The Prevalence of Atypical Features Across Mood, Anxiety, and Personality Disorders

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This study examines and compares the prevalence rates of the atypical features subtype across each of the major mood, anxiety, and personality disorders (PDs). It also evaluates the impact that comorbid anxiety and PDs have on the likelihood that depressed patients will present with atypical symptoms. Eleven hundred thirty psychiatric outpatients were evaluated for the presence of atypical symptoms. All axis I diagnoses were made using the Structured Clinical Interview for DSM-IV (SCID). PDs were assessed in a subset of 530 patients using the Structured Interview for DSM-IV Personality Disorders (SIDP-IV). From a sample of 579 patients diagnosed with a current major depressive disorder, 22.5% met criteria for the atypical subtype. Prevalence rates were similar in bipolar and unipolar patients, although the pattern of symptoms was distinct. Prevalence rates were lower in patients with dysthymic disorder (12.5%), adjustment disorder with depressed mood (9.4%), and depression not otherwise specified (NOS) (7.9%). When major depression existed in the presence of a comorbid anxiety disorder, the likelihood of presenting with atypical features doubled. Nine percent of the patients diagnosed with an anxiety disorder (without a comorbid depressive disorder) met criteria for atypical features. Two of the four atypical symptoms, leaden paralysis and rejection sensitivity, were found to be especially prominent in nondepressed anxiety disorder patients. Of the 10 PDs listed in DSM-IV, only avoidant PD was associated with the atypical features subtype. In large part, this was accounted for by the high rate of rejection sensitivity in these patients. In conclusion, as many as one quarter of depressed patients who present for outpatient psychiatric treatment meet criteria for the atypical features subtype. There appears to be a strong association between anxiety and atypical depression, but the exact nature of this relationship needs to be further elucidated. It is unclear whether personality pathology is independently associated with the atypical features subtype.

THE ATYPICAL FEATURES subtype was introduced into DSM-IV following a series of antidepressant trials showing that such patients responded preferentially to monoamine oxidase inhibitors (MAOIs).[1-4] Further support for the validity of this subtype was offered by biological studies[5-9] and latent class analyses,[10,11] which have suggested that depressed patients with atypical features differ from those without atypical features.

In antidepressant trials, estimates of the prevalence of atypical features have ranged from 16% to 42%.[5,12-17] Lower rates of atypical depression have been reported in psychiatric outpatient settings. Mezzich et al.[18] found that less than 4% of the depressed patients from their practice had atypical features, while Zisook et al.[19] reported a 15% prevalence rate. Two epidemiological studies[20,21] found that 11.3% and 15.7% of depressed patients in the community had atypical features. Integrating these results, however, has been difficult because investigators have often used different criteria to define the atypical features subtype (Table 1).[5,12-23] Of the studies using DSM-IV criteria, most have found that about one quarter to one third of all depressed patients would meet the atypical features subtype.

Only a handful of studies have assessed or compared rates of atypical features in disorders other than unipolar major depression (Table 2).[15,19,23-26] The Pittsburgh group has described an "anergic depression" characterized by severe fatigue, reversed neurovegetative symptoms, and psychomotor retardation, and has argued that such a presentation is especially common in bipolar patients.[27-29] Some support for this was given by Akiskal et al.,[30] who found that atypical symptoms in unipolar depressed patients predicted a higher likelihood for subsequently developing mania or hypomania. Benazzi[31] found a significantly higher rate of atypical features in bipolar patients compared to unipolars, though Robertson et al.[23] did not. Although anxiety and phobic states have often been conceptualized as being integral to the atypical syndrome,[3,4,15,32-37] only one study to date has compared prevalence rates of atypical features in depressed and anxious patients. In that study, whose findings should be interpreted cautiously

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Table 1. Summary of Studies That Have Reported Prevalence Rates of Atypical Features in Patients With Major Depression

Study	No.	Setting	Method of Diagnosis	Criteria Used to Define Atypical Features*	Prevalence (%)
Alpert, 1997[12]	243	AD	SCID-P	MR + 2/4	28.4
Asnis, 1995[5]	99	O	SADS	MR + 1/4	26
Benazzi, 1999[31]	203	O	CASH	MR + 2/4	31.0
Derecho, 1996[40]	21	I	SCID-P	MR + 2/4	33.3
Horwath, 1992[21]	662	C	DIS	HS + HP	15.7
Levitan, 1997[20]	8,116	C	CIDI	HS + HP + WG	11.3
Lonquist, 1994[13]	209	AD	Unspecified	MR + 2/4	25.4
Mezzich, 1987[18]	3,455	O	Clinical	Not defined	3.6
Nierenberg, 1998[14]	396	AD	SCID-P	MR + 2/4	42
Robertson, 1996[23]	109	I + O	ADDS	MR + 2/4	29
Robinson, 1985[15]	169	AD	SDI	MR + 2/4	30.3
Sotsky, 1999[16]	119	AD	SADS	MR + 1/3	25.2
Thase, 1991[17]	211	AD	SADS	MR + 2/4	16
Zisook, 1993[19]	175	O	Clinical	MR + 2/3	15

*Fractions refer to number of atypical B symptoms required for diagnosis (see text for explanation).

Abbreviations: AD, antidepressant trial; C, community; O, outpatient; I, inpatient; MR, mood reactivity; HS, hypersomnia; HP, hyperphagia; WG, weight gain; SCID = P, Structured Clinical Interview for DSM = IV, Patient Version; SADS, Schedule for Affective Disorders and Schizophrenia; CASH, Comprehensive Assessment of Symptoms and History; DIS, Diagnostic Interview Schedule; CIDI, Composite International Diagnostic Interview; ADDS, Atypical Depression Diagnostic Scale.

since the criteria used to define atypical features were idiosyncratic (Table 2), similar rates were found.[26] Despite the historic link between histrionic traits and atypical depression,[38,39] an association between the two disorders has never been confirmed. Two studies have found higher rates of atypical features in depressed patients with avoidant personality traits.[12,40]

In the present report, we sought to evaluate the prevalence of atypical symptoms across a broad range of psychiatric disorders by analyzing findings from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project. The MIDAS project has now collected detailed information on 1,130 psychiatric outpatients who have presented for treatment. This study is unique in that the presence of atypical symptoms was ascertained in all patients, not only those with a major mood disorder. In addition to establishing prevalence rates of atypical features across each of the major mood, anxiety, and personality disorders (PDs), we were also interested in addressing the

Table 2. Summary of Studies That Have Examined and/or Compared Rates of Atypical Features in Disorders Other Than Major Depression

Study	Setting	Diagnoses	No.	Criteria Used to Define Atypical Features*	Prevalence (%)
Benazzi, 1999[31]	O	Unipolar	103	MR + 2/4	23.0
		Bipolar	100		38.8
Han, 1995[24]	O	Dysthymia	37	MR + 2/4	24.3
Perugi, 1998[25]	D + O	Bipolar	86	MR + 2/4	32.6
Pollitt, 1971[26]	O	Depression	147	Insomnia, HP, IL, RD	46.9
		Anxiety	101		42.6
Robertson, 1996[23]	I + O	Unipolar	79	MR + 2/4	28
		Bipolar	30		30
Robinson, 1985[15]	O	Depression	132	MR + 2/4	30.3
		Depression NOS	37		21.6
Zisook, 1993[19]	O	Depression	175	MR + 2/3	15
		Dysthymia	102		20

*Fractions refer to number of atypical B symptoms required for diagnosis (see text for explanation).

Abbreviations: O, outpatient; I, inpatient; D, day hospital; NOS, not otherwise specified; MR, mood reactivity; HP, hyperphagia; IL, increased libido; RD, reversed diurnal variation.