

THE CONNECTION BETWEEN BIPOLAR SPECTRUM DISORDERS AND EATING DISORDERS

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SUMMARY

The bipolar spectrum of mood, in its broadest sense that includes all kinds of mood instability, presents various symptoms related to instability and mood swing, including symptoms and manifestations of "mixed states" (the symptoms of "mixity") and symptoms of eating disorders (ED). It is essential not to forget that depression itself is only "a phase" of the wider bipolar spectrum of mood, which therefore remains the pathology to be treated adequately with a polytherapy composed by mood regulators and antidepressants. "Mixed" symptoms (including symptoms of eating disorders), if not properly treated, can subtly enter the patient's life, leading to a worsening of the clinical picture to a clear chronicity.

Key words: bipolar disorders - mixed states - eating disorders - mixed states treatment

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INTRODUCTION

It is essential to emphasise once again what has been described in previous articles: that is, it is "mood instability", rather than "depression", the pathology towards which clinical psychiatrists should focus their diagnostic attention in the manage mood disorders; emphasizing the essential concept that the depressive episode is only "a phase" of the broader "bipolar spectrum of mood" (Tavormina 2007, 2013, 2014).

The symptoms to be taken into consideration when doing a mixed state diagnosis are as follows (at least two of them must be present at the same time; Tavormina 2013, 2014):

- overlap between depressed mood and irritability,
- presence of internal agitation, restlessness, irritability, aggression and impulsiveness,
- difficulty in the concentration and mental overactivity,
- high internal and muscle tension, gastritis, colitis, headache or other somatic symptoms (e.g.: cough without broncho-pulmonary evidence; tachycardia without cardiological evidence; worsening of eczema or psoriasis),
- comorbidity with anxiety diseases (PAD, GAD, Social Phobia, OCD),
- insomnia (especially: fragmented sleep and/or poor quality sleep),
- eating disorders (ED),
- sense of desperation and suicidal ideation,
- hyper/hypo-sexual activity,
- substance abuse (alcoholic and/or drugs) and addictions,
- antisocial behaviour.

Symptoms of the so-called "mixity" of depressive phases (the most insidious symptoms caused by the over-

lap of depression-restlessness-irritability, with frequent colitis, gastritis, headache, ED) can lead to increased suicidal risk (Akiskal 2007).

The eating disorders (ED) as described in DSM-5, according to the diagnostic approach that goes "beyond DSM" (Akiskal 1996, Rihmer et al. 2010, Tavormina 2019) would all fall among the mixed states of bipolar spectrum of mood, except then for Anorexia Nervosa (which is comorbidity with bipolar spectrum disorder) and except for Pica and Rumination Disorder (which do not fit).

The "G.T. Mixed States Rating Scale", or "G.T. MSRS" (Tavormina 2014), a rating scale to be self-administering and structured in 11 items (one of them concerns ED; 7 of them have related sub-items) was born to help the clinician to make a diagnosis of mixed state of bipolar spectrum (Figure 1 and Figure 2); the score presented after the administration of "G.T. MSRS" would only suggest a "generic" diagnosis of a mixed state of the bipolar spectrum, as described in the Akiskal's bipolar spectrum scheme (Akiskal 1999) or Tavormina's (Tavormina 2013). Subsequently, it is up to the clinician to make a careful diagnosis of mixed state subgroups (always based on the Akiskal's or Tavormina's schemes).

METHODS AND STUDY

A retrospective observational study has been conducted among the outpatients patients visited in my office: all the "first visits" consecutively seen over three and a half years were evaluated (from January 2016 to June 2019): that is 192 patients, all diagnosed among the bipolar spectrum mood disorders. Among them, 19 patients (10% of all; all women) had ED symptoms in various forms, defined according to DSM-5: binge-eating disorder (4 patients), restrictive eating disorder (13 patients), bulimia nervosa (2 patients).

"G.T. Mixed States Rating Scales", or "G.T. MSRS"

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Self-administered rating scale -

Has there ever been a period of time during last three months when you frequently were and/or presented/felt ...

	Yes	Not
1) Hyperactivity (euphoria) quickly alternating with periods of psychomotor retardation (apathy)?
If Yes, for how many days/weeks?	
2) Depressed mood together with irritability and/or internal tenseness?
If Yes, for how many days/weeks?	
3) Substance abuse (alcohol and/ or drugs)?
If Yes, for how many days/weeks?	
4) Disorders of appetite?
If Yes, for how many days/weeks?	
5) A sense of despair and suicidal ideation?
6) Anhedonia and widespread apathy?
7) Delusions and hallucinations?
8) Hyper or hypo-sexual activity?
If Yes, for how many days/weeks?	
9) Insomnia (or sleep fragmentation) or hypersomnia?
If Yes, for how many days/weeks?	
10) Reduced ability to concentrate and mental overactivity?
If Yes, for how many days/weeks?	

Figure 1. Mixed states rating scale – 1st part

The administration of the "G.T. Mixed States Rating Scale" ("G.T. MSRS") highlighted the level of "mixity" reached by the aforementioned 19 patients: 5 of them reached the "High Mixed State Level" and the other 14 all a "Medium Level mixed state"; none was in the "Medium-Light Level", to emphasize how much the ED present increases the intensity of the "mixity" and that the ED are "mixed states" of the bipolar spectrum of mood.

Besides: two of the above 5 patients who reached the "High Level of Mixed State" achieved the highest score (score 17: all items represented, except for that related to "substance abuse" and "delusions-hallucinations"), presenting a serious anorexic picture: remarkable weight loss, amenorrhea, apathy and irritability together, considerable internal and muscular tension, somatizations (gastritis and colitis), insomnia, difficulty in concentration.

The first of these two patients, that I will call now "patient A" (aged 22; h: 155 cm; kg 37; with a 3 years of amenorrhea; my diagnosis is: dysphoric depression) had previously been treated with antidepressants (Fluoxetine) and BDZ, with little or no results; a pharmacological therapy composed by an antidepressant (Fluoxetine, with the subsequent addition of Venlafaxine) and mood regulators (Lithium, Olanzapine, Gabapentin) led after two years from the "first visit" in my office to reach a stability of mood, to a more adequate and varied diet (as well as "accepted" by the patient), to a her progressive increase in weight and the reappearance of the menstrual cycle (this at reaching 46 kg).

The second of these two patients, that I will call now "patient B" (aged 18; h: 160 cm; kg 42; with a 6 months of amenorrhea; my diagnosis is: cyclothymia) had never taken related therapies; a pharmacological therapy composed by antidepressants (Escitalopram, with the subsequent addition of Venlafaxine) and mood regulators (Olanzapine, Gabapentin and Valproate) led nine months after the "first visit" in my office to reach also in this case a stability of mood, to a more adequate and varied diet (as well as "accepted" by the patient), and to a her progressive increase in weight and the reappearance of the menstrual cycle (this at reaching 50 kg).

	Yes	Not
11) Gastrointestinal disorders (colitis, gastritis), headaches, and various somatic symptoms (muscular tenseness; tachicardia)?
If Yes, for how many days/weeks, and what of those symptoms?		

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Additional points -

Could it be considered that, at the age of about 18-20 years (if you are more than 20 years old; if you are younger, please consider the answer as "during actual last years"), you were:
 (choose only one of these three following answers)

- a person of very lively character-hyperactive and extremely cheerful ?
- or
- a person who always tended to be tense and irritable ?
- or
- a person always tended to be taciturn, solitary and melancholy, and also with anxiety symptoms (panic, phobia between persons, claustrophobia) ?

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"G.T. Mixed States Rating Scales" - Scores

- The "Additional Points" help to focus about the Temperaments of the patient (hyperthymic temperament for the first point; cyclothymic temperament for the second point; depressive-anxious temperament for the third point).

There is a Mixed states diagnosis if at least two YES answers are present ;

- Give *Double* scores in the points 1-2-3-4-8-9-10-11 if at least 50% of the month is involved;

- Level: Medium-light level of mixed state: from 2 to 6 scores;

- Level: Medium level of mixed state: from 7 to 12 scores;

- Level: High level of mixed state: from 13 to 19 scores.

The positive result following to "G.T. MSRS" will conduct to do a generic diagnosis for mixed states sub-types of bipolar spectrum disorders, following Akiskal's scheme (The evolving bipolar spectrum: Prototypes I, II, III, IV. Psychiatr Clin North Am. 1999) or Tavormina's scheme (A study of the incidence of bipolar spectrum disorders in a private psychiatric practice. Psichiatria Danubina 2007) for bipolar disorders.

The clinician will need of special care to do the correct sub-diagnosis of sub-group of mixed state.

Figure 2. Mixed states rating scale – 2nd part

All 17 other patients have also achieved a good mood-clinical stability over time with a pharmacological therapy based on mood regulators and low-dose antidepressants.

It is crucial at the beginning of the clinical interview with the patient that the psychiatrist evaluates both the current clinical situation that induced the patient to go to the doctor, and his initial symptoms when his mood pathology began, despite the symptoms may have been attenuated or modified; on making a correct diagnosis of mood disorder, with or without associated ED symptoms, it is essential to highlight a longitudinal clinical history of the patient (as well as a family psychiatric anamnestic history) with particular attention to the sub-threshold symptoms (Tavormina 2007).

What Rihmer and Akiskal wrote some years ago depicted as well the notion of the premorbid affective temperaments: "Premorbid affective temperament types have important role in the clinical evolution of minor and major mood episodes including the direction of the polarity and the symptom formation of acute mood episodes. They also significantly affect the long term

course and outcome, including suicidality and other forms of self-destructive behaviours, such as substance abuse and eating disorders" (Rihmer et al. 2010).

CONCLUDING REMARKS –

Although several past scientific papers have highlighted doubts about the usefulness of antidepressants in "mixed mood states", in my previous papers (Tavormina 2013, Tavormina 2014) I pointed out how low doses of antidepressants used together with one or more mood regulators become essential to give a good thymic balance, especially when you are in the presence of constant emotional lability and apathy. In addition, both the first validating study on the rating scale on mixed states "G.T.MSRS" (Tavormina 2015) and the second (Tavormina et al. 2017) highlighted what was said above, that low doses of antidepressants used along with one or more mood regulators are important in contributing to a good mood balance of the patient.

It should also never be forgotten that all mood regulators (and especially anticonvulsants), for their terato-

genicity, have to be used carefully and with informed consent in women of childbearing age.

The two patients A and B above mentioned are always followed by myself personally, and on the date of writing this paper they always present an excellent mood stability (patient A graduated; patient B is a university student with excellent results): patient A is euthymic, has a good body weight and a good image of herself; patient B had been slightly overweight and is now doing a balanced diet and physical activity, always with euthymia.

The consequences of non-diagnostic recognition (and subsequent inadequate treatment) of a mood disorder can lead to a real increase in suicidal risk, as well as a reduction in expectations and quality of life (both personal, family and work); not to mention increased absences or the frequent increased use of health resources for both the same mood disorders and other concomitants of those chronically suffering from these diseases without being adequately treated. In this way, mood disorders would tend towards a clear chronicity, including ED symptoms when present, and a worsening of the dysphoric state.

We can certainly conclude by saying that almost all Eating Disorders are not a "disease unto itself" but are an integral part of the broader "bipolar spectrum of mood" (especially "mixed states"): so that the bipolar spectrum of mood becomes the real pathology to be treated by clinical psychiatrists, with a careful diagnostic-therapeutic management.

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