PSYCHOSOMATIC COMPLAINTS PRESENTED TO THE GENERAL PRACTITIONER IN A DUTCH TOWN 1971 - 1986

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Summary

In the context of a Continuous Morbidity Registration project (C.M.R.) in Nijmegen, the Netherlands, four general practices recorded all morbidity from 1971 onwards.

The years of the recession witnessed no increase in incidences of morbidity, either for morbidity as a whole or for psychosomatic problems in particular. A decline rather than a peak in morbidity is seen in the years 1980-1983. This pattern is similar across social class and sex.

It is argued that this absence of harmful effect cannot be attributed to the insensitivity of the indicator. Probably the recession did not hurt because it did not really hit that hard in the Dutch welfare state.

1 THE PROBLEM

This chapter considers whether the economic recession has harmed mental health in the Netherlands. The focus is the morbidity presented to the general practitioner, on psychosomatic complaints in particular. Two questions are considered: 1) Was there an increase in complaints during or shortly after the recession; 2) Was this increase more pronounced for those most likely to be harmed by a recession, the (male) patients of the lower social class?

2 DATA

The data analyzed are collected in the Continuous Morbidity Registration (C.M.R.) in Nijmegen, the Netherlands. (Van Weel et al., 1987; v.d. Hoogen et al., 1985) This is a university organized registration project. It involves four general practices with about 12,000 patients.

The practice/study population has been quite stable for the past 18 years. The sex-age distribution is comparable to the Dutch population.

The region has a high level of unemployment. As a country the Netherlands was relatively badly afflicted by the economic recession and the population was certainly not left untouched by the recession.

Registration started in 1971. Three periods can be distinguished: 1. a pre-recession period (1971-1979, or better 1977-1979 because of the earlier oil-recession in 1975), 2. the recession period (in the Netherlands 1980-1983), and 3. the post recession period (1984-1985).

An increase in the incidence of morbidity could be expected in the in- between period if the crisis really harmed mental health. The focus is on `psychosomatic' problems; in the registration these are labelled `nervous-functional problems'.

Symptoms are classified as `nervous-functional' if there are 1. `no clear organic lesions which could explain the symptoms, and 2. if there are positive indications of stress in life or at work to explain the symptom'. (Van den Hoogen et al., 1985)

Nervous functional problems constitute a relatively stable proportion of the total morbidity. Over the years this proportion is 10 to 15%. Surveys elsewhere in the Netherlands and abroad report similar proportions. (Lamberts, 1984; Hodgkin, 1978).

The data will be analyzed for social class and sex. These variables have been described in particular as being related to the consequences of economic decline, in terms of unemployment morbidity. (Beale and Nevercott, 1988)

3 RESULTS

Did the years of the recession indeed stand out for their increased incidence of morbidity in family practices, for psychosomatic problems particularly? Figure 1 refers to the total morbidity during the last 16 years. Rather than a peak a decline is seen during the years of recession. The pattern is similar for the three social classes and for both sexes. The psychosomatic disorders show a similar pattern (figure 2). There is no increase in incidence during the years of recession.

4 DISCUSSION

As we have seen, the predicted rise in mental complaints does not appear. Why not? Is it because this indicator is not sufficiently sensitive? The incidence of psychosomatic disorders seems to be rather sensitive both to transitions and to events in patients' personal conditions of life. In earlier studies a clear association was found between stressful life events, for instance death of a family member, and the number of morbidity episodes presented to the general practitioner. (Van Eijk et al., 1987)

Also, the registration data appeared sensitive enough to reflect significant personal and group effects as a consequence of even less serious events such as a change of doctor. (Van der Velden, 1978)

Another possibility is that the registration failed to capture actual harmful effects because it is selective in some way. This analysis was based on morbidity presented in general practice. Presented morbidity forms only a proportion of perceived morbidity in the population, and it is well known that the threshold at which professional care is sought varies enormously between individuals as well as between families. (Van de Lisdonk, 1985) However, it is known that reported morbidity is a rather stable percentage fraction of total (experienced) morbidity. This changes only occasionally, for instance as a consequence of important threatening life events.

It is more probable that mental health is simply not that sensitive to (minor) external stresses of life. In a longitudinal study based on the same recording system, Huygen found no relationship between recorded morbidity and social stress, but a very significant relationship between personal characteristics (like neurotic instability) and overall morbidity and nervous disorders. (Huygen, 1982, 1988) In this context it does not seem improbable that real but relatively marginal crisis effects have been neutralized by the excellent welfare facilities in our country. There is every reason to assume that other intervening and more significant variables play a role in the patients'

well-being. Probably psychosomatic disorders are generally more related to the patients' inner functioning than to outer economic whims and fancies.

Another question is why morbidity has declined during the recession rather than increased. Possibly this is because people focus less on themselves and their health in rough times. This view is expanded in more detail in the contribution of Hutschemaekers in this volume (chapter 9).

5 CONCLUSION

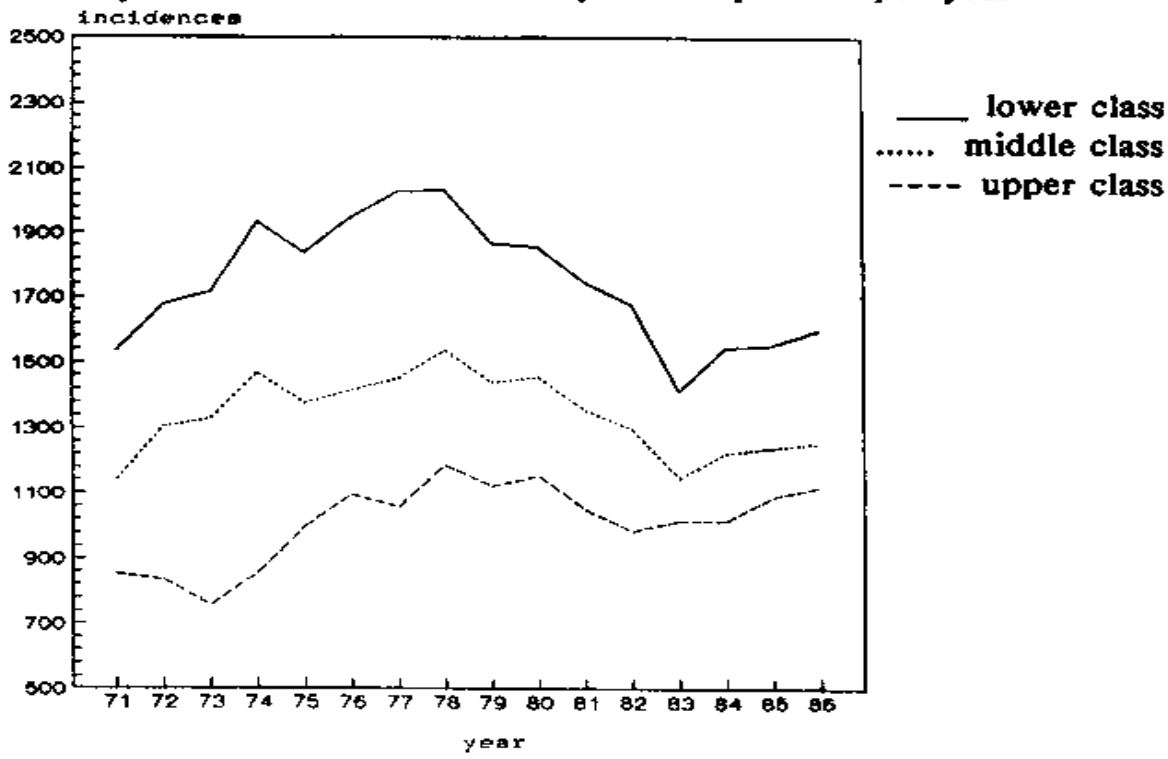
General practitioners in Nijmegen, the Netherlands, did not record signs of a deterioration of health during or shortly after the last economic depression, even though the economic decline was relatively pronounced in this country and in their region in particular.

Rather than a peak in morbidity, a dip is apparent in the years of the recession. This dip appears both in overall morbidity and in psychosomatic disorders.

FIGURE 1

Total morbidity and socioeconomic status per 1000 patients per year

male:



female:

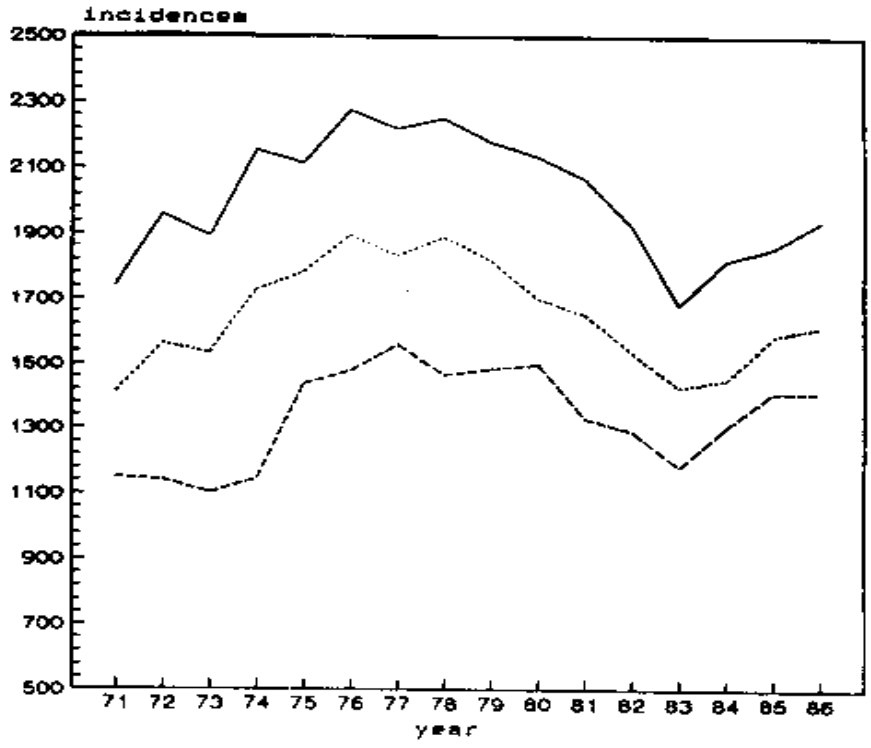
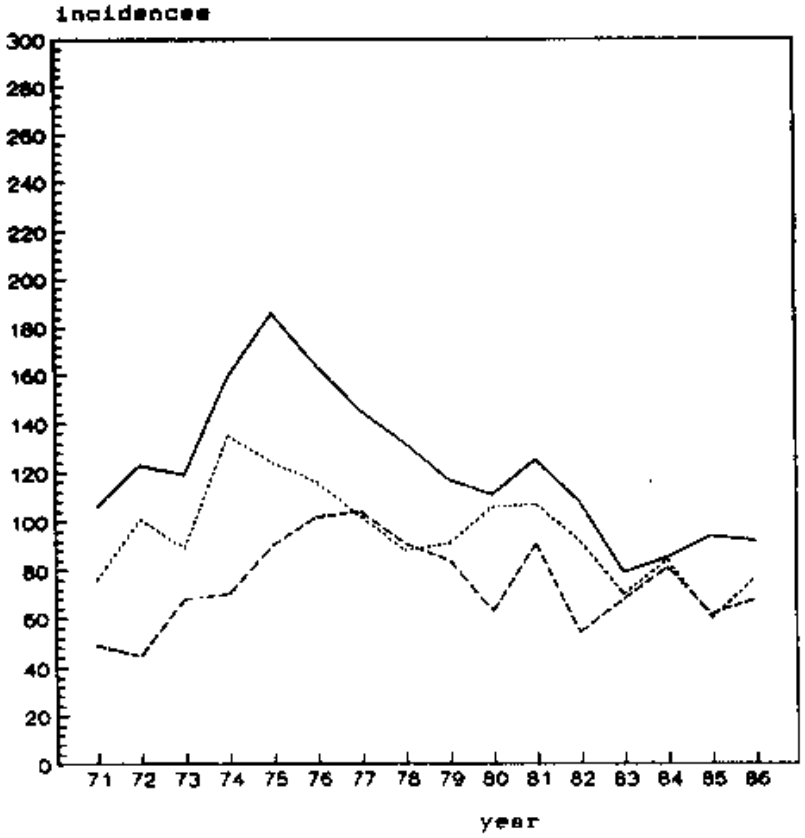


FIGURE 2

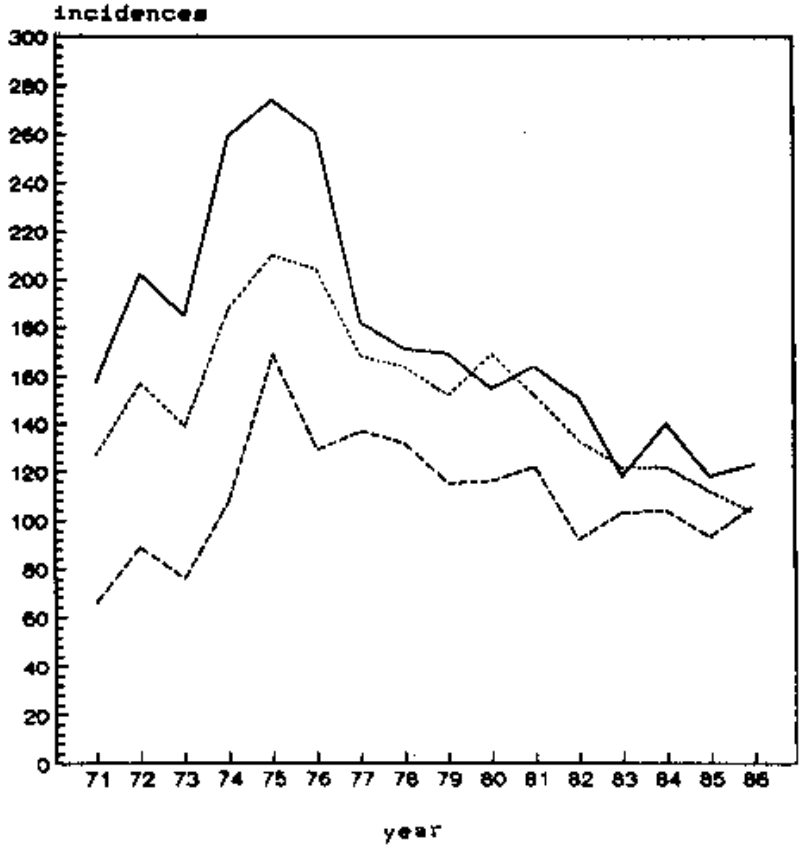
Nervous-functional disorders and socio-economic status per 1000 patients per year

male:



____ lower class
..... middle class
---- upper class

female:



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