Understanding the Vocational Impact of Mental Health Disorders

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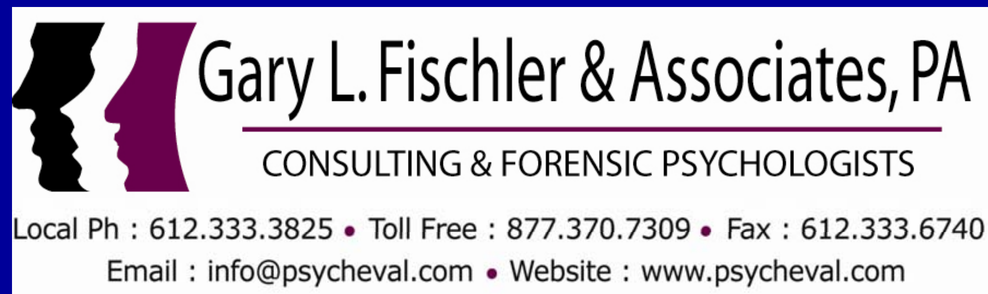

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Agenda

8:00 – 10am	- Overview: Relationships between mental health disorders and vocational functioning -Video presentations and discussion: Symptoms & functional impairment of Axis I mental health disorders
10:00 – 10:15	- Break / Networking
10:15 - noon	- Personality disorders: Functional impairments & rehabilitation strategies -Problem-solving approaches; Partnering with mental health service providers, employers, & consumers

Some Facts and Figures

- About 20% of adults have a diagnosable mental disorder in a year (Surgeon General's Report, 1999)
- 48% lifetime prevalence (Kessler et al. 1994)
- Mental disorders are the second leading cause of disability after cardiovascular disease (Surgeon General's Report, 1999)
- Mental disorders account for 20% (primary) to 65% (secondary) of all disability claims (Wagner et al., 2000)
- General employment rate of SPMI is only 10-30% (Anthony, 1994)

Clients Seeking Rehab Services By Diagnosis*

Primary Disability	Percent of Cases
Mental illness	32%
Orthopedic	20%
Learning disability	12%
Mental retardation	10%
Chemical dependency	7%
Deafness	5%
Brain injury	4%
Other	9%

*Minnesota Dept. of Rehab Services (1999)

Relationship Between Psychiatric Disorders and Job Duties

Psychiatric Disorders

Essential Psychological Factors

Job Duties

ESSENTIAL PSYCHOLOGICAL FACTORS IN JOB PERFORMANCE (Fischler & Booth, 1999)

PSYCHOLOGICAL FACTORS	EFFECTS ON JOB PERFORMANCE	DIAGNOSTIC EXAMPLES
Cognition	Intelligence, memory, academic skills, and the ability to use these skills	Depression, anxiety, bipolar, schizophrenia, dementia, chronic chemical abuse
Pace	The ability to perform tasks at a reasonable speed.	Depression, obsessive-compulsive disorder, passive-aggressive personality disorder
Persistence	The ability to stay with a task until it is complete.	Bipolar disorder manic phase, attention deficit hyperactivity disorder, histrionic personality disorder, somatization disorder, schizophrenia.
Reliability	Coming to work every day in spite of personal or emotional problems.	Agoraphobia, somatization disorder, mood disorders, avoidant personality disorder, chemical abuse
Conscientiousness and Motivation	Wanting and trying to do a good job; persisting until it is accomplished.	Major depression, personality disorders, chemical abuse

PSYCHOLOGICAL FACTORS	EFFECTS ON JOB PERFORMANCE	DIAGNOSTIC EXAMPLES
Interpersonal Functioning	The ability to accept supervision, to get along with coworkers or the public.	Bipolar disorder manic phase, post-traumatic stress disorder, many personality disorders, chemical abuse.
Honesty, trustworthiness	The ability to be truthful, direct, and straightforward, to refrain from such things as lying and theft at work.	Anti-social personality disorder, borderline personality disorder, chemical dependency.
Stress tolerance	The ability to withstand job pressures such as deadlines or working with difficult people.	Schizophrenia, post-traumatic stress disorder, somatization disorder, agoraphobia, major depression, chemical abuse
Job-specific requirements	e.g., Typing speed, conflict resolutions skills, "people skills."	Any

Overview of Psychiatric Diagnosis (DSM-IV)

- *Axis I: Clinical syndromes*
  - Depression, anxiety, schizophrenia
  - Somatoform disorders
  - Learning disorders
- *Axis II: Personality traits & disorders; mental retardation*
- *Axis III: Physical problems*
- *Axis IV: Psychosocial stressors*
- *Axis V: Global assessment of functioning (0-100)*

Schizophrenia

- Onset and prevalence
  - Most commonly has progressive onset beginning in teens to mid-thirties
  - Affects about 1% of population
  - Women have better prognosis
  - Often intermittent symptoms

Characteristics of Schizophrenia

- *Compromised reality operations*
  - Hallucinations and delusions; illogical thinking; may show denial or poor insight; may show poor judgment
- *Communication problems*
  - Unusual or illogical language; disorganized thought and speech
- *Negative symptoms*
  - Flat affect; low energy; sleep disturbance; amotivational and anhedonic
- *Cognitive problems*
  - Reduced concentration and memory; compromised decision-making skills
- *Interpersonal problems*
  - Suspicious; frightened or argumentative; social withdrawal, indifference; unusual appearance or behavior

Schizophrenia's Effect on Work

- Misperceives communications, instructions
- Distrusts coworkers and supervisors; may be fearful or argumentative; criticism is viewed as attack; difficult to work in a team
- Coworkers may become rejecting or hostile in return, creating vicious cycle
- Interested in achievement or promotions may be diminished by negative symptoms; passive or avoidant in response to performance demands
- Easily distracted; cognitively inefficient; increased error rate
- Symptoms increase under stress; reliability problems

Schizophrenia's Effect on Essential Psychological Factors

Level of Impairment:

1. No impairment.
2. Mild -- minimal impairment with little or no effect on ability to function.
3. Moderate -- some impairment which limits ability to function fully.
4. Serious -- major impairment which may at times preclude ability to function.
5. Severe – extreme impairment .

Understanding and Memory	*1*	*2*	*3*	*4*	*5*
Remembers locations and basic work procedures		x			
Understands and remembers short, simple instructions		x			
Understands and remembers detailed instructions.			x		

Concentration and Persistence	*1*	*2*	*3*	*4*	*5*
Carries out short, simple instructions.		x			
Carries out detailed instructions.				x	
Maintains attention and concentration for extended periods of time.					x
Can work within a schedule, maintain attendance, and be punctual.		x			

Concentration and Persistence (Con't)	*1*	*2*	*3*	*4*	*5*
Sustains ordinary routine without special supervision.		x			
Can work with or close to others without being distracted by them					x
Makes simple work-related decisions		x			
Works quickly and efficiently, meets deadlines, even under stressful conditions.					x
Completes normal workday and workweek without interruptions due to symptoms					x
Works at consistent pace without an unreasonable number or length of breaks.			x		

Social Interaction	*1*	*2*	*3*	*4*	*5*
Interacts appropriately with the general public.				x	
Asks simple questions or requests assistance when necessary.			x		
Accepts instructions and responds appropriately to criticism from supervisors.					x
Gets along with coworkers without distracting them					x
Maintains socially appropriate behavior			x		
Maintains basic standards of cleanliness and grooming			x		

Adaptive Behavior	*1*	*2*	*3*	*4*	*5*
Responds appropriately to changes at work.				x	
Is aware of normal work hazards and takes necessary precautions.		x			
Can get around in unfamiliar places, can use public transportation.	x				
Sets realistic goals, makes plans independently.		x			

Management Strategies with Schizophrenia

- Refer for treatment; encourage compliance
- Flexible scheduling
- Needs high degree of structure and routine; avoid occupations with less structure where misinterpretations are more likely (e.g. human services)
- Avoid high-speed or cognitively complex assignments
- Allow solitary work; avoidance of team participation; needs low-key social support
- Tangible and frequent incentives (e.g., piecework, break-times, cigarettes)
- Dress and behavior codes may need to be clarified
- Open and direct communication; discuss upcoming changes
- Consider debriefing coworkers regarding oversensitivity and need for benign environment

Treatment of Schizophrenia

- Medication is usually very helpful to reduce psychotic symptoms
- Reality-oriented psychotherapy is useful for education, identify symptom precipitants, lifestyle issues, and learn to ignore hallucinations and delusions
- Milieu therapy helpful for social dysfunction and negative symptoms
- Family psycho-educational therapy may also be useful

Major Depression

- Onset and prevalence
  - Affects up to 25% of females; 12% of males
    - Chance of 2nd episode = 50%
    - Chance of 3rd episode = 70%
    - Chance of 4th episode = 80-90%
  - Usually begins in mid twenties
  - Dysthymia is milder, more chronic, and predisposes individual to major depression
  - Up to 15% die of suicide

Characteristics of Major Depression

- ♦ Sad, depressed mood, tearful
- ♦ Lack of interest in life; low motivation
- ♦ Poor sleep; poor appetite; fatigue
- ♦ Pessimism; low self-confidence; feelings of worthlessness; guilt
- ♦ Poor concentration, memory, & decision-making (pseudodementia)
- ♦ Hopelessness; preoccupation with dying; suicidal ideation
- ♦ Sometimes irritable

Major Depression's Effect on Work

- Low motivation, energy
- Low initiative for independent activity
- Poor persistence, endurance
- Distractible; increased error rate
- Hypersensitive to criticism or rejection
- Poor ability to deal with stress, pressure, deadlines
- Irritable with, or withdrawn from, coworkers

Management Strategies for Major Depression

- Quiet work setting
- Avoid speed-dependent tasks
- Maximize predictability in work assignments; improve self-confidence for new tasks
- Consider written guidelines, protocols
- Flexible scheduling, including breaks
- Maximize social support; work on team; maximize positive feedback
- Avoid jobs with suicide risks

Treatment of Major Depression

- Anti-depressant medication is usually very effective, especially for physical symptoms (e.g., fatigue, sleep disturbance, concentration)
- Cognitive-behavioral psychotherapy can also be very effective, especially for mood disturbance, relationship issues, etc.
- Combination often produces long-term relief from symptoms
- Shock therapy (ECT) may be effective for severe cases that are resistant to other treatments but produces temporary memory impairment that often interferes with ability to work

Bipolar Disorder, Manic Phase

- Onset and prevalence
  - Occurs in .4% to 1.6% of population
  - 90% will have second episode
  - 75% will return to full functioning
  - Suicide may occur in 10-15% of cases
  - Onset is later than schizophrenia – twenties to forties
  - Equally common among men and women
  - Intermittent episodes and symptoms

Characteristics of Mania/Hypomania

- Elevated, expansive, or irritable mood
- Grandiosity
- Reduced need for sleep
- Increased sociability, flamboyance
- Pressured speech, hyperactivity, racing thoughts, flight of ideas
- Mood-congruent hallucinations and delusions

Mania's Effect on Work

- Inflated self-concept; unrealistic goals
- Excessive energy, but inefficient & disorganized
- Reduced social judgment; irritable or aggressive behavior
- Distractibility; distracts coworkers
- May not see relevance of safety precautions
- Work quality decreases under stress and pressure
- Can be very creative and productive

Management Strategies with Mania

- Refer for treatment; encourage compliance
- Encourage a structured, predictable lifestyle
- Clear deadlines
- Appropriate outlets for creativity, socializing
- Flexible scheduling
- Set limits regarding appropriate behavior, if necessary
- Consider debriefing coworkers; “buddy” can help with organizational tasks

Treatment of Mania

- Medication is often quite effective to stabilize mood
- Anti-psychotic medication may also be helpful if psychotic symptoms are present
- Reality-oriented psychotherapy can be useful to improve judgment and identify lifestyle precipitants

Axis I Problem-Solving Approaches

Accommodations for Psychiatric Disorders

- EEOC recommendations for “non-obvious” disabilities (Also see American Bar Association, 1997):
  - ✓ Determine essential functions of job
  - ✓ Assess functional limitations (re: essential psychological factors)
  - ✓ Employee and employer mutually identify accommodations
  - ✓ Accommodations implemented by employer, taking into account employee input

- ***Mutual accommodations require disclosure of psychiatric problems to employer:***
  - ✓ Likely to result in better “fit” between functional limitations and accommodations.
  - ✓ Employees can be coached to make adjustments for themselves.
  - ✓ Employee may be coached in asking for workplace adjustments without disclosure.
  - ✓ Indirect suggestions by employee may result in unilateral decision by employer to accommodate.

Types of Accommodations *(e.g., Mancuso, 1993)* :

- ✓ Most frequent – schedule flexibility or changes (e.g., part-time, flex time, more frequent breaks, unpaid leave)
- ✓ Formal or informal job coaches during difficult times
- ✓ Change of supervisory methods (e.g., written, verbal, frequency)
- ✓ Rearranging job duties with other employees
- ✓ Reassignment to “less stressful” work
- ✓ Private or solitary work space
- ✓ Telecommuting
- ✓ Additional supervisory support

Treatment May be Required

- Employer can require treatment as accommodation:
  - "[a] qualified individual with a disability is not required to accept an accommodation, aid, service, opportunity or benefit that such qualified individual chooses not to accept. However, if such individual rejects a reasonable accommodation, aid, service, opportunity or benefit that is necessary to enable the individual to perform the essential functions of the position held or desired, and cannot, as a result of that rejection, perform the essential functions of the position, the individual will not be considered a qualified individual with a disability." (U.S. Dept. of Labor, 41 CFR 60-741.21).

Treatment May be Required (Con't)

- Doctor concluded that, with treatment, plaintiff's depression should not affect his work performance. Several of his supervisors urged him to seek treatment, which he refused to do for more than fourteen months. Plaintiff's refusal to seek the recommended and available treatment precludes him from being a 'qualified individual with a disability' under the ADA (*Roberts v. County of Fairfax*, 937 F. Supp. 541, E.D. Va. 1996)

Treatment May be Required (Con't)

- Employees who do not take their meds may be considered to have a "voluntary disability." Employer's duty to accommodate ends if employee is non-compliant with treatment:
  - An employee with bipolar disorder had problems with attendance and performance was "not otherwise qualified" because of med noncompliance. (*Keoughan v. Delta Airlines, Inc.*, No. 96-4072, 1997, U.S. App., LEXIS 12232, 10th Cir.)

Debrief Coworkers or Supervisors

- Employee must be willing to *disclose* that he or she has a mental health problem ("disability" if accommodation is sought)
- Educational in nature
- Reframe client's problems at work as caused by factors that are external rather than volitional:
  - Cognitively slow vs. unmotivated ("lazy")
  - Concentration difficulties vs. not capable ("stupid")
  - Interpersonally sensitive vs. rude ("snobbish")
- Consider within the context of "team building"

Disclosure of Mental Health Problems - Advantages

- Seek accommodations
- Receive support from colleagues
- Therapeutic affirmation
- Becoming a consumer advocate
- Most have no regrets (Ellison et al., 2003)

Disclosure of Mental Health Problems - Disadvantages

- Psychic pain
- Shame & embarrassment
- Stigma
- Discrimination

Encourage Treatment Compliance

Reasons for noncompliance:

- Side effects
- Need to remember and organize
- Expense & inconvenience
- Stigma
- Denial
- Post hoc reasoning

♦ Involve family & social supports

General Vocational Facts About (SPMI)

- Vocational programs increase likelihood of employment, especially when they are integrated with mental health treatment programs (Drake et al., 1996)
- Longer involvement → better outcomes (Bond, 1998)
- OTJ training produces outcomes equal to or better than extended unpaid pretraining (Bond, 1998)
- Work disincentives (e.g., SSI) can be significant negative predictors (e.g., Edelson, 1993; Ford, 1995)

Positive Psychosocial Predictors of Job Placement for SPMI

(Alforson et al., 1998)

- Close relationships with family and friends
- Positive attitudes towards treatment
- Values competitive employment as contributing to positive mental health
- Strong desire for financial independence
- Ready transportation to and from work
- Shows strong job-seeking initiative independent of VR system

Axis II: Personality Traits and Disorders

- *Personality traits:*

  "enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of social and personal contexts"

- *Personality disorders* are extreme variants of these traits, which lead to either:
  - Impairment in social or occupational functioning;
  - Poor impulse control; or
  - Clinically significant distress

Psychological Predictors

- Presence of *negative personality traits* and *cognitive confusion* are strongest negative predictors of VR outcomes (Edelson, 1993)
- *Agreeable* and *Conscientious* personality traits are related to positive employment outcomes (Costa & Widiger, 1994)
- *Interpersonal problems* are the most frequent cause of unsatisfactory terminations (Becker, et al. 1998)

Prevalence and Onset of PDs

- 10-20% occurrence in general population
- 47-90% incidence in those diagnosed with Axis I disorders
- PDs tend to improve with age
- Compulsive and histrionic traits (not disorders) improve functioning; all others worsen functioning
- PDs more likely in those with abuse histories
- Onset by early adulthood

Diagnosis of PDs

- PDs tend to be "ego-syntonic"
  - Insight tends to be poor
  - Self-ratings and peer ratings are only modestly related:
    - r = .36 (Klonsky, Oltmanns, & Turkheimer, 2002)
- Diagnosis is more difficult than Axis I, requiring:
  - Extensive history-taking,
  - Review of records
  - Personality testing

Treatment of PDs

- Personality is resistant to change
  - Treatment outcomes are uneven:
    - Long-term psychotherapy or group therapy is treatment of choice
    - Dialectic Behavior Therapy (DBT) is especially effective
    - Medication often ineffective
    - Impossible to change without motivation
    - Subjective distress improves prognosis
- Positive RTW outcomes are also difficult

PDs by Cluster

- *Cluster A – "Odd"*
  - Idiosyncratic thinking, suspiciousness, social withdrawal
  - Paranoid, Schizoid, & Schizotypal
- *Cluster B – "Dramatic"*
  - Intense emotional expression, mood instability, poor frustration tolerance and impulse control
  - Antisocial, Borderline, Histrionic, Narcissistic
- *Cluster C – "Anxious"*
  - Anxious, worried, emotionally constricted, poor decision-making, risk-adverse, cowardly
  - Avoidant, Dependent, Compulsive, Passive-Aggressive

"Dramatic" Cluster Characteristics

- Grandiose
- Sense of entitlement; Self-centered
- Lack of empathy for others; exploitative
- Reacts to criticism or rejection with rage, shame
- Disregard for rules and ethics
- Irresponsible and unreliable
- Impulsive; seeks immediate gratification; self-centered; shows poor judgment
- Often argumentative, hostile, and aggressive
- Oppositional relationships with authority
- High co-occurrence of substance abuse
- Unstable mood; often have co-occurring mood disorder
- Unstable relationships; unstable self-identity
- Impulsive, irresponsible, unreliable
- Self-destructive behavior, often manipulative motive

"Dramatic" Cluster Effects on Work

- Overestimates skills, accomplishments; underestimates weaknesses
- Feels entitled to better status, pay, conditions
- Resents coworkers and supervisors who make demands and don't recognize "specialness"
- Takes direction or criticism poorly
- Can be talented, charming, entertaining
- Superficial, conflictual relationships with coworkers
- Chafes under supervisory direction
- Easily bored; work quality is inconsistent
- Shows poor judgment
- Violates workplace rules, including safety procedures
- Potentially violent
- Can be superficially charming and persuasive

Management Strategies with Dramatic Cluster

- Maximize positive feedback; supportive but firm
- Set clear expectations, boundaries, & consequences
- Maximize objectivity of performance review standards
- Allow opportunity to feel important and valued, but monitor for exploitation of others
- Maximize strengths such as superficial charm and a desire to be noticed, such as in some customer service work
- Must be closely and persistently supervised; supervisor must be firm, “street smart,” but not thin-skinned
- Standards for performance and attendance must be set and maintained; manipulation resisted
- Random drug testing may be valuable

Management Strategies with Dramatic Cluster (con't)

- Consider occupation with high activity level and change of scenery
- Avoid jobs that are detail-oriented
- Closely monitor adherence to safety procedures; avoid dangerous work
- Consider time-outs (with docked pay) for inappropriate behavior
- Flexible scheduling to accommodate mood swings
- Can develop close relationships with coworkers, but boundaries should be clarified and monitored
- Consider debriefing coworkers regarding boundary issues and employee's need to avoid hostile situations

Psychological Evaluation: Recommended Practices

- Examiner qualifications
  - Training and experience in forensic and/or occupational health settings
  - Is preferably not the treating clinician:
    - Roles of therapist and evaluator are “irreconcilable” (Greenberg & Shuman, 1997):
      - Who is the client/patient?
      - Competency issues
      - Interference with therapeutic relationship
      - Evaluation procedures

Psychological Evaluation: Recommended Practices

- "A treating psychiatrist should generally avoid agreeing to…perform an evaluation of his patient for legal purposes because his forensic evaluation usually requires that other people be interviewed and testimony may adversely affect the therapeutic relationship." (American Academy of Psychiatry and the Law, *Ethical Guidelines for the Practice of Forensic Psychiatry*, 1995)

Psychological Evaluation: Recommended Practices

- Clear informed consent, including:
  - Procedures
  - Confidentiality
  - Distribution of information
  - Consequences of cooperating or declining
- Review relevant collateral information, including:
  - Medical records
  - VR records
  - School or employment records

Psychological Evaluation: Recommended Practices

- Psychological testing
  - Personality (e.g. MMPI-2)
  - Cognitive (intelligence and memory)
  - Academic
- Structured interview:
  - Mental health, chemical dependency, employment, education, legal, medical, social, family histories
  - Observed behavior
  - Reported symptoms
  - Cause-effect relationships

Psychological Evaluation: Recommended Practices

- Written report:
  - Summary of personal history, symptoms, and test results
  - DSM-IV diagnoses
  - Functional strengths and limitations
  - Treatment recommendations
    - Individual, group, or family therapy
    - Medication evaluation
  - Environmental recommendations for successful return to work

Ethical Issues: Interpretation of Results

- F.1.a. RCs:
  - *"Will take reasonable steps to ensure that appropriate explanations are given to the client."*
- A.3.a. Disclosure to clients. RCs
  - *Take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports…"*
- B.3.1. Records. RCs:
  - *"Provide access to records and copies of records when requested by clients…In instances where the records contain information that may be sensitive or detrimental to the client, the RC has a responsibility to adequately interpret such information to the client."*

Guidelines for Interpreting Exam Results to Clients

- Review reasons for psychological exam:
  - Abilities, strengths, & weaknesses
  - Personality & emotional "fit" with VR plan
- Briefly describe the tests and test results:
  - Describe intellectual and academic strengths
  - Explain how identified weaknesses can be dealt with
  - What implications do the diagnoses have for functional impairments and VR plan?
  - *Helps insure that VR plan is "consistent with the abilities and circumstances of the client."* (see A.1.b. Client Welfare)

Guidelines for Interpreting Exam Results to Clients

- Allow client to vent feelings, but keep client's focus on understanding self with regards to developing a:
  - *realistic* plan that is
  - *"consistent with the abilities and circumstances of the client."* (see A.1.b. Client Welfare)

DISCUSSION

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