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Socio- Cultural Challenges in the Management of Bipolar Disorder:

A Trans- Cultural qualitative Study by the International Society of Bipolar Disorders (ISBD)

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BACKGROUND

Clinical management of bipolar disorder patients might be affected by culture and is further dependent on the context of healthcare delivery. There is a need to understand how healthcare best can be delivered in various systems and cultures. The objective of this qualitative study was to gain knowledge about culture-specific values, beliefs, and practices in the medical care provided to patients with bipolar disorders from a provider perspective in various areas of the world.

SAMPLING AND METHODS

The International Society of Bipolar Disorders (ISBD) network provided the framework for this qualitative study. An electronic interview with open ended questions was administered to 19 international experts on BD representing the ISBD chapter network in 16 countries and six continents. In addition, there were two in-depth interviews with BD experts done prior to the survey. The data was analysed using content analysis, and the information was structured using the software NVivo by QSR International Pty Ltd.

RESULTS

Culture in relation to health systems, treatment practices and training of clinicians

"A lack of literacy, or health literacy, usually correlates with poorer access to mental health services"
(Europe)

"Lack of beds, lack of psychiatrists, resulting in the use of PCOs (psychiatric clinical officers) with basic diplomas in mental health… treating the majority of the patients"
(Africa)

"We have some form of county medical service insurance for some people that doesn´t have Medicaid. We have some public assistance for the poor. 57% of people have no health insurance, or insurance for the poor. And insurance for the poor, if you go (…) it would buy you seven minutes of service. Can you practice psychiatry in seven minutes? You can´t. And Medicare is ten minutes. So basically we are dealing with a population who doesn´t have access to psychiatric services"
(North-America)

"Many bipolar patients only receive acute psychiatric attention and no maintenance or follow up. Private psychiatric help in Mexico is expensive for most of the population. Insurance does not cover psychiatric help"
(Latin-America).

"The health system is broadly divided into public and private.(…) It is clear that many people with bipolar disorder fall between the gaps of the two systems. In terms of the treatments offered, in the public system case management and pharmacotherapy is offered but formal psychotherapy is rare. In the private system, the full spectrum of treatments is available but these are largely concentrated in the most privileged areas; and access is limited by supply constraints and cost"
(Australia)

"….Mainly biomedical approach. Cognitive behavioral therapy and other socially based psychiatric interventions are rarely given because the mental health workers are overwhelmed"
(Africa)

"Services vary in different countries. Developing countries unfortunately do not have many sub-specialty services. Most the emphasis is on pharmacotherapy."
(Asia)

"Most delusional contents depend on different cultural backgrounds. Additionally, understanding the patient's background is critical to implement a proper psychoeducation."
(Europe)

"Proper mental health literacy measures should be considered to improve the general population knowledge on bipolar disorders, especially in social environments with problematic issues in accessing the public health system, such as migrants." (Europe)

Stigma in bipolar disorder

"In general, psychiatry services are stigmatized, which could explain delayed intervention, though it is improving. Bipolarity for singles, especially women, could affect future marital status and could lead to divorce."
(Asia)

"I think there is a difference between Jewish and Muslim populations in our country. In the Jewish population, physical illness is regarded as something that is not your fault, and it is very important to get medical care. It is a religious value to get medical care, and to see a doctor. (…) But the mental illness is a great shame, and something to hide, and not to tell anyone about. If people would know, then no one would marry your daughter. It is a great stigma."
(Middle East)

"I believe Mexican women are more open of sharing a mental disorder and they accept easily the idea of suffering from a bipolar disorder. Mexican men tend to deny more the consequences of bipolar disorder and they tend to abuse more alcohol and drugs."
(Latin America)

"Many bipolar patients have been misdiagnosed in the past and considered unable to work, to have fulfilling relationship or to be trusted. Such condition is slowly improving and bipolarity is progressively being linked to more positive features, such as maintained ability to function (if treated), creativity and bright intelligence."
(Europe).

Gender and Culture in Relation to Bipolar Disorder

"There are culturally based gender differences in presentation of symptoms ex. woman will never tell that she is depressed rather she has pain in different parts of her body."
(Asia)

"Latino males, in a great many cases, have an incredible narcissistic investment in their sons that leads to the denial of psychopathology. The mother often desires treatment but the father opposes. Unless the father is out of the house providing treatment may be impossible."
(Latin America)

"So I think definitely bad things are normalized, I know that the sexual abuse stuff is, women go from one sex abuse relationship to the other, and then their daughters do, and I have to talk to the girls about it."
(Latin America)

"Relating to gender differences, male patients may have an early onset. I can't detect major differences in symptoms presentation, treatment or outcome, especially in bipolar I patients."
(Europe)

Importance of Religions in Relation to Bipolar Disorder Cross-Culturally

"But in the Muslim population, all illness is treated very fatalistically. It is from Allah, you can´t do anything about it. (…) I try my best to keep them in treatment, but they have a very high dropout rate."
(Middle East)

"Certain religious communities have the view that mental illness is due to sin. Those in these communities are very difficult to treat."
(North- America)

"Religion does influence the treatment as so many patients with bipolar disorder first seek treatment from the faith healers. "
(Africa)

"There are curanderos and curanderas who are Mexican traditional healers. (…) They integrate the whole community. They mobilize the whole community into the healing process. So it is a social process, in Mexican culture to involve the whole family, the whole community."
(Latin America)

"Education is much more important than ethnicity and religion."
(Europe)

DISCUSSION

These findings from a global study about culture and bipolar disorder initiated by the Transcultural Task Force of the International Society of Bipolar Disorder (ISBD). It includes the responses of 19 informants (all ISBD bipolar experts) from 16 countries representing all continents. In-depth interviews and information acquired through an electronic survey with open-ended questions were used. To a large degree the current leading ethnomedical theory about bipolar disorder worldwide is the biomedical model, with a correspondingly strong emphasis on psychopharmacology.

Firstly, in many parts of the world, access to healthcare for bipolar patients mirrors a general lack of psychiatric or even medical services and in such situations local faith healers represent the only available treatment option--often including shamanistic rituals as part of a religious understanding of mental disorders. Secondly, it also became evident that the organization of the financial reimbursements for different treatments directly shaped bipolar patient's access to health care, typically limiting access to long-term follow up, psychotherapy and psychoeducation in some public health care systems.

According to our study experts, the biomedical model for understanding and treating bipolar disorder seems to be shared by most health care professionals globally. However, this does not mean that cultural or psychological factors are unimportant. On the contrary, almost all of the experts considered the lack of access to proper psychotherapy as a major deficiency, whether the result of a general lack of competent personnel, or the result of a financial reimbursement system thwarting necessary treatments for less privileged inhabitants of rich societies. This reads as recognition by the experts of the importance of expanding the biomedical model to the bio-psycho-social-cultural model that constitutes the current understanding of psychiatric disorders and treatment interventions.

Multiple socio-cultural factors related to stigma were reported to affect important aspects of the disease, influencing the clinical management of patients. The informants clearly reported that stigma was related to such social constructs. They highlighted that mental disorders in general are stigmatized, and in some social environments this is true to such a degree that patients and families will try to hide the disease and even avoid seeking professional help. Sometimes, the stigma was related to religious postulates about mental disorders being caused by sinful thoughts and behaviours, or religious belief systems seeing mental illness as the result of supernatural forces such as spirit possession or sorcery. In other cases, stigma was more strongly linked to social factors, as highlighted by several informants focusing on the lack of insight and acceptance of mental disorders in some "macho" cultures characterized by denial of mental illness. As a consequence, many patients - especially male ones - risk not getting proper therapy for their bipolar disorder. In the worst case scenario they often reportedly develop severe substance abuse problems instead. Stigma may also distress women more than men, and several informants stated that having a bipolar disorder may cause more social consequences and isolation in women, especially in parts of the world where women still depend on marriage to be socially included and financially secure. In other countries, tailored active anti-stigma campaigns are changing the social landscapes.

The current study has several limitations. Even though the region of origin of different quotations is reported in the result section, no claim is made that such quotes necessarily represent the general opinion of health care professionals in that part of the world. The characteristics of the expert interview might vary to a great extent in terms of international exposure and might have given them increased innate knowledge that have deepened their reflections on the topic of interest compared to their national representatives. Other informants might have different experiences and opinions. The focus of this qualitative investigation was to identify themes that arose during the interviews with BD experts about socio-cultural factors and the management of BD patients. The study had a geographically wide approach and could only scratch the surface of the themes covered. Future more in-depth studies could be conducted in selected geographical regions to fully understand the culture bound issues relevant for understanding the presentation and psycho-educative aspects of BD. Further, follow-up studies with a larger variety of methods including expanding the findings to include patient perspectives are clearly warranted.

CONCLUSION

The global chapter representatives described that cultural factors affected the manner patients present and clinicians understand and respond to symptoms. Knowledge of variations in stigma, gender and religion across different ethnic groups was considered central to the delivery of good clinical care. Consequently, there is a need for continued research to identify cultural characteristics in bipolar disorder that can improve adaptation of contextual training and service provision for BD patients as emphasized in the recently updated WHO Mental Health GAP Action Program Guidelines.