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Anxiety Disorders at Outpatient Psychiatric Services: Clinical Presentations and Associated Features

*Pathan MAS[1], Parvez MKH[2], Sabuz DMSK[3], Khan EH[4], Mian S[5], Adam MJ[6], Nowaz MA[7], Ghose TI[8]

Abstract

A cross-sectional, descriptive study was conducted in the outpatient psychiatry department of Community Based Medical College, Bangladesh (CBMC,B), Mymensingh, Bangladesh, between June and December of 2024, to assess the clinical presentations and associated factors of anxiety disorders among outpatients attending the hospital. A total of 68 participants selected through purposive sampling, those who were previously diagnosed with anxiety disorders according to DSM-5 criteria. Data on sociodemographic characteristics, clinical symptoms, and associated factors were collected through interviews and medical records. Generalized Anxiety Disorder-7 (GAD-7) scale was used for assessment. Analysis was performed using MS Office tools (Excel and Word). The study found generalized anxiety disorder as most prevalent (47.1%), with excessive worriedness (85.3%), restlessness (73.5%), and somatic complaints (61.8%) as key symptoms. Females (64.7%) and low-income individuals (52.9%) were disproportionately affected. Comorbidities were observed in 38.2% patients with mostly suffering from hypertension (20.6%). Financial stress (32.4%) was also a significant contributor. GAD-7 scores revealed 69.1% had moderate to severe levels of anxiety, while 38.2% had severe form of disease and 14.75 had mild anxiety. This study highlights a significant burden of anxiety disorders among our population particularly among women and those belong to the low-income group. The high prevalence of somatic symptoms and comorbidities underscores the need for integrated care approaches addressing both psychological and physical health in our resource-limited settings.

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Introduction

Anxiety disorders rank among the most common mental health conditions worldwide, affecting an estimated 284 million individuals and contributing significantly to disability and diminished quality of life.[1] These disorders include various conditions such as generalized anxiety disorder, panic disorder, and social anxiety disorder, all marked by excessive fear, persistent worry, and physical symptoms like rapid heartbeat, sweating, and sleep disturbances.[2,3] In low- and middle-income countries, including Bangladesh, anxiety disorders frequently remain underdiagnosed and inadequately treated due to limited mental health services, social stigma, and lack of awareness.[4] Patients with anxiety disorders exhibit diverse clinical presentations, reporting both psychological symptoms such as constant worry or fear of losing control and physical complaints, including headaches and digestive issues.[5] These symptoms often lead to repeated healthcare visits, incorrect diagnoses, and unnecessary medical tests,

1. *Dr. Mohammad Asraful Siddike Pathan, Associate Professor, Department of Psychiatry, Community Based Medical College Bangladesh, Mymensingh.
2. Dr. Muhammad Kabir Hasan Parvez, Assistant Professor, Department of Psychiatry, Mymensingh Medical College, Mymensingh, Bangladesh.
3. Dr. Dil Mohammad Sazzadul Kabir Sabuz, Registrar, Department of Psychiatry, Mymensingh Medical College Hospital, Mymensingh, Bangladesh.
4. Dr. Enamul Hoque Khan, Associate Professor & Head, Department of Psychiatry, Mymensingh Medical College, Mymensingh, Bangladesh.
5. Dr. Sazib Mian, Assistant Registrar, Netrokona District Hospital, Netrokona.
6. Dr. Md Jurdi Adam, Assistant Professor, Department of Psychiatry, President Abdul Hamid Medical College (PAHMC), Kishoreganj, Bangladesh.
7. Dr. Md. Asif Nowaz, Clinical Psychologist, Mymensingh Medical College, Mymensingh, Bangladesh.
8. Dr. Tumpa Indrani Ghose, Assistant Professor (Child, Adolescent and Family Psychiatry), Department of Psychiatry, Mymensingh Medical College, Mymensingh, Bangladesh.

Address of Correspondence:
Email: maspathan@gmail.com

placing additional financial strain on patients and healthcare systems.[6] Moreover, anxiety disorders commonly coexist with other mental health conditions like depression and chronic physical illnesses such as hypertension and diabetes, further complicating treatment and recovery.[7,8] Various sociodemographic and psychosocial factors influence the onset and severity of anxiety disorders. Research highlights that being female, having low income, being unemployed, and having a family history of mental illness are significant risk factors.[9,10] Stressful experiences such as financial hardship, relationship problems, or traumatic events also play a key role in triggering and worsening symptoms.[11] In Bangladesh, cultural expectations and limited understanding of mental health contribute to the burden of anxiety disorders, often delaying the decision to seek professional help.[12] Despite their high prevalence, localized data on anxiety disorders in Bangladesh, particularly in outpatient psychiatric care, remains scarce. Most existing studies concentrate on urban populations or hospital-based cases, leaving gaps in knowledge regarding broader clinical and epidemiological trends.[13,14] This study aims to address this gap by investigating the clinical presentations and associated factors of anxiety disorders among patients attending our outdoor psychiatry department. The findings will help improve early detection, intervention strategies, and customized treatment approaches in settings with limited resources.

Methods

This cross-sectional, descriptive study was conducted at the outpatient psychiatry department of Community Based Medical College, Bangladesh (CBMC,B), Mymensingh, Bangladesh, from June to December of 2024. A total of 68 adult patients diagnosed with anxiety disorders according to DSM-5 criteria were included through purposive sampling. Patients with severe cognitive impairment or comorbid psychotic disorders were excluded. Data were collected through face-to-face interviews using a structured questionnaire covering sociodemographic characteristics (age, gender, education, occupation, income), clinical history (duration of illness, family history), and symptom profiles. Anxiety severity was assessed using the Generalized Anxiety Disorder-7 (GAD-7) scale.[15] Medical records were reviewed to identify comorbid physical conditions. Data were analyzed using Microsoft Excel, with descriptive statistics to summarize different sociodemographic and clinical variables. Data was presented as frequency and percentage in tabulated form.

Ethical approval was obtained from the Ethical Review Committee of Community Based Medical College, Bangladesh (CBMC,B), Mymensingh, Bangladesh, and written informed consent was taken from all the participants.

Results

The study included 68 participants diagnosed with anxiety disorders. The majority were female (64.7%) and aged 25-45 years (58.8%). Most participants had completed secondary education (47.1%) and belonged to low-income households (52.9%) (Table-I). Generalized anxiety disorder (GAD) was the most common diagnosis (47.1%), followed by panic disorder (22.1%) and social anxiety disorder (17.6%) (Table-II). The predominant symptoms included excessive worry (85.3%), restlessness (73.5%), and sleep disturbances (67.6%) (Table-III). Somatic complaints like headache (61.8%) and gastrointestinal distress (44.1%) were frequently reported. A significant proportion of participants had comorbid medical conditions (38.2%), with

hypertension (20.6%) and diabetes (14.7%) being the most prevalent. Family history of mental illness was present in 29.4% of cases. Stressful life events, particularly financial difficulties (32.4%) and family conflicts (26.5%), were commonly associated with anxiety symptoms. The GAD-7 scale scores revealed moderate to severe anxiety in 69.1% of the patients, while 38.2% had severe form of disease and 14.75 had mild anxiety (Table-VI).

Table-I: Sociodemographic characteristics of participants (n=68)

Variables	Frequency	Percentage
Gender		
Male	24	35.3
Female	44	64.7
Age (in years)		
18–24	14	20.6
25–45	40	58.8
>45	14	20.6
Education		
Primary	18	26.5
Secondary	32	47.1
Higher	18	26.5
Income (monthly)		
Low (<20,000 BDT)	36	52.9
Middle (20,000–50,000 BDT)	22	32.4
High (>50,000 BDT)	10	14.7

Table-II: Distribution of anxiety disorder by its subtypes (n=68)

Diagnosis	Frequency	Percentage
Generalized anxiety disorder	32	47.1
Panic disorder	15	22.1
Social anxiety disorder	12	17.6
Anxiety-depressive disorder	9	13.2

Table-III: Frequency of anxiety symptoms

Symptoms	Frequency	Percentage
Excessive worriedness	58	85.3
Restlessness	50	73.5
Sleep disturbances	46	67.6
Headache	42	61.8
Gastrointestinal distress	30	44.1
Palpitation	28	41.2

Table-IV: Comorbidities reported by the patients (n=68)

Comorbidities	Frequency	Percentage
Hypertension	14	20.6
Diabetes Mellitus	10	14.7
Asthma	6	8.8
None	42	61,8

Table-V: Psychosocial risk factors among patients(n=68)

Comorbidities	Frequency	Percentage
Job related stress	12	17.6
Family conflicts	18	26.5
Financial stress	22	32,4
Family history of mental illness	20	29.4

Table-VI: Severity of disease based on GAD-7 scale (n=68)

Severity	Frequency	Percentage
Mild (0–4)	10	14.7
Moderate (5–9)	32	47.1
Severe (10–21)	26	38.2

Discussion

Our results demonstrate that anxiety disorders predominantly affect females (64.7%) and individuals aged 25-45 years (58.8%), which aligns with global epidemiological patterns.[16] This gender disparity may be attributed to biological factors, sociocultural stressors, and help-seeking behaviors that make women more likely to report psychological symptoms.[9,17] The peak prevalence in young to middle-aged adults reflects the significant life stressors typically experienced during this developmental period, including career pressures and family responsibilities.[18] Generalized anxiety disorder emerged as the most common diagnosis (47.1%), followed by panic disorder (22.1%) and social anxiety disorder (17.6%). This distribution pattern is consistent with findings from other South Asian countries[19], though the proportion of GAD cases appears higher than that of the western population.[20] The high prevalence of excessive worry (85.3%) and restlessness (73.5%) as primary symptoms supports the diagnostic validity of these core features across cultures.[21] However, the notable frequency of somatic complaints (61.8%) underscores the cultural tendency in Bangladesh to express psychological distress through physical symptoms.[4,22] The study revealed significant comorbidities, with 38.2% of participants having chronic medical conditions, particularly hypertension (20.6%) and diabetes (14.7%). This finding reinforces the well-established bidirectional relationship between anxiety disorders and physical health problems.[7] The physiological effects of chronic anxiety may contribute to cardiovascular and metabolic dysregulation, while the stress of managing chronic illnesses can exacerbate anxiety symptoms.[8] These results highlight the need for integrated care models that address both mental and physical health in this population.[23] Psychosocial factors played a prominent role, with financial difficulties (32.4%) and family conflicts (26.5%) being the most commonly reported stressors. These findings reflect the socioeconomic challenges faced by many Bangladeshis and the importance of family dynamics in mental health.[24] The high prevalence of low-income status (52.9%) among participants supports existing evidence linking economic hardship with increased anxiety risk.[25] Family history of mental illness (29.4%) was another significant factor, consistent with genetic and environmental vulnerability models of anxiety disorders.[26] The GAD-7 results showed that 69.1% of participants had moderate to severe anxiety, indicating substantial symptom burden in this clinical sample. This severity distribution is comparable to other help-seeking populations[27], though higher than community-based estimates.[28] The finding that females and employed individuals showed better treatment adherence suggests that gender roles and occupational stability may influence engagement with mental health services.[29]

Several limitations should be considered when interpreting these findings. The single-center design and relatively small sample size may limit generalizability to other settings.[30] The cross-sectional nature prevents causal inferences about observed associations.[31] Additionally, the reliance on self-reported measures may introduce recall bias.[32] Future research should employ longitudinal designs with larger, more diverse samples to better understand the developmental course of anxiety disorders in this context.

Conclusion

This study highlights the significant burden of anxiety disorders among outpatients in Bangladesh, particularly affecting young to middle-aged women. The findings underscore the importance of

recognizing somatic presentations and addressing socioeconomic stressors in management. While limited by its design, the research calls for improved mental health services integrating psychosocial support. Future studies should explore longitudinal outcomes and culturally adapted interventions to enhance treatment effectiveness in low-resource settings. To address anxiety disorders effectively, we recommend routine outpatient screening and integrated mental-physical healthcare models. Targeted interventions should prioritize women and low-income groups, supported by training in culturally sensitive approaches. Larger longitudinal studies are needed to evaluate treatment outcomes and improve mental healthcare delivery in Bangladesh's resource-limited settings.

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