

Integral Vision of Bipolar Disorder: Clinic Necessary Conditions and Research

Bipolar Affective Disorder (BAD) is a great concern not only for current psychiatry but for public health in general. The old conception that BAD has a more favorable evolution and prognosis regarding other mental disorders has drastically changed: results show greater prevalence than traditionally assumed, also showing a higher comorbidity, high social cost and great suicide risk (1). Population suffering BAD keeps showing a high dysfunction degree in their daily lives. This fact becomes evident by the great number of days under sick leaves per year (2).

This scenario has led psychiatry to give a turn, away from the schemes of traditional evaluation of maniac and depressive status to consider other associated symptoms, signs and factors that generate a greater number of episodes. Proposals introduced in order to modify diagnostic criteria for BAD in the DSM-V, are partially intended to help researchers and general practitioners to decrease a negative impact of the disease, both upon patients and in the society as a whole (3). Therefore, the general practitioner should analyze the disorder's surrounding elements, from the presence of mood sub-syndrome symptoms persisting during the remission periods to the effect of medications, including social and family costs generated to the disorder.

Given the scope of variables to be considered for an effective BAD clinic, the *Revista Colombiana de Psiquiatría* is willing to issue a special supplement devoted to this disorder. Such supplement includes the contributions of expert researchers worldwide known as well as the active participation of national groups introducing original works. Articles included in this special issue shed light on the knowledge of new BAD approaches.

The current BAD approach has ever more support from neuropsychology since constant neurocognitive difficulties from patients have led to include the analysis of their performance in field such as memory, attention, executive function as well as labor social and family performance together with adequate adherence to treatments as well as to life styles

proposed in the psycho-educational processes. This approach allows, then, greater integration with the different disciplines participating in the BAD's integral attention (4.)

Besides, it is possible to relate the analysis of neurocognitive and functional performance to neurofunctional response with MRI (Magnetic Resonance Imaging) techniques, thus approaching new technologies for the integral attention to BAD's patients. Such new technologies provide, in turn, another perspective on the classic dilemmas around BAD, such as the effect of medication in neurocognitive performance, the damage caused by depressive and maniac crises and the relation between clinic and functional variables (5).

In the search for decreasing BAD's damage and severity, it is necessary to gain wider knowledge of the BAD's start. Therefore, early evaluation and analysis of populations under greater risk, such as first degree relatives presenting the disorder is required (particularly their children, in cases where there is a history of heritability.) Approaching this sort of populations allows the acquisition of psychopathological, neurocognitive and family data which will indicate if there is greater probability of suffering the disorder. This can greatly contribute to considerably shorten the time needed by general practitioners to establish an initial accurate diagnosis within this population. Occasionally, it takes even years thus negatively affecting the disorder prognosis.

This supplement, then, provides a wider view of BAD including research results, among other, on BAD's history, functionality analysis, use of diagnosis tools (such as functional magnetic resonance), effects of certain medications, suicide and family burden. All this, shows the importance and the need for a more integral vision on BAD so as to develop investigations aimed to create a real impact upon the reduction of the patient's damage and suffering caused by this type of pathologies.

Carlos López-Jaramillo
Guest Editor

References

1. Angst F, Stassen HH, Clayton PJ, et al. Mortality of patients with mood disorders: follow-up over 34-38 years. *J Affect Disord.* 2002;68:167-81.

2. Goodwin F, Redfield K. Manic-depressive illness: bipolar disorders and recurrent depression, 2nd ed. US: Oxford University Press; 2007.
3. Regier DA. Dimensional approaches to psychiatric classification: refining the research agenda for DSM-V: an introduction. *Int J Methods Psychiatr Res.* 2007;Suppl:S1-5.
4. López-Jaramillo C, Lopera-Vásquez J, Gallo A, et al. Effects of recurrence on the cognitive performance of patients with bipolar i disorder: implications for relapse prevention and treatment adherence. *Bipolar Disord.* 2010;12:557-67.
5. López-Jaramillo C, Correa-Palacio A, Delgado J, et al. Diferencias en la resonancia magnética funcional en pacientes con trastorno bipolar usando un paradigma de memoria de trabajo. *Rev Col Psiquiat.* 2010;39:481-92.