Journal of Affective Disorders 195 (2016) 15–20

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

Prevalence of psychiatric morbidity in the primary health clinic attendees in Kuwait

Sulaiman Alkhadhari [a], Aseel Omran Alsabbrri [b], Ibrahim H.A. Mohammad [b], Amina Abdullah Atwan [b], Fatma Alqudaihi [c], Muhammad Ajmal Zahid [a,*]

[a] Department of Psychiatry, Faculty of Medicine, Health Sciences Center, PO Box 24923 Safat, Kuwait 13110, Kuwait
[b] Abdullah & Shereefa Almehry Health Center (Alkhaldia Poly Clinic), Alasima Primary Health Area, Kuwait
[c] Technical Department in the Ministry of Health, Kuwait

ARTICLE INFO

Article history:
Received 16 October 2015
Received in revised form
9 January 2016
Accepted 18 January 2016
Available online 21 January 2016

Keywords:
Mental health
Depression
Anxiety
Primary clinics
Kuwait

ABSTRACT

Background: A substantial proportion of primary clinic attendees suffer from psychiatric disorders and many of them are neither recognized nor adequately treated by primary clinic physicians.
Objectives: To determine the point prevalence of, and identify risk factors for, depression, anxiety, and somatisation disorder in the primary health clinics in the country.
Method: The Physical Health Questionnaires (PHQ-SADs), were administered to a randomized sample of 1046 primary clinic attendees in all the five governorates of the country over a 5-month period. The descriptive data were computed with chi-square tests while the association of demographic characteristics with psychiatric disorders was determined with the logistic regression test.
Results: 42.7% of the our patients suffered from psychiatric disorders including depressive (22.9%), anxiety (17.7%), and somatization (33.4%) disorder. Comorbidity between the three disorders was found in 20.4% of the sample; 11% had two and 10.4% had all three disorders. The Kuwaiti nationals, female gender, older age group subjects and those with lower level of education were more likely to suffer from psychiatric disorder.
Limitations: The inter-rater reliability may have affected the results as large number of physicians were responsible for administering the questionnaires. Moreover, the study did not include eating and substance-abuse disorders and the findings were limited to detection of somatization, depression, and anxiety disorders.
Conclusions: In order to ensure timely provision of appropriate treatment, the primary care physicians need adequate information on different forms of presentation, and basic front line treatment, of the common mental disorders at the primary care level.

1. Background

Mental disorders affect a large percentage of population and constitute important cause of morbidity, mortality, and disability (Ormel et al., 2008). It has been estimated that one out of every three primary care patients suffer from one or another kind of mental illness (Kroenke et al., 1997). Moreover, as many as half of the patients presenting with medically unexplained physical symptoms, suffer from psychiatric rather than medical illnesses (Roca et al., 2009). Despite improvements in the clinical training of primary clinic physicians and availability of numerous reliable screening instruments, a substantial number of the mentally ill patients pass unnoticed at the primary care level. The reported co-morbidity between medical and psychiatric illnesses, coupled with the tendency in some patients to somatize emotional distress in physical terms, adds to the difficulty in identifying such patients. Consequently, these patients end up getting repeatedly examined and investigated resulting in increased resource utilization, higher costs, greater disability, and poorer outcome (De Waal et al., 2004; Alonso et al., 2007). Over the last two decades, numerous efforts have been made to improve the early identification of, and provision of appropriate help to, the mentally ill patients presenting in the primary health clinics. Depending on the methodology and the assessment tools used, the rates of psychiatric morbidity among the primary health clinic attendees have varied between 26% and 60%, (Ansseau et al., 2004; Baca et al., 1999; Nortin et al., 2007; Jackson et al., 2001). Although there are some reports describing the presence of depression among the primary clinic attendees in the Gulf Cooperation Council (GCC) countries comprising Kingdom of Saudi Arabia, Kuwait, Qatar, Sultanate of

* Corresponding author.
E-mail address: Zahid@hsc.edu.kw (M.A. Zahid).

http://dx.doi.org/10.1016/j.jad.2016.01.037
0165-0327/

Oman, United Arab Emirates, and Bahrain ((Suleiman et al., 1998; Al-Otaibi et al., 2007; Al-Qadhi et al., 2014), there are few, if any, methodologically sound studies investigating the presence of overall psychiatric morbidity at the primary care level. In a study of 2320 primary clinic attendees in Kuwait, 37.1% were found to be suffering from depression (Al-Otaibi et al., 2007). In another study of psychiatric morbidity among the primary clinic attendees from Saudi Arabia, the point prevalence of depression was found to be 49.9% (Al-Qadhi et al., 2014). We decided to determine the prevalence of psychiatric morbidity among the primary clinic attendees in Kuwait.

Kuwait is a rich Arab country with a population of three and a half-million (Health Kuwait, 2012). The health services are provided by 87 evenly distributed primary clinics, six regional general hospitals, and specialized centers including Ophthalmology, Cardiology, Cancer treatment center, Obstetrics and Gynecology, Neurology and Neurosurgery, and Chest and Cardiology units (Health Kuwait, 2012). The psychiatric services are essentially hospital based. The psychiatric hospital has more than 900 beds, including 200 beds for drug addiction disorders, and 20 beds for the Child and Family Psychiatry unit. In addition, the hospital psychiatrists provide outpatient services in the general hospitals, and recently, these outpatient services have been extended to include (eight) primary health clinics.

The aim of this study was to determine the prevalence of, and identify the possible risk factors for, the common psychiatric disorders at the primary clinic level. To the best of our knowledge, this is the first cross-sectional epidemiological study carried out in the primary care settings in the country.

2. Subjects and methods

2.1. Sampling

The ethical approval of the study was obtained from the Scientific and Research Committee, Ministry of Health. Out of the total number of 87 primary health centers in all the five state Governorates, 16 centers were blindly selected from the random table. The sample size was calculated to significance level set at 0.5% and a precision of 2%, for an estimated 16% prevalence of psychiatric disorders. An adequate sample size (using power curve) was estimated to be 1000 participants. As a result, a total number of 1046 consenting subjects were recruited so as to allow for 5% of the missing data cases.

2.2. Instruments

The Patient Health Questionnaire-Somatic/Anxiety/Depression (PHQ-SAD) is an easy-to-administer, brief diagnostic assessment tool, designed to measure rates of psychiatric morbidity in the primary care settings (Spitzer et al., 1999). The PHQ's measure depression, anxiety, and somatic disorders, and have been reported to have good psychometric properties.

3. Patient Health Questionnare-9 (PHQ-9)

The PHQ-9 is a self-administered questionnaire used to screen patients suffering from depression. It has been extensively used with medical populations and has been shown to be an effective case detection tool in all patients and also as a diagnostic procedure in patients in whom mental illness is suspected. It has demonstrated high sensitivity and specificity in primary clinic populations. The 4-option response format allows scores of 0, 1, 2 and 3 to the response categories of “not at all”, “several days” “more than half the days” and “nearly every day” respectively. The total PHQ-9 score for the nine items ranges from 0 to 27 and scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe, and severe depression respectively.

4. Generalized anxiety disorder-7 anxiety (GAD-7)

The GAD-7 is a brief self-administered questionnaire used to screen and measure severity of generalized anxiety disorder. It has been extensively used and validated in primary care settings and has been shown to have good sensitivity and specificity as a screener for generalized anxiety disorder. The GAD-7 anxiety severity is calculated by assigning scores of 0, 1, 2, and 3 to the response categories of “not at all, “several day”, “more than half the day” and “nearly every day” respectively. The total GAD-7 score for the seven items ranges from 0 to 21; scores of 5, 10, and 15 represent cut points for mild, moderate and sever anxiety, respectively.

5. Patient Health Questionnaire-15 somatic symptoms (PHQ-15)

The Patient Health Questionnaire (PHQ-15) is a diagnostic tool used to detect psychiatric disorders in patients presenting with multiple somatic symptoms. It is quick and easy to complete. The somatic symptoms severity is calculated by assigning scores at 0, 1 and 2 to the response categories of “not at all” bothered a little” and “bothered a lot” for the 15 somatic symptoms. The PHQ-15 scores of 5, 10, and 15 represent cut points for low, medium and high somatic symptoms severity respectively.

5.1. Procedures

A total number of 16 physicians administered the PHQ's to all the consenting primary clinic attendees, and their demographic characteristics recorded while they waited for consultation with the physician. The physicians were instructed with the use of instruments, which were presented in an easy-to-use paper format, specifically designed for the study. Since the questionnaires are self-administered, the training basically involved familiarizing the investigators with the questionnaires and clarifying, where necessary, the content matter of the different items. Both the English and the Arabic versions of the questionnaires were made available. The illiterate patients were helped by physicians in completing questionnaires. The treating physicians were requested to refer any patient found to be mentally ill. The patients were recruited on alternative mornings and afternoons during the 4-month period from 1st May to 30th September, 2012.

5.2. Data analysis

The data were analyzed on SSPS, version 22 (IBM corp. Armonk, NY: 2013). Descriptive statistics including mean, SD, frequencies and percentages were used to describe the data. The cut off score of 10 or above was used to ascertain the rates of all three disorders. Categorical variables were compared using chi-square test. We used multiple logistic regression analyses to find significantly associated factors with mental disorders. Somatoform, Anxiety and Depression (dichotomous mental disorder scores coded as $\geq 10 = 1$ and scores $< 10 = 0$) or any mental disorders (coded as 1 = presence of any of the disorders and 0 = absence of all the disorders) were separately used as dependent variables and sociodemographic variables such as gender, age group, nationality, marital status and level of education as independent variables. The