THE MISDIAGNOSIS OF BLACK PATIENTS WITH MANIC DEPRESSIVE ILLNESS

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It has been shown repeatedly that, contrary to earlier beliefs, blacks may well demonstrate similar prevalence rates for manic depressive illness when compared with whites. Yet the authors believe that black manic depressive patients are frequently misdiagnosed as being chronic undifferentiated schizophrenics and treated with major tranquilizers when lithium is the drug of choice. This contention is supported by three case histories and some institutional dynamics that cause this form of iatrogenic morbidity to continue to prey upon black psychiatric patients.

INTRODUCTION

It has been repeatedly reported that blacks have lower rates of affective disorders when compared with whites. According to Thomas and Sillen, earlier reports (such as done by Babcock in 1895, O'Malley in 1914, Green in 1914, and Bevis in 1921) attributed this finding to blacks' state of primitive mentality.[1] Later, in the 1960s, several studies also reported racial differences with respect to the incidence of affective illness. However, the etiology of these differences was at that time attributed to psychodynamic theory. The reasoning was that since most blacks were deprived of self-esteem, material possessions, status, etc, they did not have what was required to experience a "loss" which was the precipitating factor to trigger depression. Malzberg[2] found that manic depressive diagnoses in blacks were at one-fourth the rate in whites. Prange and Vitols found that only one percent of blacks were diagnosed as having psychotic depressive reactions compared with 4.3 percent of whites.[3] Jaco reported his study showed blacks with one-seventh the rate of affective disorders when compared with whites.[4] Finally, Johnson et al were unable to find one case of a black patient diagnosed as manic depressive during three years of admissions at Bellevue Psychiatric Hospital.[5]

In diagnosing schizophrenia there again appears to be racial differences, with blacks exhibiting a higher rate. Favis and Dunham report a 25 percent higher rate among blacks.[6] Frumkin[7] and Malzberg[2] both reported that black patients received a diagnosis of schizophrenia on first admission more than twice as often as white patients. Taube[8] at the National Institute of Mental Health (NIMH) found that blacks have over a 65 percent higher rate than whites.

While there have been several attempts to demonstrate that these diagnostic differences tend to reflect a subtle form of institutionalized racism, the lack of recognition that blacks seem to have as high a rate of affective illness as whites continues. Simon et al pointed out, "This hesitancy to diagnose blacks as affectively ill is more than compensated for by a strong tendency to diagnose blacks as schizophrenic more frequently than whites."[9] This same study demonstrated that the hospital diagnoses were strongly correlated with race with a diagnosis of schizophrenia rather than affective illness given more frequently to blacks than to whites. Yet, when independent diagnoses were done by the project's personnel, race and diagnosis were not related. This finding is consistent with Helzer's finding that (with the exception of a greater degree of alcoholism in paternal relatives of black men) the clinical and familial expression of bipolar affective illness is similar in both white and black men.[10] In 1976, Cannon and Locke[11] of NIMH reported that the tendency toward diagnostic confusion in the treatment of black patients continues at an alarming rate.

The purpose of this paper is to demonstrate that this frequent misdiagnosis of black manic depres-

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sive patients is still prevalent in 1979, and to outline some of the institutional forces which cause this harmful carelessness to continue. While statistical data are presently incomplete, the use of individual cases adequately presents the alarming degree of iatrogenic morbidity caused by diagnostic haphazardness.

BACKGROUND

The mental health system in Illinois is a fairly standard system in that the state is regionalized, ie, set up into specific target areas to be serviced by specific state institutions. Region 2 is one such region composed of Chicago and several surrounding counties. Region 2 is divided into 53 planning areas with one or more making up eight subregions. Subregion 12 (located on the south side of Chicago) has a target population of 700,000, and is composed of six planning areas consisting of South Shore, Chatham Avalon, Roseland, Southwest, Southeast, and Beverly Morgan. The first four areas are primarily inhabited by black residents, with 25 percent of the population on welfare in each area. Patients of subregion 12 are served by Tinley Park Hospital which has a total of 220 adult beds. Tinley Park also serves two other subregions and, as a result, 220 psychiatric beds serve a target population of three million. The beds utilized by patients of subregion 12 range between 110 and 140 of the 220 "first come—first served" state hospital beds. Subregion 12 has six outpatient psychiatric clinics whose target population lives in the six planning areas comprising subregion 12. Five are operated by Chicago's Department of Mental Health and one by Jackson Park—a general medical hospital. In addition, the state aids Jackson Park in maintaining a 14 to 21 day stay unit with 14 beds.[12]

Patients who develop psychotic illness in subregion 12 either enter the state hospital system via the intake center at Tinley Park or they are serviced at Jackson Park's 24-hour Psychiatric Emergency Service, where patients are either hospitalized in a private facility, referred for hospitalization at Tinley Park, or treated in the crisis intervention program. The average stay at Tinley Park is two to three weeks which is about the same at Jackson Park. On discharge, patients are then referred for aftercare treatment at one of the six outpatient clinics. The focus of treatment at both Jackson Park and Tinley Park tends to be the medical management of acute psychotic episodes. This focus continues on an outpatient basis at the various outpatient clinics with additional work on the patients' social and interpersonal environment. As a result of the focus of medical management, a clear differentiation between manic depressive illness and schizophrenia is essential. Unfortunately, as already noted, blacks tend to receive more than their share of schizophrenic diagnoses.

Tinley Park only has statistics regarding whether patients are diagnosed as mentally ill or developmentally disabled. As a result, it is quite difficult to demonstrate hard data on the percentages of patients diagnosed as manic depressive or schizophrenic. However, the authors have been struck by the misdiagnosis of many black patients with manic depressive illness as being chronic undifferentiated schizophrenics. Because this could not be supported by State of Illinois diagnostic statistics, it was decided to examine the case histories of the patients attending Jackson Park's outpatient clinic who had been diagnosed and treated as manic depressives.

CASE HISTORIES

Case 1

Mrs. A., a 70-year-old black female, was first hospitalized in 1970 at Tinley Park Mental Health Center (TPMHC) with clinical findings of flight of ideas, hyperactivity, confusion, excessive talking, and paranoia. She was diagnosed as having manic depressive illness and was discharged on chlorpromazine 200 mg twice a day. She functioned optimally for about six months when she was rehospitalized at TPMHC with a history of combativeness, hyperactivity, confusion, paranoid thinking, irritability, accelerated rate of speech, and grandiose ideations. At this time a diagnosis of schizophrenia, schizoaffective type, was made and the patient was treated with amitriptyline 25 mg three times a day. Mrs. A. was discharged 12 days later with remission of symptomatology to a community mental health clinic for follow-up. Remission continued for four months, when during October 1971, she was rehospitalized for nine days at TPMHC with confusion, hallucinations, delusions, verbosity, incoherence, and circumstantiality. A diagnosis of schizophrenia, chronic undifferentiated

type, was made and the patient was discharged to a community mental health clinic on chlorpromazine 300 mg three times a day and trifluoperazine 15 mg twice a day. The fourth hospitalization occurred 11 months later due to a history of paranoid implications, hostility, loose associations, and fragmented thought processes. At this time a diagnosis of anxiety neurosis was made and the patient was treated with amitriptyline 25 mg three times a day. A year later she was rehospitalized the fifth time for follow-up. Remission continued for 22 days with a diagnosis of alcoholism and cerebral atherosclerosis. Clinical findings at this time were arrest for misdemeanor charges, irritability, grandiosity, and hyperactivity. Again she was discharged to a local clinic for follow-up while on chlorpromazine 50 mg twice a day and trihexyphenidyl 2 mg daily. Ten weeks later she was rehospitalized for four weeks with a diagnosis of acute psychotic episode associated with alcoholism and with clinical findings of bizarre behavior, making phone calls at all hours during day and night, hostility, and uncooperativeness. She was treated with fluphenazine enanthate 25 mg intramuscularly and benztrophine mesylate 2 mg daily. The seventh hospitalization occurred four months later during May 1974 due to agitation, elation, disturbing behavior, and flighty speech. The diagnosis of manic depressive illness was made and she was treated with fluphenazine decanoate 25 mg intramuscularly every two weeks. The remission of her illness continued this time for two years when she was rehospitalized in April 1976 with a history of shoplifting, hyperactivity, confusion, talkativeness, flight of ideas, delusions, and hallucinations. She was discharged after 23 days on no medication, with a diagnosis of schizophrenia, chronic undifferentiated type. A year later she was rehospitalized for one week with disorderly conduct, agitation, hyperactivity, confusion, disorganized verbal output, and irritability. The diagnosis of manic depressive illness was made, and she was treated with lithium carbonate 300 mg three times a day (her first treatment with lithium) and haloperidol 5 mg three times a day. Currently, the patient has been followed at Jackson Park's outpatient clinic for over two years while on lithium carbonate and supportive psychotherapy. Although there have been a few episodes of hypomania and depression she has been successfully maintained on lithium and has been able to avoid further hospitalizations. Currently Mrs. A. enjoys complete remission of symptomatology, has stable interpersonal relationships, and is living independently.

Case 2

Mrs. B. is a 30-year-old black female who was first hospitalized at TPMHC at the age of 21 in 1970 with a history of agitation, excitability, disrobing herself, pressured speech, very talkative, ideas of reference, and uncooperativeness. She was diagnosed as schizophrenic, chronic undifferentiated type, and was discharged after four weeks on chlorpromazine 100 mg four times a day, trifluoperazine 5 mg twice a day, and benztropine mesylate 2 mg twice a day. In 1973, she was rehospitalized with a diagnosis of schizophrenia, chronic undifferentiated type. At this time, she had religious preoccupation, ran from house to house, was agitated, irritable, and delusional, and was treated with thiothixene 5 mg and trifluoperazine 5 mg, both three times a day, and trihexyphenidyl 2 mg twice a day. The third hospitalization occurred two years later in 1975 when she was hospitalized for seven days with a diagnosis of schizophrenia, paranoid type. This time she had religious preoccupation stating "I have the Holy Spirit in me," grandiosity, agitation, insomnia, psychomotor excitation, irritability, euphoria, and talkativeness. She was discharged on fluphenazine decanoate 25 mg intramuscularly every ten days and thioridazine 200 mg twice a day. The fourth hospitalization occurred two years later in 1977, with a diagnosis of schizophrenia, paranoid type. The patient had pressured speech, irritability, religious preoccupation, elated mood, delusions, and paranoid ideation. She was discharged on haloperidol 5 mg three times a day. Nine months later she was rehospitalized for a fifth time with a diagnosis of schizophrenia, chronic undifferentiated type. Clinical findings included wandering in the street, laughing and talking constantly, sexual preoccupation, insomnia, pressured speech, hallucinations, and delusions. The sixth hospitalization occurred six months later and the patient was diagnosed as having schizoaffective illness when she displayed delusions, agitation, and restlessness. She was treated with haloperidol 10 mg three times a day and discharged nine days later with complete remission of symptoms. Since her fifth hospitalization, the patient had been followed regularly at Jackson

Park's outpatient clinic on lithium carbonate four times a day and supportive psychotherapy. She had done so well that she dropped out of treatment and as a result she had to be hospitalized the sixth time. Since that hospitalization she has remained symptom free, exhibited good interpersonal relationships, and failed to exhibit a deterioration in personality. She is quite pleased with the lithium because it calms her down and keeps her from getting too excited, yet does not sedate like the major tranquilizers she had been given in the past.

Case 3

Mrs. C. is a 28-year-old black female who was first hospitalized at TPMHC during December 1972 at the age of 20 with a diagnosis of schizophrenia, schizoaffective type, depressed. At this time the clinical findings were as follows: irrelevant speech, disorganized thought processes, and cooperative. She was discharged on thioridazine 100 mg twice a day, imipramine hydrochloride 50 mg three times a day. The next hospitalization took place in August 1975 for seven weeks when she was diagnosed as having schizophrenic reaction and was treated with fluphenazine decanoate 25 mg intramuscularly every two weeks, chlorpromazine 200 mg three times a day, trifluoperazine 5 mg twice a day, trihexyphenidyl 2 mg twice a day. Her clinical picture at this time was described as including psychomotor agitation, auditory hallucinations, and visual hallucinations. Ten months later, she was hospitalized for a third time with a history of depressed mood, slow responses, auditory hallucinations, and confused thinking with a diagnosis of schizophrenia, chronic undifferentiated type being made. She was discharged after seven days on fluphenazine decanoate 25 mg intramuscularly, and thioridazine 50 mg in the morning and 100 mg at bedtime. The fourth hospitalization took place eight months later in February 1977 when she was given a diagnosis of schizophrenia, chronic undifferentiated type. She was hospitalized this time for calling the police, neglecting her children, and agitation. She was treated with chlorpromazine 100 mg twice a day. Mrs. C. came to the clinic following her last hospitalization with irritability, flight of ideas, insomnia, distractibility, and pressured speech. At this time a diagnosis of manic depressive illness was made and the patient was placed on lithium carbonate 300 mg four times a day. The patient has managed to avoid hospitalization for two and one half years and has been asymptomatic. She has exhibited good interpersonal relatedness and a good range of affect. Like patient B., Mrs. C. is glad she no longer has to feel "drugged" by major tranquilizers in order to carry out her activities of daily living.

DISCUSSION

From the above case histories which clearly manifest manic phenomenology, one wonders how it is that such symptomatology is misdiagnosed as schizophrenia, especially chronic undifferentiated type. Admittedly, the problem is quite complex, yet we would like to present a few possible explanations.

The problem clearly has its root in how these patients are treated. The patients with psychoses are hospitalized on short-stay (two to three weeks) hospital units. As they are hospitalized in a fragmented state, little history is obtained from the patients and because of cognitive disorganization, the patients cannot fully verbalize their thought processes; thus it is difficult for the inpatient psychiatrist to establish a firm diagnosis. As Taylor and Abrams point out ". . . over diagnosis of schizophrenia results from failure to recognize mania and from the belief that certain psychopathological phenomena (eg, persecutory delusions, auditory hallucinations, catatonia, first rank symptoms) occur only in patients with schizophrenia."[13] In addition, the language barrier between the patient and physician (many of whom are foreign medical graduates and are unfamiliar with cultural aspects of black patients' language and behavior) makes for further difficulties leading to misinterpretation, and thus misdiagnosis. Often the fragmented speech of a manic patient with pressured speech appears the same as the fragmented speech of the schizophrenic patient with cognitive slippage. By the time the psychosis is somewhat under control with neuroleptic therapy the patient is discharged to aftercare facilities for follow-up. Once on an outpatient status, the patient is likely to be treated for the diagnosis they were discharged. This is likely due to time constraints which outpatient clinics must function within in order to service their patient load, the difficulty with which lithium blood levels are obtained, language and cultural barriers, and the schizophreniform appearance of

manic depressive illness. Thus, correct evaluations fail to occur and the patient does not get prophylactic benefit of lithium carbonate therapy which leads to further psychotic breaks, increased recidivism, and unwanted neurological and other adverse effects of long-term neuroleptic therapy. When hospitalized again, the prior diagnosis plays a heavy role in arriving at the current diagnosis, thus repeating the vicious cycle of misdiagnosis, improper management, and an increase in iatrogenic morbidity.

In addition to the management dynamics of patient care, there are obviously other factors leading to the misdiagnosis of black manic depressive patients. It is a common belief that manic depressive illness is clustered in higher socioeconomic patients.[14] This belief tends to support the notion that black patients (frequently at the bottom of the socioeconomic totem pole) do not get affective illnesses. The authors believe that these myths significantly contribute to the misdiagnosis of a patient exhibiting euphoria, pressured speech, poor interpersonal relatedness, hyperactivity, and a lack of personality deterioration as schizophrenia, chronic undifferentiated type. It is further felt that these myths are rooted in a pervasive, covert form of racism which has been institutionalized in psychiatry to the point that low prevalence and incidence of manic depressive illness in blacks is given. While the schizophreniform nature of manic depressive illness might understandably lead to a misdiagnosis of paranoid schizophrenia or catatonic schizophrenia,[13] the repeated diagnosis of schizophrenia, chronic undifferentiated type, of a patient with manic symptoms is almost inconceivable, especially (as with Mrs. B.) if it is the first acute psychotic episode (whether it is due to manic depressive illness, schizophrenia, acute type, drug abuse, borderline syndrome, hysterical psychosis, etc) as a catchall diagnosis simply because they are of a lower socioeconomic class and of a minority ethnic background.

CONCLUSIONS

While hard statistical data are not presently available, a clear trend regarding the misdiagnosis of manic black psychiatric patients has been uncovered. Specifically, the patients who demonstrate obvious manic symptomatology in their case histories and who are doing quite well on lithium carbonate therapy are frequently diagnosed as schizophrenics, chronic undifferentiated type. This diagnosis carries poor prognostic implications and tends to lead to treatment with neuroleptic medication which results in an iatrogenic morbidity from poor medication compliance, relegation to low intensity supportive therapy, neurologic complications from long-term neuroleptic treatment, high rehospitalization rates, and discomfort from the side effects of neuroleptic therapy. It is felt that this misdiagnosis has its roots in the lack of recognition that black patients suffer from manic depressive illness and in the patient management dynamics in a community with less than adequate resources for patient care.

Finally, it is true that physicians must keep dispelling myths about blacks which lead blacks to receive unsophisticated medical care because of the misconception that as an unsophisticated people we have a limited number of diagnostic categories.

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