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LIVING WITH ANXIETY DISORDERS – UNEMPLOYMENT AS A BARRIER TO SOCIAL INCLUSION

Abstract

Individuals living with anxiety disorders often face significant obstacles in their day to day lives. While trying to manage the physical and emotional symptoms associated with these disorders can be a challenge, sufferers also encounter barriers by way of social exclusion from key life domains: family life, relationships, education, employment and community and civic engagement. One of these life domains – employment has the ability to promote social inclusion and social connectedness and can improve health and wellbeing. It is observed that individuals living with mental health disorders are overrepresented in the unemployment population. This paper addresses the challenges anxiety disorder sufferers encounter, the way unemployment acts as a barrier to social inclusion and strategies to promote social inclusion through employment for individuals living with anxiety disorders.

Introduction

> *We live in the state and in society; we belong to a social circle which jostles against its members and is jostled by them; we feel the social pressure from all sides and we react against it with all our might; we experience a restraint to our free activities and we struggle to remove it; we require the services of other [people] which we cannot do without; we pursue our own interests and struggle for the interests of other social groups, which are also our interests. In short, we move in a world which we do not control, but which controls us, which is not directed toward us and adapted to us, but toward which we must direct and adapt ourselves.*
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> Gumplowicz, 1963, p. 6

Anxiety – medical approach

Anxiety has been noted to be the most common mental health disorder (Medical Disability Guidelines, 2009), with middle aged people being at the highest risk. With regard to a more general definition of anxiety, 16% of the general population suffer from some form of pathological anxiety, with a lifetime prevalence of 28% (Medical Disability Guidelines, 2009). According to the Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing (2007), anxiety disorders are the most prevalent mental health problems in Australia with 14.4% of Australians reporting symptoms consistent with this diagnosis, during the 12 months prior to the survey. The prevalence rate is higher in females (18%) compared to the rate in males (11%); women are more likely to seek specialist's help.

Anxiety refers to the state in which an individual is inordinately apprehensive, tense and uneasy about the prospect of something terrible happening (Halgin & Whitbourne, 2008). It typically causes a combination of physical and psychological symptoms. Physical symptoms include: headaches, dizziness, flushing, dry mouth,

problems with swallowing, breathlessness, tachycardia, nausea, diarrhoea, urinary frequency, trembling, cold clammy hands, sweating, muscle tension, restlessness and fatigue. Psychological symptoms include: feelings of threat, distraction, difficulty in concentrating, feeling tense, irritability, labile mood, noise intolerance, early insomnia, nightmares, panic attacks, perceptual distortion and depersonalisation (dream-like sensation of unreality). In the ICD-10 Classification of Mental and Behavioural Disorders anxiety disorders are classified as phobic anxiety disorders (F40) and other panic disorders (F41). Post Traumatic Stress Disorders (PTSD) are categorized as a reaction to severe stress – adjustment disorders (F43.1), however often high level of anxiety is observed (http://www.who.int/classifications/icd/en/GRNBOOK.pdf).

Anxiety as an emotion (fear, nervousness or vigilance) is essential to the human experience and serves as a natural and necessary response mechanism in times of crisis or danger. Anxiety disorders are associated with high impairment as defined by poor self-perceived health and low quality of life (Wittchen et al., 2000), interfering with day to day functioning (Meadows, Singh & Grigg, 2011).

Treatment for anxiety disorders includes psychotherapy and pharmacotherapy. These interventions can be done singly or in combination. Although treatment for anxiety disorders through pharmacotherapy plays an important role in lessening the burden of symptoms, the power of social and environmental factors in managing mental disorders is underestimated (Nikelly, 2001).

Employment

From a social perspective, employment serves many important functions within most societies (Noble, 1998): it provides an essential source of income – when adequate, allows individuals to meet their basic needs, offers them choices in the selection of goods and services, and promotes independence. Employment also plays an important role in determining social class and social standing, being a means through which people develop social relationships. From an individual perspective (Linhorst, 2006) employment status promotes a subjective sense of empowerment and integration into the community and provides a means to which individuals can obtain independence, shape self-esteem and form their identity. Knisley, Hyde and Jackson (2003) stated: *In our society we define ourselves as well as others by what we do – our work. Work is an essential element of our participation and acceptance in our communities* (p. 140). Consequently, employment, or lack of it, has implications not only on how others view us but also on how we view ourselves.

Unemployment and mental health

The social psychology literature (Feather, 1990) distinguishes between three, interrelated mechanisms by which unemployment may have negative emotional consequences, the first of which is the loss of self-esteem. Although self-esteem is generally considered to be fairly stable over an individual's life cycle (and mainly shaped during childhood), major life changes may alter it – unemployment is such an event, remembered by many persons as a very stressful and unpleasant experience. The second mechanism is the feeling that as a consequence of being

without a job, life is not under one's control. The feeling of helplessness and hopelessness caused by the fact that employment prospects seem to be independent of one's efforts to obtain a job is experienced as depressive by many who are unemployed. A third mechanism, emphasized by Jahoda (1982), is the loss of several aspects of working life, such as the time structure of the working day or working week, the contacts with people outside home, workplace social network and the status and identity associated with having a job. Deprivation of these life functions can be psychologically harmful for many persons.

The lack of participation in the workforce can not only restrict social connectedness with others but also limit the opportunities to contribute to completing shared tasks, and developing self-efficacy (Himle et al., 2014). In this context, for individuals living with mental disorders, compared to the general population, the detriments of unemployment are often deeper and more critical since sufferers are often defined by their diagnosis instead of their qualifications, skills and value, making them feel stigmatized and marginalized. In a vicious cycle, their condition deteriorates. Moreover, exclusion from the workforce coupled with isolation from society are factors that can often lead to chronicity (Warner, 1985 in Nikelly, 2001).

Linhorst (2006, p. 206) outlines several key conditions for empowering people diagnosed with mental health problems through employment. These are:

- *psychiatric symptoms management: they should be managed to the degree necessary to participate in a specific job at a specific time;*
- *participation skills: the person should possess the skills required to participate in a particular job;*
- *psychological readiness: the person has the confidence, motivation, and willingness to seek employment and maintain a particular job;*
- *reciprocal concrete incentives: concrete incentives exist for the person suffering mental disorders to obtain and maintain employment and for employers to hire and retain people with such a condition;*
- *availability of choices: the person has choices of jobs that are meaningful to him or her;*
- *participation structures and processes: the person has structures and processes through which he or she can obtain and maintain employment;*
- *access to resources: the person has access to the resources needed to obtain and maintain employment;*
- *supportive culture: work setting and mental health organization from which the person receives supportive services in regards employment.*

Linhorst's recommendations are important in illustrating that professional assistance should be multidisciplinary – with mental health professionals, educators, social workers, employers and policy makers applying a collaborative approach.

Social inclusion

Social inclusion takes on a wide range of different meanings making it an often disputable term in various contexts (e.g. health, unemployment, homelessness), and degrees – in narrowest interpretation as access, in a broader one as participation, and as the widest as empowerment (Gidley et al., 2010, p. 2). The latter of these,

empowerment, focuses on nurturing human potential, claiming social trans-formation, cultural diversity, lifelong learning and is characterized not only by an individual being a present member of a society but by also having a meaningful place in it (Cobigo et al., 2012). Integration into the community, the opportunity to fulfil expected social roles and reciprocal emotional support are associated with a satisfying quality of life (Nikelly, 2001).

Living with anxiety disorders – unemployment as a barrier to social inclusion

At a population level, little is known about the degree of disability and employment restrictions experienced by persons with anxiety disorders. When diagnosed, sufferers often "quit" the public mental health systems, hence the nature and extent of employment restrictions among persons with anxiety disorders may be underestimated (Waghorn & Chant, 2005). In their study, Waghorn and Chant find that the proportion of persons with anxiety disorders not in the labour force (47.1%) was more than double that of healthy persons (19.9%). Once out of work, people were more prone to longer periods of unemployment than healthy persons. Among anxiety disorders sufferers 24.9% were out of work for 104 or more weeks and 55.2% for 26 weeks or less. Persons reported a need for special arrangements or equipment, 23.3% indicated a need for a support person. When participants were asked "Are you receiving any assistance from a disability job placement program or agency?" only 2.5% of job seekers confirmed this form of assistance. Waghorn and Chant (2005) concluded that anxiety disorders appeared both directly and indirectly associated with degraded career trajectories.

A subsequent report by the ABS National Survey of Mental Health and Wellbeing (2007) focusing on mental health in Australia found that people unemployed or not in the paid workforce have the highest rate of mental disorders, a prevalence rate of 26% for unemployed men and 34% for unemployed women.

Goldsmith and Diette (2012) state that short term unemployment does not significantly harm mental health, however, long term unemployment can be devastating. Unemployment is defined as being long term if the individual is unemployed for in excess of twelve months (ABS National Survey of Mental Health and Wellbeing, 2007). The longer an individual is out of the workforce, the more difficult it is to get back in. This phenomenon can be attributed to: a decrease in social or workplace networks, loss of relevant skills, decreased confidence and motivation and employers' negative perception of those who are unemployed.

Practical implication for rehabilitation services

Paid work in open employment settings is increasingly viewed as a strategy to help people recover from mental disorders i.e. to participate more fully in community life, improve their standard of living and reduce their dependence on income support. Vocational rehabilitation is structured around a set of holistic services to enable people to obtain and maintain employment. In supporting individuals with anxiety conditions enter or return to the workforce, their health considerations and work capacity should be at the forefront vocational rehabilitation. An inappropriate vocational plan can inadvertently exacerbate one's condition and

symptoms e.g. – an individual who has been unemployed for an extended period of time and who suffers from an anxiety disorder such as agoraphobia may not be well placed to work as a security officer where he or she is required to monitor open spaces, interact with customers and often manage difficult and unpredictable situations.

One of the suggested approaches is Supported Employment (SE) where clients are placed directly in integrated work settings at award wages and provided with training and support.

Some anxiety sufferers are not yet ready to return to the workforce. In such circumstances, pre-vocational structured and personalised interventions can be implemented in order to support the individual to increase their confidence, build their skills and improve coping strategies. Pre-vocational rehabilitation generally focuses on services and support that are required prior to engaging in job seeking and on interventions that aim to address psychosocial- spiritual development, career exploration and promote structured activities. These interventions can include: career counselling to determine potential vocational pathways, work experience or volunteering activities to build work capacity, the development of interpersonal skills and education or re-training (Center for Substance Abuse Treatment, 2000). Some pre-vocational interventions such as re-training can be conducted in a group, rather than one on one setting to enable participants to socialise, work together with other participants and mimic interactions that are commonly encountered in the workplace.

Finally, it should be asked, what can be done for individuals whose anxiety condition is so severe that it renders them unable to participate in paid employment. This is of particular concern with regard to military veterans, many of whom after reoccurring exposure to traumatic events in combat develop Post Traumatic Stress Disorder (PTSD) (Richardson, Freuh & Acierno, 2010) and find it difficult to transition into civilian life. For many of them, prognosis is often poor and any likelihood of obtaining work is unrealistic. For those who fit into that category, there are alternative options that can to some extent replicate the benefits of employment and promote civic engagement and the broader social inclusion. If we look at the importance of social inclusion as described by Verdonschot et al. (2009) employment is just one of the factors listed. Other factors are community and civic life including volunteering, hobbies, leisure activities and other forms of socialising.

Conclusion

The medical model's approach to assess and treat anxiety conditions is crucial. However, a greater level of emphasis is now being placed on the social environment as a catalyst for positive change and recovery among mental health sufferers. For individuals living with anxiety disorders, social exclusion from key life domains such as employment has often been a barrier to maintaining quality of life. With the right job fit and in applying practical strategies through rehabilitation services, suitable and sustainable employment can play a key role in supporting individuals with anxiety conditions to break down barriers associated with social exclusion, obtain a greater sense of connection to the community, increase self-esteem and improve health and wellbeing.

This overview sets the stage for further research aimed at uncovering how anxiety disorders undermine employment. Semi-structured interviews with job seekers would likely yield further insights into the relationship between anxiety disorders and employment difficulties, guiding both vocational service and mental health professionals to plan feasible and effective vocational rehabilitation programs. When implemented, further analyses are needed to determine ramifications on mental health clients, their families and carers.

References

Center for Substance Abuse Treatment (2000): *Integrating Substance Abuse Treatment and Vocational Services*. http://www.ncbi.nlm.nih.gov/books/NBK64287/.

Cobigo, V., Ouellette-Kuntz, H., Lysaght, R., Martin, L. (2012): Shifting Our Conceptualization of Social Inclusion. *Stigma Research and Action*, 2(2), 75-84.

Feather, N. (1990): *The Psychological Impact of Unemployment*. New York: Springer-Verlag.

Gidley, J. M., Hampson, G. P., Wheeler, L. & Bereded-Samuel, E. (2010): Social inclusion: Context, Theory and Practice. *The Australasian Journal of University-Community Engagement*, 5(1), 6-36.

Goldsmith, A. & Diette, T. (2012): *Exploring the Link Between Unemployment and Mental Health Outcomes*. http://www.apa.org/pi/ses/resources/indicator/2012/04/unemployment.aspx.

Gumplowicz, L. (1963): *Outlines of sociology*. (2nd Edition). New York: Paine-Whitman.

Halgin, R. P. & Whitbourne, S. K. (2008): *Abnormal Psychology: Clinical Perspectives on Psychological Disorders*. New York: McGraw- Hill.

Himle, J. A., Weaver, A., Bybee, D., O'Donnell, L., Vlnka, S., Laviolette, W., Steinberger, E., Golenberg, Z., Levine, D. S. (2014): Employment barriers, skills, and aspirations among unemployed job seekers with and without social anxiety disorder. *Psychiatric Services*, 65, 924-930.

Jahoda, M. (1982): *Employment and Unemployment: A Social Psychological Approach*. Cambridge: Cambridge University Press.

Knisley, M. B., Hyde, P. S. & Jackson, E. (2003): Involvement of state and local mental health authorities in addressing the employment needs of people with serious mental illness. In D. P. Moxley & J. R. Finch (Eds.) *Sourcebook of rehabilitation and mental health practice*. New York: Kluwer Academic/Plenum Publishers, 127-142.

Linhorst, D. M. (2006): *Empowering People With Severe Mental Illness: A Practical Guide*. New York: Oxford University Press.

Meadows, G., Singh, B. & Grigg, M. (2011): *Mental Health in Australia: Collaborative Community Practice*. Melbourne: Oxford University Press.

Medical Disability Guidelines (2009): Generalized Anxiety Disorders. http://www.mdguidelines.com/anxiety-disorder-generalized. December 2009.

Medical Disability Guidelines (2009): Panic Disorders. http://www.mdguidelines.com/panic-disorders. June 2009.

Nikelly, A. G. (2001): The Role of Environment in Mental Health: Individual Empowerment through Social Restructuring. *The Journal of Applied Behavioral Science*, 37(1), 305-323.

Noble, J. H. Jr. (1998): Policy reform dilemmas in promoting employment of persons with severe mental illnesses. *Psychiatric Services*, 49, 775-781.

Richardson, L. K., Frueh, B. C. & Acierno, R. (2010): Prevalence estimates of combat-related PTSD: a critical review. *Australian and New Zealand Journal of Psychiatry*, 44(1), 4-19.

The Australian Bureau of Statistics (2007): *National Survey of Mental Health and Well-being: Summary of Results*. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0.

Verdonscot, M. M., de Witte, L. P., Reichrath, E., Buntinx, W. H. & Curfs, L. M. (2009): Community Participation of People with an Intellectual Disability: A Review of Empirical Findings. *Journal of Intellectual Disability Research*, 53(4), 303-318.

Waghorn, G. R. & Chant, D. C. (2005): Employment restrictions among persons with ICD-10 anxiety disorders: characteristics from a population survey. *Journal of Anxiety Disorders*, 19(6), 642-657.

Wittchen, H-U., Kessler, R. C., Pfister, H. & Lieb, M. (2000): Why do people with anxiety disorders become depressed? A prospective-longitudinal community study. *Acta Psychiatrica Scandinavica*, 102, Suppl. 406, 14-23.

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