CHAPTER 10

PSYCHIATRIC CONSULTATION IN THE WORLD OF WORK

David Bruce Robbins

Prior to the dawn of the 20th Century, psychiatry and the world of work ignored one another, save for rare and furtive glances through opalescent isinglass curtains. The busy universe of commerce and industry had little time for, and less interest in, emotional problems. While individual psychiatrists acknowledged the vital importance of work in human existence, (e.g. Freud's comment re "arbeiten und leiben"), the profession as a whole ignored the workplace and seldom focused on job-related stress and conflict. In his comprehensive reviews of Occupational Mental Health (McLean, 1966; 1975), McLean begins the saga of the psychiatrist in the occupational community with C.C. Burlingame's work in The Cheney Silk Co., circa 1915. During the past sixty years, occupational psychiatry has cycled from impoverished curtailment to dedicated and creative expansion. Important variables have included wars, economic cycles, and fads within the psychiatric profession. There has been considerable variation in time commitment, organizational affiliation, and structural levels of intervention.

The most basic format for psychiatric consultation in industry has been the employment of a psychiatric clinician, part-time, to serve as a consultant to the Medical Department (Auster, 1967; McLean, 1966; 1975; Modlin, 1973; Ross, 1963; Warshaw, 1970). Here the role expectations are familiar to the physician, viz. diagnosis, referral, brief treatment. The opposite spectral pole involves a full-time psychiatrist, collaborating closely with several departments, including medical, personnel, management development, and highest level management (Cohen, 1969; Longaker, 1972; Warshaw, 1970). Several models have appeared in recent years, involving varying admixtures of clinical, educational, and research activities (Auster, 1967; Longaker, 1972; McLean, 1959; 1961; Modlin, 1973; Ross, 1963).

Recent advances in general systems theory and in community psychiatry have increased the potential contribution of the psychiatric consultant to the occupational universe. It is now possible to accurately conceptualize a problem, select the appropriate level or levels of intervention, and resolve a crisis promptly (Cohen, 1969). We can specify the interrelated subsystems involved, focus on their interfaces, change the dynamic interrelationships, and then allow the system to reach a new equilibrium. For example, an individual employee, suddenly depressed and possibly alcohol-dependent, manifests deteriorating job performance. We could describe this clinical situation as a series of definable, interrelated problems operating at diverse levels of organization:

- intrapsychic - loss of self-esteem, "narcissistic wound", hunger, and need for sedation;
- interpersonal - regressive demands for emotional supplies;
- work group - role expectations, attitudes toward failure to perform, morale, and esprit;
- family - role as husband, father; family's response to withdrawal, alcohol sedation;
- corporation - policy and unofficial approaches to poor work performance; intervention by management, personnel, medical departments; and
- community - resources for treatment, including A.A., outpatient and inpatient psychiatry; attitudes toward drug abuse.

A complete program of psychiatric intervention in a business community includes tripartite preventative efforts, closely integrated with management, personnel, and medical departments (Auster, 1967; Cohen, 1969; Longaker, 1972; McLean, 1975; Modlin, 1973; Ross, 1963; Warshaw, 1970). Tertiary prevention focuses upon the reduction of disability and morbidity, and includes post-hospital follow-up, job modification and equal employment opportunity programs. Detection of affected individuals, early in the course of their disease, with prompt, effective treatment constitutes secondary prevention. Here the emphasis shifts toward education and community outreach programs. And, finally, the most effective means of reducing the prevalence and incidence of a definable health problem is alteration of the human environment to remove necessary and sufficient conditions for the genesis of the problem. Primary prevention of psychiatric illness requires involvement at all significant levels of a work community with particular emphasis on stressor reduction; improvement of "hygiene factors", and consistent efforts to improve communications and mediate conflict.

I recently published a follow-up study of psychiatric patients in a large corporate community (Robbins, 1976). The consultation model is a part-time psychiatrist working within the medical department. Employees are self-referred or referred by physicians, nurses, personnel specialists, or managers. The consultant is involved in management development and maintains an active collaboration with the corporate medical director's staff.

The retention rate for psychiatric patients exceeded 60% for periods up to three years after initial consultation. More than half of these employees were rated as exceeding job requirements or outstanding by their managers. Significantly, 59% of a subgroup of 83 employees, initially rated as unsatisfactory by management, were retained in the business after psychiatric intervention and were performing satisfactorily at the time of follow-up. A more comprehensive, prospective study is now in progress.

This study illustrates the value of in-house psychiatric consultation and highlights the possibilities for successful employment of psychiatric patients. Opportunities for primary prevention, the principal topic of this conference,

require close collaboration of management, labor, and clinical support systems. Hopefully, we can implement ideas from this conference in the workplace and accomplish meaningful changes.

REFERENCES

Auster, Simon L., "Clinical Programs" in McLean, Alan A., Editor: "To Work Is Human: Mental Health and the Business Community", New York: MacMillan Co., 1967.

Cohen, R. Robert, "Preventive Industrial Psychiatry", Journal of Occupational Medicine, December 1969, Vol. II, No. 12, 674-677, 1969.

Longaker, William D., "The Full Time Psychiatrist in Industry", IBM Corp., Endicott, N.Y. presented 56th Annual Meeting, Industrial Medical Association, Atlanta, JOM 14:216, 1972.

McLean, Alan A., "Management Discovers Psychiatry", THINK Magazine, 2-5 , March, 1959.

McLean, Alan A., "From the Viewpoint of the Psychiatrist", New York State Journal of Medicine, 2901-2904, Vol. 61, No. 17, September 1961.

McLean, Alan A., "Occupational Mental Health: Review of an Emerging Art", The American Journal of Psychiatry, 961-973, March 1966.

McLean, Alan A., "Psychiatric Consultation in IBM", Unpublished Paper.

McLean, Alan A., "Occupational (Industrial) Psychiatry" in Freedman, Alfred M., Kaplan, Harold D., and Sadock, Benjamin J., "Comprehensive Textbook of Psychiatry - II", Baltimore: Williams & Wilkins Co., 1975.

Modlin, Herbert C., "The Occupational Physician and the Psychiatrist", Journal of the American Medical Association, Vol. 226, No. 1: 50-55, 1973.

Murphy, H.B.M., Editorial "The Decline of Industrial Psychiatry", Psychological Medicine, 3:405-410, 1973.

Robbins, David B., "The Psychiatric Patient at Work", AJPH, Vol. 66, No. 7, 655-659, 1976.

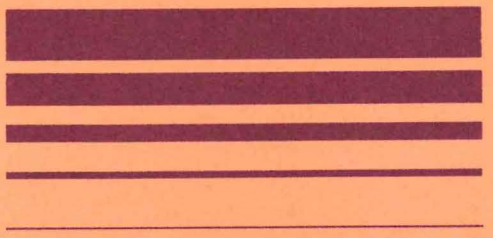
Ross, W. Donald, "Mental and Emotional Health Problems in the Worker", Archives of Environmental Health, Vol. 7, 100-102, 1963.

Warshaw, Leon J. and Phillips, Betty-Jane A., "Mental Health Programs in Occupational Settings" in McLean, Alan A., Editor: "Mental Health and Work Organizations", Chicago: Rand McNally & Co., 1970.

NIOSH

PROCEEDINGS

Reducing Occupational Stress



U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Center for Disease Control
National Institute for Occupational Safety and Health

REDUCING OCCUPATIONAL STRESS

Proceedings of a Conference
May 10-12, 1977
Westchester Division, New York Hospital-Cornell Medical Center

Sponsored by
Center for Occupational Mental Health, Cornell Medical College
and the
National Institute for Occupational Safety and Health
with the cooperation of
International Committee on Occupational Mental Health
Permanent Commission and International Association on
Occupational Health
World Health Organization
Work In America Institute

Alan McLean, Editor-in-Chief
Gilbert Black and Michael Colligan, Co-Editors

Contract No. 210-77-0041

U.S. DEPARTMENT OF HEALTH, EDUCATION,AND WELFARE
Public Health Service
Center for Disease Control
National Institute for Occupational Safety and Health
Division of Biomedical and Behavioral Science

April, 1978

DISCLAIMER

The contents of this report are reproduced herein as received from the contractor.

The opinions, findings, and conclusions expressed herein are not necessarily those of the National Institute for Occupational Safety and Health, nor does mention of company names or products constitute endorsement by the National Institute for Occupational Safety and Health.

NIOSH Project Officers: Michael Smith
Alexander Cohen

DHEW (NIOSH) Publication No. 78-140