Job Loss—
A Psychiatric Perspective

Formulated by the
Committee on Psychiatry in Industry
Group for the Advancement of Psychiatry
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FIRST EDITION
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## Statement of Purpose

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

JOB LOSS: A PSYCHIATRIC PERSPECTIVE was formulated by the Committee on Psychiatry in Industry, which acknowledges on
page xi the participation of others in the preparation of this report. The members of this committee are listed below. The following lists the members of the other GAP committees as well as additional membership categories and current and past officers of GAP.

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Duane Q. Hagen, M.D., Chairman
INTRODUCTION

"With the loss of job goes the great loss of prestige values, within and without one's home. No matter how humble the job, it had sufficed. In our civilization, work is what man lives by. We work to earn the necessities of life, to secure its comforts, to provide as befits a man for our families. It helps still the feelings of inferiority that unconsciously beset us; it gains us parity with our fellow and the acceptance of the community. It dignifies our daily life, no matter how humble. In it we may expend our aggressive impulses and ward off the profound feelings of insecurity and helplessness... For the unemployed man, all this is changed."*

Job loss, the principal theme of this monograph, inevitably has a tremendous impact on individuals, as well as their families and colleagues.

The disadvantaged, the unskilled, and the undereducated are not the only ones at risk. Job loss is increasingly hitting the professions, management, and the white-collar world as well.

In the preparation of this monograph, we were intensely aware of the ramifications of job loss. It became evident that it was not just the job that was lost. This trauma has a ripple effect, affecting not only the individual but the family, the employer, and the community.

Perhaps no single activity defines adulthood more specifically than work. To a large extent, it influences how and where the person lives; it provides a title, a description, and an environment that reinforce an identity intrapsychically and interpersonally. Some are thrust into work without realistic alternatives as a result of limited education, physical, or emotional handi-

We recognize the importance of specific groups (the hard-core unemployed, migrant workers, immigrants, and those in the lower socioeconomic sectors) who may lose their jobs. However, the special problems of these groups are not discussed in detail in this report. In this work, we especially emphasize retirement and aging, as well as the problems of families and psychiatric patients. Many other groups deserve emphasis, such as young people, members of minorities, and other workers in other subcategories.

A survey of research on job loss will reveal certain realities. Job loss and the threat of job loss are excruciatingly threatening to many and seriously disruptive, at the least, to others. The attendant psychological and physiological changes are measurable. Job loss contributes to higher levels of ill health; it is also associated with development of severe mental disorders, as evidenced by suicide rates and first admissions to mental hospitals. For those who already have chronic mental disorders it may cause an exacerbation of symptoms.

The case histories we present will give readers some flavor of the subjective emotional experience of workers who have been dismissed. It is true that many cope well with this catastrophic event. Is this because their support systems are adequate? Are others more or less vulnerable for other reasons?

**Self-Esteem as an Intervening Variable**

How, where and why one works are significant factors in contributing to one’s sense of self-esteem or self-worth.

Bibring notes that the sense of worth as a person depends on perceiving oneself as strong and effective, as conforming to ideas of what is right, and being valued by other people. The lowering of self-esteem when any of these perceptions are lacking may result in a feeling of depression.

Rochlin believed that the question of self-worth is raised early in life. “All people appear to be concerned with their worth. A
sense of worth is not a stable value. It is fluid, subject to circumstance and is revealed as fragile” (p. 149). We are constantly reviewing and revising our worth to ourselves. Individuals work very hard to preserve it, and its loss must be redeemed. A forfeited, damaged, or decreased self-esteem is unacceptable.

Erikson has clearly indicated the need for progressive, worked-through stages, starting with trust and autonomy, to establish a sense of strong self-esteem. “The sense of ego identity, then, is the accrued confidence that one’s ability to maintain inner sameness and continuity is matched by the sameness and continuity of one’s meaning for others. Thus, self-esteem, confirmed at the end of each major crisis, grows to be a conviction that one is learning effective steps towards a tangible future, that one is developing into a defined personality within social reality which one understands” (p. 89).

Hence the job and the self are intimately tied to each other, and a threat to one’s job is immediately perceived by the individual as a threat to himself or herself. As Greiff and Muntz pointed out, “It doesn’t matter what you call it, fired, axed, sacked, canned, kicked upstairs or allowed to resign. The only certainty about losing a job is that it hurts, it threatens everyone, not only the person fired but the family, peers and, to a significant extent, the community” (p. 117). Consequently, the loss of a job has serious implications. How one reacts to this loss depends on many things: (1) pre-existing feelings of self-worth, (2) the capacity to handle loss, (3) the options available, (4) the reality of the limitations of finding a new job, (5) age and education, (6) physical and psychological vulnerability, (7) the circumstances under which the job was lost (industry phase-out versus personal reasons), and (8) the support systems available (spouse, friends and career counselors).

We recognize the complex problem of people whose self-esteem is never enhanced by the work experience. Terkel, in the introduction to his book, *Working*, quoted Nora Watson as saying, “I think most of us are looking for a calling, not a job. Most of us, like the assembly line worker, have jobs that are too small for the spirit. Jobs are not big enough for people” (p. xxix). Certain studies reveal some positive responses to job loss. These exceptions, we believe, are determined by the mitigating or aggravating factors cited.

### The Function of the Work Role

Our experience in industry and with patients suggests that those who lose their functional role as workers may behave as if their society no longer values them. Because they accept that as true, they suffer a consequent loss in the perception of their value in their families and to themselves.

The loss of a functional role experienced as a loss of self-value may precipitate a kind of grief reaction and may constitute a threat to, or a disruption of, the integrity of the self. This impairs the balance between the self and the environment, and may result in anxiety, depression, psychosomatic illness, or even a psychotic reaction.

The successful high school graduate who becomes a college freshman goes from being “Mr. Big” to being “Mr. Little,” and often feels a similar disruption of psychic balance. The employee who experiences a functional role loss, from whatever cause, feels the same disruption. Being fired, retired, transferred to a new site—or even being promoted—all carry the threat of a disturbance to psychic equilibrium.

Job loss often creates a financial quandary of variable intensity. Loss of work, and the concomitant loss of income, contribute to individual and family distress. It is severe at a time of increased family need, for example, illness or children in school. For those without other sources of income or with sizable debts, the loss is crucial. All too often a need for medical care coincides with a lapsed insurance coverage.
REFERENCES


RECENT RESEARCH ON JOB LOSS

Rapidly evolving technology and the obsolescence of certain skills contribute to drastic changes in the world of work. Not only have technological advances restructured or destroyed many jobs—the changes in society have also had an impact on jobs. As Secretary of Labor Willard Wirtz said in 1967, “Over the years the changing nature of work has been the cause of the greatest continuing restructuring of American lives of any major force in our history.”

Changes in the economy are potent measurable forces, which affect the type of work and the opportunity to perform it.

Economic Changes and Health

What effect does the state of the economy have on an individual’s health? Do economic changes that occur over the long term, cyclically, or in relation to technological innovations also affect physical and mental health? Since the mid-nineteenth century in the United States, there has been a long-term decline in the mortality rate, usually attributed to increased income, living standards, and levels of education and occupation. A consistent finding in the field of psychiatric epidemiology is that the prevalence of mental disorders (treated or untreated) is inversely related to socioeconomic status. Higher rates of morbidity and mortality due to physical disorders and a shorter life expectancy are found among lower socioeconomic groups. Stresses brought about by large-scale economic fluctuations fall most heavily on those in lower socioeconomic groups.

The experience of losing a job has been studied extensively.
the opportunity to work has major significance, then those without that opportunity could be expected to show specific characteristics. Cohn reported on a longitudinal study (1968-73) of 3,000 heads of families. Those who became unemployed and reemployed over a five-year period were compared with employed control subjects. He found that becoming unemployed led to a negative self-concept, a measurable dissatisfaction with self. The extent of the dissatisfaction was modified by other determinants, such as prior achievements and the availability of an external cause for the job loss. Accepting alternative roles (such as motherhood) after job loss was helpful. For many, the negative self-concept persisted after reemployment.

In another study, a group of jobless men was compared with a control group. A dramatic loss of self-esteem was evident. They felt small, insignificant, and redundant. Even after reemployment, their self-esteem never reached the level of the control group whose members had never been laid off.

The national suicide rate was perhaps the first indicator of psychopathology to be recognized as related to adverse changes in the economy (p. 24). Pierce, using a social model from Durkheim, hypothesized that economic fluctuations reduced social cohesion and led to increased frequency of suicide. The U.S. white male suicide rate for the peace years 1919-1940 was compared with changes in the index of common stock prices. When the suicide data were lagged one year behind the stock index, a significant positive relationship ($r = .74$) was found.

The hypothesis has been tested and partially confirmed that those in higher status categories (chiefly white men with higher incomes) are more likely to commit suicide during economic downturns (Henry and Short, p. 190). Also, the rate of suicide for American men is higher in areas characterized by many women in the work force. This finding coincides with Lloyd's prediction that as women become increasingly competitive in a previously male-dominated vocational structure, the subjective security of some males will be threatened.

In the Soviet Union and England, the suicide rate has been associated with chronic unemployment. Other authors have found a relation between unemployment and homicide, wife abuse, and child abuse.

Intensive research relating economic factors to physical and psychiatric illness has been done by M. Harvey Brenner of Johns Hopkins. His complex statistical analysis correlated economic indices, such as the unemployment rate, with measures of social pathology, such as the suicide rate. Critics of his work are concerned mainly with what they consider spurious correlations and the lag of social stress indicators one to several years after the economic changes. In a book published in 1973, he described a continuity of relation between unemployment and first admissions to mental hospitals over 127 years (1840-1967).

Brenner subsequently prepared a series of studies for the Joint Economic Committee of Congress, in which he again confirmed a strong relation between changes in employment and various indicators of illness and social stress. In fact, he found a statistically significant relation between unemployment and suicide, state mental hospital admissions, state prison admissions, homicide, mortality from cirrhosis of the liver, mortality from cardiovascular renal disease, and total mortality. Brenner's findings suggest that a 1.4 percent rise in unemployment (about 1,500,000 jobs) during 1970 was directly responsible over the next five years for some 51,570 total deaths, including 1,740 additional homicides and 1,540 additional suicides; there were, in that period, 5,520 additional mental hospitalizations.

The lag period for economic changes and health changes differ. For suicide and homicide, the rates rise within one year of an increase in the unemployment rate. For cardiovascular disease, the lag period is two to three years. One must suppose that severe economic loss and downward mobility initiate patterns of interaction over several years among chronic disease processes, vulnerability to economic stress, and mortality.

The findings apply to virtually all ages, both sexes, and both whites and nonwhites in the United States. In three other countries—England, Wales, and Sweden—similar findings have
emerged. By way of comparison, the rate of inflation and pathological indices were interrelated, but never reached the extent of unemployment.\textsuperscript{6,89,99}

Brenner's correlations are macroscopic, complex, and controversial. However, others are beginning to confirm his findings.\textsuperscript{13,20} At Fairfield Hills State Hospital (Connecticut) an increase in hospitalizations with job-related precipitants was observed during the economic decline of 1974.\textsuperscript{31} Readmissions to Missouri public mental hospitals were recently found to correlate positively with unemployment statistics.\textsuperscript{22} In Australia, the mortality rate from ischemic heart disease increased one and a half to three and a half years after the great recession of 1961.\textsuperscript{25}

One report showed that retired subjects have a greater risk of coronary mortality than non-retired control subjects.\textsuperscript{24} This is consistent with Brenner's findings of increased mortality in the older age group during economic downturns. However, a recent critique of Brenner's work, which applied alternative statistical methods, confirmed his findings only for the working age population, not the young and the aged.\textsuperscript{25}

Intervening variables affecting the relation between economic change and illness have been elucidated in a study in the Kansas City metropolitan area.\textsuperscript{26} During 1971–1973 measures of depressed mood were significantly greater within two to three months after a rise in unemployment. An increase in symptoms (both physical and psychological) was also found. This study partially extended Brenner's findings. Monthly reports of symptoms from normal people were used rather than records of objective events such as suicide or hospitalization.

Do Brenner's studies indeed indicate that all forms of social stress, the one with the greatest impact on mental disturbances is change in the economy and, as a ramification, change in the economic situation of individuals? A recent conference at the National Institute of Mental Health\textsuperscript{37} reviewed the evidence for a relation between economic and mental health, with special emphasis on Brenner's findings.

Traditionally, clinicians have not looked upon economic changes in the lives of individual patients as a major issue in their illnesses or their entry into treatment. Rather, economic factors have been considered only one of many types of stress. Recent data indicate that unemployment benefits do not reduce mental illness among certain affected groups. If financial support is not a determinant, then job loss could result in basic alteration in the individual's self-esteem. This might explain why increased morbidity and mortality are found among the retired and others not looking for work.\textsuperscript{28}

**Research on Plant Closings**

The effects of plant closings on worker's physical and psychological health were studied in two companies. Regularly employed workers were used as controls. The period of greatest ill health occurred during the period when job loss threatened.\textsuperscript{29}

Somatic complaints were prominent. Cases of hypertension and joint swelling were significantly greater during the threatening phase and the actual termination. There was substantial evidence of depressive symptoms.

On the positive side, some people ended up better than before. Some employees had been underemployed, and the change led to better positions. In addition, a strong social support system was effective for many employees.\textsuperscript{50}

In a study of a plant closing in Appalachia, many of the elements of a classic grief response, with degrees of denial, depression, and defensive responses were found. Some job seekers were adversely affected by repeated failure to find work. Assumption of the sick role was frequently observed.\textsuperscript{31}

**Other Physical, Psychological and Behavioral Consequences of Job Loss**

Favorable responses to job loss have also been reported. One hundred technical professional men who had recently lost their positions were interviewed.\textsuperscript{32} A positive attitude was reported in
48 percent of the sample. These men found the job loss an opportunity to escape from undesirable jobs. However, the author emphasized that these findings should not be interpreted to mean that job loss had been a pleasurable experience for these workers and their families. Although there was mental and financial anguish in almost all cases, these men displayed considerable adaptability. Support systems were available and were utilized. Many workers are dissatisfied with their jobs, but they continue with their jobs and, seemingly, adapt.  

Job loss was found to be a psychosocial risk factor for malignancy. A group of patients was studied after discovery of pulmonary lesions. Those whose lesions were found to be malignant had a significantly increased incidence of loss (including job loss) during the preceding five years.

A well-controlled study from Wales found an increased incidence of accidental self-poisoning in young children in families under stress. Unemployment was significantly more prevalent in the affected families than in the general population, although the socioeconomic backgrounds were similar.

The studies reviewed here are indicative, but certain variables require further clarification. Further research would undoubtedly lead to a greater understanding of these changeable factors.

Cultural, Ethnic and Minority Issues

Certain subgroups within the population are more vulnerable to job loss or unemployment than others. These include members of minority groups, certain immigrants, individuals with low socioeconomic status, and the physically and mentally handicapped. These same groups are often victims of social discrimination. Society tends to ascribe blame or responsibility to the individual who experiences job loss or is unemployed. Such attitudes must be challenged so as to achieve an objective appreciation of the intricate relationship between the determinants and the consequences of these phenomena, as identified by psychosocial research.

Other factors are in reality more closely related to the phenomena of job loss and unemployment. For example, one of the largest groups of unemployed consists of those who have just entered the labor market, or who are making their initial attempt to do so. Having less seniority on their jobs, the young are often the first to be dismissed during periods of economic recession.

A person who has been repeatedly fired develops "ecosystem distrust" as described by Triandis and coworkers: a gradual reduction of trust, and a rejection of authority figures and establishment institutions. This mind-set makes it even more difficult for such individuals to become stably integrated into the work market. Many without marketable skills (and some with) become numb and discouraged, and withdraw into non-work roles. They have frequently been accused of enjoying their unemployment dependency, but a study by Kalacheck demonstrates that the lack of job opportunities, rather than erosion of the work ethic, is responsible for low participation in the labor force among teenagers and young adults. He believes that job opportunities for this group will improve only when employment opportunities increase generally.

One great obstacle to the employment and advancement of minority group members is the attitude on the part of management that these individuals have neither the desire for employment nor the capability to maintain it. The vocational vulnerability created by such an atmosphere perpetuates marginal participation by a substantial segment of the black population. Staples points out that young black people are able to obtain employment in large numbers only in periods of economic prosperity.

Traditional cultural attitudes toward women's participation in the work force are embodied in the cliché, "A woman's place is in the home." At present, women constitute half the work force in the United States. For most, work is an economic necessity. Discriminatory practices impede the acquisition by women of certain job skills as well as their acceptance into substantial positions in the labor force. Women's employment is more wide-
spread and consistent than it ever has been. However, many women have only recently entered the world of paid employment and therefore they are often the most vulnerable to layoffs. The restriction of opportunities for women in certain occupations often increases the impact of job loss or unemployment for them. In particular, it tends to make prospects for reemployment somewhat less bright. There is a particularly high unemployment rate for migrant and unskilled women, who constitute a large percentage of the labor force in the garment industry. Some women, out of economic desperation, gravitate toward prostitution.99,40

There is evidence that low socioeconomic status predisposes to job vulnerability. The segment of the population living near or below poverty level is burdened by a lack of basic educational training, few marketable job skills, higher rates of mental illness, and poor general physical health.11, 92 Each of these factors weighs heavily against obtaining employment and job security.

**Sociocultural Sequelae of Job Loss.** Two studies from England consider the impact of rising levels of unemployment on racial tension. Tentative evidence supports the hypothesis that unemployment breeds racism. Prejudicial racial attitudes of the white unemployed have been sharpened by high levels of unemployment and competition for jobs.14

Many studies point to a wider gulf between those low and those high on the socioeconomic scale during economic recession and increased unemployment. Hodge, for instance, states, “The more depressed the economy, the greater the unemployment differential between disadvantaged and advantaged.”15

In the United States, unemployment and job loss have been described as factors that determine the extent of organized crime.96, 97 The consequences of criminal behavior often include, particularly for members of minority groups, removal from the open labor market.49 Staples99 presents statistics showing that black youths commit the largest number of crimes against person and property and suggests that subtle influences impel black youths into violence. This study also asserts a positive relation among unemployment, criminal behavior, and the high death rate seen among black men.

**Intervention.** In books and articles dealing with proposed solutions to problems of the unemployed and counseling and training programs, the frustrations of many authors are clearly apparent. The need for large-scale programs, particularly for the disadvantaged, is stressed.92 Both successful and unsuccessful psychological counseling is described.31, 32 Morissette35 claimed that traditional psychiatric treatment has failed to deal with these problems, and recommended that psychiatric hospitals be changed to centers for rehabilitation and learning.

Many obstacles impede the transition from classroom to market place. There are recommendations for legislation, incentives to alleviate these obstacles, and exhortations for greater subsidies by both public agencies and employers. Practical suggestions for twelve-month schools, with shifting vacation periods and an emphasis on education that produces saleable skills, come closer to reality than most of the idealistic recommendations elsewhere in the literature.38

One typically pessimistic author35 asks whether the problem of unemployment lies more with the hardened core than with the hardened shell of work organizations. His case study of job training for the hard-core unemployed in a midwestern chemical manufacturing plant is presented. The results indicate that the experience of black trainees in the chemical plant was dehumanizing. Elaborate preparations had created expectations of inevitable failure. These trainees were met with hostility at every level of the plant, from foreman to fellow-workers. They were even deprived of the primary relationships crucial for integration into a complex organization.

Zimbel36 compiled forty articles on the problem of how to improve the unemployment situation among disadvantaged
hard-core unemployed. He focused on recruiting, training, testing, upgrading the unskilled, and untrained, and undereducated minority workers. Influences that determine the success of such programs include the attitudes of top management, first-level supervisors and the union, and the elimination of improper or discriminatory psychological testing. Zimbel believes that both public and private efforts are needed to solve the pressing social issue of how best to fit the unemployed into a permanent employment pattern. This survey of the literature linking disturbed behavior with unemployment makes for pessimism.

Unemployment is inextricably linked with complex economic variables quite literally beyond the control of any individual member of society; as such, it is threatening for many and a reality for millions. In times of high unemployment, the external factors loom large in the scheme of interplay among individual vulnerability, specific stressors and the external world.37

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CASE HISTORIES, WITH INTERPRETIVE COMMENT

Case Histories, with Interpretive Comment

“Not every technique for the conduct of life attaches the individual so firmly to reality as the emphasis on work; for his work at least gives him a secure place in a portion of reality, in the human community.”

The following three cases are examples of limited or fairly successful treatment of patients suffering the psychiatric sequelae of job loss.

One may argue that pre-existing psychiatric problems were possible or probably contributing to job loss in two of the cases. If so, such problems increase vulnerability to more severe disorders. In the second case, a series of conflicts in interpersonal relationships was compounded by job loss.

The Job Loss Experience

Case #1. Mr. P. was a 55-year-old married man, with one teenage son. He had lived in the same city all his life and had a stable marriage. After two years of college he was offered a job as a technician with a large international manufacturing company and became a highly valued employee. He was with the company thirty-five years and was promoted to a job beyond his educational training.

During a recession, the company cut back on its southern branch. Mr. P. was told of his job termination six months ahead of time. Supervisors told him clearly that this was not a reflection of his performance. Soon after hearing the news, he became depressed and made an unsuccessful suicide attempt. Discovered by a family member, he was referred for voluntary psychiatric hospitalization. He had no previous history of psychiatric problems.

Mr. P. had few outside interests, and the job loss was a severe blow to his self-esteem. He had never actively searched for a job on his own, and looking for a new position frightened him. His family style was one of separateness. From individual interviews, it was clear that the family members cared for one another, but they had great difficulty sharing their feelings.

While he was in the hospital, Mr. P.’s company offered him a comparable position with a branch in a midwestern city. After this he felt much better, denied suicidal thoughts, and insisted on leaving the hospital. He was discharged after a three-week hospitalization so that he could visit the midwestern city. After returning from the visit, he started weekly psychotherapy, continued to take the prescribed medication, and considered his options. He could look for another job in the same city or move the whole family to a new location. His son threatened to stay behind if the rest of the family moved. If Mr. P. were to stay, he might lose retirement benefits and might not find a comparable job because of his limited education. If he were to move, he would lose the social support of his community and extended family in the area. He acknowledged some depression but denied suicidal plans. He firmly resisted including his family in therapy. Within three months he died of a self-inflicted gunshot wound.

Comment on Case #1. This case demonstrates the limitations of individual psychiatric treatment including pharmacotherapy and hospitalization. The patient claimed to be improved upon discharge, but the outcome might have been different if work and family issues had been more adequately addressed. We can only speculate that involvement of individuals in Mr. P.’s larger social network, including his employers, might have helped him survive his suicidal crisis. The psychiatrist might have been able to intervene with Mr. P.’s company, using the medical director as liaison, had he known this was an option. Working together, they might have helped Mr. P. make an employment decision consistent with his vocational and personal needs.

More active family involvement would have been another appropriate intervention. When an individual faces job loss, the whole family is in pain. They may require support for themselves so that their full attention can be given to the affected individual. The psychiatrist may need to take the initiative in enlisting the support of employer and family in a case like that of Mr. P., who had an overt style of denial but who was nevertheless in enormous pain.

Case #2. Mrs. K., 38, a twice-married mother of a 16-year-old daughter, consulted a psychiatrist on her own after she lost her job, when she found herself tearful, feeling troubled in her interpersonal relationships, and concerned that she was becoming progressively more depressed. She stated that the current episode had been precipitated by the death of a former supervisor, the general manager of a local manufacturing plant. On the same day, she also learned of the serious illness of another former coworker.

Mrs. K. had been employed in the same plant since age 18. She worked on the manufacturing line for three years while attending business school at night. She then became a secretary, and nine months later married an attorney. She left employment when her child was born, but returned two and a half years later to the same company as secretary to the vice president and plant manager. She described that position as the “top job in the plant for a girl.”
Mrs. K. spoke of her work proudly: “I had a succession of six plant managers and three vice presidents. I took all their phone calls and letters, got their coffee, and made their plane reservations.” Her work became the central focus of her life.

Her first husband's work was very important to him. He seldom came home promptly after work. They lived in a small community, and his excessive drinking and frequent sexual infidelities soon became evident to her. When she was 35, her husband abandoned her to live with a teenaged girl. Soon after, Mrs. K. divorced him and two years later she remarried.

“One month after I got married, they told me they were closing the plant. They said we were going into a recession and the company could not afford to keep that plant open. They said my last day of work would be ninety days later. Everyone at the plant was so upset and nervous. Lots of them had worked there all their lives. The plant was like a family. We all got so close. It was getting to everybody that the plant was closing.” Indeed, the plant closed and her job was terminated. She maintained regular telephone contacts with some of her former work colleagues for many weeks.

At that point, she decided to seek psychiatric consultation. Her mood was characterized primarily by depression and impairment of self-esteem, which seemed related to devastating losses of the past (her first husband and her employment) as well as the recent sudden death of her former supervisor.

A brief course of medical psychotherapy was instituted. Within three months Mrs. K.'s symptoms markedly abated. She subsequently secured a job as an executive secretary in a major corporation. She held that position for approximately six months before she voluntarily decided to pursue her responsibilities as a wife and mother. Her symptoms have not recurred as of a year and a half following the initial consultation.

Case #3. Mr. O., 54 years old, was seen in psychiatric consultation stating that his problem was “inability to cope.” “I never measure up to my goals, and it hurts.” He had never married, and lived with a widowed sister in a small southern resort community.

For seventeen and one-half years, he worked as a scheduler for a manufacturing company. He was fired in 1974. About that termination he said, “They told me it was between me and another guy, and since I was the slower they fired me.” He had been depressed for about two years before being terminated. He found himself “not measuring up.” He felt that he was slower than his younger fellow-employees. After losing his job, he felt more depressed, and although he applied for other jobs, he was never hired. No one, it seemed, wanted to hire somebody aged 49 with only a high school diploma.

Mr. O.'s current interests and activities were constricted. He owned an automobile, but stated he drove little because of fears about everyday events. He neither shopped for groceries nor cooked, looking to his sister to fulfill these needs. He occasionally helped her clean house. He read “rather light things,” and tended his garden during the warm months.

He stated, “My goals have always been too high. I wanted to go to college, but I didn’t have the background.” The impairment of self-esteem that he revealed pervaded all the descriptions of himself and his life. “I’m not doing a very good job of thinking or trying to tell you what you want to know.” His mood was one of moderate depression. In the initial conference, his level of affective expression varied within only a narrow range and generally reflected his depressed mood.

Comment on Cases #2 and 3. In each case, we see a middle-aged person who has apparently performed successfully over many years despite episodes of depression. Patient O. lost his job in the recession of 1974–1975. Patient K. lost her job because the plant closed. Both of these former employees associate current depression with major difficulties in their life resulting from job loss.
In the case of Mr. O., it seemed clear that a basically dependent patient has engaged in a lifelong quest for maternal nurturance and affirmation of worth. The psychiatrist had the impression that Mr. O.'s employment of seventeen and a half years was experienced as a source of self-worth which was lost when his job was terminated. Since then, apparently, he has progressively lived a more dependent and less adaptive form of life at the home of an older sister. Another important aspect of Mr. O.'s case is the fact that the onset of depression preceded the job loss by two years. Had Mr. O. received early treatment, his performance may not have deteriorated so noticeably. Psychiatric illness (whatever the cause) precipitating the job loss is not infrequent. Job loss then compounds the problem. This is an issue that needs further study.

To Mrs. K., job loss represented a severe deprivation of her sense of identity as a nurturing person. When her job was terminated, she adapted less and less well to life in general, and became more concerned about her possible failings as a nurturing figure at home. She seemed to be managing reasonably well until the job loss coincided with news of the death of a former coworker and the serious illness of another on the very same day.

Certainly the ultimate occupational stressor—the loss of one's job—can evoke a crushing grief reaction. It may be brief and self-contained or it may lead to a very real sense of bereavement. In the latter case there will be emotional pain, often feelings of depression. Usually the individual will exhibit physical reactions such as feelings of weakness and emptiness, exhaustion, decreased appetite, and insomnia. Anxiety and tension may also be prominent symptoms, as well as agitation, restlessness, confusion, and puzzlement.

The expression of grief is a signal to others, often drawing support that may lead to the formation of new bonds. But the mourning process, which helps a person work through the reaction to the loss of a loved person or loss of a skill or expertise, is not always successful. As Freud pointed out, melancholia instead of grief may ensue.

**Executive Dismissal**

The following cases illustrate some of the problems and pain associated with an increasingly common corporate practice: the sudden dismissal of an upper-level executive. The various reasons for dismissal range from macroeconomic events, such as plant closings, to individual separations related to performance failure or to character deficiencies.

An interesting question arises. Why are some workers dismissed and others retained? Are there character traits that predispose certain individuals to termination? Do they transmit signals (consciously or unconsciously) as to their perceived incompetence? Or are there “personality conflicts” between parties?

The interrelation between internal and external etiological factors should be thoroughly examined in evaluating the dismissed individual. These sudden dismissals cause profound alterations in self-esteem and the way executives perceive themselves.

**Case #1.** Mr. Z. was a 53-year-old executive vice president and general manager of a “Fortune 500” company engaged in manufacturing and marketing a highly competitive product. He was the only child of a very poor immigrant family and had worked his way through college doing shift work and going to night

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*dismiss, vb. (1) To send away. (2) To send or remove from office, service, or employment. (3) To put aside or out of mind. (4) To refuse further judicial hearing or consideration.*

—*Webster's Third*
school. He started climbing the corporate ladder by working summers in a plant. He was well liked by employees at all levels. Being very sensitive to psychological issues, he successfully increased the profit margin. A new chief executive officer was brought in over his head—younger, less experienced, a “bull in a china shop.” The new chief executive officer was inconsistent in his demands and not particularly knowledgeable about the industry. He transferred Mr. Z. to an insignificant staff position. Mr. Z. became depressed and immobilized; he lost his self-confidence. His former fellow workers described him as “a shadow of his former self.” He began to mark time until his retirement. He then developed an autoimmune disorder and suffered a heart attack. He was retired on medical grounds. He remained severely depressed. Although under continuing medical treatment for his somatic disorders, he refused any kind of psychiatric intervention.

Case #2. Mr. X. was the 50-year-old chairman and chief executive officer of a large firm. He was the eldest son of a very competent and successful father and was himself extremely competitive in all aspects of his life. He took over the company when it faced financial collapse in a recessionary economy. He managed to reorganize and gather about him a group of competent lieutenants. He also gained the support of an effective board of directors and acquired the necessary lines of credit. He was, however, a controversial figure. He was distant with employees and tended to work entirely through his managers.

Just as it appeared that he had “turned things around,” a simmering discontent among the directors boiled over and he was summarily dismissed. His reaction to this was to become extremely depressed, which immobilized him for a year with great self-doubt. He had no job for the next three years. Although he did show some improvement in his depression, the self-doubt continued, with no return of his former self-confidence. He would not consider psychiatric treatment. (This is a common thread that seems to run through these cases. Any form of psychiatric treatment is seen by these people as an intolerable weakness.) He eventually sought psychotherapy, however, and a first interview revealed a severe depression with strong suicidal ideation. He responded to psychotherapy and tricyclic antidepressants, and now heads his own company.

Case #3. Mr. Y. is a man in his 50’s, a group vice president of a large vertically integrated company. Aggressive and highly ambitious, the youngest son of a large and socially prominent family, he had come to his position through a corporate acquisition and company political influence. He had little insight into his own quirks and personality problems. For six weeks he attended an advanced management course, with sensitivity groups an integral part of the program. While participating in the course, he was confronted with the unreality of his self-image by other executives, who “cut him down to size” repeatedly. He returned to his job struggling with some severe ego conflict which was partially manifested in highly inappropriate aggressive actions interspersed with serious indecisiveness in his managerial role. This was accompanied by boastful behavior with his peers and superiors. His performance suffered badly and he was terminated.

He has had several jobs since but has never regained his former level of performance. He denies underlying depression and accompanying anxiety and continues in an aggressive and barely compensated emotional state.

Comment on Cases #1, 2 and 3. There is tremendous pain associated with these terminations. Occasionally the pain is communicated to those who did the firing, and one wonders again about the effects on those executing the terminations. Another issue is the “over-fifty” age barrier, which is seen as a drawback in coping with an abrupt termination and the search for new employment.
Group Support during the Process of Dismissal

The following case history illustrates some of the complexities in the aftermath of a firing. For city managers, being fired is an ever-present threat. Their profession tries to bring rational management principles into a political arena. They are continually confronted not only with political decisions and high visibility, but also the irrational dynamics of city councils and citizens’ groups. So, while members of the profession know that being fired may not be associated with their competence, they must live with the likelihood of dismissal.

Case History. Mr. L. was a city manager in a progressive community. In an election, community politics shifted in a conservative direction. Mr. L. identified with his profession’s concepts of using community resources for the total population rather than protecting the status quo. Several members of the city council disagreed. After a year of simmering conflict, while Mr. L. was out of town, one vote was switched and the council decided to fire him.

That meant many personal stresses. The family had lived in the community for many years. The children had friends at school and wanted to go to the local university. As a skillful reader of political realities, Mr. L. had anticipated his vulnerability; however, he was surprised and disappointed because of the timing. Within several days he became mildly depressed. Like many professional managers who overemphasize intellectual, analytic problem-solving, he was emotionally detached. His wife tended to express much of the anger for the family, and their teenaged children expressed some of the rebelliousness for the family. They complained about having to leave their house, and wondered about alternatives such as splitting up the family if Mr. L. had to move to another city or whether he should leave his profession to find a different job in the town.

For the previous two years, Mr. L. had been a member of a group of city managers, which met once a month to discuss pressures from work and family. The group was modeled after Balint’s physicians group. In rotation each member had the opportunity to participate in one-hour individual interview after the group meeting (approximately once a year). Coincidentally, Mr. L.’s individual interview followed the first meeting after he had been informed of his dismissal. He had been told to keep the dismissal confidential because the mayor and city council did not want to announce it “for another month or so.” For that reason he had not mentioned it in the group. In the interview Mr. L. was despondent, felt some shame about being fired, and was worried about his future. He had plans for sending out his résumé but did not have much energy to work on it. The group leader, a psychiatrist, laid out a clear case that the mayor and the city council had engaged in some legal but unscrupulous shenanigans to avoid dealing with personal issues themselves when they fired him. Afterwards they told him sanctimoniously that it was “in his own best interests.” Thus they were probably feeling some guilt. The psychiatrist talked to Mr. L. about motivating them to give him real help in finding a new job and providing support in the interim. The two examined Mr. L.’s support systems and devised a strategy to use the city council, the mayor, and friends as resources in his job search.

Mr. L. used the strategy to negotiate nine months’ full severance pay. Members of the city council helped him look for a job and gave good references. After a full family discussion, they all decided to keep the family together. Since city management was his profession, he looked for other city manager jobs. Several opportunities arose, but none came up to his standards. The support of full pay while looking enabled him to turn them down. During that same time he continued to meet with the group of city managers. His colleagues offered not only understanding and friendship, but occasionally made pragmatic suggestions. Three months later, Mr. L. found a job closer to his personal requirements in another state. His family moved with-
out serious incident. A follow up found him happily at work on the challenges and political intrigues in the new community.

REFERENCES


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SPECIAL PROBLEMS OF VULNERABLE GROUPS

Job Loss and the Family

Case History. Sonny T. was a 13-year-old boy who was brought by his parents for psychiatric evaluation which was precipitated by his arrest—along with several other teenagers—for attempting to illegally purchase alcoholic beverages. It came as a great shock to the family: Sonny had “always been a really good boy... He had very nice friends... was always critical of others who used drugs.” Sonny made only one comment during the initial evaluation: “I was getting old enough to do things on my own, and... my dad really does not have the right to tell me what to do.”

As additional history was obtained, the parents outlined the following: Mr. T., the father, 59 years old, lost his job as a tool and die maker three months earlier. He had been working for the same company, in this, his second, position since the age of 31. Because his own father had died at an early age of a heart attack, he had not been able to graduate from high school. When his job was terminated, Mr. T. was told that although he had always been a good worker, advances in technology made his particular skills no longer necessary. His initial feelings of betrayal, anger, and anxiety were soon compounded as he attempted to find other work. At one point he expressed suicidal ideation; however, he made no suicidal attempt.

Mr. T.’s wife, 37 years old, worked as a licensed practical nurse during the early years of their marriage. She left this career at the time of her first pregnancy, and had since been a housewife and a mother to the growing family. Two months after her husband’s job termination, she returned to work as a nurse’s aide in a local
hospital. (She had allowed her L.P.N. license to lapse years earlier.)

The family had two other children besides Sonny; a boy seven and a girl eleven. The parents reported noticing changes in these children. The younger son had become rather critical of his parents. He was displeased with the effects of his parents’ role reversal, and complained particularly of his father’s demanding and critical attitude regarding his friends, reluctance to do his homework, and other aspects of his life. He also began to experience nightmares and frequent enuresis.

The daughter did not show any particular symptoms, but she was unhappy with her mother’s sudden return to work and absence from the home, as well as the “need to be so quiet while she is sleeping.”

The psychiatrist approached the problem from a family-oriented perspective. Members of the family were encouraged to express their feelings of guilt, shame, embarrassment, anger, and anxiety. The first several months were rocky. Mr. T. had no success in finding employment. He expressed feelings of failure and anger at himself for being unable to deal with the situation. He worked through his anger toward his father for dying and “forcing” him into a work role with such a high degree of vulnerability.

It became apparent that the anger of both sons represented, in part, their anxiety about a threat to their security and their previous perception of their father as a strong role model, and in part represented a subtle acting-out of the hostility they perceived their mother as having, but not directly expressing.

With time, these and other dynamic aspects were addressed. Mr. T. was referred to the local department of vocational rehabilitation. He obtained his general equivalency diploma and was trained for work in an automotive shop. As the father began his “second education,” the children demonstrated more interest in their school work. Sonny, the “identified patient,” soon began to express the feeling that “those older boys really would never amount to much,” and once again started to socialize with his “real friends.”

Within eighteen months, Mr. T. completed his training and found new employment. He felt much more optimistic about work, and remarked, “I’ll even have the chance to own part of the shop.” His wife left her job, but did take refresher courses so as to have her nurse’s license reinstated. At this time, therapy for the family was concluded.

Discussion. In most cultures there is an intricate interrelation between the work roles the individual performs and the structure of the family unit. Indeed, the idea of family is a reflection of the necessity for group cohesiveness and cooperation as a means of ensuring survival in an increasingly complex social structure. The family as the primary unit of social structure has influenced the nature of work roles. The relation of the family to that part of society that is concerned with the creation and distribution of valued goods and services is in dynamic equilibrium, influencing and being influenced by the social structure.

The traditional social pattern of Western culture has been for the husband to be the provider and head of the household. The development of this model was established by longstanding attitudes of the Judeo-Christian ethic, as well as by legal practice and custom derived from English common law. This tradition ascribed both privileges and responsibilities to the men of society, which were based, at least in part, on the assumption of the natural superiority of the male.

A prevailing belief in this country has been that working and striving for achievement and self-improvement lead to happiness and increased self-esteem, and that working hard leads to rewards and significantly enhances the quality of one’s life. Within the framework of this cultural model, the identity, self-esteem, and status of the worker and the worker’s family are greatly influenced by the value that the culture places on that individual’s work role.

There are indications of change with respect to the universality
of this model. Rapid industrialization in the United States during the twentieth century has reduced what was at one time a relative isolation of the family. With the development of advanced modes of transportation and communication, family members were exposed to many different value systems. The strict transmission of family values relating to ethics, and work role expectations, from generation to generation within the extended family, has been diluted.

The role of women in the family has undergone considerable change as a result of their increased participation in the labor market. For the first time in the history of the United States, most households are classified as having double incomes, with both husband and wife working out of the home. The variety of occupational fields into which women are entering is growing. Increased participation of women in the labor market seems to be leading to a corresponding change in the power structure of many family units. More family units acknowledge a mutuality between the parents, which establishes a new equilibrium within the family. Coupled with this change in family life is the increased dependence of grown children on their families for economic support.

As the divorce rate rises, the single-parent family is becoming commonplace. The changed nature of the family structure influences the role of workers at home and the way in which they and the family react to job loss.

As a result of technological change, demands on workers to be flexible and mobile in order to obtain promotions or simply to maintain their positions has increased. This tendency markedly reduces the contact that many nuclear families have with their extended families. It also may interfere with the normal process of identity formation within the family (as a unit). In many situations the demands of work have superseded the demands and needs of the family. This may result in a sense of alienation and have a direct adverse effect upon the family.

In the past, an achievement orientation has characterized the style of workers. However, we can now detect the emergence of a different perspective of work, particularly in younger generations. As productivity has increased, workers have demanded more pay for fewer hours of work spent on the job. Between 1950 and 1960, the average work week fell from 52 hours to 40 hours. During the 1960s, the time workers spent on job-related activities decreased by 50 percent. There has been an emphasis on fringe benefits, such as health insurance, sick pay, pension and retirement plans, and job security. While these benefits materialize improve the workers' quality of life, they have acquired the status of "rights" to many. This creates a subtle type of dependency of which workers are generally unaware. The situation might be likened to the dependency of a child on nurturance and protection from the parent. Workers are more dependent on this containment than ever before, yet at the same time are increasingly alienated from it. This highly ambivalent relationship sets the stage for the reaction of the individual and the family to job loss.

The loss of a job precipitates affective and cognitive responses. Workers often feel that they have been making a contribution that their work has been worthwhile. Initially, they may feel a sense of alienation and rejection. They perceive society as being callous and uncaring, and feel that they have been treated unfairly. They may be bewildered by the fact that the security system they have worked so hard to maintain, and perhaps have taken for granted, has crumbled. They may feel embarrassed and ashamed in their relations with family and close friends.

Bakke's study in the 1980s described the stages through which a family goes in adjusting to job loss. The family has to make adjustments to (1) the reduced means of support, (2) the employment and job outlook, (3) expenditures, (4) community associations and activities, (5) foresight and planning, and (6) rationalization of position and maintenance of moral standards. He described the process of gradual disorganization and reintegration of family structure. Initially, and for a short time, the
family structure and relationships continue unchanged. There is an early tendency to “protect” the children, especially the younger ones, from the impact of economic and social stress. Older children become alienated as they assume the work role of adults, and are likely to demand more freedom from parental control.

Family members initially were protective and apparently maintained family unity in extrafamilial relationships. This protectiveness and unity eventually deteriorated. At this point the family reached a peak of disruption. Activities that had previously sustained family unity, such as celebrations of holidays and birthdays, were abandoned. The family became socially isolated and withdrawn, and individual members began to turn to relationships outside the family structure. This period tended to resolve quickly, followed either by reintegration or destruction of the family unit. One important determinant of this outcome was obtaining work. If this occurred within a reasonable time, the family tended to re integrate. When reemployment was delayed, the outlook was much more bleak.

Komarovsky, in a 1935 study of sixty-nine homogenous families in which the husband/breadwinner had been unemployed for at least one year, noted that significant loss of his status occurred in many of these families. He was seen as being “less of a man.” Sexual contact was described as infrequent, and impotence was often a problem. Families affected by chronic unemployment broke social contacts and isolated themselves.

With chronic unemployment, the individual begins to internalize previously projected anger and guilt. This leads to marked loss of self-esteem and to “giving up.” The anxiety, guilt, and anger that pervade the family take a tremendous toll. There are similar relations between unemployment and child abuse, wife abuse, self-poisonings by the children of the unemployed, and criminal behavior. In one study, Peterson found that 75 percent of the men who remained unemployed nine months or longer eventually faced divorce proceedings.

A French study of unemployment and its effect on family life summarized surveys on unemployment, with emphasis on its psychological effect on the family. Its impact on children often leads to symptoms for them as well as for other family members. As a general rule, the authors find that the unemployed person appears first as a defeated victim whose fall drags down the entire family group. The role of the family may either be strongly supportive of the unemployed worker or contribute to his or her distress.

The powerlessness, frustration, sense of betrayal, and alienation one encounters in the unemployed individual and the family may be associated closely to other developmental conflicts. Childhood experiences related to parental nurturance, control and discipline, as well as the processes of individuation and identity formation, will influence later responses to job loss. If these developmental conflicts were unsatisfactorily resolved initially, the response to job loss in later life is likely to be intensified.

The disruption of lifestyle, impairment of confidence in the social order, alteration of political beliefs, and the creation of personal resentment among family members leave permanent scars and have a tremendous impact, not only on the individual and the family but ultimately on society itself.

Retirement and Aging

Retirement from gainful employment is one of the many hurdles on the path to anticipated peace and tranquility as a senior citizen. Social and behavioral scientists are intensifying research on this phase of the life span. Reports are conflicting. The helping professions that treat the casualties of this period of life may have a distorted and overly pessimistic perspective of the problem as a whole. Those who find retirement emancipating, invigorating, and happy do not seek or need our help. The full spectrum of the human condition demands consideration. Our focus in this monograph, however, is upon those at the troubled end of the spectrum.

Erikson describes the principal mastery task of this age as the
achievement of ego integrity. Those who have done so are congruent with their world. Failure to do so gives rise to despair, depression, and self-denigration. Suicide rates are reported to increase consistently with advancing years, a correlation that is especially marked for white men. A number of factors point to "lack of occupation as predisposing to suicide, especially in the elderly male." 11

Retirement may be viewed as one type of job loss associated with similar emotional reactions. Successful retirement requires coping with a number of challenges or problems:

1. **Successful handling of all the phases of growth of the personality thus far.** If this is done, the following characteristics are apparent: capacity to trust others, a sense of autonomy, excitement and joyful engagement in new activities, industriousness, a full sense of identity, the capacity to love and be loved, the enjoyment of work, and creative enterprise.

2. **Flexibility under stress.** Change and the stress that results are old friends rather than enemies to be avoided. Each successful encounter with stressful change adds strength to the person through the years. Ideally, the best-equipped individual can cope with almost any level of stress, and if knocked down will get back up, ready to try something different. Although every person theoretically has his or her breaking point when subjected to multiple or sequential calamities, the best-equipped will be the most likely to survive.

3. **A diversified psychological investment portfolio.** Much advice has been given about not putting all the eggs in one financial basket. We have been less instructive about the need to have diverse sources of gratification: emotional, vocational, and recreational. For example, Grandma Moses did not magically acquire her ability when she first picked up an artist's brush at age 74; she developed it over the course of her lifetime.

4. **Maintaining a sense of mission.** When one loses a sense of mission and has no sense of goal or direction, the process of psychological death has begun. The need for intervention is critical. Physical death sometimes follows quickly, sometimes much more slowly. A new sense of mission, such as volunteer work or attending university classes, is revitalizing. Being able to make a needed contribution can restore a sense of usefulness and provide new direction.

5. **Successful evolution of the parenting role.** The last event in this long process is the full establishment of the child as an independently functioning adult, no longer dependent on the parent. 12 The new relationship becomes that of adult relating to adult. This process, successfully concluded, releases those energies formerly used in parenting for coping with the exigencies of retirement.

6. **Care of the body.** Good exercise programs, recreational activities, adequate rest, good nutrition, and appropriate medical care are important in successful retirement.

Planning for the later years is sometimes all fantasy and no work. The workman at the lathe, the clerk at the desk, the executive in the office, the carpenter at the bench—who among them does not daydream: "Some day, when I don't have to work any more—on a such a day as this, I'll relax in the nice warm sun, maybe fish a while, garden a bit, or just lie in the hammock." The castle in the air is built, and with it individual may become a prime candidate for a promotional pitch from hucksters who extoll the pleasures of a "Golden Years Retirement City"—the provision of all one's retirement needs. All we need bring is an old body and money!

Such castles in the air will crash without proper foundations. The section that follows will focus on the history of a successful man who did not tend well to the work of planning for his retirement, which we might title "An Executive's Rush to Obsolescence and Despair."

**Case History.** Mr. J. is a 59-year-old vice-president of a manufacturing company operating worldwide. He has been with the
company for thirty-seven years and has lived his entire life in the
city in which the company maintains corporate headquarters.

Mr. J. was the older of two sons reared in a middle-income
family. His father was a skilled craftsman noted for his inven-
tiveness. The family adhered to traditional values; they were
prudent and self-sacrificing. Mr. J. went to college and graduated
as an engineer in 1932. It was six months before he acquired a
job as a stockboy in the drafting department of the only company
for which he had ever worked.

After a year he became a draftsman. In ten years he became
the department supervisor. During World War II, the company
grew quickly, and promotions for Mr. J. were rapid. By the time
he was 50 he was vice-president of operations. Throughout these
years he was content. He allocated time with his family, played
golf and bowled in season, and seemed to have diversified his life
very well. He felt comfortable with his fellow-workers and
thought those he supervised regarded him favorably. Even at 59
he had given no thought to retirement planning. “I’ll cross that
bridge when I come to it.”

The reality of retirement came much sooner and more pre-
cipitately than he expected. The company president and the
chairman of the board began organizational reassessment. Mr.
J.’s functioning was examined and long-overlooked deficiencies
were spotlighted. Consequently, Mr. J. was relieved of his execu-
tive duties and given two options: (1) early retirement, to begin
immediately, or (2) a minor post in a foreign country.

Mr. J. reacted with a scathing denunciation of such treatment
of a loyal and faithful employee who had devoted his entire life
and talents to the company. Because of the intensity of his feel-
ings, the president offered him executive psychiatric consultation.

Mr. J. accepted the offer out of sheer desperation. Although he
had been happy and seemingly mentally healthy before his
demotion, he was totally unprepared for this exigency. Suddenly
he was shorn of most of his sources of psychological sustenance
whichever alternative he chose.

Foreign assignment represented a change of overwhelming
magnitude for a man with so little experience. Fear, anger, guilt,
and anxiety were all compounded by the many losses he would
be incurring: his familiar job assignment and work environment
of fifteen years, loss of community, the cultural shock of living in
a foreign country for the first time, loss of prestige and self-
esteeem, leaving the family home, and loss of immediate contact
with his sons and grandchildren.

Early retirement was slightly less fearsome. At his age he
considered the likelihood of finding a suitable job minimal at
best. His preparation for retirement was nonexistent. He had no
hobbies or avocational interests. His occasional outings (golf,
bowling, an occasional dinner out with his wife, minimal social
life, and rare short vacations) could not become realistic sub-
stitutes for work. In addition, he was already beginning to
experience the loss of energy and fatigue that accompany
depression.

From his perspective he had no reasonable choice. The con-
clusion of his consultant was that this man would incur a
depression of suicidal magnitude should he at this time exercise
either option. At the same time he was recognized as having been
a mentally healthy and happy man until his demotion. Two
recommendations were made to Mr. J.’s boss, the company
president: (1) if at all possible, to find a third, more workable
option; and (2) that he be provided with the support of psycho-
therapy throughout the transition.

The company responded by offering Mr. J. a lesser job,
whereby he retained some responsibilities of his former job and
had two years within which to prepare for early retirement.

It is not surprising that Mr. J. gladly accepted the new offer
while at the same time refusing offers of psychiatric help.
A follow-up nine months later disclosed a man in great
distress. He was severely depressed and acknowledged that he
was considering suicide. Reiteration of his need for sustained
psychotherapy found him receptive. During the next two years
his survival was constantly in doubt. With the combined support of wife, children, company and therapist, he was able (though barely) to survive the transition to retirement.

Discussion. Retirement can be a crisis of great proportions in the later years of life. It can have the same effect as other role losses, even though not defined as job loss, which terminates active employment for pay. A man struggling through the aftermath of divorce has lost his job as husband, father, and partnership in the management of a household. A mother loses her job when children leave home. The energies discharged in these tasks and the resultant gratification are no longer available. New interests must be found and developed for the investment of these freed energies and the development of a system of gratification equal to the one that has been lost.

We observe a wide range in resilience to stress during adaptation to loss of role. Some people adapt quickly and seemingly easily, whereas others fail altogether. Those who fall between the two extremes of this spectrum of human behavior will reveal, if examined, symptoms of stress varying from mild to severe. For many, the only noticeable change, a diminished capacity to carry on as well as before, may persist for only a limited time, after which there is full recovery of function.

Whether people retire early, at or near 65, or later, their adaptive responses range from a joyous new sense of freedom and emancipation to devastation, despair, and even death. As is usually the case, the medical profession ministers to those with problems of adaptation. As in the example chosen, the most devastated worker-patient can be salvaged by skillful and well-planned therapeutic intervention. For all of them, psychiatrists can offer hope. For those less stressed by the prospect and act of retirement, we can offer advice and help.

Obsolescence

Another form of role loss is a result of becoming obsolete in the work force. Whether by the employer or the worker, the perception of no longer valuing or being valued can result from one or several causes:

1. Technological change can render a job obsolete. The displaced employee must either successfully handle the difficult transition and acquire new skills that restore his or her value in the work force or must leave. The nearer one is to retirement age, the more difficult it seems to be to make the necessary investment of energy.

2. Change of needs and the range of need gratification is often a function of maturation. A young worker who chooses a career based upon mastering control over the physical phenomena in the external world—for example, the physical sciences—may lose a sense of excitement about such work in the middle years. Instead, the investment of energy in more introspective pursuits may be far more attractive. Adaptation to this need shift may require career change and the beginning of yet another difficult transition.

3. New workers entering the job market inexorably force upon the existing workers the need to modify established attitudes and values. These new workers bring with them new values and attitudes which the older ones have made possible by providing an environment within which they grew and flourished. Even though the older workers have provided the opportunity and perhaps generated the ideas that have now become values and attitudes, they still must contend with them in operation in a completely new way. This, too, is job loss, for they can no longer perform in the old valued way.

4. Government influence on the work place has been and will probably continue to be unsettling. Laws are passed forbidding some practices that have been the norm. Partial job loss results—the old ways must cease, and new adaptational methods must be quickly implemented. Those affected will manifest behaviors resembling the disgruntlement of those who have actually lost their jobs.

5. As small companies grow large and large companies become even bigger, many workers are faced with the new task of
coping with an emerging bureaucracy. For many this is equivalent in scope to job loss itself.

**Job Loss or Unemployment and the Chronic Psychiatric Patient**

In healthy people involuntary job loss is of concern to everyone. Unemployment of the chronic psychiatric patient, on the other hand, has been almost totally neglected. This is distressing because most psychiatric patients, even those with severe disabilities, will likely spend most of their lives in the community.

In general, poor mental health correlates with poorer employment history. As a social group, unemployment rates are highest among the chronically mentally ill. Vaillant followed a group of inner city men for over thirty years. He found that, when comparing the bottom third to the top third in terms of mental health, the least healthy spent fifty times as many weeks unemployed as the healthier group. We have discussed the effects of job loss on relatively healthy individuals with previously good employment records. Job loss for the chronic psychiatric patient poses a special set of problems which will be addressed below.

Several factors are necessary for the successful rehabilitation of psychiatric patients: neuroleptic drugs, psychotherapy, social supports, family supports, and vocational rehabilitation. In a recent paper, Beisser, himself a quadriplegic, describes the need to affirm health in persons with chronic disabilities, that is, what they can do rather than what they cannot do. Work is one way in which the healthy side of a mentally handicapped individual can be utilized.

There is evidence to suggest that work may reinforce a person's self-respect and sense of self-worth, and that individuals with chronic psychiatric problems, who have made successful work adjustments may, in fact, be rehospitalized less often than those with impaired work adjustment. In the late nineteenth century and around the turn of the twentieth century, the usefulness of work as treatment of the mentally ill was well known and constructively utilized. Employment within the hospital setting could exert a strong and beneficial influence on patients, and could moderate the effects of institutionalization and prevent regression. Through the years there were many abuses of patients working in mental institutions. In 1973 the *Shoulder v. Brennan* case held that federal minimum wage standards must be enforced for patient-workers. Although this decision was necessary to prevent exploitation of patients, as well as to protect paid hospital employees, it also eliminated some beneficial effects of patient work programs in state hospital systems.

In recent years some sheltered workshops, where patients are paid for their labor, have been set up in state hospitals. Schwartz discusses such a workshop in a state hospital in Willard, New York, where the patients made toys on consignment from a local manufacturer. Wages were based on the workshop's success as a business and did not come through the state. Members of the workshop staff observed a beneficial effect on the patients. The patients themselves responded to a questionnaire. More than 85% said they enjoyed working, felt more respected by others when they worked, felt a greater sense of self-respect, and considered work a form of therapy. Many thought that work was a great opportunity for them and that their problems did not seem as great when they were working.

In a Boston State Hospital project in the early 1960's, Freeman and Simmons reported that work was a moderately good predictor of rehospitalization. Studying a group of patients who had been discharged from the Boston State Hospital, they found that about 60 percent of patients who remained in the community continuously for one year were working at the end of that time and that only 35 percent of patients rehospitalized within the first year were working. The results, however, were not completely clear-cut, since there was a considerable overlap in work history between the two groups. Still, this study (as well as others in the
literature) shows that individuals with good work adjustment have a better chance of staying out of the hospital and coping despite their disability.

There have been several studies of the performance of former psychiatric patients in industry. Schizophrenics show less job mobility than other psychiatric patients; they elicit more complaints for slow work, disagreeable behavior, dangerous behavior, and odd behavior than patients in other diagnostic groups except those with personality disorders. Wansbrough and Cooper concluded that patients with schizophrenia did well provided they were not under undue stress. For example, some schizophrenic patients did not seem to do well in shift work, but responded better to a more structured, regular environment. Despite the fact that they generated a fair number of complaints, many schizophrenic patients, especially those who had been employed for a considerable time, were able to maintain their jobs. Absences and job turnover were often caused by relapse rather than poor performance.

The subgroup of psychiatric patients maintaining the best work adjustment consists of those with the diagnosis of psychoneurosis. Their job performance and job mobility are roughly equal to those of controls. Still, the patients with the diagnosis of psychoneurosis seem to have some difficulty holding up under stress, and some of them drop out of the work environment.

The patients with the poorest work performance appear to be those with the diagnoses of drug dependence and personality disorders. Robbins, and others, studied a group of individuals employed at IBM. Employees were seen by the consulting psychiatrist either at their own request or at the request of their supervisors because of their poor work performance. In this company employees cannot be terminated because of psychiatric diagnoses per se, but they can be released for nonperformance. At the end of two to three years, after psychiatric intervention, individuals with a diagnosis of drug dependence, alcoholism, or personality disorders had the least favorable retention rates. Those with schizophrenia, on the other hand, did surprisingly well. The authors point to the value of psychiatric consultation in an occupational setting to provide treatment and rehabilitation for those individuals with known psychiatric problems.

A particularly informative study of the work performance of former psychiatric patients was done in 1965 by Simmons. In his book he cites eight case studies, each illustrating a pattern of employment, and the effect of mental illness on that pattern, in eight hospitalized individuals. All of them were psychotic, yet some were successful workers, while others were not. One particular individual was a patient who had been employed continuously over the course of several years except for the periods when he was rehospitalized. After each hospitalization, he would quickly find a new job and, characteristically, the jobs he found were situations in which he was comfortable.

Mental illness in itself is not a deterrent to successful work adjustment. The influence of illness and hospitalization on the pattern of a career may depend on how patients come to terms with the occupational world, the state of the labor market, the attitude of the significant others in their lives, and their job performance before hospitalization. Individuals who had a history of good work or school performance before their illness and whose families were supportive might be expected to continue that pattern after hospitalization, especially if their employment goals are realistic and if they have the skills to meet the demands of the job. Absences from work because of rehospitalization do not necessarily preclude a successful work career.

Those with chronic psychiatric problems generally have special needs. Appropriate vocational evaluation of such individuals may lead to greater success in a work environment. In evaluating such an individual, close attention should be paid to vocational skills and personal resources. These should be matched to an appropriate work environment. Attention should
be paid to both the worker’s expectations and those of the potential employer. Placing individuals in jobs they cannot do, either because they lack vocational or personal skills, will almost inevitably lead to frustration, anger, and disappointment.

It is most frequently counter-productive for psychiatrists to encourage patients to stay in jobs that are inappropriate for them. A gratifying job that a person can handle satisfactorily is less likely to lead to unemployment. In making such an assessment, the psychiatrist can usefully determine the individual’s previous level of function as well as the diagnosis. Each diagnostic category presents a potentially different set of problems in the work environment.

Everyone does not need formal employment. Vocational adjustment is only one aspect in the rehabilitation of the psychiatric patient. For some, work is provided not by a paying job but rather by family duties and household tasks. For those who do want to work and whose self-esteem is thereby bolstered, several work settings should be considered. At the lowest level are the hospital itself and a sheltered workshop within the hospital. The next is the sheltered workshop, usually in combination with a more extensive rehabilitation program that provides opportunities for socialization. The third alternative is private employment. In the course of a work career, a chronic psychiatric patient may go back and forth between these settings.

REFERENCES

3. See citations 10, 11, 12, 13, 14, 15, 16, Chapter 2.
4. See citation 35, Chapter 2.


22. See above citation.

23. See above citation.


25. See citations 20 and 24.


29. See citation 24.


5

**THE PROBLEMS OF DECISION-MAKERS AND THOSE WHO STAY**

**Executives**

Thus far, the focus has been on those who lose their jobs. Earlier sections of this work discuss the central importance of work in contributing to or influencing one’s psychological equilibrium. It is perhaps easier to understand the problems of those who lose their jobs than it is to perceive the problems of those who must impose job loss on their employees, or the feelings of those who remain employed while many of their coworkers are displaced. The relation Brenner draws between periods of high unemployment and psychiatric (or medical) illness appears at first glance to reveal casualties only among the unemployed. These figures, however, are obtained from the entire population: workers and nonworkers. They confirm the observation of consultants within organizations that there are casualties among those who remain employed during layoffs of other workers.

Freud, among others, recognized the importance of work for individuals to express aggressive drives appropriately (for example, driving nails through wood, analytically destroying a patient’s smoke-screen, or confronting a subordinate in a performance appraisal). Aggression is commonly seen as “bad,” whereas variations of it, such as initiative, are seen as “good.” When an individual’s work involves “bad” aggression, such as firing employees, problems may arise. Commonly, those who make the decisions to terminate the jobs of large numbers of people are seen as insensitive and uncaring.

There is a widespread myth of “The Good Of Boys’ Club.” At the “club” people with power get together to support each other
and make decisions that will profit themselves and each other; "they" callously manipulate the "outsiders." Perhaps belief in a "club" increases in times of crisis, such as an economic setback. When people are stressed, they are more susceptible to magical thinking and primitive defenses, such as denial, projections, splitting, and idealization. Groups, particularly large ones, are more receptive to primitive thinking and functioning than individuals.

The experience of occupational psychiatrists and consultants frequently runs contrary to the myth. They often encounter isolated, distressed managers and officers agonizing over such decisions, and coping as best they can—usually in private. It is surprising how many quiet tragedies there are in the families of organizational leaders—leaders and families whom most onlookers envy. These tragedies result not only from the frequently difficult decisions that must be made in terms of organizational structure, but also result from pressure that such hostile perceptions by others create.

Feelings of guilt are frequent in those who must separate people from their job. These feelings may be related to the sense of aggressiveness inherent in such action, to the failure to maintain one's own ideal and sense of benevolent omnipotence, or the recognition that one's own role and shortcomings may have contributed to the necessity of the layoff. Guilt, depression, and anxiety may also be the response of the executive to his or her perception of the hostility and resentment often felt by subordinates. These emotional responses may not be directly manifested. One can, instead, encounter attitudes and behaviors based on compensatory coping devices such as denial, projection, and withdrawal.

These are not just problems for the leader in his or her family; they are problems for the entire organization. Since most executives are poorly trained to deal with guilt and anxiety in either the personal or interpersonal arena, they may attempt to handle these unpleasant feelings by withdrawal. The wish to "make the decision and then forget about it" may be followed by a hasty retreat or an advance to the next technological problem. During times of stress, the organization needs its leaders to make sound decisions about tough issues. Decisions affecting people should especially be thoughtful, objective, and wise, but stressed individuals tend to make poor decisions, particularly in the less structured interpersonal sphere.

Executives under stress sometimes regress not only to more primitive ways of thinking, but also to those subjects they knew best. For most executives, those subjects are technological (engineering, finance, accounting, or law). Denial can lead to a failure to perceive all factors, particularly the human aspects (suffering, morale problems, one's own feelings). Excessive projection leads executives and others to confuse their own feelings and needs with the feelings and needs of other people within the organization. A sense of uneasiness associated with these dynamics, at times, impairs judgment as to when to confront or fire an employee. A typical example of this situation is seen in managerial efforts to avoid confrontation of the alcoholic employee, choosing instead to protect and cover up, thereby reinforcing the employee's illness.

Unfortunately, in our experience, most mental health professionals hold to the myth of the "club." They judge business executives from reports they read in the newspapers, certain periodicals, or an "informed patient." They judge, instead of using their professional skill (unless the executive is a patient or friend). Information about national unemployment figures and illness can be used to help realistically and it is not helpful to use it as something new to attack and further isolate the sensitive executive willing to take the risk of leadership. Our profession should not inadvertently (and self-righteously) contribute to further job loss.

Mental health professionals, and particularly psychiatrists, have a tradition of seeing victims realistically. Unfortunately it is common for some laymen to perceive stress, discomfort, and
danger as basically the same. While sometimes related, they are all different. All discomfort does not cause stress, nor is it dangerous. Stress and discomfort are part of growth and need not be dangerous. Not all dangerous things cause discomfort (for example, excessively avoiding conflict in a family). Unfortunately, even some professionals writing for the lay public seem to have that same misconception. If that confusion isn’t corrected, we are vulnerable to a subtle collusion (probably unconscious) between those feeling discomfort, their helpers, and well-meaning onlookers who demand security and try to abolish all personal risk. Psychiatrists can review their own prejudices against executives, business, aggression, and those who are comfortable with high visibility. They can refuse to idealize or degrade leaders and those we call healthy just as they refuse such primitive responses to patients. They can look for the hidden suffering in organizations and management teams just as they do with patients, families, or members of a therapeutic milieu team.

Executives operate in a world of diminished structure and the greater stress of making significant decisions. They are usually not trained in the interpersonal dimensions, but they make decisions that affect people profoundly. Most executives have the capacity to ask for and use help if it makes sense to them. Many people are willing to offer them advice that may not always be in their own, their organization’s, or society’s best interest. Executives too need support in the form of reliable information, objective and honest confrontation, empathic listening, an opportunity to ventilate and accept their vulnerability, and help with personal and family distress. They should not have to get sick to receive such support.

Those Who Stay On the Job

A second group at psychological risk during times of significant layoffs consists of those who do not, for one reason or another, lose or leave their jobs. The psychological response of some who have survived armed combat and have experienced the random death of their companions provides a useful analogy. The uncertainty with which one must deal in such a situation, coupled with an awareness that one is particularly vulnerable and unable to exert any control over what is to happen, can generate high anxiety. This may be defended by denial, emotional detachment, or rationalization. Anger towards imagined (or real) persecutors, as well as anger that is directed inward as the result of one’s powerlessness, compounds the situation. These factors may contribute to the development of overt psychological symptoms or to the onset of various psychophysiological disorders or hypochondriasis.

We also frequently encounter patients who feel guilty for having survived. These conflicts may be manifested in a multitude of ways.

REFERENCE

1. See citation 1, Chapter 3.
SUPPORT SYSTEMS

Social support has been shown to buffer some of the potentially deleterious health and psychological consequences of crises and stressful life changes. Social support, defined as “communicated caring,” has the following three components: (1) emotional support, leading the recipient to feel he or she is cared for and loved; (2) esteem support, leading the recipient to believe he or she is esteemed and valued; and (3) network support, leading the recipient to believe he or she has a defined position in a social network of communication and mutual understanding.  

Social support should be differentiated from physical support, such as nursing care, from material support of goods and services, and from the direct psychological support of counseling or psychotherapy. However, any of the three may involve or imply some degree of secondary social support. Common sources of social support are family, friends, clubs, community and work organizations, and formal religious affiliations. Normal people have meaningful social networks that ordinarily include about twenty-five individuals.

The beneficial effects of social support on physical and mental health have been reported in many different study populations for a large number of life stresses. Cobb has reviewed the literature on the relation of social support to such stressful events as pregnancy, birth and early life, illness, alcoholism, bereavement, and retirement. He concluded that although social support is no panacea, supportive interaction can protect people in crisis from various pathological effects.

Most psychiatrists would agree that employment termination is among the most stressful of life events. Gore has studied the effect of social support on the health consequences of unemployment. Fifty-four rural and forty-six urban laid-off workers were compared with matched controls. Physical and mental health was evaluated through direct interview of the subject. These were correlated with the degree of social support as measured by a 13-item index. She found that unemployed, unsupported individuals showed a higher incidence of physical symptoms and depression than did unemployed individuals with adequate social support.

In addition to the stress of job loss itself, job loss may actually precipitate a breakdown in an individual’s preexisting social network. Interpersonal relationships within a job setting are often important sources of social support, but may be lost upon termination. Also, many families with unemployed wage earners tend to become socially isolated, probably because of a loss of self-esteem and feelings of humiliation. Some families may actually break up because of the stress of unemployment. Thus unemployed workers, who may have had adequate social networks while working, may be at high risk upon job termination of losing much of their previous social support.

In light of this information, it seems important to prevent social isolation of the unemployed individual. How can this be done? The company, the union, the community and the family are among potential resources.

The study of a large industrial plant in London, Ontario, demonstrated that with advance notice and planning, unions and local agencies were able to help workers find new positions in anticipation of the plant closing. Thus the social isolation of workers was avoided in most cases.

Large corporations that terminate the employment of executives frequently enlist the services of “outplacement” consultants. These organizations help the executive find new employment quickly, and, in addition, can be a source of social support.

The psychiatrist can help individuals by making them aware of
their potential vulnerability. They should be encouraged to maintain the social supports they have or to develop new ones. Dismissed individuals may find self-help groups, unions, professional organizations, or peer groups particularly helpful during this period of high stress.

A clear-cut policy on the part of employers acknowledging the gravity of such events as plant closings, shutdowns, or layoffs will reduce the psychosocial impact associated with these events. Whether dealing with a blue-collar worker or a top-level executive, the ideal support system would include some agency that assists in securing employment. The functions of such agencies range from job placement and retraining programs to career counseling.

The Psychiatrist's Role as Consultant

A large midwestern manufacturing plant, hit by the 1970 recession and by technological change, cut its number of employees from 9,600 to 3,700 in three years. About three-quarters of the way through the cutback, a psychiatrist was asked to consult with top management so they could support the remaining people. The top sixty managers received psychological testing and were individually interviewed by psychiatrists.

Those tests and interviews revealed a great deal of depression, with several people described as suicidal. An unusually large number of management people used primitive defenses such as splitting, denial, and projection. The managers felt that aggression was very destructive and it was primarily expressed covertly. There was little open discussion of interpersonal issues. All the managers showed a great deal of concern about the victims of the cutback. Many people described family crises, ranging from children taking dangerous drugs to spouses with newly developed phobias. In their management meetings, people withheld information but with a little prodding they openly expressed their fears of taking personal risk. It is important to note that the cutbacks were not caused by any failures of the individuals involved. They resulted from macroeconomic trends, the state of that particular industry, and technological advances.

The new plant manager was concerned about the impact of the cutbacks and changes on the workers. Most of what is described in the previous paragraph was not visible to him or any other one person at the time, but he was sure many people had significant problems. He had been transferred from another location one year before the start of the consultation. He began to work for more open communication. He handled the crisis by being unusually open with everyone (including union employees) about future cutbacks. He shared that information in weekly newsletters and long breakfast meetings with employees twice a month. For the breakfast meetings, employees were selected at random by the computer. At those meetings the employees were permitted to ask any questions they wanted. It was the new plant manager who asked the psychiatrist to help. Because of the large numbers, the focus was on top management, that is, those people who had to make the decisions that would affect the entire personnel. The psychiatrist was asked to do the following:

1. Educate top management, sixty managers about human motivation, needs, and responses.
2. Help the leaders understand and express feelings in both individual and small group sessions.
3. Create opportunities for top management to ventilate their feelings in appropriate and safe settings.
4. Improve interpersonal communications.
5. Give some help to individuals who were unusually troubled themselves or whose families showed symptoms.

That work was done through seminars, small-group discussions, individual interviews, and consultations with appropriate groups concerned with communication. Individuals at all levels inside the organization, outside consultants, and people in the community who knew the organization in some way described increased sensitivity to the human issues in the work place. Unexpectedly, five months after the consultation began, the
plant showed an increase in productivity and efficiency, an improvement not seen in other plants in the same corporation undergoing similar cutbacks. In subsequent years, the plan was six to twelve months ahead of the rest of the parent organization in diagnosing and beginning to work on managerial concerns and solutions (for example, morale problems, communications, realistic performance appraisals). The business manager and the psychiatric consultants were unable to objectively determine the specific causal relation between specific interventions and the excellent results. We believe it was because the determinants were all interrelated.

The case, which involved a large number of people and many years of work, may prompt more questions than it answers because of its brevity. Four important points should be clear, however: First, those people who stayed, including those people who fired others, were suffering. Second, the managers were not insensitive and uncaring. Third, the increased stress was associated with some undesirable problems on the part of the leadership and their families. Fourth, appropriate psychiatric intervention was helpful in dealing with the cutback.

The Psychiatrist's Role as Clinician

Psychiatrists must be prepared to take an adequate work history when dealing with a patient who has a work-related problem. Only then will they have a full understanding of the issues involved in the threat of job loss.

The Work History. The factors that contribute to one's choice of work and adjustment to vocational life are as characteristic as those contributing to coping techniques in any other facet of life. How those who work spend that one-third of their lives is decided by genetics, early interpersonal experiences, and learned patterns of defending against anxiety. Understanding the employee's motivation for work and the adjustment within the work organization provides important information to the psychiatrist about almost every other aspect of life as well.

In trying to understand occupational choice and work adjustment, the psychiatrist can begin exploring the careers of the patient's parents. As significant as "What did your father (mother) do?" is "How did you feel about your father's (mother's) work?" "Were you proud of it?" and "Did you feel in any way degraded by your parents' work identity?" "How else did your parents' work influence your early life?" Geographic mobility, economic security, time spent with the patient, the quality of early childhood relationships, social status, identification with parental work role, and identification or rejection of parental vocational aspirations are all significant factors.

The development of vocational interests also has its roots in early task-oriented play activity. "Before going to school, what kinds of things did you like to do?" "Did you prefer being with other children or alone?" "Were you good at games?" "Did you help your mother (father) with chores (hobbies) around the house?"

Other developments in the early years that could become important in subsequent work adjustment include the number of siblings, sibling order, the size of the nuclear and the extended family, and the vocational and avocational interests and activities of family members. We could stress avocational interests of significant others in particular, since hobbies, athletic activities, and the level and intensity of involvement with various social systems that play a significant role determine both occupational choice and adjustment in later life.

The roles of authority figures in determining subsequent choice of work continues throughout life, of course, but is particularly important during school years. Teachers play an extraordinarily large part in nurturing skills and interests that are subsequently modified and applied in the world of work. "What subjects did you enjoy the most in school?" "In which subjects did you do particularly well?" "Which gave you a hard time?"
“Did you learn any skills (sewing, woodworking, etc.) that particularly interested you?" “What about sports?" “Were there any particular teachers or coaches whom you particularly admired?"

The pattern of one's interaction with others is established early and affects subsequent work patterns. “What kinds of things did you enjoy doing with other children?" “Did you have a lot of close friends or generally only one or two?" “Did you enjoy more being by yourself or with a group?"

In attempting to understand job choice as well as the appropriateness of a patient's present work to his or her skills and personality, one can ask a series of questions: “What kinds of things do you like to do best?" “What sorts of hobbies and outside interests give you the greatest satisfaction?" “What parts of your work do you enjoy most?" “What other kinds of work have you thought you would like to do?" “What kinds of work would you like to do in five years? in ten years?" “What kind of person is your supervisor?" “How do you get along with him (her)?" “Do you feel your skills, talents, abilities are being utilized in your present work?" “Do you feel you are fairly treated by your employer, your union?" “Are you really satisfied with your work?" “Are there things about your job that you find stressful?"

This is hardly an exhaustive list of questions. Others could specifically delineate the relation of the individual to authority figures, formal education and training, and the response to thwarted aspirations. Some questions could explore feelings of dependency or stressors on the job in more detail. Others might well examine the work climate and the corresponding degree of social support or lack of it. Yet another series of inquiries could usefully focus on feelings of vulnerability to various threats (real or imagined) that are conceivable in a work organization.

Many questions could relate to current adjustment off the job—but in terms of work. For instance, how does one's spouse view one's current work? Is he or she supportive? Does the spouse work? How do children feel about the parents' work?

One can even explore psychosexual adjustment at this point. Similarly, interviews with the spouse, family members, and others in the work organization are often helpful. The psychiatrist ideally is informed of the social, family, and work systems of patients. If this information is available, a more realistic assessment of patients is possible. For example, is the job below or beyond the patient's capacities? What kinds of work are they ready to do at this time?

In short, by focusing an interview on matters relating to work and work alone, one may develop an excellent understanding of personality development and current adaptation, and consequently achieve both a clear view of the patient's vocational adjustment and a much better perception of his or her life adjustment.

Related Issues, Including Confidentiality. The psychiatrist's role is complicated by the aspect of confidentiality. This is a vital issue that must not be compromised. Clearly, ethical and legal imperatives require written, witnessed, and informed consent to allow any communication outside the physician/patient relationship. There may be practical problems in a recovered employee's return to work. Some communication with the employer, preferably with the occupational health unit, if the company is large enough to have one, is advisable.

One experienced executive, on the other hand, spoke of five employee patients who worked for him. In none of these instances “would the psychiatrist speak with [him].” He stated, “I was upset, I was disturbed.” He felt that if the psychiatrist could tell him something it would be more helpful than channeling the case through the medical director, who might or might not know the employee well. The executive wanted to know the employee's prognosis, and especially “what can [he] do to help?"

In discussing the situation, the question of whether the psychiatrist can trust the employee's supervisor is often raised. The psychiatrist may tend to "talk too much." The concerned man-
ager and concerned psychiatrist have to be careful in their discussions, and flexible guidelines can be set out. It probably would be helpful to request that the medical director be included. There are reasonable questions that the psychiatrist can answer: "What is the patient's prognosis?" "Should he or she be treated in any special way or treated like any other employee?"

The answers depend on the patient. A capable patient who is in psychotherapy perhaps may be relied upon to deal with these situations without the intervention of the psychiatrist in the work scene. The more impaired the patient, the more understanding the psychiatrist must bring to the work situation, as well as to provide more detailed information, such as possible effects of medication on performance.

The psychiatrist's effectiveness could be impaired if there are "prejudicial attitudes towards management" in the experience of most occupational psychiatric consultants, executives are by and large concerned and willing to deal with patients who have emotional disturbances.

**Specific Psychiatric Interventions.** We have discussed the work history, the importance of knowing the work system of the patient, and the difficult matter of communicating with those in the work system without violating confidentiality.

Braginsky and Braginsky questioned the value of psychiatric intervention following job loss, and have pointed out that being a "patient" may augment the individual's sense of self-blame and internal deficit. The labeling so commonly associated with psychiatric difficulty might indeed result in this initially. However, these feelings are, in reality, primarily an expression of impaired ego-function, and they can be resolved during psychiatric treatment. The increased likelihood of mental hospitalization following job loss highlights the importance of psychiatric appreciation of the psychosocial ramifications of this life crisis.

Traditional psychiatric approaches to emotional disturbance are ordinarily indicated for the patient whose job is threatened or lost. One issue seems to be a basic threat to self-esteem as the individual deals with a real or threatened dismissal. At the least, the astute clinician will take a work history and explore some of the issues. Any functional role loss should be considered a psychiatric alert or even an emergency. Techniques of crisis intervention are useful. Consultation with colleagues in other medical branches will identify patients at risk of loss of functional role as a sequel of a heart attack or other illness. Educational efforts can be initiated for occupational physicians and organizational executives dealing with the potential psychological and health effects of job changes or dismissals. Pre-retirement training programs may prevent the psychiatric distress we believe to be a cause of the widely recognized post-retirement disability or death.

New treatment approaches that integrate work issues with psychotherapy are promising. Further research on such integration is needed.

**REFERENCES**

5. See Citation 2, Chapter 4.
7

RECOMMENDATIONS FOR DEALING WITH JOB LOSS AND WORK-RELATED PROBLEMS

Planning is indispensable to prevent job loss or to cope well with it. This is an issue for the former employee, family members, employers, union leaders, and policy-makers. Planning should not only be thoughtful and careful, but also include recognition and discussion of feelings. If effects on self-esteem are taken into account, the plans will be more productive. Here are some general and specific recommendations related primarily to job loss or broader work-related issues. Other recommendations can be found in particular sections of this work, especially the sections on retirement and support systems. We highlight a few suggestions here for the employee, the psychiatrist, and policy-makers in industry, government, and unions.

For the Individual Employee

Keep in mind the ever-present possibility of being dismissed. Preparations should begin as soon as is feasible. What kind of preparation?

1. Build up support systems, including a confidant and a professional such as a physician. Economic preparations for possible income reduction are helpful. Treat the job to some degree as expendable. The possibility of other jobs, other careers, and other skills developed on the side should be actively considered.

2. Develop a diversified psychological portfolio. This helps to deal with such issues as the “empty-nest syndrome” and retirement.
3. Recognize that the spouse is a strong part of one's support system. Marriage as a team effort is an obligation to help when the spouse is threatened with job loss or has to deal with its actuality.

4. Stay adaptable and abreast of things. Examine your ability to change and move on.

5. Avoid entertaining such ideas as "as long as I do my job, I don't have to get along with the people I work with."

6. If your job performance starts to deteriorate because of emotional problems, drug, or alcohol abuse, seek out appropriate psychiatric consultation.

7. Self-help groups are useful and supportive. Certain books such as What Color Is My Parachute and Getting Fired provide valuable cognitive information for the employees dealing with job loss.

For the Psychiatrist

1. Take a competent work history. This should be part of the diagnostic assessment and treatment plan for most patients.

2. Learn to work with employees' representatives such as occupational physicians, personnel officers, and union officials, with appropriate safeguards for confidentiality.

3. If psychiatry is to influence the present trends associated with job loss and unemployment, it will develop models of intervention that go beyond a focus on the individual to address familial, organizational, and social issues, in a comprehensive approach encompassing prevention as well as reparative efforts.

4. Psychiatrists should recognize flaws such as insufficient clinical and theoretical attention to the importance of work for a patient's self-esteem. The importance of work itself should not be underemphasized. People spend one-third of their lives at work. All too often most of the available energy and productive time are expended in the work setting. Not enough time is left for a satisfactory personal, family, and community life. The proper balance for mental and physical health needs further, well-designed research.

5. Investigate and be aware of your own biases toward management or union systems when you deal with employees who have work-related problems.

6. Psychiatrists accustomed to working in the doctor/patient relationship need to be alert to the tendency to adopt a similar stance when consulting with executives in industry. The more power the executive wields in the company, the more vulnerable and defensive the psychiatrist may feel and the more likely to revert to a traditional doctor/patient relationship. The relation to the executive as patient should not be confused with the relation of psychiatrist and executives in a consultative effort.

For Policy-Makers in Industry, Government, and Unions

1. Conduct yearly employee evaluations, which give the employee a realistic assessment of performance and feedback based strictly on the employee's functioning. This process is an often-overlooked opportunity to improve mental health.

2. Firing employees may have an adverse effect on those who do the firing as well as those who are spared. Consider the dignity of the individual, and dismiss him or her in as sensitive and humane a way as possible. If possible, explain the real reasons for dismissal.

3. Financial support is urgent for those who lose their job, but work is essential to the individual's self-esteem. We suggest job retraining as an adjunct to unemployment compensation, and concomitant with it.

4. Besides the financial consequences, job loss may have a disastrous effect on the mental and physical health of employees and their families.

Public policy issues must be considered. Effective strategies to
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