Bipolar Disorders in Mexico

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Introduction about Mexico

Mexico is a country with an approximate area of 1958 thousand square kilometers; has great cultural, social and economic diversity, its population in 2010 was 112 336 538 inhabitants, with an estimation of 119 426 000 inhabitants in 2014, of which 51% are women and 49% men; the country is composed of 31 states and the Federal District, the capital city and headquarters of the three branches of government (executive, legislative and judicial). The life expectancy at birth is 74 years for males and 79 years for females (UNO, 2005-2010) [8, 9].

Despite being considered by the World Bank as a country with a medium-high income, the inequality, expressed in health, education, food and basic services remains one of the main difficulties.

In the last two decades, Mexico City, its capital, has transformed its face to a modern cosmopolitan city. Considered as one of the most highly populated cities in the world, has a competitive economical center that gathers an important number of transnational companies and business that view Mexico as the door to the rest of Latin America.

Mexico' s mental health history

The first mental hospital in America was the Hospital of San Hipólito, founded by Bernardino Álvarez in 1567 in Mexico City. In 1774, José Ignacio Bartolache, a professor of medicine, conducted the first study on hysteria in Mexico, and according to Robles (1942), possibly in the entire continent.

At the end of the 19th century, Ezequiel Chávez introduced a high-school-level psychology course. Later, in 1916, Enrique C. Aragón, a psychiatrist, founded the first psychology laboratory in Mexico. Following his death in 1942, two posthumous publications were released: *Works in Neurology and Psychiatry* (1942) and *History of the Soul* (1944).

Thirty years ago, influences from the United States and Europe began to increase in Mexico. Graduates from training programs in Mexico began to pursue masters and doctoral degrees in other countries. Consequently, significant advances in mental health took place in Mexico. With the advent of these trends in Mexico, modern psychiatry and psychology underwent a change in emphasis and eventually widened its scope to include so-called normal behavior and biological theories in the pathogenesis of mental disorders.

Health Services in Modern Mexico

The country´s 32 states have full autonomy to administer their health care systems. Because states differ substantially in their tax base and other

resources and the degree of social need, states also differ substantially in their health investments, as measured both by their per capita health expenditures and by the fraction of their budgets allocated to health [2].

Health care in Mexico is provided via public institutions, private entities, or private physicians. Health care delivered through private health care organizations operates entirely in the free-market system, available to those who can afford it. On the other hand, public health care delivery, is accomplished via an elaborate provisioning and delivery system put in place by the Mexican Federal Government.

Mexico´s health care system is markedly different for individuals with public insurance coverage–approximately 60% of the population–and those who lack insurance coverage–the remaining 40%. A parallel private health care system that serves self-paying individuals offers expensive services to a very small fraction of the population (2%). Publicly insured individuals are those employed in the formal sector of the economy and their dependents. Care of these population is offered through a network of publicity funded health care facilities (so called social insurance institutions). These facilities have a stable funding source and offer a fairly well defined benefit package that includes medications. Access to and quality of health care are much poorer for the uninsured, a group composed of individuals who work in the informal economy or who are unemployed and their dependents. This population is served by a vertically integrated network of publicity funded and by publicity managed health care facilities. Individuals gain access to the network by paying flat, one-time user fee for each episode of illness. Although the fee is based on a person´s ability to pay and is heavily subsidized, it contributes to high out-of-pocket expenses for a sector of the population with extremely limited spending capacity [1].

Mental health is specifically mentioned in the general health policy. A mental health plan exists and was approved in 2007. The mental health plan components include: 1) Timelines for the implementation of the mental health plan; 2) Shift of services and resources from mental hospitals to community mental health facilities; 3) Integration of mental health services into primary care [8].

Legal provisions concerning mental health are also covered in other laws (e.g., welfare, disability, general health legislation, etc.), and the General Health Law establishes "Mental Health" as a basic service and as a health priority [8].

Prescription regulations authorize primary health care doctors to prescribe psychotherapeutic medicines. The department of health does not authorize primary health care nurses to diagnose mental disorders, prescribe and/or to continue prescription of psychotherapeutic medicines [8].

Mental health services and costs

Worldwide, mental disorders are common, persistent, costly, and contribute substantially to the total burden from disease. In spite of this, studies of developed Western societies have consistently documented that only a minority of people with psychiatric disorders receive some form of treatment [7].

Given that Mexico is currently in a process of transformation aimed at improving its standards of living, the need arose to train professionals to respond to the challenge of helping detect, analyze, understand, and resolve

mental health problems in the different strata of Mexican society. Because of various socioeconomic issues confronting Mexico, it has become necessary to train more professionals to meet the country' s needs [3].

Although the federal government has made several attempts to develop a national mental health policy, improvements in access to and quality of mental health care have been modest at best. The mental health care system in Mexico is underdeveloped and underfunded, and as a result, high-quality mental health services have been largely unavailable to most Mexicans. Most mental health services are provided through 33 large psychiatric hospitals concentrated in Mexico City and other large cities, some of which are in substandard physical condition and many of which provide largely custodial care [1].

According to a report by the Mexican Research and Analysis Service, Division of Social Policy, mental health is closely linked to poverty in Mexico [4]. The risk of mental health problems has increased in many Mexican families because of the need form more members of the family to join the labor force, including mothers and children. Furthermore, traditional male and female roles are changing within families, and environmental stressors are unfavorable for positive family communication and child supervision, all of which provoke additional stress that can lead to more mental health difficulties [5].

Unfortunately, many children and adolescents in Mexico need to work in order to contribute to family earnings. This puts them at a great disadvantage given that they cannot attend school. Consequently, they are exposed to exploitation, drug use, violence, sexual abuse, prostitution, and sexually transmitted diseases. Disability in Mexico is often associated with poverty. This compounds the suffering and results in psychosocial imbalances, problems of familial disintegration, illiteracy, and

unemployment– all of which are associated with significant emotional stressors. People with disabilities in Mexico have been secluded from a number of opportunities and have not received adequate services by mental health professionals [3].

There are different costs associated with health conditions: direct and indirect costs to the individual and to society, and costs related to the lost years of healthy life, productivity and performance. Internationally intended 2.8% of the health budget to mental health, although these disorders represent 13.1% of the global burden of disease. Studies in the literature have shown that both physical illnesses such as mental health (such as hypertension, cardiovascular disease, arthritis, muscle pain, uni and bipolar depression, alcohol abuse, etc.) are associated with absenteeism at work, less performance and days of operation generally lost. In Mexico, It has been reported that the highest number of days lost are due to depression and panic attacks, while the lowest number of working days lost are due to physical conditions as a whole [9].

Costs associated with loss of employment, loss of working hours and compensation payments are significantly higher in patients with bipolar disorder. Another strong spending in these patients, are health benefits due to sick leave, disability, short-and long-term compensation and medical and drug expenses [11].

Indirect costs are more difficult to measure than direct costs, and represent lost productivity associated with the disease, any type of disability associated with the disease and premature death caused by suicide; Indirect costs also include costs that bipolar disorder brings to the family, such as job loss and unemployment. Due to the early age of onset, it may cause a delay in the acquisition of social, occupational and academic skills necessary

to live independently, make an income and maintain social relationships [11].

Despite advances in pharmacotherapy, hospitalization continues to be necessary in a high percentage of patients with bipolar disorder and this greatly increases the costs of the disease. In this connection, it has been tried to develop best available

outpatient treatment programs and rehabilitation. It has been observed that patients treated with effective stabilizers have better results, thus reducing the costs spent on the overall health of the patients [11].

The amount of effort required to meet Mexico´s mental health needs in the immediate future is extensive. For instance, adequate social and economic infrastructure does not exist in many places to even provide basic mental health services. Moreover, economic support to pay for psychological counselors is quite limited. Because economic disparities in Mexico are immense, more mental health professionals are needed to help improve the quality of life of marginalized Mexican communities [3].

Recent developments offer new hope that the problems of underuse and inadequate use of mental health services in Mexico can be better understood. In 2001-2002, the National Institute of Psychiatry in Mexico conducted the Mexico National Comorbidity Survey, which is part of the World Health Organization' s (WHO) World Mental Health Initiative, devoted to evaluating the prevalence of psychiatric disorders in countries with varying degrees of development, determining the extent of unmet needs for mental health services, and directing public policy in this area [7].

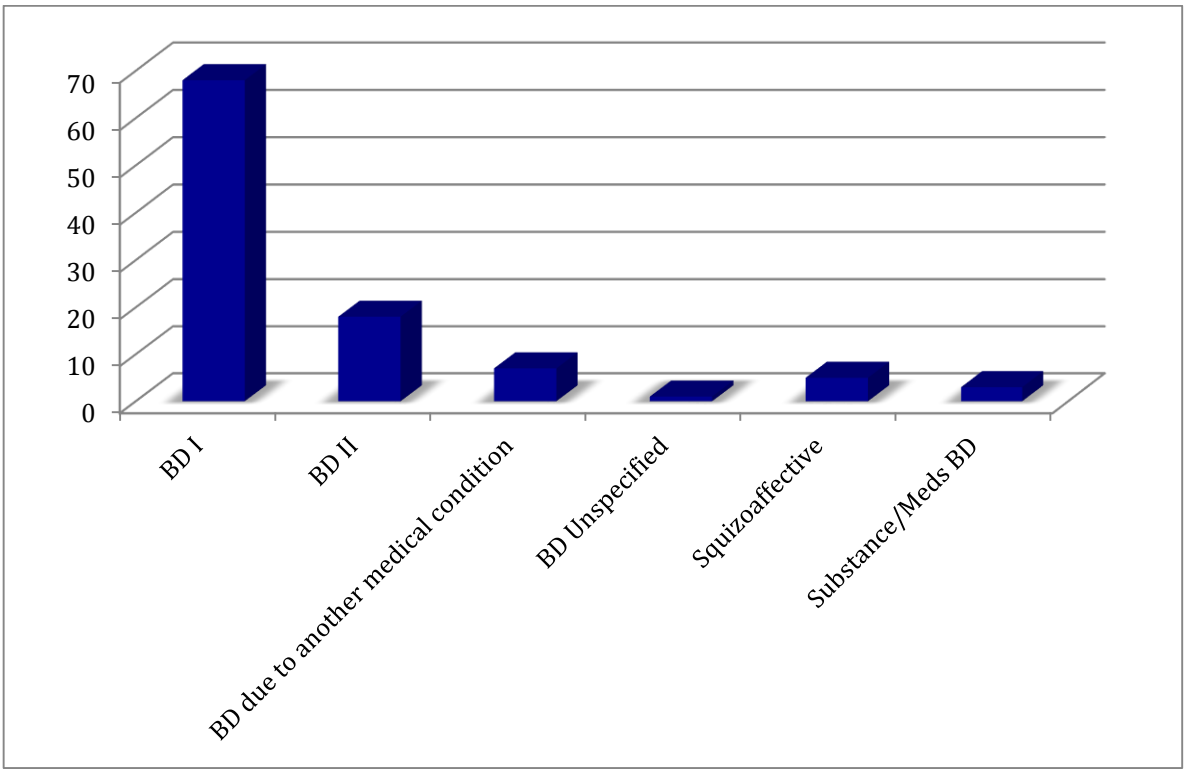
Epidemiology of BD in Mexico

Bipolar disorder (BD) is one of the six leading causes of years lived with disability. (WHO, 2004) Worldwide prevalence is estimated at 1.6 to 0.2%, affecting men and women equally. The remission of all symptoms occurs in 26% of patients and functional recovery can occur in up to 24%. 10 to 19% of these patients die by suicide. Among the comorbidities associated with bipolar disorder, anxiety disorder is the most common (71%), followed by the abuse of alcohol and other psychoactive substances of abuse (49%).

In Mexico, the prevalence of bipolar disorder I is 1.3%, affecting men in 1.6% and women in 1.1%; the results of the National Comorbidity Survey regarding mania and hypomania of bipolar disorder show a rate of 0.9 and 1.1 respectively [Medina-Mora et al, 2003].

One of the problems for assessing the magnitude of bipolar disorder is inadequate diagnostic misclassification or lack of identification of the clinical condition.

Diagnostic distribution of the bipolar patient in Mexico [13]:



ISBD Mexico

In 2008 the Mexican Chapter of the International Society for Bipolar Disorders was constituted in the need of organizing a group that united researchers, clinicians, mental health professionals, advocacies, patients and families in Mexico.

Since its beginnings ISBD Mexico has worked in several international collaborations that have ranged from research projects, surveys, to participation in conferences held in other ISBD Latin American chapters.

Mexican Bipolar Survey

During a two year period, 352 Mexican psychiatrists were interviewed by the ISBD Mexico team, regarding their clinical practice and experience in bipolar disorders diagnosis and treatment. Bipolar depression was described as the most challenging phase of the disorder to treat and diagnose in the patient that has never experienced hypomania or mania. Bipolar Disorder type II, was also shown as difficult to recognize and it was concluded that in Mexico a high number of cases are never diagnosed. (14)

Psychoeducation

The ISBD Mexican Chapter has developed a community psychoeducative psychosocial approach directed to bipolar patients and its families. Life mood charting and specific learning material have been designed and adapted the needs of the Mexican patient and families. Trained psychiatrists and psychologists have used in the stable bipolar patient cognitive and Logo therapeutic techniques, with very positive results. (15)

Mexican families have a tight and closed familial structure, most of them follow a patriarch organization and is a common situation that siblings live with their parents well into adulthood. Therefore any psychosocial approach in Mexico has to consider these issues and work with all the elements of the family.

ISBD Mexico has worked this psychosocial approach in different levels of attention, as a multimedia course aimed to large groups of patients and their families, as discussion and focus groups of 10 to 20 patients, and in a one on one basis.

The Bipolar Connection Program *(Conexión Bipolar),* is a non profit community educational program designed to reach patients and family members that need to receive and learn updated information about the disorder. The first stage of the program consisted of a 120-minute multimedia presentation that covers genetics, basic neuroscience information, symptoms, classification, mood charts, trigger identification, and key pharmacological treatment concepts. An audience of 800 patients and family members from Mexico' s three most important cities, constituted this phase. The audience was recruited with collaboration of the main advocacy and patient groups of the country. The second stage of the program consists of developing free educational material posted in ISBD Mexico' s web page (www.isbdmexico.org). (15)

ISBD Mexico JJ Award

This is an award that exemplifies the collaboration between patient families and mental health professionals. In this case JJ are the initials of a 23 year old young adult who commits suicide without ever receiving a proper diagnosis and treatment. After his death, it was concluded that he suffered bipolar disorder and that JJ was suffering from a manic phase with depressive features.

Since his death, his family in an admirable gesture, has developed in conjunction with ISBD Mexico the JJ Award, a recognition that gives a Mexican young psychiatrist the opportunity to improve his training on bipolar disorders in an international center of excellence.

Stigma in Mexico

People with bipolar disorder in Mexico, in addition to integration difficulties and disabilities arising directly from the illness, suffer the consequences of social ignorance that exists towards mental illness and those who suffer. This determines social prejudice and amplified, in many cases, the difficulties of social and labor integration of these people. Social attitudes of rejection towards these people and the consequence of a negative social image can raise additional social barriers that increase their risk of isolation and marginalization [12].

Bipolar disorder is a chronic disease that can lead to serious difficulties in the family, social functioning and labor. Some studies have shown that people with bipolar disorder have difficulties at work and about 20% of them have a permanent disability. In addition, they may have fewer social interactions with friends and family, less interest or pleasure in leisure activities and, in severe cases, poorer cognitive functioning.

People, very concerned about the social stigma that produces their bipolar disorder diagnosis, adapt their social behavior to avoid discrimination. This behavior creates a vicious circle between perceived stigma and the impact on the level of functioning.

It is therefore evident that a comprehensive care for people with mental illness not only has to sufficiently cover their needs for support and integration, but simultaneously also must establish actions to reduce or eliminate the negative consequences of stigma that traditionally weighs on them [12].

My story as a Mexican woman that suffers Bipolar Disorder

"My name is Ana, and I was diagnosed Bipolar Disorder type I, fifteen years ago when I had a severe manic phase. I lived in a small city in western Mexico and when I was diagnosed I was only 16 years old, the stigma I suffered was terrible. Everyone in my community knew about my breakdown, I had cycled into a severe manic phase in a two-day school excursion to a nearby lake. I totally lost it, I was all over the place, highly verbal, extremely active and behaving in a non desirable way for a young decent girl. Even though I was very lucky in being diagnosed and treated after my first manic episode, it was sufficient to make loose a complete year at school and entered a severely depressive state. I thought my life was over, I had lost my friends, had no goals and my reputation was something that my family had to be ashamed.

The best decision I ever made was to move to Mexico City and began visiting a psychiatrist that specialized on bipolar disorders. It was then, three years after my diagnosis, that for the first time I really understood and realized I had bipolar disorder. It took me some time and some mistakes to accept I needed my medications if I wanted to lead a happy and stable life. The anonymity that Mexico City offered was excellent for me to go back to school and finish my education.

Through out the years I have experienced a couple of depressive episodes and hypomanic symptoms that thanks to the psychoeducation I have received, I was fortunate to stop them just on time.

At the present time I am working in a corporate office and married five years ago. I have just given birth to a beautiful daughter and I was able to successfully manage with my medications and pregnancy.

I am happy collaborating with ISBD Mexico in helping young people to receive all the information needed to cope with the disorder. I don´t want them to suffer the painful years I had to face when I was diagnosed. I look forward to continue fighting against the stigma to bipolar disorders. "

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