to obtain information are very substantial, and my ability to seek out the truth wherever it may be found gives weight to my recommendations. Public estimates of the usefulness of my Office seem to vary a great deal, and while I would not go so far as to echo the views of one complainant who wrote: 'Only Almighty God or yourself can help me', I can understand what prompted another person to write: 'I understand that you are the conscience of the Government, the Civil Service and any other blunders that may come along.'

In conclusion, I would just like to mention a phenomenon which appears from time to time in complaints to my Office and which I find intriguing. Like all complaint-handling organizations, we have our share of the eccentric, obsessive and disturbed. Often, we are able to tell that a particular complainant will be in this category as soon as we open his or her letter. Typically, the complaint will be written or typed very closely, using up the whole page and with few paragraphs to guide the reader. Passages which the writer considers particularly important will be picked out in capital letters, often in red and often underlined, frequently several times. I call this the 'underlining syndrome'. Faced with such a letter, which may be many pages long, our hearts tend to sink. The current record stands at 300 pages. Another clear sign is the eminence of those to whom the letter is copied, which often include one or more to the Queen, the Archbishop of Canterbury, the Lord Chancellor and the Prime Minister. But someone who is disturbed may also have a genuine complaint, and we have first to sift through the material to see if there is a grievance there that we can look into. However, even if there is, I usually find that the person is dissatisfied with the results of my efforts and will often attempt to carry on a correspondence long after my report has been issued. Eventually, of course, I have to say politely but firmly that I will answer no more letters. But I am sure most of you here will understand that such complainants are not easily dissuaded. No doubt this phenomenon is only too familiar to you and you have long ago analysed or classified it and given it a name. Perhaps one day my Office will be occupied by a distinguished member of this College. I am sure that he would be eminently fitted for the task.

Unemployment: A Psychiatric Problem As Well?

LEONARD FAGIN, Consultant Psychiatrist, Claybury Hospital, Essex

The spate of suicides and riots in unemployment-stricken towns has recently brought to public attention a feature of joblessness which had not figured in the minds of those that thought that it would only have financial and probably minor social consequences. Since then, a flurry of interest has been spurred by the media; they regularly report on studies that show some association between unemployment and ill health, quite often, and not surprisingly, to make party political meal of a long-term problem that is bound to have implications for health provision in this country, at least over the next two decades. As psychiatrists we all know the central role played by regular, satisfying employment in the mental health of our patients, and I am sure many of us are affected by our total inability to secure adequate rehabilitation alternatives on which we are sure our patients' future, and that of their families, depend to a great extent. Some of us may also have been aware of the increased demand on mental health resources over the past few years and of the worrying tendency for admissions into psychiatric hospitals to be prolonged because of the time it takes for an ex-patient to re-enter the labour force.

Despite this, and until recently, unemployment has been virtually ignored by the British health care professions as a possible pathogenic force. This is surprising when one considers that other major life changes, mostly involving loss, appear to be associated with alterations in psychological and physical well-being. Studies have shown how, for example, bereavement, immigration and loss of limbs are followed by psychological phases of adjustment and sometimes long-lasting emotional and physical problems. Other writers have found that when these loss experiences are unresolved they may be at the core of many psychosomatic disorders, such as asthma, ulcerative colitis and psoriasis. This neglect is all the more surprising when one finds that evidence has slowly been accumulating since the 1930s associating unemployment and increased morbidity. Marie Jahoda[1] and Eisenberg and Lazarsfeld[2] described the three psychological phases following unemployment which have been corroborated by later researchers and which follow a similar pattern to other experiences of loss. Briefly, the first phase amounts to a denial of the situation, a feeling of relief and sense of holiday, with an increase in the activities which had had to be postponed because of the work routine, such as house repairs and decoration, car maintenance, etc. The second phase is experienced with increasing distress as the ex-worker is confronted by the seriousness of his situation when he successively fails to regain employment and with the prospects of poverty and inability to provide for his family. Job seeking during this time is done in earnest. In the third phase the ex-worker is broken and resigned, adjusting to an unemployed style of life, dropping his efforts in job seeking and curtailing his social interests, spending most of his time at home, in front of the TV set and even isolated from his family circle.

These phases are obviously an abstraction, and there are many exceptions to the rule. One or two of them may be entirely missed or they will vary in length and degree according to, among others, the worker's past job record, previous

experiences in unemployment, his attachment to his job and status, the way in which he lost his job (i.e., whether it was voluntary or forced, massive or individual), age and marital status, how chances of re-employment are personally assessed and the level of unemployment in his area. It is perhaps relevant here to mention that these phases apply to men rather than women in our society. No studies have looked at the plight of the unemployed woman, although one suspects that the adaptability of the woman's role may render her more capable of sustaining the pressure to regain employment.

Kasl and Cobb[3] found increases in physiological measures, such as blood pressure, cholesterol and uric acid levels, in workers undergoing job loss in factories in Detroit, all these measures indicating how the body might be responding to the stress associated with redundancy. Professor Brenner's[4] studies, correlating over long periods of time a group of economic indices (such as growth rates, employment rates, decline in per capita real income and rate of inflation) and health indices (such as suicide and homicide rates, admissions to psychiatric hospitals, mortality rate, cardiovascular disease mortality rate, cirrhosis rate), have shown that there is an association in timing between these factors, often with lags of one to three years. Although Brenner's findings have recently been the subject of controversy, they are impressive and need to be corroborated. A United Kingdom study, done at Queen Mary's College, will be out shortly, and hopefully it will answer some of the criticism to Brenner's work, mostly centred on the way he has interpreted the different lag periods when correlating various indices. One thing that Brenner does not answer in these macrostatistical studies is whether it is the unemployed who are experiencing the brunt of the variation of health problems during business cycles, and he leaves us with the suspicion that those at work may suffer equally from economic instability and the threat of redundancy during hard times. Especially worrying is Brenner's assertion that societies which experience increases of unemployment of one million over five years, are likely to have 50,000 more deaths through general illnesses, 167,000 more deaths through heart disease and 63,900 more admissions into psychiatric hospitals. In the UK unemployment has risen by over a million in one year, and since 1972 the rate of increase has been far higher than in any other industrialized country. At the moment of writing 11.4% of the workforce are jobless, with those out of work for over six months accelerating in proportion.[5]

In 1978, when the rate of unemployment took a massive upward swing, there were very few researchers looking at the psychological response to joblessness, and none at all focusing on the family as the unit of observation. With this in mind, we approached the DHSS in the hope of getting a sample of 22 unemployed male workers from a national unemployment survey they were undertaking (3,000 respondents) so that we could interview them and their families while undergoing the experience of unemployment. We selected married breadwinners who registered as unemployed in October 1978, who had dependents and had not been out of work in the year prior to registration. We interviewed groups of families in South Wales, Midlands, Tyneside and the North East, and in the Greater London area. Each family was interviewed twice, six months and one year after the male breadwinner registered as unemployed. The interviews consisted of a structured questionnaire, covering in detail family life, past history, life events, job, medical records and dependency on health and social services; a time-schedule questionnaire, in which we explored how use of time had been affected before and after unemployment; a Malaise Inventory, a modification of the Cornell Medical Index Health Questionnaire; and an unstructured taped interview in which we explored changes following unemployment. Although we did not set out to write on health and unemployment in families, health matters seemed to be so important during our interviews that we decided to focus on these.

The main finding from this pilot study[6] was that health in the families deteriorated following the event of unemployment, and that these subjective changes in health were not restricted to the breadwinner but were also experienced by the wives and children. Some husbands and wives showed clinical features of moderate to severe depression, taking antidepressants, tranquillisers or sleeping pills supplied by their doctors. Quite often their GPs were unaware of the main breadwinner's unemployment. People who had previously experienced psychosomatic disorders such as asthma, psoriasis, gastro-intestinal complaints, insomnia and headaches, and had not been bothered by them for some time, had recurrences of these illnesses. Disabled people who had managed to keep their disabilities at bay throughout their working lives, suffered serious and rapid decline in their physical handicaps.

The 'ill role' appeared to be something many of the male breadwinners turned to, as an unconscious way of justifying their joblessness when they felt under family and societal pressure to regain employment, more so in those people who irrationally blamed themselves for being out of work. The children of the families also experienced a variety of disorders, many of them stemming from their feeling of neglect by their parents, who were totally taken over by the experience of being out of work and worrying about how they would provide. A number of children from our sample deteriorated in their school performance, experienced incidents of truancy and wandering, and sometimes showed uncharacteristic behaviour such as stealing from their mother's handbag or becoming more infantile and demanding. Some children were taken to their doctor because of refusal to eat, tummy upsets, earaches, or general 'unmanageability'. In the marital relationships there was evidence of sexual difficulties and violence. A number of families separated permanently following the onset of unemployment.

In a small, but interesting number of cases, subjective and objective experiences of health improved. This was the case for a man who was chronically disgruntled with his job, and for wives who assumed a central wage-earning role to supplant that lost by her husband. In those families in which no health problems were reported, members were more likely to be mutually supportive, the husband retained some authority despite his joblessness, the wife was already working prior to her husband's registration or the husband had turned to other interests whilst he was on the dole. Social class did not appear to be a crucial factor, as far as one can tell from the size of the sample; if anything, those in higher status jobs appeared to suffer more dramatically in the initial months of their unemployment.

If unemployment is a cause of illness, how is this mediated? In the thirties, the prevailing thoughts were that the misery caused by unemployment, such as malnutrition, poverty and inactivity, would contribute to ill health. Although one can by no means dismiss these factors, there was no doubt that the families we interviewed experienced severe distress, that this had a lot to do with present social attitudes towards the unemployed, and that factors such as loss of identity, loss of family role, loss of wage earning capacity, reduced socialization, inability to control one's affairs, loss of skill, inability to fill one's time, all contributed to these feelings of distress.

Since the completion of our pilot study, other researchers have found associations between unemployment and minor psychiatric morbidity, in adults as well as in school-leavers, and most agree that although the subject is a complex one for study, unemployment and employment seem to be major contributory factors in determining well-being. Although more research is needed, there is a great deal of concern for those masses of unemployed currently experiencing distress and specially those at risk of developing health problems. These appear to be the jobless in their fifties, the disabled, those with previous records of physical or mental ill-health, the non-achieving school leavers and those in ethnic minorities. Health care professionals must be alerted to the fact that unemployment can manifest itself in terms of ill health, and be aware of their educative and counselling role. Many of the unemployed are oblivious to the possible effects their experience has in store for them and their families, and preparing them for it may have preventative results. This is particularly important in view of the finding that 'unemployment leaves scars which remain even after re-employment' in terms of irreparable damage to self-confidence and self-esteem.[7]

Lastly, we must not be expected to be able to patch up ills that are generated by decisions made by social planners, economists and Government, who often lose sight of the human response to their actions. Although this moves medical practitioners into the political field, in my opinion it is part of our practice and responsibility to make representation to those in power and create a lobby of resistance for the sake of our present and future patients. Perhaps the College, aware of the impact that their stand on Russian dissidents has had on the Soviet misuse of psychiatry, may discuss these matters and influence politicians.

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