Transcultural aspects of bipolar disorder
Transtorno afetivo bipolar: um enfoque transcultural

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Abstract
Cultural variations in the expression of emotions have been described. Consequently, there are cross-cultural influences on the diagnosis and management of bipolar disorder. This article provides a review of the evidence regarding the main aspects of transcultural psychiatry and bipolar disorder.

Keywords: *Bipolar disorder/diagnosis; Cultural factors; Diagnosis*

Resumo
Considerando-se que existem diferenças importantes na maneira como as emoções são vivenciadas e expressas em diferentes culturas, a apresentação e o manejo do transtorno afetivo bipolar sofrem influência de fatores culturais. O presente artigo realiza uma breve revisão da evidência referente aos aspectos transculturais do transtorno bipolar.

Descritores: *Transtorno bipolar/diagnóstico; Fatores culturais; Diagnóstico*

Introduction

Bipolar disorder (BD) is one of the most prevalent and potentially severe psychiatric disorders. Characterized by significant mood swings, oscillating between the poles of excitement (or euphoria) and depression, BD is chronic and recurrent, implying a high degree of morbidity and incapacity for BD patients.[1]

From the pathophysiological point of view, it is postulated that BD is related to dysfunction in brain circuits involved in emotion regulation. Considering that there are important differences in the way emotions are experienced and expressed in different cultures, it is natural to infer that BD diagnosis and management are influenced by cultural factors.[2] The classic US-UK study, conducted in the 1960s, showed that the criteria used by British psychiatrists to characterize mania and schizophrenia differ greatly from those used by American psychiatrists.[3] This study, which had a significant influence on the development of the DSM-III and its nosology, presented some of the first evidence of transcultural differences related to BD diagnosis.

The present study carries out a brief review of the main aspects related to prevalence, diagnosis and treatment of BD in various ethnic groups and cultures.

Current classifications of mental disorders and Bipolar Disorder: transcultural aspects

Codification of BD is similar when employing either of the two principal systems currently used for the classification of psychiatric disorders: DSM-IV[4] or ICD-10.[5] In both systems, BD falls into a category of its own, apart from unipolar depressive disorders. In the ICD-10, BD diagnosis is based on evidence of two or more mood-swing episodes (at least one of which should correspond to a manic or hypomanic episode). In contrast, in the DSM-IV, evidence of one episode or multiple episodes, respectively, of mania or hypomania results in a diagnosis of BD type I or BD type II. Neither of the classification systems include the diagnosis of "unipolar mania", as described in the ICD-9 (predecessor to the ICD-10). However, the ICD-10 provides for the classification of patients who have had a single manic episode as non-BD patients.

When the DSM–IV was devised, the need to make the criteria adopted valid in different cultures was taken into consideration. The result was "Appendix 1", which includes a plan for the cultural formulation of each case. The plan consists of gathering data related to the cultural identity of the individual, identifying cultural explanations for the disease, cultural factors related to the psychosocial environment and level of function and cultural components of the patient-physician relationship, as well as assessing the general cultural influence on diagnosis and care. The appendix also contains a glossary of culture-specific syndromes. Furthermore, a topic named "Culture-, age- and gender-specific characteristics", containing information specifically related to the disorder in question, was included in several categories. In the case of mood disorders, many conclusions are drawn concerning significant cultural variations in the way depressive episodes are experienced, although there is no specific mention of maniac episodes. In the case of BD type I, it is stated that "there is no evidence of a race- or ethnicity-based differential incidence of BD" and that "clinicians may tend to overdiagnose schizophrenia (rather than BD) in some ethnic groups and in younger individuals".[4]

Due to its universality, the ICD-10 became too broad, ignoring characteristics specific to mental disorders found in different regions or groups. Although the ICD-10 was designed by the World Health Organization as an instrument for use in countries that, from a sociocultural point of view, differ greatly, it does not make reference to any differences related to the characterization and diagnosis of BD in different cultures or ethnic groups.

These observations illustrate the difficulties encountered in studying BD as a transcultural nosologic entity. Considering that the two most commonly used classification systems are deficient regarding these issues, diagnoses made in non-western cultures and based on either system should be viewed with caution. In addition, in cases of BD, diagnostic instruments that are entirely based on DSM-IV and ICD-10 criteria and guidelines are often translated and applied in different cultures, with no transcultural validation. The validity of these instruments, as well as the

diagnoses obtained in specific populations or ethnic groups through their use, may therefore well be questioned.[6]

Cultural psychiatry and epidemiological aspects of BD

Similar to what has been observed in unipolar depression, differences in the prevalence and incidence of BD based on gender, region and ethnicity have been suggested.[7-8] However, few studies have provided any support for this hypothesis. The Epidemiologic Catchment Area study found that, when other variables were controlled, the prevalence of BD was similar in different ethnic and religious groups in the USA.[7] A study comparing the epidemiological characteristics of BD in different countries showed remarkable similarities among the various regions of the globe in prevalence, male/female ratios, and age at onset of the disorder.[9]

On the other hand, a recent study demonstrated differences among various countries in the prevalence of BD and other bipolar spectrum disorders. These differences were related to factors such as lifelong consumption of seafood in the different regions of the countries studied.[10] Since seafood is rich in Omega-3 fatty acids, such consumption has been defined as protective against BD.

Another study comparing the effects of ethnic aspects on seasonal variations in hospital admission rates of patients with mood disorders demonstrated that the ethnicity variable had no effect on the number and seasonal distribution of hospital admissions of BD patients.[11]

In the United Kingdom, a tendency has been found for African-Caribbean immigrants to be at greater risk for presenting manic profiles than are Caucasians.[12] Considering the fact that this ethnic group is also at greater risk for developing schizophrenia, it is possible that this difference is attributable to the presence, within this population, of a risk factor common to both disorders, such as problems related to post-immigration stress and racial prejudice.[13]

In summary, there is no consistent evidence that BD is more prevalent in certain ethnic groups or that it shows a different epidemiological profile in different ethnicities. Chance differences reported might be due to the presence of confounding factors to which individuals of certain ethnicities are subject to, such as environmental aspects related to a higher or lower risk of BD.

Differences in the clinical presentation of BD in different cultures

Data in the literature suggest that, among patients of different ethnicities or cultures suffering from mood disorders, there are differences in the proportions of patients in whom the attending physicians correctly identify those disorders. For instance, there is evidence that, among African-American patients in the United States, BD and schizoaffective disorder are underdiagnosed and schizophrenia is overdiagnosed.[14] It is possible that such differences are due to factors inherent to the psychiatrist-patient relationship, such as linguistic and vocabulary problems, cultural differences in the interpretation of certain symptoms, and racial stereotypes that affect the diagnostic process.[15-16] However, it is possible that such factors are also due to cultural variations in the clinical presentation of BD. Some studies have focused specifically on these issues.

Egeland et al[17] focused specifically on peculiarities in the clinical presentation of BD among individuals belonging to the Amish religious order in the United States. The authors concluded that, in the characterization of symptoms, some manic symptoms, such as psychomotor agitation and a decreased need for sleep, could be considered free from any cultural influence. However, symptoms such as grandiosity and excessive involvement in activities may be masked by or superimposed on certain cultural behaviors observed in that specific population. Overly-inflated self-esteem, for instance, would be considered a grave sin among Amish individuals and was generally omitted from psychiatric interviews. The same authors also found that higher proportions of patients presenting loosening of associations (and not flight of ideas) were wrongly diagnosed as schizophrenics. In addition, a high occurrence of hallucinations and delusions of persecution or grandeur, mostly of religious significance, was observed in this population. In a study focusing on manic patients in the east of India, phenomenological peculiarities were also observed, with a low occurrence of flight of ideas and a relatively high proportion of patients presenting persecutory and self-blaming delusions.[18]

In a study carried out in England, a comparison was made between Caucasian, African-Caribbean and Black BD patients, based on to the clinical profile presented during diagnosis.[19] The authors found that, among patients diagnosed with BD type I, Black patients presented a higher proportion of manic symptoms than did Caucasians, whereas Afro-Caribbean patients presented more mood-incongruent psychotic symptoms when compared to manic patients of the other ethnicities.

Finally, there seem to be differences among certain ethnicities in the course and evolution of BD. The Chinese Classification of Mental Disorders (the Chinese equivalent of the DSM) opted for maintaining the diagnostic category "unipolar mania", considering it valid in Chinese patients.[20] In a prospective study evaluating the evolution of Chinese patients presenting recurrent mania, no depressive episodes were observed during a ten-year follow-up period.[21] Similar evidence was found in a study involving patients belonging to the Yoruba tribe in Nigeria, where a high proportion of patients apparently presenting unipolar manic disorder was found.[22] In a retrospective study of bipolar patients in Israel, a predominance of manic episodes over depressive episodes was observed over time, a tendency opposite to that routinely observed in European patients. This is likely due to the influence that climatic factors have on the course of BD.[23]

In summary, data in the literature indicate that there are cultural peculiarities in the clinical presentation of BD. This may have implications for the diagnosis of this disorder in specific populations and subpopulations.

Transcultural aspects in the treatment of BD

The management of mental disorders in different therapeutic environments may suffer the influence of ethnic and cultural factors. Nevertheless, studies approaching this aspect in the treatment of BD are surprisingly scarce.

In the United States, there seems to be a higher probability for African-American patients under psychiatric treatment to receive supplementary psychotropic medication ("as needed") and to be submitted to physical restraint when hospitalized.[24] A retrospective study focusing specifically on the psychopharmacological management of BD showed that African-American teenagers diagnosed with BD and hospitalized were twice as likely to receive antipsychotics than Caucasian patients with the same diagnosis.[25] It is possible that this is related to overestimation of psychotic symptoms in African-Americans.

In a recent study, Mitchell and Romans[26] evaluated the role of religious and spiritual beliefs in the management of BD. Patients having religious beliefs that were considered "strong", showed a lower rate of adherence to treatment regimens than did those whose beliefs were considered "weak". In addition, nearly 25% of the patients reported conflicts between the directions given by mental health professionals and those coming from spiritual counselors (the latter stating, for example, that the patients should discontinue drug treatments, against the advice of their physicians).

Moussaoui and Kadri[27] conducted two interesting studies involving bipolar patients and their relatives in Morocco. In one of the studies,

the authors showed how a cultural environment of extremely strict morals deals with manic episodes in women and the consequences that has on treatment. In the other study, the authors reported the occurrence of relapse in previously stable bipolar patients under treatment with lithium and attributed the relapse episodes to fasting and changes in routine during Ramadan.

Finally, pharmacogenetic studies have shown differences in BD therapeutic response related to certain genotypes, some which are certainly associated with specific ethnic groups.[28] This aspect, despite the fact that it is undoubtedly included in studies of the transcultural aspects of pharmaceutical treatment of BD, will not be dealt with in the present review.

Conclusions

The objective of the present article was not to make an extensive review of BD and transcultural psychiatry but rather to examine some of the aspects related to the theme, posing some questions to be considered. First, the current psychiatric classification schemes adopted seem to be inadequate, especially regarding the transcultural variations of BD. Second, there seems to be no evidence that individuals belonging to certain ethnic groups present a greater risk of acquiring BD. Third, ethnocultural aspects seem to influence the clinical presentation, diagnosis and treatment of this disease.

Finally, the fact that the literature on the theme comes mainly out of developed countries is noteworthy. The evaluation of sociocultural aspects of clinical expression and the potential influence that such factors have on access to and modalities of treatment of mood disorders (especially BD) in the Brazilian population is a field of research that is of great interest and that, to date, has not been explored.

References

1. Kasper S. Issues in the treatment of bipolar disorder. Eur Neuropsychopharmacol. 2003;13 Suppl 2:S37-42. Review.
2. Kirmayer LJ, Groleau D. Affective disorders in cultural context. Psychiatr Clin North Am. 2001;24(3):465-78, vii.
3. Cooper JE, Kendell ER, Gurland BJ, Sharpe L, Copeland JRM, Simon R. Psychiatric Diagnosis in New York and London. London: University Press; 1972.
4. American Psychiatry Association. Diagnostic and statistical manual of mental disorders: DSM-IV. 4th ed. Washington: Apa; 1994.
5. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva, Switzerland: WHO; 1992.
6. Jorge MR Adaptação transcultural de instrumentos de pesquisa em saúde mental. Rev Psiquiatr Clín (São Paulo). 1998;25(5):233-9.
7. Levav I, Kohn R, Golding JM, Weissman MM. Vulnerability of Jews to affective disorders. Am J Psychiatry. 1997;154(7):941-7.
8. Minsky S, Vega W, Miskimen T, Gara M, Escobar J. Diagnostic patterns in Latino, African American, and European American psychiatric patients. Arch Gen Psychiatry. 2003;60(6):637-44.
9. Weissman MM, Bland RC, Canino GJ, Faravelli C, Greenwald S, Hwu HG, et al. Cross-national epidemiology of major depression and bipolar disorder. JAMA. 1996;276(4):293-9.
10. Noaghiul S, Hibbeln JR. Cross-national comparisons of seafood consumption and rates of bipolar disorders. Am J Psychiatry. 2003;160(12):2222-7.
11. Suhail K, Cochrane R. Seasonal variations in hospital admissions for affective disorders by gender and ethnicity. Soc Psychiatry Psychiatr Epidemiol. 1998;33(5):211-7.
12. van Os J, Takei N, Castle DJ, Wessely S, Der G, MacDonald AM, Murray RM. The incidence of mania:time trends in relation to gender and ethnicity. Soc Psychiatry Psychiatr Epidemiol. 1996;31(3-4):129-36.
13. Jarvis E. Schizophrenia in British immigrants: recent findings, issues and implications. Transcult Psychiatry. 1998;35(1):39-74.
14. Strakowski SM, Shelton RC, Kolbrener ML. The effects of race and comorbidity on clinical diagnosis in patients with psychosis. J Clin Psychiatry. 1993;54(3):96-102.
15. Strakowski SM, McElroy SL, Keck PE Jr, West SA. Racial influence on diagnosis in psychotic mania. J Affect Disord. 1996;39(2):157-62.
16. Minnis H, McMillan A, Gillies M, Smith S. Racial stereotyping:survey of psychiatrists in the United Kingdom. BMJ. 2001;323(7318):905-6.
17. Egeland JA, Hostetter AM, Eshleman SK 3rd. Amish Study, III: the impact of cultural factors on diagnosis of bipolar illness. Am J Psychiatry. 1983;140(1):67-71.
18. Sethi S, Khanna R. Phenomenology of mania in eastern India. Psychopathology. 1993; 26(5-6):274-8.
19. Kirov G, Murray RM. Ethnic differences in the presentation of bipolar affective disorder. Eur Psychiatry. 1999;14(4):199-204.
20. Lee S. From diversity to unit. The classification of mental disorders in 21st-century China. Psychiatr Clin North Am. 2001;24(3):421-31.
21. Xu WY, Chen JZ. An eight-to-ten-year outcome study of unipolar mania. Arch Psychiatry. 1992;4(1):88-90.
22. Makanjuola RO. Recurrent unipolar manic disorder in the Yoruba Nigerian: further evidence. Br J Psychiatry. 1985:147:434-7.
23. Osher Y, Yaroslavsky Y, el-Rom R, Belmaker RH. Predominant polarity of bipolar patients in Israel. World J Biol Psychiatry. 2000;1(4):187-9.
24. Flaherty JA, Meagher R. Measuring racial bias in inpatient treatment. Am J Psychiatry. 1980;137(6):679-82.
25. Delbello MP, Soutullo CA, Strakowski SM. Racial differences in treatment of adolescents with bipolar disorder. Am J Psychiatry. 2000;157(5):837-8.
26. Mitchell L, Romans S. Spiritual beliefs in bipolar affective disorder: their relevance for illness management. J Affect Disord. 2003;75(3):247-57.
27. Moussaoui D, Kadri N. Cultyre matters too in bipolar disorder. In: Maj M, Akiskal HS, Lopez-Ibor JJ, Sartorius N, editores. Bipolar Disorder. Chichester: Wiley; 2002. p. 355-7.
28. Alda M. Genetic factors and treatment of mood disorders. Bipolar Disord. 2001;3(6):318-24. Review.

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