American Handbook of Psychiatry

MENTAL HEALTH PROGRAMS IN INDUSTRY

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

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> The communal life of human beings has ... a twofold foundation: a compulsion to work, which was created by external necessity, and the power to love. . . . Eros and Ananke have become the parents of human civilization.

Sigmund Freud

The purpose of this chapter is to explore the application of psychiatric concepts in work organizations. The term "work organizations" is used to encompass mental health programs to be found both inside and outside private industry. Indeed there are probably fewer than 500 psychiatrists who serve the private sector of American business; many more are concerned with public institutions and agencies, military organizations, government, and universities. All are concerned with the individual adapting to an occupational setting.

The Occupational Milieu

To intelligently view the role of the psychiatrist in the world of work it is important to review (1) the changing meaning of work in today's society, (2) the reasons employers seek psychiatric consultation, and (3) a brief history of earlier programs of occupational psychiatry.

The Changing Meaning of Work

"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." In making this statement to a 1967 meeting of state labor commissioners, then Labor Secretary Willard Wirtz went on to say that work satisfaction is as great a problem in our time as unemployment was during the 1930s and that the pace of change in work organizations is rapidly increasing. Not only has technology brought a restructuring of jobs, but change in society outside the world of work affects the job. It is within this context that mental health programs operate in the occupational setting. Before reviewing mental health practices, it would seem appropriate to examine both the work setting and current changing patterns of motivation for work.

Basic statistics suggest part of the picture. Fuchs provided graphic demonstration of recent trends. He asserted that, if one considers the shift in the labor force in the field of education between 1950 and i960, one finds that just the net increase in that period of time is greater than the total number of people engaged in the automobile and associated industries in i960. Former Secretary of Health, Education, and Welfare Wilbur Cohen said that 70 million will be involved in all phases of education by the mid-1970s, more people than in the active noneducational labor force. Further, comparing the services to industry from 1945 to 1965, the service sector increased by 13 million and the industry sector by 4 million; of the 4 million swelling the industry sector

the vast increase was in white collar jobs, many in service-related industries.

Manufacturing techniques utilizing more automated processes and some frighteningly complex technologies present, in many industries, the need for frequent adjustment to job change. Skills are made rapidly obsolete; technical education is often outdated within five years of graduation. In fact, "The obsolescence of education in rapidly developing fields of knowledge has become about equal in rate to the obsolescence of an automobile."

Gooding's sound journalistic study of the automobile industry cited recent dramatic attitude changes. Younger workers are bringing new perspectives into the factory. They are restless, changeable, mobile, demanding, and therefore, have great difficulty adjusting to routine assembly-line operations. One-third of the hourly workers at Chrysler, General Motors, and Ford are under age thirty. One-half of Chrysler's hourly workers have been employed fewer than five years. Absenteeism has doubled in the last ten years at General Motors and Ford, with the sharpest climb in 1969. Midweek, 5 percent of General Motors hourly workers are absent each day; on Mondays and Fridays, 10 percent. Gooding concluded that younger workers have never experienced economic want or insecurity. They realize that public policy will not allow them to starve, and this fact contributes to what management considers as a lack of sense of responsibility and a challenge to authority.

Job behavior is partly a result of the interaction between the industrial environment and demands of the individual for the satisfaction of what he considers legitimate aspirations. The age-old conflict of worker versus management is taking a different form. The overt and covert demands of the employee are increasingly for involvement, participation, and meaning in his work rather than for economic security.

Walter Reuther, late president of the United Auto Workers, discussed industry's problems with youth a few weeks before his death. Young workers, he said, are interested in a sense of fulfillment as human beings. In the auto industry, the young worker feels he is not master of his own destiny, and he is going to escape from it whenever he has an opportunity. This lack of involvement, Reuther felt, is a major factor contributing to absenteeism and poor worker performance. Observers from the behavioral sciences suggest that practices within the automobile industry are inconsistent with developments in society at large. They cite inflexible management practices, say that motivators are not built into jobs, and attribute younger workers' anger to a feeling that they are not a meaningful part of the work process. Some believe that workers who want a sense of self-development and who want to contribute are made to feel unimportant. While they want more control and more autonomy, they feel acted on rather than the acting agent.

The conclusions of the 1967-1969 Cornell Occupational Mental Health

Conferences suggested that it is not only the automobile industry that fails to meet the needs of its workers. The result of an intensive study and interaction of 100 distinguished participants from many disciplines was published in 1970 under the title, *Mental Health and Work Organizations.* The principal conclusion of the group was that old ideas about work and its meaning are no longer valid but that relatively few work organizations acknowledge this fact in their policies and practices. DeCarlo gave perspective to this issue saying,

> It is not unreasonable to consider the large organization, spawned and developed through the agencies of science and technology, as an entity with its own demands for survival, with its own personality and nature, and with its own peculiar demands upon its individual members. These demands may at times be at cross purposes with the individual existence of its members, often causing severe emotional reactions. Most psychiatrists would consider that the individual who is unable to adapt is indeed ill.
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> But could it be that madness lies the other way? If this is even partially true, and if we assume a kind of parity between the individual and the large organization, then we might do well to examine the relationships and the differences between the collective organization that is the personality and the collective personality that is the organization. It may well be that the organization is the one which must adapt the most to meet the characteristics, motivations, needs, and demands of the specific individual —at least more fully than has been the case in the past or present.

Perhaps one of the best ways of looking at probable future changes in the world of work is to explore the expectations of those about to join work organizations. The young automobile workers have their counterparts on college campuses who are also asking to “do their own thing” and will

probably continue to do so when they enter the labor market. Three themes appear that relate to the probable work adaptation of these youths. (1) Many young people have completely rejected the idea of education as something one goes through in a packaged way to get a set of credentials. On campuses everywhere you hear the demand that education be meaningful. Many anticipate that they will make the same demands of their occupational experience, that they will be inclined to reject work that does not have what they consider to be real meaning. (2) The young are conditioned in our culture to the idea of instant success. To go to the moon, one simply spends enough money, and in ten years the astronauts are there. As a result it appears to have been relatively easy for young people to make the transition in their own minds from the instant success of science to the demand for instant solutions to social problems. Many seem to feel that if we can get to the moon in ten years we ought to be able to change Columbia University or the telephone company in two years. (3) Youth is committed to the primacy of feelings rather than to logic. Logic, many of them have concluded, is something technicians can engineer in a black box; what is really important is what one feels. These are some of the attitudes now being carried into the work environment.

Motivation for Mental Health Programs

The changing expectations of workers both young and old is one of the

more subtle reasons employers seek psychiatric assistance. There are more compelling, largely economic, reasons as well. Most large employers provide benefits that cover at least some of the treatment costs of psychiatric disorders for employees and dependents. The plans vary considerably: Some provide very little reimbursement; others do not discriminate between organic and psychiatric disorder under either major medical or hospitalization insurance plans and are very inclusive. Programs in the automobile and associated industries provide first dollar coverage for outpatient treatment, and other work organizations include psychiatric care in the clinics and hospitals they operate for employees. Such insurance is costly, and occupational mental health programs that can reduce the number of disorders requiring treatment are often viewed favorably by management.

A utilization rate for treatment of psychiatric disorder frequently is reported as 1 percent of covered populations in any given year. That is, an employer can anticipate that 1 percent of his employees will seek treatment for psychiatric disorder each year under a health insurance program that provides such coverage. Increasingly, psychotherapy and psychiatric hospitalization are both covered without discrimination. General Electric reported that during 1968 psychiatric illness accounted for 3.1 percent of health insurance claims and 6.7 percent of benefits. The Health Insurance Plan of Greater New York reported 1 percent of members were referred for psychiatric treatment during 1966. Two percent of eligible workers covered

at the Sidney Hillman Health Center were treated during a two-year period for “mental health problems related to work.”

An in-company mental health program contributes to the early detection and referral of employees for treatment, and one might postulate that overall treatment costs would be less than without such an activity. If the mental health effort goes further and helps identify work situations that mobilize unnecessarily high anxiety levels, one might see even greater justification in economic terms alone.

Workmen’s Compensation

One motivating force for occupational mental health programs is workmen’s compensation insurance. Increasingly, workmen’s compensation benefits are provided not only to victims of industrial accidents but to individuals with psychiatric disabilities that are in some way related to work. Held as compensable have been emotional disability caused by physical trauma, physical disability resulting from emotional stress, and disabling psychiatric disorder resulting from emotional stress.

The case that focused attention on this matter was decided by the Supreme Court of the State of Michigan on December 1, 1960. By a five to three decision the court sustained an order of the Workmen’s Compensation Appeal Board awarding compensation to Mr. James Carter for psychotic

illness resulting "from emotional pressure encountered in his daily work as a machine operator." Mr. Carter's job was to remove burrs from a hub assembly, grinding out holes in the assembly with his drill and placing the assembly on a conveyor belt. Unless he took two assemblies at a time to his workbench, he was unable to maintain the pace of the job; in taking two assemblies he upset the production line. He was repeatedly instructed by his foreman not to take two assemblies, but when he only took one, he fell behind. In both instances he was criticized. On October 24, 1956 he developed an acute paranoid schizophrenic illness, and the referee awarded compensation for the disability that resulted from this. In the Carter case, the ruling was to the effect that it was not necessary to attribute the condition of the plaintiff to a single injury but that the series of events, the pressures of the job, and the pressures of his foreman "caused" an injury or disability under the law. One legal interpretation of this case was that "No single incident is essential to provoke or to sustain the claimant's right to recovery, but the cumulative efforts resulting in his concern about his job and his violation of the instructions of his foreman caused the condition of which he complained."[1]

During the past few years the courts have begun to construe workmen's compensation laws in such a manner as to relieve the employee of the burden of proving causal connection between his employment and his disability when the disability developed on the job. The courts in some instances will

now presume that the disability is employment related unless substantial evidence is provided by the employer to the contrary. An example is the recent case of *Butler* v. *District Parking Management Company,* decided on June 8, 1966, by the U.S. Court of Appeals in the District of Columbia, which directed that compensation benefits be awarded to an employee. The court stated the facts and the law as follows:

> After twenty years of employment as a parking lot attendant . . . appellant became ill during his working hours and did not report for work the following day and ensuing days. His claim is that the employment caused a mental breakdown, and it is not disputed that he was found to suffer a schizophrenic reaction. Section 20 of the . . . Compensation Act . . . provides: "In any proceeding for the enforcement of a claim for compensation under this act it shall be presumed, in the absence of substantial evidence to the contrary . . . that the claim comes within the provisions of this Act. . . ."
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> This provision places the burden on the employer to go forward with evidence to meet the presumption that injury or illness occurring during employment was caused by that employment. . . . The employer offered no substantial evidence that appellant's injury was not work-related and hence has not met the burden imposed by the statute. . . .

Most workmen's compensation statutes contain provisions similar to Section 20 of the District of Columbia Workmen's Compensation Act, and it is not unreasonable to assume that in the future the universal practice will be to require the employer to disprove causal connection between employment and disability in cases of mental disorders rather than for the employee to prove that such causal connection exists. Since the proof of the negative of

any issue is frequently impossible, the magnitude of the employer's potential liability looms even greater than in the past.

In addition to the interpretation of workmen's compensation statutes by the courts, separate legislation in 1970 stimulated major interests in occupational health. The Occupational Safety and Health Act now requires all employers to meet certain federal standards. These include detailed safety requirements, an elaborate reporting system for occupational injuries and illnesses, and a system of penalties to aid the enforcement of the act. Responsibility for administration of this legislation rests largely with the U.S. Department of Labor. The act, however, also created the National Institute for Occupational Safety and Health in the Department of Health, Education and Welfare. The latter organization is actively supporting research in occupational safety and health and developing standards to be administered by the Department of Labor. One of the early NIOSH projects involves support for a massive study of occupational stress. The stimulus for occupational health programs, physical and mental, will probably increase dramatically as a result of this congressional action.

Drug Abuse

Specific clinical and social problems have also stimulated the implementation of mental health programs in work organizations. A

contemporary example is the increasing focus on drug abuse both as a national problem and as one involving employers. During the late 1960s significant concern developed about the misuse of drugs in industry. Particularly in the northeast and in the large urban centers, employees using heroin have created serious administrative problems in addition to the well-known personal and social disruption attendant addiction.

While no epidemiological studies have yet been completed, a survey in one metropolitan area showed that 60 percent of the larger companies screen job applicants for drug use. With the development of simplified thin-layer chromatography, many work organizations are screening the urines of applicants and, in some instances, employees on a routine basis. Informal reports suggest that in the New York City area, approximately 10 percent of applicants show some urine metabolite of a drug of abuse. Only 34 percent of organizations are said to have formal policies on drug abuse among employees.

Among the reports are the following:

1. The Metropolitan Life Insurance Company reported that it first became concerned about misuse of drugs in its employee population during 1967, when increasing numbers of the younger employees developed patterns of absenteeism or lateness and frequently left their jobs for long

periods of time, spent a lot of time in the washroom, had unauthorized visitors, and showed erratic and below par work performance. Occasionally they were seen in the medical department because of an altered state of consciousness. Most frequently, employees denied drug use and refused referral to rehabilitation agencies even though urine tests were positive for heroin.

2. Bisgeier, the medical director of New Jersey Bell Telephone Company, reported a 1969 rate of heroin abuse among applicants of 4 per 1,000 and a 1970 rate of 8 per 1,000.

3. The Manhattan-Brooklyn-Queens section of the New York Telephone Company found, that, between March and May of 1970, 9.8 percent of applicants had a positive chromatography for a suspicious drug. Of these, 58 percent were for quinine (used for cutting heroin in the northeast), 4 percent amphetamines, 20 percent barbiturates, 3 percent morphine, 5 percent morphine plus quinine, 4 percent one of the phenothiazines, and the balance mixed drugs without morphine.

Medical directors recognize that the problems related to the use of alcohol remain far more important to the work organization than those concerning the abuse of other drugs. And most firms with adequate employee health services have long-established programs to cope with the “problem

drinker," a term preferred to "alcoholic" by most occupational physicians who feel they may become legitimately concerned about behavior stemming from the use of alcohol when it interferes with productivity or social relationships at work even though they recognize many of these cases may not properly be diagnosed as alcoholics.

Thus we have disruptive and expensive overt psychopathology, specific subtypes of that pathology such as addiction, and legal requirements that stimulate employer interest in the development of mental health programs. These are in addition to the enlightened self-interest of some more sophisticated employers who seek greater understanding of work-related behavior for whatever reason.

The experience of several such programs suggests that one should make no attempt to "sell" such mental health programs on economic terms alone. During the first years of psychiatrists' consultation, the rate of referral for therapy by the organization's medical department is likely to soar and the utilization rate to increase considerably. Nor is it possible to cost out mental health services to justify the budget under which they operate. One cannot easily put an exact dollar value on somewhat better selection and placement of employees, or the training and enhanced sophistication of medical staff, members of management, and personnel departments. As a result of the work of the consultant, the communications among members of a work group are

often greatly improved, problems being seen in a different light, but it may be difficult to see the results on a balance sheet.

Historical Considerations

"Industrial medicine exists; industrial psychiatry ought to exist. It is important for a modern psychiatrist not to hide his light under a bushel; he must step forth to new community duties. . . . [His] function [should] be preventative rather than curative. . . ." This observation by Southard in 1920 predated by two years the first clearly documented industrial mental health program. To be sure, a variety of relevant research was completed or underway both in this country and Europe, and there were several generalized commentaries in the literature suggesting occupational roles for psychiatrists as well as nosologies relating psychopathology to work adjustment, but 1922 saw the first full-time psychiatrist begin work in an American business organization when Giberson was employed by the Metropolitan Life Insurance Company. She remained with Metropolitan until her retirement in 1962. Her initial role was as a consultant in the employee medical department, her time being largely spent seeing individual patients referred by other physicians. In 1949 she left the medical unit to become personal advisor to employees and a consultant in the office of the president of the company.

In 1924 another pioneer, V. V. Anderson, established a mental health service at the R. H. Macy's Department Store in New York. The first book on industrial psychiatry, which summarized this program in 1929, remains a classic. Initially, Anderson was concerned with interviewing techniques in the personnel office and with the introduction of psychological tests during placement procedures. He also studied workers involved in accidents and effected a remarkable reduction in the accident rate of delivery truck drivers for the store. In his clinical work he used the team approach, drawing on earlier experience in child psychiatry and enlisting the aid of a psychologist and social workers who worked on a broad array of employee mental health problems. The depressed economy of the early 1930s ended this activity, and it was a decade later before Macy's engaged the services of another psychiatrist, this time Temple Burling, who was particularly concerned with problems of morale and interpersonal relationships within various divisions of the company.

Giberson's work was largely with individual employees and with the education of management personnel. Anderson, while also concerned with individual psychopathology, conducted the first applied mental health research in industry, and Burling was principally interested in interpersonal relationships. Thus, prior to the end of the 1930s the principal activities of occupational mental health consultants had been established. The core activity continues to be individual clinical case consultation directly with the

employee or with an occupational physician. The psychiatrist works with personnel or administrative managers as well. The teaching of management and medical department staff, both formally and informally, is an important adjunct. Applied research concerned both with the incidence and prevalence of psychopathology and with factors in the work organization that unnecessarily mobilize anxiety is of increasing importance. Finally, the psychiatrist is seen as a facilitator of interpersonal communication and understanding. Giberson, Anderson, Burling, and the many who followed brought the following comment from Menninger,

> Theirs was an unexciting day by day task of demonstrating not only to business men but also to their colleagues the contributions to the maintenance of mental health which psychiatrists could make in industry. Often they met apathy in both quarters. Sometimes they faced open hostility. And always skepticism. Perhaps not the least of their contributions is that they remained in the field.

Perhaps the greatest early stimulus to the study of industry as a social system came from Elton Mayo. In the 1920s he became interested in studies of fatigue and monotony at the Harvard physiology laboratory. In 1923 he investigated the high rate of turnover in a textile mill and noted that with the introduction of rest periods for workers in monotonous jobs, morale rose and turnover decreased. In 1927, Mayo and his associates undertook the now classic study of working conditions at the Hawthorne plant of the Western Electric Company in Chicago. These studies concluded that industrial

enterprise has both economic and social functions. Production was demonstrated as a form of social behavior, and all the activity of the plant was viewed as an interaction of structure, culture, and the individual personality of workers. The alteration of any variable produced change in the other two. Reactions to stress on the part of individual employees arose when there were resistance to change, faulty control and communication systems, and poor adjustment of the individual worker to his structure at work.

Early clinical studies of industrial accidents, fatigue, and psychiatric illness in the work setting began during World War I at the Industrial Fatigue Research Board in England. They were, however, given little currency in this country, even though our basic concepts of accident proneness and our first indications of the prevalence of psychiatric disorder in an industrial population derived from this work.

Role of the Psychiatrist[2]

Several considerations are important for the psychiatrist who functions as a consultant in a work organization. Most psychiatrists have had little training for or experience in industry. In the community, hospital, and university, they are seen as authorities in dealing with mental disorder. The psychiatrist is not however an expert in the management of an organization, and there are many executives better able to resolve interpersonal conflicts in

a corporation than psychiatrists to resolve intrapersonal conflicts in patients.

In commencing a consulting relationship, the psychiatrist must both give up many pre-conceived, stereotyped ideas about work organizations and at the same time recognize that he is adding his skills to many that already exist. In large organizations with well-established medical departments there are occupational physicians and other medical specialists on the staff. Occupational nursing is a recognized specialty. Many organizations employ psychologists—clinical, industrial, and social—and there are experts in various facets of personnel administration. Members of the union hierarchy represent the employees' point of view to management, and there are those in management and executive positions with long years of experience in organizing men and materials around a common task. Each of these individuals correctly considers himself an expert in human behavior in his organization. Each is knowledgeable in some detail about one or another facet of the organization, and it behooves the psychiatrist at the outset to become acquainted with key figures in the other disciplines who concern themselves with its people.

In seeking the identity of the work organization he serves, the psychiatrist who is able to put aside industrial stereotypes will obviously be more successful than the one who does not. No two organizations, of course, are the same in any real sense. The individuality of an organization is made

up of a vast array of variables. We might think of this in terms of the "personality" of the organization. This organizational personality or subculture represents the major purpose, policies, practices, affiliations, and values that define and symbolize the identity of the company. It is composed of those features usually put forth by members of the company management to represent its unique character. Much of the social environment is oriented to this concept. It can be identified by appropriate slogans, traditions, folklore, rituals, documents, and written statements. "But its home is in the minds of the members of the organization, and an imperfect reflection is in the minds of those who view the organization from outside." This characteristic personality of each organization represents a strong social pressure for each employee. Most of these factors of organization personality can be studied. We further recognize that some organizations are authoritarian in character and others are permissive. Certainly he who needs an authoritarian setting would be at sea in a permissive one. While not always true, a worker tends to gravitate to the job and to the industry and to the company or institution that suits his personality. His own personality in turn contributes to the overall personality of the organization.

The psychiatrist must study the actual situation in which he is to function, applying the classical natural history method of medicine to the study of a system of interpersonal relationships. As elsewhere, he is concerned with an initial set of observations, the development of various

tentative diagnoses, and the formulation of hypotheses. He must test his hypotheses in many ways in his attempt to understand the size and the shape of the units and the events he observes—all this before he offers suggestions that might be thought of as treatment for the corporate personality. His identity is that of an expert in deviant human behavior. Both he and members of the work organization recognize this role from the beginning of a consulting relationship. Yet each may harbor a different interpretation of the role. Some psychiatrists feel they are properly concerned with the promotion of executives, evaluating and nominating candidates on the basis of freedom from psychopathology to be officers in an industrial organization. Others believe their background suits them for even more direct involvement in the economic affairs of the company, such as assisting with the marketing of a product, for evaluating the potential for default of creditors of the organization. Many believe it is unethical for a psychiatrist to function in industry at all, presuming that he would be asked to help management manipulate and exploit workers. None of these are real or proper views or activities.

Members of management also require guidance as to their expectations of the psychiatrist. They may be all too willing to abdicate responsibility for the administrative aspects of cases of psychiatric illness, in cases of applicants for employment with a history of such illness and in situations involving the establishment of corporate policy. The psychiatrist can evaluate and advise,

but the responsibility for decision making lies with line authority.

The consultant has many valid concerns and activities. He is principally interested in the successful adaptation of the individual to his work organization. He is also concerned with facilitating organizational survival when it is threatened by individual deviant behavior or interpersonal and group strife. The legitimate satisfaction of appropriate psychological needs within an individual employee also becomes his valid concern. The provision by the organization for the security needs of its employees—both material and psychological—should be important to him. He is interested in how one deals with various personality characteristics. How does one cope with the aggressive or the passive dependent individual, the self-centered narcissistic person, or the paranoid? Job placement in keeping with these and many other personality characteristics frequently becomes his concern.

The traditional and obvious role of consultant to other physicians in an occupational medical unit differs in some respects from consultation in a clinic or a hospital. With his ongoing relationship to other professionals in such a department, he is able to play an active supporting role to the professional staff who have primary responsibility for working with the employee patient. In addition, the work organization allows a variety of techniques for early referral of the disturbed individual. For this reason the consultant is apt to see people as patients who are less ill than in other

settings and therefore more amenable to therapeutic intervention. Such intervention often includes alterations in the work environment, and this too is frequently possible on his advice. Further, he is in a position to meet with the patient's supervisor and with those in personnel departments who are able to alter the job scene or make special arrangements for the employee-patient.

Most large companies have well-established management development programs designed to keep supervisory personnel abreast of contemporary administrative issues. Here is a ready-made setting for the psychiatric consultant to enter into formal dialogue with the power structure in the organization. Formal seminars and lectures can usefully orient such a group to concepts of unconscious determinism, specific ways of coping with unusual behavior, dealing with stressful interpersonal relationships and the emotional problems stemming from the role of manager or executive. The teaching role of the psychiatric consultant is of critical importance. In it, he establishes contact with key individuals and can be seen as a nonthreatening, helpful agent to whom members of the group can turn for assistance. He can also symbolize the corporation's concern for the individual with a disabling emotional problem.

In the clinical role, there is a continuing responsibility for ensuring appropriate placement of employees and potential employees. Can the

individual applicant with a history of severe psychotic disorder be appropriately placed in the job he desires? Is the prognosis such that the organization is willing to assume responsibility for him as an employee? Would the job be stressful enough to trigger the development of further incapacitating symptoms? In such a capacity the psychiatrist is obviously principally the agent of the organization. While he is concerned with not allowing assignment that would jeopardize the health of the potential employee, his role is, to some extent, a protector of the interests of the company.

Patient Referral

The majority of the patients seen by the consulting psychiatrist are referred to him by another physician in the work setting. The physician, who is often a full-time employee, plays a pivotal role in detecting psychopathology in assisting managers who have observed disturbed or changed behavior in an employee to obtain a medical and, when indicated, psychiatric evaluation. Occasionally, a patient is referred directly by his supervisor when an obvious psychological problem exists or when it is known that the patient has been in psychiatric treatment or is returning to work following psychiatric hospitalization. Self-referrals are also frequent in most programs.

The psychiatrist may be asked to assess job applicants who appear to have emotional difficulties or who give a history of previous psychiatric treatment. Can the applicant tolerate the demands of the industrial setting? Does he have the ego strength and interpersonal skills to allow him to find satisfaction in his work, or will he be unable to be productive and experience additional disappointment and further loss of self-esteem and confidence? Are the organization and department willing to manage the possible psychological difficulties that might develop? Similarly, the psychiatrist is asked in certain cases to help determine the degree of an employee's disability and make recommendations as to whether he should return to work and under what circumstances.

Consultation and Evaluation

In evaluating a patient in the setting of an organization's medical department, the psychiatrist approaches the patient with very specific questions in mind: Is he presenting with mild to moderate neurotic traits, or is there a more serious process occurring that is on the verge of a disorganization? Is there a suicidal potential? What are the environmental structures that the patient can rely on for emotional and physical support during this period of distress—family, friends, church, and so on? Is the present situation an acute crisis, or is it an exacerbation of a chronic illness? What changes have recently occurred that may be related to the present

emotional state? If the patient has experienced similar symptoms in the past, what did he find helpful or harmful in relieving his distress?

In addition to information from the patient, the consultant is in the fortunate position of being able to obtain the opinions and reactions of the medical department staff who have often seen the patient over the years for various physical and emotional complaints. His supervisor can add significant and helpful information as can members of the personnel staff. For example, is the employee particularly productive, and has his productivity changed recently? How well does he customarily get along with his colleagues and supervisors in the work setting? Similarly, the medical staff can speak of the frequency of their contact with the patient and of their reactions to him.

Once a working diagnosis is formulated, the psychiatrist usually reviews his conclusions and recommendations both with the patient and the referring physician. It is at this juncture that he must be particularly tactful, nonthreatening, and positive. Often there is a suggestion for additional psychiatric attention. However, an occasional patient denies the seriousness of his problems and refuses appropriate or adequate treatment. Here, tactfulness, persuasiveness, and persistence are called for and often lead to a satisfying result. Occasionally, with some resistant patients, more serious emotional difficulties develop before the individual is willing to accept help. The alcoholic, for example, frequently denies the extent and consequences of

his alcohol abuse and often does not accept help until he needs hospitalization.

Regardless of the recommendations made, another appointment is usually scheduled. In this way the consultant has the opportunity to reevaluate his initial impression, reinforce his previous recommendations, and determine the extent to which the patient has begun implementing the suggestions given at the previous meeting. If the patient refuses treatment and his condition is serious and is adversely affecting his work performance, he can often be motivated to obtain treatment by using job jeopardy as a leverage point.

The psychiatrist has a unique opportunity to influence the many interacting forces in the patient's life. Improving channels of communication with a clear, insightful understanding of the patient's difficulties with management, family, private physician, and medical staff can have a decisive effect on the patient's emotional state.

The corporate employer will tend to look to the psychiatrist who has gained initial acceptance in the company for a broad consultative role in relation to company policy, procedure, and practice. This may be one of the most significant roles he can play if one of his primary functions is with the stimulation of an environment conducive to the fostering of healthy patterns

of behavior. To influence an organization away from a policy that fosters dependency upon it beyond reasonable work determinants, to help minimize the overreaction to a key authority figure's impulsively autocratic behavior—such a role has greater impact upon a company than the resolution of a single employee's disabling anxiety reaction, even though the latter remains the major clinical role of most consultants.

Frustrations

Some specific pitfalls that the consultant may anticipate seem worthy of mention: There is, in the members of the management of most work organizations, a residue of many of the common misperceptions of mental disorder. Thus, even the admission that there exists a psychiatrist on the payroll may be an anathema for some, perceived as an admission of corporate weakness. The presence of a psychiatrist can be interpreted by the more naive as part of a coddling, overprotective, and permissive attitude toward employees. This is hardly surprising, since the values of the community, not of the mental health professional, are dominant at the helm of most companies. If one couples this view of a psychiatrist with the common personality characteristics of many who rise to the top, it is possible to identify some key frustrations for the consultant. The successful executive is often an individual who is aggressive, verbal, and extroverted and who prefers to consider objective facts rather than analyzing more subtle issues. He is not inclined to

acknowledge the role of feelings and the importance of unconscious determinism. Those who tend to perceive the world in terms of black and white and who are accustomed to making daily decisions involving millions of dollars and thousands of people and whose principal goal is economic gain cannot be concerned principally with the mental health of employees.

This attitude suggests a number of problems for the psychiatrist who is interested in work adaptation of individuals and whose orientation is supportive of the employee. The psychiatrist may urge an expansion of health insurance to provide outpatient psychotherapy; top management may prefer a dental care plan. An employee with an acute schizophrenic illness may, after several months of disability, be urged by management to resign; the psychiatrist may strongly recommend his retention and efforts toward rehabilitation. The consultant may feel that a research group could benefit from improved communication; the research division's manager may question the application of psychiatric concepts in coming to grips with interpersonal issues even though they may be recognized as problems by members of the group.

Another frustration and an intriguing facet of mental health programs in some organizations is the way in which applied psychiatric research is handled. Some companies feel the results of such studies are internal and proprietary. They frown on publication. Of course, many do encourage

publication of research on their employee populations, but others are highly selective of data to be released. Details of activities on behalf of the employees are common in today's literature. Data concerning utilization rates of various benefits covering treatment for employees and their families are generally available, but the corporations vary considerably in their willingness to release internal studies of the incidence and prevalence of mental disorder. The reasons vary and are seen by organizational management as legitimate, but it is unfortunate for occupational psychiatry that such work is not universally available. In the private sector of our economy, the mission of a company is to survive and grow profitably. Such organizations are not in the business of employee health care nor is employee health the principal concern of management. Most recognize an enlightened self-interest in maintaining a healthy population of workers, but published data that suggest high levels of psychopathology in their population are occasionally seen by management as an admission to competitors and to the general public that they are less than successful in maintaining a bright corporate image. While some sophisticated companies utilize carefully developed data for making changes that will relieve various job stresses and further the psychological health of employees, they are reluctant to see exposure of this material to the outside world. Because of this secrecy, there is no way of clearly identifying the extent of such research.

The Job Corps

Perhaps the most extensive program of psychiatric consultation to components of a single work organization is that of the Job Corps. Part of the Manpower Administration of the Department of Labor (formerly in the Office of Economic Opportunity Job Corps), it provides a program of basic education and vocational training in a residential setting for young men and women aged sixteen through twenty-one from poverty backgrounds. There are 20,000 young men and women in active training in a wide range of occupations at fifty-seven Job Corps centers now in existence.

The program at each center consists of vocational training and work experience, basic education, counseling, and residential group living. Comprehensive health care is provided for all enrollees while they are at the centers. Recreational and leisure time activity programs, sometimes involving local communities, are also provided for corps members. In 1968, 84 percent of the centers had established some working contact with a psychiatric consultant, and some ninety-seven psychiatrists were so involved. The pattern of participation is well described by Caplan, Macht, and Wolfe. The rather unique concept of the psychiatrist's role is described as follows in a 1968 pamphlet, *Job Corps as a Community Mental* Health Challenge.

> Job Corps recognized that it needed clinicians to take responsibility for the care of those individuals who become ill while in the Corps. We offered to accept that responsibility within the broader context of assuming executive responsibility for all aspects of health and mental affairs.

This combined clinical and program responsibility provided our entree into the agency, and has supplied us with on-going sanction and a base from which to work. The blending of clinical and programmatic responsibilities was made possible by virtue of our role as physicians and as mental health specialists forming a part of a comprehensive health team. To implement the mandate provided us by the Director, we have had to repeatedly negotiate at all levels of the system, demonstrating our capacity to deliver on our promises and commitments.

Although we had carefully established our office in such a way that we had the opportunity to assist in all aspects of the agency's functioning related to mental health, we found that initially we were perceived only as experts in mental illness. The problem of reconciling our objectives and skills with the Job Corps' initial perception of what we could contribute, required two years' work. Our basic technique has been to make a diagnosis of the needs, resistances, and assets of the system and to gear our intervention to the system as we saw it.

The problem of altering our new associates' role perceptions of us has required an on-going educational process. At times we have had to return to our written mandate to enforce our involvement in issues having broad mental health implications. Gradually, the perception of our role has altered, allowing us readier access to all parts of the system. The delivery of services of high quality in the clinical areas has continued to form the base on which the remainder of the program is built. Were we to lose sight of this basic function, all else would soon topple.

Our work in the Headquarters, however, would be fruitless without the field Mental Health Programs, difficult as they have been to implement. They are the payoff, of course, for any programs centrally conceived. Thus, the Mental Health Program in the Job Corps is designed to be flexible regarding the changing needs of centers, but responsive to our overall objectives. Mental Health Consultation, Crisis Intervention, and Anticipatory Guidance techniques have been adapted to the particular needs of the Job Corps and its population. The actual implementation of the program can be conceptualized as a major "system-intervention." An intervention of this type cannot be achieved by fiat or by central office

policy and program direction alone. It requires the effective coordination of individuals and program components not themselves subject to direct central authority.

At the Job Corps centers themselves, the consultants have worked with individual cases in problem areas in the center program and with general program issues. Behind-the-scenes consultation regarding case management is not unlike that pattern of consultation common in other work organizations. Psychiatrists work with center physicians, counseling staff, resident workers, and teachers on problems of individual corpsmen, sometimes seeing the individual, sometimes not. Less than half the consultants, however, are engaged in formal teaching for the members of the staff. The bulk of the consultants' work remains that of direct clinical psychiatric services including evaluation and diagnosis of enrollees, short- and long-term psychotherapy, and emergency psychiatric care. From this important clinical base, a substantial number of consultants have become actively engaged in mental health efforts that seem to have great potential to influence many of the programs in the centers.

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Notes

1 *Carter* v. *General Motors* 106 NW.2d 105 (Michigan Supreme Court, 1960).

2 Specific examples of qualifications of the psychiatrist for work in industry, other types of clinical experience, and case examples are cited elsewhere by Powles and Ross.28 Patterns of occupational mental health programs also are well documented by Warshaw and Phillips.