

Atypical Depression: A Valid Subtype?

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The concept of atypical depression has evolved over the past several decades, yet remains inadequately defined. As currently defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR), the main criterion of atypical depression is the presence of mood reactivity in combination with at least 2 of 4 secondary criteria (hypersomnia, hyperphagia and weight gain, leaden paralysis, and oversensitivity to criticism and rejection). The focus on mood reactivity as the primary distinguishing criterion remains questionable among researchers who have been unable to verify the primacy of this symptom in relation to the other diagnostic criteria for atypical depression. A model challenging the DSM-IV-TR definition of atypical depression has been developed, redefining the disorder as a dimensional nonmelancholic syndrome in which individuals with a personality subtype of “interpersonal rejection sensitivity” have a tendency toward the onset of anxiety disorders and depression, thereby exhibiting a variety of dysregulated emotional and self-consolatory responses. This reformulated definition of atypical depression (in arguing for the primacy of a personality style or rejection sensitivity as against mood reactivity) may lead to a better understanding and recognition of the disorder and its symptoms as well as other “spectrum” disorders within the scope of major depression.

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Atypical depression has been characterized by a combination of personality and clinical features, and its defining characteristics have evolved over the last several decades. “Atypical” depression is not an infrequent clinical phenomenon as the term implies; rather, it is atypical in its clinical features as compared to the symptoms of “endogenous” or melancholic depression.¹ In fact, data from a small study² indicated that atypical depression occurred in 33% of inpatients with depression, whereas data from a larger study³ indicated that atypical depression is present in as many as two thirds of outpatients with depression. Atypical depression is 2 to 3 times more likely to present in women than in men,¹ its onset occurs at an earlier age than does endogenous depression, and its course is more chronic than episodic. The historical suggestion that atypical depression responded more favorably to treatment with monoamine oxidase inhibitors (MAOIs) than to treatment with tricyclic antidepressants (TCAs) further distinguished it from endogenous depression.

The current specifying criteria for atypical depression as established by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision

(DSM-IV-TR)¹ focus on mood reactivity (i.e., improving mood in response to favorable events during a depressive episode) as the primary criterion combined with the presence of at least 2 secondary criteria. However, data have been unable to substantiate the primacy of mood reactivity in relation to the secondary diagnostic criteria, leading researchers to question the accuracy of the DSM-IV-TR definition of atypical features in major depressive disorder.⁴ A refocused model of nonmelancholic depression that examines the relationship among stress, certain vulnerable personality types, and emotional responses and coping strategies has been introduced as a means to better assess and understand atypical depression.

ATYPICAL DEPRESSION: A HISTORICAL REVIEW

The concept of atypical depression emerged in the late 1950s based on data collected by West and Dally,⁵ who reported that patients who exhibited “atypical” symptoms that resembled anxiety hysteria with secondary depression responded to the MAOI iproniazid. Another distinguishing characteristic determined by West and Dally⁵ included the absence of features consistent with classic, endogenous depression. Prior to this, endogenous depression had been viewed as “melancholic” and responsive to TCAs, while atypical depression appeared less responsive to TCAs.

Over the next 2 decades, important developments in the definition of atypical depression were introduced,^{6,7} emphasizing that a personality style shaped the characteris-

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tics associated with atypical depression and deemphasizing the primacy of anxiety. In 1969, Klein and Davis⁶ augmented West and Dally's original definition, describing patients with atypical depression as being "hysteroid dysphoric" or "histrionic"—i.e., lacking the melancholic qualities of endogenous depression and exhibiting a cold, insensitive, and superficial personality as well as the characteristics of hyperphagia and hypersomnia. As a means of compensating for their dysphoria, these patients were noted to partake in exaggerated—even exhibitionist—behaviors. Also noted by Klein and Davis⁶ were the patients' marked responses to MAOIs. Taking this definition further, Liebowitz and Klein⁷ suggested that hysteroid dysphoria represented a subtype of atypical depression that not only lacked the characteristics of endogenous depression but also was characterized by an "addiction" to attention, approval, and applause, as well as a vulnerability to rejection. Additionally, Liebowitz and Klein⁷ demonstrated specific MAOI responsivity with phenelzine in hysteroid dysphoric patients, further suggesting hysteroid dysphoria as an affective disorder.

Two articles published in 1982 by Paykel et al.⁸ and by Davidson et al.⁹ further expanded upon the concept of atypical depression, suggesting that it had multiple meanings and clinical presentations. Paykel et al.⁸ included depressed patients with primary anxiety or phobic symptoms. Davidson et al.⁹ presented a historical perspective of multiple principal categories of atypical depression, including the following 5 types: (1) psychotic inpatients with agitation and paranoid features who responded to electroconvulsive therapy; (2) nonpsychotic outpatients with phobic anxiety, tension, and pain that responded to MAOIs; (3) depressed patients with atypical vegetative symptoms (e.g., increased appetite, irritability, and mood lability) that responded to MAOIs; (4) patients with bipolar depression who experienced atypical vegetative symptoms that responded to MAOIs; and (5) patients with depressive conditions, including depression secondary to residual schizophrenia.

Current Definition of Atypical Depression

As currently defined by the DSM-IV-TR,¹ the main criterion for atypical depression is the presence of mood reactivity in combination with 2 or more of the following 4 secondary criteria: (1) significant weight gain or increased appetite, (2) hypersomnia, (3) leaden paralysis (heavy, leaden feelings in the arms or legs), and (4) long-standing vulnerability to rejection that is not limited to episodes of mood disturbance and that results in significant impairment of day-to-day functioning. A combination of these characteristics must predominate within either the most recent 2 weeks of a current major depressive episode or any 2-week period in a past major depressive episode. Criteria cannot be met for melancholic or catatonic features during the same mood episode because

these symptoms may be indicative of other psychiatric disorders.

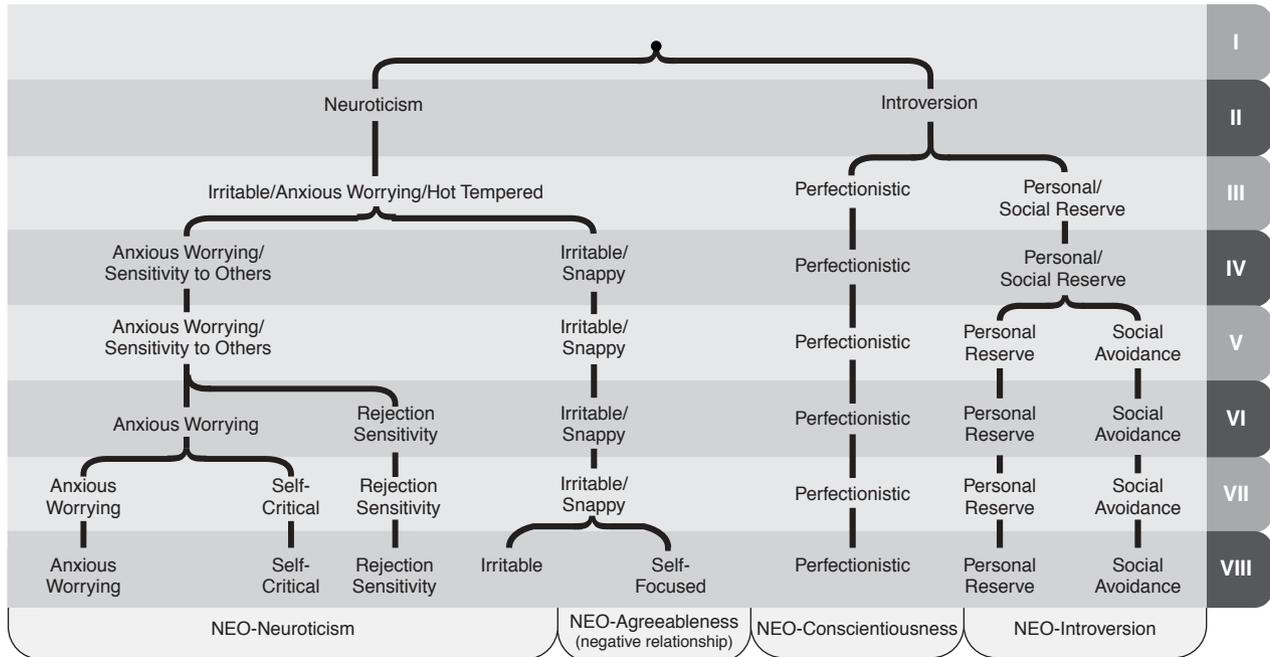
Thus, the definition of atypical depression has varied considerably since description in the late 1950s. Whereas it was initially viewed as anxious hysteria with non-endogenous symptoms of depression, the significance of anxiety was deemphasized in later definitions, and a personality style characterized by an "addiction" to attention and a vulnerability to rejection was presented as the significant marker of the disorder. Further complicating a clear understanding of atypical depression has been the inclusion of additional symptoms and diagnostic criteria without substantiating clinical evidence.

CHALLENGING THE CURRENT DEFINITION

Historical review of atypical depression has demonstrated inconsistency among its definitions and diagnostic criteria. Additionally, the focus of the DSM-IV-TR on mood reactivity as the primary distinguishing criterion for atypical depression has proved problematic to researchers who have been unable to verify the primacy of this symptom in relation to the other diagnostic criteria for atypical depression. Colleagues and I conducted an empirical assessment⁴ of atypical depression in which 270 patients who met the DSM-IV criteria for major depressive disorder were evaluated for the presence of mood reactivity as well as its relationship to each of the 4 secondary symptoms. Subjects with psychotic depression and melancholia were excluded. Sensitivity to rejection and hypersomnia demonstrated a weak association ($p = .02$) with reactive mood, as did weight gain and leaden paralysis ($p = .03$). Intercorrelational analyses among all other criteria were insignificant, arguing against the accessory features being interdependent, as might be expected for a syndrome. In particular, intercorrelation for reactive mood plus 1 or more secondary symptoms yielded no significant associations, thereby challenging the DSM-IV primacy of mood reactivity in defining atypical depression.

Similar results were reported by Posternak and Zimmerman,¹⁰ who also demonstrated a lack of association between mood reactivity and the 4 accessory symptoms of atypical depression. Hyperphagia was significantly associated with hypersomnia ($p = .03$) and with leaden paralysis ($p = .02$), and leaden paralysis was significantly associated with sensitivity to rejection ($p = .03$). However, there was no correlation among mood reactivity and the 4 accessory symptoms of atypical depression. Additionally, subjects underwent an Axis II evaluation comparing the number of DSM-IV criteria met in each of 10 personality disorders (paranoid, schizotypal, schizoid, borderline, narcissistic, antisocial, histrionic, obsessive-compulsive, dependent, and avoidant). Results confirmed that avoidant traits were significantly

Figure 1. Arborizing 2-Factor to 8-Factor Model for Temperament and Personality Styles in Nonmelancholic Depression^a



^aReprinted with permission from Parker and Manicavasagar.¹¹
Abbreviation: NEO = neuroticism, extraversion, openness.

associated with atypical depression ($p < .001$) and that subjects with atypical depression scored higher than patients with endogenous depression for each of the 10 DSM-IV personality disorder categories.

Defining Nonmelancholic Depression

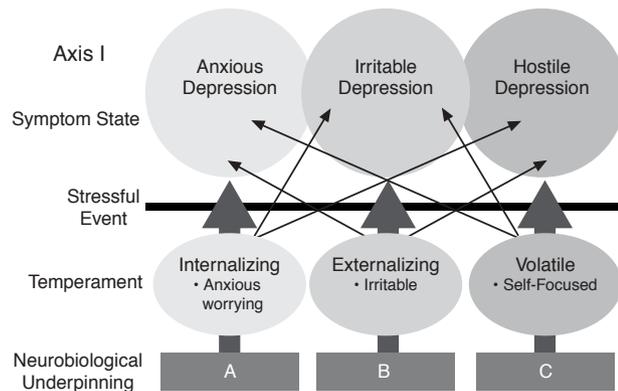
Manicavasagar and I¹¹ have broadly defined non-melancholic depression as a diverse representation of mood disorder symptoms but, as a class, lacking any specific feature such as delusions and/or hallucinations for psychotic depression or observable psychomotor disturbance for melancholic depression. Nonmelancholic depression encompasses the reactions of those with certain vulnerable personality styles (including multiple externalizing and internalizing manifestations) to life event stressors. Externalizing personality subtypes associated with nonmelancholic depression include an irritable subtype—in which high-trait anxiety individuals under stress externalize their dysphoria and emotional dysregulation by becoming testy and ill-humored—and a self-focused subtype in which patients exhibit a nonempathetic attitude and sense of entitlement (and often frustration intolerance) when experiencing a depressive episode. In addition, our data argued for 6 internalizing (albeit somewhat overlapping) personality styles: anxious worrying, perfectionistic, personal reserve, social avoidance (shyness or behavioral inhibition), self-criticism, and sensitivity to rejection.

Assessing Personality Subtypes Associated With Nonmelancholic Depression

Arborizing model. The 8 described personality facets were derived from higher-order molar personality constructs, which we developed empirically as an arborizing model (Figure 1).¹¹ The arborizing model was based on responses to an 89-item Temperament and Personality Questionnaire,¹² with items and scoring at the multitiered level available on the Black Dog Institute Web site. A sample of 903 adults who had suffered from an episode of unipolar depression responded to an initial Web-based survey. Varying factor numbers were imposed from 2-factor to 8-factor solutions to determine how the 2 contrasting higher-order categories (neuroticism and introversion) “arborized” into lower-order facets. For example, perfectionism became apparent as a subtype at Tier III and maintained an independent status across the remaining tiers, but sensitivity to rejection was not established until Tier VI. The Tier IV solution demonstrated similarities between the arborizing model and the North American Five-Factor Model¹³ (apart from lacking the somewhat problematic “openness to experience” dimension).

Spectrum model. We have also proposed a spectrum model (Figure 2)¹¹ for conceptualizing nonmelancholic disorders which allows that certain personality and temperament features (illustrated here are internalizing [anxiety], externalizing [anxiety], and volatile [self-focused]) shape reactions to stress. According to this model, neurobiologic

Figure 2. Spectrum Model Illustrating 3 Representative Personality Dimensions Predisposing Individuals to Nonmelancholic Depression and Shaping the Clinical Pattern^a



^aReprinted with permission from Parker and Manicavasagar.¹¹

processes influence personality styles, which combine with temperament to influence the clinical—or phenotypic—features of nonmelancholic depression after exposure to stress.

Colleagues and I (G.B.P., manuscript submitted) have applied the spectrum model to each of the 8 personality dimensions noted earlier as contributing to nonmelancholic depression, as well as examined related coping responses by people to their nonmelancholic depression to determine whether independent patterns could be established. Support was found for 6 of the 8 personality subtypes generating relatively independent clinical patterns, the strongest of which was exhibited by the anxious worrier group, followed by the sensitivity to rejection group. Of the 42 different emotional symptoms and coping responses that were evaluated with the Temperament and Personality measure, patients who were sensitive to rejection were more likely to feel the need for reassurance when experiencing a depressive episode and to feel abandoned, rejected, lonely, and unable to rely on other people. Additionally, such individuals reported anxiety and tension, mood swings (e.g., crying, wanting to break things), increased appetite and craving for sweets, weight gain, leaden paralysis, and sleep disturbances. They reported an increased consumption of alcohol and cigarettes and the use of other self-consolatory strategies such as spending money, warming up in a hot bath, and exercising problem-solving strategies as a means of controlling their situations. These results indicate that rather than just the 4 secondary symptoms of atypical depression as outlined by the DSM-IV-TR, atypical depression has wider manifestations, reflecting a personality style of sensitivity to rejection predisposing to a set of dysregulated emotional responses and self-consolatory strategies. A regression analysis was conducted to determine which of these features had the strongest correlation with sensitivity

to rejection. The top 5 features were: (1) feeling abandoned, (2) feeling unable to rely on other people, (3) feeling rejected, (4) feeling lonely, and (5) crying. Two of the DSM-IV-TR-specified secondary features of atypical depression—specifically hyperphagia and leaden paralysis—while overrepresented in reports by those with sensitivity to rejection, rated among the least-correlated responses to rejection sensitivity.

ATYPICAL DEPRESSION REDEFINED

Research data^{4,10} do not support the primacy of reactive mood in relationship to the DSM-IV-TR secondary symptoms of atypical depression. Rather, we suggest¹¹ that a personality style of sensitivity to rejection is the primary feature—leading to a set of emotional dysregulation and self-consolatory responses (i.e., symptoms and compensatory strategies) to shape the clinical pattern of atypical depression.

My colleagues and I have argued⁴ that atypical depression can be redefined as a dimensional nonmelancholic syndrome whereby individuals with a personality style of interpersonal rejection sensitivity are predisposed to also develop anxiety disorders—particularly social phobia and panic disorder, in addition to depression and dysphoria. Furthermore, these individuals respond to their dysphoria through a variety of dysregulated emotional and self-consolatory responses, which may reflect some homeostatic mechanisms (e.g., hypersomnia, hyperphagia) designed to settle the emotional dysregulation. Additionally, we note a waning emphasis on MAOIs as the predominant treatment for atypical depression. Data have demonstrated similar efficacy, greater tolerability, and improved patient compliance with selective serotonin reuptake inhibitors as compared with MAOIs.^{11,14} Cognitive therapy has also shown similar efficacy to MAOIs for acute-phase treatment of atypical depression.³ Thus, one of the tenets to the definition of atypical depression (i.e., specific responsivity to MAOIs) appears no longer substantiated.

CONCLUSION

Whereas depressive disorders are defined on the basis of Axis I or symptomatic features, atypical depression is unique in that it is more of a multi-axial condition, ranging across Axis I symptom states to Axis II personality styles. The DSM-IV-TR focus on mood reactivity as the primary criterion of atypical depression can be challenged. Conceptualizing atypical depression as a nonmelancholic spectrum disorder in which the primary feature is a personality style of interpersonal rejection sensitivity, accompanied by a range of dysregulated emotional and secondary self-consolatory symptoms and homeostatic features, may more fully embody the shaping

and pattern of the disorder. Additionally, this reformulated definition of atypical depression may lead to a better understanding and recognition of other “spectrum” disorders within the scope of major depression.

Drug name: phenelzine (Nardil).

Disclosure of off-label usage: The author has determined that, to the best of his knowledge, no investigational information about pharmaceutical agents that is outside U.S. Food and Drug Administration–approved labeling has been presented in this article.

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