc.	Behaviour change to strengthen attitudes and commitment
Maintenance	Activities to improve environmental support, e.g. support groups, follow-up activities	Enhanced self-efficacy
Cultural/cross-cultural change	Activities to influence attitudes, values and norms, e.g. team building, cross-cultural counselling, interpersonal feedback, creative thinking incentives	Change of culture, cultural sensitivity, climate and norms

Table 5.2: Health promotion according to levels of behaviour change (Bergh 2011).

Column 1 indicates the health promotion levels, which must be assessed accurately in order to use certain activities to achieve expected outcomes. These levels also represent a progressive level of behaviour change, which employers want to strengthen and maintain. These levels do not only relate to various progressive levels of behaviour change, but may also differentiate between levels of employees, for instance labourers, blue-collar and white-collar workers and managerial levels. These levels obviously also relate to the types of causes of work dysfunctions, existing services, facilities and resources and the types of presenting problems (Bergh 2011).

In general, it seems that organisations are quite successful in bringing about awareness, motivation and behavioural change, but often miss out the activities for the more advanced levels of maintenance and cultural change, such as organisational change exercises and relapse control. Possible solutions to these problems may be the following strategies (Bergh 2011):

- Existing organisational and human resource development functions, including selection, training and managerial practices, should form part of additional health prevention and health promotion programmes. If such practices enhance desired knowledge, skills and attitudes in employees, they will create a culture and attitude favouring being healthy in the workplace. Examples are selecting the right people for the right jobs, training in self-assertiveness, effective interpersonal communication, creative thinking, problem solving and the ability to manage change and diversity.
- Managerial support for all aspects of health promotion programmes should be ensured.
- Follow-up activities or relapse prevention need to be ensured by supporting employees and groups after the initial activities to strengthen their feelings of self-control and self-efficiency and to enable them to practise self-management of their health status at work.
- Although the responsibility for occupational health promotion is primarily an organisational responsibility, health promotion programmes must be planned, marketed, implemented and managed in consultation and collaboration with employees or their representatives, for example unions. If mutual ownership of work-site health promotion is encouraged, a win-win situation

will be created, which will ensure better health and improved quality of work life for employees, while both employees and employers will benefit from improved work performance and lower ill-health prevention costs. Too often there is mistrust between employers, employees and their unions with regard to the credentials of EAPs and other health promotion programmes.

- The manner in which employees and managers or supervisors support and manage health promotion initiatives can form part of an organisation's performance appraisal or development system. If health attitudes and behaviours are part of doing one's job and part of a health culture in organisations, such performance criteria should be accepted by employees.

Such criteria should, however, also be realistic. For instance, employees must have control of their own health and work events, which may impact on their occupational health. Health-promoting services, activities and facilities must exist in organisations and employees must have access to such facilities. Such a strategy will also require accurate and ongoing marketing of health promotion services, and communication and feedback on health policies and the health status of employees and the organisation. The health promotion needs of individuals, groups and the organisation will often be similar, but are often also very different and can be associated with the change levels in table 5.2.

Corporate support, through its vision, mission and related values, is the single most important determinant of the effectiveness of health promotion planning, implementation and maintenance. The mission statements and related values will determine all other factors in health promotion programme planning, such as the processes to be followed (phases and levels of implementation, communication processes), contents (programme components and methods of behaviour change) and the context, that is, factors inside and outside the organisation that may influence the implementation and maintenance of the programme (Bergh 2011).

5.4.3 Design aspects

Building on the needs analysis, the programme design will be determined many issues, the most important being the objectives of the health promotion activities, the levels of intervention and the types of participants. In addition to the issues illustrated in tables 5.1 and 5.2, the following issues must be considered in more detail (Bergh 2011):

- Objectives, that is, the levels of desired changes that the programme activities must achieve.
- The importance or intensity of desired activities and outcomes.
- The programme's themes or topics.
- The programme's location in the organisational structure and associations with other functions in HR and the organisation.
- Available funding for design purposes.
- Allocation of tasks to internal or contracted or external designers or developers of programme content.
- Users of the programme, such as special groups, and some or all employees.
- Development of health-related policies and procedures, for example on sickness, absence, substance abuse and referrals.
- Development of staff support systems (e.g. counselling, training, support groups)

- The criteria and methods to evaluate programme effectiveness to be determined during the programme design.
- The programme's schedule for implementation and presentation. The contents of activities, for example information, assignments, training courses and other change practices, must be designed to achieve the established outcomes, but where necessary must be adaptable to possible changes in the health promotion needs at the different levels.

5.4.4 Implementation

Programme implementation and maintenance can be viewed as separate functions and actually constitute the ongoing management of health promotion in organisations. Programme implementation is, however, also part of the planning and design stage because this stage determines most aspects of implementation, involving the following (Bergh 2011):

- orientation and training programmes for users and staff
- implementation of the total programme or certain elements only; implementation at certain stages or times and venues for certain groups only
- ongoing marketing or promotion and dissemination of information on the health promotion programme
- daily operating and monitoring of programme schedules, registrations and presentations to ensure that the programme achieves its strategies and objectives
- effectiveness evaluation of the programme or of elements of the programme
- audits on effectiveness of various aspects of health programme, including behavioural changes, costs, implementation, management processes
- follow-up on and revision of various programme aspects based on the evaluation feedback

Some of the aspects of administration or implementation and maintenance have already been addressed in previous sections. The planning aspects are paramount, especially an organisation's mission and policy statements on health matters, because these have a significant influence on components of a health promotion programme. The needs analysis, which is part of the planning process, is as important because the health needs of employees and organisations determine the outcomes, the levels at which behaviour must be influenced and changed, and the types of interventions, actions or programmes. Other elements of health promotion programme implementation are policies and procedures, marketing of services and the evaluation of programme effectiveness (Bergh 2011).

We have referred to management's mission statements, which will emphasise key values and direct decision making on health promotion in organisations. Programme managers or coordinators also have to make more specific policy on and procedural decisions about the ongoing or daily operation of a health promotion programme. The needs assessment should furnish data on things such as the types of voluntary and involuntary services provided, types of problems to be addressed, types of professional personnel and other staff involved, and aspects related to the location of services and funding. An important policy statement that needs to be made to gain employee trust is on how treatment or participation in a health promotion programme will impact on work performance and performance appraisals. The roles of supervisors and line managers in managing employee participation should be clear. Decisions must also be made on how programmes will be implemented (e.g. in phases) and how

health promotion activities will integrate with existing human resources and other organisational functions, facilities and resources (Bergh 2011).

For effective programme administration and management, a complete list of administrative and professional responsibilities, practices and activities must be established and adhered to. Administrative and professional efficiency and client confidentiality, for instance, requires specific procedures for referrals, making of appointments, fees (if any) and record keeping (Bergh 2011).

With regard to policy and procedures, the issue of referral is crucial as a responsibility of both the employee and other parties, like supervisors. It must be decided who is eligible to make referrals and the people concerned must be empowered and trained. Referral processes, including steps preceding referral, record keeping, who must be informed, whether referrals are filed in personnel records, and whether referrals are part of performance assessment criteria, must also be determined. Similar considerations apply to treatment processes, for example it must be decided what happens to therapeutic progress notes. Health issues at work can be very sensitive, especially for troubled employees or even employees who are compelled to participate in health promotion activities. The type of referral also determines the perceived sense of confidentiality that users of health promotion activities may have about such activities. Troubled employees and other users, whether they are compelled to participate or whether they participate out of their own choice, do not wish to have their status as “good” employees dented in any way. Referral, as an intake function for health promotion programmes, can be based on self-referral, when employees willingly acknowledge their problems, or want to look after their health and take curative, preventive or health promotional steps. Management referrals include referrals for treatment or participation in activities by management, supervisors and health practitioners or other involved parties, like external consultants and health providers (Bergh 2011).

Although confidentiality will always be an important issue, especially for troubled employees, we believe that the change in health management from a curative only emphasis to promotion of health will enhance self-referrals, even for troubled or stressed employees. Self-referrals need not lessen the impact and efficiency of health-improving activities, as long as employees are informed about the relevant policies and procedures. Part of self-referrals must also be empowering employees to be involved, informed and self-responsible when it comes to self-referrals (Bergh 2011).

An essential aspect of referral, whether managerial or self-referring, besides the necessary confidentiality, is quick and purposeful service for employees with health-related needs. You may do well to structure a checklist to assess whether your organisation's policies on and procedures for the daily operation or functioning of health promotion services are in place (Bergh 2011).

5.4.5 Maintenance

Occupational health promotion programmes must be well planned in order to be well designed, implemented, managed and maintained. The effective management of a health promotion programme requires all the managerial roles of planning, organising, delegating, coordinating, implementing and maintenance. These managerial functions are applicable to all the main components of employee and corporate health promotion, namely HR management, actual management of the programme, marketing of programme services, financial control and budgeting, and management of facilities and equipment. The competencies necessary for the successful management of health promotion programmes like an EAP are also required. These managerial functions are involved in the planning, design or development, implementation and maintenance of health promotion programmes (Bergh 2011):

- **Human resource management**

HR management involves the effective utilisation of all staff in health promotion programmes. This will include human resource planning such as the human resource needs for the programme, which will be determined by the programme objectives, which in turn will indicate the types of professional and administrative staff needed. To be able to recruit, select, utilise, develop and train and evaluate programme staff efficiently, it will also be necessary to establish job descriptions and responsibilities for all staffing types and levels (Bergh 2011).

- **Ongoing programme management**

Ongoing programme management refers to all the processes involved in the effective planning, design and daily running and maintenance of programme activities aimed at ensuring that health promotion is responsive to employee, corporate and environmental demands. It includes aspects such as programme planning, which includes the health promotion mission and values, goals and objectives of the programme, needs and priorities, types of programme activities and programme schedules. Programme management also entails the organisation and coordination of staff and their tasks, the promotion of programme activities and the implementation, maintenance and evaluation of programme strategies and various activities (Bergh 2011).

- **Health programme marketing management**

Health programme marketing management has to do with the strategies and activities to be used to communicate various aspects of health promotion to all interested parties, that is, to ensure that what is provided is what employees want. Marketing management attends to all the issues involved in planning and developing health activities, services and facilities for certain people or groups and in keeping people informed about all programme aspects. More specifically, marketing management does research on needs in possible or available market or consumer populations or segments (e.g. the employees and their dependants, corporate health needs and community needs), types of activities and facilities and how to promote and provide these services – where, when and at what price, if applicable (Bergh 2011).

- **Marketing health promotion programmes**

Ongoing marketing of health services may differ for in-house and externally based or contracted programmes, but must be done in various ways which are best suited to the organisation, its employees and their dependants. The success and efficiency of employee and organisational health promotion will, however, be determined by how well all parties are informed on an ongoing basis about and encouraged to support and participate in health promotion activities (Bergh 2011).

Everyone should also be informed about how to get access to internal and external health promotion interventions. It is insufficient to let employees know about health-related services without also keeping them informed about developments and achievements and encouraging them to participate and maintain health behaviours. Similarly, supervisors or special health advisors and other health practitioners in organisations must be well trained to empower them in their roles and to enable them to distinguish between matters like referral, reporting, advising, counselling, consulting and diagnosing problems, the latter being a competency of a trained professional health specialist and not of a lay person (Bergh 2011).

In profit-making health promotion programmes, marketing may also have a sales slant. However, the marketing of any health promotion programme should always inform possible consumers or users about the reasons for and advantages of participating, types of services and how work-site health promotion involves employees' families and other environmental aspects (Bergh 2011).

- **Financial and budget management**

Financial and budget management includes the projection of all costs involved, the effective allocation of funds where and when necessary, financial record keeping, audits of cost effectiveness of health promotion programmes, that is, whether the outcomes and impact of health promotion are justifiable in comparison with the costs, considering budget growth and reporting on budgets (Bergh 2011).

- **Equipment and facility management**

Equipment and facility management involves looking after all programme materials, facilities (e.g. gymnasiums and clinics) and equipment (e.g. diagnostic and training equipment) and business machines such as comprised systems. Equipment and facilities must be planned and the use and control of facilities and equipment must be spelled out in policies and procedures. The use of equipment and facilities must also be coordinated and implemented for specific purposes by well-trained staff. Facilities and equipment should be continuously evaluated for their effectiveness with regard to the programme's objectives (Bergh 2011).

These managerial processes involved in health promotion in organisations imply certain criteria for effective employee and corporate health promotion and these criteria are highlighted in the next activity (Bergh 2011).

- **Evaluation of health promotion outcomes**

It is unscientific and aimless not to evaluate the effectiveness of health promotion programmes and even of specific activities, services and facilities. Failure to evaluate such programmes means costs are not controlled and outcomes are left to chance. Employers who have clear criteria for health outcomes and a broad database on health and cost matters will have a significant strategic and cost advantage over those who apply health promotion activities haphazardly. Accurate outcomes-based assessment of health and mental health services is important for revising and maintaining health services. There are various types of effectiveness evaluation for health promotion programmes, just as there are for training and other interventions in organisations (Bergh 2011).

Process evaluation of programme effectiveness includes reviewing the quality and functioning of programme strategies and objectives, procedures and methods, materials and facilities. Impact evaluation of programme effectiveness has to do with assessing whether interventions have brought about changes at various levels and for various needs. This may include the measurement of health-related attitudes, values, culture, behaviours and improvement of knowledge and skills. Outcome evaluation of programme effectiveness entails measuring specific benefits or gains for the employee and organisation. Benefits refer mainly to hard data like medical evidence of health improvement (e.g. lower cholesterol levels, weight loss, cessation of smoking, improved fitness, improved performance and productivity, fewer accidents and deaths, lower absenteeism and personnel turnover, lower illness-related and health promotion costs, and business profits) (Bergh 2011).

Programme effectiveness evaluations at the different levels are only possible if good data collection and record-keeping systems are part and parcel of the ongoing operation of health promotion programmes. The ongoing evaluation of the effectiveness of health promotion programmes should be as important a managerial function as their planning and development (Bergh 2011).

The emphasis is, however, often on budget or cost effectiveness only, especially if health promotion programmes are profit oriented. If the key values of an organisation's health promotion mission are based on human capital rather than on financial gain, it will also be essential to assess whether programmes and

specific interventions are meeting their specified needs and outcomes in terms of managing employee and organisational adjustment and health problems (Bergh 2011).

Assessment criteria, procedures and methods should in fact be in place at the planning and development stages of health promotion programmes. The possible costs of evaluation procedures, as part of the budget of these programmes, should also be considered in the initial and ongoing budgets. Effectiveness evaluations and analysis of health promotion programmes should preferably be coupled with the administrative and computer systems to ensure reliable and complete data and progress reports. We previously mentioned different types of evaluations and criteria, which we now look at in greater detail (Bergh 2011):

- cost-effectiveness, which could be linked to budget restraints or to expected financial goals and even to the specific financial performance of activities and staff
- the ratio between the costs of planning, development, implementing and maintaining health promotion programmes, and the financial gains from improved employee performance and organisational productivity, in other words improved occupational health status of employees and the organisation
- the ratio between the costs of treating referred problems or health promotion activities and outcomes, for instance improved work performance of employees or groups, improved attendance figures and lower personnel turnover, the latter also reflecting in lower re-employment and training costs
- the ratio between cost of treatment of referred and relapse cases
- the costs of remuneration packages for programme staff and the financial and other outcomes of the programme
- the ratio between programme costs and the attendance figures for specific activities or programmes or total attendance
- follow-up needs analysis by various methods, that is to see whether the various identified outcome levels have been reached and specific needs of employees, groups and the organisation have been met
- assessing the outcomes or effectiveness of specific techniques, such as counselling and therapy, by getting feedback from clients and professionals at an individual level (In this case, it is often difficult to assess the value of health promotion in terms of cost [individual treatment is expensive] and the experienced value or gains for clients.)

Methods of evaluation and types of data may vary according to the type of assessment. They may include various report formats, schedules, checklists, surveys, questionnaires, interviews, production and performance records, financial records, organisational profits, records of client recuperation and relapse figures, loss of working days and hours, hospital fees, mortality figures, disability statistics, industrial or business failures, budget reviewing and cost analysis models (Bergh 2011).

There are many methodological problems in the assessment of and research on the effectiveness of health promotion programmes. Some of the problems stem from the failure to define specific risk factors, poor outcome criteria, confusion between input and outcome criteria, relying only on programme participant self-reports to assess programme effectiveness and poor record or data systems. The evaluation of health promotion effectiveness can be riddled with research problems and influenced by many complicating variables. It is therefore necessary for assessors to design criteria and methods purposefully and to control all confounding or complicating influences when and if possible. An important research and analysis variable is to accurately relate cause to effect. Similar or different internal and

external factors often impact on an organisation's business activities and health promotion initiatives (Bergh 2011).

Calculation of the direct and indirect costs of maladjustment remains a difficult problem because of factors such as the following: the overlapping between what people regard as direct or indirect; incorrect, inaccurate, generalised and biased statistics; diagnostic problems and differences; unrecorded cases; costs that are never or can never be calculated; and information that organisations refuse to supply. Cost analysis will only be accurate if all contributing factors are considered and if accurate data are kept and processed. As mentioned earlier, it is extremely difficult to calculate the operational costs of occupational health management accurately. There are several causes and effects of stress and many cost factors that give rise to definite direct or indirect costs which cannot always be considered or even calculated in money terms (Bergh 2011).

5.4.6 Ethical considerations

Professional psychologists working in organisations and in health promotion face various conflicting responsibilities with regard to ethical issues. These issues relate to legal aspects, roles in applying various types of treatment procedures (some of these may be sensitive or controversial) and their position in terms of their own career and interests and those of clients and employers. The issues of bias and fairness in human resources practices are as relevant in the field of health promotion as they are in psychological assessment. Providers of health promotion services in organisations should at least recognise diversity in employee needs, and diversity in gender, ethnicity, age, language and culture.

Various factors will determine ethical issues and dilemmas in health promotion in organisations. The cultural values of an organisation and related mission statements, policies and procedures have a direct impact on the ethical and moral standards involved in health promotion (Bergh 2011).

Similar influences are general values and laws on human rights, labour laws and equity and fair practice laws operating in societies and in organisations. Unions, as defenders of and negotiators for employee rights and privileges, also impact on ethical heath issues. For all these reasons, many organisations have a general code of ethics and a code for specific purposes, like health promotion programmes. The ethics and morals of each client or participant and of programme staff members will also affect the experience of aspects of health promotion programmes. The health professional may therefore often experience ethical dilemmas. Examples are privileged client information, which may or may not be divulged to other parties, referral to outside health service providers if internal services are not available, preferring to work with certain types of clients or problems only, and getting emotionally involved with clients. There are various ethical issues that need to be considered in occupational health promotion and in the planning, development, implementation and maintenance of health promotion activities and programmes (Bergh 2011):

- **Individual rights versus employer prerogatives**

In general, employers are honest in their motives for improving human capital (cognitive and psychosocial competencies), that is improving employee's quality of work life. However, if profits are coupled with such value statements it is not easy to persuade employees and unions to support or trust management, especially if employees are already dissatisfied with general working conditions and benefits. Processes, methods and consequences of health promotion programmes may easily conflict with individual rights to privacy, confidentiality and informed consent. In many countries, discrimination and preferential treatment based on race and other differences may still be a problem. For these reasons, it is essential to

establish policies on and procedures for assessment practices, referral, recording systems and other information which may adversely influence the employee's position in his or her job or the organisation. Assessment procedures, especially for assessing people for job selection and promotion purposes and diagnosing psychological maladjustment and other health problems or performance gaps, must meet the standards for fair labour practices and for psychometric efficiency, namely reliability and validity of measurements (Bergh 2011).

- **Identified "patient" or blaming the victim**

A characteristic of many people is to blame others for their misfortunes, which often is a defence mechanism. This characteristic may be involved when organisations put too much responsibility on individual employees for their own and the organisation's health management. This also makes it easy for work groups and organisations to blame psychological or other problems on individual employees and to expect them to improve their health by self-management or other behaviour change techniques. However, we know that, systemically, reported or diagnosed problems are often only an indication of other problems in the system. This may even result in treating the "wrong" person or issue, like training employees in more effective stress management techniques without changing the real causes of the stress (stressors), which might be unsafe and unhealthy working conditions. Obviously, changing the latter is expensive for the employer and also represents a conflict of interests between employer and employee. This argument does not, however, mean that employees should not be more self-efficient, taking responsibility for managing their own occupational health and considering the health of others (Bergh 2011).

- **Paternalism and coercion**

Related to employer prerogatives and interests are prescriptive and paternalistic attitudes of employers, because they are considered responsible for taking steps to promote employee health. Historically, many employers (and unions to oppose these employer attitudes) established health promotion programmes as part of their social conscience or responsibility to allow disadvantaged employees more benefits at and away from work, something which they did not offer in their initial employment contract with employees. This attitude of doing favours for employees, knowing better than or deciding for employees and introducing programmes without informed consent from employees still exists in work-site health promotion management. It must be remembered that many health matters such as dieting, smoking, drug use, drinking and sexual behaviours are very personal, and, even if they are dissatisfied with health management, employees often feel forced or compelled to participate, because of the employer's more powerful position and the scarcity of jobs. It is for these reasons that well-planned health promotion programmes will involve all interested parties at all levels of planning, development, implementation and maintenance (Bergh 2011).

- Unfulfilled expectations and unintended consequences. As mentioned in previous sections, health promotion programmes may have unintended or unexpected consequences, some of which may result from macro environmental forces or unforeseen developments in organisations. This may happen in well-planned and well-intended as well as in poorly planned programmes (Bergh 2011).

With regard to the above issues, it is valuable to be reminded of the general and specific ethical standards to which all psychologists and other human resources practitioners should adhere (Bergh 2011). The basic ideals and assumptions underlying psychological practice are based on the recognition of the worth and dignity of the individual irrespective of race, creed, sex, status, language and other personal elements. This includes the understanding that people are all alike in some respects, that some people are alike in

some respects, and that every individual is unique in some respects. In summary, these assumptions entail the responsibility of psychologists to use research knowledge, methods and skills in an objective and unbiased way to understand human behaviour better and to improve the people's welfare. Professional and scientific responsibility means that, in their different roles and through their knowledge, skills and activities, psychologists will serve the best interests of the profession and their clients and take responsibility for their actions (Bergh 2011).

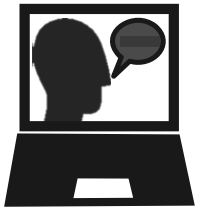
Competency refers to the psychologists' maintaining high standards by reflecting their qualifications and experience accurately, keeping up to date in their methods of practice, and performing tasks professionally and in a planned and responsible way. Moral and legal standards compel psychologists to be aware of and sensitive to standards and issues and not to act or use methods in a way that will offend or not be in the best interest of clients. Psychological tests, and other processes and decisions involving people, must be fair and undiscriminating. Confidentiality implies that any information about any client will be respected as private. Such privileged information will not be divulged, except with the client's consent, in any way or to any person, or used for any reason other than the original purpose. The psychologist must, however, be alert to possible dangers to the client if information is withheld. Informed consent refers to the client's autonomy and freedom of choice in anything that will take place and the client's right to be informed about any overt or covert procedures. The client's privacy must not be invaded, unless the client is aware of this. For example, after being given a false impression about the real motives, a client's behaviour may not be observed. If covert observations are necessary, participants must be informed in advance. Clients must not be coerced or forced to take part in any action (Bergh 2011).

The welfare of individuals and groups is always paramount. Clients must not be subjected to any physical or mental discomfort that is not realistic in the situation; no action, procedure or type of relationship must harm the integrity of the professional “contract” between psychologist or researcher and client; psychologists must not consult with family and close friends or be romantically involved with clients. Psychologists must be frank with clients about fees and termination of services if no progress is being made (Bergh 2011).

Benefits of research have to do with the careful consideration and planning of research in terms of the benefits to the research participants; financial implications, but especially the possible psychological consequences for or health risks to participants; the benefits to the researcher; and the objectives of research, that is what type of knowledge or outcome is to be achieved. Psychologists must make public statements and market services in an unbiased and non-commercialised way to avoid degrading other professionals and to give the client the freedom to choose. Psychologists may not use or receive favours in any way to enhance their services, and may not advertise directly or receive commercial gain by advertising as a psychologist (Bergh 2011).

Critical reflection: Discussion forum

Please complete the self-assessment questions entitled “EAP’s” on myUnisa.



Please participate in discussion forum 10, topic 1.

5.5 Summary

In this learning unit, the importance of employee and corporate well-being and the promotion of work-site health as a vital and necessary responsibility of management, the HR function in organisations, employees and other interested parties is considered. All organisations should operate from the stance of a health paradigm and related missions, values, objectives and methods to improve occupational health. Occupational health promotion initiatives must, however, be aimed at employee and organisational health, and not be used as a benefit to generate greater profit. Occupational health programmes must be well planned and aimed at the specific needs of employees, work groups and the organisation. Occupational psychological health promotion should assume a more prominent role in the health promotion initiatives in organisations.

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