

## Increased personality disorders and Axis I comorbidity in atypical depression

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### Abstract

**Objective:** Comparison of patients with and without atypical depression on comorbid Axis I and I disorders to determine whether atypical depression is associated with a higher comorbidity.

**Method:** Twenty-nine major depressive disorder patients with and without atypical depression were compared on clinical measures using multiple regression analyses.

**Results:** Atypical depression predicted the presence of comorbid Axis I (100% vs 33%), Axis II (90% vs 35%), and both Axis I and II (65% vs 8.14%) disorders. Personality disorders did not mediate the relationship between atypical depression and Axis I comorbidity.

**Conclusions:** The high prevalence of Axis I and II comorbidity in major depression may be explained, at least in part, by the presence of atypical depression. Our findings also suggest that the increased Axis I comorbidity observed in atypical depression is independent of the effects of personality disorders and is probably a direct effect of atypical depression subtype. Future research should confirm whether clinical findings associated with atypical depression are independent of their association with personality disorders in a larger sample of depressed patients and also examine treatment implications in atypical depression other than a preferential monoamine oxidase inhibitor responsiveness.

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### 1. Introduction

Atypical depression, a recent subtype of the mood disorders, is defined as mood reactivity and at least 2 of 4 associated features including hyperphagia, hypersomnia, leaden paralysis, and rejection sensitivity [1]. Belying its name, it appears to be a common form of depression with figures ranging from 22% to 83% [2–6]. However, studies using a specifically designed scale to diagnose atypical depression (Atypical Depressive Disorder Scale [ADDS] [1]) report rates between 30% and 46% [2–4].

Consistent with earliest conceptualizations of atypical depression [1], recent reports have observed a primacy of the personality style descriptor of rejection sensitivity over the other features [1,5–7]. A number of findings further underscore the importance of personality features in atypical depression. Researchers have observed that atypical depression is chronic, associated with a younger age of onset and a longer duration of illness [2]. In addition, some recent studies have observed high rates of some personality

dimensions in atypical depression [4–10]. However, given that major depression in general is associated with high rates of personality disorders [11], it is important to determine whether personality disorders are differentially elevated in atypical depression.

One recent study found higher rates of personality disorders in patients exhibiting atypical features [5]. However, threshold levels necessary to diagnose atypical depression were not established. Instead, atypical features were assessed retrospectively using a comprehensive general psychiatric measure (Structured Clinical Interview for the DSM-IV [SCID]), which, in contrast to the ADDS, does not include the necessary anchor points for each symptom to prospectively diagnose atypical depression [1]. For example, mood reactivity, a required criterion, is diagnosed as present in the SCID if patients state that they feel better when something good happens without specifying the extent of improvement; the Columbia Group clearly states that there must be at least 50% improvement in mood which is elicited by the ADDS [1].

Using a structured assessment measure to prospectively diagnose atypical depression, this preliminary study compared patients with and without atypical depression on

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*DSM-IV* personality disorders. Given the posited link between atypical depression and personality, we predicted that patients with atypical depression would exhibit a higher prevalence of personality disorders than those without atypical depression. Given the high levels of Axis I comorbidity observed in major depression [12], recent findings of higher lifetime comorbidity of some Axis I disorders in patients exhibiting atypical features [5], as well as recent findings that patients with atypical depression may be more symptomatic than those without the subtype [5,13,14], we also hypothesized that atypical depression would be associated with a higher current prevalence of comorbid Axis I disorders.

Because personality disorders have been associated with higher Axis I comorbidity in general [15], we wanted to determine whether the increased Axis I comorbidity in atypical depression would be independent of its association with personality disorders. We hypothesized that the association between atypical depression and comorbid Axis I disorders would be mediated by the presence of personality disorders.

## 2. Method

### 2.1. Subjects

We present preliminary data on 29 patients with major depressive disorder who presented to the Anxiety and Depression Clinic at Montefiore Medical Center in New York City. Patients were either self-referred or referred by a health professional. After a complete description of the study to the subjects, written informed consent was obtained. The institutional review board approved the protocol and informed consent.

### 2.2. Procedure

Patients were assessed using both self-report and via structured clinical interview. Axis I and Axis II disorders were diagnosed by the Structured Clinical Interview for the *DSM-III-R* (SCID-I) [16] and the Structured Clinical Interview for the *DSM-III-R* personality disorders (SCID-II) [17], respectively. Patients who met criteria for a principal Axis I disorder of major depression were interviewed using the ADDS to see whether they met criteria for the atypical subtype [1]. The ADDS assesses mood reactivity and the associated features of atypical depression: hyperphagia, hypersomnia, leaden paralysis, and rejection sensitivity. Atypical depression was defined as the presence of mood reactivity plus a minimum of 2 associated features.

General severity of depressive illness was measured using self-report and clinician-rated scales: the Beck Depression Inventory (BDI) [18], the Hamilton Depression Rating Scale (HAM-D) [19], and the extended version of the HAM-D which includes the standard 17 items plus items associated with atypical depression such as reversed vegetative features [20].

Because general anxiety, hopelessness, and suicidal ideation are common among depressed patients, patients were also given the Beck Anxiety Inventory [21], Beck Hopelessness Scale [22], and the Beck Scale for Suicidal Ideation [23].

Assessments were conducted over 2 sessions, usually spaced a week apart. The ADDS was administered by psychiatrists, psychologists, and social workers trained in the administration of relevant scales. Reliability assessments using the ADDS have previously been reported elsewhere [2]. SCID-I and SCID-II diagnoses and HAM-D ratings were made by 2 psychologists blind to the diagnosis of atypicality. Both raters were formally trained in the administration of the SCID in previous clinical trials. To determine interrater reliability, 10 randomly selected patients were assessed by both raters on SCID-I and SCID-II. A hundred percent agreement was observed on all Axis I and Axis II disorders.

### 2.3. Data analyses

Preliminary analyses used the entire sample of depressed outpatients to explore the association between the diagnosis of depression and comorbid Axis I and Axis II disorders as well as between severity of depressive illness and comorbid Axis I and Axis II disorders.

Multiple regression equations were computed to predict the presence of Axis II disorders (SCID-II) and Axis I (SCID-I) among patients with atypical depression. Mediation analyses were selected [24] to determine whether Axis II disorders mediated the relationship between atypical depression and comorbid Axis I disorders. *t* Tests were used to examine differences between patients with and without atypical depression on demographic variables and severity of illness.

## 3. Results

### 3.1. Overall sample

Mean (M) scores placed our overall sample in the moderate range of depression (BDI: M = 28.3, SD = 10.61; HAM-D: M = 23.17, SD = 6.74). Sixty-three percent of the overall sample of patients with major depression were diagnosed with one or more Axis II disorders, whereas 65% were diagnosed with one or more comorbid Axis I disorders. The correlation between Axis II comorbidity and the extended HAM-D was significant ( $r = .56, P < .01$ ), suggesting that patients with higher severity of illness on the Extended HAM-D (which takes into account atypical symptomatology) were more likely to have one or more Axis II disorders.

The correlations between Axis II comorbidity and both the BDI and the 17-item HAM-D were not significant. Correlations between Axis I comorbidity and severity of illness on the BDI and both versions of the HAM-D were also not significant.

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