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STATUS REPORT ON ANXIETY DISORDERS OF THE ADULT IN ANTANANARIVO: A PROSPECTIVE STUDY

Hasina Andrianarivony Bakohariliva[1]*, Evah Norotiana Andriamiakatsoa Raobelle[2], Mahery Nantenaina Rakotoroalahy[3], Adeline Raharivelo[4] and Bertille Hortense Rajaonarison[2]

[1]Psychiatrist and EMDR Therapist, Department of Pediatrics, CHU Pzaga Androva, Mahajanga.

[2]Chief of Clinical of Psychiatry, Psychiatrist on Mental Health Section of Analakely Public University Hospital, Antananarivo.

[3]Psychiatrist of Saint Benoît Menni Private Hospital Center of Mental Health, Imerintsiatosika.

[4]Professor and Titular of Psychiatry, Chief of Neuropsychiatric Unit Care of Joseph Raseta Befelatanana University Hospital, Antananarivo.

[5]Professor and Titular of Psychiatry, Chief of Mental Health Section of Analakely Public University Hospital, Antananarivo.

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***Corresponding Author**
Hasina Andrianarivony Bakohariliva
Psychiatrist and EMDR Therapist, Department of Pediatrics, CHU Pzaga Androva, Mahajanga.

ABSTRACT

Introduction: According to OMS, anxiety disorders are the most prevalent of mental disease, but are often under-diagnosed and miss-treated. The aim of our study is to establish an assessment of adult anxiety disorders on 2017. **Materials and Methods:** We conducted a cross-sectional prospective and descriptive study for a period of 8 months from November 2016 to June 2017. **Results:** The crude prevalence was about 2%. Those troubles mostly affected the female sex (66%), the age between 36 to 45 years old (28,13%), urban background (55%) and the senior managers (34,38%). The main purpose of consultation was: anguish (50%) mostly due to familial conflicts (21,875%), and patients were consulted previously by general practitioner (43,75%). Post-traumatic stress disorder was the most frequent anxiety disorders and depressive syndrome was the most frequent comorbidity (46,88%). Patients considered anxiety disorders as the influence of stressful events (62,5%), with most of one socio-

professional impact seen (88%). **Conclusion:** The creation of children's mental health center and medico psychological center is a major need in our country.

KEYWORDS: Anxiety disorders, epidemiology, DSM-IV, etiologies, socio-professional impact, considerations.

INTRODUCTION

According to WHO, anxiety disorders are the most common of all disorders mental health, with a lifetime prevalence of 16 to 29% and affect preferentially women (2 times more than men).[1,2] They also have a major economic impact.[3] Anxiety disorders are intense and prolonged feelings of fear and distress who are out of proportion to the real threat or danger. Feelings of fear or distress hinders the functioning of daily life.[4] However, in our medical practices, these disorders often seem to be minimized and taken lightly and are therefore under-diagnosed and under-treated. Which brings us to the justifications of our study, because of the absence of study similar conduct in our country before on the impact of anxiety disorders, then intensity can range from mild to severe, and these disorders constitute psychiatric emergencies and requiring adequate care. Our main goal is to establish an inventory of anxiety disorders, with the specific objectives of determining the epidemiological and clinical profile of the disorders anxious, to collect the considerations from the Malagasy patient, and to determine the impact of these disorders at the socio professional level. To achieve these goals, our work will consist of three parts, the first part will concern the general considerations on anxiety disorders, the second part, our study proper, the third and last part will talk about our comments followed by our suggestions before concluding.

MATERIALS AND METHODS

We conducted a prospective, descriptive cross-sectional study over a period of 8 months from November 2016 in June 2017, where we investigated in order to get our study population in 3 institutions: 2 institutions including the Psychiatry Department of Joseph Raseta Befelatanana University Hospital and the Mental Health Service of the CHU of Care and Public Health Analakely; and 1 private institution in a suburban environment: Saint Benoit Private Hospital Center Menni Imerintsiatosika. Our main objective was to obtain an inventory of the anxiety disorders of adults in those institutions with the specific objectives to determine the epidemiological and clinical profile of anxiety disorders, to identify the considerations by the Malagasy patient and evaluate the impact of these disturbances at the socio professional level.

The parameters of the study where dependent parameter as the presence of the following anxiety disorders: Panic disorder, Panic disorder with agoraphobia, Generalized anxiety disorder, post-traumatic stress disorder, acute stress disorder, adjustement disorder, social phobia and specific phobia. But we also analyzed non-dependent parameters like sociodemographic, clinical parameters, the considerations of anxiety disorders by the patient and socio-occupational impact of anxiety disorders. Patients were previously informed about their participation in the study and a consent form were presented to them. We recruited our patients using a medical observation form collection sheet and a pre-established survey sheet and pre-tested in another center outside the institutions study. The interveners consisted of qualified interns in psychiatry, psychiatrists and psychologists who had observed, treated and followed these patients. We intervened precisely both at the CHU Befelatanana as well as from the Private Hospital Saint Benoit Menni Imerintsiatosika where we consulted, treated and took psychotherapy patients. We included all the patients aged 16 and over who were diagnosed as anxiety disorders according to DSM-IV criteria (with the exception of anxiety disorders induced by a substance, or due to a general non-specific anxiety disorders) who came for consultation or hospitalized during our study period and who agreed to answer our fact sheet. And we excluded all patients who did not agree to respond to our questionnaires. We analyzed our data using the Excel software.

RESULTS

During our study period, we surveyed both institutions public and 1 private institution, in total n = 1580 patients Of these patients, n = 36 cases were diagnosed with an anxiety disorder. These cases were mostly outpatient (n = 27) versus 5 patients hospitalized. (Fig. 1).

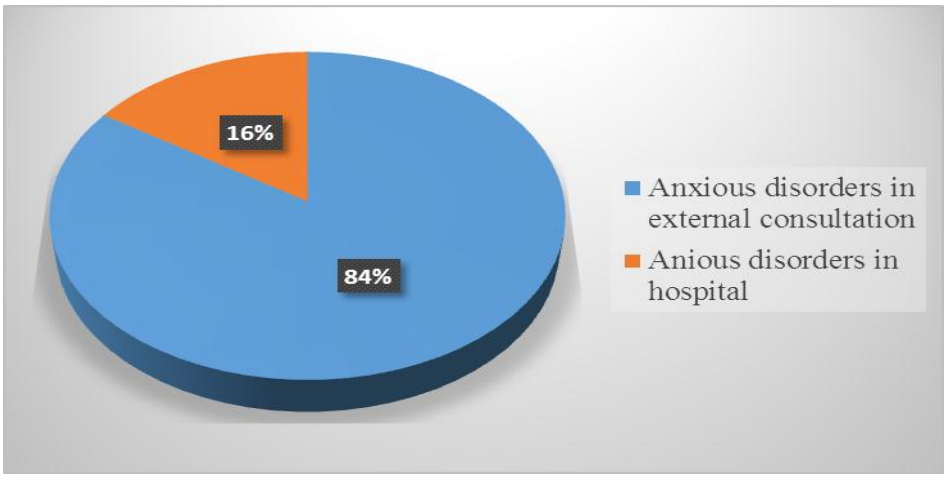

Figure 1: Graphical distribution of treatment modalities for anxiety disorders.

Thus, the clinical prevalence of anxiety disorder was 2%. Among these 36 cases, 4 cases have not been included due to age under 16 years. That makes us a population study of 32 cases of anxiety disorders. The average age was 46.4375 years old, with 16 years as the minimum and 59 years old maximum. The age group of 36 to 45 years was predominant at 28.13% and the female gender was the majority. The sex ratio was 0.51. Urban patients predominated in 55% of cases. Patients with business executives predominated in 34.38% of cases, followed by students at 28.13% and the tertiary sector at 25% of cases. The 91% of patients had a religious affiliation. Single patients were the most common in 50% of cases, followed by married patients in 37.5% of cases. (Table I).

Table I: Sociodemographic parameters of patients with Anxiety Disorders.

Variables	n	%
Age (years old)		
15 to 25	12	37,5
26 to 35	5	15,63
36 to 45	10	31,26
46 to 55	4	12,5
Over 55	1	3,11
Gender		
Female	21	66
Male	11	34
Living environment		
Urban	18	55
Suburban	14	45
Profession		
Business executives	11	34,38
Students	9	28,13
Tertiary sector	8	25
No profession	4	12,5
Religious attendance		
Yes	29	91
No	3	9
Marital status		
Single	16	50
Married	12	37,5
Divorced	2	6,24
In concubinage	1	3,13
Widowed	1	3,13

As a reason for consultation, anxiety was most frequent in 50% of cases, followed by sleep disorders in 25% of cases and agitation in 6.25% of cases. The recourse to care of the general practitioner prevailed in 43, 75% of the cases followed by the absence of treatment (none) in 18.75% of cases and in third place found the use of mixed type treatment (12.50%). The latter

grouped together medical, traditional and religious treatment. The 66% of patients with an anxiety disorder had no particular history and the 22% of the patients were chronic hypertensives. The 68.75% of patients with an anxiety disorder had no antecedent particular psychiatric staff. A history of anxiety disorders have been found in 15.63% of patients followed by attempted suicide in 12.50% of cases. The majority of patients did not have toxic habits in 69% of cases. No patient had a psychiatric family history. Entangled factors as well as psychic traumas alone predominated in 31.25% of cases, followed by chronic stress in 18.75% of case. Mourning was the most common trauma in 15.63% of cases. Post-traumatic stress disorder prevailed in 28.10% of cases, followed by the panic disorder in 21.88% of cases and generalized anxiety disorder in 18.75% of cases. (Fig. 2).

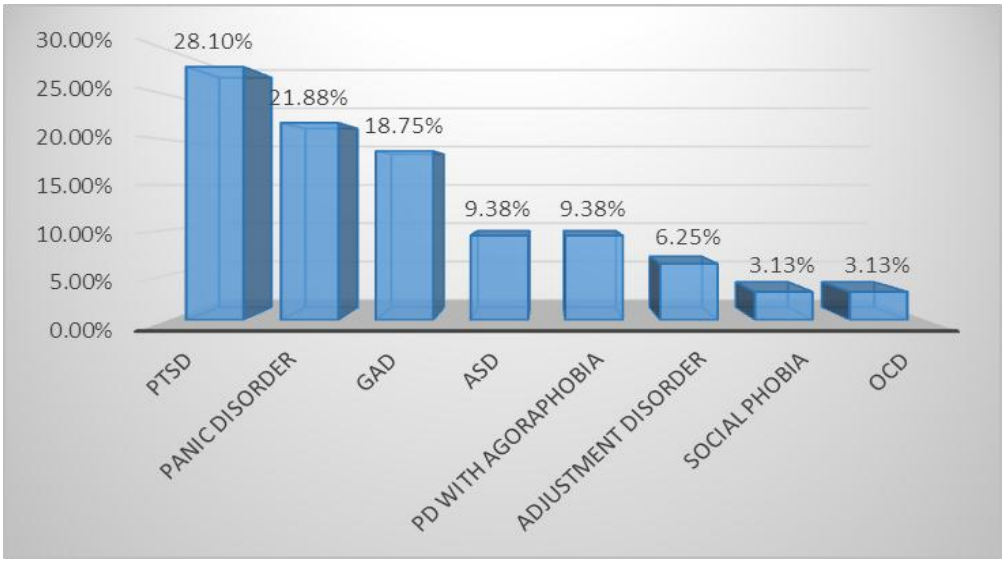

Figure 2: Patient distribution by type of anxiety disorder.

Depressive syndrome was the pathology most associated with anxiety disorders in 46.88% of the cases. The association psychotherapy and drugs were predominant in 88% of cases. Influence by stressful life events was most 62.5% of cases, followed by consideration for lack of calcium and / or magnesium in 15.63% of the cases and as due to the work overload in 6.25% of the case.(Fig 3).

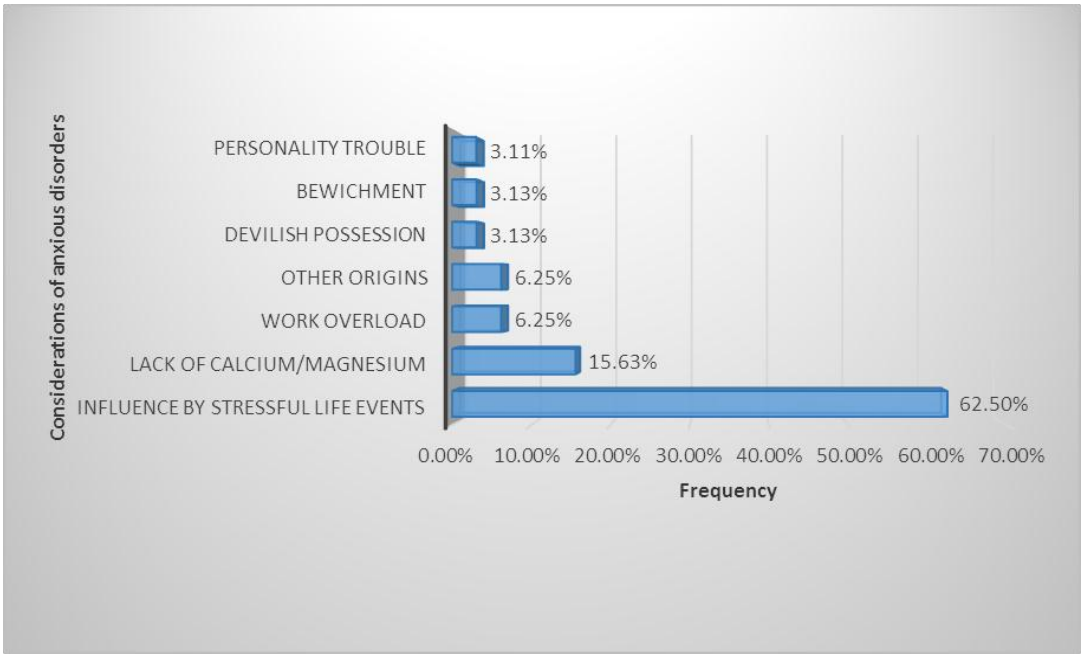

Figure 3: Distribution of patients according to their considerations of anxiety disorder.

The 87% of cases reported several socio-professional impacts. The difficulty in dealing with professional activities predominated in 35% of cases, followed by limitations of social and recreational activities in 30% of cases.

DISCUSSION

According to our study, the 8-month prevalence of anxiety disorders was 2%. What differs from the figures found in the literature and in various studies.[5] Indeed, the World Mental Health Surveys (WMHS) found that in multiple countries, anxiety disorders are more prevalent than mood disorders, disorders related to substance abuse and impulsive disorders.[6,7] He also noted the wide variability in the prevalence of anxiety disorders worldwide and from one study to another ranging from 4.8 to 10.9%.[8,9] More precisely one systemic study of several journals found prevalences in Anglo-Saxon cultures (3.8-10.4%), Indian and Asian cultures (2.8%), African (4.4%), Central and Eastern Europe (3.2%), North and Middle East (4.9%), and Latin cultures (6.2%).[10] Our figures would be closer to Indian and Asian cultures. However, The difference is striking in relation to the prevalence of other crops found on the global plan. This could be due firstly to the difference on the consideration of symptoms anxiety disorders as a disease, which reduces the frequency of consultation in the specialist.[11] Second, the symptoms of anxiety disorders cause many embarrassments (the constant checks of the Obsessive Compulsive Disorder, the floating anxiety in the Panic disorder etc ...), which hinders people to consult also.[12] But there may

be a real difference from the numbers because the risk and resilience factors of each culture are different, and if anxiety disorders are the most prevalent mental disorders elsewhere, they can not to be prevalent in our country, this could be cultural.[13] About sociodemographic characteristics, our findings about age and gender, and living environment, has been found in the literature where anxiety disorders affect the youngest adults and the female gender.[14] About the profession in our study, patients with business executives predominated 34.38% of cases, followed by students in 28.13% of cases. Our results are different from those found in most studies where disorders Anxiety is limited to people with low levels of education and unstable employment.[15] The explanation in these latter would be that people with stable employment and therefore with a high level of education have more potential to cope with stress, less educated people have fewer "unscrambling" strategies and change employment leads to a stressful life and thus increases the risk anxiety.[16] Our results could be explained by the non-management of the productivity pressure and great responsibility at work, as well as the hierarchical conflicts that increase work stress in managers.[17] In reality in Madagascar, everything is also a question of wages because the most Malagasy executives work hard but are underpaid. That could be the origin of ill-being and major conflicts in the home, thus generating disturbances anxious, of course in association with other individual factors. No profession is thus spared from the risk of anxiety disorder if one can say. About the predominance of single patients in 50% of cases in our study, this result matches that of literature and other previous studies.[18] About the religion, the 91% of patients had a religious affiliation according to our study. Which is discordant with data from literature and that of other studies where religion appears to be a protective factor against mental disorders in general.[19] This makes us ask questions, and if in our country, religion is not used as a positive resource but would only be limited to a ritualized practice for to integrate a particular company or keep a good image within it? About the consultation reason and start mode in our study, anxiety was the most common reason for consultation in half of the cases (50%). However, the other half was the disorder sleep (25%), restlessness (6.25%), then asthenia, behavioral disorders, palpitations, unconsciousness, hyper irritability, dyspnea were each seen in 3.13% of cases. The most frequent start mode was progressive in 68.75%. Our results are similar to those in literature where, most of the time, anxiety is rarely expressed in the foreground, patients often report diffuse complaints and durable, having already progressed, and the bad being anxious can express itself by complaints subjective (asthenia, pain, functional complaints, etc.), symptoms behavioral (avoidance, agitation, etc ...) or psychological (worries, emotional expressions ...) that evoke to the clinician a pathological

anxiety or bewilder to miss even.[20] And about the precipitating factors, family conflict was predominant (21.88%), followed by conflict (15, 63%) and the sudden death of a relative / relative (15.63%). This joins the data from the literature where environmental factors precipitating factors for patients with anxiety disorders.[21] And this reflects the specificity of the Malagasy family, where the *"Fihavanana"* reigns in the extended family type. Concerning primary care of the general practitioner in 43.75% of cases, followed by therapeutic abstinence in 15.75% of cases. this is in line with the result found by other studies that people neurotic seek "non-psychiatric" help, prefer to go to the doctor family or general practitioner, before being diagnosed as neurotic, ashamed or embarrassed to evoke these disorders.[22] In our study, the majority of patients had no personal history (66% of cases) and no psychiatric personal history was reported in 68.75% of cases, the personal history of anxiety disorders was 15.63% of cases. In terms of toxic habits, the 69% of our patients had reported no toxic habit, occasional alcoholism was seen in 22% of cases. As for the family psychiatric antecedents, none of our patients had reported anxiety disorders in their family, at their parents. Our results are different from those of other studies found most often majority of personal anxiety disorders and / or anxiety disorders in one or more two parents.[23] Indeed, several studies argue in favor of a family aggregation of anxiety disorders, suggesting the existence of a link between anxious disorders of the child and anxiety disorders of the parents. However, if these studies emphasize the importance of transgenerational anxiety disorders, their analysis shows that with the exception of panic disorder, it is difficult to establish a continuity between anxiety disorders observed in children and those found in parents.[24] Our results could be explained by the fact that these disorders are not easily evoked from parent to child, because ignored as a disorder, and therefore not evoked as such. Regarding our results on toxic habits, they are different from that found in other studies where there is heavy consumption or substance abuse accompanying or complicating anxiety disorders. These studies found that men would be more likely than women to manage their anxiety through the abuse of substances because they would perceive alcohol as an effective strategy for to compensate for their anxiety.[25] Our results could be explained by the fact that our patients are female predominance, and women have fewer recourse to substances than women men in their anxiety management. So the main role of the clinician is then to describe with the patient precisely the semiological characteristics both to allow to eliminate an organic cause and analyze more finely the underlying. Concerning the types of anxiety disorders, in our study, the most common anxiety disorder was PTSD (28.13%) Panic Disorder (21.88%), Generalized Anxiety Disorder (18.75%), ASD (9.38%), Panic disorder

with agoraphobia (9.38%), Adjustment disorder (6.25%), and OCD and agoraphobia (3.13% each). Regarding the prevalence of PTSD, our numbers are high compared to those found other studies such as the one in Brazil with young adults finding prevalence at one year of 2.5%, or compared to the study of Kessler et al finding prevalence of PTSD at 2.7%, another study of anxiety disorders in the middle liberal finds a prevalence of 5.4%.[26] However, our results are similar to those found in a study Rwanda, with a prevalence of 37.1% in a post-genocidal context or PTSD again found in Banghi, a conflict zone in Africa, where PTSD was 33.33% prevalence.[27,28] Our results are similar with those of countries where the population was victim of intentional trauma. However the presence of trauma alone at some point in life does not is not enough to develop a PTSD on its own because the factors personal and environmental risk forecasts. In fact, in our study, past traumas, individual factors seem to play a role negligible, such as the predominance of the female gender, because women are more to be sexually assaulted while men experience more physical aggression.[29,30] But apart from that, the Malagasy tends to easily believe what the other says, the "free affirmations". Because according to a study, strongly adhere to beliefs fundamental principles of a benevolent, just and logical world and believe in its value and personal invulnerability could cause more pathological symptoms to the following a traumatic event. The invalidation of these conceptions by experience traumatic experience and difficulties in integrating the experience for the victim would development and maintenance of PTSD symptoms.[31] And Ingram and his collaborators demonstrate that a social network with little or no support is associated with poor post-traumatic adjustment responsible for the perpetuation of this peri-traumatic dissociation.[32] These cases are indeed found in the Malagasy culture where we avoid to “stir the past” or *"mamoha fota-mandry"* in the circumstances of disasters or psychological trauma, we avoid talking about it, the "psychological debriefing" does not exist not so much between loved ones in post-traumatic circumstances, which could encumber the adaptive treatment of traumatic information as well as its resolution. This could explain the high prevalence of PTSD in our results. With regard to Panic Disorder with a prevalence of 21.75% and the panic disorder with agoraphobia at 9.38%, our prevalence is high compared to those found in other studies, especially for panic disorder, and in relation to the literature. Indeed, a study in Canada showed a prevalence of TP at 3.7%, and a other in the United States at 2.7%. The prevalence of TPA was 3.5%.[33,34] Our results could be explained by predominantly entangled factors individual at the origin of Panic Disorder in Malagasy, which generally has little resilience capacity. Indeed, according to the psychophysiological model, both states psychic and corporal (eg general level of

anxiety, emotional states intensive, physical exhaustion, hormonal changes) than factors situational (an experience of anxiety through bodily activity, excessive consumption nicotine or caffeine, or drugs and drugs) may affect short term the process of positive feedback. Situational influences relatively durable (eg difficult situation of sustainable living) and individual predispositions of the person act on the other hand rather in the long run. This is very common in a developing country like Madagascar, where the economic crisis is permanent. What makes the population more risk of panic disorder more than elsewhere.[35] As comorbidity, depressive syndrome was the most common in 46.88% cases in our study. Which joins the result of other studies as well.[36] About the treatment the combination of psychotherapy and medication was predominant in 87.5% of case. Our results are similar to those of the literature. About the consideration, the majority of patients (62.5%) considered their disorder as influencing stressful life events, the 15.63% of cases as a lack of calcium or magnesium, and then 6.13% of cases each as a disorder due to work overload or to nothing in particular, and the 3.13% of the cases each was as if due to a spell, a diabolical possession, a personality disorder. Our results are consistent with data from several studies where knowledge of the general public about mental health has undergone a revolution in recent years, and anxiety disorders are currently widely considered by the general population as coming from external factors related to the stressful events of life.[37] We draw attention to the second consideration, as being the consequence of a lack of calcium or magnesium, which differs from the data in the literature. Indeed, if somatic complaints in anxiety disorders such as a neuromuscular hyper excitability lead to paresthesia and hyper-reflexivity, this translated in no case a lack of calcium in the main sign is the hand of midwife after nerve compression.[38] This often confuses the patient in his directions of seeking help. The vigilance of the practitioner is therefore essential to any interpretation of this nature coming from the patient that could hide an underlying anxiety disorder. About the socio-professional impact, several socio professional impacts predominated in 87.5% of cases. Among them, the difficulty of facing professional activities (35%) as well as the limitation social and recreational activities (30%) led the way. Our data confirm the results of several studies because the disorders anxiousness cause a heavy burden for the person and the high social costs in terms of healthcare use and overcoating all significantly reduce productivity at work. What is harmful to development of the individual and the country.[39] Regarding these findings, we recognize the limitations of the study by firstly, our sample size does not allow us to generalize our results given our places of study only with UHC patients. Include patients at the basic health centers would be more appropriate later. Secondly, the absence of

a child psychiatry center in our country has also limited in the choice of our study population because Madagascar is mainly composed of young population, children and adolescents are in greater number.

CONCLUSION

Overall, this study shows a lower prevalence of anxiety disorders at prevalence of post-traumatic stress disorder, and these disorders are mainly women, business executives, singles. The first resort of anxious patients happens to be the general practitioner. But still, these troubles are especially considered as resulting from the influence of stressful life events by the malagasy patient and have a considerable impact both on his professional activity and social. We suggest then to promote more care as much preventive than curative. To improve our practices, we encourage all practitioners to further refine the diagnosis of anxiety disorders and refer at the earliest or ask the opinion of a colleague at the slightest doubt. To do this, it would be wise to implement place simple diagnostic tools (such as the MINI) during consultations in general medicine. In the preventive framework, the media coverage, the development of radio programs or television concerning anxiety disorders should help the general population in information, understanding and management of these disorders. In addition, the extension Stress self-management tools should integrate postgraduate training because as we know now, stress is a physiological affect but when that last this chronicizes, it causes the anxiety disorders, which themselves are complicated by depression, "burnout", suicide attempt etc... As a result, learning these tools should be an important part of any doctor's use with patients. As part of a curative, the creation of child psychiatry center in our country is a major need. But also, the creation of a medical and psychological center would allow a less stigmatizing approach for the population. Finally, promoting EMDR trainning psychotherapy in our country could perpetuate in order to increase and strengthen the number of therapists for an optimal load of anxiety disorders.

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