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ORIGINAL ARTICLE

Assessing family physicians' confidence and competence in diagnosing and managing mental illnesses in primary healthcare settings in Saudi Arabia

Oqab Abdulwahab Alzahrany[1], Ibrahim Althiyabi[2], Abdullah Ahmed Alsubhi[3], Abdulelah Saad AlShamrani[4*], Mohammed Abdullah Almutawa[3], Sultan Misfer Alzahrani[5], Amr Almousa[6], Mulham Hariri[3], Ziyad Eshaq Qari Shehab Aldeen[7]

ABSTRACT

Objective: This study aimed to evaluate family physicians' confidence and competence in diagnosing and managing the most common mental illnesses in the primary healthcare centers (PHC) settings in Saudi Arabia.

Methods: A cross-sectional study surveyed 493 family physicians across various cities in Saudi Arabia, conducted from July 2025 to November 2025. The study was conducted by an online survey using Google Forms to measure self-reported confidence in diagnosing and managing major depressive disorder, general anxiety disorder, panic disorder, and premenstrual syndrome using an eight-item Likert scale. Scores were collected regarding perceived tool utilization, familiarity, and the application of validated screening tools, specifically the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), Panic Disorder Severity Scale-self-report (PDSS-SR), and Premenstrual Symptoms Screening Tool (PMSS).

Results: Overall confidence score was moderate (median 26/40, IQR 22–31). Major depressive disorder had the highest level of confidence, with 51.7% in diagnosis and 55.8% in management. The PHQ-9 and GAD-7 scales were the most recognized assessment tools. Moreover, higher professional levels were predictors of increased knowledge and familiarity with these tools ($p < 0.001$).

Conclusion: Saudi family physicians demonstrated moderate confidence in managing mental illnesses, with significant gaps noted in smaller cities. Improving mental healthcare delivery requires distributing resources fairly and incorporating organized psychiatric training into PHCs.

Keywords: Family physicians, Confidence, Competence, Diagnosis, Management, Mental illnesses, Primary healthcare settings, Saudi Arabia.

Introduction

Family medicine physicians (FMPs) play a major role in the early detection and management of the most common mental health disorders [1–6], which contribute substantially to the global disease burden in primary healthcare center (PHC) settings [1,7,8]. Effectively integrating mental health services into PHC has been an essential task for the World Health Organization, particularly in regions with limited access to specialist psychiatric care [8]. However, a significant proportion of psychiatric conditions remain underdiagnosed or inadequately treated in primary care, despite this priority and growing awareness [8,9]. These gaps might be a major contribution to symptom and treatment delay, resulting in an increased health care burden [5].

Correspondence to: Abdulelah Saad AlShamrani
Psychiatry Resident, Psychiatry Department, King Salman Hospital, Riyadh, Saudi Arabia.
Email: Ah.shomrani@gmail.com
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Integrating mental health treatments into primary care poses unique obstacles in Saudi Arabia. Effective diagnosis and treatment of psychiatric illnesses can be hampered by cultural factors, the stigma associated with mental illness, and geographical differences in healthcare infrastructure. Research showed that a physician's training background and degree of confidence have a significant influence on the accuracy of their diagnosis. For example, a University of Manchester study discovered that doctors with a good academic background perform more accurate psychiatric assessments [10]. Similarly, family doctors in Canada have expressed discontent with the mental healthcare they provided, highlighting the need for improved access to psychiatric consultation [11]. According to research, the prevalence of psychiatric morbidity in primary care populations in developing countries was found to be approximately 13.9%, highlighting the critical need to improve resources and support for primary healthcare providers [12].

Despite a wealth of evidence, there is still a great deal to learn about the factors that affect confidence and competence among family physicians in Saudi Arabia. Internationally, confidence and competence in assessing and treating mental disorders in primary health care represent a major challenge. Two studies from Greece and Turkey concluded clear evidence of poor mental disorder outcomes due to moderately decreased confidence and competence among primary health care providers [13,14]. In Saudi Arabia, similar evidence was reported. Al-Atram's study concluded that family physicians had a more positive attitude toward mental disorder patients in comparison to general practitioners; however, they had variable knowledge across the training level, which might affect the overall patient care and prognosis [15]. Moreover, Al-Qadhi and colleagues stated that more than half of the patients who attended primary health care had depressive symptoms with no proper screening or management from family physicians [16].

However, no prior studies in Saudi Arabia assessed family physicians' confidence with validated tools across the country's regions. Hence, this study aimed to assess family doctors' self-reported competence and confidence in diagnosing and managing common mental illnesses in PHC settings across Saudi Arabia, as well as to pinpoint important factors that affect these dimensions. By developing evidence-based training programs and improvements, healthcare policymakers, educators, and practitioners can improve the delivery of mental healthcare in primary care settings.

Subjects and Methods

A national analytical cross-sectional study was conducted between July and November 2025 among licensed FMPs practicing in PHCs across 17 cities in Saudi Arabia, spanning all major administrative regions of the country. Eligible participants included residents (R1–R4), specialists, and consultants who were actively practicing family medicine at the time of data collection and who provided informed consent. Physicians outside the family medicine specialty, those who declined participation, those who withheld informed consent, and those who submitted incomplete responses were excluded from the final analysis.

The minimum required sample size was calculated using the single-population-proportion formula, assuming a 50% expected response distribution to maximize the sample, a 95% confidence level, and a 5% margin of error, yielding a minimum of 384 participants. Recruitment followed a convenience-and-snowball approach, with the survey link distributed through professional networks of family medicine residency programs, institutional email lists, and social media platforms (WhatsApp groups and X/Twitter channels used by Saudi family physicians).

The survey was hosted on Google Forms and was available for four months, during which two reminder messages were circulated at approximately monthly intervals to maximize response rates. A total of 497 responses were received, of which 493 met the inclusion criteria after excluding one participant who declined consent and three non-family-medicine physicians, exceeding the minimum sample size requirement.

An investigator-developed questionnaire was used to capture demographic characteristics (professional level, gender, city of practice) and four outcome domains: self-reported confidence, perceived use of validated tools, familiarity with those tools, and self-reported practice. The confidence score was counted by summing responses to eight items - one for diagnosis and one for management of each of the four target disorders (major depressive disorder, generalized anxiety disorder, panic disorder, and premenstrual syndrome) - each rated on a 5-point Likert scale ranging from one (not confident) to five (very confident), producing a total score between 8 and 40; internal consistency was acceptable (Cronbach's $\alpha = 0.792$).

The perceived-use score assigned one point for each correct identification of the condition for which a given validated tool, including Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), Panic Disorder Severity Scale-self report (PDSS-SR), and Premenstrual Symptoms Screening Tool (PMSS), was intended, with incorrect responses scored as zero, yielding a total between 0 and 4. Familiarity and practice were captured as composite count scores from four binary yes/no items (one per tool), each ranging from 0 to 4.

Categorical variables were summarized as frequencies and percentages. The distribution of continuous outcome scores (confidence, perceived use, familiarity, and practice) was assessed using the Shapiro–Wilk test, which indicated non-normal distributions ($p < 0.001$ for all); accordingly, these variables were summarized as median and interquartile range (IQR). Separate multivariable linear regression models were constructed for each of the four outcomes, with professional level, gender, and city of practice entered simultaneously as

independent variables; Resident (R1), Male, and Abha were used as reference categories. Multicollinearity was examined using variance inflation factors, all of which were below five (maximum VIF = 2.03), indicating no multicollinearity. Model fit was reported as adjusted R^2 and overall F-statistic for each regression. Statistical significance was set at $p < 0.05$. All analyses were performed using RStudio (version 2024.9.1.394, Boston, MA, USA) running R version 4.4.2.

Results

A total of 497 responses were initially collected. However, one participant declined to take part, and three responses were excluded because they were not from family physicians. This left 493 participants in the final analysis. Most participants were R2 residents (27.6%), followed by R1 (24.1%) and R3 (20.5%). Gender distribution was almost equal, with 50.1% males and 49.9% females. The most represented cities were Riyadh (24.1%), Taif (19.7%), and Makkah (12.2%), while Najran, Al-Juf, and Hail had the lowest representation (Table 1).

The 8-item confidence score had a mean of 26.32 ± 6.12 and a median of 26.0 (IQR 22.0–31.0), with an observed range from 8 to 40. The perceived-use score had a mean of 2.24 ± 1.56 and a median of 2.0 (IQR 1.0–4.0), with values ranging from 0 to 4. The familiarity score had a mean of 2.08 ± 1.12 (median 2.0, IQR 1.0–3.0), and the practice score had a mean of 2.17 ± 1.05 (median 2.0, IQR 2.0–3.0); both ranged from 0 to 4.

Participants reported the highest confidence in diagnosing major depressive disorder, with 51.7% describing themselves as fairly or very confident. Confidence in managing depression was slightly higher at 55.8%. For generalized anxiety disorder, 41.2% felt confident in both diagnosis and management. In panic disorder, 43.6% were confident in diagnosis and 42.8% in management. For premenstrual syndrome, confidence levels were 43.0% for diagnosis and 42.4% for management (Figure 1).

PHQ-9 was most commonly linked to major depressive disorder (54.2%), although some participants also associated it with other conditions.GAD-7 was mainly recognized as a tool for generalized anxiety disorder (52.5%). PDSS-SR was most accurately identified for panic disorder (62.1%), and PMSS was mainly linked to premenstrual syndrome (55.0%). In terms of familiarity, PMSS ranked highest (55.0%), followed by PDSS-SR (54.0%), then GAD-7 and PHQ-9. When it came to actual use, PHQ-9 was the most frequently used tool (63.5%), followed by GAD-7, PDSS-SR, and PMSS (Table 2).

Compared to R1 residents, those at higher training levels generally showed better knowledge of the correct use of these tools. This trend was seen across R2, R3, R4, specialists, and consultants. Physicians working in Makkah also had higher knowledge scores compared to those in Abha. For confidence, R2 and R3 residents showed higher scores, while R4 residents, specialists, and consultants showed lower confidence. Female participants also had slightly lower confidence scores. Additionally, physicians in Najran and Yanbu reported lower confidence compared to those in Abha (Table 3).

Table 1. *Demographic and professional characteristics.*

Characteristic	Frequency (percentage) *N* (%)
Professional level	
Resident (R1)	119 (24.1)
Resident (R2)	136 (27.6)
Resident (R3)	101 (20.5)
Resident (R4)	28 (5.7)
Specialist	68 (13.8)
Consultant	41 (8.3)
Gender	
Male	247 (50.1)
Female	246 (49.9)
City of practice	
Abha	18 (3.7)
Al-Ahsa	16 (3.2)
Al-Juf	6 (1.2)
Albaha	10 (2.0)
Alkhobar	11 (2.2)
Dammam	34 (6.9)
Hail	8 (1.6)
Jazan	8 (1.6)
Jeddah	37 (7.5)
Makkah	60 (12.2)
Medina	28 (5.7)
Najran	4 (0.8)
Qassim	15 (3.0)
Riyadh	119 (24.1)
Tabuk	10 (2.0)
Taif	97 (19.7)
Yanbu	12 (2.4)

R1 – R4: "Resident year 1 – Resident year 4".

Familiarity with the tools increased with higher professional level, particularly from R3 and above. Practice scores followed a similar pattern. Female participants showed slightly higher familiarity than males. However, physicians in Najran had lower familiarity and practice scores compared to those in Abha (Table 4).

Most participants correctly identified a PHQ-9 score of five as mild depression (70.2%). For GAD-7, 39.4% classified a score of seven as moderate anxiety. Regarding PMSS, 43.6% considered a score of 219 to indicate moderate symptoms. In terms of management, 43.4% agreed that a PHQ-9 score of 25 requires active treatment, and 46.5% said the same for a GAD-7 score of 16. Over half of the participants (58.6%) correctly identified the PMSS cut-off score (132). For PDSS-SR,

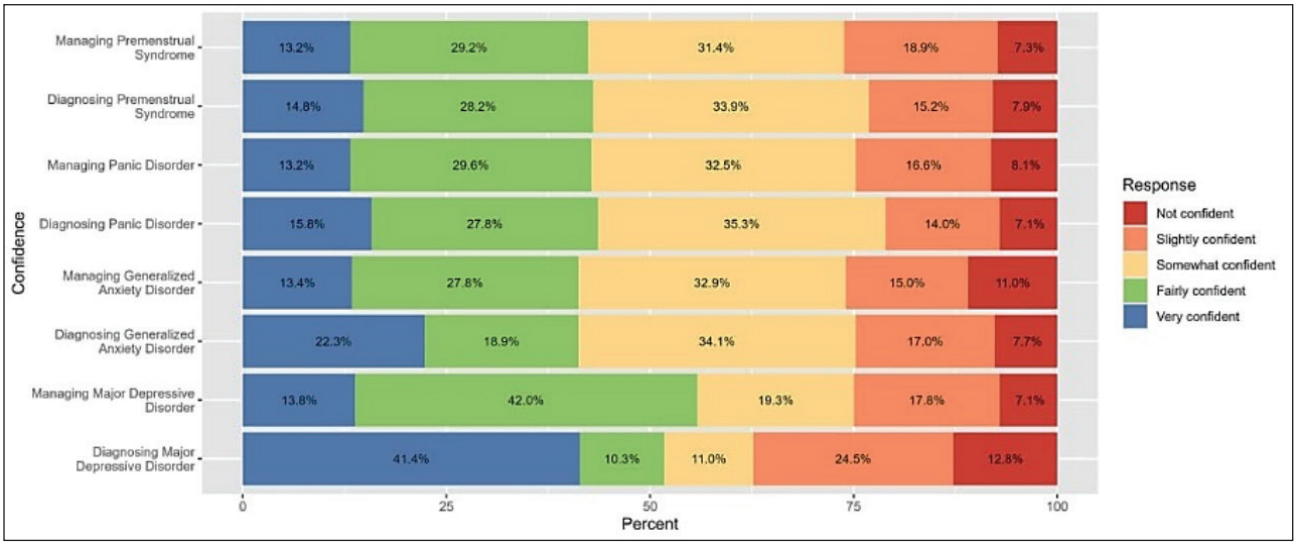

Figure 1. Distribution of family physicians' self-reported confidence levels in diagnosing and managing four common mental disorders (major depressive disorder, generalized anxiety disorder, panic disorder, and premenstrual syndrome) among Saudi family physicians (n = 493).

Horizontal stacked bars show the percentage of participants at each of five confidence levels (not confident / slightly / somewhat / fairly / very confident).

most participants viewed it as a screening tool (36.3%), while others considered it useful for treatment or diagnosis. Finally, 43.4% interpreted a PDSS-SR score of 17 as indicating a high likelihood of disease (Table 5).

Discussion

This cross-sectional study assessed the confidence of 493 family physicians from diverse cities in Saudi Arabia regarding the diagnosis and management of mental disorders in primary healthcare contexts. The study found moderate overall confidence: 51.7% of participants reported fair to very high confidence in diagnosing major depressive disorder, and 55.8% in its management. But lower confidence for generalized anxiety disorder, panic disorder, and premenstrual syndrome, ranging from approximately 41% to 44% across these diagnoses. The PHQ-9 and GAD-7 were identified as the most widely recognized and utilized screening tools.

A significant positive correlation was found between professional level and knowledge, familiarity, and the application of validated tools. However, advanced levels, specialists, and R4 residents, along with female gender, were associated with lower self-reported confidence scores. Geographic differences were also noted; physicians in smaller population cities, such as Najran and Yanbu, reported significantly lower scores in confidence, familiarity, and practice.

These findings are consistent with international evidence regarding primary care physicians' confidence in managing mental health. A recent paper of Greek general practitioners showed that approximately 52.5% felt quite to very confident in diagnosing and managing mental disorders [13], which is closely similar to current study findings regarding depression, in contrast to the results that have emerged from Turkey, where the majority of general practitioners and family physicians reportedly lack adequate competence in diagnosing and managing mental health conditions [14].

In Saudi Arabia, research investigating family physicians' confidence and competence in mental health management was found to be limited. Al-Atram found that Saudi family physicians exhibited more positive attitude toward psychiatric patients than general practitioners and specialists, with significant differences in knowledge levels across professional groups ($p <$ 0.05). The high familiarity and usage of the PHQ-9 and GAD-7 observed in the current study align with global trends; an international cross-sectional survey, for example, reported that 97.9% of primary care physicians were familiar with both instruments.

This alignment confirmed that Saudi Arabian family physicians are utilizing internationally recognized instruments, thereby enhancing the comparability and standardization of mental healthcare practices across different settings [17]. Many factors might explain the observed confidence patterns. The high confidence in diagnosing depression was unsurprising, as depression is prevalent. For instance, Al-Qadhi et al. found that nearly half of the participants in Saudi primary care settings exhibited depressive symptoms [16]. Moreover, depression screening and dealing with it are covered well in family medicine training.

In contrast, anxiety and panic disorders were found to be less focused on in training curricula, which could

Table 2: *Description of the perceived uses, familiarity, and practice of validated tools for mental illness.*

Characteristic	Frequency (Percentage) N (%)
Perceived uses of validated tools	
PHQ-9	
Generalized anxiety disorder	**184 (37.3)**
Major depressive disorder*	**267 (54.2)**
Panic disorder	**31 (6.3)**
Premenstrual syndrome	**11 (2.2)**
GAD-7	
Generalized anxiety disorder*	**259 (52.5)**
Major depressive disorder	**121 (24.5)**
Panic disorder	**89 (18.1)**
Premenstrual syndrome	**24 (4.9)**
PDSS-SR	
Generalized anxiety disorder	**65 (13.2)**
Major depressive disorder	**60 (12.2)**
Panic disorder*	**306 (62.1)**
Premenstrual syndrome	**62 (12.6)**
PMSS	
Generalized anxiety disorder	**83 (16.8)**
Major depressive disorder	**60 (12.2)**
Panic disorder	**79 (16.0)**
Premenstrual syndrome*	**271 (55.0)**
Familiarity with validated tools	
PHQ-9	**237 (48.1)**
GAD-7	**251 (50.9)**
PDSS-SR	**266 (54.0)**
PMSS	**271 (55.0)**
Practice of validated tools	
PHQ-9	**313 (63.5)**
GAD-7	**272 (55.2)**
PDSS-SR	**246 (49.9)**
PMSS	**238 (48.3)**

*An asterisk indicates a correct response

contribute to lower confidence in diagnosing these conditions. People at higher professional levels tend to be more familiar with validated tools, probably because of their experience and ongoing training. Senior residents and consultants scored significantly higher than junior residents. This is consistent with previous research showing that competence improves with experience [18]. The gradual improvement is likely due to both formal training and the hands-on learning that comes from repeated clinical practice.

Interestingly, specialists and R4 residents had lower confidence scores even though they had better knowledge. This goes against the usual idea that confidence increases with experience. One possible reason is that more experienced physicians are more aware of how complex and uncertain psychiatric diagnoses can be, so they might judge their confidence more cautiously. It might also be linked to heavier workloads, more complicated cases, or a lack of help in managing mental health. This is different from what Salama et al. [19] found, which was that more experienced professionals had better attitudes toward managing mental disorders. This suggested that confidence might not always grow in the same way in different settings.

The observed gender difference, where female physicians showed greater knowledge of mental illness assessment tools but lower confidence in diagnosis and management, aligns with previous research. A study found that female physicians reported lower self-efficacy despite having knowledge levels comparable to those of male physicians [14]. This disparity might result from social and cultural influences that shape self-perception, including differences in training experiences, professional socialization, and workplace dynamics by gender.

Physicians in the least-represented cities, including Najran and Yanbu, reported markedly lower confidence, familiarity, and practice scores than those in larger urban cities such as Makkah and Riyadh. This pattern corresponds to the global challenge of the varying distribution of mental healthcare resources, training opportunities, and specialist support [20]. Smaller cities might face barriers, including limited access to continuing medical education, fewer opportunities for psychiatric consultation, and weaker integration with primary care centers.

While this study focused on Saudi Arabia, these findings are relevant to other healthcare systems, particularly in middle-income countries and regions facing challenges in healthcare workforce distribution [20]. A positive association between experience and tool familiarity, geographic disparities in confidence and resources, and gender-based differences in confidence have also been reported internationally [17,21]. Nevertheless, unique cultural factors in Saudi Arabia, such as prevailing attitudes toward mental illness and gender roles in healthcare delivery, might limit direct generalizability.

The predictors of increased familiarity and practice with the mental illness tools showed that advanced professional levels had more familiarity (0.64) than junior levels (0.26). This consequence was found to be associated with greater confidence in diagnostic accuracy, more critical decision-making, greater exposure to cases, and the effects of burnout and fatigue on self-efficacy. However, gender differences in confidence despite equivalent knowledge might stem from differing socialization patterns, implicit bias in training environments, or variations in feedback during professional development. Geographic variations were likely influenced by healthcare factors such as health services infrastructure, availability of educational resources, and workforce distribution policies.

Table 3. *Predictors of correct uses and confidence in the use of mental illness validated tools.*

Characteristic	Correct uses *β*	95% CI	*p*-value	Confidence *β*	95% CI	*p*-value
Professional level						
R1 (ref)	Ref	—	—	Ref	—	—
R2	**0.41**	0.11, 0.72	**0.008**	**1.56**	0.20, 2.93	**0.025**
R3	**0.58**	0.25, 0.91	**<0.001**	**1.96**	0.48, 3.44	**0.010**
R4	**2.05**	1.53, 2.57	**<0.001**	**−3.79**	−6.09, −1.48	**0.001**
Specialist	**2.00**	1.61, 2.38	**<0.001**	**−3.18**	−4.90, −1.47	**<0.001**
Consultant	**2.30**	1.84, 2.76	**<0.001**	−1.47	−3.51, 0.57	0.159
Gender						
Male (ref)	Ref	—	—	Ref	—	—
Female	0.19	−0.04, 0.41	0.110	**−1.54**	−2.55, −0.52	**0.003**
City of practice						
Abha (ref)	Ref	—	—	Ref	—	—
Al-Ahsa	−0.33	−1.17, 0.50	0.430	−0.73	−4.45, 2.98	0.699
Al-Juf	0.29	−0.85, 1.43	0.622	−3.83	−8.93, 1.27	0.142
Albaha	0.25	−0.71, 1.20	0.614	−0.89	−5.16, 3.38	0.684
Alkhobar	−0.17	−1.10, 0.76	0.719	0.09	−4.04, 4.23	0.964
Dammam	0.23	−0.49, 0.94	0.534	−1.69	−4.88, 1.50	0.299
Hail	−0.54	−1.57, 0.49	0.305	−3.90	−8.50, 0.70	0.097
Jazan	−0.14	−1.17, 0.89	0.786	−3.48	−8.08, 1.13	0.140
Jeddah	0.66	−0.05, 1.38	0.069	−1.55	−4.75, 1.65	0.343
Makkah	**0.84**	0.18, 1.50	**0.013**	−1.68	−4.65, 1.28	0.267
Medina	0.61	−0.14, 1.35	0.111	1.22	−2.10, 4.54	0.472
Najran	−0.46	−1.79, 0.88	0.505	**−9.44**	−15.4, −3.46	**0.002**
Qassim	0.45	−0.39, 1.30	0.295	0.63	−3.16, 4.42	0.745
Riyadh	0.53	−0.09, 1.15	0.093	0.21	−2.57, 2.98	0.883
Tabuk	0.25	−0.71, 1.20	0.614	0.77	−3.51, 5.04	0.726
Taif	−0.20	−0.83, 0.42	0.526	2.11	−0.70, 4.91	0.142
Yanbu	0.76	−0.14, 1.66	0.100	**−6.40**	−10.4, −2.37	**0.002**

Table 4. *Predictors of increased familiarity and practice of using mental illness validated tools.*

Characteristic	Familiarity			Practice		
	Beta	95% CI	*p*-value	Beta	95% CI	*p*-value
Professional level						
Resident (R1)	Reference	Reference		Reference	Reference	
Resident (R2)	0.19	0.00, 0.38	**0.048**	0.17	0.01, 0.35	0.066
Resident (R3)	0.54	0.26, 0.82	**<0.001**	0.67	0.41, 0.94	**<0.001**
Resident (R4)	0.82	0.39, 1.26	**<0.001**	0.72	0.30, 1.13	**<0.001**
Specialist	0.93	0.60, 1.25	**<0.001**	0.57	0.26, 0.88	**<0.001**
Consultant	1.02	0.64, 1.41	**<0.001**	0.87	0.50, 1.23	**<0.001**
Gender						
Male	Reference	Reference		Reference	Reference	
Female	0.19	0.00, 0.38	**0.048**	0.17	−0.01, 0.35	0.066
Najran	−1.63	−2.75, −0.51	**0.005**	−1.74	−2.81, −0.66	**0.002**

CI = Confidence Interval.

Table 5. *Participants' responses to selected items regarding the use of validated tools.*

Clinical scenario / Question	Response option	Frequency (Percentage) *N* (%)
PHQ-9 score of 5 is categorized as	No or minimal symptoms	41 (8.3)
	Mild (correct answer)	**346 (70.2)**
	Moderate	89 (18.1)
	Severe	17 (3.4)
GAD-7 score of 7 is categorized as	No or minimal symptoms	64 (13.0)
	Mild (correct answer)	**185 (37.5)**
	Moderate	194 (39.4)
	Severe	50 (10.1)
PMSS score of 219 is categorized as	No or minimal symptoms	51 (10.3)
	Mild	92 (18.7)
	Moderate	215 (43.6)
	Severe	135 (27.4)
Patient with a PHQ-9 score of 25 needs:	No intervention	46 (9.3)
	Medication alone	114 (23.1)
	Psychotherapy alone	119 (24.1)
	Active treatment with psychotherapy, medications, or a combination (correct)	**214 (43.4)**
Patient with GAD-7 score of 16 needs:	No intervention	36 (7.3)
	Medication alone	100 (20.3)
	Psychotherapy alone	128 (26.0)
	Active treatment with psychotherapy, medications, or a combination (correct)	**229 (46.5)**
PMSS positive cutoff score:	119	52 (10.5)
	132 (correct)	**289 (58.6)**
	219	104 (21.1)
	232	48 (9.7)
PDSS-SR primary purpose:	For research only	64 (13.0)
	Screening (correct)	**179 (36.3)**
	Diagnostic	110 (22.3)
	Therapeutic	140 (28.4)
PDSS-SR score of 17 indicates disease probability:	No probability	36 (7.3)
	Mild	124 (25.2)
	Moderate	119 (24.1)
	Markedly high (correct)	**214 (43.4)**

Bold rows indicate the correct response. All questions were single-select. *N* = 493.

PHQ-9 = Patient Health Questionnaire-9, GAD-7 = Generalized Anxiety Disorder-7, PMSS = Premenstrual Symptoms Screening Tool, PDSS-SR = Panic Disorder Severity Scale - Self-Report.

Several interventions could strengthen mental health care within Saudi PHC settings. First, structured psychiatric rotations and standardized mental-health modules should be embedded within family medicine residency programs, with particular emphasis on anxiety, panic, and premenstrual disorders, where confidence was lowest. Second, targeted continuing medical education and mentoring programs should be established to address confidence gaps among senior trainees and physicians practicing in underserved regions. Third, collaborative stepped-care models linking PHCs to psychiatric specialists, particularly in smaller cities, would ensure more equitable access to specialist consultation and support.

One of the main strengths of this study was the sample size, which not only met but exceeded the minimum calculated requirement, with 493 participants recruited from 17 cities across Saudi Arabia. This geographic spread lends the findings a degree of national representativeness that is rarely achieved in similar local studies. Further,

assessment of knowledge was grounded in four widely validated tools (PHQ-9, GAD-7, PDSS-SR, and PMSS), which added a layer of credibility to the comparisons drawn. The internal consistency of the confidence scale was acceptable (Cronbach's $\alpha = 0.792$), and the analytical approach accounted for key confounding variables across demographic, professional, and geographic domains

Despite these strengths, the study had limitations worth acknowledging. The cross-sectional nature of the design captured a snapshot in time, and no causal conclusions can be drawn. Recruitment relied on convenience and snowball sampling, which, while feasible for this type of study, might not fully represent all Saudi family physicians. Another consideration was that this study measured self-reported confidence rather than observed clinical performance; the two do not always align, and participants might have rated themselves more favorably than their actual practice would suggest. Geographic coverage, though broad, was uneven; Najran and Al-Juf contributed only four and six participants, respectively, making it difficult to draw reliable conclusions at the city level. Several variables that could meaningfully shape a physician's confidence and competence were not captured in this study, including age, years of clinical experience, prior psychiatric rotations, and CME attendance in mental health, all of which warrant inclusion in future investigations. Finally, the questionnaire was not piloted before use, and some items might not have been interpreted as intended.

Conclusion

Saudi family physicians had moderate confidence in diagnosing and managing mental health conditions in primary care settings, with a high rate for major depressive disorder. However, significant gaps remained in confidence regarding other common psychiatric conditions, the appropriate use of validated screening tools, and the consistency of competence across geographic regions. This study recommended that more structured, progressive psychiatric training be implemented within family medicine residency programs, that equitable resource distribution be ensured, and that collaborative care models be implemented to connect primary care and psychiatric specialists, which would enable Saudi Arabia to improve the quality of mental healthcare in primary care settings.

List of Abbreviations

PHC	Primary Healthcare Center.
FMP	Family Medicine Physician.
PHQ-9	Patient Health Questionnaire-9.
GAD-7	Generalized Anxiety Disorder-7.
PMSS	Premenstrual Symptoms Screening Tool.
PDSS-SR	Panic Disorder Severity Scale - Self-Report.

Conflict of interest

The authors declare that there is no conflict of interest regarding the publication of this article.

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None

Consent for participation

Informed consent was obtained from all the participants.

Ethical approval

Ethical approval was granted by the Institutional Review Board of the Riyadh Second Health Cluster via reference number 25-226. Dated: 27-07-2025.

Author details

Oqab Abdulwahab Alzahrany[1], Ibrahim Althiyabi[2], Abdullah Ahmed Alsubhi[3], Abdulelah Saad AlShamrani[4] , Mohammed Abdullah Almutawa[3], Sultan Misfer Alzahrani[5], Amr Almousa[6], Mulham Hariri[3], Ziyad Eshaq Qari Shehab Aldeen[7]

1. Family Medicine and Mental Health Consultant, Prince Mansour Military Hospital, Taif, Saudi Arabia
2. Consultation-Liaison Psychiatrist, Director Psychiatry Residency Program, and Head of Department of Mental Health, Prince Mohammed bin Abdulaziz Hospital, Riyadh, Saudi Arabia
3. Psychiatry Resident, Psychiatry Department, King Fahad Medical City, Riyadh, Saudi Arabia
4. Psychiatry Resident, Psychiatry Department, King Salman Hospital, Riyadh, Saudi Arabia.
5. Family Medicine Resident, Family Medicine Department, Prince Mansour Military Hospital, Taif, Saudi Arabia.
6. Family Medicine Resident, Family Medicine Department, Makkah Health Cluster, Makkah, Saudi Arabia
7. Medical Student, College of Medicine, Umm Al-Qura University, Makkah, Saudi Arabia

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