Working life and mental health –
A challenge to psychiatry?

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According to the World Health Organization, “mental health problems and stress-related disorders are the biggest overall cause of early death in Europe”. Some of the root causes of this morbidity and mortality are related to living and working conditions that are accessible to preventive and therapeutic interventions, individual as well as collective ones. A political mandate for such interventions is now developing. Members of the WPA Section on Occupational Psychiatry have contributed to this development and we now invite the readers to join the Section in its endeavours.

Key words: Occupational mental health, work-related stress, disease prevention, health promotion, systems approach

According to Hippocrates, “A physician visiting common people should not immediately feel the patient’s pulse, disregarding his conditions of life. And he should not discuss what is to be done standing up … but sit down for a while … and cheerfully ask the patient what is ailing him, how it came about, and how many days it has already been bothering him … Also if he has had evacuation and what he eats”. To this quote, Ramazzini (1) added: “He should also enquire which craft the patient pursues”.

The latter, ground-breaking, statement was published more than three centuries ago. Since then, there is no doubt whatsoever that a wide variety of living and working conditions are powerful determinants of health, for better or for worse. The relationship works both ways. Working conditions affect health, but health more often than not also affects a person’s productivity and earning capacity, as well as his or her social and family relationships. Needless to say, this holds true for all aspects of health, both physical and mental.

However, before issuing any “call for action”, by psychiatrists or others, we need to consider whether there is, indeed, a problem – whether work-related or other stress and depression are widespread, have serious consequences, are becoming more prevalent and severe – and whether this is accessible to interventions (2). The available evidence indicates that the answer to all these questions is yes. According to the World Health Organization (WHO) (3), “mental health problems and stress-related disorders are the biggest overall cause of early death in Europe”. But they are not only a matter of premature mortality. According to the same report, mental ill health and disorders are among the major health concerns in Europe today. In particular, depression, suicide and other stress-related conditions, together with destructive lifestyles and psychosomatic diseases, cause immense suffering to people and their families, as well as placing “a great economic cost on society”.

How great is this “economic cost”? According to a report prepared during the Finnish European Union (EU) presidency and quoted by the International Labour Office (ILO) (4), the cost of mental health problems in the 15 member states of the European Union in the year 2000 was estimated to be on average 3-4% of gross domestic product (GDP). If we approximate the percentage to, say, 3.5% and use the EU15 GDP (19,301 billion euro in 2003) as a basis for our calculation, the cost would amount to 325 billion euro.

THE ROOT CAUSES

Do we know the root causes of these outcomes, and, if so, are they accessible to change?

According to the WHO (3), mental health problems can be caused by a combination of circumstances: biological, social and psychological factors and stressful events. They are usually associated with difficulties either in our personal lives or in the wider environment in which we live. In its analysis of such circumstances, the British govern-

Table 1 Factors affecting health (according to the British government, 5)

<table>
<thead>
<tr>
<th>Fixed</th>
<th>Social and economic</th>
<th>Environmental</th>
<th>Lifestyle</th>
<th>Access to services</th>
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<tbody>
<tr>
<td>Genes</td>
<td>Poverty</td>
<td>Air quality</td>
<td>Diet</td>
<td>Education</td>
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<td>Sex</td>
<td>Employment</td>
<td>Housing</td>
<td>Physical activity</td>
<td>National health system</td>
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<td>Ageing</td>
<td>Social exclusion</td>
<td>Water quality</td>
<td>Smoking</td>
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<td></td>
<td></td>
<td>Social environment</td>
<td>Alcohol</td>
<td>Transport</td>
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<td></td>
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<td>Sexual behaviour</td>
<td>Leisure</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Drugs</td>
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ment (5) calls attention to five different types and exemplifies each of them (Table 1). The “fixed” factors in the first column are difficult to adjust, whereas successful interventions are feasible against those listed in the other four columns: social and economic; environmental; lifestyle; and access to services.

The causal significance of the latter four types of factors has been analysed by Wilkinson and Marmot (6). The authors conclude that the “solid facts” are that: a) social and economic circumstances affect people’s health strongly throughout life; b) work-related stress increases the risk of disease as do unemployment and job insecurity; c) social exclusion creates health risks, while social support promotes health and well-being; d) individuals may turn to alcohol, drugs and tobacco and suffer as a result of their use, but this process is also influenced by the wider social setting, which is often beyond individual control.

THE SCIENCE-POLICY-IMPLEMENTATION GAPS

The awareness that it is possible to intervene on the above four types of factors has existed for quite a while, with a very considerable and growing body of circumstantial evidence to support it. In spite of this, there is still a broad science-policy gap, and an even broader one between policy and implementation. This is why there has, so far, been “great cry and little wool”. As I see it, the WPA, its member bodies, and you, the reader, may wish to feel challenged to contribute to correcting this state of affairs.

Back in 1970, the WHO and the University of Uppsala co-sponsored a high-level international, interdisciplinary symposium at the Karolinska Institute in Stockholm on the broad theme of “Society, Stress and Disease” (7). This was followed up by four subsequent symposia with a more specific focus on major phases of the human life cycle, from the cradle to the grave (8-11), summarizing a host of scientific evidence for subsequent policy formulation and implementation. In 1973, the WHO designated our department at the Karolinska Institute as its first collaborating centre on psychosocial factors and health. In 1974, the 27th World Health Assembly was devoted to an in-depth discussion of this field. In 1979, the US Surgeon General’s ground-breaking report on disease prevention and health promotion included a chapter on psychosocial factors in preventive medicine (12). Following a series of agency specific and joint consultations and workshops, the Joint International Labour Office (ILO)/WHO Committee on Occupational Health issued its report on “Psychosocial Factors at Work: Recognition and Control”, which was subsequently endorsed by the ILO Governing Body and the WHO Executive Board and published (13) as a set of joint recommendations to the social partners worldwide. Soon after, the WHO compiled and published its state-of-the-art document on “Psychosocial Factors at Work and their Relation to Health” (14), which was updated, five years later, in an ambitious ILO (15) report, “Preventing Stress at Work”.

WIDESPREAD EXPOSURES, MORBIDITY AND MORTALITY

During the 1990s, the European Foundation for the Improvement of Living and Working Conditions conducted and published three major surveys of working conditions and workers’ health in the EU Member States.

According to the most recent one (16), more than half of the 160 million workers in EU15 report working at a very high speed (56%), and to tight deadlines (60%). More than one third have no influence on task order. 40% report having monotonous tasks. Such work-related “stressors” are likely to have contributed to the present spectrum of ill health: 15% of the workforce complain of headache, 23% of neck and shoulder pains, 23% of fatigue, 28% of “stress”, and 35% of backache (16). And to many other diseases, even to life-threatening ones.

Sustained work-related stress is an important determinant of depressive disorders. Such disorders are the fourth leading cause of the global disease burden. They are expected to rank second by 2020, behind ischaemic heart disease, but ahead of all other diseases (17).

It is further likely that sustained work-related stress is an important determinant of the metabolic syndrome (18,19). This syndrome comprises a combination of: abdominal accumulation of adipose tissue; a decrease in cellular sensitivity to insulin; dyslipidemia (increase in low density lipoprotein cholesterol and triglycerides, and decrease in high density lipoprotein cholesterol); and hypertension, probably contributing to ischaemic heart disease and diabetes type 2 morbidity.

The most important pathogenic pathways from psychosocio-economic determinants to ill health in Europe usually comprise (2): a) psycho-socio-economically induced physiological over-arousal; b) psycho-socio-economically induced pathogenic behaviours; c) pathogenic interpretation of environmental characteristics; d) pathogenic interpretation of proprioceptive signals (signals originating within the tissues of the body); e) pathogenic “patient’s delay”; f) psychosocial “avitaminosis”.

COMPLEMENTARY EUROPEAN INITIATIVES

Over a decade ago, in 1993, the Belgian EU Presidency, the European Commission and the European Foundation jointly organized a major Conference on “Stress at Work – A Call for Action”. The conference highlighted the increasing impact of stress on the quality of working life, employees’ health and company performance. Special attention was devoted to stress monitoring and prevention at company, national and European level. Instruments and policies for better stress prevention were presented and discussed. Finally, a round table on “Future Perspectives on Stress at Work in the European Community”
brought together representatives from national governments, the European Commission, the European Social Partners and the Foundation (20). Based on these deliberations, the European Commission created an ad-hoc group to the Advisory Committee on Health and Safety on “Stress at Work”. The ad-hoc group proposed and the Advisory Committee endorsed (21) the preparation of a “Guidance” in this field.

This Guidance (22) emphasizes that, according to the EU Framework Directive, employers have a “duty to ensure the safety and health of workers in every aspect related to the work”. The Directive’s principles of prevention include “avoiding risks”, “combating the risks at source”, and “adapting the work to the individual”. In addition, the Directive indicates the employers’ duty to develop “a coherent overall prevention policy”. The Guidance provides a solid and detailed basis for such endeavours.

Based on surveillance at individual workplaces and monitoring at national and regional levels, work-related stress should be prevented or counteracted by job redesign (e.g. by empowering the employees, and avoiding both over- and underload), by improving social support and by providing reasonable reward for the effort invested by workers, as integral parts of the overall management system, also for small and medium sized enterprises (SMEs). And, of course, by adjusting occupational physical settings to the workers’ abilities, needs and reasonable expectations – all in line with the requirements of the EU Framework Directive and Article 152 of the Treaty of Amsterdam. Supporting actions include not only research but also adjustments of curricula in business schools, in schools of technology, medicine, and behavioural and social sciences, and in the training and retraining of labour inspectors, occupational health officers, managers and supervisors, in line with such goals.

This overall approach was further endorsed in the Swedish EU Presidency conclusions (23), according to which employment not only involves focusing on more jobs, but also on better jobs. Increased efforts should be made to promote a good working environment for all, including equal opportunities for the disabled, gender equality, good and flexible work organisation permitting better reconciliation of working and personal life, lifelong learning, health and safety at work, employee involvement and diversity in working life. An obvious interlocking question is – how? The answer to this question is considered in three recent European documents (24): the European Commission’s “Guidance on Work-Related Stress” (22) described above; the European Standard on Ergonomic Principles Related to Mental Work Load (25); and the European Commission’s Green Paper on “Promoting a European Framework for Corporate Social Responsibility” (26).

A COMPARISON BETWEEN THE THREE APPROACHES

The stress-stressor-strain concepts

The European Standard defines “mental stress” as a stimulus – generally in line with the corresponding definition in physics, as “a force that tends to strain or deform a body”. The Guidance has chosen the current psychosocio-biological stress concept originally introduced by Selye (27), comprising the common denominators in an organism’s adaptational reaction pattern to a variety of influences and demands. According to the European Standard, stress (= the stimulus) induces “mental strain” (= the reaction). The non-specific aspects of the latter is what the Guidance refers to as “stress”. The European Standard’s “stress” concept equals the Guidance’s concept of “stressor”. It is, of course, important to keep in mind these fundamental differences between the two sets of definitions, to avoid confusion.

Negative, positive, or neutral connotations

The European Standard emphasizes that its stress concept is regarded as neither intrinsically negative or positive. Depending on the context it can be both or neither. Similarly, the Guidance indicates that stress can be positive (“spice of life”) or negative (“kiss of death”), depending on the context and on interindividual variation.

Unfavourable long-term effects?

The European Standard excludes consideration of possible negative long-term effects because of “the yet inconclusive results of research”. The Guidance, prepared almost a decade later, takes the opposite view and presents evidence of a wide variety of negative (health) effects of long-term stressor exposures. The latter evaluation is also in line with the WHO (3) formulation that “mental health problems and stress-related disorders are the biggest overall cause of early death in Europe”.

Different paradigms

The three approaches are based on different but related paradigms. The European Commission’s Guidance has its roots in workers’ protection, stress medicine and psychology, and in an ecological or systems approach. The European Standard is based on ergonomics – an applied science of equipment and work process design intended to maximize productivity by reducing operator fatigue and discomfort. And the Green Paper has as its basic core a consideration for ethics and human rights (24).

The Guidance was prepared with the awareness that “one size does not fit all”. It is a hors-d’oeuvre, a smorgasbord, from which all stakeholders are invited to choose the combination of interventions considered to be optimal in their specific setting, for subsequent evaluation. It is chinned with the European Framework Directive and aims at preventing work-related ill health and promoting well-being and productivity.

The Standard is more precise in its indications of what to include and what to promote and how. It refers to all
kinds of human work activity with the explicit aim to “fit the work system to the user”. It never says so but leaves the reader with the impression that productivity (rather than health and well-being) should be considered as the primary outcome.

**A EUROPEAN VOLUNTARY AGREEMENT**

The Summary of the Commission’s Guidance has been a basis for recent negotiations between the European Social Partners. On May 27, 2004, the Partners reached a European Framework Agreement on Work-related Stress (28), which has been formally ratified on October 8, 2004 by the constituent bodies of the four European social partner organisations. Its aim is to a) increase the awareness and understanding by employers, workers and their representatives of work-related stress; b) draw their attention to signs that could indicate problems of work-related stress.

According to it, identifying whether there is a problem of work-related stress can involve an analysis of factors such as work organisation and processes (working time arrangements, degree of autonomy, match between worker’s skills and job requirements, workload, etc.), working conditions and environment (exposure to abusive behaviour; noise, heat, dangerous substances, etc.), communication (uncertainty about what is expected at work, employment prospects, or forthcoming change, etc.) and subjective factors (emotional and social pressures, feeling unable to cope, perceived lack of support, etc.).

Anti-stress measures could include, for example: a) management and communication measures such as clarifying the company’s objectives and the role of individual workers, ensuring adequate management support for individuals and teams, matching responsibility and control over work, improving work organisation and processes, working conditions and environment; b) training managers and workers to raise awareness and understanding of stress, its possible causes and how to deal with it, and/or to adapt to change; c) provision of information to and consultation with workers and/or their representatives in accordance with EU and national legislation, collective agreements and practices.

Now ratified, the agreement is to be implemented by the national member organisations according to the procedures specific to management and labour at national level within a 3-year timescale.

**CORPORATE SOCIAL RESPONSIBILITY?**

The corporate social responsibility (CSR) initiative constitutes a broad approach, comprising employee health, well-being and productivity, as well as economic and ecological sustainable development.

At its final meeting on June 29, 2004, high level representatives of business, trade unions and civil society presented the final report of the European Multi-Stakeholder Forum (29) on CSR to the Enterprise and Employment Commissioners of the European Commission. The report, containing recommendations on raising awareness, building capacity and creating an enabling environment, represents the final outcome of many months of intense discussions. The starting point for the Forum’s discussion was the definition of CSR provided by the European Commission (26): “CSR is a concept whereby companies integrate social and environmental concerns in their business operations and in their interactions with their stakeholders on a voluntary basis”.

Through CSR, businesses contribute to sustainable development. The baseline understanding is that: a) CSR is the voluntary integration of environmental and social considerations into business operations, over and above legal requirements and contractual obligations; b) the commitment of management in driving CSR forward is essential; c) CSR is about the core business activities of a company and, while companies are there to make profits, an approach which integrates environmental and social considerations and is based on dialogue with stakeholders is likely to contribute to the long-term sustainability of business in society; d) CSR is one means amongst many for achieving economic, social and environmental progress, and for integrating these concerns into business practice; e) the dialogue with relevant stakeholders adds value to the development of companies’ CSR practices and tools; as employees are an integral part of a company, it is important to pay particular attention to the role of employees and their representatives and dialogue with them; f) CSR is complementary to other approaches of ensuring high environmental and social performance: there are limits to CSR, and it alone cannot be expected to ensure environmental and social improvement and should not be used to shift public responsibilities to companies; g) CSR is an ongoing learning process for companies and stakeholders; the development of tools and practices is work in progress; companies need to consider their approach carefully and choose tools which suit their needs and respond well to stakeholders’ expectations; companies need to refine and develop their approach over time, responding to changing circumstances and expectations; scope for flexibility, innovation and refinement are important for successful CSR; h) when operating in developing countries and/or in situations of weak governance, companies need to take into account the different context and challenges, including poverty, conflicts, environment and health issues.

Although attempts have been made to instrumentalize the CSR concept by providing quantitative and qualitative measures of targets, interventions and outcomes (30), there is a considerable risk of some stakeholders paying lip service to CSR without taking more than token action.

Even so, all the above three initiatives constitute important bases for tripartite collaboration for the promotion of high productivity, high occupational and public health and high quality of life. There is an urgent need to disseminate