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ORIGINAL ARTICLE

Systematic Review and Meta-analysis of the Prevalence of Bipolar Disorder in China from 2000 to 2020

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Abstract

Background

China's recent rapid development may influence the incidence of bipolar disorder (BD). This meta-analysis aimed to assess the prevalence of BD and its trends over the past two decades in China, providing a scientific basis for early prevention and intervention.

Methods

A systematic literature search was conducted for studies published in China between 2000 and 2020 using Chinese databases. Study quality was assessed with the Joanna Briggs Institute (JBI) checklist. The prevalence of BD and subgroup analyses by gender and region were performed using RevMan 5.2. Publication bias was evaluated with Egger's test and funnel plots, and sensitivity analysis was conducted by sequentially excluding studies.

Results

Forty-five articles were included, with a total sample size of 142,583,741. The point prevalence of BD in China was 0.70‰ (95% CI: 0.62‰–0.78‰), and the lifetime prevalence was 1.85‰ (95% CI: 1.16‰–2.70‰). Subgroup analysis showed no significant difference in BD prevalence between genders ($P > 0.05$) or between rural and urban areas ($P > 0.05$). Prevalence was significantly lower in 2011–2020 than in 2000–2010 ($P = 0.013$). BD type I prevalence was significantly higher than that of type II and NOS (Not Otherwise Specified) types ($P = 0.01$).

Conclusions

The point prevalence of BD in China was 0.70‰ (95% CI: 0.62‰–0.78‰), and the lifetime prevalence was 1.85‰ (95% CI: 1.16‰–2.70‰). BD prevalence did not differ by gender or residential area. A significant decrease in prevalence was observed over the last decade. BD type I showed the highest prevalence among subtypes.

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Keywords: Bipolar disorder, Prevalence, Epidemiology, Systematic review, Meta-analysis

1. Introduction

China's recent rapid development may influence the incidence of bipolar disorder (BD). This meta-analysis aimed to assess the prevalence of BD and its trends over the past two decades in China, providing a scientific basis for early prevention and intervention.

Bipolar disorder (BD) is a group of severe mental illnesses with an unclear etiology, diverse clinical presentations, variable treatment responses, and fluctuating disease courses [1]. The first systematic review and meta-analysis of BD prevalence in children was published in 2011 [2], followed by a similar study in adults in 2017 [3]. An updated meta-analysis in 2019 confirmed that rates of bipolar spectrum disorders are not higher in the United States than in other Western countries [4]. A meta-analysis of BD incidence across all ages was published in 2015 [5].

In 2015, a meta-analysis reported a pooled lifetime prevalence of 1.06% (95% CI: 0.81–1.31) for BD type I and 1.57% (95% CI: 1.15–1.99) for BD type II. The pooled 1-year prevalence was 0.71% (95% CI: 0.56–0.86) for BD type I and 0.50% (95% CI: 0.35–0.64) for BD type II [5]. This study was described as "a relevant addition to the epidemiology of this disorder with clinical, socioeconomic, and policy-making implications" [6]. Consequently, meta-analyses of BD prevalence in various populations have become increasingly common. Among homeless individuals, the pooled prevalence of BD was 11.4% (95% CI: 7.5–16.9) [7]. In patients with multiple sclerosis, the pooled prevalence was 2.95% (95% CI: 2.12–4.09%), with higher rates in the Americas than in Europe [8]. Meta-analyses have also examined BD comorbidity with other disorders. Among 5273 individuals with BD (mean age 39.94 ± 11.78 years, 44% male), the prevalence of comorbid borderline personality disorder (BPD) was 21.6% (95% CI: 17.0–27.1), with higher rates in BD type II (37.7%, 95% CI: 21.9–56.6) and North American studies (26.2%, 95% CI: 18.7–35.3) [9]. The pooled prevalence of obsessive-compulsive disorder (OCD) in BD was 17.0% (95% CI: 12.7–22.4%), comparable to the prevalence of BD in OCD (18.35%, 95% CI: 13.2–24.8%) [10]. Substance use disorders (SUDs) were highly prevalent in BD, with alcohol use (42%) followed by cannabis use (20%) and other illicit drug use (17%). Meta-analysis indicated higher lifetime SUD risks in males than females [11].

The 1982 epidemiological survey of mental disorders in 12 regions of China is one of the most cited studies in Chinese psychiatric epidemiology. It reported a point prevalence of 0.37‰ and a lifetime prevalence of 0.76‰ for affective psychosis (including depression and BD) [12]. A 1993 follow-up survey in 7 of the same regions found a slight increase, with point prevalence of 0.52‰ and lifetime prevalence of 0.83‰, though the difference was not statistically significant [13]. In 2019, China released the China Mental Health Survey (CMHS), covering 31 provinces, which found anxiety disorders to be the most common class of disorders (12-month prevalence 5.0%, lifetime prevalence 7.6%), surpassing schizophrenia. The lifetime prevalence of BD was 0.6%, with BD type I at 0.1%, BD type II at 0.1%, and nonspecific BD at 0.1%. Despite some controversy, this remains the latest and largest epidemiological survey in China [14].

Changes in the epidemiological investigation of mental disorders involve numerous factors, including methodological updates and diagnostic criteria revisions. Over recent decades, China's economic growth, societal values, and lifestyles have undergone substantial changes, which may also influence the mental disorder spectrum [11]. BD diagnosis has undergone significant changes in criteria. Moreover, China has a large population, vast territory, numerous ethnic minorities, and considerable regional cultural diversity. Since 2000, many provinces and regions in China have conducted extensive epidemiological surveys of mental disorders.But there was great gap of epidemiology in BD in China.This systematic review and meta-analysis involved 45 studies with total sample size of 142,583,741.We also analyzed prevalence of different clinical subtype of BD and their quality was assessed by better tool.And valuable data provide a solid foundation for comprehensive analysis.

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2. Materials and Methods

A systematic literature search was conducted for studies published in China between 2000 and 2020 using Chinese databases. Study quality was assessed with the Joanna Briggs Institute (JBI) checklist. The prevalence of BD and subgroup analyses by gender and region were performed using RevMan 5.2. Publication bias was evaluated with Egger's test and funnel plots, and sensitivity analysis was conducted by sequentially excluding studies.

This study was registered at PROSPERO with code of CRD420251147253

1. Literature Search

This study followed MOOSE guidelines [15]. Two reviewers independently searched Chinese databases, including CBM, CNKI, WanFang, and CSSCI. MEDLINE and EMBASE as English databases were also included thought we have only found two studies about BD prevalence articles,which one is duplicate and other is not limited in 2000-2020 in English database.

2. Search Terms

"Bipolar disorder OR affective disease OR mental disease OR psychosis" AND "prevalence OR epidemiology".

3. Search Strategy

A combined search strategy was used. All articles published between January 1, 2000, and December 31, 2020, were retrieved. See the PRISMA flowchart (Figure 1) for study selection.

4. Quality Assessment

Study quality was assessed using the Joanna Briggs Institute (JBI) critical appraisal checklist for analytical cross-sectional studies [16].The each retrieval paper were reviewed by two psychiatrists independently according to the 11-item checklist of Agency for Healthcare Research and Quality (AHRQ) [17]. '0' was 'NO' or 'UNCLEAR'; '1' was 'YES'. Article quality 3 levels: low quality = 0–3; moderate quality = 4–7; high quality = 8–11. The all information about article was extracted.

5. Statistical Analysis

All analyses were performed using RevMan 5.2. A two-tailed P-value < 0.05 was considered statistically significant. Heterogeneity was assessed using I^2.I2 as the heterogeneity of all involved studies was assessed. If I2 was lower than 50%, an acceptable heterogeneity were considered in the studies, and then the fixed-effects model(FEM) with Mantel-Haenszel method was adopted. If I2 was higher than 50%, an unacceptable heterogeneity ere considered in the studies, a random effect model(REM) with the Der Simonian and Laird (DL) method was used.

3. Results

Forty-five articles were included, with a total sample size of 142,583,741. The point prevalence of BD in China was 0.70‰ (95% CI: 0.62‰–0.78‰), and the lifetime prevalence was 1.85‰ (95% CI: 1.16‰–2.70‰). Subgroup analysis showed no significant difference in BD prevalence between genders (P > 0.05) or between rural and urban areas (P > 0.05). Prevalence was significantly lower in 2011–2020 than in 2000–2010 (P = 0.013). BD type I prevalence was significantly higher than that of type II and NOS (Not Otherwise Specified) types (P = 0.01).

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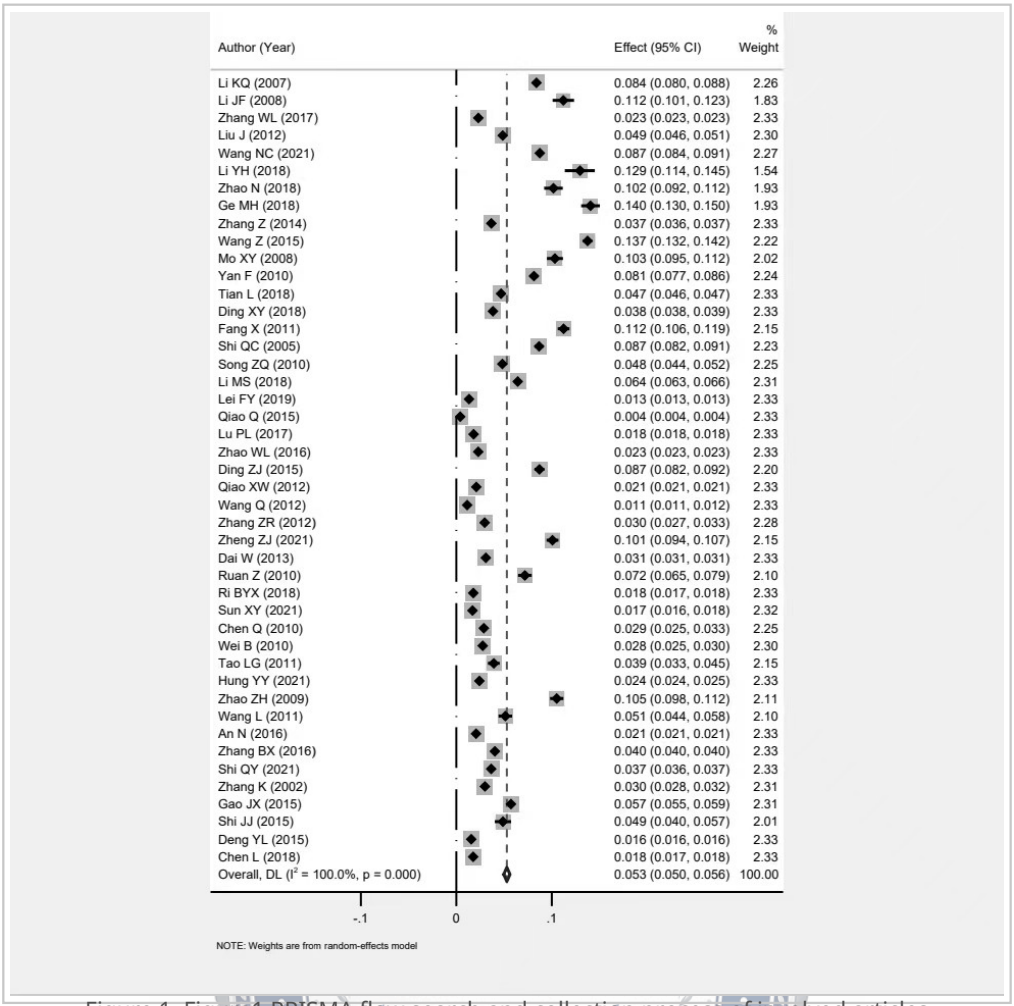


Figure 1. Figure1.PRISMA flow search and collection process of involved articles

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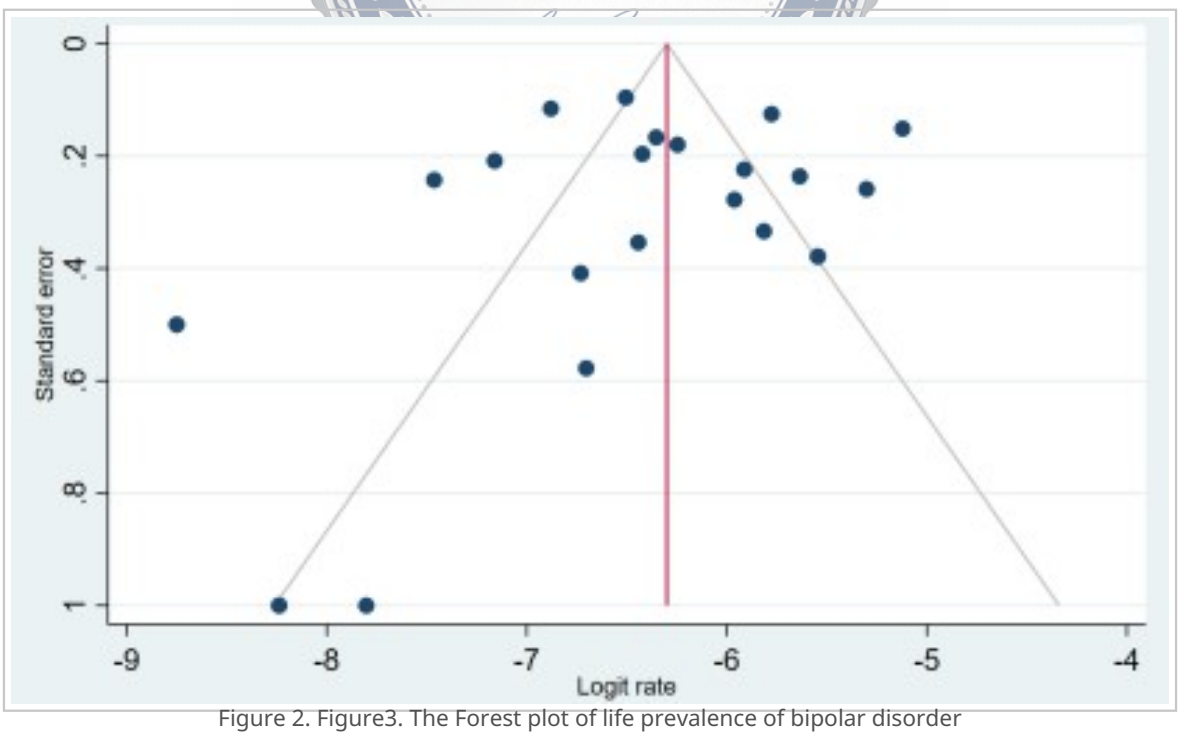


Figure 2. Figure3. The Forest plot of life prevalence of bipolar disorder

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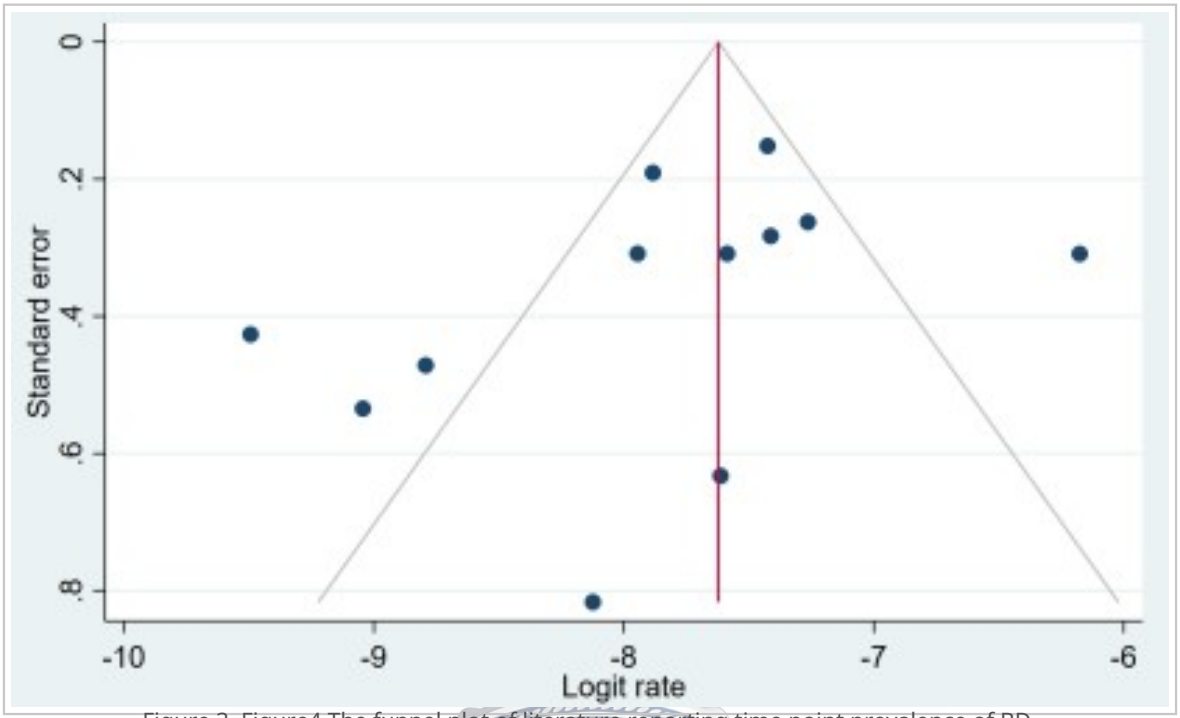


Figure 3. Figure4.The funnel plot of literature reporting time point prevalence of BD.

1. Study Characteristics

Initially, 1086 articles were retrieved. After applying inclusion and exclusion criteria, 45 Chinese studies were included, with a total sample size of 142,583,741 (see Table 1). Only 12 studies reported lifetime BD prevalence. Eighteen studies reported gender-specific data, 12 reported rural/urban distribution, and 11 reported data by BD subtype.The quality rating of all retrieved studies was 6 points or more.

2. Prevalence of Bipolar Disorder

Using a random-effects model, the pooled point prevalence of BD in China was 0.70‰ (95% CI: 0.62‰–0.78‰). For lifetime prevalence , the pooled estimate was 1.85‰ (95% CI: 1.16‰–2.70‰) (see Figures 2 & 3).

3. Subgroup Analysis

Gender: Eighteen studies provided gender-specific data. Using a random-effects model , no significant difference was found between males (0.92‰, 95% CI: 0.62‰–0.96‰) and females (1.03‰, 95% CI: 0.94‰–1.26‰) (P = 0.095) (Table 2).

Rural vs. Urban: Twelve studies provided rural/urban data. Prevalence was higher in rural areas (0.90‰, 95% CI: 0.70‰–1.21‰) than in urban areas (0.55‰, 95% CI: 0.50‰–0.60‰) by random-effects model , but the difference was not statistically significant (P = 0.08) (Table 3).

Temporal Trend: Prevalence was significantly lower in 2011–2020 (0.58‰, 95% CI: 0.48‰–0.68‰) than in 2000–2010 (1.26‰, 95% CI: 0.70‰–1.93‰) (P = 0.013) by a random-effects model.

BD Subtype: Ten studies reported subtype data. BD type I prevalence (0.62‰, 95% CI: 0.51‰–1.52‰) was significantly higher than that of type II (0.42‰, 95% CI: 0.18‰–0.46‰) and NOS (0.31‰, 95% CI: 0.18‰–0.46‰) (P = 0.01) (Table 4) by a random-effects model .

4.Sensitivity analysis and test of publication bias

The results showed that there was no significant change in the prevalence of BD at the time point and lifetime after excluding any one literature, so the results of this meta-analysis were stable.The egger test was used to test the publication bias in time point and life prevalence(time point prevalence,t = 0.68, life prevalence, t = 0.54,P > 0.05, indicating no significant publication bias.see Figure4 &5.

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5.Meta regression and prevalence of BD

Meta-regression analysis revealed that year regression coefficient: -0.82, 95% CI: 0.149, 0.613, P>0.05)genderregression coefficient: 0.07, 95% CI: -0.839, 0.993, P>0.05)districtregression coefficient: 0.165, 95% CI: -1.369, 1.699, P>0.05) did not have a significant effect on the point prevalence and year also did not have a significant effect on the lifetime prevalence (regression coefficient:-0.55,95% CI: -1.69, 0.618, P>0.05).

4. Discussion

BD is a mental illness primarily characterized by mood disturbances [1]. The 1982 Chinese epidemiological survey reported point and lifetime BD prevalences of 0.37‰ and 0.76‰, respectively. The 1993 survey showed increases to 0.52‰ and 0.83‰, indicating an upward trend. The most recent survey by Huang et al. reported a lifetime prevalence of 0.6‰ [12–14]. The first meta-analysis of BD prevalence in China, published in 2017, estimated point, 12-month, and lifetime prevalences of 0.09%, 0.17%, and 0.11%, respectively [62]. This systematic review included 45 studies with a total sample of 142,583,741. The point prevalence was 0.70‰ (95% CI: 0.62‰–0.78‰) and the lifetime prevalence was 1.85‰ (95% CI: 1.16‰–2.70‰). These results differ from both Huang's survey and Xiang's meta-analysis, suggesting that this study provides an updated epidemiological profile of BD in China. However, these rates remain considerably lower than the global lifetime prevalence of 2.4% and the U.S. prevalence of approximately 4% a decade ago [63,64].

This meta-analysis found no significant gender difference in BD prevalence (P = 0.095), consistent with some prior studies [8,62], despite known clinical differences such as suicide rates, substance abuse, employment status, marital history, number of depressive episodes, and psychiatric service utilization [65,66].

Although rural BD patients have been reported to have lower education levels, alcohol consumption, smoking rates, and family history of psychiatric and cardiovascular diseases compared to urban patients, they exhibit a more favorable cardiovascular risk profile despite higher cardiovascular morbidity [67]. For most psychiatric disorders except intellectual disability and childhood-onset behavioral/emotional disorders, individuals born in capital cities show higher incidence than those born in rural areas [68]. However, our analysis found no significant rural-urban difference in BD prevalence.This maybe mainly due to the fact that the cultural and economic differences between urban and rural areas in China have further narrowed.

Temporal changes in BD prevalence involve multiple factors, including diagnostic criteria and public awareness. In China, BD was historically classified under affective disorders, which themselves had low reported prevalence [12,13]. After 2000, reported BD prevalence increased significantly, likely due to increased clinical recognition rather than a true rise in incidence. Our study found lower prevalence in the last decade compared to the previous decade, aligning with some reports [5,62], but contrasting with others [6]. Nevertheless, current BD prevalence in China remains lower than global estimates, based on both survey [14] and meta-analysis [62] results.This is mainly because the earlier CCMDChinese Criteria of Mental Disorder diagnostic system included a wide range of affective psychosis, sometimes treating depression as affective psychosis, which is different from the current ICDInternational Classification of Disease

and DSMDiagnostic and Statistic manual of Mental Disorder diagnostic systems. Although the prevalence of BD is high at present in China, it has not increased significantly compared to the past.It is understandable that this study reports a lower prevalence of BD over a specific period compared to actual surveys conducted domestically and even lower than the global prevalence of BD. Furthermore, the prevalence of BD in China itself is already lower than the global rate.

Different BD subtypes may have varying incidence rates. According to DSM-5, the prevalence of BD type II is often higher than that of type I, as observed in clinical practice [1] and meta-analyses [5]. A Brazilian study reported lifetime prevalence of 1.06% for BD type I and 1.57% for BD type II [5]. However, another study found higher point, 12-month, and lifetime prevalences for BD type I compared to type II [62]. Although the recent CMHS reported equal prevalence for BD type I and II in China, this finding remains debated [14].

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There is one phenomenon worthy of our attention. The literature collected in this study has a relatively high degree of heterogeneity, which may have an impact on the conclusion,which also really exist. However, this high level of heterogeneity not only reflects the obvious differences between the data, but is more likely to reflect that there are also relatively large differences in the recognition of among Chinese psychiatrists.

Sensitivity analysis is a crucial statistical method used to assess the robustness and reliability of combined results. Its primary objective is to examine whether the conclusions of a study remain stable, meaning whether the final combined effect size will significantly change when the analysis conditions, inclusion criteria, or certain key aspects of the study are altered.It is particularly worth noting that the final statistical results may be affected by different diagnostic criteria. For example, our statistical results show that the point prevalence and lifetime of bipolar disorder in China are lower than those in the United States, which is one aspect we need to pay attention to and also reflects some problems with sensitivity.

The defects of this study include the following aspects: First, the literature data are not all provincial; second, the data published abroad may not be exhaustive;, the national survey data have not been included, such as reference 14.Fourth, the heterogeneity between the data is very high, so it is necessary to use a random effects model, and there are also some problems with the of the data. These may affect the statistical results.Fifth,we can not conduct a meta-regression due to the data type of the resume when entering data,which is is an important aspect that could potentially impact the research conclusion.

The strength of this study lies in its systematic evaluation of BD prevalence in China, providing current data for reference and supporting health resource allocation and policy-making.In the diagnosis, prevention and treatment of BD, it should be integrated with the international community. Strict diagnosis of BD is helpful for treatment and prevention. the following research on the prevalence of BD, age,ethnic and cultural factors should be included, because there are 56 ethnic groups in China. Also, the region is not only a of urban and rural areas, such as south and north. In addition, it would be better to include provincial data in future research.

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DECLERATIONS

1. Ethics approval and consent to participate

Not Available

2.Consent to publication

All authors agree to publish our paper and no conflict in any interests.

3.Availability of data and material.

Contact with corresponding author if required

4.Competing interests

There were not any financial and non-financial competing interests.

5.Funding

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6.Author’s contribution

Dr LYHand THJ participated in collection of data and the writing of the article, Dr THJ and Dr CHH assessed the quality of researched papers. Dr THJ and Prof SFL complete most statistic analysis.All authors reviewed all researched paper. Prof JWD and Dr SFL participated in the design , statistical processing and the final revision of the article.Prof SFL participated in final revision of the article.

7.Acknowledgment

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8.Abbreviations

MEDLINE=The National Library of Medicine

EMBASE=Excerpta Medical Database

CBM=Chinese Biomedical Database

CNKI=China Nationa lKnowledge Infrastructure

CSSCI=Chinese Social Sciences Citation Index (VIP)

CMHS=China Mental Health Survey

JBI=Joanna evidence-based nursing center

CCMD=Chinese Criteria of Mental Disorder

ICD=International Classification of Disease

DSM=Diagnostic and Statistic manual of Mental

5. Conclusion

The point prevalence of BD in China was 0.70‰ (95% CI: 0.62‰–0.78‰), and the lifetime prevalence was 1.85‰ (95% CI: 1.16‰–2.70‰). BD prevalence did not differ by gender or residential area. A significant decrease in prevalence was observed over the last decade. BD type I showed the highest prevalence among subtypes.

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77 Table 1.The primary information for analysis of time prevalence and life prevalence

Table 1.The primary information for analysis of time prevalence and life prevalence

Author	Year	Province/City(District)	n1	n2	Total sample	Quality assessment
Li KQ	2007	Hebei	64	36	20716	16
Li JF	2008	Chengde/Hebei	15	9	3025	15
Zhang W	2017	Cangzhou/Hebei		225	1695752	17
Liu J	2012	Zhengzhou/Henan	23	17	29636	14
Wang LZ	2021	Shandong		52	27489	18
Li YH	2018	Liaocheng/Shandong	7	7	1799	13

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Zhao N	2018	Linyi/Shandong		9	3670	15
Ge MH	2018	Weifang/Shandong		23	4797	19
Zhang Z	2014	Binzhou/Shandong		143	426389	19
Wang Z	2015	Liaoning		92	19733	16
Mo XY	2008	Dalian/Liaoning	18	13	5062	15
Yan F	2010	Beijing	31	26	16032	16
Tian L	2018	A district/Beijing		711	1298000	15
Ding XY	2018	Shunyi/Beijing		375	1020000	15
Fang X	2011	Fujian		31	9986	17
Shi QC	2005	Zhejiang		27	14639	14
Song ZQ	2010	Qinghai		6	11178	18
Wang DX	2018	Hunan	109	75	72999	13
Lei FY	2019	Hengyang/Hunan		317	7141462	15
Qiao Q	2015	Guiyang/Guizhou		18	4451700	19
Lu PL	2017	Minhang/shanghai		208	2539500	19
Zhao WL	2016	Ganshu		3403	25775500	16
Ding ZJ	2015	Tianshui/Gansnu		21	11350	15
Qiao XW	2012	Lanzhou/Gansnu		397	3616402	16
Wang Q	2012	Yingchuan/Ningxia		18	570939	15
Zhang RZ	2012	Yibin/Sichuan		2	11227	18
Zheng ZJ	2021	Yaan/Sichuan		22	8876	17
Dai W	2013	Jinmen/hubei		685	2873687	16
Ruan Z	2010	Kunming/Yunan	8	6	5033	15
Ri BYX	2018	Shanan/Tibet		28	360185	15
Sun XY	2021	Linzhou/Tibet		4	62171	16
Chen Q	2010	Guangxi1	1	1	7028	16
Wei B	2010	Guangxi2	3	3	18219	18
Tao LG	2011	Guilin/Guangxi	1	1	3783	16
Hung YY	2021	Jieyang/Guangdong		86	592400	18
Zhao ZH	2009	Guangzhou/Guangdong	44	20	7418	14
Wang L	2011	Panyu/Guangdong		2	3752	15

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An N	2016	Helongjiang		4024	37637540	18
Zhang BX	2016	Tianjin		6191	15176620	17
Shi QY	2021	Neimenggu		8379	25139161	16
Zhang K	2002	Fuyang/Anhui		7	33332	15
Gao JX	2015	Changzhou/Jiangsu		36	44551	15
Shi JJ	2015	Xian/Shanxi	3	1	2447	16
Dang WM	2015	Hainan		552	9040909	16
Chen L	2018	Bintuan/Xinjian		522	2767647	18
			327	26831	142583741	

78 *n1:Number for life prevalencen2:Number for time point prevalence

Table 2.

Author	Year	Province(City/District)	Male patients	Male sample	Female patients	Female sample
Li KQ	2007	Hebei	17	10343	19	10373
Li JF	2008	Hebei/Chengde	4	1454	5	1571
Wang LZ	2021	Shandong	30	11283	22	16206
Zhao N	2018	Shandong/Linyi	2	1513	7	2157
Zhang Z	2014	Shandong/Binzhou	65	209109	78	217280
Wang Z	2015	Liaoning	20	8723	72	11010
Mo XY	2008	Liaoning/dalian	12	2315	6	2747
Tian L	2018	Beijing/A district	328	641000	383	657000
Song ZQ	2010	Qinghai	4	5652	2	5526
Wang DX	2018	Hunan	36	36198	39	36801
Qiao Q	2015	Guizhou/Guiyang	10	2281400	8	2160300
Zhao WL	2016	Ganshu	1594	13168700	1809	12606800
Wang Q	2012	Ningxia/Yinchuan	11	280218	7	290721
Ruan Z	2010	Yunan/Kunming	1	2416	5	2617
Wei B	2010	Guangxi2	1	9196	2	9023
Tao LG	2011	GUangxi/Guilin	0	1827	1	1956
Wang L	2011	Guangdong/Panyu	1	1847	1	1905
Shi JJ	2015	Shanxi/Xian	0	950	1	1497
			2136	16674144	2467	16035490

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79 Table 2. The primary information for analysis of prevalence in male and female

80 Table 3 The primary information for analysis of prevalence in rural and urban

Table 3 The primary information for analysis of prevalence in rural and urban

Author	Year	Province(City/ District)	Patients in rural	Sample in rural	Patients in urban	Sample in urban
Li JF	2008	Hebei/Chengde	9	2553	0	472
Wang LZ	2021	Shandong	40	17597	12	9892
Zhang Z	2014	Shandong/Binzhou	45	152364	98	274025
Wang Z	2015	Liaoning	54	11144	38	8589
Mo XY	2008	Liaoning/Dalian	8	1856	10	3206
Song ZQ	2010	Qinghai	6	8546	0	2632
Wang DX	2018	Hunan	38	34966	37	38033
Qiao Q	2015	Guizhou/Guiyang	11	131200	7	3139700
Zhao WL	2016	Guanshu	2872	15787500	531	9988000
Wang Q	2012	Ningxia/Yinchuan	3	83358	15	487581
Wei B	2010	Guangxi2	2	11191	1	7028
Tao LG	2011	Guangxi/Guilin	0	2628	1	1155
			3088	16244903	750	13960313

81 Table 4 The primary information for analysis of prevalence in different clinical type

Table 4 The primary information for analysis of prevalence in different clinical type

Author	Year	Province(City/ District)	Patients with type I	Patients with type II	Patients with type NOS	Samples
Li KQ	2007	Hebei	14	10	12	20716
Liu J	2012	Henan/Zhengzhou	10	3	4	29636
Wang LZ	2021	Sandong	36	11	5	27489
Ge MH	2018	Sandong/Weifang	16	17	0	4797
Wang Z	2015	Liaoning	56	28	8	19733
Mo XY	2008	Liaoning/Dalian	2	1	10	5062
Fang X	2011	Hujian	18	9	4	9986
Shi QC	2005	Zhejiang	17	5	5	14639
Song ZQ	2010	Qinghai	3	2	0	11178
Wang DX	2018	Hunan	43	27	5	72999

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Ding ZJ	2015	Ganshu/Tianshui	9	7	2	11350
			224	120	55	227585

Figure1.PRISMA flow search and collection process of involved articles

Figure2. The Forest plot of point prevalence of bipolar disorder

Figure3. The Forest plot of life prevalence of bipolar disorder

Figure4.The funnel plot of literature reporting time point prevalence of BD.

Figure5.The funnel plot of literature reporting life prevalence of BD.

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