

Introduction

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Guest Editor

Bipolar Affective disorder is a very common condition in Mental Health Services in both Primary and Secondary Care. However, it is often not suspected and consequently it is both underdiagnosed and inappropriately managed. This is a cause for concern because patients who are inadequately treated for bipolar disorder can be at high risk of suicide. Patients with bipolar disorder are often misdiagnosed as having recurrent unipolar depression; the explanation for this is that although they often have recurring episodes of hypomania and depression, the hypomania is not identified by the doctor and misinterpreted as normality by the patient.

Hagop Akiskal has made the following comments about this situation. "Melancholia as defined today is more closely aligned with the depressive and/or mixed phase of bipolar disorder. Given the high suicidality from many of these patients, the practice of treating them with antidepressant monotherapy needs re-evaluation" (1).

The consequence of this was his development of the concept of the bipolar spectrum, describing among others Bipolar I, core manic-depressive illness and Bipolar II, depression with discrete spontaneous hypomanic episodes (2), hence distinguishing both these conditions from unipolar depression. The development of the concept of the bipolar spectrum has led to the identification of subgroups of bipolar patients and the identification of groups of patients who have particular suicidal risk. It has also raised the possibility that some unipolar depressed patients may develop bipolar disorder. All these issues, and the consequent differences in treatment between unipolar and bipolar disorder are dealt with in this issue. What also arises is the fact that bipolar illness is linked to a number of co-morbidities which make it particularly difficult to treat. This difficulty is also discussed in the issue, together with bipolar disorder in different situations. We describe interventions in the psychological field which alleviate the distress caused by this disorder and promote patient resilience. Further, we discuss the consequences for the design of mental health services to deal with this disorder.

The bipolar spectrum is a group of clinical conditions. It is very important to work out the underlying neurobiology if we are fully to understand what is happening in bipolar disorder. We need to answer a number of questions. Does unipolar depression really develop into bipolar disorder? Is the bipolar spectrum a description of the progression of an illness from an early to a more serious late stage of the same illness? What are the biological processes involved? In this issue we also endeavour to present what we know about the answers to these important questions.

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References

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