Mental Health and Occupation

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OCCUPATION and mental health are related in many ways. A person's occupation (life role, kind of work) not only provides him with a livelihood but also symbolizes his degree of success. Thus it is a vehicle for expressing many basic drives inherent in all men, as well as needs unique to each individual. When a man is out of work, in the wrong field, misplaced or dissatisfied with his job—that is, when his job does not satisfy his basic requirements—he will, of necessity, seek to satisfy them in other ways. On some occasions he may successfully meet these needs; at other times, he may fail, find himself thrown off balance, and become emotionally ill.

The high prestige attached to certain occupations often leads parents to select them as future careers for their children and causes people to strive for occupational roles beyond their abilities. Such fruitless striving is likely to produce feelings of failure and rejection and result in withdrawal, defeatism, and other states of disequilibrium. This tendency to stratify occupations into low and high status regardless of individual performance has often been decried. Gardner (*1*), for instance, writes: "We must learn to honor excellence (indeed to *demand* it) in every socially accepted human activity, however humble the activity, and to scorn shoddiness, however exalted the activity. As I have said in another connection: 'An excellent plumber is infinitely more admirable than an incompetent philosopher. The society which scorns excellence in plumbing because plumbing is a humble activity and tolerates shoddiness in philosophy because it is an exalted activity will have neither good plumbing nor good philosophy. Neither its pipes nor its theories will hold water.' "

Despite the strictures of Gardner and others, the tendency to classify occupations without regard to performance continues. The great significance of a person's occupation for all other aspects of his life makes occupational level one of the principal indices for differentiating social classes. Although some studies have also used such indices as education and area of residence, as the sociologist Clausen has pointed out, in modern industrial living class is linked most closely with occupational status (*2*). To learn how occupation is related to mental health we may therefore appropriately examine the impressive literature on social class and mental illness.

Studies consistently show correlations between low social status (hence, low occupational status or no present occupation) and high rates of mental illness. A higher incidence of schizophrenia in the lower socioeconomic class has been found in a number of studies based on hospitalized patients or diagnosed cases (*3–9*). Another study by Hyde and Kingsley of army rejectees also shows an inverse relationship between the economic level of the draftee's community and the draft rejection rate for all mental disorders, including schizophrenia (*10*). It should be pointed out, however, that the psychoneuroses do not follow the distribution of schizophrenia. In fact, in some studies a tendency toward a positive correlation with economic status is reported (*10*, *11*). The psychosomatic illnesses are also distributed in more random fashion than schizophrenia (*12*).

Even though mental illness shows a marked correlation with lower socioeconomic status and unemployment, it is not known whether there is a causal relationship; nor, assuming such a

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relationship, is its modus operandi clear. It would appear that the apathy, withdrawn behavior, depression, and feelings of helplessness that exist among the unemployed, particularly after recent job loss, are related symbolically, at least in part, to parental abandonment or withdrawal of love. A deep sense of inferiority for not meeting the expectations of family (parents) and for not "being a man" is evident.

For many of the unemployed there is little hope for change. Being in the lower socioeconomic class greatly limits a person's possibility of obtaining another job. The resulting feelings of helplessness and hopelessness are probably significant in the development of mental illness. Schmale related these same feelings to medical illness in a hospitalized population (*13*).

Fried and Lindemann (*14*) have formulated the concept of role satisfaction as an important variable in mental health, defining it as ". . . the extent to which a person can accept an institutional definition of his roles with minimal conflict between personal needs and the externally provided definition of the situation." They state:

> Our work to date suggests, along with other studies of the working class, that there are more severe restrictions on freedom of role definition and role selection for the working class than for middle- and upper-class Americans. Whether in the sphere of occupational activity, educational choice, or familial patterns, members of the lower class less frequently have the opportunity to make an initial choice from a wide range of possibilities, to alter their choices without drastic consequences, or to reformulate the definition of the situation so that it is more need-gratifying and remains socially acceptable. Although this may not be uniformly so in all institutional areas, it seems to be predominantly the case. This impression can be related to an observation Alex Inkeles has made on the basis of preliminary work on poll results which have been obtained throughout the world. Inkeles finds that working-class people show stronger and more widespread dissatisfaction, are less optimistic on a wide range of issues and are less confident and self-confident than the middle or upper class. We would anticipate that in this area of the rigidity or plasticity of institutional definitions of roles and the relationship between such limitations and Role Satisfaction lie some of the most important sociocultural regularities which affect mental health and mental illness. The existence of such sociocultural regularities would not vitiate the importance of psychological determinants of mental health and illness but they would establish some of the basic conditions within which specific psychological patterns are likely to produce "pathology" and the extent to which conflicts between need systems and institutional roles lead to the phenomena of mental illness.

Several pointers for remedial programs may be drawn from the literature relating social class, low occupational status, and poverty to mental illness. A program to combat poverty must do more than increase financial assistance. More job opportunities and better preparation of the lower socioeconomic groups to give them a greater range for coping with role dissatisfaction would rate a high priority. Most important would be a major effort to help deprived families so they would avoid the crippling effects of physical and emotional deprivations. Massive help of this kind is needed to eliminate the syndrome referred to as "the culture of poverty," which is transmitted in ever-widening circles from generation to generation. Anything short of sustained and dedicated multidisciplinary effort, beginning with intensive study and planning, will fail.

It may be questioned that poverty is the province of the psychiatrist. In view of the intimate relationship between poverty and mental ill health, however, there can be little doubt that the insight of the psychiatrist and of other behavioral scientists can contribute to solution of this problem.

Mental Health in Industry

When a person begins his first job he is not, of course, totally unprepared for the kind of social experience he faces; he has been living among, and interacting with, people since birth. In his early years, through interaction with his family, he learned what to expect from the world. He has gained, or failed to gain, mastery over his impulses. In passing through these early phases of personality development, he has developed a wide or narrow range of abilities to adapt to stress. With the aid of various dynamisms he has evolved a method of handling the conflicts which constantly arise as internal demands meet external as well as internal restrictions. Later on in childhood he began to depend more for support on persons and institutions outside of his family. At first his friends and peer groups, his school and

church provided support. Later he has relied on formal organizations and institutions, including the law, the army, welfare services, and hospitals and other medical facilities. The formal and informal organizations of the place of work offer similar experience in developing means to meet the demands of the external world.

A person's job situation embodies what Levinson and associates (*15*) conceptualize as the "unwritten psychological contract," an agreement which includes both the employer's and the employee's expectations. Dependency conflicts, rewarding relationships with others, and use of the work situation to cope with stresses occurring within one's self or environment appear to be elements in this contract.

Much psychological stress derives from interpersonal relations and is frequently unconscious and insidious. Chronic stressful situations in industry may arise from a wide variety of causes, for example, from production requirements for quantity or speed perceived as unfair, the threat of automation or other change, isolation, poor physical equipment, overheating, too little light, poor or sick leadership, improper or insufficient instructions, marked conflict in labor relations, punitive and hostile disciplinary measures, unexplained promotion policies, racial discrimination, or inability to gain prestige, recognition, and understanding through the job. Since each employee has a personality constellation with varying degrees of ego strength, these stressful situations will affect each person in a unique way. Each employee will react according to his character structure. The number of variables precludes simple and necessarily premature conclusions regarding causal relationships.

Herzberg (*16*) states that "the jobs most people do are not a rich source for psychological health and, in fact, they may best be classified as mental health hazards." He points out that his studies, as well as those of McGregor (*17*) and Argyris (*18*), shed light on factors that influence job satisfactions or dissatisfactions. Argyris maintains that there is a "basic incongruency between the needs of a mature personality and the requirements of formal organization." He believes dependency is promoted in most organizations.

Herzberg (*16*) finds that job satisfactions are related to job content. Satisfactions are influenced most commonly by achievement, recognition, responsibility, advancement, and the work itself. The causes of dissatisfaction, however, relate to job context or job environment, such as company policy and administration, supervision, status, salary, and working conditions. This has been a consistent finding in studies of engineers and accountants, U.S. Air Force personnel, nonsupervisory employees in the auto industry, general managers, schizophrenic patients, and physical rehabilitation patients.

Kornhauser (*19*) found that the mental health scores of workers in the Detroit area showed a "strong and ominous relationship with the skill level of the jobs performed." He believes that the skill required by the jobs, and not other factors associated with the type of persons in the various echelons of the job hierarchy, is the crucial factor. From the analysis of his data, only 16 percent of middle-aged workers doing repetitive semiskilled jobs show "high" mental health scores. This percentage drops to 7 percent for those classified in the "young" age bracket.

In a Pittsburgh social rehabilitation center for discharged mental patients, a constant source of defeat is the inability of most of the patients to obtain and retain positions that offer the positive supports the work situation should provide. It is a real question whether some rehabilitation programs for the mentally ill do not waste time and money for this reason.

Mental health statistics from a number of sources bear on the incidence of emotional disequilibrium in industry. About 6 percent of persons in job situations will suffer an acute mental illness, according to Jackson; 25 percent of an industrial population experience emotional disturbance of sufficient severity to adversely affect their work production (*20*). MacIver estimates that 10 to 20 percent of the work force at any given time has clinical behavorial problems (*21*). Himler estimates that, while occurrence of frank psychosis is small, 50 percent of the referrals to the medical departments are for psychiatric problems (*22*). He also states: "It is believed that stress of industrial work may be considered the primary cause

of some emotional disorders but certain occupational stresses act merely as releasing or uncovering factors for personality reaction patterns and adjustment problems of chronic nature that originated on the job." Moreover, Jackson estimates that 80 percent of industrial mental health problems stem from conditions outside business and may only be touched off by conditions on the job (*20*).

Kasl and French report that "the skill level (and pay level) of a job will be associated with indices of [ill] health"—such as increased dispensary visits (*23*). Even among foremen, the higher the skill level of the workers supervised, the less frequent are the dispensary visits. From a review of the literature these authors assembled support for their conclusion that job satisfaction is positively correlated with job status and negatively with mental illness (*24–26*).

The complexity of the relation of mental illness and the job is shown, however, by those who report little positive correlation of high status jobs and low incidence of illness (*27*). Vertin in a study of the rate of ulcers in a large factory in Holland found that the foremen's rate was about seven times as high as that of the workers (*28*). A linear relationship existed between skill level and ulcers, with the skilled workers having a lower incidence. The foremen's ulcer rate was the exception (which makes it fallacious to generalize with indices of status as the sole factors). Dunn and Cobb, in a personal communication to Kasl and French (*23a*), also reported a higher incidence of ulcers in foremen. The executives and craftsmen were similar in ulcer incidence. To add further complication, however, the mean serum pepsinogen value (an indicator of a person's gastric secretory potential and usually higher in persons with an ulcer) is higher in executives than in craftsmen or foremen with or without ulcers (*23, 29*). In other studies, tests for blood uric acid latex agglutination and blood cholesterol suggest similar relationships (*30–32*).

A positive relationship between occupational environment and the health of the worker unquestionably exists. The evidence to date, however, does not begin to give a satisfactory explanation. The Hinkle and Wolfe study of illness experiences, recorded over a 20- to 30-year period, of workers in a medium-sized corporation is one of the most illuminating (*33*). These authors found that illness occurred in clusters over time, rather than being evenly distributed, and that those who had many minor illnesses tended to have major illnesses as well and to experience behavioral and affective changes. The study data showed that these clusters occurred in workers who were having difficulties in adaptation to life situations in general. These difficulties were presumed to be dependent on the individual's total perception (both conscious and unconscious) of his situation. Furthermore, those most frequently ill had been reared in an atmosphere of parental conflict and rejection.

Despite incomplete knowledge of the exact relationship of illness and the job situation, an increasing number of workmen's compensation cases in which the job environment has been blamed for the stress that caused the emotional illness are being decided in favor of the plaintiff (*34*).

Responsibility of Industry

Mental health and illness have a profound effect on the industrial complex and its efficiency. Available evidence suggests that management's accountability to the owners and responsibility to the workers demand close scrutiny of the cost of mental illness in time, money, and waste of human effort. A review of the literature indicates that nearly all professional personnel in industrial medicine, including psychiatry, believe industry has a major responsibility first for study and then for action in the mental health field. At a symposium on "Self Actualization in Industry," McLean (*35*) asked, "Does management have an obligation to create jobs which provide satisfaction, recognition, and opportunities for creativity? To what extent does a technical society have a responsibity to create a world of work which has meaning and in which the individual employee may find opportunities for personal growth?"

Grestle says industry needs to put existing knowledge in the field of preventive psychiatry into practice (*36*). Miller and Kaplan urge adoption in all industries of a health program for executives (*37*). Goldstein (*38*), the medical director of the *New York Times*, says, "It

is axiomatic, of course, that the medical department in industry must appreciate its responsibility in the areas of mental health."

Robertson sums up current belief by emphasizing the significance to industry of recognition of mental health problems (*39*). Although many tools are available for secondary prevention of mental disease, they are used for only a small fraction of the employees in the country. He stresses the need for a multidisciplinary approach to primary prevention. Robertson further points out the inadequacies of the present-day preemployment examination and its failure to assess personality and emotional makeup. He states that generally only lipservice is given to employee education, the emotional environment is neglected, and records of employees need to be improved.

To indicate what industry can do is far form simple. General remedial action for all industries cannot be postulated.

The goals of industrial enterprise are the production of needed goods and services at a profit for the owners. Industry must also recognize, however, that the achievement of these goals will be enhanced if it assumes some responsibility for the improvement or maintenance of the mental health of workers. This recognition must occur before any mental health program is introduced. To dichotomize between good employment practices and efficient production is fallacious. The assumption of responsibility for mental health necessitates an educational program on the subject at all levels. The role of the foreman or supervisor in industrial health needs redefinition and restructuring (*40*). Closer involvement of the medical department and the management team would enable the industrial psychiatrist to offer suggestions on policy and program which affect job skill and job status, for example, aspects related to automation and other changes.

Companies and employees would benefit if more industries would open their doors to multidisciplinary studies similar to the Midland Study (*15*). Authors of that study offer excellent suggestions for present and future use of such studies.

Presumably the low-status employee in industry needs major support from his supervisor, just as the aide needs it in the hospital. The foreman or supervisor, by his middle position, requires support and understanding from both management and workers. The industrial nurse might be his primary support; in crises she could turn to the industrial physician or psychiatrist for advice. By this pyramid arrangement, the expert knowledge of a number of the persons best trained in mental health and mental illness would be spread throughout an industrial organization.

Foremen, nurses, and other key personnel need to be taught that absenteeism, misconduct, troublemaking, resentment of authority, accidents, drinking, and other aberrant behavior are frequently a red flag, signifying that something in the individual, and perhaps in the organization, needs study and attention. The industrial nurse and physician require training in counseling and interviewing, along with an understanding of group dynamics. Every level of management, however, needs to be involved in a mental health program. Information about mental health and illness geared to every echelon is perhaps the key factor in the success of such a program. Little is gained from training the nurse or foreman or teaching the worker if the medical department or top management cannot see the program's importance.

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