ELSEVIER

Journal of Affective Disorders 87 (2005) 193–201

JOURNAL OF AFFECTIVE DISORDERS

www.elsevier.com/locate/jad

Research report

Prevalence and clinical characteristics of bipolar I disorder in Butajira, Ethiopia: A community-based study

A. Negash[a], A. Alem[a], D. Kebede[b], N. Deyessa[b], T. Shibre[a], G. Kullgren[c,*]

[a]*Department of Psychiatry, Addis Ababa University, Addis Ababa, Ethiopia*
[b]*Department of Community Health, Addis Ababa University, Addis Ababa, Ethiopia*
[c]*Department of Clinical Sciences, Division of Psychiatry, Umeå University, SE-901 85 Umeå, Sweden*

Received 1 December 2004; received in revised form 18 March 2005; accepted 18 March 2005
Available online 23 May 2005

Abstract

Background: Bipolar disorders have been extensively studied in the high-income countries but community-based studies from low-income countries are very rare. The main objectives of the current study are to estimate the lifetime prevalence of bipolar I disorder in the general population of the Butajira district in Ethiopia and to characterize the onset and course of the disorder in a predominantly treatment naïve population.
Method: Cases were identified by a door-to-door screening of the district's entire adult population aged 15 to 49 years (N=83,387), where 68,378 were successfully screened. CIDI and key informant method were used in the first stage of screening followed by confirmatory SCAN interviews.
Results: Three hundred fifteen cases were identified and complete information could be collected for 295 individuals. Of these, 55.3% were males, 83.1% were from a rural area, and 70.2% were illiterate. Lifetime prevalence of bipolar I disorder was estimated to be 0.6% for males and 0.3% for females. The mean age of cases was 29.5 years, with no significant sex difference. The mean age of first recognition of illness was 22.0 years; for men 22.3 years and for women 21.2 years. The mean age at onset of manic phase of the illness was found to be 22.0 years (22.5 for men and 21.4 for women). The mean age at onset of depressive phase was 23.4 years (24.1 for men and 22.5 for women). There was no significant sex difference in the age of onset of manic or depressive phases. In 22.7% of the cases bipolar I illness started with a depressive episode and in 77.3% of the cases it started with a manic episode. Two or more episodes of the illness were reported by 64.1%. Over half of the study subjects (55.9%) had never sought any help from modern healthcare sector, and only 13.2% had ever been admitted to psychiatric hospital. During the survey 7.1% of the cases were undergoing treatment. A previous suicide attempt was reported by 8.1% of the males and 5.4% of the females.
Conclusion: The overall lifetime prevalence and age of onset are within the range of findings from other studies in Western countries. In contrast to most previous studies, prevalence of the disorder among females was half of that among males. Our

* Corresponding author.
E-mail address: gunnar.kullgren@psychiat.umu.se (G. Kullgren).

doi:10.1016/j.jad.2005.03.011

finding that prevalence of this disorder among males and females appeared to be different from many other studies warrants further research.

Keywords: Bipolar I disorder; Rural Ethiopia; Onset and course; Epidemiology

1. Introduction

Valid and representative epidemiological data on magnitude, patterns, predictors, and outcome of specific psychiatric disorders derived from community-based surveys have important scientific and health policy implications. Studying community samples is especially important as the majority of people with severe mental disorders do not seek treatment, particularly in low-income countries. Accumulated evidence suggests that mental disorders could be the most burdensome of all human diseases. They are common, have much earlier ages of onset than most chronic physical diseases, have high rates of chronicity exposing the affected individuals to high risks of impairment and disablement, and rates of treatment are often low (Kessler et al., 1997).

There is a paucity of scientific data regarding the prevalence, course, and outcome of mental disorders in low income countries. Few resources are allocated to the health sector in general and only a tiny portion of these is allocated to mental health services. This is very much the case in Ethiopia where health services are poorly developed, extremely understaffed, suffer from budgetary deficiencies, and mental health services are the least developed (Alem, 2000). Previous studies conducted in Ethiopia have consistently shown that mental disorders are common problems in the country (Alem et al., 1995; Kebede and Alem, 1999; Awas et al., 1999; Jacobsson, 1985).

Bipolar I disorder is one of the major and disabling mental illnesses. The lifetime prevalence is reported from various countries ranges from 0.3% to 3% (Robins et al., 1991; Weissman et al., 1996; Kessler et al., 1997; ten Have et al., 2002; Witchen et al., 1992; Kupfer et al., 2002; Hilty et al., 1999; Szadoczky et al., 1998). It represents a major public health problem and leads to high mortality from suicide, accidental death, and somatic complications (Tsuang et al., 1980; Weeke and Vaeth, 1986; Sharma and Markar, 1994). To our knowledge, no previous population-based study on bipolar I disorder has been conducted in a rural area of a low income country, and there is very limited knowledge regarding onset and course from countries where psychiatric services are very poor.

This paper reports on the lifetime prevalence of bipolar I disorder in a predominantly rural district of Ethiopia and the onset and course of the disorder based on retrospective data obtained from the subjects at the time of recruitment.

2. Method

2.1. The setting

The study was conducted in Meskan and Mareko District, in south central Ethiopia. The district is named after two predominant ethnic groups residing in it. Butajira is the capital town of the district and the whole district is thus often referred to as Butajira. The town is located about 135 km south of Addis Ababa. According to the 1994 census, the district has a total population of 227 135 (OPHCC, 1994). It is bounded by the Great Rift Valley in the east and its altitude ranges from 1500 to 3400 m above sea level. The population is predominantly Moslem and the vast majority live in rural areas. Health facilities are very much limited to towns and mostly to sub districts accessible by transport (health posts). There was no psychiatric service in the district prior to the establishment of a psychiatric outpatient unit in Butajira town by the present research project.

2.2. Instruments

First stage screening was using Composite International Diagnostic Interview CIDI (WHO, 1997) with additional key informants identification of prob-