

The Assessment of Mobbing Damage: When the Psychological Pain Becomes Physical

Galletta D¹, Confuorto M¹, Improta G² and Marcelli V³

¹Department of Head-Neck Care Unit of Psychiatry and Psychology “Federico II” University Hospital Naples, Italy

²Local Health Agency Naples 3 south, Italy

³Local Health Agency Naples, Italy

*Corresponding author: Galletta D, Department of Head-Neck Care Unit of Psychiatry and Psychology “Federico II” University Hospital Naples, Italy, Tel: 0817462957, E-mail: diana.galletta@unina.it

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Abstract

Mobbing was defined by Leymann “a form of psychological terrorism that implies an unostentatious and unethical attitude in a systematic form by one or more subjects, usually towards a single individual who, because of this persecution, finds himself in a defenceless condition and becomes object of continuous vexatious and persecutory activities that recur with a systematic frequency and over a period of time that is not short, causing considerable mental, psychosomatic and social suffering” (Leymann, 1988) [1].

DSM-5 has underlined the correlation between mobbing and psychopathology. Post-traumatic stress disorder is frequently associated to a mobbing condition. Mobbing relates also to physical symptoms. In this study we present the case of a man who covered an important job position who was victim of mobbing. This man developed a serious anxious depressive symptomatology complicated by several physical damages such as arterial hypertension and a neurosensory acoustic deficit- sudden deafness- with the presence of subjective tinnitus.

The subject received a psychological assessment including MMPI-2, Rorschach test and rating scales (SAS, SDS, HAM-D, HAM-A, STAI, DTS, Q-LES-Q) for the personality and symptomatology evaluation.

Finally, it was made a diagnosis of Post-traumatic stress disorder due to mobbing and associated to neurosensory hypoacusis with subjective tinnitus.

Further researches should propose guidelines to prevent mobbing and improve working climate.

Keywords: Mobbing; Ptsd; Hypoacusis; Tinnitus; Psychological Assessment

Introduction

Mobbing is a widespread phenomenon with important consequences for the healthcare of workers. It can be defined as a set of violent behaviours such as sexual abuse, slanders, marginalization, humiliations, demotion, realized on workplace by a co-worker or who covers a higher or lower position characterized by high frequency and intentionality (Tong *et al.*, 2017) [2]. It was identified for the first time by Leymann at the last of 1980s who indicates two important criteria for the individuation of mobbing: frequency (once a week) and lasting (six months).

Mobbing isn't a single event or a generalized conflict. It's persistent, systematic with a clear persecutory intent. This situation is very devastating for the victims and can generate physical and psychological Symptoms (Ulas *et al.*, 2018) The International Classification of Diseases, 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) indicate two disorders associated to Mobbing: Post traumatic stress disorder (PTSD) and Adaptation disorder [3]. PTSD requires that the person was exposed to an especially stressful event like death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence and causes symptoms of intrusion so the person reverts continuously the trauma through thoughts or dreams, symptoms of avoidance of the stimulus associated with the trauma and it generates an increased arousal (American Psychiatric Association, 2013; World Health Organization, 1993) [4,5]. Iperarousal can produce exaggerated alarm responses that can modify the neurobiological function of the body and cause physical effects. When distress brings emotive and behavioural symptoms within three months from the stressor, we talk of adaptation disorder. These symptoms create great discomfort and compromise the social and working functioning of the individual who can show anxiety, depression and behavioural alterations. Mobbing can also have psychosomatic effects such as hypertension, headaches, gastritis, and dermatitis. These clinical features are related to the persistence of stressful event and to the inability to implement coping strategies (Leymann, 1990) [6]. When a

mobbing damage occurs it's essential evaluating the healthcare state of the victim and estimating the negative effects on body and mind. They can be very extensive and serious involving permanent harms to the organism. In this paper we present a case of a man who experienced serious physical and psychological impairments due to mobbing.

Case Report

Degree in Medicine and Surgery, Mr I. achieved several specialities. He held posts of coordination and responsibility for many years, until the achievement of the ability to hold the post of Local Health Agency and Hospital Agency's General Manager. Since 2003 he is Chief Medical Officer for a medical district of an Italian region. Here, just after some months, he experiences a conflict with the management, in a first step characterized by "a deep silence towards every proposal or request". According to Mr I. the conflict broke out in the workplace for the "missed mediation between the parts, the hostile attitudes, the slow disavowal and it caused a progressive isolation and no recognition". This condition was accompanied by a large manifestation of symptoms such as restlessness, sleep rhythm disturbances with initial insomnia and repeated night-time awakening, easy irritability, free and somatic anxiety, interpersonal, family and marital relationships impairment.

On 16th August 2004 the health damage made itself known: while he was driving to go working an Epistaxis occurred. After another episode of epistaxis, the medical examinations ascertained that the cause of this hypertensive crisis was a HPA (hypothalamic-pituitary-adrenal) axis deficit so he received the diagnosis of arterial hypertension due to primary hyperaldosteronism. Since October 2009 health conditions of Mr I. went worse above all on the psychosomatic side. He developed a new symptom: a neurosensory acoustic deficit- sudden deafness- with the presence of subjective tinnitus related to the recurrence of hypertensive crises.

The hospitalization of 2010 produced the diagnosis of post-traumatic stress disorder related to mobbing and complicated by neurosensory hypoacusis with subjective tinnitus.

Materials and methods

Mr I., after been informed of psychodiagnostic examination's nature, accepted to undergo the following tests: MMPI-2, Rorschach test, rating scales (SAS, SDS, HAM-A, HAM-D; Davidson Trauma Scale; Q-LES-Q). The decision of using both MMPI-2 and Rorschach test derives from the need to detect any patient's simulation attempts. This practice is useful in forensic, psychiatric and psychological field as highlighted in literature (Hartmann and Hartmann, 2014); moreover, the combined use of both tests is corroborated by previous researches (Nørbech *et al.*, 2016; Dao *et al.*, 2008; Lindgren and Carlsson 2003; Meyer *et al.*, 2000) [7-11].

The Minnesota Multiphasic Personality Inventory (MMPI) is a self-report test widely used all over the world. The original MMPI, first published by the University of Minnesota Press in 1943, was replaced by an updated version, the MMPI-2, in 1989. The current MMPI-2 has 567 items correlated to 7 Validity Scales, 10 Basic Clinical Scales, 15 Content Scales and 15 Supplementary Scales. The Rorschach test is a psychological test in which subjects' perceptions of inkblots are recorded and then analysed using psychological interpretation and precise techniques procedures. It is used to examine personality characteristics and emotional functioning but also to detect underlying thought disorders.

There are different methods of interpretation. In our study we use the Klopfer\Rizzo method.

Self-Depression Scale (SDS) and Self Anxiety Scale (SAS) are short self-administered surveys introduced by the psychiatrist William Zung to assess respectively the level of depression and anxiety. They are made up of 20 items. Hamilton Rating Scale for depression (HAM-D) and Hamilton Rating Scale for Anxiety (HAM-A) are hetero administration questionnaires used by the clinician to evaluate the severity of depression and anxiety. They were created by Max Hamilton in 60's. State-trait anxiety inventory (STAI) consists of 40 self-administered questions and measures two types of anxiety: state anxiety related to a specific event and trait anxiety as a personality feature. It was developed by Charles Spielberger and other psychologists in 1983. Davidson Trauma Scale (DTS) was realised by Davidson in 1997 for measuring PTSD symptoms in subjects who experiences one or more traumatic events. It is a self-report scale made up of 17 items. Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) contains 58 items that evaluate the grade of enjoyment and satisfaction experienced by the person in five areas: physical health, subjective sensations, hobbies, social relationships, general activities. There are other 2 items that let to assess general satisfaction.

Results

MMPI-2

The analysis of MMPI-2 reveals an acute depression of the mood and a tendency to the anxiety somatization (D=73; Hy=78; Hs=87).

The supplementary scales point out a high score of the Dominance Scale (72) indicating that Mr I. presents dominance in the social situations, calm and security in the groups, he feels comfortable in the social relationships, he has strong opinions and he perseveres his commitments showing respect for the others. At the content scales there are anxiety symptoms with tension

and somatic problems like asthenia, insomnia, concern tendency and low concentration capacity (ANX=81; HEA=76). It can be present feelings of resent and bitterness toward people whose behaviours are motivated by personal and egoistic interests (CYN=72). The subject seeks to develop physical symptoms in response to the stress. This kind of people shows somatisation and can develop psychosomatic diseases (Neurotic Score= $Hs+D+Hy/3 = 238/3 = 79, 33$; normal values 35-65).

Rorschach test

Considering the responses of the subject to the Rorschach test we can detect a good productivity on the cognitive profile (R=34) and a qualitative variety on the emotional profile (3 FM; 1M). The subject hardly controls his emotive impulse (Impulsivity Index=; 2CF). The affective index (32%) underling a small response to the environmental stimulus and the average time to response of 40, 5" can indicate an emotive depression. The Red Shock at Table II represents the control and the defenses of the Ego in relation to the deeper emotions, so its presence suggests: emotional liability, anxiety and guilt for his own aggressive impulse, fear for the other aggressiveness. A normal Reality Index (5) indicates a good criticism but a reduced adaptation grade.

Rating Scales

Observations have been integrated by the results of rating scales. At the SDS (Self Depression Scale) Mr I. obtained a score of 68 and a depression index of 85%. At the HAM-D (Hamilton Rating Scale for Depression) he obtained a score of 24 that indicates a moderate depression. The SAS (Self Anxiety Scale) reveals, with a score of 52 and a Zung Index of 65%, the presence of state anxiety. The HAM-A (Hamilton Rating Scale for Anxiety) confirms this result with a score of 24. At the STAI (State-trait Anxiety Inventory) used for discriminating state or trait anxiety, Mr I. in the STAI 1 (for state anxiety) ranks at 98° percentiles with a score of 68, instead in the STAI 2 (for trait anxiety) he falls within the 57° percentile (normality for Italian males) with a score of 38. This highlights the condition of state anxiety. The DTS (Davidson Trauma Scale) with a score of 96 shows several intrusion and hypervigilance symptoms. Lastly, at the Q-LES-Q (Quality of Life Enjoyment and Satisfaction Questionnaire) used for investigating the satisfaction of the different life areas, Mr I. achieves the following results: physical health=33%; subjective sensations=34%; hobbies=67%; social relationships=16%; general activities=23%; general life satisfaction= low.

Discussion

As previously exposed Mr I. developed a large symptomatology ascertained by the psychological assessment. His health state progressively got worse imposing the intake of sartans anti- hypertensives (ARBs) and a psychopharmacological therapy with hypnoinducent anxiolytics to dominate anxiety symptoms and insomnia. Particularly in the acute phase he took sertraline 100 mg, prazepam 20 mg, cinnarizine dimenhydrinate 20 mg and perphenazine 2 mg. afterwards he reduced the dosage of drugs and he began a cognitive behavioral therapy (CBT). The short-term efficacy of CBT in the treatment of PTSD is well documented (Bisson *et al.*, 2013; Bisson *et al.* 2007) [12,13]. Watkins *et al.* (2018) report the best treatment for PTSD including CBT as strongly recommended therapy by APA and the VA/DoD.

This kind of psychotherapy typically uses both behavioral techniques such as exposure and cognitive techniques such as cognitive restructuring. Exposure provide for the creation of a scale of anxiety- inducing situations that will then be addressed, in imagination or in vivo, starting from the least disturbing. This allows the recovery and reintegration of those emotional memories that our mind has defensively dissociated from the traumatic experience. Cognitive restructuring focuses on teaching patients to identify dysfunctional thoughts and thinking errors, elicit rational alternative thoughts, and reappraise beliefs about themselves, the trauma, and the world.

Recently Glasscock *et al.* (2018) realised a randomized controlled trial about the efficacy of CBT in reducing work related stress finding that this intervention led to faster reductions in perceived stress and stress symptoms [14].

The correlation between a stress condition and the presence of tinnitus or of an audio cochlear vestibular damage is well documented (Moring *et al.*, 2018; Swan *et al.*, 2017; Fagelson and Smith, 2016) [15-17]. The intensity of tinnitus is often exacerbated by noises that set off the anxiety related to PTSD. There is a strict physical and psychological relationship between tinnitus and PTSD. Several neural mechanisms associated both to tinnitus and PTSD shape the behaviour. People with tinnitus show altered evaluation processes during the stress exposition, even if the physiologic reactivity is only slightly compromised. Zass *et al.* (2017) report the links between auditory, audio cochlear systems and stress: limbic system which regulates instinctive behaviour and emotions is connected to auditory system with geniculate body (amygdala) [18]. Hypothalamus, which represents the integrative centre of autonomous and endocrine system, is connected to the auditory system through the lower colliculus. Reticular system that mediates attention and stimulation behavioural patterns projects serotonergic fibers to all the ways of the auditory system, from the cochlea to the auditory cortex. Patients with serious tinnitus and audio cochlear damage should be considered for a psychiatric comorbidity diagnosis and addressed to psychotherapy and psychopharmacological therapy if necessary [19-34].

Conclusion

In this article we report a case of mobbing associated to PTSD and physical pathology to underline how a psychological distress can produce several psychological and physical symptoms. CBT in association with a psychopharmacological therapy should be the

first choice treatment in this situation. The impact of mobbing on people can be devastating so further researches should improve our knowledge and suggest guidelines to prevent mobbing conditions on working places.

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