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Executive Stress

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Dr. Daniels addressed a group of alumni of the Graduate School of Business at a meeting held in conjunction with the 19th Annual Management Conference on March 18, 1971, at McCormick Place, Chicago. His subject was "Executive Leadership and Psychological Stress"; the remarks he delivered on that occasion became the basis for this Selected Paper.

Executive Stress

A FEW WORDS of introduction may give you some idea of why I was invited to talk to you and why I have chosen the subject of executive stress. By basic training I'm a psychiatrist, but for the past three years one of my areas of involvement has been the Graduate School of Business. What, you may ask, is a psychiatrist doing in the Graduate School of Business? I shall try to answer that first. The Business School encompasses the Center for Health Administration Studies, which educates people for the management of hospitals and medical care systems and which also conducts research into social, behavioral, and administrative aspects of medical care. I have been involved in this work. In the field of "administrative medicine" I've been interested in the qualities of leadership and how one trains for administrative responsibility.

My psychiatric interests have run in two apparently parallel but frequently intersecting lines. One has had to do with social psychiatry, which is concerned with the interrelationship between the way family life, the community, and society are organized and the psychological adaptation of the individual. The second line is psychoanalysis. That, as you know, is the discipline which views psychological adaptation in an intrapsychic framework, exploring the phenomena within the individual which influence him to be adaptive or maladaptive.

These administrative and psychiatric interests have led to a concern with community medicine and what the University should or can do in the delivery of health care on the

South Side of Chicago. In that area, many of the disciplines and activities represented in the Center for Health Administration Studies of the Graduate School of Business are applicable. We have economists, sociologists, management experts, and a variety of other people involved with trying to understand the social science and administrative aspects of health care. Their interests range all the way from individual patient interactions with the system, with physicians and with other personnel, through the effectiveness of total health care systems. They are also involved with health financing, health manpower, and health planning.

MY TOPIC today has to do with the interface between the individual, his work, and the organization for which he's working. It also has to do with personal factors in administration—the quality of leadership, the factors leading to good or poor leadership, and the internal psychological state which promotes high quality leadership.

My observations are partly based on individual treatment of executives over the last 10 years. They are also based on the recent trying times in the University. This period has been one of very great stress for the University leadership, particularly in its relationships with students. Although the student-university situation may be somewhat different from the typical stresses of other organizations, I think there are also some similarities and parallels.

My observations are also based upon a body of knowledge that has not been as widely recognized or used as it might be. The source of this knowledge may surprise you, but I hope that as we proceed you will see its relevance and value. I refer to the understanding that we have acquired about people in military organizations, particularly during World War II and the Korean War. These observations are important in understanding psychological adaptation

in any large organization where individuals find themselves under extraordinary and prolonged stress.

EXECUTIVES and leaders have always had severe stresses, but in a society in which one questions many issues that were formerly held as truths, leaders are subjected to very special and extreme stresses. Today we are concerned about a wide variety of social issues. There's an almost endless laundry list of them, but just to mention a few: pollution, population, the war, drugs, youth, poverty, racial discrimination, and our economic capacity. While we are concerned with these issues we're also involved with an ever-increasing technological society in which, by and large, organizations grow larger, more complicated, and less humanistic. There are tendencies toward fragmentation, that is, the performance of bits and pieces of activity without a feeling of being involved with anything that is complete or whole.

Now I would like to turn to discussion of a syndrome, or group of symptoms, some or all of which may be present in individuals under stress. These particularly affect people between 40 and 60, the years of maximum leadership expectation and very often of the greatest stress for individuals in executive positions,

What are these symptoms? Often the person under stress becomes irritable; he has a diminished tolerance for frustration; he gets angry easily; he frequently looks tired; he is sometimes fearful; and he startles easily. There may be symptoms of depression and anxiety. In depression there is an internal feeling of sadness, but there are also external signs, such as the individual's attitude and behavior. He looks sad or depressed; his forehead is furrowed; his mouth corners are down-turned; frequently his posture is stooped and he seems turned in upon himself. In anxiety there is a kind of internal uneasiness or dread, as if something distressing,

even catastrophic, is about to happen. There may be tremulousness, sweating, disturbances in bowel function, and sleeplessness.

Anxiety may be helpful or it may be disabling. In many situations it is a motivating force which drives us to accomplish much of what we do. The question is not whether anxiety is present but rather, in a particular set of circumstances and at a particular point in time, what level of anxiety seems optimum for the adaptation of an individual. If there is too little, he may produce less than expected and may not be comfortable or happy in his work. If there is too much, symptoms may appear which are very disturbing and which may disrupt his capacity to do whatever job he wishes to accomplish.

Sleeplessness is very common. If an individual is anxious, he tends to have difficulty sleeping early in the evening. If he is depressed, he tends to awaken later in the night or early in the morning. Frequently people who have trouble sleeping begin to use medications, often another warning sign.

Disturbing dreams, even nightmares, are common. Often they involve repetition of a situation that wasn't quite mastered during the day. Many of us, reviewing the unsuccessful handling of a situation, will think, "Gee, I wish I'd said that," or, "I wish I'd done that." We may think about it again and again; it helps to resolve anxiety and also prepares us to manage future, similar situations more adequately. In a stress situation, however, that kind of repetitive reworking is not enough. The situation is relived during the night and is expressed in a variety of dreams, which typically are not identical with the disturbing situation but which relate to it.

We frequently see disturbances in appetite -people either lose their appetite or eat too much. Constipation or diarrhea are common. In women, menstrual disturbances may occur.

Sexual activity may frequently be impaired in this syndrome. Men in the 40-to-60 age range in particular may have problems with premature ejaculation, impotence, and difficulty in obtaining and maintaining an erection.

BEGINNING after World War II, with some of the Kinsey studies and subsequently in the work of Masters and Johnson, we have become better informed about sexual behavior. We are aware that, in their late 30's or the 40's, men begin to find a gradual change in their sexual interest and performance. It is rare to find a physiological basis for these difficulties. What is common is a psychological genesis. Through better information and more accurate life histories we have learned that capacity for sexual activity continues into the 60's and 70's, often without limitations or impairment.

The stress syndrome often results in increased smoking, drinking, eating, and taking drugs. Frequently these symptoms interact with other problems to further impair sexual behavior. A well-known situation is one in which a man works harder and harder, longer and longer **hours**, under more and more stress, until one drink becomes two, two becomes three or more. Drinking spreads from after work to noon to the morning. It is an attempt to contain anxiety and gain pharmacologic relief from stress and tension. Then, at a time of fatigue, after a little too much to drink, an attempted sexual performance results in failure. Great anxiety follows the failure and subsequent attempts in situations of very high anxiety lead to further failures.

This sequence often occurs at a time when the marital partner, the wife, is also troubled about her sexual adaptation and her attractiveness. For her it is the time of the menopause. Again there is no evidence that this physiologic event interferes in any way with sexual activity; even though there is no physio-

logic basis for such problems, there is anxiety. "How productive am I?" "What does it mean that my childbearing years are finished?" "What will my life be like in the next 25 years?" Questions like these intrude. The concurrent fears of husband and wife fit together so that often they cannot be helpful to one another. One set of anxieties intensifies the other, resulting in a descending spiral and worsening difficulties in sexual performance. Yet another symptom of this kind of situation is infidelity, or strong temptation to act out sexually.

This situation is often accompanied by certain physical symptoms and disease states. Gastric distress, indicating peptic ulcer, and high blood pressure—often the prelude to heart disease—are so common that they could almost be viewed as epidemic. If you observed a group of 100 men at age 40 and followed them through to age 60, you would find that 20 of that 100 had had heart attacks. In other words, in that 20-year span there is a 20 percent incidence of heart attack—almost an epidemic in its proportions.

I THINK we have fairly well covered the symptoms, and some of the by-products, of stress. What, you may ask, are the remedies? Some clues may be had from examination of knowledge derived from our military experience during World War II and the Korean War. We discovered that when soldiers were in combat for prolonged periods of time, there was a sharp increase in psychiatric casualties. These casualties were increased when the threat to life was increased, and were greatest when combat units were in positions of great personal danger, surrounded by death and fear of death. They might also be deprived of the usual life supports, without much to eat, and little possibility for sleeping. Men kept in such situations too long developed a much increased rate of psychiatric disorder, often three or four times

greater than might otherwise be anticipated. We called that syndrome a "traumatic neurosis." In World War I we had called it "shell shock," and in each war preceding it had been known by a different name. It's not a new phenomenon. It has to do with an external situation which is overwhelming to the individual and puts him under such stress that psychological decompensation occurs.

Most people have limits of stress they can tolerate. If, in fact, those limits are exceeded the number of psychiatrically disabled would increase several-fold. The "traumatic" aspect of the condition refers to those kinds of external traumas or stresses that impinge upon the individual.

DO WE EVER see this disorder in civilian life? Yes, occasionally. In its rarer form it can be precipitated by civilian disasters, such as airplane crashes or natural catastrophes. More commonly in civilian life this disorder occurs under conditions of chronic stress such as that to which the executive is exposed.

What safeguards against traumatic neuroses were developed by the military? Many who were in military service will recognize some of the policies and procedures. When possible, personnel were trained in small groups where there could be depth and continuity of relationships. Again, when it was possible to do so, personnel were placed in situations where they continued to maintain the same relationships after training, even into combat.

All of us in military service become aware of how intense some of these relationships might be. Quickly-established, intense relationships, such as develop at camp or college, come readily to mind. Where previous relationships with family and friends are interrupted, it becomes necessary to adapt to an entirely new environment in a brief period of time. The Army attempted to take advantage of this psy-

chological phenomenon. Actually, in military units with high morale the men form a relationship which is much like the relationship within a family. People get very close to one another, often after brief contact. There seems to be some value in small groups. People trained in small groups get to know one another very well, they get to know their leaders, and they develop a kind of trust and confidence in one another which offers the members of the group a great deal of support. Of course when that state is combined with the moral issue of having a highly valued purpose or cause, it is a powerful influence in shaping human behavior. The absence of that factor may be one of the problems in Viet Nam; the sense of purpose or cause isn't there, and some of the issues disturbing our troops may result from a lack of that shared ideal goal.

The military also attempted to dispose of the troops in such a way that only a part of them were in combat at any point in time, with perhaps two-thirds in and one-third out. Part of the military's reason for this is that they need reserves, which have to be mobile and ready to move in or out at times of military crisis. There is also a sound psychological principle, the rest and rotation idea. The troops should be moved out of immediate danger regularly. They should be provided with physical and psychological supports that they lack in combat, including good food and an adequate and safe place to sleep, to give them some relief from combat stress.

WE ALSO LEARNED that when soldiers with psychological symptoms were treated close to where the symptoms occurred (typically, this was the divisional level), 95 percent were returned to duty and into combat. If they were evacuated to farther points, then, as the distance grew, the capacity to return to combat was sharply reduced. Removal to even 50 or 100

miles from the front lines resulted in decreasing the incidence of return to duty from approximately 95 percent to 50 percent. Out of this experience came a principle subsequently applied extensively in civilian life: Psychological maladaptations ought to be detected and treated as early as possible and the individual should be treated as close to his usual activities and supports as possible. The treatment system attempts to get the disabled individual back as quickly as possible to his everyday functioning.

What was actually done for those casualties at the divisional level? They needed safety, physical comforts and supports, and, importantly, someone to talk to. In combat the psychological trauma is sometimes extreme, perhaps involving the death or serious injury of friends. Occasionally hypnosis or sodium pentothal-truth serum-were used but more often the therapist simply listened and talked. This conversation brought psychological relief; something tightly bound inside the individual was released. Fairly soon, perhaps in 48, 72, or 96 hours, there was relief from the symptoms and the soldier was ready to return to his unit.

The military experience also taught us that mental health professionals could be useful to command, at the divisional or at other levels. The right professional, the right kind of leadership, and the right organizational framework were required. When those conditions came together a mental health professional often made a valuable contribution to people in organizational and administrative authority. What could he do? First, he could advise on individual problems, diagnose, and treat. He could also advise on classes of problems, such as alcoholism, venereal disease, minor and major criminal activities, drugs, absenteeism, and a wide variety of things, many of them as relevant to industry as to the military.

He also has something to offer with respect

to personnel policies—for example, what types of information and education should be provided for employees; what circumstances are optimum for promotion; when punitive action may be necessary, and what it should be; how judgments are made about potentials for leadership. Often the mental health professional can make contributions to training in interpersonal relations, also.

WE HAVE DETERMINED that the principles evolved for dealing with psychological problems in the military may also be useful in the civilian area. How may they be applied?

The rest and rotation principle has relevance here. Individuals in positions of leadership and responsibility need relief from time to time. There must be rotation of authority and depth in command, so that a single individual does not endlessly have to cope with decision-making and the kinds of stresses that go with leadership. Periods of relief may be arranged in a recurring way, or they may be made available at certain critical times.

The occasional brief holiday is valuable. However, from our experience with people in chronic executive stress, the 72 or 96 hours usually required for treatment in the military may not be enough. It takes longer for the executive under stress to unwind; the condition is chronic and relief may require a week or ten days. In a situation of continual fatigue, the weekend off or the Sunday free of responsibility isn't enough to bring the man back Monday feeling rested. The inability to recuperate with a day off is the warning signal that one ought to be thinking about a longer period of time away from work responsibilities and the leadership situation.

It becomes important, therefore, to have small groups of people who occupy leadership positions, who know each other quite well, who recognize their own and their fellows' capaci-

ties, who feel closely involved with one another, and who have respect and trust in one another. This can provide both alternative leaders and opportunities to develop small-group supports.

Recently there has been great interest in small group process, in various kinds of training situations—T groups, encounter groups, process groups, and others. These aid one in learning a great deal about oneself and about one's fellows.

They are powerful instruments, so they have potential problems connected with them. Some professionals have been concerned that, because of the tremendous interest and demand on the part of businesses and individuals, sometimes people without much leadership training or capacity have been thrust into positions of small group leadership. Nevertheless, there is something to be learned out of small group process and the interrelationships and interactions which develop—something which is worth duplicating at staff leadership levels. It is important that there be the kind of openness in communication that permits one to talk with one's fellows about what is happening. A comparable outlet in the military was the opportunity to discuss the terrible things that had happened with someone who was willing to listen. It is also important to all of us, in our everyday situation, to build the degree of openness among one's fellows that will allow one to talk about frustrations and difficulties.

Occasionally, the direct availability of a mental health professional may also be useful. Two myths about psychiatric service may need to be dealt with. One myth is that if you go to a psychiatrist you're crazy. Clearly that's not so; most people who go to psychiatrists are far from crazy. The second myth is that in working with a mental health professional it takes a very long period of time to get anything accomplished. That myth arose from the variety of treatment known as psychoanalysis. Actually,

much can often be done in just a few contacts, given the right person, the right time, and the right situation. It is possible, in periods of stress, to obtain a good deal of help even through as few as two to six or eight contacts.

It becomes important for one to recognize and understand these symptoms. Too much alcohol, problems with sexual adaptation, and problems in marriage and family life are typical. The recognition of these symptoms in ourselves or others serves a diagnostic function. Willingness to be open and to allow other people to know what you're feeling under situations of stress, to recognize the need for assistance or for a brief vacation, relief from responsibility, support of one sort or another—these are important.

There may be difficulties when one observes stress in a colleague, particularly if he's a superior. The question then arises as to how open one can really be. Help must be suggested with some tact and sensitivity. With some individuals it is difficult to do so any time, with others it becomes a matter of timing. If a man is obviously disturbed, under great stress, and needs relief, but has no self-recognition of it, the situation can be very difficult, almost impossible to deal with. But if people have developed that availability to one another and the willingness to be open, it is surprising how often they can be helped.

THE PRIMARY point of all of this is the willingness to recognize the potential difficulty in one's self and in others. If one is in touch with himself in relation to stress, then his own capacity for executive action, for leadership, is greater. One may leave potentially damaging situations for periods of time before the stress becomes too great.

I have identified for you some of the tell-tale symptoms. Certainly you can recognize the times when stress is most likely to occur. It's

clear that we can build in certain safeguards. Appropriate leadership, supervision, and training as people grow into executive positions are important. The potential for group process training, and also the development of group cohesiveness and relatedness, are safeguards.

Each corporation should have a response system available. With recognition in one's self and others that there is a constructive way to manage this set of problems, stress should not come as a surprise or as something unexpected, and its effects can be contained, with minimum damage to the individual and loss to the organization.