

## Original Article

# Prevalence of Depression among Kuwaiti Patients Attending the Sawaber Health Center

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**ABSTRACT**

**Objective:** To determine the prevalence of depression among Kuwaiti patients attending a primary health care clinic.

**Subjects and Methods:** A cross-sectional study of consecutive Kuwaiti patients who attended the Sawaber clinic for physical medical problems, aged between 21 and 64 years during November and December 2002. One hundred and twenty-five patients were interviewed in detail about their socio-demographic characteristics, and the mental status examination was done by using the items of the American Diagnostic and Statistical Manual for Mental Disorders (DSM-IV criteria) to elicit symptoms of depression. Diagnosis of depression was based on DSM-IV criteria.

**Result:** The study group consisted of 45 (36%) males and 80 (64%) females; 46.4% were clerks, 83.2% were married and 76% belonged to the medium socio-economic level. Based on the clinical interview, 29.6% of subjects fulfilled DSM-IV criteria for depression. Out of these, 78.4% were females, 70.3% were married and 64.9% were of intermediate socio-economic level. Significantly, more female patients had depression. Depression was significantly commoner among patients who were married and from the low socio-economic group. None of the subjects had suicidal thoughts.

**Conclusion:** It is recommended that doctors in primary care settings should be aware of psychiatric morbidity in general, and depression in particular, with a view to

KEY WORDS: depression, prevalence, primary care, Kuwait

**INTRODUCTION**

Depression is an illness that affects the entire mind and body. The clinical picture of a depressive episode includes depressed mood, loss of interest and pleasure, and reduced energy. Other symptoms are, reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt or worthlessness, ideas of self-harm or suicide, poor sleep and appetite. The episode can vary from mild to severe, depending on the number and severity of the symptoms and on the disturbance they cause to the work and family commitments<sup>[1]</sup>. The classical features of depression may be masked by a complex of somatic complaints. Such symptoms include headache, fatigue, anorexia, weight loss, menstrual changes, unusual sensations in the abdomen, chest or head, bodily aches and pain, dry mouth and difficulty in breathing<sup>[2]</sup>.

The aim of our study was to determine the prevalence of clinical depression among young adult and middle aged Kuwaiti citizens attending the health center in Sawaber area, and to study the relationship between the prevalence of depression and socio-economic status, gender and marital status. The rationale for this study is the widely held impression that depression is common in

general medical settings and results in more days of disability than chronic medical conditions such as heart disease, hypertension and diabetes<sup>[3]</sup>. However, the primary care system is inefficient at recognizing and managing this disorder<sup>[4]</sup>. In all countries, the recognition of depression by clinicians in the primary care settings is low (generally less than 50%)<sup>[5]</sup>.

**SUBJECTS AND METHOD**

A cross-sectional study was conducted during November and December 2002. The study included 125 consecutive Kuwaiti patients aged between 21 and 64 years who attended the Sawaber primary health care clinic for any medical complaint. Non-Kuwaiti patients were excluded. The study focused on Kuwaiti nationals because they are the regular clinic attendees at the clinic, and hence the clinic presented a unique opportunity of a convenient sample from which mental health data on Kuwaiti nationals could be generated. A questionnaire was used to collect information on socio-demographic characteristics from the patients. Thereafter, patients' mental status were examined by asking them questions to elicit the psychiatric symptoms itemized in the DSM-IV criteria for depression. All

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interviews were conducted by one of us (MSA) who has postgraduate general practice experience in psychiatry. Interviews were conducted in the presence of EMA, an experienced general practitioner, and consensus diagnosis was arrived at, based on the DSM IV criteria after reviewing each case jointly. The items (from the DSM-IV) were incorporated into a questionnaire.

#### DSM-IV Diagnostic Criteria

For Major Depression, at least five of the following symptoms must be present for two weeks, including criterion 1 or 2 (which are essential):

1. Depressed mood
2. Loss of interest or pleasure
3. Significant appetite or weight loss or gain (usually poor appetite)
4. Insomnia or hypersomnia (early morning waking is a classical symptom)
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Impaired thinking or concentration, indecisiveness
9. Suicidal thoughts/thoughts of death

The diagnosis of depression requires symptoms that almost always occur, such as depressed mood, or loss of interest and pleasure in usual activities. As indicated above, at least four of the following should be present: reduced concentration and attention, fatigue or loss of energy, reduced self-esteem and self-confidence, ideas of guilt or worthlessness, ideas of self harm or suicide, poor sleep and appetite, psychomotor agitation and retardation. We devised a scale for grading socioeconomic status from a previous study, which combined educational level and family income. Data obtained from questionnaires were coded and fed into a computer. The Statistical Package for Social Sciences (SPSS) software window version 11.0 was used for data analysis. The student t-test was used to test the significance between two means of continuous variables.

#### RESULTS

In this survey, 125 subjects were interviewed. Of all participants, 45 (36%) were males and 80 (64%) were females. Significantly more females (36.3% or 29/80) had depression than males (17.8% or 8/45) ( $\chi^2 = 4.7$ ,  $df = 1$ ,  $p = 0.04$ ) (Table 1). The majority of subjects worked as clerks 58 (46.4%) and 104 (83.2%) were married. As judged by the DSM -IV criteria, the prevalence of clinical depression was 29.6%. Significantly more of the depressed patients were married ( $\chi^2 = 6.3$ ,  $df = 1$ ,  $p = 0.018$ ). The mean age ( $\pm$  SD) of all subjects was 38.8 ( $\pm$  10) years. The mean age of all males was 41 ( $\pm$  9.5) years and for

**Table 1**

Sociodemographic characteristics of 37 depressed patients and 88 non-depressed patients listed in Depression Survey 2002

Characteristics	Depressed		Non-depressed	
	Frequency	%	Frequency	%
Gender				
Male	8	21.6	37	42.0
Female	29	78.4	51	58.0
Social status				
Single	6	16.2	4	4.5
Married	26	70.3	78	88.6
Divorced	3	8.1	3	3.4
Widow	2	5.4	3	3.4
Socioeconomic level				
High	1	2.7	12	13.6
Intermediate	24	64.9	71	80.7
Low	12	32.4	5	5.7

**Table 2**

Symptoms of depression found among 125 Kuwaiti patients of Sawaber clinic in Depression Survey 2002

Symptoms	Frequency	%
Depressed mood		
Yes	41	32.8
No	84	67.2
Loss of interest		
Yes	30	24
No	95	76
Impaired thinking or concentration		
Yes	38	30.4
No	87	69.6
Feeling of worthlessness or excessive guilt		
Yes	28	22.4
No	97	77.6
Insomnia or hypersomnia		
Yes	50	40
No	75	60
Early morning waking		
Yes	42	33.6
No	83	66.4
Appetite or weight loss or gain		
Yes	32	25.6
No	93	74.4
Feeling of fatigue or loss of energy		
Yes	48	38.4
No	77	61.6
Symptoms of psychomotor agitation or retardation		
Yes	35	28
No	90	72
Suicidal thoughts		
Yes	0	0
No	100	100
Duration of symptoms more than 2 weeks		
Yes	49	39.2
No	76	60.8
Do you take any psychiatric treatment?		
Yes	0	0
No	100	100

**Table 3**

Symptoms of depression among 37 patients of Depression Survey 2002

Symptoms	Frequency	%
Depressed mood		
Yes	26	70.3
No	11	29.7
Loss of interest		
Yes	30	81.1
No	7	18.9
Impaired thinking or concentration		
Yes	30	81.1
No	7	18.9
Feeling of worthlessness or excessive guilt		
Yes	21	56.8
No	16	43.2
Insomnia or hypersomnia		
Yes	25	67.6
No	12	32.4
Early morning waking		
Yes	20	54.1
No	17	45.9
Appetite or weight loss or gain		
Yes	21	56.8
No	16	43.2
Feeling of fatigue or loss of energy		
Yes	28	75.7
No	9	24.3
Symptoms of psychomotor agitation or retardation		
Yes	24	64.9
No	13	35.1
Suicidal thoughts		
Yes	0	0
No	37	100
Taking any psychiatric treatment?		
Yes	0	0
No	37	100

all females was 37.5 ( $\pm 10$ ) years. Student t-test showed significant difference between the age of males and females ( $t = 2.1$ ,  $df = 123$ ,  $p = 0.04$ ). The mean age of depressed patients was 38.3 ( $\pm 10.4$ ) years and for non-depressed patients was 39.1 ( $\pm 9.8$ ) years. There was no significant difference between the age of depressed and non-depressed patients ( $t = 0.4$ ,  $p < 0.05$ ). 32.8% of all patients had depressed mood, and 24% had loss of interest in usual activities. None of our subjects had prior psychiatric treatment (Table 2). 78.4% of depressed patients were females, 37.8% were clerks, 70.3% were married, and 64.9% were of intermediate socio-economic level. Significantly more of the depressed patients were in the low socio-economic level (32.4% or 12/37) compared with the non-depressed group (5.7% or 5/88) ( $\chi^2 = 17.6$ ,  $df = 2$ ,  $p > 0.0001$ ). None of our subjects had suicidal thoughts (Table 3). All our depressed patients experienced symptoms for two weeks or more.

## DISCUSSION

A survey of 125 Kuwaiti citizens of Sawaber area attending clinic for other physical problems, aged between 21 and 64 years showed that the prevalence of depression was relatively high. However, it is consistent with the prevalence of depression in other countries. Barkin *et al*<sup>[6]</sup> showed that depressed patients consult their primary care physicians before engaging the service of a mental health care provider. Major depression has been estimated to have 5% to 10% prevalence in the general population, with up to three times that percentage having significant subsyndromal depressive symptoms. Patients frequently deny their depression, often neglecting to recognize their own somatic and cognitive/behavioral subjective symptoms, underestimating symptom severity, and having a reluctance to validate their existence because of social stigmata. Furthermore, up to 25% of primary care facility patients may satisfy the criteria of DSM-IV for depression. In a similar study in Australia 42% were identified as clinically depressed<sup>[7]</sup>. In our study, most of our depressed patients were females. Our data showed a significant relationship between gender and depression ( $\chi^2 = 4.7$ ,  $df = 1$ ,  $p = 0.04$ ). This result is consistent with other authors who showed that women are at an increased risk for first onset of major depression from early adolescence until their mid-50s and have a lifetime rate of major depression 1.7 to 2.7 times greater than that for men<sup>[8]</sup>. Other studies showed that females distinguished the depressed groups from the non-depressed group<sup>[9]</sup>. Our data showed significant relationship between socio-economic level and depression ( $\chi^2 = 17.6$ ,  $df = 2$ ,  $p > 0.0001$ ). It has been reported that adverse socio-economic status was strongly associated with depression<sup>[10]</sup>. Other studies showed that when adjustments for education, income, psychosocial, behavioral, and health problem factors were made, the least acculturated subjects were at higher risk for depression than highly acculturated Mexican Americans<sup>[11]</sup>. In our results, none of the depressed patients had suicidal thoughts. This is consistent with the study conducted in America and Kuwait, which showed that Kuwaiti students, though more depressed than the American students, reported less prior suicidal preoccupation<sup>[12]</sup>. Additionally, our data showed that none of our depressed patients took any prior psychiatric treatment and our findings were consistent with other studies which showed only 7.4% of those with current major depression being treated with an antidepressant<sup>[13]</sup>.

## CONCLUSION

Depressive illness is one of the commonest illnesses in medicine and is often confused with

other illnesses. Hence it has been noted that, the depressed patients usually have multiple minor complaints of the "ticket of entry" type. Although failure to adequately treat depression may have far-reaching impact on health, functional status, quality of life and cost of care for such patients, it is usually misdiagnosed<sup>[2]</sup>. Since depression is so common, primary care doctors are recommended to watch actively for its signs and symptoms and to treat the patients accordingly. The family doctor should also suspect depression in a patient with a multitude of physical complaints or with complaints that do not fit into any definite pattern of organic disease.

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