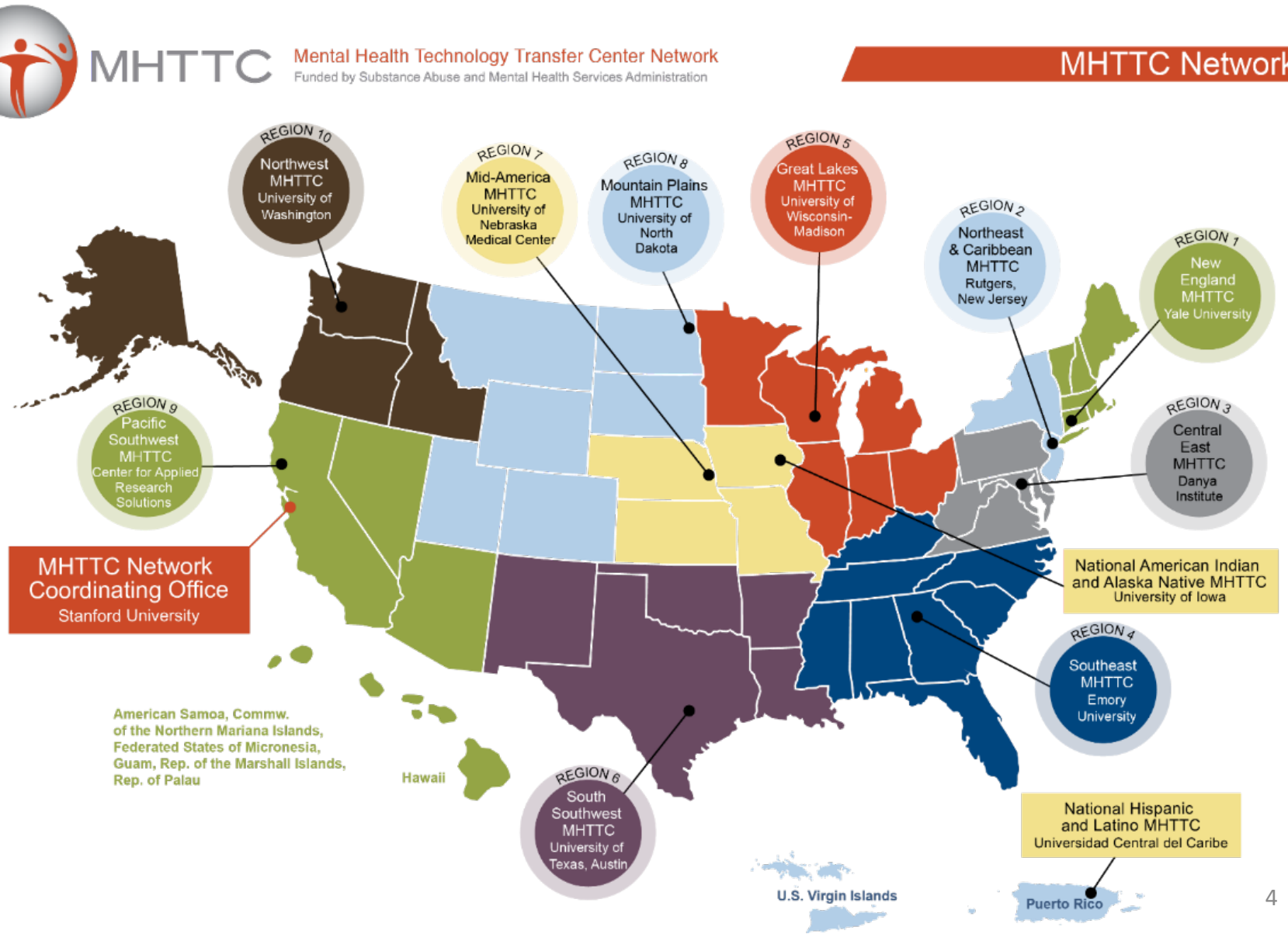
Bipolar Disorder in the Black Community

William Lawson, MD, PhD

June 3, 2021

Central East (HHS Region 3)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



MHTTC Purpose

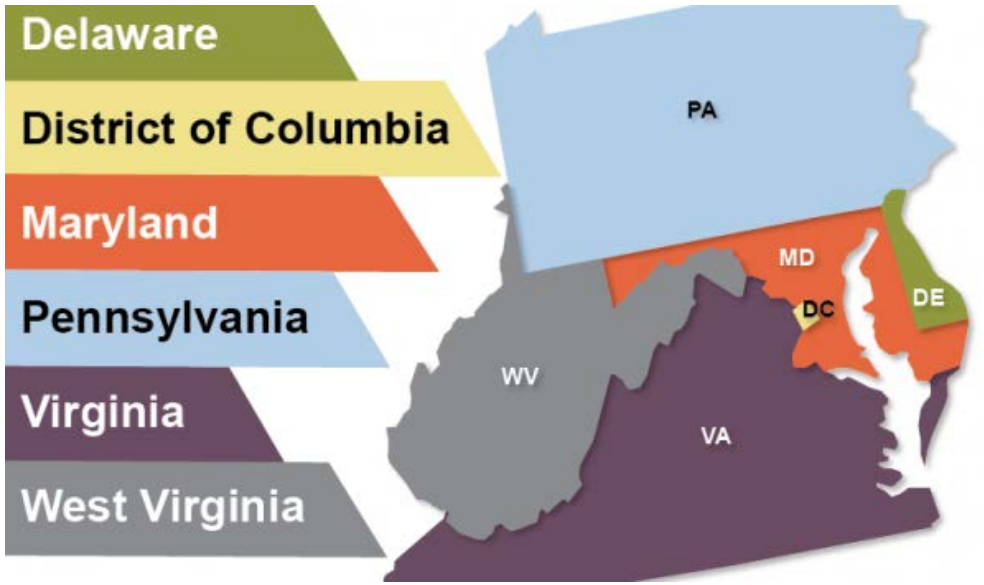
The MHTTC Network vision is to unify science, education and service to transform lives through evidence-based and promising treatment and recovery practices in a recovery-oriented system of care.

Central East MHTTC Goals

Funded by SAMHSA to:

- Accelerate the adoption and implementation of mental health related evidence-based practices
- Heighten the awareness, knowledge, and skills of the behavioral health workforce
- Foster alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers
- Ensure the availability and delivery of publicly available, free of charge, training and technical assistance

Central East Region 3



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At the time of this presentation, Tom Coderre served as Acting Assistant Secretary for Mental Health and Substance Use at SAMHSA. The opinions expressed herein are the views of the speakers, and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

Evaluation Information

As part of receiving funding through SAMHSA to provide this training, the Central East MHTTC is required to submit data related to the quality of this event. At the end of today's presentation, please take a moment to complete a brief survey about today's training.

Bipolar Disorder in the Black Community

William Lawson, MD, PhD
Treasurer, Black Psychiatrists of America

Health Equity Webinar Series
A collaboration of the CE-MHTTC and the Black Psychiatrists of America
June 3, 2021

Moderator:
Annelle B. Primm, MD, MPH
Black Psychiatrists of America, Council of Elders

COVID-19: Unprecedented Disaster

- Catastrophic impact on Black and other marginalized communities with disparate levels of illness, death, and economic fallout superimposed on layers of pre-existing inequities
- Symptoms of anxiety and depression
- Potential exacerbation of underlying mental disorders such as bipolar disorder

Today's Program

- Special thanks to the CE-MHTTC for its support of this tenth session of the Black Psychiatrists of America Health Equity Webinar Series
- Today's program features William Lawson, MD, PhD, Treasurer of the Black Psychiatrists of America

Recognizing and Treating Bipolar Disorders in African Americans

William B. Lawson, MD, PhD, DLFAPA

Adjunct Professor
Department of Psychiatry
University of Maryland School of Medicine
Professor Emeritus
Dell Medical School University of Texas, Austin
Professor Emeritus
Department of Psychiatry
Howard University College of Medicine
Email Dr. Lawson

People with Bipolar Disorder

Jane Pauley, TV presenter and journalist. The former *Today* and *Dateline* host describes being diagnosed with bipolar disorder in her autobiography "Skywriting: A Life Out of the Blue", which she wrote in 2004, as well as on her short-lived talk show.
Dick Cavett, television journalist. Quote from CNN transcript from *Larry King Live*, broadcast June 12, 2005:
"CAVETT: Both in hypomanic, which I have had, and incidentally, one has to admit many patients say I am cured now, I am fine. But I must say I miss those hypomanic states. They are better off where they are.“

Timothy Treadwell, American environmentalist and bear enthusiast, featured in the 2005 documentary film by Werner Herzog titled *Grizzly Man*.
Margaret Trudeau, Canadian celebrity.
Mark Twain, author. (as "Samuel Clemens") Jean Claude Van Damme, actor — Australian Woman's Day magazine — January 30, 2006
Kurt Vonnegut, author
Virginia Woolf, poet and novelist. see also Virginia Woolf's psychiatric history and Virginia Woolf and Her Madness

Kanye West

Musician/Entrepreneur

STATED:

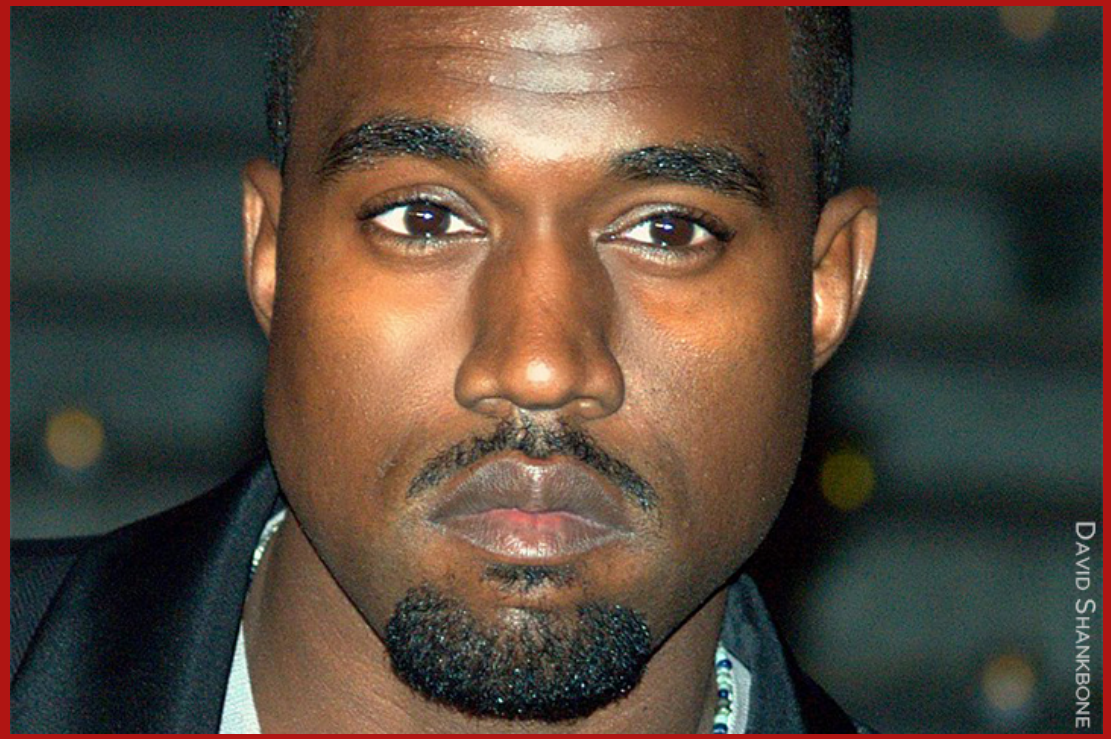
He's running for president in 2020 under the new banner of the Birthday Party. Tesla/Space X founder Elon Musk is giving him advice, and he will name a preacher from Wyoming as his vice-presidential candidate. In addition, he said, "I'm speaking with experts, I'm going to speak with Jared Kushner, the White House, with Biden."

He no longer supports President Trump: "I'm taking the red hat off."

He's suspicious of a potential COVID-19 vaccine, as vaccines are "the mark of the beast."

He believes "Planned Parenthoods have been placed inside cities by white supremacists to do the Devil's work."

He envisions a White House organizational model based on the fictitious country of Wakanda in the "Black Panther" film.



DSM V Criteria for Mania

- Distinct period of abnormal Mood:
  - Euphoric, Expansive, Irritable
- 3 (or 4) Associated Features present to a significant degree during 1 week

- **↑ Self Esteem**
- **↓ Need for Sleep**
- **↑ Talking**
- **FOI/ Racing Thoughts**
- **Distractible**
- **↑ Goal Directed Activity**
- **↑ Participation in pleasurable activities with potentially painful consequences/ Risk taking**

Bipolar disorder, previously known as manic-depressive illness, involves alternating periods of intense mania (high energy and activity) and severe depression (low energy and mood).

- Manic periods, which can last days to weeks, are associated with:
  - an intense internal drive to be active and inability to sit still
  - grandiose ideas and motivation to achieve big things
  - fast speech that's difficult to interrupt
  - poor sleep
  - a strong sense of oneness with the world
  - irritable or elated moods

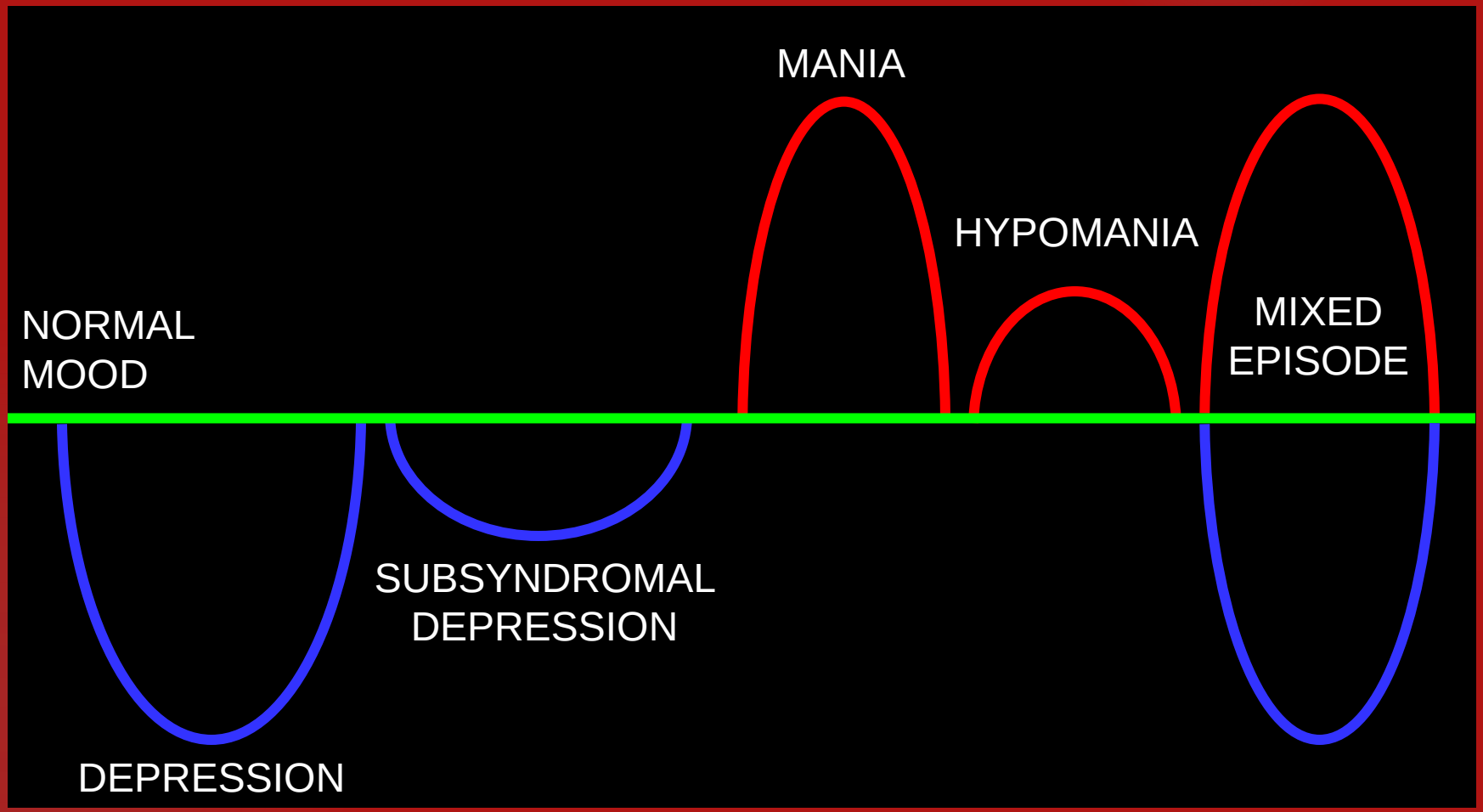
What is bipolar disorder?

- When these periods are less severe or shorter, it's typically referred to as hypomania
- West's recent public behavior indicates he may have been experiencing a hypomanic period
- Depressed periods, which often last weeks to months, are associated with:
- overwhelming fatigue
- low moods
- suicidal thoughts and behaviors

Bipolar Disorder

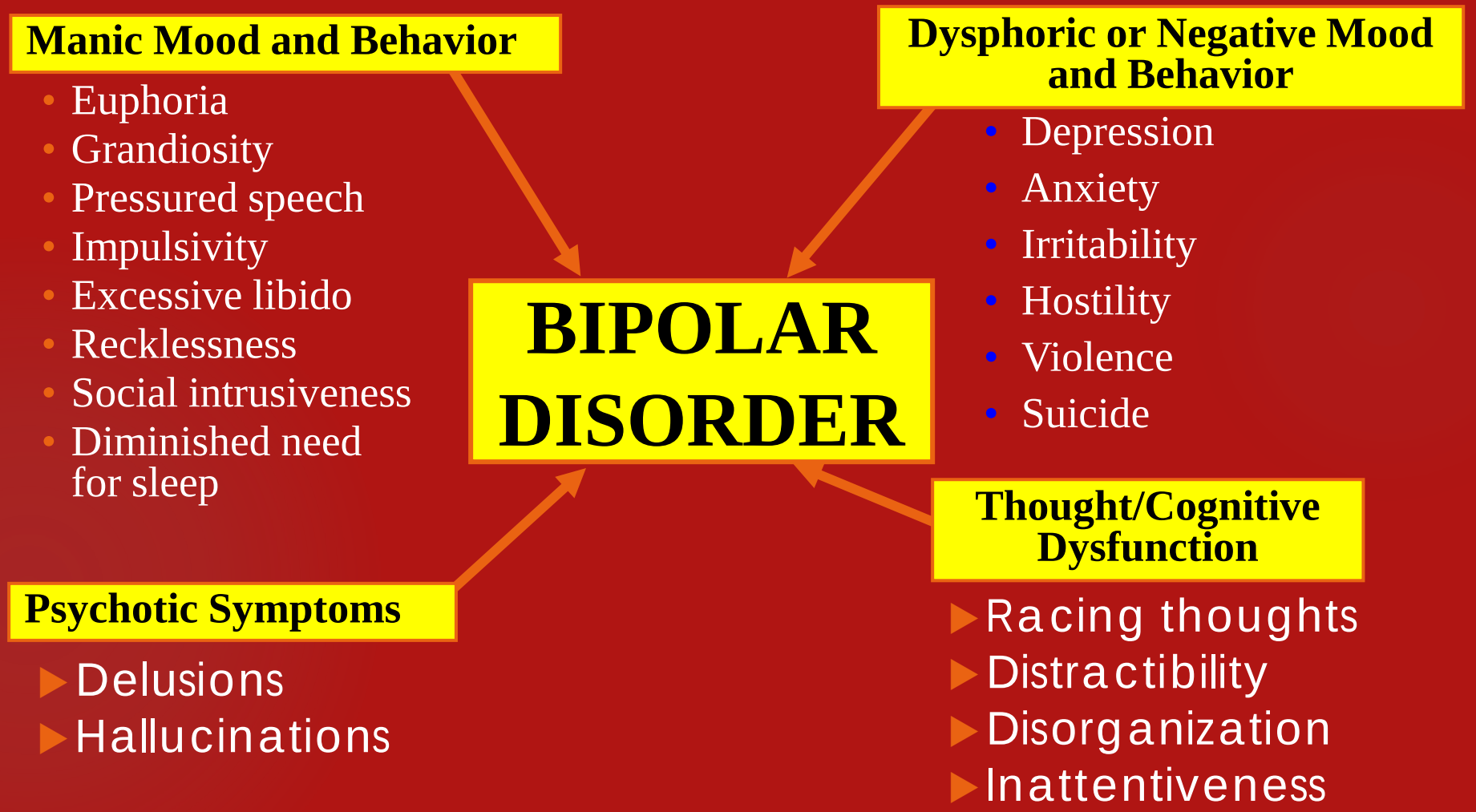
- Bipolar I Disorder— defined by manic episodes that last at least 7 days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least 2 weeks. Episodes of depression with mixed features (having depression and manic symptoms at the same time) are also possible.
- Bipolar II Disorder— defined by a pattern of depressive episodes and hypomanic episodes, but not the full-blown manic episodes described above.
- Cyclothymic Disorder (also called cyclothymia)— defined by numerous periods of hypomanic symptoms as well numerous periods of depressive symptoms lasting for at least 2 years (1 year in children and adolescents). However, the symptoms do not meet the diagnostic requirements for a hypomanic episode and a depressive episode.
- Other Specified and Unspecified Bipolar and Related Disorders— defined by bipolar disorder symptoms that do not match the three categories listed above.

Bipolar Disorder: The Ingredients



Stahl SM. *Essential Psychopharmacology.* New York, NY: Cambridge University Press; 2000.

Symptom Domains of Bipolar Disorder



adapted from Goodwin FK, Jamison KR. *Manic-Depressive Illness.* Oxford University Press: New York, NY; 1990.

Bipolar Disorder

- Lifetime prevalence
  - BP I = 0.4%–1.6%
  - BP II = 0.5%

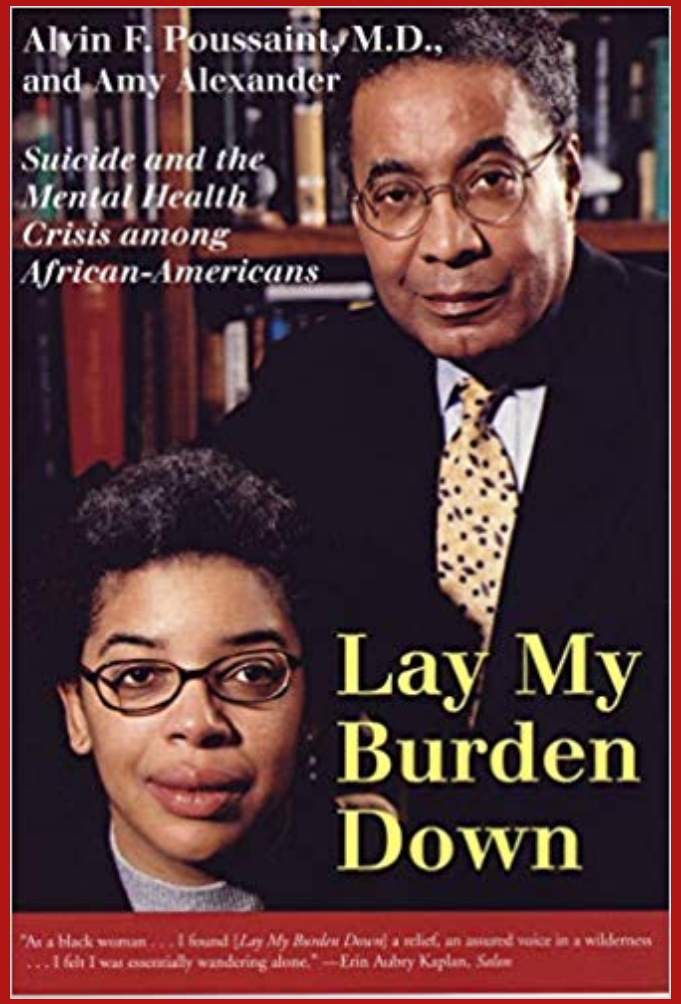
} **May be underestimated**

- 90% recurrence
- Number of episodes correlates with residual symptoms between episodes and response to treatment
- At least 25% of bipolar patients attempt suicide
  - High comorbidity, e.g., substance abuse
- Strongly familial
- Complicated by other medical and psychiatric disorders
- 6th leading cause of disability worldwide

Suicide occurs in Black folks

Dr. Alvin Poussaint and journalist Amy Alexander offer a groundbreaking look at 'posttraumatic slavery syndrome,' the unique physical and emotional perils for Black people that are the legacy of slavery and persistent racism.

- Not new



INSIDE THE BIPOLAR BRAIN

Scientists can't point to one lobe that makes a person bipolar, but they have identified several areas that are involved in ways they are just beginning to understand

AMYGDALA

WHAT IT DOES: One of the brain's emotional centers; helps in the recognition of facial expressions and tones of voice. Neural transmissions increase in response to emotional stimuli. Normally, repeated exposure to the same experiences or images leads to habituation, or reduced response

WHAT HAS GONE WRONG: Habituates slowly to some stimuli, remaining reactive beyond the usual response time

HIPPOCAMPUS

WHAT IT DOES: One of the brain's memory centers. One layer of the hippocampus, the subiculum, helps recognize contexts that represent danger or reward

WHAT HAS GONE WRONG: Loss of branches that connect neurons may lead to a constant state of anxiety because the person can no longer identify safe situations

VENTRAL STRIATUM

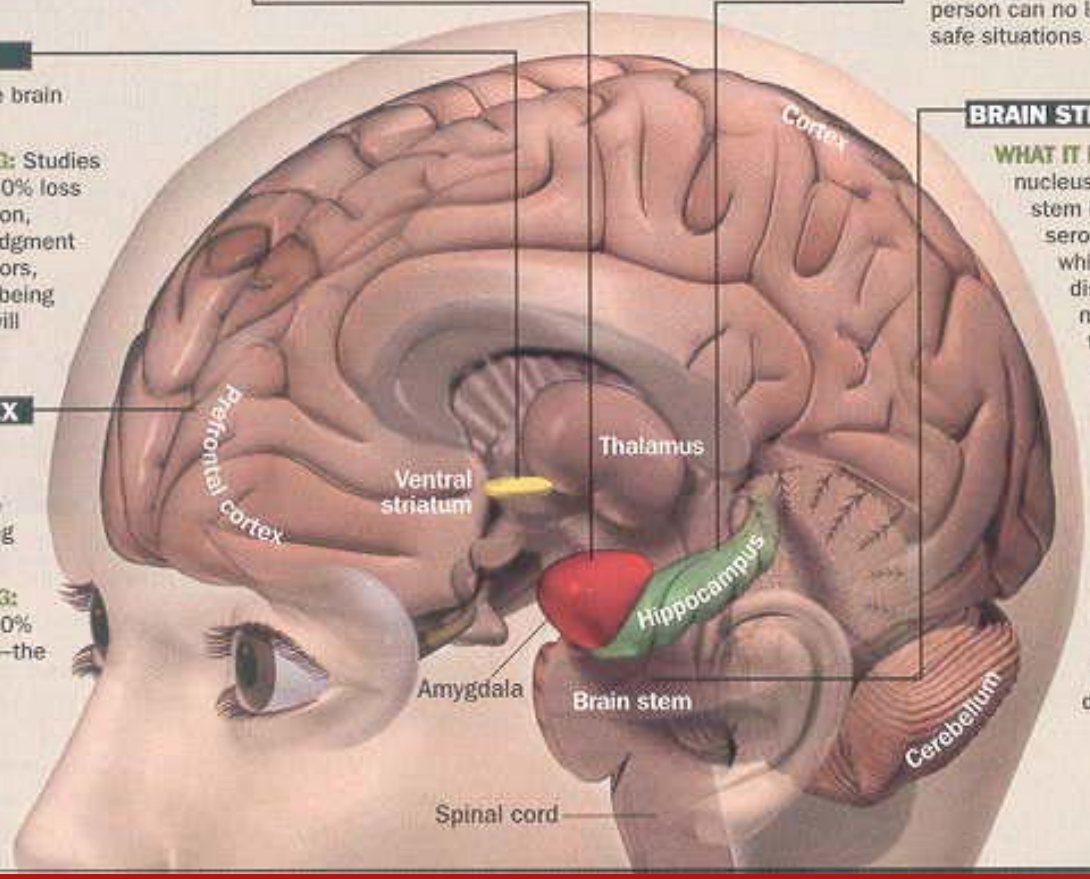
WHAT IT DOES: Helps the brain process rewards

WHAT HAS GONE WRONG: Studies show overactivity and a 30% loss in gray matter in this region, causing people to lose judgment about how certain behaviors, such as overspending or being sexually indiscriminate, will affect their lives

PREFRONTAL CORTEX

WHAT IT DOES: Parts of the prefrontal cortex regulate emotion and are instrumental in processing rewards and motivation

WHAT HAS GONE WRONG: Studies show a 20% to 40% reduction in gray matter—the result of a loss of the branches that connect neurons



BRAIN STEM

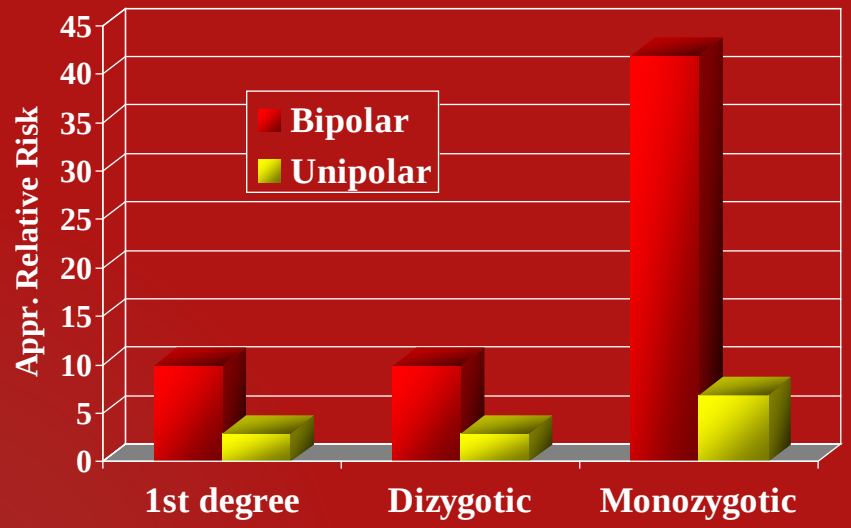
WHAT IT DOES: The raphe nucleus in the brain stem is home to serotonin cell bodies, which create and disperse the neurotransmitter to different parts of the brain

WHAT HAS GONE WRONG: Bipolar patients have a 40% loss of the serotonin 1a receptor in the raphe, which may contribute to atrophy of neurons and depression

SOURCE: Wayne Drevets, M.D., National Institute of Mental Health

Text by Sora Song
TIME Diagram by Joe Lertola

Genetics: Family Studies



Andreasen et al 1987; Gershon et al 1982;
Kendler et al 1995; Kupfer et al 1988 & 89.

Genetic and childhood trauma interaction effect on age of onset in bipolar disorder: An exploratory analysis.

Anand A, Koller DL, Lawson WB, Gershon ES, Nurnberger JI; BiGS Collaborative.
J Affect Disord. 2015 Jul 1;179:1-5. doi: 10.1016/j.jad.2015.02.029. Epub 2015 Mar 10.

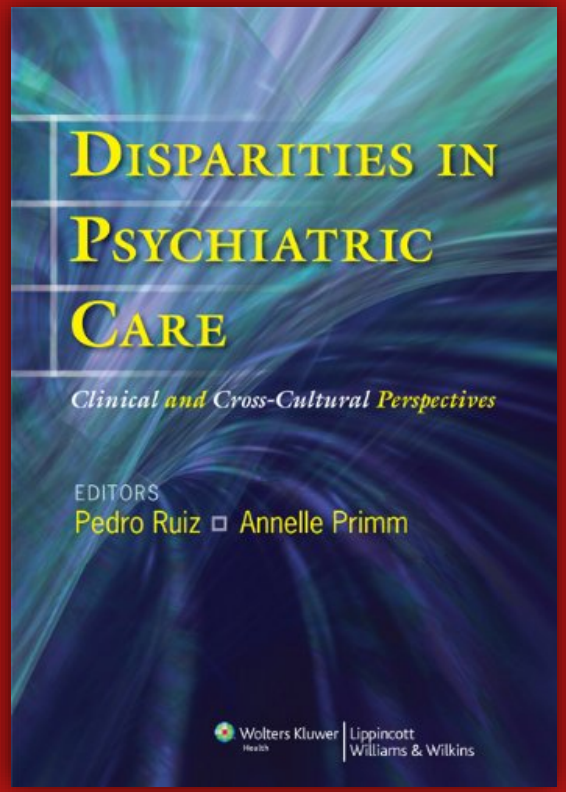
The distribution of age at onset for bipolar disorder showed a broad peak between ages 12 and 18, with the majority of subjects having onset during that period, and a significant decrease in age of onset with the number of traumatic events.

Social Determinants of Health are Highly Important

- Misdiagnosis
- Early traumatic events important

Primm, A.B. and **Lawson, W.B**. "Disparities Among Ethnic Groups: African Americans" in Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives; Eds. P. Ruiz and A. Primm, Wolters Kluver /Lippincott Williams & Wilkins, Baltimore, 2010, Pp19-29

- Disparities in treatment

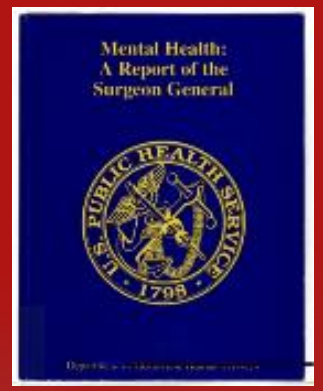


Epidemiology of Bipolar Disorder:
Prevalence

- Nationwide survey evaluated prevalence using mood disorder questionnaire (MDQ)
- Prevalence of 3.7% vs. previously accepted 1%
- Onset highest in 18 - 24 age range
- 1 in 5 are diagnosed correctly
- 1 in 3 are initially diagnosed with unipolar major depression
- Minorities may be overdiagnosed as schizophrenic[1]

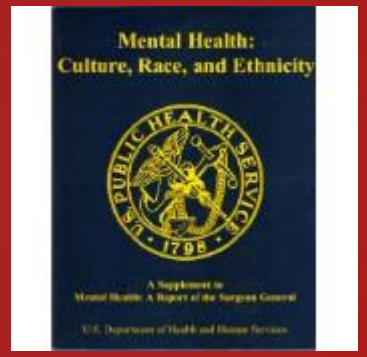
Hirschfeld RMA, Holzer C, Calabrese JR, et al, Am J Psychiatry 2003;160(1):178-180
[1]William Lawson, personal communication.

Landmark Reports



Mental Health: A Report of the Surgeon General (1999)

- First Surgeon General's Report on Mental Health



Mental Health: Culture, Race, and Ethnicity

- A supplement released in 2001

REPORTS

- SUPPLEMENTAL SURGEON GENERAL'S REPORT ON MENTAL HEALTH OF MINORITIES 2001
- NO SUBSTANTIAL DIFFERENCE IN PREVALENCE
- SIGNIFICANT ILLNESS BURDEN
- LACK OF ACCESS

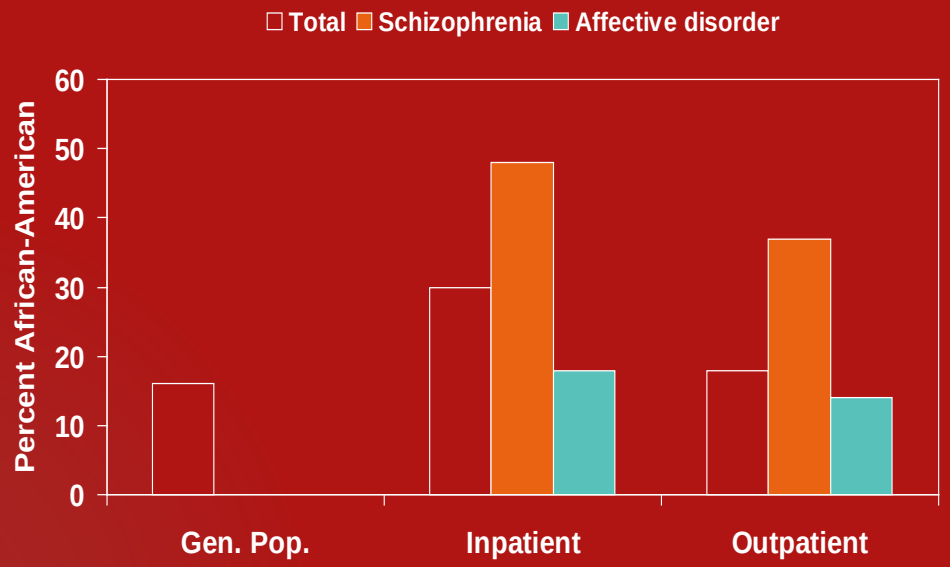
BIPOLAR AFFECTIVE DISORDER IN AFRICAN AMERICANS

- Thought to be rare in African Americans (Jones and Gray, 1986)
- Often misdiagnosed as schizophrenia (Adebimpe, 1994)
- Frequently not diagnosed: may be referred to the correctional system
- More often treated with antipsychotics

Schizophrenia More Common in African Americans?

Schizophrenia & Ethnicity

Results from Tennessee



Similar findings have been recently reported by Lawson et al (2013) in MD & CA
Lawson et al, *Hosp Comm Psychiatry* 1994

Persistent disparities

- Bipolar ll OVER DIAGNOSIS OF SCHIZOPHRENIA
- Under diagnosis of Bipolar Disorder especially bipolar ll misdiagnosed as depression
- Under diagnosis of PTSD
- UNDERDIAGNOSIS OR UNDER RECOGNITION OF DEPRESSION

Influence of Patient Race and Ethnicity on Clinical Assessment in Patients with Affective Disorders

- 610 White, African-American and Latino patients with significant affective or psychotic symptoms
  - 6 sites: UC, UMDNJ, UM, UCLA, UTHSCSA, Howard
  - Multiple steps to rate symptoms and diagnosis
- Schizophrenia clinical diagnosis: AA>W, L
- Cultural mistrust associated with symptoms scores:
  - SAPS total psychosis ($p<.04$)
  - SAPS hallucinations/delusions ($p<.03$)
  - MADRS total score ($p<.01$)
- Protective wariness of patients leads to symptom misattribution and misinterpretation

Lawson et al. Presented at APA 2012, MS in preparation

Psychotic symptoms more prevalent in AA with BP?

PSYCHOSIS
PARANOIA
CONSPIRACY BELIEFS

Continuum

- Distrust (DST), Perceived Hostility of Others (PHO), and False Beliefs and Perceptions (FBP)
- Rather than pathology, consequence of discrimination to self or others, and awareness of historical mistreatment
- Whaley 1997
- African Americans 4X more likely to be aware of Tuskegee study
- Katz 2008
- Other concepts such as:
- Micro insults
- Healthy paranoia

AFFECTIVE SYMPTOMS IGNORED

- Clinician-related
  - failure to elicit symptoms
  - failure to understand ethnic differences in expression
  - overt or covert stereotyping
- Patient-related
  - real differences in symptom expression
  - protective wariness - misinterpreted as paranoia

Strakowski et al 1997; Neighbors et al 1989; Adebimpe et al 1981

Minorities Overrepresented in Treatment Settings With Limited Mental Health Service

- Bipolar disorder is often misdiagnosed
- Bipolar disorder often requires complex pharmaceutical regimens which are often unavailable
- Inappropriate treatment can worsen outcome
- Skilled providers are needed or should be readily available but are seldom consulted

Bipolar Disorder in African Americans

- Is NOT Rare
- May contribute to health disparities
- Must be recognized outside of mental health specialty care centers

Bipolar Disorder in Primary Care Settings

Depression is common but often underrecognized and undertreated

Bipolar disorder is common and often underrecognized, not treated, nor is consultation sought

Depression is a prominent symptom of bipolar disorder

Some antidepressants when given alone worsen bipolar depression, increasing the risk of manic breakthrough or rapid cycling

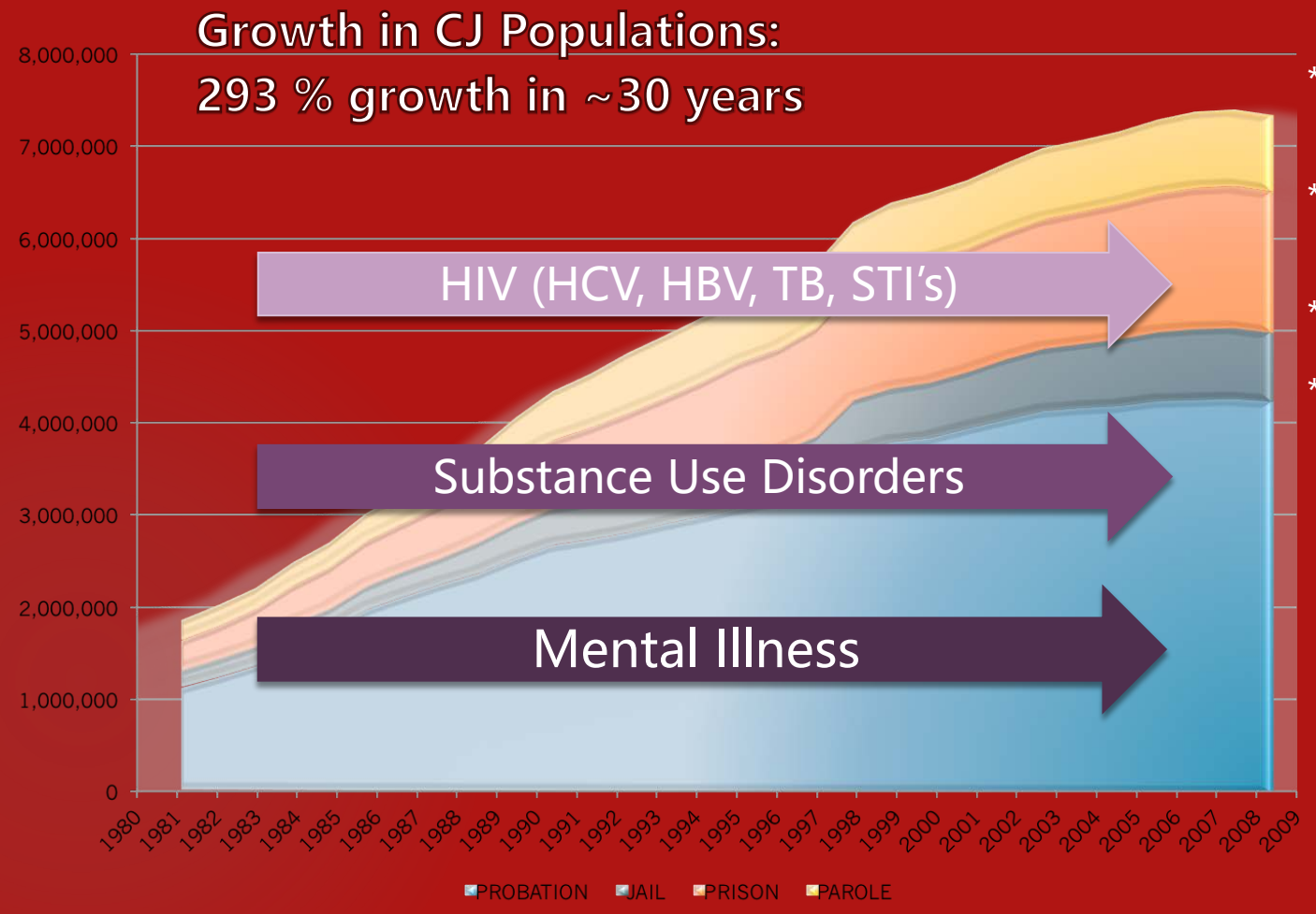
	Columbia University [1] *(New York City)*	*Howard University* [2] *(Washington, D.C.)*
% Positive screen for bipolar disorder	With MDQ 9.8%	With MDQ 34.7% With SCID 10.4%
Diagnosed with bipolar disorder	8.4% of those with positive screen	
Received Mood stabilizer	6.5%	11.1%

Das et al. *JAMA.* 2005;293:956-9631.1
Graves, et al In J Bipolar Dis 2006 in press 2

Bipolar Disorder in Primary Care Settings

- Bipolar disorders (bipolar II, bipolar depression) also likely to be common in primary care clinics but likely to be misdiagnosed
- Bipolar disorders Likely to be treated with antidepressants alone leading to high risk of medication induce mania
- Often not referred or have consultation with a mental health provider

People of color more likely to be incarcerated



*Sources: Glaze, 2009. *Correctional Populations in the United States, 2009*. Bureau of Justice Statistics.

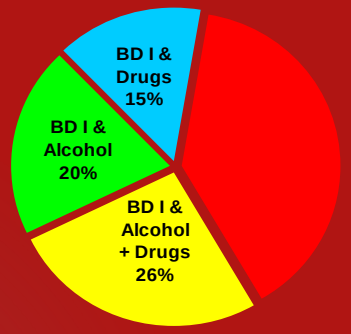
*Langan & Levin, 2002. Recidivism of prisoners released in 1994. *Federal Sentencing Reporter*, 15(1), 58.

*Uniform Crime Reports, 2010. U.S. Department of Justice.

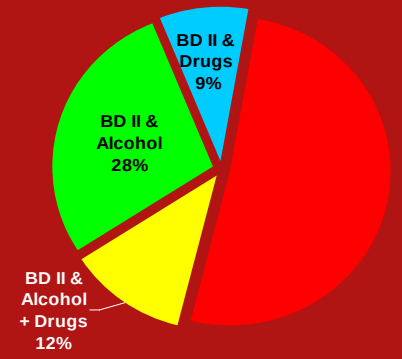
*Bureau of Justice Statistics Correctional Surveys, 2009. *The Annual Probation Survey, National Prisoners Statistics Program, Annual Survey of Jails, and Annual Parole Survey.* Bureau of Justice Statistics - Key Facts at a Glance

Bipolar Disorder and Substance Abuse

Lifetime Community Prevalence (ECA)



BD I Only 39%



BD II Only 51%

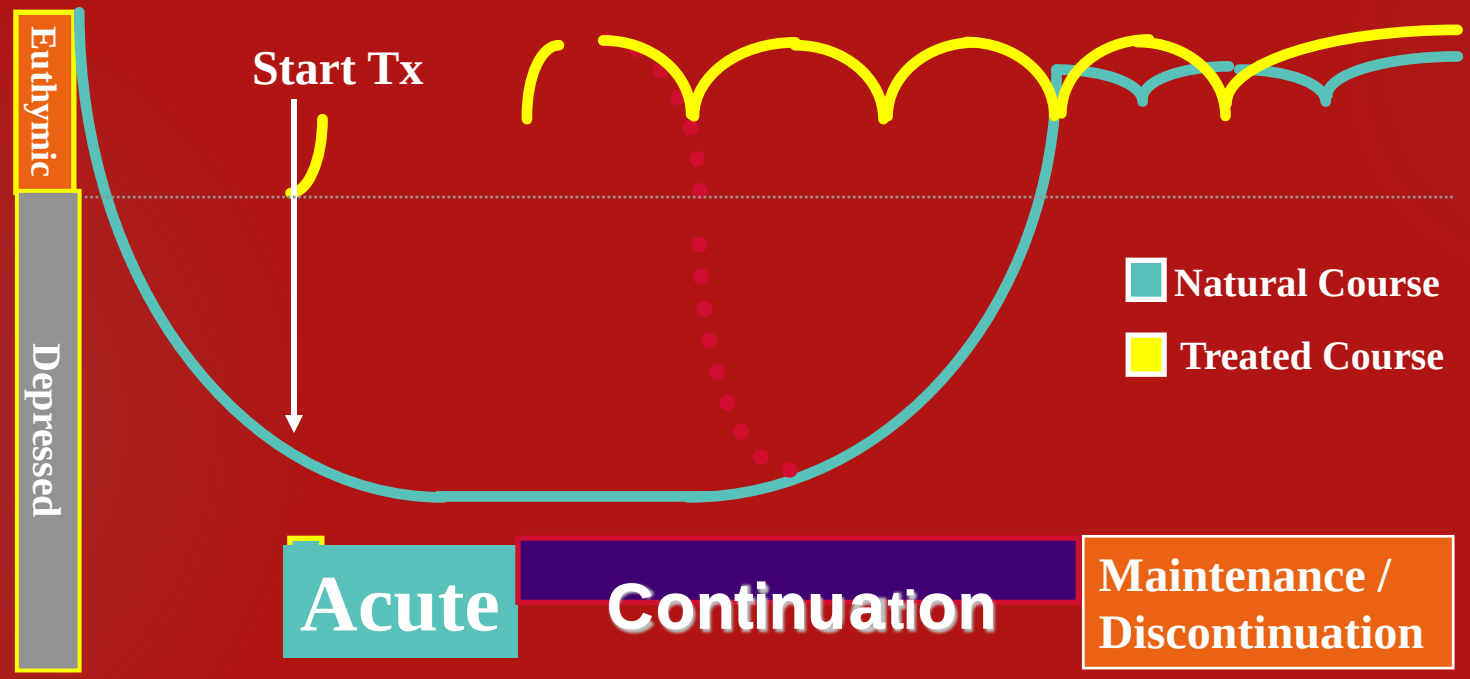
Bipolar I With SA

Bipolar II With SA

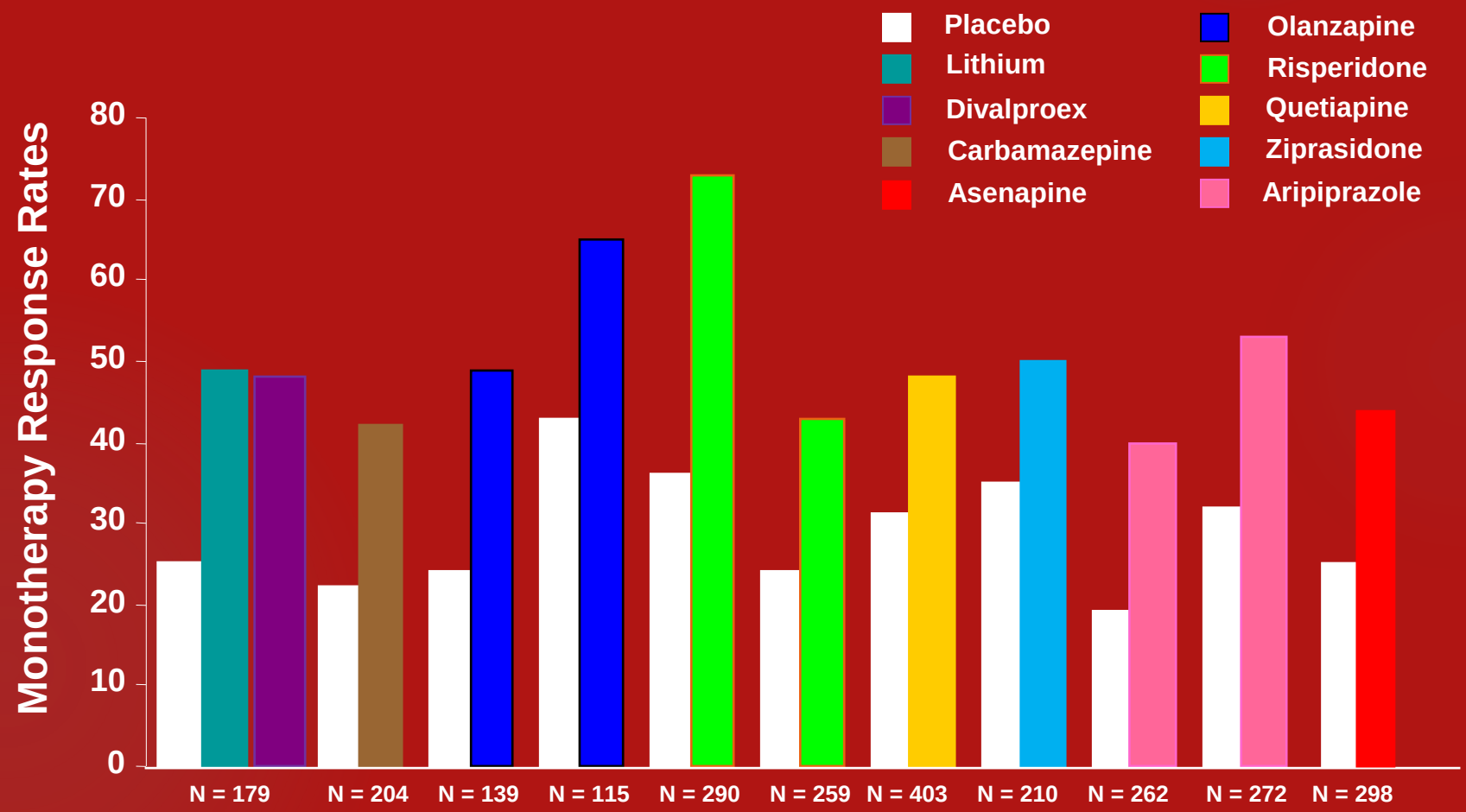
ECA = Epidemiologic Catchment Area Study; BD = bipolar disorder; SA = substance abuse.

Weissman MM, Johnson J et al. *N Y State J Med.* 1991;91(suppl 11):S19-S23.

Phases of Treatment



Monotherapy Treatment for Acute Mania: all about the same



Adapted from Sachs G. *FOCUS*. 2007;5(1):3-13.
McIntyre R, et al. *Bipolar Disorders*. 2009;11:673-686.

Medications commonly used in bipolar disorder

Medication	Mania	Depression	Maintenance
Lithium	X	A	X
Conventional antipsychotics			
Chlorpromazine	X	D	D
Haloperidol	A	D	D
Atypical antipsychotics			
Risperidone	X	C	X[1]
Olanzapine	X	X[2]/B[3]	A
Ziprasidone	X	D	X[4]
Quetiapine	X	X	X[4]
Aripiprazole	X	D[5]	X
Cariprazine	X	B	D
Lurisadone	C	X	B
Asenapine	X	C	D
Paliperidone	A	C	B
Clozapine	C	D	C
Antiepileptics			
Divalproex	X	B	B
Carbamazepine	X	C	B
Lamotrigine	D	A	X
Oxcarbazepine	C	C	D

X=USFDA approved for this phase; o/w: A= replicated double-blind placebo-controlled clinical trial or meta-analysis ; B= at least one double-blind placebo controlled trial; C= uncontrolled trials or expert clinical use/opinion; D=minimal evidence for efficacy or failed trials.

[1]USFDA approved in slow-release injectable form. [2]USFDA in combination with fluoxetine. [3]As monotherapy.

[4]USFDA approved for augmentation of lithium and divalproex. [5]USFDA approved for augmentation therapy in major depressive disorder, not bipolar depression.

Strakowski, SM. *Bipolar Disorder*. Oxford U. Press, NY 2014

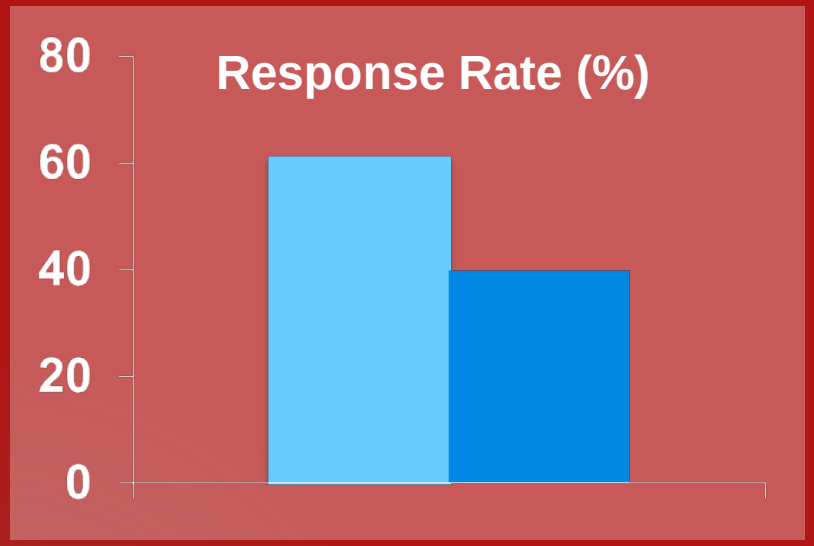
African American and other ethnic minorities

- *Lower adherence rate* Diala 2000, Mark et al, 2004
- Different attitudes to medication?
- More side effects?
- Less efficacy?

LITHIUM IN AFRICAN AMERICANS

- More side effects at standard plasma levels
- Effective at low plasma levels?
- Poorer compliance?
- Strickland et al. 1993; 1995)

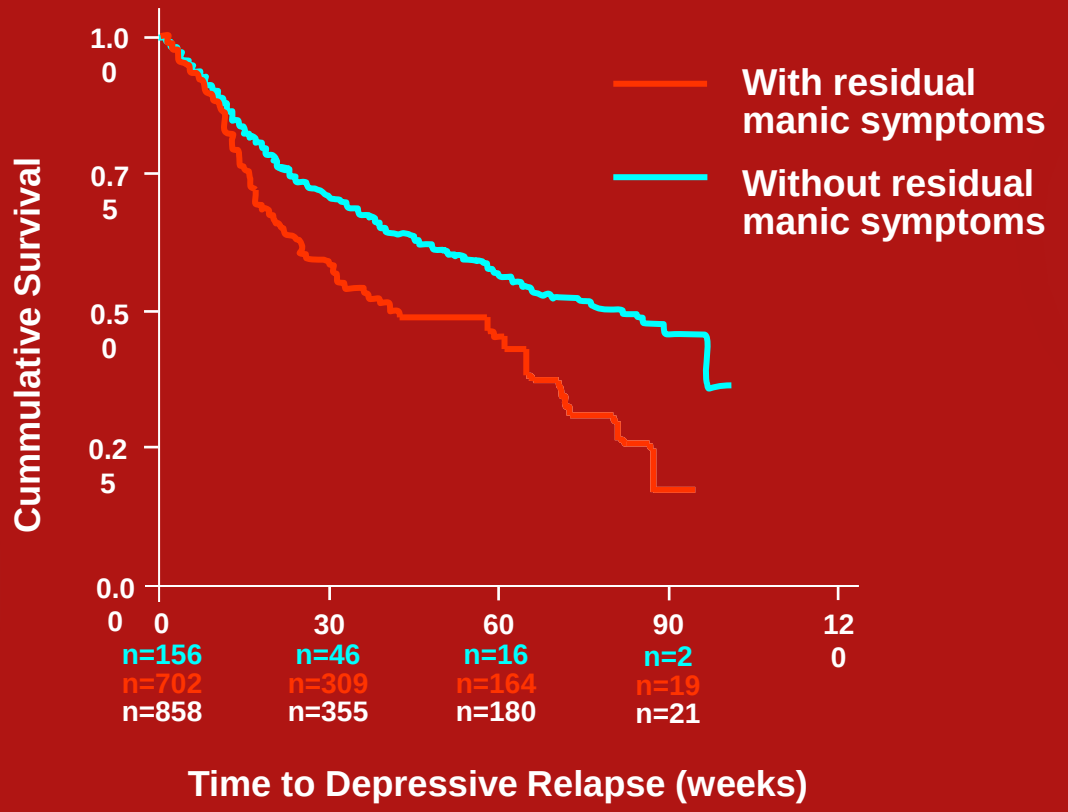
Selecting an Initial Treatment



- Some data suggest combination therapy is more effective than monotherapy
- Two meta-analyses suggest atypical antipsychotics may be preferable to lithium/divalproex
- Selection is largely based on matching side effect profiles with a specific patient
- Very little evidence for predictive reliability of demographic or clinical factors

Correll CU, et al. *Bipolar Disord.* 2010;12(2):116-141.
Ketter T, et al. *J Clin Psychiatry.* 2008;69 (Suppl 5):9-15.
Yildiz A, et al. *Neuropsychopharmacology.* 2011;36(2):375-389.

Outcomes From STEP-BD: Approximately 50% Recur Within 2 Years...Many More Drop Out



Perlis RH et al. *Am J Psychiatry*. 2006;163:217-224.

Why Such Poor Outcomes?

- Failure to address ethnic and cultural issues
- Lack of optimal treatment in non-mental health settings
- Patient factors
  - Treatment adherence
- Intervention factors
  - Maintenance efficacy is modest
- Clinician factors
  - Guideline adherence
- Limitations in the guidelines
  - What's wrong with the evidence base?

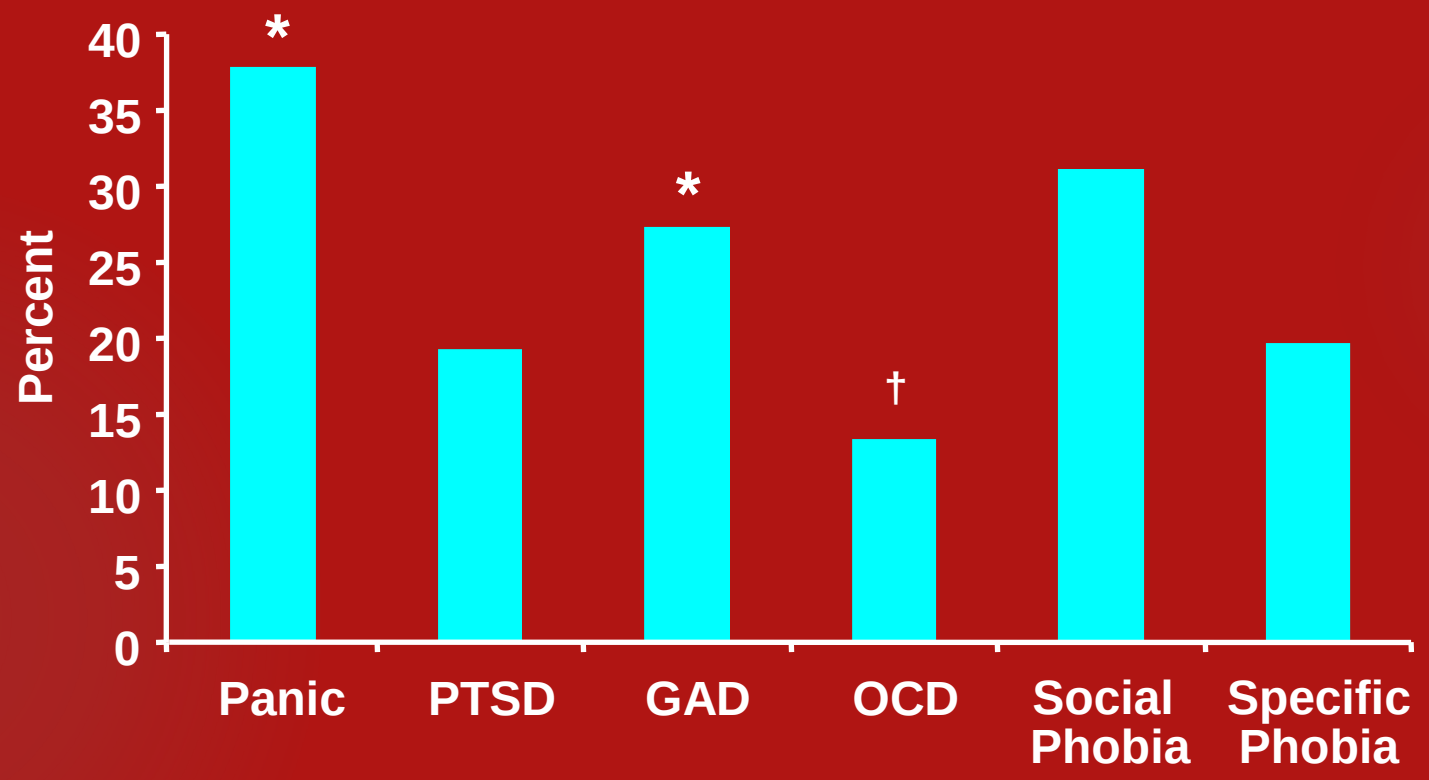
Perlis RH et al. *Am J Psychiatry*. 2006;163:217-224.

Treatment of SUDs in BPD

- No clear common mechanism
- Minimal pharmacotherapeutic overlaps
- Some psychotherapeutic overlaps (e.g., CBT techniques)
- Not really temporally linked well
- So:
  - Treat both aggressively (medications wisely)
  - Try to develop/use integrative approaches
  - Track outcomes of both
  - Aim for sobriety
  - Education!

Weiss RD, Connery HS. *Integrated Group Therapy for Bipolar Disorder and Substance Abuse.* NY, Guilford Press, 2011
Strakowski SM. *Bipolar Disorder*. NY, Oxford University Press, 2014.

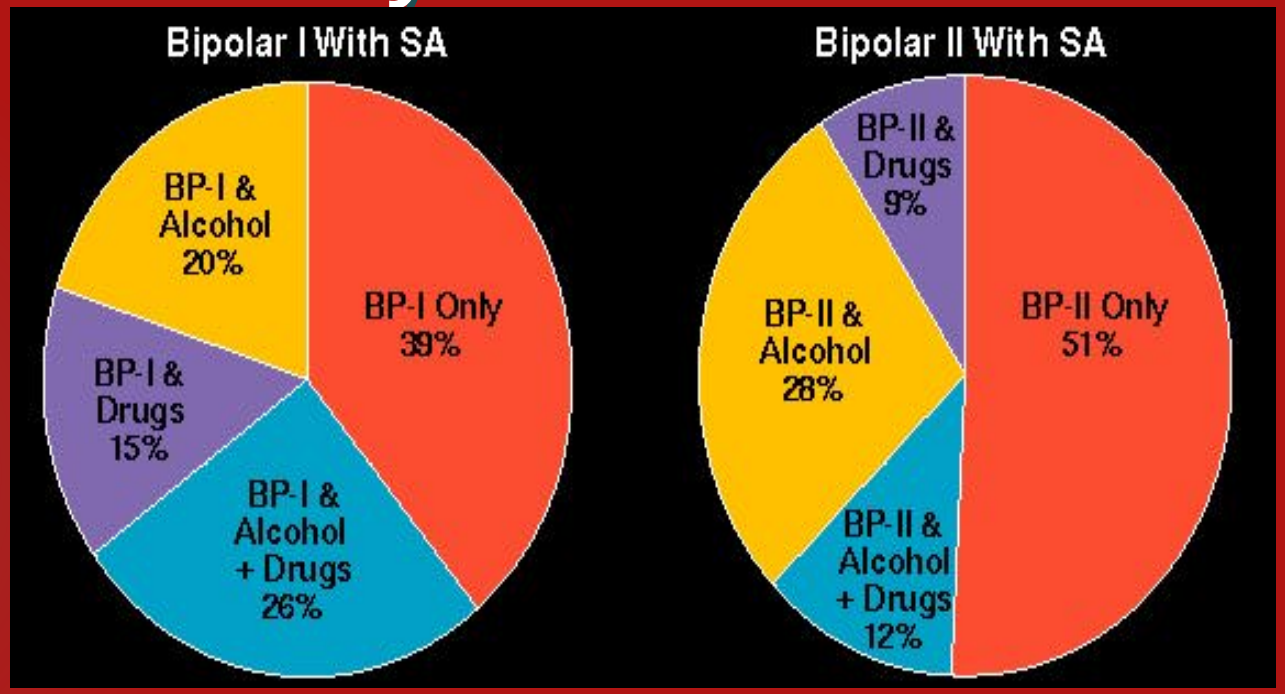
Comorbidity Matters!



*P<.01; P<.05 vs N=114 subjects with MDD; N=122 bipolar I and II subjects, mean age = 40.8 (12.2), 49% women.
MDD = manic depressive disorder; **PTSD = posttraumatic stress disorder; GAD = generalized anxiety disorder; OCD = obsessive-compulsive disorder.**

Simon NM et al. *J Psych Res*. 2003;37:187-192.

Substance Abuse (SA) and Bipolar Disorder: Lifetime Community Prevalence



Weissman et al, 1991.

BPD Requires Programmatic Treatment

- Bipolar disorder is dynamic and complex so:
  - Comprehensive assessments
  - Ongoing safety evaluations
  - Aggressively manage symptoms/episodes
  - Building a support network
  - Integrating all aspects of care for long-term management into systematic appointments.

- ***It requires well trained professionals for treatment***

Limited Therapeutic Options

- Lack of access to culturally competent therapists
- Lack of access to evidence-based therapy
- Lack of contact with mental health and substance abuse provider specialists

Education

1. Clinical presentation
   -Symptoms
   -Diagnostic criteria
   -Early identification of relapse
   -Course of illness & prognosis
2. Common Comorbidities
3. Epidemiology
4. Neurobiology
5. Genetics &family risk patterns
6. Treatment options
   -Medications – risk vs. benefits
   -Psychotherapy options
   -Lifestyle management
   -Treatment adherence
7. Finding a support group
8. Educational resources

Sure, call it psychoeducation, but just educate!!

Strakowski SM. *Bipolar Disorder*. Oxford U. Press, NY 2014

Continuation Phase

- Begins with remission of acute symptoms
- Continue successful acute therapies at full dose
  - Maintain effective serum levels (if known)
  - Consistent with ability to tolerate medication
- Choose duration 8wks - unless
  - documented natural course is longer
  - documented history of early affective switch
- Goal is to achieve recovery

Sachs et al 2000

Evidence-Based Therapies

Impact on relapse and rehospitalization rates:

- Group psychoeducation
  - 25% hospitalized vs 35% in unstructured group[1]
- Cognitive behavioral therapy (CBT)
  - 1 year relapse 44% vs 75% usual care[2]
  - 2-year follow-up found no reduction in relapse rates after first 6 months [3]
- Interpersonal & Social Rhythms Therapy (IPSRT)
  - Decreased symptoms and improved function.[5]
- Family focused treatment (FFT)
  - 2-year relapse 28% with FFT vs 60% with individual support[4]
  - Perceived criticism may be an indicator[6]

1. Colom F, et al. *Arch Gen Psychiatry*. 2003;60:402-407.
2. Lam DH, et al. *Arch Gen Psychiatry*. 2003;60:145-152.
3. Lam DH, et al. *Am J Psychiatry*. 2005;162:324-329.
4. Rea MM, et al. *J Consult Clin Psychol*. 2003;71:482-492.
5. Inder ML et al. *Bipolar Disord* 2015; 17:128-138.
6. Miklowitz DJ, et al. *Psychiatry Res.* 2005;136:101-111.

Goals of Maintenance Therapy

- Prevent new dangerous symptoms
  - Suicide, agitation, psychosis
- Stabilize mood symptoms
  - Control mania without provoking depression
  - Control depression without provoking mania
- Minimize subsyndromal symptoms
- Maximize inter-episode function
- Avoid harming patient
  - Minimize adverse effects
- Enlist patient into treatment goals and planning
  - Teach disease management

Strakowski SM. *Bipolar Disorder*. Oxford U. Press, NY 2014

Other interventions

- A number of nonpharmacologic interventions may help stabilize patients over time
  - Maintaining a regular schedule & sleep
  - Phototherapy for seasonal depression
  - Develop strategies for managing stressors
- Remember to treat comorbidities
  - E.g., substance abuse
- Education, education

Strakowski SM. *Bipolar Disorder*. Oxford U. Press, NY 2014

Redefining the Illness and Treatment

I. **Bipolar Disorder is not rare**
II. **Bipolar Disorder is often misdiagnosed**
III. **Bipolar disorder often requires complex treatment**
IV. **Many individuals are in settings where treatment is not optimum**
V. **Psychosocial factors interact with ethnicity to limit access to effective treatment.**

Treat the Biopsychosocial Determinants

Treatment must attend to multiple needs of the individual

- Remaining in treatment in a therapeutic environment for adequate time is vital for success
- Treatment should be readily available no matter race, gender, orientation, or socio-economic status
- Treatment should be based on the latest findings in the neurosciences AND social determinants of health
- The comorbidities must also be treated
- Gender matters
- Cultural matters
- Age matters
- Ethnicity matters

Questions

Appreciation

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