

Epidemiological and Clinical Aspects of Anxiety Disorders in Chu Conakry

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Abstract

The general objective of our study was to describe the clinical and epidemiological aspects of anxiety disorders. This was a retrospective descriptive cross-sectional study, lasting 5 years, from January 01, 2019 to December 31, 2023, on 225 patients seen in consultation for anxiety disorders in the department. The prevalence of anxiety disorders was 2.5% in consultation. The 20 - 29 age group was the most represented at 33.3%. Females were slightly represented at 55.1%, with a sex ratio of 1.2. The secondary level was the most affected, accounting for 36.4% of cases. Insomnia was the most frequent reason for consultation, accounting for 71.1% of cases. A larger general population study would be necessary to better assess the extent of anxiety disorders in Guinea.

Keywords

Anxiety Disorders, Epidemiology, Clinic, CHU, Conakry

1. Introduction

Anxiety disorders are a group of psychiatric disorders whose symptoms are represented by excessive anxiety, a feeling of widespread fear, worry and coping

behavior, the clinical manifestations of which may be psychological, somatic and/or behavioral. They have in common pathological anxiety.

We all experience anxiety from time to time. However, anxiety is part of the normal human emotional register and is seen as a normal response to daily stress. It is defined as a “fear without an object”. The fear of unclear danger, of a painful feeling of expectation [1].

Its possible pathological nature should be assessed using diagnostic criteria that are as precise as possible. There are indeed real “anxiety diseases”, which are characterized above all by the persistence over time of their manifestation and by their impact on the subject’s life (subjective suffering, social or professional handicap, for example). This is different from depressive states, although they may coexist in some patients [1].

This is a ubiquitous reaction that exists in normal humans and is encountered to varying degrees in all disease states, both in somatic medical practice and in psychiatry. It is qualified as pathological when the subject’s suffering leads him or her to feel it as such, due to its intensity, duration or the inability to tolerate it, use it or defend against it [2].

Classically, anxiety refers to the reactions of the visceral body and anxiety to strictly psychic reactions. But both terms can be used differently.

We can say that anxiety disorders manifest themselves in three types of responses [3].

- Physiological responses, which include the physical translations of anxiety;
- The bio-behavioral responses which associate the notions of hypo or hyper function of the corticotropic axis with the behaviors of the fight (to fight) or flight (to flee), which correspond to a function of brutal and coarse adaptation of orientation towards flight, inhibition or attack;
- Cognitive responses, which include automatic thoughts revolving around a limited number of themes, postulates, grouped into patterns. Regarding descriptive epidemiology, the lifetime prevalence for all anxiety disorders worldwide is around 30%, the most frequent disorders are phobic disorders around 15%, generalized anxiety disorders around 8% [4].

In Canada in 2016, O’Donnell S. *et al.* reported a lifetime prevalence of 24% for all anxiety disorders [5].

In France, the general population mental health study published in 2011 reported a lifetime prevalence of 21.6 for all anxiety disorders [6].

In Mali, Traore K. A. *et al.* reported in their study on anxiety disorders in outpatient consultation in 2009 at the G-spot CHU, a prevalence of 28.3% [7].

In Guinea, Dabo L. *et al.* reported in their 2008 study of anxiety disorders in the psychiatric department of Donka a prevalence of 6.91% [8].

These clinical entities affect the socioeconomic performance of those who suffer from them. They are often responsible for diagnostic wandering.

General objective: describe the clinical and epidemiological aspects of anxiety disorders in the psychiatry and neurology department of CHU Conakry.

2. Methodology

The psychiatry and neurology department of Conakry University Hospital provided the setting for this study. It is the country's reference center for the management of anxiety disorders.

It has a triple vocation of care, training and research.

Patient records provided the material for our study. The consultation registers and a data collection sheet drawn up for this purpose served as support.

This is a retrospective cross-sectional descriptive study lasting 5 years, from January 01, 2019 to December 31, 2023.

Our target population consisted of all the files of the patients received in the service during the study period and the study population, the files of all the patients received in the service during the study period in which the diagnosis of one or more anxiety disorders was carried out. Our sampling was exhaustive. We included in our study all the files of patients received in the department during the study period in which the diagnosis was established according to the standardized diagnostic criteria of the DSM-5 and the Diagnostic Interview Schedule.

However, not all patient records received by the department during the study period for psychiatric disorders other than anxiety disorders were included.

The variables in our study are quantitative and qualitative, broken down into epidemiological and clinical. From a list of all addresses, systematic samples are selected from different regions, including both urban and rural. Then, we contact these households and interview selected members using a structured questionnaire. To obtain a complete picture, representative surveys must also include patients currently hospitalized or in long-term care facilities. However, not all published studies have included the inpatient-hospitalized population, perhaps because of the heavy administrative burden associated with such surveys.

In this study, people consulting neurological and psychiatric healthcare services were examined for psychological problems and neurological disorders, regardless of the reason for consulting these services, *i.e.*, people consulting for a non-psychiatric disorder, such as motor deficit or hypertension, were included.

In these surveys, patients with anxiety disorders are generally under-represented, as anxiety disorders rarely require inpatient treatment.

The various information gathered in the files has been kept anonymous.

After the data was collected, the analysis was done manually; the entry was made using a computer equipped with Microsoft Office 2010 software. Our results were presented in the form of tables and figures and then discussed, commented on, and compared to current data in the literature.

The main difficulty of this study was the incomplete filling of medical files.

3. Results

Out of 9015 patients seen in psychiatric and neurological departments, 225 cases of anxiety disorders were examined, representing a prevalence of 2.5%. The remaining 97.5% represented other psychiatric pathologies. The 20 - 29 age group

was the most represented at 33.3%, followed by the 10 - 19 age group (23.6), with extreme ages of 0 and 89 years, for an average age of 44.5 years. The female gender was more affected, 55.1% compared to 49.7% for the male gender, with a sex ratio F/M = 1.2.

The secondary level was the most concerned, *i.e.*, 36.4% of cases, followed by patients without educational level (22.2%). 60.9% of our patients had no psychiatric history compared to 22.7%. 72.9% of our patients had a progression of ≥ 1 year. The formal training sector was most affected (33.8%), followed by the formal sector and housewives, *i.e.*, 15.6% respectively. Singles were by far the most represented (64.4%).

Insomnia was the most common reason for consultation, accounting for 71.1% of cases, followed by psychomotor instability. The main sources of referral were represented by parents in 71.1% of cases or health personnel (16.9%).

Among psychoactive substances, 49.8% of our patients used cannabis 27.1%, tobacco and 20.4% alcohol, while 16.9% of these patients made a combination of APS: cannabis + alcohol + tobacco, alcohol + tobacco or cannabis + valium + alcohol.

In 41.3% of our patients, no triggering factors were noted. The predominant diagnoses made were Panic Disorder (38.7%) followed by Generalized Anxiety (33.3%) cases. 94.2% of our patients had outpatient care.

Socio-professional characteristics: the frequency of anxiety disorders was 2.5 compared with other disorders. **Figure 1** shows the frequency of anxiety disorders in general consultations during the study period. **Table 1** shows that the 20 - 29 age group was the most represented with 33.3%, followed by the 10 - 19 age group (23.6), with extremes of 0 and 89 years for an average age of 44.5. **Figure 2** shows that the female sex was more affected, 55.1% versus 49.7% for the male sex, with a sex ratio F/H = 1.2. **Table 2** shows that the secondary school was the most affected, accounting for 36.4% of cases, followed by patients with no schooling (22.2%). **Table 3** shows that 60.9% of our patients had no psychiatric history, compared with 22.7%. **Figure 3** shows that 72.9% of our patients had an evolution $\geq A$ 1 year. **Table 4** shows that the formal training sector was more affected (33.8%), followed by the formal sector and housewives (15.6% respectively). **Table 5** shows that the singles were by far the most represented (64.4%). **Table 6** shows that insomnia was the most frequently cited reason for consultation, accounting for 71.1% of cases, followed by psychomotor instability. **Table 7** shows that the main sources of referral were parents (71.1% of cases) and health professionals (16.9%). **Table 8** shows that among psychoactive substances, 49.8% of our patients used cannabis, 27.1% tobacco and 20.4% alcohol, while 16.9% of these patients used a combination of SPAs: cannabis + alcohol + tobacco, alcohol + tobacco or cannabis + valium + alcohol. **Table 9** shows that in 41.3% of our patients, there were no triggering factors. **Table 10** shows that the predominant diagnoses given were Panic Disorder (38.7%), followed by Generalized Anxiety Disorder (33.3%). **Figure 4** shows that 94.2% of our patients were managed on an outpatient basis.

Table 2. Distribution of 225 patients by level of education.

Level of education	Number of cases	Percentage
Without level	50	22.2
Primary	30	13.4
Secondary	82	36.4
Superior	63	28
Total	225	100

Table 3. Distribution of 225 patients according to psychiatric ATCDs.

Psychiatric ANTCDs	Number of cases	Percentage
No history	137	60.9
Family	27	12
Collaterals	10	4.4
Personal	51	22.7
Total	225	100

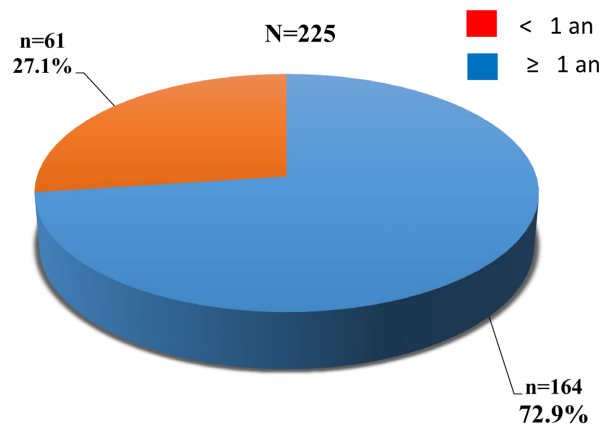


Figure 3. Distribution of 225 patients according to evolution.

Table 4. Distribution of 225 patients according to socio-professional category.

Socio-professional category	Number of cases	Percentage
Formal sector	35	15.6
Informal sector	28	12.4
Formal training sector	76	33.8
Informal training sector	32	14.2
Housewife	35	15.6
Security and Defense Force	6	2.7
Without profession	13	5.7
Total	225	100

Table 5. Distribution of the 225 patients by marital status.

Marital status	Number of cases	Percentage
Married	65	28,9
Single	145	64,4
Divorced	11	4,9
Widowed	4	1,8
Total	225	100

Table 6. Distribution of 225 patients by reason for consultation.

Reason for consultation	Number of cases	Percentage
Insomnia	160	71.1
Psychomotor instability	150	66.7
Anxiety	143	63.6
Decreased concentration	142	63.1
Sweating	140	62.2
Transpiration	140	62.2
Headache	132	58.7
Muscle tension	131	58.2
Tremor	130	57.8
Anorexia	130	57.8
Fear	101	44.9
Psychomotor agitation	87	38.7
Sadness	82	36.4
Crying	77	34.2
Psychomotor slowing	71	31.6
Forgotten	68	30.2
Physical asthenia	68	30.2
Anguish	62	27.6
Tight chest	59	26.2
Avoidance	55	24.4
Nightmares	52	23.1
Decreased libido	40	17.8
Semi-silence	38	16.9
Inconsistent words	37	16.4
Crazy ideas	37	16.4
Silence	25	11.1

Continued

Red face	24	10.7
Hypervigilance	24	10.7
Sweating	22	9.8
Pollakiwria	20	8.9
Choking	20	8.9
Ball in the throat	20	8.9
Sensation of imminent death	20	8.9
Feelings of insecurity	18	8
Motor deficit	15	6.7
Compulsion	13	5.8

Table 7. Breakdown of 225 patients by referral source.

Referral source	Number of cases	Proportion
Parents	169	75.1
Health personnel	38	16.9
Knowledge	0	0
Authority	0	0
Himself	18	8
Total	225	100

Table 8. Distribution of 225 patients according to consumption of psychoactive substances.

Consumption of psychoactive substances	Number of cases	Proportion
Tobacco	61	27.1
Cannabis	112	49.8
Alcohol	46	20.4
Valium	17	7.6
Tea/Coffee	57	25.3
Cocaine	0	0
Others**	3	1.3
SPA Association***	38	16.9
Without SPA consumption	57	25.3

***Combination: cannabis + alcohol + tobacco; alcohol + tobacco; cannabis + valium + alcohol; **Others: liquid glue, essences.

Table 9. Distribution of 225 patients according to triggering factors.

Triggering factors	Number of cases	Percentage
Divorce/Separation	11	4.9
Illness	51	22.7

Continued

Death	38	16.9
Voluntary termination of pregnancy	2	0.9
Childbirth	6	2.7
Dismissal	1	0.4
Family or professional difficulties	23	10.2
Without triggering factors	93	41.3
Total	225	100

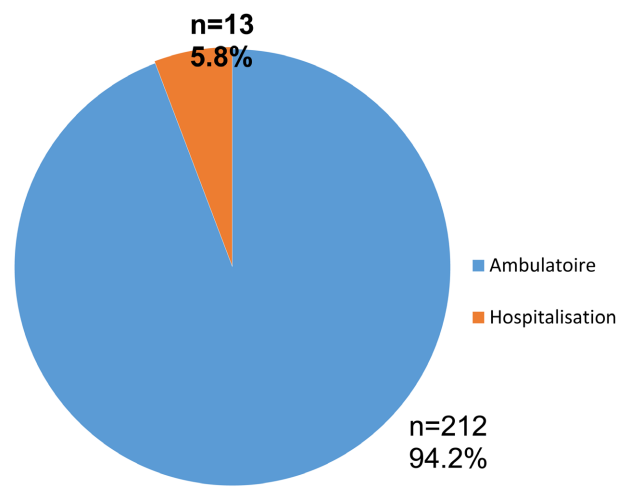


Figure 4. Distribution of patients according to the management methods.

Table 10. Distribution of 225 patients by type of anxiety disorder.

Diagnosis	Number of cases	Percentage
Generalized anxiety	75	33.3
Panic disorder	87	38.7
Social phobia	7	3.1
Specific phobia	2	0.9
Obsessive disorder	2	0.9
Acute stressful state	20	8.9
Post-traumatic stress disorder	11	4.9
Agoraphobia	10	4.4
Separation anxiety	3	1.3
Hysteria	8	3.6
Total	225	100

4. Discussion

We carried out at the psychiatry and neurology departments of the Conakry

University Hospital, a retrospective descriptive cross-sectional study which, due to its retrospective nature, did not allow us to describe all the aspects linked to anxiety disorders, but we nevertheless noted certain features.

Thus, during the study period, 9015 patients were seen in the department, among whom 225 cases of anxiety disorders were diagnosed, which corresponds to a prevalence of 2.5%. This prevalence is markedly lower than that found by Okitundu *et al.* 20% [9].

This low rate could be explained by the fact that the majority of patients with anxiety disorders are generally referred to traditional therapists, general medicine services and who arrive in the psychiatric service only in the complication phase.

The 20 - 29 age group was the most represented with 33.3% of cases. This finding is related to certain data in the literature (Andre C.) [10].

The high rate of anxiety disorders in this group could be explained by the fact that this age group, represented by young adults, constitutes the period of onset of the majority of psychopathological disorders.

The female sex was the most represented with 55.1% of cases against 44.9% of cases in men with a sex ratio of 1.2.

Traore K. A. *et al.* reported 75.9% [7].

This female predominance in our study could be explained by the condition of women in our socio-cultural context which is a source of constraints and traumatic situations for the female sex.

In our study, we found that single people were the most affected, with a significantly high rate of 64.4%.

Dabo L. *et al.* [8] reported in their study 60.67%.

The high rate among single people could be explained on the one hand by the permanent concern for individual success, which is a psychosocial stressor favoring the onset of anxiety disorders and, on the other hand, the early onset of episodes (on the other hand). Adolescence or young adulthood) which most often compromises any marriage plan.

In our work, all levels of education were reached with a predominance of secondary level, *i.e.*, 36.4% of cases, followed by higher level 28% of cases.

Dabo L. *et al.* [8] in their work contributed 38.10%.

The high rate at the secondary level is explained on the one hand by the presence of young people and, on the other hand, by the role of different socio-cultural factors in the genesis of anxiety disorders.

We did not note a known psychiatric history in the majority of our patients (60.9% vs. 22.7%) who had a psychiatric history.

The high rate of no psychiatric history could be explained on the one hand by the fact that the majority of cases of anxiety disorders can occur in a subject who has not presented any psychiatric illness in the past, and on the other hand, the taboo nature of psychiatric pathologies and the feelings of shame that they cause, making it difficult to find a psychiatric history.

Most of our patients resided in the Conakry region, *i.e.*, 67.6%. Traore K. A. *et*

al. [7] found 41.4% in his doctoral thesis.

This is said to be due to their proximity to the psychiatric service, which is the only reference center in the country, their level of information on the service, and the growing modernity in the region.

Cannabis was the most consumed psychoactive substance by our patients with 49.8% of cases. This high frequency of cannabis consumption is explained on the one hand by the easy accessibility and the lower cost on the other hand by the fact that some people use it to relieve their anxiety. However, the consumption of psychoactive substances is a risk factor for the onset of anxiety disorders.

The majority of our patients were without triggering factors, *i.e.*, 41.3%.

The significantly high rate of patients without triggering factors could be explained by the fact that anxiety disorders occur in the majority of cases without apparent triggering factors.

All the classic symptoms have been found; however, we observed certain symptoms in the majority of our patients: insomnia and psychomotor instability were the most dominant symptoms, *i.e.*, 71.1% and 66.7% of cases.

This could be explained by the existence of anxiety in neurotic disorders.

More than half of our patients were presented with disorders whose evolution was greater than or equal to one (1) year, *i.e.*, 72.9% against 27.1% of cases whose duration of evolution was less than one (1) year.

This high rate could be explained by the fact that it is a pathology that progresses in a progressive manner, most often leading to a delay in consultation.

In our study, hospitalization represented 5.8% of cases versus 94.2% of outpatient follow-up cases. The high rate of outpatient follow-up cases could be explained by the fact that it is a state of neurosis in which only complications can lead to hospitalization.

In our work, panic disorder was the most represented with 38.7% of cases, followed by generalized anxiety or 33.3% of cases.

The same observation was made by Rangaraj J., who found that panic disorder appears in young subjects between 20 - 30 years [1].

The predominance of these forms is due to the fact that they lead to the complicated phase of major agitations with profound disruption of socio-professional life, forcing those around them to refer them to an appropriate care structure.

5. Conclusions

In short, anxiety disorders are uncommon reasons for consultation in Guinean hospitals. They are often considered a complication, making diagnosis difficult.

The two sexes were affected unevenly, with a high percentage of women being affected. Young adults were the most represented. The higher educational levels are more affected, and the affected subjects are mostly single.

Cannabis was the most consumed psychoactive substance by our patients

Insomnia and restlessness were the most dominant signs.

A large study of the general population would be necessary to appreciate the

extent of anxiety disorders.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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