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Original Article

Primary Health-Care Physicians Attitude toward Depression in Primary Health-Care Centers Saudi Arabia - Al-Ahsa, 2018

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Abstract

Background: Depression is one of the most common mental problems worldwide, 350 million people estimated to be affected by depression. Early recognition and management of depression is valuable, attitude of physicians can be a cornerstone in this process. This is the first study in Al-Ahsa, Saudi Arabia, examining attitude of primary health-care (PHC) physicians attitude toward depression.

Methodology: A cross-sectional study conducted in Al-Ahsa with a target population of 237 doctors who are working in 70 PHC centers in three PHC sectors. A random stratified sample of the target population approached using the validated revised depression attitude questionnaire.

Results: Of 237 targeted population, 168 (70.8%) responded to the questionnaire. Majority of the respondents were agreed with that antidepressant therapy (83.3%) and psychotherapy (79.8%) are effective in the treatment of depression. Few of them (18.5%) were agreed with that the depression is not amenable to change. Board certified and master degree holders were significantly having higher depression attitude than MBBS, and diploma qualified in the aspects of professional confidence therapeutic optimism. Respondents whom received training in mental health have better attitude in the aspects of professional confidence.

Conclusion: Experience side by side to mental health training during pregraduate or postgraduate years is important, as they affect doctors' confidence in dealing with the mental health problems, in general, and depression, in particular. Doctors seeing a large number of patients per day tend to have lower scores in attitude to depression.

Keywords: Al-Ahsa, Attitude, Depression, General practitioners, Primary health-care physicians, Saudi Arabia

INTRODUCTION

Depression is one of the most common mental problems worldwide, 350 million people estimated to be affected by depression.[1] It is characterized by persistence of sad mood and loss of interest in enjoyable activities, associated with inability to do daily work.[2] In addition, people who are suffering from depression may complain of anxiety, loss of energy, sleep disturbance, low concentration, appetite change, feelings of guilt, worthlessness, hopelessness, and thoughts of self-harm or suicide.[2]

Although women are more likely to have depression, all age groups, both sexes, and all races in all countries can be affected by depression, causing a global major health burden.[2] In 17 courtiers, The World Mental Health Survey has been conducted, finding that 1 in 20 person on average reported as having a depression episode in the previous year.[1]

Depression may be converted to a serious health problem when last long, with a moderate-to-severe intensity, it can affect person's function in family, at work, and school.[2] It can even lead to suicide. Depression is the most noticeable

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risk factor for suicide.[3] Every year, 800,000 people die due to suicide, it is the second leading cause of death in 15–29-year-old age group.[2]

In 2008, a report published by the World Health Organization and World Organization of Family Doctors estimated the prevalence of mental health problems presenting in primary health care (PHC) to be as much as 60%.[4] Recognition of these mental health problems is important to reduce patient suffering and decrease wasting of public resources.[4]

<10–50% of patients affected by depression are receiving an effective, sufficient treatment despite its availability in most of the countries worldwide.[2] Lack of trained health-care provider and lack of resources are on the top of the list of barriers to effective care.[2] Other barriers to effective care include social stigma associated with mental disorders and inaccurate assessment.[2]

Objectives

The objectives of this study were as follows:

- To assess the attitude of the PHC physicians toward depression diagnosis.
- To assess the attitude of the PHC physicians toward depression management.
- To rise up recommendations about the attitude of physicians toward depression management.

Rational

Depression is one of the most prevalent diseases worldwide. Recognition and management of depression is very important at the level of PHC setting. Attitude influences the clinicians assessment and responding to the patients. Hence, measuring the attitude of the PHC doctors to depression is important to reach the target of the early recognition and management of depression.

METHODOLOGY

Study Design

The study has been conducted as cross-sectional study.

Study area

The study has been conducted in Al-Ahsa, which is the largest governorate in the Eastern Province of Saudi Arabia.[5] The total number of population in Al-Ahsa reached 1,198,113. There are three PHC sectors; Hofuf sector, Mubarazz, and Omran. The total number of PHC centers in Al-Ahsa is 70.[6]

Study population

Doctors working in the PHC centers are the target population of the study.

Sampling

Sampling method

The sample has been collected as stratified random sample.

Inclusion criteria

The participants of the study were selected from the total population as the following:

- General practitioner (MBBS holder)
- Family physicians (board and diploma certified)
- Doctors covering the general clinics (including antenatal and pediatrics clinics) and chronic diseases clinics.

Exclusion criteria

The following criteria were excluded from the study:

- Interns.
- Doctors under training program.
- Doctors working in the terminal PHC centers (Hujrah).
- Doctors working in the specialized clinics (ENT, ophthalmology, dermatology, and psychiatry clinics).
- Doctors working exclusively in administrative position.
- Doctors working in the laboratory and clinical pharmacist.

Sample size

The total number of population after applying the inclusion and exclusion criteria is 237.

The total sample size, with confidence level of 95%, calculated by the statistician (Moharib Amir) to be as the following: 92 participants; 35 participants from Hofuf sector, 32 participants from Mubarazz sector, and 26 participants from Omran Sector.

Data Collection

Data collection instrument

Data have been collected by a two pages self-administered questionnaire. The first page was about the participant's characteristics as follows:

- Demographic characteristics (age, gender, marital status, nationality, sector, and language).
- Training characteristics (qualifications, local or international MBBS qualification, specialty after MBBS, and mental health training status).
- Practice characteristics (years of experience, number of patients seen per day, and clinic covering usually).

The second page of the questionnaire was the validated revised attitude depression questionnaire (R-DAQ), which developed by Haddad *et al.* The questionnaire is available for the public use as an open access.[7]

R-DAQ is measuring the attitude of the clinicians to depression; it consists of 22 items scale and classified into three parts:

- The first part is professional confidence in depression care.
- The second part concerning therapeutic optimism about depression.
- The third part about physician perspective about depression occurrence, recognition, and management.

Ethical Considerations

1. The investigators applied for the approval of the Ethics Committee in the General Directorate of Health Affairs, Al-Hasa, and an official approval letter received.
2. The investigators obtained an informed consent from each participant and clearly explained the aim of research.
3. All data were anonymous.

Resources and Workforce

1. Three doctors needed as investigators.
2. Financial recourses not required, the study was self-sponsored.

RESULTS

Respondents Characteristics Demographics, Training, and Practice

A total of 168 (70.8%) of the PHC doctors returned the questioner, 52 (31%) of them were from Hofuf sector, 71 (42.3%) from Mubarazz sector, and 54 (26.8%) from Omran sector [Table 1]. The mean age of the respondents who returned the questioner was 34.9 (SD = 7.76, range 26–60). The male respondents account for 102 (60.7%) and the female respondents account for 66 (39.3%), 147 (87.5%) of the respondents were married. Saudi respondents were 116 (69%), while non-Saudi were 52 (31%) [Table 1].

The mean of the years of the experience of the respondents was 9.38 (SD = 8.23, range 1–37). Respondents speaking Arabic only were 3 (1.8%), English speaker were only 2 (1.2%), while most of them were speaking both Arabic and English (97%). Bachelor (MBBS) qualified were 125 (74.4%) of total respondents, 92 (54.8%) of them did their MBBS inside Saudi Arabia, while 76 (45.2%) outside Saudi Arabia. Diploma qualified were 34 (20.2%) of the total respondents, and 10 (5.9%) were board certified [Table 1].

Doctors covering the general clinic were 53 (31.5%) of the respondents, 18 (10.7%) covering chronic disease clinic, 16 (9.5%) covering pediatric clinic, 14 (8.3%) covering antenatal care clinic, and 67 (39.9%) were covering all clinics [Table 1].

Table 1: Characteristics of survey participants (*n*=168)

Variables	Frequency (%)
Age	
(Min, Max)	(26, 60)
Mean, SD	34.91, 7.767
Years of experience	
(Min, Max)	(1, 37)
Mean, SD	9.38, 8.229
Gender	
Female	66 (39.3)
Male	102 (60.7)
Marital status	
Divorced	1 (0.6)
Married	147 (87.5)
Single	20 (11.9)
Nationality	
Non-Saudi	52 (31)
Saudi	116 (69)
Language	
Arabic only	3 (1.8)
Both Arabic and English	163 (97)
English only	2 (1.2)
Sector	
Hofuf	52 (31)
Mubarazz	71 (42.3)
Omran	45 (26.8)
Qualification	
Board	9 (5.4)
Diploma	27 (16.1)
Fellowship	1 (0.6)
Master	6 (3.6)
MBBS	125 (74.4)
Pediatrics	1 (0.6)
Where did you do your MBBS?	
Inside Saudi Arabia	92 (54.8)
Outside Saudi Arabia	76 (45.2)
Which clinics do you covering in usual?	
All of them	67 (39.9)
Antenatal	14 (8.3)
Chronic disease	18 (10.7)
General	53 (31.5)
Pediatrics	16 (9.5)
Did you receive any training in mental health before?	
Yes	80 (47.6)
Average number of patients/day	
20–29	17 (10.1)
30–39	29 (17.3)
40–49	46 (27.4)
50–59	27 (16.1)
60–69	27 (16.1)
70 or more	17 (10.1)
<20	5 (3)
Years of experience	
<5 years	59 (35.1)
5–10 years	52 (31)
11–15 years	24 (14.3)
>15 years	31 (18.5)

Doctors whom seeing 42–69 patients daily were 100 (59.5%), 46 (27.38%) were seeing 22–39 patients daily, and 17 (10.1%) were seeing 70 patients or more per day [Table 1].

Around half of the respondents (47.6%) received training in mental health. Moreover, 52.4% did not receive mental health training [Table 1].

Attitudes to Depression

Most participants considered depression as it is due to a lack of willpower (64.3%) or poor stamina (56.5%), and 36.3% agreed that it was a natural part of growing old [Table 2].

Majority of the respondents were agreed with that antidepressant therapy (83.3%) and psychotherapy (79.8%) are effective in the treatment of depression. Few of them (18.5%) were agreed with that the depression is not amenable to change.

"All health professionals should have skills in recognizing and managing the depression" was an attractive sentence, 88.7% of the respondents endorsed it. Most respondents (87.5%) were strongly agreed with the importance of recognizing and managing depression is related to the other health problems. Among the PHC physicians, 87.5% of the

Table 2: Number of agreement, percent (%), mean, SD, and direction values for each question (without reverse scoring)

Question number without reverse	Number in agreement (%) (*n*=168)	Mean±SD	Direction
Professional confidence in depression care			
19 It is rewarding to spend time looking after depressed patients	113 (67.3)	3.71±0.878	Agree
8 I am more comfortable working with physical illness than with mental illnesses like depression	96 (57.1)	3.53±1.158	Agree
7 I feel confident in assessing depression in patients	102 (60.7)	3.51±1.067	Agree
1 I feel comfortable in dealing with depressed patients' needs	80 (47.6)	3.34±1.002	Neither disagree nor agree
11 My profession is well placed to assist patients with depression	78 (46.4)	3.24±1.069	Neither disagree nor agree
17 I feel confident in assessing suicide risk in patients presenting with depression	66 (39.3)	3.15±1.048	Neither disagree nor agree
15 My profession is well trained to assist patients with depression	70 (41.7)	3.09±1.104	Neither disagree nor agree
Therapeutic optimism/pessimism about depression			
5 One of the main causes of depression is a lack of self-discipline and willpower	108 (64.3)	3.63±0.971	Agree
12 Becoming depressed is a way that people with poor stamina deal with life difficulties	95 (56.5)	3.41±0.962	Agree
9 Becoming depressed is a natural part of being old	61 (36.3)	2.9±1.133	Neither disagree nor agree
6 Depression treatments medicalize unhappiness	32 (19)	2.73±0.912	Neither disagree nor agree
21 There is little to be offered to depressed patients who do not respond to initial treatments	48 (28.6)	2.71±1.096	Neither disagree nor agree
13 Once a person has made up their mind about taking their own life no one can stop them	34 (20.2)	2.6±1.039	Neither disagree nor agree
18 Depression reflects a response which is not amenable to change	31 (18.5)	2.57±0.977	Disagree
20 Becoming depressed is a natural part of adolescence	42 (25)	2.57±1.124	Disagree
3 Psychological therapy tends to be unsuccessful with people who are depressed	11 (6.5)	1.99±0.869	Disagree
4 Antidepressant therapy tends to be unsuccessful with people who are depressed	14 (8.3)	1.84±0.898	Disagree
Generalist perspective about depression occurrence, recognition, and management			
10 All health professionals should have skills in recognizing and managing depression	149 (88.7)	4.31±0.935	Strongly agree
16 Recognizing and managing depression is often an important part of managing other health problems	147 (87.5)	4.27±0.932	Strongly agree
14 People with depression have care needs similar to other medical conditions such as diabetes, chronic obstructive pulmonary disease, or arthritis	133 (79.2)	4.06±1.114	Agree
2 Depression is a disease like any other (e.g., asthma and diabetes)	128 (76.2)	3.95±1.144	Agree
22 Anyone can suffer from depression	147 (87.5)	4.18±0.981	Agree

Table 3: Difference between Saudi and Non-Saudi in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	Non-Saudi (*n*=52)	Saudi (*n*=116)	Independent sample *t*-test (Nationality)	
	Mean (SD)	Mean (SD)	*t*	*P*-value
Professional confidence	3.465 (0.894)	3.176 (0.721)	2.228	0.027
Therapeutic optimism	3.823 (0.635)	3.595 (0.533)	2.416	0.017
Generalist perspective	4.358 (0.712)	4.06 (0.76)	2.391	0.018
Total R-DAQ (22 items)	3.605 (0.435)	3.408 (0.308)	2.946	0.004

R-DAQ: Revised depression attitude questionnaire

sample agreed with the concept that anyone could suffer from depression [Table 2].

Professional confidence in the management of depression was variable; more than half of the respondents (60.7%) were feeling confident in assessing depression in patient, but only 39.3% were confident in assessing suicidal risk in depressed patient [Table 2].

Although two-third (67.3%) of doctors were agree that it is rewarding to spend time looking after depressed patients, more than half (57.1%) of them were feeling comfortable in dealing with physical rather than mental health problems [Table 2].

Nearly half of the PHC physicians were agreed with that their profession is well placed (46.4%) or well trained (41.7%) to assist patients with depression [Table 2].

Relationship between Depression Attitudes and Respondent Characteristics

There was no significant association between gender, marital status, or spoken language [Table 4] and attitude scores measured by R-DAQ subscales. However, there was a significant difference between Saudi and non-Saudi physician. Non-Saudi physicians tend to have higher levels of attitude to depression than Saudi in the aspect of professional confidence ($t = 2.228$, $P = 0.027$), therapeutic optimism ($t = 2.416$, $P = 0.017$), generalist perspective ($t = 2.391$, $P = 0.018$), and total R-DAQ (22 items) ($t = 2.946$, $P = 0.004$) [Table 3].

There was significant difference between the three PHC sectors ($f = 4.535$, $P = 0.012$) in the aspect of generalist perspective [Figure 1]. Doctors working in Hofuf and Mubarazz sectors got higher depression attitudes in generalist perspective than those working in Omran sector [Table 8]. Board certified and master degree holders were significantly having higher depression attitude than MBBS, and diploma qualified in the aspects of professional confidence ($f = 5.973$, $P = 0.001$), therapeutic optimism ($f = 3.48$, $P = 0.017$), and R-DAQ 22 items ($f = 10.836$, $P = 0.001$). In the aspect of generalist perspective, board-certified doctors were got higher score ($f = 4.847$, $P = 0.003$) than MBBS, diploma, and master holders [Table 6].

Physicians whom did their MBBS outside Saudi Arabia have higher depression attitude ($t = -2.112$, $P = 0.036$) than those whom did it inside [Table 7]. In the aspect of general perspective, physicians covering the chronic disease

Table 4: Difference between languages in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	One-way ANOVA (language)	
	f	*P*-value
Professional confidence	0.463	0.63
Therapeutic optimism	0.034	0.967
Generalist perspective	0.144	0.866
Total R-DAQ (22 items)	0.068	0.935

R-DAQ: Revised depression attitude questionnaire

Table 5: Difference between sectors in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	One-way ANOVA (sector)	
	f	*P*-value
Professional confidence	1.03	0.359
Therapeutic optimism	0.221	0.802
Generalist perspective	4.535	0.012
Total R-DAQ (22 items)	2.17	0.117

R-DAQ: Revised depression attitude questionnaire

Table 6: Difference between qualification types in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	One-way ANOVA (Qualification)	
	f	*P*-value
Professional confidence	5.973	0.001
Therapeutic optimism	3.48	0.017
Generalist perspective	4.847	0.003
Total R-DAQ (22 items)	10.836	0.001

R-DAQ: Revised depression attitude questionnaire

Table 7: Difference between MBBS source in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	Inside Saudi Arabia (*n*=92)	Outside Saudi Arabia (*n*=67)	Independent sample *t*-test (Where did you do your MBBS)	
	Mean (SD)	Mean (SD)	*t*	*P*-value
Professional confidence	3.15 (0.694)	3.405 (0.872)	−2.112	0.036
Therapeutic optimism	3.611 (0.525)	3.732 (0.626)	−1.359	0.176
Generalist perspective	4.12 (0.666)	4.192 (0.855)	−0.618	0.537
Total R-DAQ (22 items)	3.419 (0.292)	3.531 (0.427)	−1.944	0.054

R-DAQ: Revised depression attitude questionnaire

Table 8: Difference between clinics covering in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	One-way ANOVA (Which clinics do you covering in usual?)	
	f	*P*-value
Professional confidence	3.518	0.009
Therapeutic optimism	2.121	0.08
Generalist perspective	3.095	0.017
Total R-DAQ (22 items)	0.805	0.524

R-DAQ: Revised depression attitude questionnaire

clinic and antenatal care clinic ($f = 3.095$, $P = 0.017$) got higher attitude score than other physician covering general clinic, pediatric clinic, or all clinics [Figure 2]. However, doctors in CDC ($f = 3.518$, $P = 0.009$) scored better in the aspect of the professional confidence than the others [Table 11] [Figure 3].

Respondents whom received training in mental health (continuing medical education, courses, and lectures) have better attitude in the aspects of professional confidence ($t = -3.174$, $P = 0.002$) and total R-DAQ ($t = -2.711$, $P = 0.007$) [Table 9]. The number of patients seen by the doctor per day was associated with the attitude of doctors to depression; doctors seeing <70 patients per day had higher score in the aspect of therapeutic optimism ($f = 3.352$, $P = 0.004$) [Table 10] [Figure 4].

More years of experience were associated with better attitude to the depression, the group of physicians with

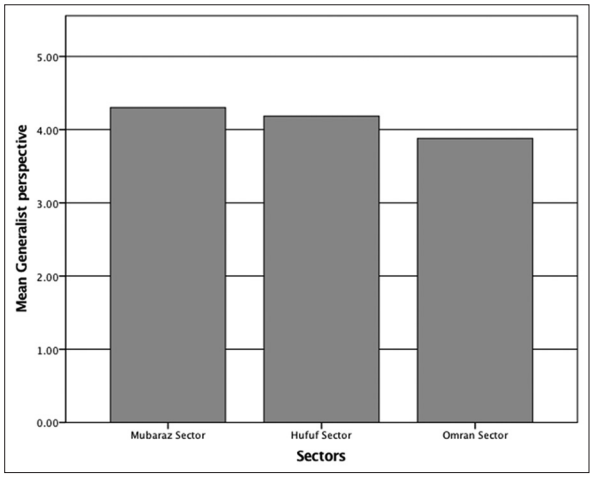

Figure 1: Generalist perspective among sectors

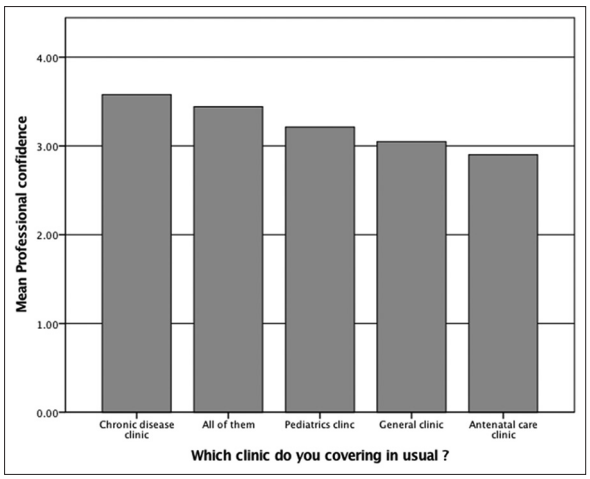

Figure 3: Mean of professional confidence among different clinics' types

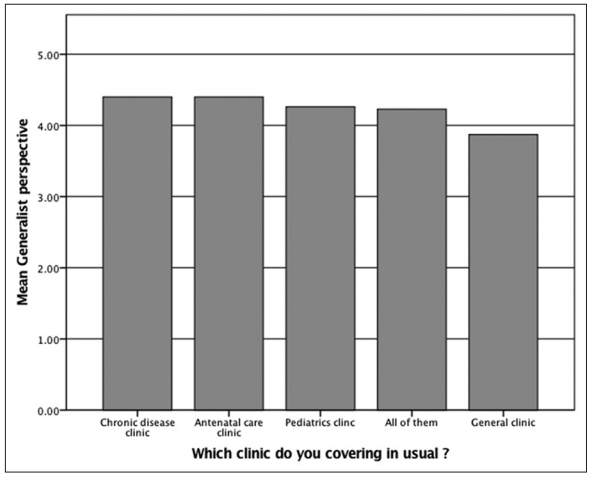

Figure 2: Mean of generalist perspective among different clinics' types

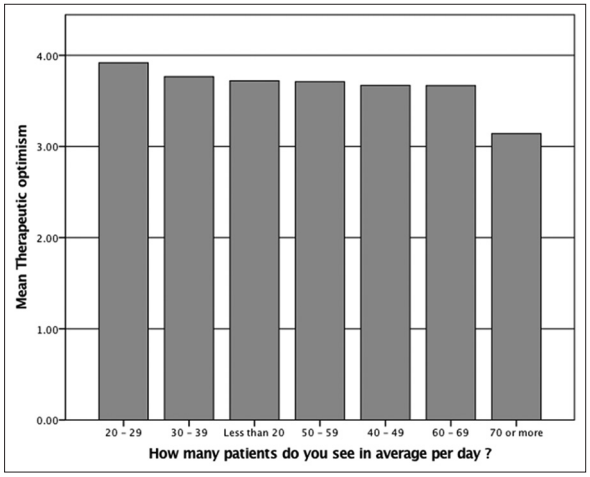

Figure 4: Mean of therapeutic optimism among different ranges of number of patients seen per day

Table 9: Difference between mental health training statuses in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	No (*n*=88)	Yes (*n*=80)	Independent sample *t*-test (Did you receive any training in mental health before?)	
	Mean (SD)	Mean (SD)	*t*	*P*-value
Professional confidence	3.086 (0.803)	3.463 (0.726)	−3.174	0.002
Therapeutic optimism	3.632 (0.598)	3.703 (0.548)	−0.796	0.427
Generalist perspective	4.182 (0.669)	4.12 (0.844)	0.528	0.598
Total R-DAQ (22 items)	3.398 (0.325)	3.547 (0.386)	−2.711	0.007

R-DAQ: Revised depression attitude questionnaire, SD: Standard deviation

experience of 11–15 years has more depression attitude in the aspect of R-DAQ ($f = 3.878$, $P = 0.01$) than the rest [Table 11] [Figure 5].

DISCUSSION

Main Findings

Most respondents were speaking both Arabic and English as the first and second language. That is, why language barrier did not affect the physicians' attitude.

Physicians with more years of experience expected to be exposed to more training in mental health than younger physicians. Among respondents, mental health training, age, and years of experience were associated with a positive attitude to depression.

Doctors dealing with chronic diseases patients were more confidants in dealing with depressed patients than others. May be because of the high prevalence of depression among old and chronic disease patients.

Table 10: Difference between numbers of patients seen daily in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	One-way ANOVA (How many patients do you see in an average per day?)	
	f	*P*-value
Professional confidence	0.588	0.74
Therapeutic optimism	3.352	0.004
Generalist perspective	0.194	0.978
Total R-DAQ (22 items)	0.472	0.829

R-DAQ: Revised depression attitude questionnaire

Table 11: Difference between years of experience in depression attitude (R-DAQ)

Depression attitudes (R-DAQ)	One-way ANOVA (years of experience)	
	f	*P*-value
Professional confidence	2.11	0.101
Therapeutic optimism	2.231	0.087
Generalist perspective	2.247	0.085
Total R-DAQ (22 items)	3.878	0.01

R-DAQ: Revised depression attitude questionnaire

The higher number of patients seen per day affects attitude of physician in their therapeutic optimism negatively, as the consultation time is limited in busy clinics.

As expected, post-graduated physicians had more positive attitude to depression than MBBS holder. Though, non-Saudi respondents and those who did their MBBS abroad had a better attitude to depression.

Regression

The most important variables affecting the professional confidence model were training in mental health, nationality, and age, respectively [Table 12].

Therapeutic optimism model was affected more by MBBS qualification source, then qualification after MBBS [Table 13].

Years of experience, qualification grade, and clinic where the physicians cover were the most important variables affecting general perspective model [Table 14].

Nationality, mental health training, and age of the respondents affected R-DAQ model more [Table 15].

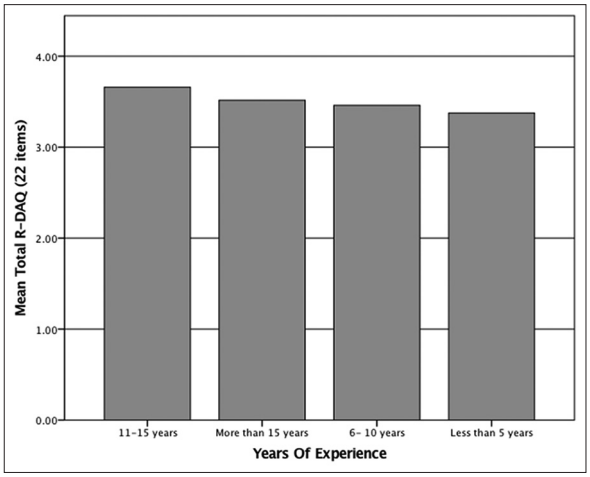

Figure 5: Mean of total revised depression attitude questionnaire (22-items) among different ranges of the years of experience

Table 12: Linear regression (professional confidence model)

Model: Professional confidence	Unstandardized coefficients		Standardized coefficients	*t*	Significant
	B	SE	Beta		
(Constant)	4.559	0.855		5.333	0.000
Mental health training	0.712	0.193	0.396	3.692	0.000
Nationality	−0.861	0.244	−0.491	−3.521	0.001
Age	−0.028	0.014	−0.289	−2.084	0.041

SE: Standard error

Table 13: Linear regression (therapeutic optimism model)

Model: Therapeutic optimism	Unstandardized coefficients		Standardized coefficients	*t*	Significant
	B	Standard error	Beta		
(Constant)	3.209	0.226		14.192	0.000
MBBS source	0.485	0.138	0.409	3.506	0.001
Qualification after MBBS	−0.091	0.039	−0.272	−2.331	0.023

Table 14: Linear regression (generalist perspective model)

Model: Generalist perspective	Unstandardized coefficients		Standardized coefficients	*t*	Significant
	B	Standard error	Beta		
(Constant)	4.539	0.400		11.344	0.000
Years of Experience	0.236	0.088	0.299	2.678	0.009
Qualification	−0.160	0.062	−0.285	−2.556	0.013
Which clinics do you covering in usual?	−0.154	0.068	−0.238	−2.264	0.027

Table 15: Linear regression (R-DAQ - 22 items model)

Model: R-DAQ (22 items)	Unstandardized coefficients		Standardized coefficients	*t*	Significant
	B	Standard error	Beta		
(Constant)	4.547	0.371		12.245	0.000
Nationality	−0.450	0.112	−0.567	−4.030	0.000
Mental health training	0.164	0.086	0.201	1.915	0.060
Age	−0.027	0.009	−0.594	−3.055	0.003
Years of experience	0.146	0.071	0.415	2.067	0.043

R-DAQ: Revised depression attitude questionnaire

Strength and Weakness

Participants' selection approach was seeking the involvement of all doctors working in PHC centers whom meet the inclusion criteria. All PHC centers (70 centers) in the three PHC sectors in Al-Ahsa were involved in the stratified sample, >2–3rd (70.8%) of the target population responded to the questionnaire. This high percentage of response assures the generalization of the results to the target population.

This study is the first one using R-DAQ instrument to measure the attitude of doctors to depression in Saudi Arabia. Although it is validated, and used in more than one study in the United Kingdom and Pakistan, the different culture and language in Saudi Arabia may be a limitation.

>1 study in more than one country used the R-DAQ and the previous version DAQ. Using the same questionnaire used in all these studies conducted among different cultures, make this study comparable to the previous and future studies in this field.

Exclusion of the terminal PHC centers (Hejrah) was because difficulties in transportation and communication. The number of doctors working in these PHC centers was small.

Implications and Recommendations

The finding that PHC physicians in Al-Ahsa who have more training in mental health got more positive attitude to depression, make this study ends with a clear recommendation for more training in mental health for doctors working in PHC, as the training will change their attitude to depression in a positive way, and may help a bigger number of patients to seek the medical advice at the level of PHC rather than mental hospitals to avoid the stigma associated with mental illnesses.

Researches in the field of knowledge, attitudes, or practice of physicians toward depression are needed to help in raising more clear recommendations to health policy-makers, universities, and any organization interested in the training of the doctors.

CONCLUSION

This study has been conducted to explore the possible associations between the characteristics of PHC physicians and their attitude to depression.

Experience side by side to mental health training during pregraduate or postgraduate years is important, as they affect doctors' confidence in dealing with the mental health problems, in general, and depression, in particular.

Doctors seeing a large number of patients per day tend to have lower scores in attitude to depression. More actions are needed to reduce the number of patients seen per day.

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