15 Work and Health

Mark L. Savickas

One can live magnificently in this world, if one knows how to work and how to love, to work for the person one loves, and to love one's work.

LEO TOLSTOY

The great majority of us are required to live a life of constant, systematic duplicity. Your health is bound to be affected if, day after day, you say the opposite of what you feel, if you grovel before what you dislike and rejoice at what brings you nothing but misfortune . . .

BORIS PASTERNAK
Dr. Zhivago

About 400,000 new cases of occupational disease and work-generated illness occur each year. About 90% of family practice physicians report that they encounter occupationally related illness or injury in their practices at least once per week. These statistics notwithstanding, medical school curricula and textbooks do not adequately address either work-related illness or occupational history-taking techniques. Thus, it is not surprising that when researchers inspected patient reports written by family physicians, they find that only about 25% of the reports mention occupation or current employment status, and only 1% or 2% of the reports include additional information on the patient's occupational history. Because work is so fundamental to human health and adjustment, physicians can benefit from knowing about their patients' work lives.

This chapter describes what work does to and for people. The four sections into which the chapter is divided correspond to five different perspectives on work and adjustment:

1. Work as a cultural role
2. Work as a personal experience
3. Occupation as a source of social identity
4. Job as a person-environment interaction

A case study and brief list of resources to help physicians understand and cope with their own work, occupation, and career appear at the end of the chapter.

WORK AND CULTURAL ADJUSTMENT

Humans must adapt to their environment to survive and reproduce. Unlike other creatures, humans meet their biological needs with the help of a symbolic environment we call **culture.** A culture emerges when people band together to enhance each individual's chance to survive. Although not often thought of in this way, a culture is an adaptive strategy. Individuals use their culture to adapt to their physical environment. We are "generalist" animals prepared to specialize or function in any number of varied cultures. We assimilate a particular culture's interpretation of life through our thoughts and feelings, and most important, through our willingness to cooperate. Anthropologists have identified cooperative culture as the key to human evolution.

To cooperate, individuals must first learn what the community expects from each person. Cultures differ in how they define the meaning of life and how they structure the social roles that link individuals to the community. A culture's roles, rules, and rituals channel behavior and provide criteria for judging whether these behaviors are normal or deviant. What one culture condones, another may condemn. Representatives of a particular culture must teach new members what is expected of them. Young children

first learn from their families how to behave appropriately. Agents of other cultural institutions then reaffirm what families have taught and correct faulty learning that may have occurred during the primary socialization experience. Churches, schools, theaters, and courts use the culture's collective common sense to induct children into culturally designed adult roles. These institutions welcome children into the community and try to convince them that they belong. They teach children the attitudes and skills necessary to perform social roles competently and confidently.

What, then, do we expect from one another in our culture? The simplest answer to this question seems at once the most profound. Sigmund Freud believed that work and love are the parents of our civilization. When asked what a mature person must do, Freud answered, "love and work." Alfred Adler, an early twentieth century community-minded psychiatrist, added friendship, saying that to be well adjusted, an individual must successfully deal with the challenges presented by work, friendship, and love. Some cultural scholars expand the tasks of life beyond those involved in adapting to our little crust of the earth and advise unity with the cosmos. For example, early in this century, Richard C. Cabot, the Harvard professor of medicine who founded the "Case Reports from Massachusetts Hospital" section of the *New England Journal of Medicine,* advised physicians that a well-adjusted life must be balanced among work, play, love, and worship.

Among these core roles, work has always been primary in Western culture. Work concerned our ancestors from dawn to dusk. In struggling to survive, they spent most of their time engaged in hunting and fishing and in associated rituals. Friendship, love, and worship can be valued sources of personal support, but work is of paramount importance. Yesterday's families functioned as a unit for physical survival, not personal development. For them, even love was an economic decision. Not until late in the eighteenth century did people consider love an important part of marriage. Until then, all but the upper class viewed marriage as a business arrangement in which partners contracted to help each other survive. Because so many children died by age 5 years, society discouraged parental bonding with young children. Even then, many parents sent their surviving 6-year-old sons to live with master craftsmen for 7-year apprenticeships. The Industrial Revolution, in moving work from the home to the factory, made work a circumscribed role separate and distinct from other life roles such as friendship, love, play, and worship.

Postindustrial societies like ours still maintain the primacy of the work role, although some observers would disagree. Friedmann and Havighurst (Table 15.1) succinctly explicated the cultural functions of work and related these functions to the fulfillment of workers' needs. They argued that work is the only cultural role that can meet all five levels of human need: income, expenditure of time and energy, identification and status, association, and source of meaningful life experience. In discussing the five functions listed in Table 15.1, Friedmann and Havighurst concluded that work is more basic to survival and self-esteem than are friendship and love. Work challenges individuals to assume responsibility for their sustenance. It also encourages them to actively identify with and contribute to their "tribe" and thus experience a sense of belonging. Through work individuals resolve the generational crisis by changing from dependent consumers to self-sufficient producers and then to cultural stewards and caretakers of the next generation. Erik Erikson's schema of progression from industry to identity and eventually to generativity aptly testifies to the centrality of the work role in the human life cycle. (See Chapter 10 for an overview of Erikson's model.)

TABLE 15.1 Relationship between the functions and meanings of work

Work function	Work meaning
Income	Maintaining a minimum sustenance level of existence
	Achieving some higher level or group standard
Expenditure of time and energy	Something to do
	A way of filling the day or passing time
Identification and status	Source of self-respect
	Way of achieving recognition or respect from others
	Definition of role
Association	Friendship relations
	Peer-group relations
	Subordinate-superordinate relations
Source of meaningful life experience	Gives purpose to life
	Creativity; self-expression
	New experience
	Service to others

From Friedmann, E.A., Havighurst, R.J.: *The meaning of work and retirement,* Chicago, 1954, University of Chicago, p. 7. Used by permission.

During the fourth of Erikson's eight stages of life, young children must turn from their "mothers to others" as they enter elementary school. There they learn about rules and relationships in the world of work. They experience the crisis of **industry vs. inferiority** as they balance their ability to use the tools of their culture with feelings of inadequacy about their own skills as compared with those of their peers. Children who can stave off feelings of inadequacy and low self-esteem emerge from elementary school with a sense of competence, that is, a belief that they can engage in serious tasks and learn what they need to know to complete these tasks successfully. This sense of competence sustains their later cooperative participation in adult work roles. Without a sense of competence, adults may approach work with a competitive attitude based on childlike feelings of inferiority and inadequacy.

In 1981, the *American Journal of Psychiatry* published the results of Vaillant and Vaillant's longitudinal study of inner-city men that empirically underscores the importance that Erikson attributed to the achievement of a sense of competence. The Vaillants prospectively followed 456 inner-city males from age 14 to 47. Judges, who were not told the adult outcomes, rated systematic observations that were recorded when the subjects were 14 years old for success at tasks reflecting the Eriksonian crisis of industry vs. inferiority. On an 8-point scale to measure competence, each boy was assigned a 0 or 1 for a regular part-time job, regular household chores, participation in extracurricular clubs or sports, and regular school participation in activities and a 0, 1, or 2 for school grades relative to IQ and for ability to make the best of the environment (planning and coping capacity). This scale assessed what the boys did, not what they said or thought. By age 47, men who had scored 7 or 8 on this boyhood scale, compared with men who had scored 0 to 2, were twice as likely to be rated as generative (i. e., productive, caring, and concerned about the next generation), twice as likely to have warm relations with a variety of people, and five times more likely to be well paid for their adult work. Moreover, they were 16 times less likely to have experienced significant unemployment. Those who scored 0 to 2 were 10 times more likely to be rated as emotionally disabled and 6 times more likely to have died.

The relation of competence to death reminds us that work is the root of adjustment. This assertion was illustrated in a report of a longitudinal (13-year) interdisciplinary study on aging that correlated 39 variables with longevity and found that the strongest predictor of longevity, after controlling for age, was work satisfaction. Vaillant's report of data from his longitudinal study of mental and physical health lends further credibility to the work-health connection. For 188 college graduates, job satisfaction at age 40 correlated 0.34 with deterioration in physical health during the succeeding 9-year period.

Beyond sustaining physical health, work fosters mental health by binding individuals to reality. Work requires that people leave their private logic and fantasies to participate in the ironclad logic of community living. As Freud wrote, work provides the worker with a "secure place in a portion of reality, in the human community." For many psychoanalysts, work capacity is the cardinal sign of mental health. Vaillant and Vaillant, among others, reported that job satisfaction is closely associated with mental health. They concluded that "mastery in the workplace reflects ego strength just as much as it reflects social conformity and good luck." In contrast, incapacity to work is correlated with poor mental health. Unemployment is highest among the mentally ill, not the socially disadvantaged, and prior work history is one of the most powerful predictors of recovery from schizophrenia, drug addiction, delinquency, and alcoholism.

PERSONAL EXPERIENCE OF WORK

No other technique for the conduct of life attaches the individual so firmly to reality as laying emphasis on work.

SIGMUND FREUD

Work is effortful activity performed by an individual who seeks to produce goods and services valued by other people, as well as by oneself.

People know they are working when they forgo present pleasures for future rewards. A future orientation distinguishes the personal experience of work and play. Humans work because they can imagine the future and worry about surviving in that future. Work involves channeling drives into making tomorrow better than today. The aggression involved in attacking medical studies, making a killing in the stock market, or carving a tree into a chair all improve an individual's future. Constructive aggression manages objects and ideas, allowing individuals to control their environment and to feel a sense of mastery. Society's most accomplished workers use their time efficiently to produce more while they compete with their previous performance or that of other workers. What an individual produces affords a sense of identity based on the objective and active "I did it" rather than the subjective "I feel it" or the passive "I own it." Accordingly, as people work, they feel goal directed, constructive, in control, efficient, productive, achieving, and self-defined. It is no accident that many of the characteristics that define the personal experience of work are also used to define mental health. Psychologists maintain that future orientation is an essential ingredient in mental health. Thus, individuals who work productively are well on their way to mental health and a secure place in society. They know that because they produce things that others value, they are valued in return.

However, relative to physical and mental health, more work can mean less well-being. Too much work is almost as maladaptive as too little work. Compulsive ambition, aggression, control, efficiency, productivity, competition, and self-definition-what some have labeled the failure of success-reduce life expectancy and quality. Individuals who feel a sense of personal competence and belongingness use work to contribute, cooperate, and earn a living. By attending to occupational requirements, they can comfortably begin and end each day's work. In contrast, those people who lack a sense of belonging or personal competence use work to bind their anxiety, protect their fragile self-esteem, or avoid friendship and intimacy. Instead of attending to occupational requirements, they concentrate on *how* they are doing rather than *what* they are doing. They try to con-

vince themselves and others that they are worth more, not worthless. They rigidly do more and more in a fruitless struggle to validate their worth.

Excessive attention to how an individual is doing at work leads to a characteristic work-style. To bind anxiety, reduce insecurity, or avoid liking and loving, the individual must exaggerate work's importance. This approach leads to an excessive goal orientation that requires compulsive planning and worrying. *Being* goals (e. g., I want to be a great physician) overshadow *doing* goals (e. g., I want to help sick people). Efficiency becomes time urgency and impatience. Constructive aggression detaches from "what is required" and attaches to "how good I am." Free-floating hostility emerges and serves to deflect any threats to self-esteem. Compulsive competitiveness about almost everything and with almost everyone causes the successful failure to view coworkers as challengers in a zero-sum contest for a limited supply of power, prestige, and possessions. Healthy productivity and self-evaluation yield to an obsession with keeping score and winning the contest. Cynicism and distrust toward coworkers generate unreasonable and dominating behaviors. Rather than using work to build an identity as a prelude to joint identity or intimacy, the successful failure uses work to maintain rigid identity boundaries and thus hold friendship and love at bay.

Taken together, competitiveness, time urgency, impatience, hostility, and overinvolvement in work have been called the **Type A behavior syndrome.** As individuals with Type A styles engage in daily combat with time and coworkers, their exertion places them at risk for personality deterioration, emotional exhaustion, or pathophysiological processes associated with coronary heart disease (CHD). An individual need not be gainfully employed to exhibit Type A behaviors. Homemakers with a Type A work-style report more daily stress, less self-esteem, and poorer health.

Available experimental evidence on altering Type A behavior is positive; however, habits deeply ingrained since childhood die hard, especially when these habitual work behaviors lead to occupational success and tangible societal rewards. Because many workers derive status, pride, and financial security from overworking behaviors, they are reluctant to consider the possibility that these behaviors are causal factors in CHD and mental distress. Because of this resistance, intervention can modify Type A behaviors more readily in postinfarction patients than in healthy individuals. Among the experimental interventions tried, cognitive training in stress management shows the best potential for reducing Type A behaviors.

Essentially, programs to modify Type A behavior teach patients to balance work with love, which is expressed through play, intimacy, and worship. The programs are founded on the assumption that life is best lived by balancing goals with spontaneity. Competition must alternate with cooperation, aggression with altruism, efficiency with patience, control with reciprocity, and identity with empathy. Balancing work with love allows an individual to relax, repair the damages done by work, and recreate himself or herself.

OCCUPATION

"When you come to a patient's house, you should ask him what sort of pains he has, what caused them, how many days he has been ill, whether the bowels are working, and what sort of food he eats." So says Hippocrates in his work Affections. I may venture to add one more question: What occupation does he follow?

C. RAMAZZINI
Diseases of Workers (circa 1700)

Thus far we have examined work as a cultural role and a personal experience. In this section we consider occupation as a source of social identity. **Occupation** denotes a life role, one that has important financial and social consequences. **Work** is the activity performed in an occupational role. Asking people about their work implies interest in their activities, whereas asking them about their occupation implies interest in their social status.

Occupations emerge in human societies when survival no longer demands that individuals do everything for themselves. The division of labor within a society structures its social order. An individual's occupation then profoundly affects his or her social status and experience within the society. Hunting and gathering societies typically divide work by sex; men work outside and women work inside the home. Sexual segregation of labor within occupations has replaced the earlier labor segregation between home and occupation. Women who work outside the home in industrial societies tend to be channeled into light work or jobs such as teaching children, pediatrics, and nursing that extend their traditional nurturing role. In 1969 half the women in the work force were employed in only 21 occupations. Even with the social movements and government intervention of the 1970s, only minor changes in occupational sex segregation occurred through the early 1980s. About half of U. S. companies are still completely segregated by sex.

Occupational sex segregation is implicated in most of the problems that trouble women in the workplace. For example, sex segregation allows differential pay for comparable work, short career ladders that block advancement, stereotypes of "women's work" that devalue certain jobs, treatment of women as casual workers who come and go

depending on family responsibilities, and sexual harassment. As a result, women who work in traditional female-dominated (370%) occupations report more depression and anxiety and less self-esteem and job satisfaction than women who work in either male-dominated or neither-sex-dominated occupations. In multicultural societies, occupational segregation by race also thwarts self-realization and limits social contributions from minority group members. Throughout its history, U. S. society has depended on minority workers to do its least desirable work. Moreover, minorities are more likely to be unemployed or to be employed in occupations with higher risk for disability and disease. It is unfortunate that sex and race should prove to be such powerful predictors of occupational role in a society striving toward the democratic ideal of living and working together as equals.

Research on occupational groups addressed the effects of occupations on workers' well-being. In research published in the *American Journal of Public Health* in 1981 and 1988, Karasek and his colleagues in 1981 proposed that work demands and control (operationally defined as range of decision-making freedom or latitude) jointly influence levels of psychological and physiological distress. In their view, work demands both motivate and stress workers, whereas decision latitude allows them to direct that motivation and release stress. Because high-demand/low-control work situations increase workers' stress while preventing its release, these situations place workers at greater risk for mental distress and CHD. Rushed tempo and lack of situational control are associated statistically with marked elevation of blood pressure and heart rate.

In a study to test their theoretical model, Karasek and his colleagues in 1988 assessed 221 occupations for **control** and **demand.** They operationally defined amount of **strain** for each occupation as a multiplicative function of control times demand. Occupations in the top 10% for strain included cashier and waiter; those in the bottom 10% included forester, natural scientist, and civil engineer. The researchers then assigned a strain score based on occupation to 4,833 men who had participated in two national health surveys and found that men in the top 10% for occupational strain had 3.8 (in one survey group) and 4.8 (in the other survey group) times the risk for myocardial infarction (MI) when compared with men in the bottom 10%. In a second analysis they found that men in the top 20% for occupational strain had 2.5 and 3.3 times, respectively, the risk of MI as the rest of the group. When they controlled for age, occupational strain accounted for 25% and 33%, respectively, of MI prevalence. This magnitude is similar to that for smoking and for serum cholesterol levels reported in other studies.

JOB

I have now no relief but in action. I am becoming incapable of rest. I am quite confident I should rust, break, and die if I spared myself. Much better to die doing.

CHARLES DICKENS (who died of heart disease thought to be exacerbated by his work habits)

After choosing an occupation, a person must obtain a job within that occupation. A job exists in a particular establishment at a specific site; within any one occupation many jobs vary slightly across different locales and establishments. For example, the job of a family physician in an urban academic health center differs from that of a family physician in a rural health clinic. Even if these two physicians perform identical work, their jobs differ with respect to contextual variables such as organizational climate, supervisor style, coworker personalities, pace, pay, and productivity norms.

Having obtained a job, an individual must then adjust to it. The social environment and mental health research team at the University of Michigan's Institute for Social Research has proposed a dynamic model of job adjustment that distinguishes between objective and subjective fit. Objective fit refers to the correspondence of the actual environment (independent of an individual's perception of it) to the person as he or she really is. Subjective fit refers to the correspondence between a person's perception of the environment and that person's self-concept. Researchers can calculate four indices of fit by measuring the same dimension relative to the objective environment, objective person, subjective environment, and subjective person. The Michigan group illustrated these indices using typing speed as a dimension. A clerk who believes that he or she is capable of typing 55 words per minute (subjective person) may actually be able to type 40 words per minute (objective person). The supervisor may expect the clerk to type 70 words per minute (objective environment), and the clerk may think that the supervisor expects her or him to type 60 words per minute (subjective environment). Using these numbers, researchers can assess the clerk's subjective person-environment (P-E) fit, objective P-E fit, contact with reality, and accuracy of self-assessment as outlined in Figure 15.1. Each of these four indices reflects an aspect of fit, and minimal discrepancy scores for each of the four comparisons indicate good fit.

Researchers use these discrepancy scores to define job stress operationally. The stress stimuli occasioned by a poor person-job fit (sometimes called job stressors) can be al-

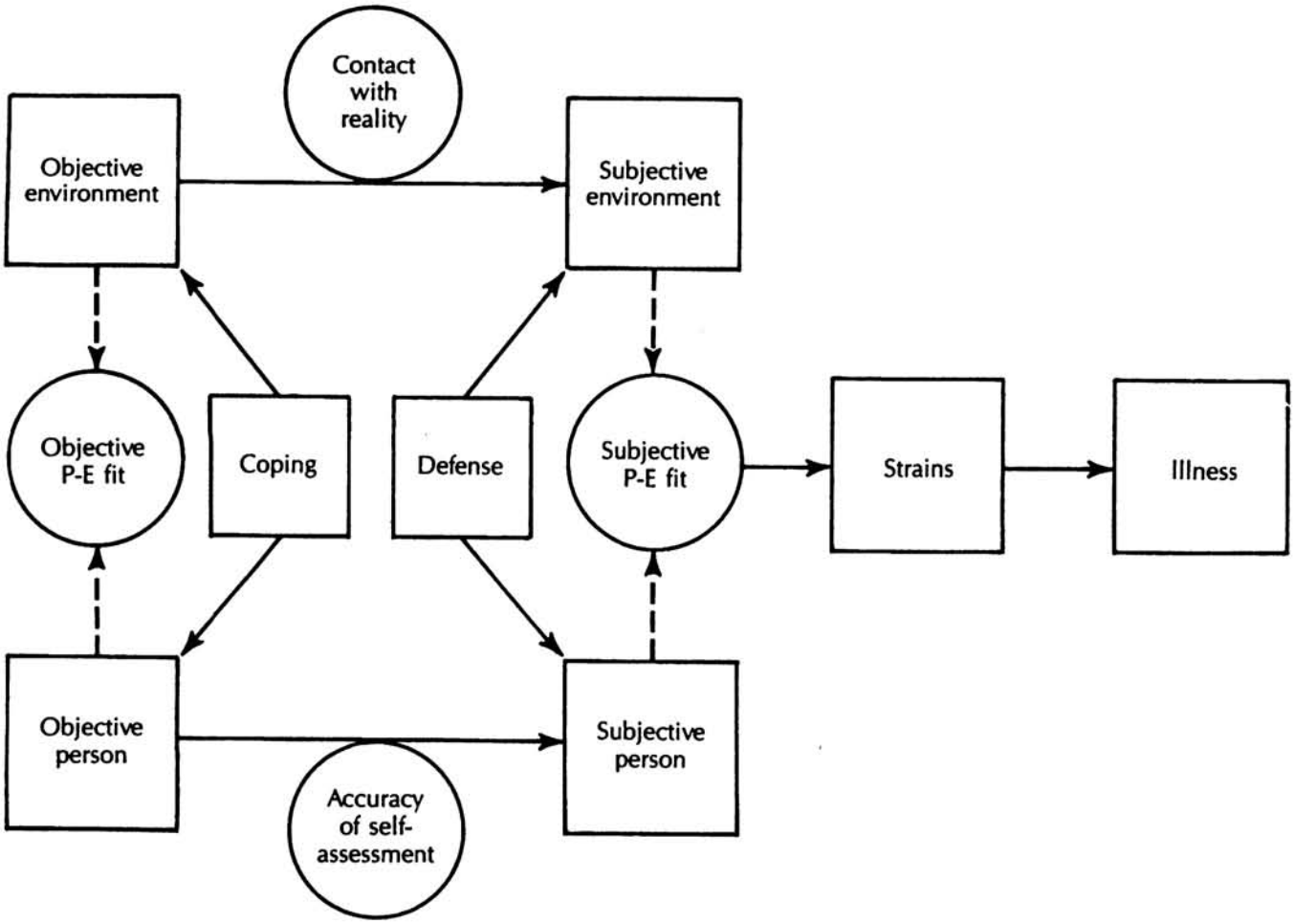

FIGURE 15.1 *A model describing the effects of psychosocial stress in terms of fit between the person and the environment (P-E). Concepts within circles are discrepancies between the two adjoining concepts. Solid lines indicate causal effects. Broken lines indicate contributions to interaction effects. (From Harrison, R.: Person-environment fit and job stress. In C.L. Cooper, R. Payne (Eds.), Stress at work. New York: Wiley & Sons 1978, p. 108. Used by permission.)*

most endless. Nevertheless, job stressors can be grouped into six major categories:

1. Role overload: too much work, too few resources
2. Role insufficiency: too little work or use of talents
3. Role ambiguity: unclear expectations or evaluation standards
4. Role boundary: conflicting demands or loyalties
5. Responsibility: too much responsibility for other people or things
6. Physical environment: exposure to noxious stimuli, shift rotation, or isolation

To distinguish these job stresses from their effects on workers, researchers define **job stress** as pressures that challenge the worker and **personal strain** as the injurious effects of those pressures on the worker. Researchers have grouped strains into four major categories. Psychological strain includes affective responses such as anxiety, demoralization, and hostility. Physical strain includes sleeping and eating problems, alcohol and drug abuse, and smoking. Interpersonal strains manifest themselves in such social behaviors as withdrawal, isolation, and anger. Vocational strain is reflected by reduced work attendance, productivity, and job satisfaction. As strain accumulates over time, an individual may become increasingly susceptible to distress, that is, various mental and physical illnesses.

Every worker experiences some amount of job stress. Thus, rather than asking a patient, "Do you have any stress on your job?" a physician should ask, "What stress do you encounter at work, and how do you deal with it?" Then the physician may assess the soundness of the patient's responses to job stress and determine whether personal strain has occurred. The Michigan group explicated two basic types of responses to stress. **Coping responses** change the objective environment or objective self to improve P-E fit. Through conscious, accurate, and socially reasonable actions these responses deal with demands, solve problems,

and help the individual tolerate greater amounts of stress. In contrast to the direct action of coping responses, **defensive responses** involve interpretative reappraisals that reduce the stress of subjective P-E misfit through some negation or distortion of objective reality. Unlike coping responses, defensive responses are unconscious, inaccurate, and unreasonable. Although they do not solve problems, they do safeguard self-esteem and reduce tension, anger, and depression. Defenses usually produce rigid and fragmented behaviors that work only in the short run because they prompt no new learning about the objective environment or objective self; in the long run they actually increase threat. In effect, coping improves fit, whereas defense maintains misfit while reducing perceived stress.

Although only trained observers can recognize all the classic defenses described in Chapter 18, almost everyone can recognize the three main tactics workers use to safeguard their self-esteem. Workers who use the first tactic, **optimistic comparison,** view themselves as better than their peers, the present as better than the past, and the future as likely to be better than the present. Workers who use the second tactic, **selective inattention,** find positives to counter the negatives in a situation, immerse themselves in the pleasant aspects of a job, and downplay the importance of work as compared with friendship, play, and love. Workers who use the third tactic, **restricted expectations,** accept unsatisfying job conditions as inevitable and concentrate not on the job itself but on outcomes such as money, security, and vacations.

Coping reduces stress, and defense delays strain and its consequences. However, when workers do experience strain, they may use palliative responses to ease their discomfort. Three types of responses help people live with strain and discharge some of its effects. Social support garnered by talking with sympathetic people allows catharsis. Recreational play interrupts thoughts about job stress and alleviates anxiety and anger. Self-care, such as proper nutrition, sleep, and exercise, dissipates the physical tensions that accompany strain and increases the energy available for coping responses. As a group, social support, recreation, and self-care often help people turn problems into opportunities and empower them to actively master what once had been passively suffered.

Because most studies of job stress, strain, and distress have used self-report measures and cross-sectional designs, their data include correlation, not causality. Stress and strain relate consistently to many types of distress, including depression, low self-esteem, high blood pressure, change in blood eosinophils, elevated serum cholesterol levels, stuttering, and increased physician visits. These studies suggest strong relationships among P-E misfit, strain, and illness but do not explain these relationships. Initial evidence suggests that strain may cause mental and physical illness; to date, no theory adequately explains these findings.

Heavy the Oar to Him Who is Tired, Heavy the Coat, Heavy the Sea
Ivan Le Lorraine Albright (1929). Oil on canvas, 135.6 by 87 cm. Gift of Mr. and Mrs. Earle Ludgin. Copyright 1989, the Art Institute of Chicago, Chicago. All rights reserved. Work can be viewed as a blessing or a curse. Read Ernest Hemingway's The Old Man and the Sea for an example of someone whose life is defined by his work.

A significant percentage of primary care physician's patients are experiencing occupational stress and vocational strain. Often, demoralization has triggered their physical symptoms. The physician who suspects that strain may be affecting a patient's mental and physical health can help the patient cognitively by exploring the meaning of the strain and correcting mistaken ideas about it and emotionally by allowing affective catharsis, instilling hope, and encouraging effort. At a minimum the physician should help the patient physically. Because strain is frequently accompanied by changes in patients' self-care practices, physicians can help their patients avoid or reduce stress-related health problems by encouraging sound health practices relative to sleep, exercise, elimination, dental hygiene, smoking, alcohol use, and nutrition.

SUMMARY

In this chapter we consider work from four perspectives. First, work is the core role with which our culture structures life. Second, we explain how individuals differ in the personal meaning they invest in work roles and in how they work. Third, occupation is discussed as an element in the social structure and as a source of identity. This leads to, fourth, a conception of jobs as person-environment interactions that require adjustment through the use of coping or defensive responses.

One or more of these topics may be at issue in a patient's life. In fact, the four issues may characterize the life situation of certain patients. Immigrant and culturally different patients may have trouble relating to the dominant culture's view of work and its importance. Work-style issues may trouble successful executives and professionals, as well as marginal workers with histories of absenteeism and low productivity. Occupational segregation caused by sexism, racism, or ageism may thwart the self-expression and personal development of homemakers divorced from their spouses, people discriminated against by society, and older workers displaced by technology. Psychological, physical, social, or vocational strain may trouble people with jobs that bore or overwhelm them. Depending on the circumstance, a physician may find it useful to ask a patient about work, work-style, occupational identity, and job stress. A physician who wants to know his or her patient as a person needs to learn what work does for and to that person.

CASE STUDY

Having just read about the general relations between work and health, now consider the specific ways in which work interpenetrates the life and well-being of one patient. The following dialogue between a family physician and a new patient was excerpted from the transcript of the initial visit. The patient was a 44-year-old man who complained of diarrhea of 2 years' duration. He finally chose to make an appointment because he had begun to experience stomach cramps with the diarrhea. The symptoms do not seem to be associated with time of day or with any foods, although coffee seems to exacerbate the symptoms. Aluminum and magnesium hydroxide (Maalox) and opium tincture (Paregoric) have not relieved the symptoms.

After the portions of the interview directed at eliciting the chief complaint, the history of the present illness, and the review of systems, the physician conducted a psychosocial systems review to learn about the patient as a person and to locate the chief complaint in the context of his daily life. Note that the patient spontaneously gives his social identity as an engineer, describes his father's prolonged transition from employment to retirement, his wife's plan to get an MBA and reenter the labor market, his daughter's failure to choose a major and stay in college, his job stress, and his use of recreation rather than social support to handle the strain. Clearly work is doing much for-and to-this patient.

Physician: Tell me a little about yourself.

Patient: Well, I graduated from Ohio State with an engineering degree and went into business with my father, and we worked very hard. I appreciated it. We spent a lot of time at it because when you are in business for yourself, you're counting on yourself so you do put in a lot of extra hours. My father's about to retire. He's 69. Of course, he's been "retired" for the last 4 years, maybe. He keeps his office, keeps coming in and, uh, it disrupts things because of conflicting orders, that type of thing. Maybe it's more disrupting than it was in the past. I can understand his position, uh, that he's worked very hard. It's very difficult for him to get out, perhaps because he didn't develop other hobbies. That's why I took up finishing antiques at home, because I work with my hands and kind of get away, and it gives me something else to do not related to the job, children. My wife would probably have a different approach, or a different viewpoint, but I think as your children grow up, particularly when they leave home, you find you talk less about those kinds of problems because usually you talk about your children, right? My wife's aware of the problem I have with my father, so there's no need to review that. I don't discuss it every night. Since she's getting her MBA, if I do discuss a problem, business related, in general, or a specific problem, she does make comments (laughs) you know, related to the MBA. I try to show some interest, too, in what she's doing, but, uh, if we have a problem domestically it's because of our daughter dropping out of college. My wife has a heck of a time relating to that. I don't. I think she does need time to look around. She's got the rest of her life, and I think it's important to pursue the right career. And it's very difficult for a young person to make that decision without any exposure to something. But actually our life's pretty well organized. I don't see any problems.

Physician: Okay. Do you feel a little concerned, though, that your wife and you have opposing viewpoints on your oldest daughter?

Patient: No, not really. You know, husbands and wives don't go through very many years of marriage without differences of opinions. And they all work out. I think that my wife particularly finds it very, well, down time with the children grown up cause she spent all her time at home. The MBA is a good pursuit for her. I would say our life is pretty well organized, satisfying.

Physician: Do you feel any concern about the situation with your father?

Patient: Sure. I can understand how he feels but I think 69 years old is time to let go. I'm perfectly confident that we can handle it and he can let go of the reins. But I don't

think he will. Can I swing with that? Yeah, I can swing with that. I think I can.

Physician: Do you feel this is a significant problem to you, though?

Patient: Well, it's significant that I face it every day. It's not significant when I look at other people's problems. I'm sure people go through the same type of thing. It's more intimate because it's my father. I just hope I don't do the same thing myself.

Physician: Well, you're more or less coping with this situation until he makes his mind up.

Patient: "Yeah, that's correct."

Physician: Do you see any problems with waiting around until that time?

Patient: No, No I don't. You know I've talked to other people who've been in the same situation as myself. Some people will say, "I ain't gonna stay" and they leave. They leave. I certainly don't want to push my son into that position. Or would I? Maybe it's because of my exposure, uh, right or wrong. Just like with my older daughter. I think people make their own decisions, you know. I can't say I haven't been forceful and tried to direct them, give them advice.

Physician: Mm-hmm.

Patient: And I think they listen. I think we have a very normal relationship at home. I don't feel the least bit depressed about it. I'm confident that all this will work out.

Physician: But you do feel that your life has been a little disrupted?

Patient: "Well, yes. Yes, I'd have to say that."

Physician: Approximately when did you first start talking to your father about taking over the business?

Patient: "I've been buying him off for the last 2 years."

Physician: Do you see any significance in the fact that you've been having this problem for 2 years and you've had the diarrheal problem for 2 years? Do you see any relationship there?

Patient: I, uh, I can't say that it is. And I can't say that it isn't either. It's been 2 years, and we haven't made a decision. It's like never getting over the hurdle. I don't know.

Physician: How do you normally handle stress? If you feel the need to talk about this type problem, to whom do you turn?

Patient: I try not to discuss it with outsiders. I don't talk about it with too many people because it's really a confidential thing, personal. More personal. Because I think the world of my father. He worked. He worked hard at it and now the time should be rewarding for him. But he doesn't feel that reward. I don't feel that close to too many people to dwell on that subject. Uh, a few friends. We don't have a broad circle of friends. I just don't discuss it.

Physician: Okay. How are things going for you at work other than the situation with your father?

Patient: We have our ups and downs right now. Business is pretty good compared to the rest of the economy. We're holding our own. It isn't exactly booming right now. So there's a lot of things on the drawing boards that we started. When the economy changes, we'll be busier than usual. Right now we're holding our own.

SUGGESTED READINGS

Gerber, L. (1983). *Married to their careers.* NY: Tavistock.
This book offers advice about integrating the physician work role with personal and family life.

Hilfiker, D. (1987). *Healing the wounds: A physician looks at his work.* NY: Penguin Books.
A family practitioner presents a compelling account about the painful truths involved in the daily work of a primary care physician.

Lowman, R.L. (1993). *Counseling and psychotherapy of work dysfunctions.* DC: American Psychological Association.
A clinical psychologist explains the cause and treatment of common work dysfunctions.

McCue, J. (1982). The effects of stress on physicians and their medical practice. *New England Journal of Medicine, 306,* 458–463.
This article discusses how physicians can deal with the stress they meet in dealing with patients' suffering, fear, sexuality, death, and uncertainty.

Menninger, R., & Gabbard, G. (1983). Physicians and their families: Normative issues. *American Psychiatric Audio Review.*
Four audiotapes deal with compulsive work-style, medical marriage problems, physicians as parents, and balancing values and priorities.

Myers, M.F. (1994). *Doctors' marriages: A look at their problems and solutions.* NY: Plenum.
An excellent discussion of how physicians balance work and love.

USMLE REVIEW

1. A 32-year-old dot.com executive presents with classic signs of type-A behavior. This patient is most likely to be at risk for which of the following illnesses:
   A. Obesity
   B. Hypertension
   C. Somatoform disorders
   D. Coronary artery disease
   E. Cancer
2. Individuals first learn about the roles and rules of the world of work:
   A. During free play activities with peers
   B. In infant-caretaker interactions
   C. In high school
   D. When they enter their first real job
   E. In elementary school
3. When age is controlled, the strongest predictor of longevity is:
   A. Genetic predisposition
   B. Work satisfaction
   C. Physical functioning
   D. Use of tobacco or alcohol or both
   E. Performance IQ