Psychiatric Morbidity among Housemaids in Kuwait

a. Prevalence of Psychiatric Disorders in the Hospitalized Group of Housemaids

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Key Words

Housemaids · Migration · Immigrants · Psychiatric morbidity, prevalence

Abstract

Objectives: To determine the first hospital admission rates and the nature of psychiatric disorders among housemaids and compare them with the Kuwaiti female patients. **Subjects and Methods:** Based on the *International Classification of Diseases* (10th revision; ICD-10) symptom checklist, a semi-structured interview was administered to all the housemaids and the Kuwaiti female patients hospitalized during the 2-year study period. **Results:** The hospital admission rates were 1.86 times higher in housemaids than in the Kuwaiti female patients and the nature of psychiatric disorders was also different in the two groups. The stress-related disorders were more common among housemaids while schizophrenia was the commonest disorder among Kuwaiti patients. Duration of hospital stay was significantly shorter for housemaids, and four fifths of them were repatriated on mental health grounds. **Conclusions:** The psychiatric morbidity is higher among housemaids than Kuwaiti females and a substantial number of them are prematurely repatriated

on health grounds. Further studies are needed to explore the possible pre-immigration risk, and post-immigration precipitating factors, to prevent this 'expatriate failure'.

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Introduction

There is a large body of literature relating mental health levels to immigration. Numerous studies have identified immigration as a potential risk factor for the development of psychiatric disorders [1, 2]. Higher rates of psychiatric morbidity among immigrants are common but not universal. Some workers have failed to show any relationship between migration and mental health [3, 4] while others have found psychiatric morbidity to be lower among immigrants than the host population [5, 6]. This discrepancy in the findings has highlighted a number of methodological difficulties including use of differing assessment procedures, factors surrounding migration, and cross-cultural comparisons between immigrants and the host population [7, 8]. Since some groups have high rates, but others do not, the question arises which subgroups of immigrants and, under what circumstances, have high rates of psychiatric morbidity. As Rack [8] has rightly

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pointed out, it is naive to construct any general hypotheses about 'migrants' as if they were a unitary category. The differing ethnic groups studied have included subjects with diverse socio-economic and occupational backgrounds. Most of the studies have been carried out on refugees [9] or on immigrants [8, 10], defined in general terms, as individuals leaving home for better job/education opportunities/living standards [11]. Foreign housemaids are a relatively homogeneous immigrant subgroup in terms of their gender, ethnicity, socio-economic status, and defined nature of their occupation.

The number of housemaids in Kuwait has progressively increased from 19,552 in 1980 to 140,000 in 1998 [12]. The housemaids, mainly from Sri Lanka, India, Philippines, and Bangladesh, come from lower socio-economic backgrounds and the main aim of their coming to Kuwait is to improve their income. They come on 2-year contracts, renewable upon mutual agreement between the housemaids and the employer. The average monthly salary of a housemaid varies from US\$ 120 to 150 (KD 40 to 50) for 64 h of work per week in a household with an average of 2.8 children [13]. In addition to the salary, the employer is usually required to provide the airfare and board and lodging facilities. When a housemaid becomes psychiatrically disturbed, the employer usually takes her to the local recruiting agency office, the general practitioner, or emergency department of a general hospital. Depending upon the nature and degree of her behavioural disturbance, the housemaid is either given symptomatic treatment or referred to the Psychiatric Hospital for further assessment and management. The Psychiatric Hospital, the only facility of its kind in the country, serves the whole of its population of 2.2 million [14]. It was established in 1958 and has more than 400 beds. Apart from running a 24-hour emergency service, the hospital provides outpatient clinics on all 5 weekdays.

El-Hilu et al. [15] in a previous study on the subject, conducted at the same place during the 3-year period from 1982 to 1984, found the hospital admission rates to be 5 times higher for the housemaids than the Kuwaiti female patients [15]. They used the diagnostic criteria of the *International Classification of Diseases*, 9th revision (ICD-9) [16] and found that 'Acute situational disturbance' (25.3%), 'Schizophrenia' (10.1%), and 'Conversion hysteria' (7.6%) were the commonest disorders among them. 'Stress-related disorders' (Acute situational disturbance) were reported to be significantly higher among housemaids while 'Depressive illness' and 'Organic psychosis' were significantly higher among the Kuwaiti female patients. This study was based on the hospi-

tal diagnoses retrieved through retrospective review of the case-notes.

We decided to determine the prevalence and the nature of psychiatric morbidity among housemaids and to investigate the possible predisposing and precipitating factors leading to the higher, if any, rates of mental disorders among this subgroup of immigrants. This paper describes the prevalence, as suggested by their first hospital admission rates, of psychiatric disorders among the housemaids, and compares them with Kuwaiti females hospitalized during the same period. The role of predisposing and precipitating factors has been discussed elsewhere [17, 18].

Subjects and Methods

Sampling

A formal approval of the consent form was obtained from the ethical committee. The sample consisted of all the consenting housemaids hospitalized for the first time during the 2-year study period. All the Kuwaiti female patients admitted for the first time during the same period served as controls.

Procedures

All the newly admitted housemaids and the Kuwaiti female patients were assessed by the co-authors (M.A.R., M.M.A.M., A.A.S.), trained psychiatrists, each with well over 10 years experience in psychiatry. The psychiatric assessment was based on semi-structured interview, derived from the ICD-10 symptom checklist [19]. The interview has been found to be a reliable diagnostic tool (overall kappa 0.72). It allows the clinician to rephrase symptom questions according to the level of respondent's education and intelligence. In view of the varied ethnic background and the lower socio-economic status of the housemaids, the authors found the instrument to be especially useful because, by exploring and rephrasing the questions, they were able to confirm the clinical relevance of the responses in relation to the respective diagnostic category and also exclude the associated conditions, as stated in the ICD-10 [20]. Figures from the *Annual Statistical Abstract* [14], an annual official publication containing census data, were used as the denominator to calculate the first hospital admission rates among the housemaids and Kuwaiti and non-Kuwaiti females.

Measures

In addition to the psychiatric diagnoses assigned to the two groups of patients, information obtained about the housemaids included their age, ethnic origin, marital status, duration of stay in Kuwait, duration of hospital stay, and the mode of discharge from the hospital. The measures recorded about the Kuwaiti female patients included their age and the duration of hospital stay.

Statistical Analysis

The data was analyzed on Statistical Package for Social Sciences (SPSS, version 8). Two proportions variance, between the diagnoses of the hospitalized and the control group, was calculated with Z test.

Table 1. Characteristics of the sample

Age, years	range 15–50	mean 29.92	SD 6.99	
Nationality	Sri Lankan 105 (53.3%)	Indian 46 (23.4%)	Philipino 32 (16.2%)	others 13 (6.4%)
Marital status	single 65 (33%)	married 125 (63.5%)	widowed 4 (2%)	divorced 2 (1%)
Education, years	illiterate 52 (26.4%)	1–4 years 79 (40.1%)	5–9 years 51 (25.9%)	10 > years 14 (7.1%)
Duration of stay in hospital, days	1–14 64 (32.5%)	15–30 50 (25.4%)	31–60 45 (22.8%)	61 17 (8.6%)
Duration of stay in Kuwait, days	1–30 55 (27.9%)	31–60 26 (13.2%)	61–180 36 (18.3%)	181 80 (40.6%)
Religion	Muslim 41 (20.8%)	non-Muslim 154 (78.2%)		

Results

A total number of 197 housemaids against 157 Kuwaiti females were hospitalized during the 2-year study period (table 1). More than half of them were Sri Lankan and just less than one quarter were Indians. About one third of the housemaids were single and just under two thirds were married. More than a quarter ($n = 55$) broke down within 1 month of their arrival, 19 breaking down within the 1st and another 13 during the 2nd week, while more than a half ($n = 100$) were hospitalized within the first 3 months of their arrival. Eighty-one percent (160 out of 195) of the housemaids were deported, directly from hospital, back to their respective countries while the remaining 19% ($n = 37$) were discharged back to the care of the employer. Just over half of the housemaids ($n = 103$) were able to communicate in either English or Arabic and in 94 (47.7%), help of an interpreter was needed for assessment.

Comparison with the Control Group

Duration of Hospital Stay

The duration of hospital stay of the Kuwaiti patients was significantly higher than that of the housemaids (table 2).

Psychiatric Diagnoses

Reaction to severe stress, including ‘Acute stress reaction’ and ‘Adjustment disorder’, accounted for almost half (49.2%) of the diagnoses (table 2) among the housemaids. ‘Manic episode’, ‘Depressive episode’, and ‘Acute

and transient psychotic disorder’ were other common disorders and together with ‘Reaction to severe stress’ constituted 94.3% of all the diagnoses.

‘Reaction to severe stress’ was significantly higher among the housemaids. None of the housemaids was diagnosed as schizophrenic (the commonest diagnostic category among the Kuwaiti patients) while none of the Kuwaiti patients was diagnosed as ‘Acute and transient psychotic disorder’ (the fourth commonest diagnostic category among the housemaids).

The average number of Kuwaiti and non-Kuwaiti female residents (15 years and above) living in the community during the study period were 225,200 and 212,475, respectively [14]. The average number of housemaids during the same period was 151,570 [12]. Since the study was conducted over a 2-year period, the numbers were doubled to determine the annual rates of the psychiatric disorders. First hospital admission rates of housemaids were 1.86 times higher than those of Kuwaiti females and 2.12 times higher than those of non-Kuwaiti females (table 3). Overall, housemaids constituted 40.7% of all the first female hospital admissions.

Discussion

Results of our study suggest higher rates of hospital admission, differing patterns of psychiatric diagnoses, and shorter duration of hospital stay among the housemaids than the native-born Kuwaiti female patients. It is possible that some Kuwaiti female patients might have been hospitalized abroad for psychiatric treatment there-

Table 2. Comparison of age, duration of hospital stay, and psychiatric diagnoses between the housemaids and the Kuwaiti females

Characteristics	Housemaids		Kuwaiti females	
Age, years				
Range	15–50		15–51	
Mean	29.92		29.03	
SD	6.99		10.6	
Duration of hospital stay, days ¹				
Range	1–124		1–252	
Mean	26.88		41.36	
SD	22.14		51.02	
Psychiatric diagnoses	n	%	n	%
Reaction to severe stress ²	97	49.2	35	22.3
Manic episode	32	16.2	21	13.4
Depressive episode	30	15.2	32	20.2
Acute and transient psychotic disorder	27	13.7	–	–
Dissociative disorder	7	3.6	–	–
Recurrent depressive disorder	2	1.0	–	–
Bipolar affective disorder	1	0.5	–	–
Epilepsy	1	0.5	–	–
Schizophrenia	–	–	42	26.8
Mental retardation	–	–	8	6.4
Multiple drug use	–	–	5	3.2
Personality disorders	–	–	4	2.5
Others ³	–	–	12	7.5
Total	197	100	157	100

¹ ANOVA, $p < 0.01$ ($F = 11.719$).

² $p < 0.5$ (Z value = 2.768).

³ Include opioid abuse, anxiety disorders, sexual dysfunction (2 each); dementia, organic personality disorder, unspecified organic mental disorder, and transient delusional disorder (1 each).

by underestimating the rates of psychiatric morbidity amongst them. The psychiatric services have been upgraded in Kuwait, especially during the last decade. New inpatient psychiatric and substance abuse facilities have been made available and rehabilitation programmes have been started. In keeping with these developments, the number of Kuwaiti female psychiatric patients seeking inpatient treatment abroad has fallen considerably in recent years.

Comparison of Diagnoses between Housemaids and Controls

The stress-related disorders were significantly more common (49.2 vs. 22.3%) in the housemaids than the Kuwaiti female patients. A variety of stressors surrounding migration of the housemaids contribute to this finding. The housemaids come from a low socio-economic

Table 3. Comparison of first admission rates between housemaids, non-Kuwaiti females, and Kuwaiti females

Patient group	Number of admissions (1997–1998)	Mid-year population (1997–1998)	Rates (per 10,000)
Housemaids	197	303,140	6.49
Non-Kuwaiti females	130	424,950	3.05
Kuwaiti females	157	450,400	3.48

background and the main aim of coming to Kuwait is to improve their income. The act of migration itself implies separation from families and friends and exposure to unfamiliar culture. The vast majority of housemaids have never been abroad before. Almost none of them can

understand Arabic and many of them have little or no knowledge of English (second language in Kuwait). In our sample, just under half of them could not communicate at all, either in Arabic or in English, and the help of an interpreter had to be sought for their assessment. Schizophrenia, the commonest disorder in the Kuwaiti female patients, was conspicuously absent among the housemaids. The authors believe that some of the patients diagnosed as 'Acute and transient psychotic disorder', the fourth commonest diagnosis, may have been schizophrenic. The ICD-10 diagnostic system requires 1-month duration of symptoms, but the average duration of hospital stay of our patients was 26 days. Many of our acutely disturbed patients, following symptomatic control and, upon their own or employer's request, were deported back to their countries. In fact, about one third of them were discharged within 2 weeks and another one fourth within the next 2 weeks. Moreover, the accuracy of psychiatric diagnoses rests on phenomenological elaboration of the underlying psychopathology. The psychiatric assessment of just less than one half of our patients was based on interpreter-based interviews and behavioural disturbances as observed during their hospital stay. Diagnostic bias due to misinterpretation of the clinical manifestations in some of our patients, therefore, is possible.

Comparison with the Previous Study

Firstly, El-Hilu et al. [15] reported the first admission rates to be 5 times (against 1.86 times in our study) higher in the housemaids than in the Kuwaiti female patients. The total number of housemaids working in Kuwait was much smaller at the time. The number of housemaids has since grown more than threefold (from 46,247 in 1985 to 151,570 during 1997–1998). The Psychiatric Hospital, with just over 450 beds, remains the only facility of its kind in Kuwait. It is, therefore, possible that only patients with grossly abnormal behaviour and more serious 'psychotic' symptoms were hospitalized during our study period. This observation is supported by the fact that 81% of our patients (against 25% reported in the earlier study) were deported, directly from hospital, back to their respective countries, indicating severity of their illnesses. If the housemaids had a relatively less severe psychiatric disturbance, they would usually be discharged from hospital to resume their work. However, if they developed a major psychotic illness, they would usually be sent back to their countries of origin. This is because the employing families are not prepared to 'assume responsibility' and take the risk of having a person with grossly disturbed and/or suicidal behaviour in their homes nor 'entrust' that

person with the responsibility of taking care, for example, of their young children.

Secondly, although the 'Stress-related disorders' (Acute situational disturbance) were reported to be significantly higher among housemaids, the 'Depressive illness' and 'Organic psychosis' were found to be significantly higher among the Kuwaiti females. It is difficult to draw diagnostic comparisons between the two groups because of the differing methodology and the diagnostic systems used in them. The relative excess of disorders attributable to stress in our study may be explained by the more elaborate description and the wider spectrum of clinical manifestations included in the 'Stress-related disorders' category in the ICD-10 as compared to the corresponding 'Acute situational disturbance' in the ICD-9. The relatively premature discharge of housemaids in our sample, as remarked earlier, may partly explain the notable absence of 'Schizophrenia' diagnosis among our patients, which was the second commonest diagnosis reported in the previous study.

Hospital Stay of Housemaids Compared to Controls

The shorter hospitalization time among housemaids than the Kuwaiti females is interesting. The reason for this finding could be that the housemaids have less severe illnesses than the Kuwaiti females. The commonest disorder among housemaids was the 'Severe reaction to stress', especially the 'Acute stress reaction', with relatively self-limiting, benign course while the most common disorder among Kuwaiti females was bipolar affective disorder with relatively longer course duration. This also applies to the 'Acute and transient psychotic disorder' in the housemaids against 'Schizophrenia' in the Kuwaiti female patients. Another possible explanation may be the 'premature' discharge of the housemaids in the form of repatriation once the acute manifestations had subsided. Many housemaids felt extremely frustrated on having to be hospitalized, especially soon after their arrival in the country. Overridden by home sickness, they insisted on an early repatriation back to their families. Similarly, alarmed by the disturbed behaviour of the housemaids during the acute phase of their illness, the employing family and the agency responsible for their migration no longer regarded them capable of fulfilling their contractual obligations, at least in the foreseeable future. Early repatriation, therefore, presented the most amicable resolution; bringing an end to the maid's ordeal on the one hand and acquisition of a substitute maid by the employer, on the other. Lastly, as documented in the previous studies [21, 22], in some cases the housemaids may well have been undertreated.

Finally, the authors would like to mention some of the shortcomings of the study. Just under half of the housemaids were interviewed with the help of a nurse interpreter, which may have, in some cases, resulted in misdiagnosis due to linguistic interpretation errors. Similarly, our poor familiarity with the housemaids' cultural background may have limited our ability to make accurate interpretations of the psychiatric phenomenology. In order to partly overcome these difficulties, the psychiatric assessments in a number of cases were extended to more than one interview.

Our findings confirm the previous reports of excess of psychiatric morbidity among immigrants in general and housemaids in particular. A substantial number of housemaids break down within the first few months of their arrival, which, in many cases, results in their premature repatriation. This causes considerable distress to the em-

ployers on the one hand and the families and countrymen of the housemaids on the other. It is, therefore, important to investigate the possible psychosocial stresses associated with the increased psychiatric morbidity among housemaids and to identify any possible pre-immigration risk factors to prevent this 'expatriate failure'. The psychosocial stresses encountered by the housemaids surrounding the act of migration and the possible pre-immigration risk factors for their prospective psychiatric breakdown have been addressed in the second and third parts of this study [17, 18].

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