



Revista de Psiquiatría y Salud Mental

www.elsevier.es/saludmental



ORIGINAL ARTICLE

Impact of a social and employment crisis on the demand for mental health care (Footwear Crisis, Elche 2004)

Carlos Jeremías Martínez Pastor,^{a,*} Miguel Alfonso García Escudero,^a
Ana Martí Martínez,^b Francisco Fenollar Iváñez,^b Julio Quiles Lloret,^a
Vicente Real Román^a

^aUSM Altabix, Hospital General Universitario de Elche, Spain

^bPsiquiatría, Hospital General Universitario de Elche, Spain

Received July 7, 2010; accepted February 16 2011

KEYWORDS

Socioeconomic factors;
Stressful life events;
Unemployment;
Mental health

Abstract

Introduction: Between December 1999 and December 2004 the footwear manufacturing industry in Elche suffered a 24% fall in employment. In this context, it was decided to conduct study to detect possible changes in the demand for mental health care.

Material and methods: The first-time consultations between December 2001 and June 2002 were compared with those seen between October 2004 and April 2005. Differences were looked for in the percentage of referrals for work-related stress factors. The role of these work-related stress factors in the changes detected in the sociodemographic profile of the patients was also evaluated.

Results and conclusions: Changes were detected in the sociodemographic profile (gender and education level), employment status and reason for consultation. First consultations increased in the following groups: males, with a higher education level, unemployed, on sick leave or pensioners, and also those with employment problems as the main reason for consultation or a worsening of other health conditions.

© 2010 SEP and SEPB. Published by Elsevier España, S.L. All rights reserved.

PALABRAS CLAVE

Factores
socioeconómicos;
Acontecimientos vitales
estresantes;
Desempleo;
Salud mental

Impacto de una crisis sociolaboral en la demanda de atención en salud mental (crisis del calzado, Elche 2004)

Resumen

Introducción: Entre diciembre de 1999 y diciembre de 2004 la industria manufacturera de calzado de Elche sufrió una disminución del empleo del 24%. En este contexto se decidió realizar un estudio para detectar posibles variaciones en las demandas de salud mental.

Material y métodos: Se compararon las primeras consultas atendidas entre diciembre de 2001 y junio de 2002 con aquellas atendidas entre octubre de 2004 y abril de 2005. Se

*Corresponding author.

E-mail: carlosj_mtnez_pastor@yahoo.es (C.J. Martínez Pastor).

buscaron diferencias en cuanto al porcentaje de derivaciones por estresores de índole laboral. En un segundo momento se valoró el papel de los estresores laborales en los cambios detectados en el perfil sociodemográfico de los pacientes.

Resultados y conclusiones: Se detectaron cambios en el perfil sociodemográfico (sexo y nivel de formación), situación laboral y en el motivo de consulta. Aumentaron las primeras consultas de los siguientes grupos: varones, con mayor nivel de formación, en paro, de baja laboral o pensionistas, y también aquellos con problemas laborales como principal motivo de consulta o agravando otros cuadros.

© 2010 SEP y SEPB. Publicado por Elsevier España, S.L. Todos los derechos reservados.

Introduction

There is currently a growing interest in studying the relationship between socio-economic crisis and mental health. Although the general impression, at present, is that economic crises translate to a surge in mental illnesses,¹ there is a remarkable lack of studies to date here in our country. This is why data from studies is more important than ever, for data enables us to move beyond mere impressions.

For a long time, the assumption has been that the impact of economic change on mental health extends beyond the workers directly involved. Durkheim² postulated that rapid economic change triggers various forms of instability and suicidal behaviour. Catalano's 1977 study³ documented that economic change was associated with significantly more stressful events, which caused an increase in depressed mood. In 1995, Weyerer and Wiedenmann⁴ noted positive correlations between labour market indicators and the incidence of depression and suicide. Pritchard,⁵ in 1997, also found a relationship between unemployment and the incidence of suicide. In 2000, Dooley et al⁶ showed that high rates of unemployment were associated with a greater risk of depression. In summary, there is considerable empirical data indicating that exposure to stressful circumstances, at multiple levels of analysis, can play an important role in the onset of mood disorders.

Between December 1999 and December 2004, the footwear manufacturing industry in Elche underwent a 24% reduction in work force, from 11,415 down to 8,639 workers on the Social Security rolls. Even though the same trend was being seen at the local and national level, this was a particularly sharp drop in Elche. According to data on Elche from the offices of the *Servicio Valenciano de Empleo y Formación (SERVEF)* [Valencia Employment and Training Service], on 31 December 2004, there were 13,317 layoffs—24% more than the previous year. More than 40% of the increase in layoffs was directly attributable to the footwear industry crisis, increasing by 1,000 those laid off who had worked in this sector prior to losing their jobs.⁷ In this context, the decision was made to conduct a study to discover whether there were changes in the demand for mental health services during that period, in terms of both the percentage of referrals that were for work-related stressors and the sociodemographic profile of clients. In a second stage, the role of work-related stressors in the changes discovered in the sociodemographic profile was evaluated.

Materials and methods

La Unidad de Salud Mental de Altavix [Altavix Mental Health Unit] (Elche) serves a population of 125,000 inhabitants. Patient referrals come mainly from primary care physicians, who fill out an interconsultation sheet giving information about the reason for the referral, possible diagnosis, and treatment given.

Under a program of coordination with primary care, a first wave of referrals to mental health was collected between December 2001 and June 2002.⁸ Data was collected on the family doctor's actions (type of referral, treatments, latency to treatment), the type of pathology referred, the coordination with mental health, and the patient's sociodemographic profile. Two years later, a number of initial observations led us to propose the hypothesis that the type of patient care demanded of our unit was changing in connection with a series of events related to the footwear industry crisis that the area around Vinalopó was experiencing.⁹ For this reason, we decided to collect a second wave so we could compare it with the first wave. The primary hypothesis we proposed was that a period of economic crisis in our healthcare area was associated with increased use of mental health services by clients with work-related stressors. We obtained information on all referrals received in the mental health unit over 2 periods of 6 months. The first period extended from December 2001 to June 2002 and the second from October 2004 to April 2005.

When the interconsultation was received in the mental health unit, the clinician filled out a questionnaire designed by the researchers for the purpose of gathering information on sociodemographic data and the possible underlying reasons for the demand for care in the mental health unit. The following types of reasons for the demand were established: the presence of a problem directly related to work, a problem indirectly related to work, a family problem, a problem with spouse or partner, a medical problem, a social problem, a school-related problem, another type of problem. The case was considered a problem directly related to work when the problem for which the demand was made was confined to the work setting, regardless of the diagnosis made by the clinician. It was considered a problem indirectly related to work when a problem in the work setting was in addition to problems in other areas or was exacerbating the chief complaint.

With regard to statistical analysis of the data collected, first of all, a descriptive type of statistic was used so that

Table 1 Sociodemographic characteristics of the sample

	First wave	Second wave
<i>Sex (male/female)</i>	87/230 (27.4%/72.6%)	137/250 (35.4%/64.6%)
<i>Age, mean (\pmSD)</i>	51.24 \pm 17.9	45.99 \pm 17.7
<i>Marital status</i>		
Single	57 (26.3%)	112 (34.6%)
Married/Cohab.	121 (55.8%)	156 (48.1%)
Separated/Divorced	25 (11.5%)	33 (10.2%)
Widowed	14 (6.5%)	23 (7.1%)
<i>Educational level</i>		
Uneducated	17 (7.9%)	19 (6.1%)
Read/Write	40 (18.6%)	48 (15.4%)
Elementary	96 (44.7%)	83 (26.6%)
8th Grade	7 (3.3%)	66 (21.2%)
High School	35 (16.3%)	67 (21.5%)
College	20 (9.3%)	29 (9.3%)
<i>Work status</i>		
Active	76 (35.5%)	84 (26%)
Unemployed	20 (9.3%)	39 (12.1%)
Laid off	27 (12.6%)	67 (20.7%)
Retired	26 (12.1%)	56 (17.3%)
Student	16 (7.5%)	28 (8.7%)
Homemaker	49 (22.9%)	49 (15.2%)
<i>Living situation</i>		
Alone	23 (10.6%)	33 (10.3%)
Family	149 (68.7%)	151 (47.3%)
Spouse/partner	28 (12.9%)	75 (23.5%)
Family of origin	17 (7.8%)	60 (18.8%)

the population being studied could be visualised. Pearson's chi-square test was used to analyse the qualitative variables and sample homogeneity. Student's t-test was used for comparison of the means. The data was analysed using version 15.0 of the SPSS software.

Results

A total of 704 interconsultations were assembled: 317 in the first wave and 387 in the second. The sociodemographic characteristics of the 2 client groups are shown in table 1.

When the sample as a whole was analysed, looking for any statistically significant differences in sociodemographic profile, variations between the 2 waves were discovered. In terms of sex, the number of females dropped in the second wave (72.6% in the first wave and 64.6% in the second), while the number of males increased from 27.4% to 35.4% ($\chi^2 < .024$). As regards educational level, the number of clients with an 8th grade or high school education increased (from 3.3% to 21.2% in the first case and from 16.3% to 21.5% in the second), while there was a drop from 71.2% to 48.1% in the number of clients with a lower level of education (uneducated, read/write, and

elementary level). With reference to work status, there was an increase in the number of laid off, unemployed, or retired clients ($\chi^2 < .012$).

In terms of reasons for the demand, there was a statistically significant difference ($\chi^2 < .000$) in the number of clients with problems indirectly related to work, which increased from 7.2% to 17.3%. The number of clients with problems directly related to work increased from 6.9% to 10.8%, although this difference was not statistically significant. As for the remaining problems, significant differences were found only with regard to medical problems, which declined from 19% to 10.3%.

Analysis of the subgroup of clients in a work status other than "retired" ($n=528$) revealed that the number of clients in the second wave who came in demanding care for a problem directly related to work was approximately double the number from the first wave (from 8.4% to 15.1%), a statistically significant difference ($\chi^2 < .019$). Similarly, the number of clients whose reason for demanding care was a problem indirectly related to work increased from 7.2% in the first wave to 24% in the second ($\chi^2 < .000$) (table 2).

Analysis of the differences between the 2 waves in the subgroup of clients with a problem directly related to work showed that the only statistically significant difference was

Table 2 Incidence of work-related problems in the non-retired

Work-related	First wave	Second wave
<i>Directly</i>		
No	228 (91.6%)	237 (84.9%)
Yes	21 (8.4%)	42 (15.1%)
<i>Indirectly</i>		
No	231 (92.8%)	212 (76.0%)
Yes	18 (7.2%)	67 (24.0%)

Table 3 Educational level of clients with problem directly related to work

Level of education	First wave	Second wave
Uneducated	1 (4.8%)	1 (2.7%)
Read/Write	0 (0.0%)	1 (2.7%)
Elementary	14 (66.7%)	8 (21.6%)
8th Grade	1 (4.8%)	14 (37.8%)
High school	4 (19%)	9 (24.3%)
College	1 (4.8%)	4 (10.8%)

Table 4 Educational level of clients with problem indirectly related to work

Level of education	First wave	Second wave
Uneducated	2 (10.0%)	0 (0.0%)
Read/Write	1 (5.0%)	6 (9.8%)
Elementary	11 (55.0%)	18 (29.5%)
8th Grade	0	12
High school	4	16
College	2	9

in their level of education. There was an increase in the number of 8th grade level (from 4.8% to 37.8%), high school level (from 19.0% to 24.3%), and college level (from 1.7% to 6.9%). Among those at elementary level or lower, there was a decrease (from 66.7% to 21.6%), these results being significant ($\chi^2 < .014$) (table 3).

In the subgroup with a problem indirectly related to work, again, the only statistically significant differences were in their level of education. There was an increase in those at the read/write level (from 5.0% to 9.8%), the 8th grade level (from 0% to 19.7%), high school level (from 20% to 26.2%), and university level (from 10% to 14.8%); those who were uneducated decreased (from 10% to 0%) as did those at the elementary level (from 55% to 29.5%). As a group, those at elementary level or lower decreased from 70% to 40%, and those at 8th grade or higher level increased from 30% to 60% ($\chi^2 < .018$) (table 4).

In connection with work status, results were not significant. Among clients with a problem directly related

to work, the trend appeared to be that the active clients declined while the laid off and recent and long-term unemployed increased. In the case of clients with a problem indirectly related to work, it appeared that the recent and long-term unemployed and the students declined while the laid off and the retired increased. The percentage for "active" clients remained constant.

Discussion

There is an extensive body of research showing that exposure to stressful life experiences may constitute an important link between the social milieu and the risk of suffering mood disorders.¹⁰⁻¹³ Major life events are stressful factors that are distinct and observable, whereas chronic stress is related to ongoing problems, both the serious ones related to the individual's role and the minor ones usually referred to as problems of everyday life.¹⁴ The literature on stress identifies stressful macrofactors as a different stress subtype.¹⁵ Stressful macrofactors are systematic and large-scale stressful factors, such as major economic changes and recessions, for example. The aggregate indicators for these types of change have also been linked to the incidence of mental health problems.¹⁶

The results of this study indicate a direct correlation between a period of economic crisis and the increase in demand for mental health services due to work-related problems; the demand doubles when these problems are the only reason for the referral and triples when they are part of the reason or exacerbate the reason. From one wave to the next, there was an increase in the percentage of males and of clients at the 8th grade and college education level. There was also an increase in the percentage of clients laid off and unemployed short- and long-term.

Various authors have shown unemployment to be a factor affecting mental health,¹⁷ the differences found being related to the social profile of the individuals. In the Breslin and Mustard study,¹⁴ unemployment caused stress and depression in adults 31-50 years of age, but this finding was not repeated in young people 18-30 years of age, which the authors suggest may be because they do not have family responsibilities and do not think about the possibility of being excluded from the labour market for good. Artazcoz et al¹⁸ showed that unemployment had a greater impact on mental health in men, this being related to their family responsibilities and social class. While marriage caused men to have a worse psychological response to unemployment, for women, being married and having children acted as a protective factor against the stress of losing a job.

In analysing the entire group of clients with problems related to work, both directly and indirectly, it was noted that the same trend appeared as in the sample with no filter applied for the increase in the percentage of males; in this case, however, it was not statistically significant. In terms of level of education, the change was similar to that of the sample as a whole as far as the percentage at the 8th grade and college education levels increasing and the percentage of those with less education decreasing. In analysing this data, it is important to remember that the

level of education in Elche is lower than that of Spain as a whole, and this may be a reflection of the importance of the working class among its population compared with the rest of this region or the rest of Spain. This low level of education characterizes sectors where manual labour is prevalent and where certain professions are learned hands-on, typically in the same home, so that individuals enter the labour market at a young age. Compared with the mean nationwide, Elche has 5% more people with no education or elementary level education and 10% fewer people who are educated. According to the INEM [*Instituto Nacional de Empleo*], unemployment dropped among those with a college degree and grew among the rest, particularly among those at elementary level and lower. So the increased demand due to work-related problems was not because of those who supposedly had a higher rate of unemployment. We believe other factors should be taken into consideration to explain these data, such as the individual's way of facing the problem (for example, the perception of a quick return to the working world) or how a drop in employment in a key sector of a community affects the other sectors of that community.

One piece of information that also merits analysis is the fact that, for clients who had problems related to work, whether directly or indirectly, there were no statistically significant differences between the 2 waves in terms of their work status. While there was an increase in the percentage of clients with work-related problems, no differences were found in their work status; the INEM data notwithstanding, there was no evidence of an increase in layoffs. Although because of the submerged economy we should be careful in analysing it, this lack of correspondence indicates that the increased demand seen in the crisis is not directly related to the loss of employment; therefore, to explain it, factors more complex than a simple correlation between unemployment and the demand for mental health services must be taken into account. On the one hand, all demands related to work issues but unrelated to the symptoms would have to be considered, such as the need for reports for legal purposes (for example, to request disability pensions or claims from the company). Another portion of the demand could be explained by what Ortiz Lobo and de la Mata Ruiz define as the psychiatric colonisation of everyday life,^{19,20} where circumstances of legitimate pain and suffering are decontextualised from the individual's biography and social milieu and recoded as problems for which a healthcare response is appropriate. In this way, mental health may become an individualised alibi in unfair social circumstances, contributing to the deterioration of traditional self-control systems or filling the void left by other state institutions or agencies that are being demolished: pre-retirees in search of pension, victims of unjust labour relations who are led by the syndicate itself to mental health centres, etc. The same authors point out another risk incurred by mental health services: the risk of promoting an adaptationism, in which the diagnosis transfers the cause of the unwellness from the environment to the individual's failure to adjust, so that it is the individual's responsibility to adapt himself/herself to the new situation, however extremely unfair it may be. In our area, as a result of the crisis, there may have been

an increase in cases of a new diagnosis pathology such as *mobbing*, increased worries in the face of an uncertain labour outlook, or simply a worsening of labour conditions. Thorlacius and Olafsson²¹ described how fluctuations in the rates of unemployment were correlated with an increased incidence of physical and mental disability pensions. They concluded that, although physical and mental health are the major determining factors in the incidence of disability pensions, there are marginal fluctuations that appear to be related to factors in the job market climate, especially the unemployment rate.

One of the limitations of this study is a methodological one, for no control group was used that would have detected a cohort effect, nor were hypotheses other than the economic crisis considered for the change in the demand. It should be pointed out that, during the study period, there was no variation in the size of the population being cared for nor in the patient care system. This study was focused on the demand for mental health services and not on mental pathology per se, so no parallels could be established between the economic crises and psychopathology; factors related to the type of work were not evaluated, either, nor was it determined whether the client was connected with the footwear industry crisis and whether the demand was clinical. These are the main limitations of the study. However, the coincidence in time of the footwear industry crisis and the change in demands and client profiles at our mental health unit could indeed be established, as well as the fact that the change in client profile was brought about, at least in part, by clients with work-related problems.

In view of the data from this study, we do not believe that the economic crisis can be reduced to a stressful macrofactor that gives rise to treatable psychopathology; rather, it should be viewed as giving rise to a number of demands on mental health services that are directly related to symptoms only in part. Our scope has thus become wider because, on the one hand, we have stress and other psychopathology connected with work-related problems and, on the other hand, demands that have nothing to do with clinical practice and, in between, Psychiatry's colonisation of everyday life, which blurs the boundaries of illness and, consequently, our competence.

Conflicts of interest

The authors declare no conflict of interest.

References

1. Ministerio de Sanidad y Consumo. El ministerio de sanidad y consumo crea el observatorio de la salud mental con la fundacion nacional de psiquiatria [accessed 2009 Dec 200]. Available from: <http://www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1313>.
2. Durkheim E. El suicidio. Madrid: Akal; 1992.
3. Catalano R, Dooley CD. Economic predictors of depressed mood and stressful live events. J Health Soc Behav. 1977;18:292-307.

4. Weyerer S, Wiedenman A. Economic factors and the rates of suicide in Germany between 1881 and 1989. *Psychol Rep.* 1995;76(3 Pt 2):1331-41.
5. Pritchard C, Cox M, Dawson A. Suicide and 'violent' death in a six-year cohort of male probationers compared with pattern of mortality in the general population: evidence of accumulative socio-psychiatric vulnerability. *J R Soc Health.* 1997;117:180-5.
6. Dooley DP, Ham-Rowbottom KA. Underemployment and depression: longitudinal relationships. *J Health Soc Behav.* 2000; 421-36.
7. Cachón Rodríguez L. Bases sociales de los sucesos de Elche de septiembre de 2004. Crisis industrial, inmigración y xenofobia. Ministerio de trabajo y asuntos sociales. Secretaria de estado de inmigración y emigración. Observatorio permanente de la inmigración. Madrid, 2005.
8. Martí Martínez AF, Fenollar Iváñez F, García Escudero, MA, Martínez Pastor CJ. Análisis descriptivo de las derivaciones a un centro de salud mental (USM Altabix-Elche). Congreso nacional de psiquiatría, Valencia, 2008.
9. Lorenzo C. Intereses contrapuestos y racismo. El incendio de los almacenes chinos en Elche (septiembre 2004). Circunstancia; Mayo 2006. p. 1-19.
10. Abas M, Robinson E, Crampton P. More deprived areas need greater resources for mental health, *Aust N Z J Psychiatry.* 2003;37:437-44.
11. Peen J, Dekker J. Social deprivation and psychiatric service use for different diagnostic groups. *Soc Sci Med.* 2001;53:1-8.
12. Pritchard C. Psychiatric targets in "Health of the Nation": regional suicide 1974-1990 and employment prospects in 1990-1994 in Britain: Precursors of failure?. *J R Soc Health.* 1995;115:120-7.
13. Wiedenmann A. Testing Durkheim's theory of suicide: additional results from Germany. *Eur Arch Psychiatry Clin Neurosci.* 1994;244:284-6.
14. Breslin FC, Mustard C. Factors influencing the impact of unemployment on mental health among young and older adults in a longitudinal, population-based survey. *Scand J Work Environ Health.* 2003;29:5-14.
15. Williams DR. Perspectivas sociales de los trastornos del estado de ánimo. In: Stein DJ, Kupfer DJ, Schatzberg AF, editors. *Text book of mood disorders.* Barcelona: American Psychiatric Publishing; 2006. p. 131-43.
16. Dooley D, Catalano R. Introduction to underemployment and its social costs. *Am J Community Psychol.* 2003;32:1-7.
17. Ensminger ME, Celentano D. Unemployment and psychiatric distress: social resources and coping. *Soc Sci Med.* 1988;27: 239-47.
18. Artazcoz L, Borrell C, Cortès I. Unemployment and mental health: understanding the interactions among gender, family roles, and social class. *Am J Public Health.* 2004;82-8.
19. De la Mata Ruiz I, Ortiz Lobo A. La colonización psiquiátrica de la vida. Archipiélago: Cuadernos de crítica de la cultura. 2007; 39-50.
20. Ortiz Lobo A. Los profesionales de la salud mental y el tratamiento del malestar. *Atopos.* 2008;26-34.
21. Thorlacius S, Olafsson S, Rafnsson V. Changes in the prevalence of disability pension in Iceland. *Scand J Public Health.* 2002; 1976-96.