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A Socio-demographic Study of New Referrals to the Psychiatric Out-patient Clinic in Qatar

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ABSTRACT

A Socio-demographic analysis of 438 new referrals seen at the Psychiatric Out-Patient Clinic at Doha, Qatar, during a period of six months showed that the rate of first consultation was 4.6/1000/year for general population, 6.6 for Qataris and 2.6 for non Qataris. Majority of patients were married males in age group 25 – 39. More than half of the patients were suffering from depressive and anxiety disorders. 75 of patients studied were admitted to the psychiatric in-patient unit during the same poriod.

INTRODUCTION

Qatar is an Arab State on the western coast of the Arabian Gulf. It is a peninsula about 100 miles long and 55 miles across its broadest part, the area being about 4000 square miles.

A large number of studies have considered the relationship of immigration and mental illness (Malzberg, 1969). Nevertheless, there are few comparative studies of psychiatric morbidity among sub-groups of different nationalities living in a community (Carpenter and Brockington, 1980). Many studies have shown that immigrants to Europe, Great Britain and U.S.A. have higher rates of psychiatric disorders (Murphy, 1973), especially schizophrenia (Dean et al., 1981), and

higher admission rates to mental hospitals (Stonequist, 1961; Hitch and Rack, 1981). However, many of these studies did not allow for differences in age, sex, marital status and social class structure between immigrants and host population (Dean et al., 1981).

Recently, a study by Cochrane (1977) showed that Asians who immigrated to Britain had lower rates of admission to psychiatric hospitals while Americans had rates similar to native born population. Other comparative studies (Simoes, 1980; Cox, 1977), shook the notion that immigrants are generally more vulnerable to mental illness and/or have higher rates of psychiatric morbidity compared to host populations.

Qatar is a booming oil exporting Gulf State that attracts temporary immigrants from many nationalities (Statistical Report, 1981). There is a national health service, free for all. Psychiatric service includes an out-patient clinic and an inpatient unit (29 beds), which is a part of Hamad General Hospital, and it serves the whole population through a referral system from primary health centres, other hospital departments and self-referral.

The situation is a unique chance for comparative studies of psychiatric morbidity among many nationalities. The Qataris are facing a culture shock due to rapid social change and affluence (Oberg, 1954; Hughes, 1969; Mead, 1947), similar to what expatriates face on coming to work and live termporarily in Qatar. Thus, a common culture shock challenges both groups and taxes their mental health.

Our clinical experience in Qatar led us to formulate few questions which the present study aimed to answer.

1. What are the rates of psychiatric morbidity in Qatar in both the native born and expatriate populations ?
2. Who gets psychiatrically ill to the extent of referral ?

3. What psychiatric conditions befall people as they present to the only psychiatric clinic in Doha - Qatar ?

The present study documents results of analysis of 438 new referrals to the out-patient clinic, psychiatry department of Hamad General Hospital during the period lst Sept. 1981 to 28th February, 1982.

METHOD

All new referrals during the period of 6 months, from lst Sept. 1981 to end of Feb. 1982 were seen by either of the two Consultants for initial assessment. These patients (N=438) were screened for age, sex, marital status, occupation, nationality and diagnosis.

Population

Recent census data is not available by age, sex, marital status and nationality. The only census done was in 1971. Yet, estimates of the population based on Immigration Office records, show that the population in 1981 was 240,000; 60,000 being Qataris and 180,000 non-Qataris (Ratio = 1:3) (Statistical Report, 1981).

Non - Qataris

Non-Qataris were divided for purpose of the study into three groups : Asians, Arabs, and Others. Asians comprised nationalities of South East Asia, Indian Sub-Continent and Iran. Arabs included all nationals of states that are members of the Arab League, thus comprising Africans and Asians speaking Arabic, Saudi Arabia and the Gulf States.

Immigration policy determines the profile of the immigrant population. Low income groups (Labourers and Soldiers) are not allowed to bring their families to the country. They live in a working camp type of life, in hostels provided by the State or by their employers. Professionals and bureaucratic staff of high pay are joined by their

wives and children. The non-Qatari population is skewed towards being mostly males, of young age 26 – 45. The majority are married; yet they are, in reality, living in a split family status; they are highly motivated to get a job of better pay in a competitive recruitment policy.

Non-Qataris from developed countries (Western) are the most advantaged in terms of education, and the right to be joined by their families. Those from poor, over-crowded, developing countries represent the disadvantaged group. The majority are unskilled labourers, and average skilled technicians. Majority are married with children, whom they leave in their country of origin to visit every two years on average (Year Book, 1981). These are the lower paid group compared to others in the country.

Qataris

Qataris are Arabs from the Arab Peninsula and Coasts of the Gulf. The 1971 census showed that male : female ratio is almost 1:1, children below the age of 15 years form almost 45% of the population. Because of polygamy, a father has many biological children from his wives. As the practice is still widespread, one would expect the population to be skewed towards a younger age group. Most Qatari males are employed by the State in either bureaucratic jobs or in the army, a minority are businessmen and very few professionals.

Diagnoses

All new referrals were seen by either of the two Consultants. Diagnoses were classified under the following categories : Schizophrenia, depression, mania, organic psychosis, anxiety neurosis, hysteria, obsessive neurosis, personality disorder, alcoholism, drug dependence, psychosomatic disorder, epilepsy, subnormality, dementia, childhood neurosis, impotence and stammering.

Analysis

First consultation rates per 1000 per year were calculated for Qataris and Non-Qataris, as well as for both groups together. Estimates

of numbers in community were obtained from Statistical Report, 1981. The fact that the psychiatric out-patient clinic is a referral clinic and the only psychiatric out-patient facility in Doha, made it possible to rely on these figures as rough indication of treated psychiatric morbidity during a specified period. 75 patients of 438 first psychiatric consultations were admitted to the psychiatric in-patient unit in Doha hospital. First admission rates were similarly calculated.

RESULTS & DISCUSSION

Rates & Nationalities (Table 1)

First Psychiatric Consultation Rates : Were found to be 4.6/1000/ Year for the whole population.

For Qataris, it was 6.6/1000/year and for Non-Qataris it was 2.6/1000/year.

First Admission Rates :

For all groups = 6.25 per 10.000 per year

For Qataris = 6.6 per 10.000 per year

For non-Qataris = 6.1 per 10.000 per year

Comparing rates, for the whole population, one every six new patients was admitted. For Qataris, this ratio was one eve y ten patients (⅛). This is generally in agreement with many studies, yet the higher ratio of those admitted to hospital among Non-Qatari patient population is probably due to :

1. Psychiatric disorders amongst Non-Qataris were severer than in Qataris. Severity does not necessarily equate with the diagnostic dichotomy of psychosis versus neurosis. Majority of Non-Qataris admitted were actually showing "social breakdown syndrome" (Gruenberg, 1966), leading to admission.

2. Although Qataris report more to psychiatric clinic, they usually have minor psychiatric disorders. This is probably explained by either of two mechanisms; Qataris have a lower threshold to express distress, so they overuse the service, or they suffer mainly from reactive psychiatric conditions. In the turmoil of social change, illness behaviour among them becomes a socially acceptable outlet for social problems such as marital disharmomy, intergenerational conflicts and role confusion (El-Islam, 1978; El-Akabawi et al., 1982).

Lower rates for immigrants disagree with many similar studies (Malzberg, 1969; Dean et al., 1981 and Hitch & Rack, 1980), but some recent studies had shown either similar or lower admission rates for immigrants. The explanation is probably a "positive selection" being responsible for a less vulnerable immigrant (Cochrane, 1977).

The majority of non-Qataris are nationals from poor, over crowded under-developed countries, for whom material comfort will be a compensation to tolerate stresses of immigration such as split family status and language difficulties. Expatriates here are a selected group, mostly young males who are achievers with a highly competitive psychological make-up.

The native born population showed higher rates compared to immigrants. This is probably explained by the nature of stress locals are facing with modernization and the rapid tempo of social change (Melikian, 1980; Kiev, 1972).

Analysis of first admissions to the Psychiatric Unit during the same period showed similar trends in that, comparatively more Qataris were using the service (El-Akabawi et al., 1982).

Age & Sex (Table 2)

Preponderance of males in the young age group reflects the general characterisitics of the population. The majority of Non-Qataris are young males forming the bulk of the working force. For Qataris, more males than expected were referred. This is probably due to more velnerability of males in the face of stress of social change. Male Qataris are required to play new roles at work for which they are hardly prepared. Male Qataris in the age group 36 – 45 are better equipped to negotiate changing roles and very few of them appear in the sample. This group lived through their identity crises during the pre-oil boom era.

Marital Status

Contrary to most studies, more married males and females were represented, for both Qataris and immigrants (Married, N = 238, 54.3%). For Non-Qataris, this is explained by the over-representation of married males living in Qatar without their families. For Qataris, however, other causes are probably responsible. The practice of polygamy and arranged marriages irrespective of education of females and the exposure of both males and females to nontraditional models of marriage through mass media and travelling create a unique situation. Ambivalence and resentment of the young towards marriage as a social institution make these marriages in most cases essentially non -personal and lacking intimacy. Both partners in such a relationship do actually face added stress, being locked in a bond not fulfilling intimacy or one's self-image (Erickson, 1966).

Occupation (Table 3).

Hollingshead and Redlich (1958) reported that mental illness is associated with lower socio-economic status. Jobless patients (N=52) were exclusively Qataris, which points to independence of loss of job, socio-economic factor and immigrant status. Among Non-Qataris, education as a variable implicit in socio-economic status is probably a protection against breakdown.

TABLE 1

Distribution of Cases

According to Nationality & Rates

Nationality		No.	Percentage	Rate/1000
ARABS	Qataris	199	54.53 %	6.6/1000/Y
	Non-Qataris	154	35.15 %	2.6/1000/Y
ASIANS		82	18.72 %	
OTHERS		3	0.68 %	
Total		438	99.98 %	4.6/1000/Y

TABLE II

Distribution of Cases According to Age and Sex

Age Group	Males No.	Females No.	Total	
0 – 9	10	11	21	
10 – 19	47	33	80	
20 – 29	137	44	181	61 %
30 – 39	60	28	88	
40 – 49	26	12	38	
50 – 59	8	7	15	
60 & above	2	13	15	3.4 %
Total	290	148	438	

TABLT III

Distribution of Cases According to Occupation

	Occupation	No.	%
1	Soldiers	114	26.02
2.	House Wives	97	22.14
3.	White Collars	59	13.48
4.	Students	58	13.24
5.	Labourers	52	11.88
6.	Businessmen	6	1.36
7.	None	52	11.88
	Total	438	100

TABLE IV

Diagnostic Distribution According to sex

Diagnosis	Male	Female	Total
Schizophrenia	26	4	30
Depression	101	66	167
Mania	6	—	6
Organic Psychosis	1	1	1
Anxiety	74	34	10
Hysteria	23	10	33
Obsessive Neurosis	4	1	5
Personality disorder	9	5	14
Alcoholism	10	—	10
Drug dependence	—	2	10
Psychosomatic disorder	—	3	3
Epilepsy	19	16	35
Subnormality	7	6	13
Dementia	—	2	2
Childhood neurosis	2	—	2
Impotence	6	—	6
Total	290	148	438

Diagnoses (Table 4)

More than half of lst attenders were diagnosed depression or anxiety states (N = 275, Depression : N = 167 & Anxiety : N = 108). With reservation about the loose diagnostic label of depression, this finding confirms previous studies in Qatar (El Islam, 1974) and other similar studies in Egypt (Okasha, 1977, Shaheen and Rakhawy, 1971). Most of those patients were usually referred after being under medical care for vague somatic symptoms or indefinite organic diagnoses.

30 patients earned the diagnoses of schizophrenia, of whom only 16 were admitted to hospital. Epilepsy was diagnosed in 35 patients.

CONCLUSION

This study showed that psychiatric morbidity as expressed in terms of first psychiatric consultation rates per 1000 per year in Qatar was low.

The demographic structure of the community, being predominently Non-Qatari males of young age group reflected a generally non-vulnerable population. Analysis of different rates of morbidity among nationalities showed that immigrants had lower rates of reporting psychiatrically sick and when they do a higher ratio of them, than Qataris, were admitted to psychiatric in-patient unit.

Majority of first attenders to the psychiatric clinic suffered from anxiety and/or depressive illness. This confirms previous similar studies in the area and points to a special need for training general practitioners who run the nation-wide primary health care centres in Qatar.

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الموجـــــــز

دراسة اجتماعية ــ ديموجرافية للحالات المحولة للعيـــادة الخارجيـــة النفســـية فى دولة قطر

أجرى الباحثون تحليلا اجتماعيا ــ ديموجرافيا لعدد ٤٣٨ مريضـــا محولين ــ للمرة الأولى ــ للعيادة الخارجية النفسية فى الدوحة ــ قطر خلال ستة أشهر . ووجدوا أن معدل حدوث الاضطرابات النفســـية هو ٣ر٦ : ١٠٠٠ بالنســـبة لمجموع السكان ومعـــدل حدوثها فى القطرين هو ٦ر٦ : ١٠٠٠ ولغير القطريين ٢ر٦ : ١٠٠٠ .

وجد أن معظم المرضى ذكور ومتزوين وتقـــع أعمارهم بين عشرين وتسع وثلاثين عاما . كما وجـــد أن معظم المرضى يعانون من اضطرابات

القلق والاكتئاب ، واستدعت حالة خمس وسبعين مريضا من المجموع الكلى للمرضى الاحالة للقسم الداخلى .

ABSTRIAT

Une Etude Socio-demographique des

Nouveaux referés à la Clinique Psychiatrique á Quatar

Une analyse socio-demographique de 438 nouveaux referés à la clinique psychiatrique à Doha, Quatar, durant une période de six mois, a montré que le taux des premières consultations était de 3.6/ 1000/ année pour la population générale, 6.6 pour les quataris, et 2.6 pour les non-quataris. La plupart des malades étaient des mâles, marriés. dans le groupe d'âge 20–39. Plus que la moitié des malades souffrait de depréssion et d'anxiété. 75 malades du groupe étudié ont été admis dans un département psychiatrique durant la même période.