



RESEARCH ARTICLE

PREVALENCE OF FIBROMYALGIA AMONG INDIVIDUALS WITH PSYCHIATRIC DISORDERS

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ABSTRACT

Although fibromyalgia was historically viewed as a psychiatric disorder, it is now recognized as a distinct clinical entity characterized by chronic widespread pain and a range of associated symptoms. Numerous studies have sought to identify the factors involved in the onset, precipitation, and persistence of fibromyalgia. The present study aimed to assess the prevalence of fibromyalgia across the different psychiatric diagnostic categories encountered at the National Institute of Public Health (INSP) in Côte d'Ivoire. A total of 320 patients attending psychiatric consultations were recruited on a voluntary basis. Fibromyalgia screening was performed using the Fibromyalgia Rapid Screening Tool (FiRST) developed by Perrot *et al.*, combined with the assessment of Yunus tender points. Different proportions of fibromyalgia cases were observed across the psychiatric categories. Overall, the prevalence of fibromyalgia was estimated at 41.6%. As the first study on fibromyalgia conducted in Côte d'Ivoire, these findings provide evidence for the existence of this condition within the Ivorian population, particularly among psychiatric patients. Further population-based studies are needed to determine the overall prevalence of fibromyalgia in the general population.

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INTRODUCTION

The year 1992 marked a decisive turning point in the history of a condition that had long attracted attention without being fully recognized by the scientific community. Historically, fibromyalgia was frequently interpreted through psychogenic and psychosomatic frameworks before gradually gaining recognition as a distinct clinical syndrome." (Graham, 1953). It has since moved beyond this framework and continues to generate considerable debate regarding its recognition and clinical legitimacy (Millêtre-Bernadin & Memran-Pourcher, 1995 ; Kahn, 2001; Serisès, 2004). Over time, several definitions of fibromyalgia have emerged, reflecting the various pathophysiological mechanisms proposed to explain the condition (Russell, 2001). However, the definition most widely accepted by researchers is derived from the work of Wolfe and colleagues. According to these authors, fibromyalgia is characterized by widespread pain associated with a reduced pain threshold and a constellation of characteristic symptoms, including non-restorative sleep, fatigue, mood disturbances, irritable bowel symptoms, and headaches (Wolfe *et al.*, 1990; Wolfe *et al.*, 1995). In essence, fibromyalgia can be described as a chronic musculoskeletal pain syndrome occurring in the absence of identifiable structural pathology (Cathébras, 2006). This conceptualization has contributed significantly to the recognition of fibromyalgia as a distinct clinical entity and has stimulated extensive research into its epidemiology, etiology, and clinical

manifestations. Although no curative treatment for fibromyalgia is currently available, the condition has been consistently associated with a variety of psychiatric disorders at varying rates (Goldenberg, 1986; Epstein *et al.*, 1999). Research aimed at identifying its underlying causes has highlighted the contribution of biological, psychological, and social factors. Consequently, the biopsychosocial model has emerged as the most appropriate framework for understanding and investigating fibromyalgia (Engel, 1977, 1980; Sarafino, 1990; Bruchon-Schweitzer & Dantzer, 1994; Dantzer, 2001; Bruchon-Schweitzer, 2002; Santiago-Delefosse, 2002). Over the years, screening and diagnostic tools for fibromyalgia have diversified, most of them relying on the assessment of pain-related symptoms and clinical manifestations (Wolfe, 1996; Perrot *et al.*, 2010). Although no specific psychopathological profile has been identified among individuals with fibromyalgia, mood disorders have repeatedly been reported as common clinical features of the syndrome. The number of patients diagnosed with fibromyalgia has shown considerable variation depending on the medical specialty consulted (Bresseur, 1997; Thomas & Blotman, 2002). Likewise, estimates of the worldwide prevalence of fibromyalgia vary substantially across countries and studies, largely depending on the diagnostic criteria employed and the methodological approaches adopted by researchers. In the general population, prevalence rates have been reported to range from approximately 1% to 12%. In most cases, patients with fibromyalgia are encountered in rheumatology departments

and specialized chronic pain clinics. Conversely, relatively few studies have explored the prevalence of fibromyalgia among individuals receiving treatment for psychiatric disorders. Investigating the relationship between fibromyalgia and common psychiatric conditions may therefore provide valuable insights into the clinical and epidemiological overlap between these disorders.

Study Objective and Hypothesis: The primary objective of this study was to determine the prevalence of fibromyalgia among individuals diagnosed with psychiatric disorders and receiving care at the National Institute of Public Health (INSP), Côte d'Ivoire. It was hypothesized that fibromyalgia prevalence would differ significantly across psychiatric diagnostic categories.

METHODS

Participants: The clinical sample consisted of 320 participants diagnosed with common psychiatric disorders according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR; American Psychiatric Association [APA], 2003). Participants were recruited from two categories of patients attending the National Institute of Public Health (INSP): individuals presenting for their first psychiatric consultation and patients already engaged in psychotherapeutic follow-up. The participants were receiving treatment for a range of psychiatric conditions, including schizophrenia, major depressive disorder, acute psychotic disorder, chronic hallucinatory psychosis, bipolar disorder, seizure disorders, substance use disorders, manic episodes, paranoid psychosis, and other psychiatric conditions. Only participants aged 18 years or older, who had received a psychiatric diagnosis and were undergoing pharmacological treatment, were eligible for inclusion in the study.

Exclusion Criteria

Participants were excluded from the study if they met any of the following criteria:

- Presence of active suicidal risk;
- Diagnosis of inflammatory rheumatic diseases, including rheumatoid arthritis, systemic lupus erythematosus, or related disorders;
- Diagnosis of Sjögren's syndrome, polymyositis, vasculitis, or other autoimmune connective tissue diseases;
- Presence of infectious diseases known to be associated with chronic pain syndromes, including hepatitis B, hepatitis C, Lyme disease, or human immunodeficiency virus (HIV) infection;
- Presence of metabolic or endocrine disorders that could account for chronic musculoskeletal symptoms, including disorders of calcium-phosphate metabolism, hypothyroidism, hyperparathyroidism, osteomalacia, or phosphate diabetes.

Procedure and Data Collection: This prospective cross-sectional study was conducted in the Addictology and Mental Health Department of the National Institute of Public Health (INSP) over an 18-month period, from January 2014 to July 2015. Patients receiving treatment for common psychiatric disorders were referred to the research team by their respective clinicians during routine consultations. The research team

consisted of a neuropsychiatrist, a psychologist, a biologist, and a psychiatric nurse. During the initial meeting, the objectives and procedures of the study were explained to both the participants and their accompanying relatives or caregivers. Written informed consent was then obtained prior to enrollment. Following this stage, an appointment was scheduled, with the participant's agreement, for a semi-structured interview conducted by members of the research team. Participant eligibility and fibromyalgia screening were performed by the neuropsychiatrist based on the study inclusion and exclusion criteria, as well as information contained in the participants' medical records. During the interviews, sociodemographic information was collected and participants completed the Fibromyalgia Rapid Screening Tool (FiRST) developed by Perrot *et al.* (2010), in conjunction with an assessment of Yunus tender points (Yunus *et al.*, 1988). The FiRST is a six-item screening instrument designed to assess chronic widespread pain and associated symptoms. It evaluates the presence of joint, muscular, or tendon pain lasting for at least three months, as well as several associated manifestations, including fatigue, pain distribution, characteristics of painful and non-painful abnormal sensations, sleep disturbances, cognitive complaints, and functional somatic symptoms. According to Perrot *et al.* (2010), the presence of at least five positive responses out of the six FiRST items yields a sensitivity of 90% and a specificity of 86% for fibromyalgia screening. However, in the present study, a more stringent criterion was adopted: all six FiRST criteria had to be endorsed for a participant to be classified as having fibromyalgia. Responses to each item were recorded in a dichotomous format ("Yes" or "No").

Statistical Analysis: Data were analyzed using the Statistical Package for the Social Sciences (SPSS), version 21. Descriptive statistics were first computed to summarize participants' sociodemographic and clinical characteristics. Frequencies, percentages, means, and standard deviations were used to describe the study sample and estimate the prevalence of fibromyalgia across psychiatric diagnostic categories. Inferential statistical analyses were subsequently conducted to examine differences in fibromyalgia prevalence among the various psychiatric disorders represented in the sample. Statistical significance was set at $p < .05$.

Ethical Considerations: Informed consent was obtained from all participants prior to their enrollment in the study. Given that the findings were intended for scientific publication, participants' names and personal identifiers were not disclosed at any stage of the research process. All data and assessment results were treated as strictly confidential and were coded to prevent any direct association with participants' identities. Electronic records containing personal information were securely stored and could only be accessed by authorized research personnel directly involved in the study. Participant-specific information could only be communicated to healthcare professionals upon the explicit request and authorization of the participant concerned. Throughout the study, all procedures were conducted in accordance with the ethical principles governing research involving human participants, including respect for confidentiality, privacy, and voluntary participation.

RESULTS

The number of participants varied across psychiatric diagnostic categories. The largest groups consisted of patients diagnosed with schizophrenia ($n = 82$) and major depressive disorder

Table 1. Distribution of Psychiatric Disorders by Gender

Psychiatric Disorders	Males N (%)	Females N (%)	Total N (%)
Schizophrenia	42 (51.2)	40 (48.8)	82 (100)
Major Depressive Disorder	26 (37.1)	44 (62.9)	70 (100)
Acute Psychotic Disorder	18 (39.1)	28 (60.9)	46 (100)
Chronic Hallucinatory Psychosis	23 (51.1)	22 (48.9)	45 (100)
Bipolar Disorder	10 (50.0)	10 (50.0)	20 (100)
Seizure Disorders	7 (38.9)	11 (61.1)	18 (100)
Other Psychiatric Disorders	11 (68.8)	5 (31.2)	16 (100)
Substance Use Disorders with Psychiatric Comorbidity	8 (80.0)	2 (20.0)	10 (100)
Mania	3 (37.5)	5 (62.5)	8 (100)
Paranoid Psychosis	2 (40.0)	3 (60.0)	5 (100)
Total	150 (46.9)	170 (53.1)	320 (100)

Table 2. Distribution of Psychiatric Disorders According to Employment Status

Psychiatric Disorders	Employed N (%)	Unemployed N (%)	Total N (%)
Schizophrenia	28 (34.1)	54 (65.9)	82 (100)
Major Depressive Disorder	15 (21.4)	55 (78.6)	70 (100)
Acute Psychotic Disorder	19 (41.3)	27 (58.7)	46 (100)
Chronic Hallucinatory Psychosis	4 (8.9)	41 (91.1)	45 (100)
Bipolar Disorder	0 (0.0)	20 (100.0)	20 (100)
Seizure Disorders	0 (0.0)	18 (100.0)	18 (100)
Other Psychiatric Disorders	1 (6.3)	15 (93.7)	16 (100)
Substance Use Disorders with Psychiatric Comorbidity	0 (0.0)	10 (100.0)	10 (100)
Mania	0 (0.0)	8 (100.0)	8 (100)
Paranoid Psychosis	0 (0.0)	5 (100.0)	5 (100)
Total	67 (20.9)	253 (79.1)	320 (100)

Table 3. Prevalence of Fibromyalgia Across Psychiatric Diagnostic Categories

Psychiatric Disorders	FM n (%)	NFM n (%)	Total n (%)
Schizophrenia	23 (28.0)	59 (72.0)	82 (100)
Major Depressive Disorder	70 (100.0)	0 (0.0)	70 (100)
Acute Psychotic Disorder	4 (8.7)	42 (91.3)	46 (100)
Chronic Hallucinatory Psychosis	9 (20.0)	36 (80.0)	45 (100)
Bipolar Disorder	7 (35.0)	13 (65.0)	20 (100)
Seizure Disorders	13 (72.2)	5 (27.8)	18 (100)
Other Psychiatric Disorders	7 (43.7)	9 (56.3)	16 (100)
Substance Use Disorders with Psychiatric Comorbidity	0 (0.0)	10 (100.0)	10 (100)
Mania	0 (0.0)	8 (100.0)	8 (100)
Paranoid Psychosis	0 (0.0)	5 (100.0)	5 (100)
Total	133 (41.6)	187 (58.4)	320 (100)

Note. FM = Fibromyalgia; NFM = Non-Fibromyalgia. Chi-square test: $\chi^2 = 157.37, p < .001$.

Table 4. Distribution of Fibromyalgia According to Gender

Gender	FM n (%)	NFM n (%)	Total n (%)
Male	49 (32.7)	101 (67.3)	150 (100)
Female	84 (49.4)	86 (50.6)	170 (100)
Total	133 (41.6)	187 (58.4)	320 (100)

Note. FM = Fibromyalgia; NFM = Non-Fibromyalgia.
Chi-square test: $\chi^2 = 9.20, p = .002$.

Table 5. Distribution of fibromyalgia according to employment status

Employment Status	FM n (%)	NFM n (%)	Total n (%)
Employed	32 (47.8)	35 (52.2)	67 (100)
Unemployed	101 (39.9)	152 (60.1)	253 (100)
Total	133 (41.6)	187 (58.4)	320 (100)

Note. FM = Fibromyalgia; NFM = Non-Fibromyalgia ; Chi-square test: $\chi^2 = 1.34, p = .247$.

(n = 70). These were followed by intermediate-sized groups of participants diagnosed with acute psychotic disorder (n = 46) and chronic hallucinatory psychosis (n = 45). Smaller sample sizes were observed in the following diagnostic categories: bipolar disorder (n = 20), seizure disorders (n = 18), other psychiatric conditions (n = 16), substance use disorders with psychiatric comorbidity (n = 10), mania (n = 8), and paranoid psychosis (n = 5). Overall, the distribution of participants indicates that schizophrenia and major depressive disorder were the most frequently represented psychiatric conditions in

the study sample, whereas mania and paranoid psychosis were the least represented diagnostic categories.

Distribution of Psychiatric Disorders by Gender: Variable proportions of males and females were observed across the different psychiatric diagnostic categories. In the categories classified as *Other Psychiatric Disorders* and *Substance Use Disorders with Psychiatric Comorbidity*, males predominated, accounting for 68.8% and 80.0% of participants, respectively (Table 1). Participants diagnosed with schizophrenia, chronic

hallucinatory psychosis, and bipolar disorder were relatively evenly distributed between males and females. The proportions of male participants in these diagnostic groups were 51.2%, 51.1%, and 50.0%, respectively. In contrast, a clear female predominance was observed among participants diagnosed with major depressive disorder, acute psychotic disorder, and seizure disorders. Females represented 62.9%, 60.9%, and 61.1% of these groups, respectively. Overall, these findings indicate gender-related differences in the distribution of psychiatric disorders within the study population, with some diagnostic categories showing a marked predominance of either male or female participants.

Distribution of Psychiatric Disorders According to Employment Status:

Overall, the data revealed a marked imbalance between employed and unemployed participants (Table 2). Of the 320 participants included in the study, 67 (20.9%) were engaged in paid employment, whereas 253 (79.1%) were not employed. The unemployed group included not only individuals without a job but also students, pupils, and retirees. The distribution of psychiatric disorders according to employment status varied across diagnostic categories. Participants diagnosed with schizophrenia, major depressive disorder, and acute psychotic disorder exhibited moderately high proportions of unemployment, accounting for 65.9%, 78.6%, and 58.7% of cases, respectively. Very high unemployment rates were observed among participants diagnosed with chronic hallucinatory psychosis and those classified within the *Other Psychiatric Disorders* category, with proportions reaching 91.1% and 93.7%, respectively. Furthermore, all participants diagnosed with bipolar disorder, seizure disorders, substance use disorders with psychiatric comorbidity, mania, and paranoid psychosis were unemployed, corresponding to an unemployment rate of 100% within each of these diagnostic categories. Overall, these findings indicate that unemployment was highly prevalent among participants with psychiatric disorders, regardless of diagnostic category, with particularly elevated rates observed among individuals with severe and chronic psychiatric conditions.

Association Between Fibromyalgia and Psychiatric Diagnostic Categories:

In the present study, participants were classified as having fibromyalgia (FM) if they met two criteria simultaneously: (a) positive responses to all six items of the Fibromyalgia Rapid Screening Tool (FiRST) developed by Perrot *et al.* (2010), and (b) the presence of more than 11 tender points according to the criteria proposed by Yunus *et al.* (1988). Participants who did not meet both criteria were classified as non-fibromyalgia (NFM) cases. Fibromyalgia was distributed unevenly across the psychiatric diagnostic categories represented at the National Institute of Public Health (INSP). Cases of fibromyalgia were identified in nearly all psychiatric groups, with the exception of three categories: mania, paranoid psychosis, and substance use disorders with psychiatric comorbidity, in which no participants met the criteria for fibromyalgia (Table 3). Among the 70 participants diagnosed with major depressive disorder, all met the criteria for fibromyalgia, corresponding to a prevalence of 100%. Of the 18 participants with seizure disorders, 13 were classified as FM, representing 72.2% of the group, whereas 5 participants (27.8%) were classified as NFM. Among participants diagnosed with bipolar disorder, 7 out of 20 met the criteria for fibromyalgia, corresponding to a prevalence of 35.0%, while the remaining 13 participants (65.0%) were classified as non-fibromyalgia cases. In the acute psychotic disorder group, only

4 of the 46 participants (8.7%) met the criteria for fibromyalgia, whereas 42 participants (91.3%) were classified as NFM. Similarly, among the 82 participants diagnosed with schizophrenia, 23 (28.0%) met the criteria for fibromyalgia and 59 (72.0%) did not. Finally, within the category labeled *Other Psychiatric Disorders*, which comprised a heterogeneous group of psychiatric conditions, 7 of the 16 participants (43.8%) were classified as FM, whereas 9 (56.3%) were classified as NFM. Across all psychiatric diagnostic categories combined, a total of 133 participants were classified as having fibromyalgia, compared with 187 participants without fibromyalgia. These figures correspond to overall prevalence rates of 41.6% and 58.4%, respectively.

Distribution of Fibromyalgia According to Gender:

The study sample comprised 150 male participants and 170 female participants, corresponding to 46.9% and 53.1% of the total sample, respectively, across all psychiatric diagnostic categories. Among male participants, 49 individuals (32.7%) met the criteria for fibromyalgia (FM), whereas 101 (67.3%) were classified as non-fibromyalgia (NFM) cases (Table 4). Among female participants, 84 out of 170 (49.4%) met the criteria for fibromyalgia, while 86 participants (50.6%) were classified as non-fibromyalgia cases (Table 4). Overall, fibromyalgia was more prevalent among women than among men. Whereas nearly one out of two female participants met the criteria for fibromyalgia, approximately one-third of male participants were classified as fibromyalgia cases.

Distribution of Fibromyalgia According to Employment Status :

The study population consisted of 67 employed participants and 253 unemployed participants (Table 5). Among employed participants, 32 individuals (47.8%) met the criteria for fibromyalgia (FM), whereas 35 (52.2%) were classified as non-fibromyalgia (NFM) cases. Among unemployed participants, 101 individuals (39.9%) met the criteria for fibromyalgia, while 152 (60.1%) did not meet the criteria for the condition. Overall, fibromyalgia was observed in both employment groups, with a slightly higher prevalence among employed participants (47.8%) compared with unemployed participants (39.9%).

DISCUSSION

To our knowledge, this study is the first investigation of fibromyalgia conducted in Côte d'Ivoire. It sought to estimate the prevalence of fibromyalgia among individuals receiving treatment for psychiatric disorders. This approach is particularly innovative, as most previous studies on fibromyalgia have been carried out among patients attending rheumatology departments or specialized chronic pain clinics. Overall, the findings revealed a substantial prevalence of fibromyalgia among psychiatric patients treated at the National Institute of Public Health (INSP). The overall prevalence was estimated at 41.6%, highlighting the significant presence of fibromyalgia within psychiatric populations. This finding is consistent with previous reports emphasizing the close relationship between fibromyalgia and psychiatric disorders (Fond *et al.*, 2001). More specifically, fibromyalgia was strongly associated with certain psychiatric conditions, particularly major depressive disorder, seizure disorders, and bipolar disorder. Among participants diagnosed with major depressive disorder, all patients met the criteria for fibromyalgia, resulting in a prevalence rate of 100%. This

finding is broadly consistent with previous studies showing that depressive symptoms are highly prevalent among individuals with fibromyalgia (Goldenberg *et al.*, 1986; Kirmayer *et al.*, 1988; Okifuji *et al.*, 2000).

The strong overlap observed between depression and fibromyalgia may reflect shared biological and psychological mechanisms, including dysregulation of neurotransmitter systems, alterations in pain processing, sleep disturbances, and emotional distress. In addition to major depressive disorder, high prevalence rates of fibromyalgia were observed among participants with seizure disorders (72.2%) and bipolar disorder (35.0%). Given the relatively small number of participants in these diagnostic categories, these findings should be interpreted cautiously and warrant further investigation. Nevertheless, it is noteworthy that antiepileptic medications are frequently prescribed in the management of fibromyalgia and other chronic pain conditions, suggesting potential neurobiological links between these disorders (Foleti & Maeder-Ingvar, 2010; Desseilles *et al.*, 2016; Driouchi, 2017; Dumont, 2012). Within the psychotic disorders spectrum, represented in this study by acute psychotic disorder, chronic hallucinatory psychosis, and schizophrenia, fibromyalgia prevalence rates were 8.7%, 20.0%, and 28.0%, respectively. These findings are partially consistent with the literature. Indeed, although numerous studies have reported reduced pain sensitivity among individuals with schizophrenia (Kudoh *et al.*, 2000; Blumensohn *et al.*, 2002; Jochum *et al.*, 2006; Lévesque *et al.*, 2011), other investigations have challenged the hypothesis of generalized hypoalgesia in schizophrenia (Collins & Stone, 1966; Song & Yi, 2000; Potvin *et al.*, 2008, 2009; Potvin & Marchand, 2008). Current evidence suggests that while pain perception may be altered in schizophrenia, the nature and mechanisms of this alteration remain poorly understood. Consequently, schizophrenia should not be regarded as a condition characterized by complete insensitivity to pain (Potvin, 2011). Fibromyalgia was absent in several psychiatric categories, including mania, paranoid psychosis, and substance use disorders with psychiatric comorbidity. Given the limited sample sizes within these groups, further studies involving larger populations are needed before definitive conclusions can be drawn. Nevertheless, the overall findings support the study hypothesis that fibromyalgia prevalence differs across psychiatric diagnostic categories. Furthermore, the relationship between gender and fibromyalgia revealed a significant female predominance ($\chi^2 = 9.20$, $p = .002$). This finding is consistent with previous studies reporting that women account for between 70% and 95% of fibromyalgia cases among patients seeking treatment for chronic pain (Wolfe *et al.*, 1995; Cathébras *et al.*, 1998; Kahn, 2001; Thomas & Blotman, 2002). Female predominance was also observed across several psychiatric diagnostic categories represented in the study, in accordance with broader epidemiological findings regarding gender differences in mental health disorders (DREES, 2004). With respect to employment status, a high proportion of individuals with fibromyalgia were unemployed. However, the association between employment status and fibromyalgia did not reach statistical significance ($\chi^2 = 1.34$, $p = .247$). This observation should be interpreted within the broader socioeconomic context of developing countries, where unemployment and informal employment are common among healthcare users (Defebvre & Barnay, 2016). Mental health is closely linked to socioeconomic conditions, which may contribute both to the onset and persistence of chronic health conditions. Several

limitations should be acknowledged. First, participants were recruited through a convenience sampling procedure, which may limit the generalizability of the findings. Second, the study population was heterogeneous, including both newly diagnosed patients with less than two weeks of follow-up and individuals receiving treatment for at least three months. Finally, the cross-sectional design precludes any conclusions regarding causal relationships between psychiatric disorders and fibromyalgia. Despite these limitations, the present study provides the first evidence of a substantial burden of fibromyalgia among psychiatric patients in Côte d'Ivoire. These findings underscore the importance of systematic screening for fibromyalgia within psychiatric settings and highlight the need for further epidemiological investigations in both clinical and community populations.

CONCLUSION

This study provides the first evidence of the presence and distribution of fibromyalgia among psychiatric patients in Côte d'Ivoire. The findings indicate that fibromyalgia is a clinically relevant condition within psychiatric settings and that its prevalence varies considerably across psychiatric diagnostic categories. A particularly high prevalence of fibromyalgia was observed among participants diagnosed with major depressive disorder, while lower prevalence rates were found among individuals with psychotic disorders. These results support the hypothesis that fibromyalgia is differentially associated with psychiatric conditions and suggest the existence of specific relationships between chronic pain syndromes and certain forms of psychopathology. The study also confirmed the well-documented female predominance of fibromyalgia and highlighted the substantial burden of this condition among patients receiving psychiatric care. Given the relatively large numbers of participants with major depressive disorder and schizophrenia, the findings concerning these two diagnostic groups appear particularly robust. By contrast, conclusions regarding other psychiatric categories should be interpreted with caution because of the smaller sample sizes involved. Future research should further investigate the relationship between fibromyalgia and major depressive disorder, as well as the mechanisms underlying the association between fibromyalgia and schizophrenia. Additional studies involving larger samples are also needed to clarify the prevalence and clinical significance of fibromyalgia in less represented psychiatric populations. Overall, these findings underscore the importance of incorporating fibromyalgia screening into psychiatric practice and highlight the need for broader epidemiological studies in both clinical and community settings in Côte d'Ivoire.

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