

# THE CLINICAL NOTION OF RESTLESSNESS AS A LINCHPIN FOR A FULL UNDERSTANDING OF THE BIPOLAR SPECTRUM

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## SUMMARY

*Restlessness is the essence of the thymic disease of those who present a "mixed picture" in the bipolar spectrum of any form. Depressive suffering, always significant for the patient, never presents itself alone, but is always accompanied by a constant state of internal anxiety, restlessness with internal and muscular tension, depressive-irritable or depressive-apatetic-confused state, a sense of existential anguish that sometimes gives no hint of future prospects, and very frequent somatic symptoms associated with mood malaise. All this is summarized in the concept of "Restlessness".*

**Key words:** restlessness - bipolar disorders - mixed states - mixed state rating scale

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## INTRODUCTION

Both in the literary and scientific fields, the concept of "Restlessness" has always attracted the reader or the scientist, drawing attention both to the emotional aspect of melancholy, anxiety and sadness, and to the cognitive aspect of internal agitation, restlessness, mood swings and depression. Several writers and poets of the past have developed their poems based on their emotional discomfort, their restlessness, their mood instability; just think of Fernando Pessoa ("The Book of Disquiet"; "A Single Multitude"), the pessimism of Giacomo Leopardi, the melancholic elegies of Catullus. The scientific concept of restlessness suggests evidence of constant sensations of internal restlessness and agitation that last for hours or days, leading the subject to a constant malaise that over time, and if left untreated, leads to a progressive increase in symptoms with all the typical symptoms of mixed bipolar states. The Collins English dictionary under the heading "Restlessness" among others cites: <<worried; anxious; uneasy; not restful; without repose>>. We can affirm that Restlessness is the essence of the thymic malaise of those who present a "mixed picture" in the bipolar spectrum of any form.

## THE UNSTABLE MOOD AND RESTLESSNESS – 1<sup>ST</sup> PART

As previous articles have already described, "mood instability" is always present in the various forms of thymic disorders, even in the presence of depressive forms of mood: and restlessness is the main symptomatic manifestation, which is multifaceted in all the oscillatory characteristics typical of mood tone. Depression therefore becomes only "a phase", not a pathology in itself, of a mood balance that presents instability, which for certain periods can remain (more or less long for weeks or months) along the depressive

component, and then attenuate without going into a hyperthymic or hypomanic component. Otherwise, in the modification there may be an increase in the "restless" or "agitated" component, sometimes with underlying hyperthymia and/or irritability, presence of hyperactivity of thoughts and consequent difficulty in concentrating or maintaining it, disturbed sleep in continuity and quality (non-restorative sleep), presence of various somatic forms of tensive-restless origin (colitis, gastritis, headache, widespread muscular tension), with frequent comorbidity with eating disorders or anxiety diseases (GAD, PAD, OCD, Social Phobia) and substance abuse (McElroy et al. 2005, Tavormina 2011, 2012, 2016, 2019).

As various scientific literature states (Tavormina 2013, Akiskal 2000, 2005, Perugi et al. 2014), mood disorders in their various diagnostic manifestations, including sub-threshold forms, involve approximately 20% of the entire population. The common component of all these clinical forms is the presence of restlessness, agitation and internal tension, hyperactivity of thoughts and mood instability, whose oscillation, small or medium or high in intensity and frequency, is always present even when the mood appears "stable" in its depressive or manic phase: this is precisely the "restless" component. Even the comorbidity of mood disorders with clinical manifestations of substance abuse, with eating disorders (with bulimic or anorexic symptoms) and, as already written, with acute manifestations of anxiety (GAD, PAD, OCD, Social Phobia) fall within the large spectrum of unstable mood due to the presence of restlessness, hyperactivity of thoughts, internal tension and sleep disorders (Rihmer & Akiskal 2010, McElroy et al. 2005). The term "depression" can be misleading when approaching a clinical picture of mood disorder, as sometimes depressive symptoms may not even be present in a clearly manifest and continuous way in the

patient, or they may be masked by a greater presence of prevalent tense-irritable, impulsive or in any case anxiety-related symptoms (Akiskal et al. 2000, Akiskal & Benazzi 2006, Tavormina 2019).

## THE UNSTABLE MOOD AND RESTLESSNESS – 2<sup>ND</sup> PART

Hagop Akiskal was the world's most prominent conceptualizer of the bipolar spectrum.

In past century, in 1921, Emil Kraepelin described the mixed states: «Very often we meet temporarily with states which do not exactly correspond either to manic excitement or to depression, but represent a mixture of morbid symptoms of both forms of manic-depressive insanity» (Kraepelin 1921). He thus specified six types of mixed states, based on various combinations of manic and depressive mood, thought, and behaviour. These were: depressive or anxious mania, excited depression, mania with poverty of thought, manic stupor, depression with flight of ideas, and inhibited mania.

Taking inspiration from Krepelin, Akiskal created his own scheme of the bipolar spectrum, structuring it into 7 diagnostic subtypes, in addition to an eighth in which he inserts the schizo-affective pictures, “Schizo-bipolar disorder” (Akiskal 1999).

Bipolar disorder type I is characterized by mood swings of notable intensity between severe mania and significant depressive phases (Core manic-depressive illness).

Bipolar disorder type II is characterized by depressive phases of high intensity alternating with spontaneous episodes of discrete hypomania (Depression with discrete spontaneous hypomanic episodes).

Between bipolar I and type II, Akiskal inserts a disorder characterized by serious depression in a context of protracted hypomania (Depression with protracted hypomania), which he defines as “bipolar type I and ½”.

Following bipolar II in the Akiskal scheme, we find bipolar disorder type II and ½ (Depression superimposed on cyclothymic temperament), characterized by depression patterns superimposed on a cyclothymic temperament. It is a clearly unstable form, dysphoric and irritable hypomania superimposed on an inter-episodic cyclothymic temperament (so-called “roller coaster” pattern). Often with comorbidity with panic disorder and social phobia, as well as with eating disorders.

Next we find bipolar disorder type III (Depression with induced hypomania), characterized by a pattern of depression with induced hypomania (for example, hypomania that occurs exclusively in association with antidepressants or other pharmacological treatments).

Next we find bipolar disorder type III and ½ (Prominent mood swings occurring in the context of substance or alcohol abuse), characterized by significant

mood swings that occur in the context of the use or abuse of substances or alcohol.

Akiskal's scheme concludes with bipolar disorder type IV (Depression superimposed on a hyperthymic temperament), describing a picture of depression superimposed on a hyperthymic temperament. This is the bipolar spectrum picture that is often the most serious and at risk, presenting a depression superimposed on a stable hyperthymic temperament: a person with these characteristics is exuberant, playful, hyper-optimistic, very self-confident, full of projects and activities, with wide interests, hyper-involved, disinhibited, with a reduced need for sleep. They can suddenly slip into a deep depression, often resistant to treatment. This is an extremely risky condition because hyperthymic individuals are intolerant to any level of depression, and certainly tolerate poorly the affective dysfunction associated with a mixed depressive state: they are at high risk of suicide (Akiskal 1999).

All the basic features of Akiskal's diagnostic subtypes (bipolar type I ½, type II, type II ½, type III, III ½ and type IV), except for bipolar disorder type I (and schizo-affective), describe mixed mood pictures in which restlessness is the constant symptom of inter-connection between episodes-phases of depression and episodes-phases of hyperthymia-hypomania-cyclothymia, even with comorbidity with anxiety disorders, eating disorders, substance abuse: all this falls within the different ways of manifestation of the “mixture” within the bipolar spectrum. (Angst et al. 2003, Akiskal et al. 1977, Akiskal 2004, 2005).

## RESTLESSNESS AND MIXITY

The diagnostic subtypes of Tavormina's bipolar spectrum scheme defining the concept of “mixed state” (Tavormina 2013: which draws inspiration from Akiskal's scheme), namely agitated depression, dysphoric depression, mixed dysphoria, recurrent depression, cyclothymia, attenuated bipolar II disorder, rapidly cycling bipolar disorder, hyperthymic, depressive and cyclothymic temperaments (also part of the bipolar spectrum as sub-threshold disorders), describe a state of constant rapid or cyclical fluctuation and instability of mood, which can be described in the notion of bipolar spectrum “mixed state” in which the constant symptom common to all is that of restlessness (Tavormina 2019, 2021, Angst et al. 2003, Akiskal et al. 1977, Akiskal 2005, Akiskal & Benazzi 2005). The other diagnostic subtypes of this bipolar spectrum scheme are bipolar disorder type I, recurrent depression and a major depression episode.

The intensity of the discomfort of those who present a mixed state of the bipolar spectrum is defined by the “mixture”, which consequently becomes the evidence and description of the intensity of restlessness. There is a Mixed States Rating Scale (the GT-MSRS: Tavormina 2014) that easily highlights the intensity of the “mixture”

(and therefore of the restlessness and thymic discomfort of the subject), created with the aim of making an early diagnosis of a bipolar mixed state and quickly directing the clinical physician towards the prescription of one or more mood regulators (Tavormina et al. 2017, Cervone et al. 2022, Agius et al. 2007, Tavormina 2024).

The “mixture” of depressive phases (that are the most insidious symptoms of overlapped depression-restlessness-irritability) can cause increased risk of suicidality (Akiskal 2005). The intensity of these symptoms can be shown using the rating scale for mixed states “GT-MSRS”, an easy rating scale to administer to the patient structured in eleven items (and 7 sub-items), to demonstrate the level of mixture (a score from 2 to 6: medium-low level; a score from 7 to 12: medium level; a score from 13 to 19: high level); (Tavormina 2014, 2015, Tavormina et al. 2017).

Unstable mood, restless mood and therefore bipolar mixed states are extremely frequent, more than previously thought (Akiskal et al. 2000, Perugi et al. 2014, Tavormina 2021, 2024). The intensity of thymic distress (mixture) cannot be quantified in any way other than by describing the presence of the various symptoms, listed in the various points of the GT-MSRS scale, which also describes it numerically with an obtainable score ranging from 2 (minimum level) to 19 (maximum level), (Tavormina et al. 2017, Cervone et al. 2022).

The application of the GT-MSRS scale will highlight the score relating to the intensity of the patient's thymic distress (“mixture”, or intensity of restlessness), which is a consequence of the presence of the symptoms listed in the 11 points of the scale. Clinical practice has highlighted which mood regulators can be more effective and more tolerable both in the acute phase and in maintenance treatment, and a considerable scientific literature supports all this (Vieta 2005, De Leon 2001, Yatham et al. 2002, Fountoulakis et al. 2012, Betzler 2017, Tavormina 2016, 2024).

If mood stabilizers are the essential linchpin for the treatment of bipolar mixed states, the concomitant use of antidepressants must always be done with great caution, almost always in low doses, to be prescribed mainly in the presence of emotional lability, comorbidity with anxiety disorders (GAD, PAD, OCD, Social phobia), persistent apathy, eating disorders. The concomitant use of benzodiazepine is instead not recommended for long periods (Tavormina 2019, Vieta 2005, Fountoulakis et al. 2012).

The GT-MSRS scale does not give an exact diagnosis but highlights the intensity of the patient's thymic discomfort, i.e. the intensity of “mixture” and therefore the intensity of the restlessness, orienting the doctor to think about mixed states, to ascertain the intensity of discomfort and to evaluate the inclusion of one or more mood regulators in the therapy, once he has moved towards a complete diagnosis of the type of mixed picture to be treated.

## CONCLUDING REMARKS

When considering bipolarity, the notion of mixture becomes the basic starting point on talking on mixed states and approaching the diagnostic process; the knowledge of all the symptomatologic equipment is equally fundamental for the clinician for a correct diagnostic-therapeutic approach by clinicians managing an appropriate polytherapy with mood-stabilisers and low dosage of antidepressants (Tavormina 2024).

Much scientific literature highlights how over the past decades the presence of “restlessness” in the so-called “agitated depression” (the most frequent mixed picture) was the indirect evidence that the state of internal tension and agitation were components of unstable mood and mixed depressive states (Koukopoulos 1999, 2007, Akiskal et al. 2005).

In all these cases the depressive suffering, always significant for the patient and a stimulating event that induces him to go and ask for help from the psychiatrist, never travels alone, but is always accompanied, and fused with it, by a constant state of internal anxiety, restlessness with internal and muscular tension, depressive-irritable or depressive-apatetic-confused malaise, a sense of existential anguish that sometimes gives no hint of future prospects, very frequent and chronic somatic symptoms associated with the malaise of the mood such as to contribute to the worsening of the same mood tone. All this is summarized in the concept of “Restlessness”, a word that expresses a multifaceted and multi-composite malaise that travels in the subject along with depressive anguish and all its tense manifestations.

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### Contribution of individual authors:

Tavormina & Francesco Franza projected and designed together the manuscript;

Giuseppe Tavormina supervised and reviewed it for its final version.

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