Symptoms such as mood reactivity, hyperphagia, hypersomnia, leaden paralysis, and interpersonal rejection sensitivity are classified as atypical features of a major depressive episode. If these symptoms are concurrent with an episode of hypomania, the patient would be diagnosed with having a depressive episode in the continuum of bipolar II disorder. Because patients may have subsequent depressive episodes for years without any symptoms of hypomania, and because they can function unequivocally within the community due to the nature of the disorder, the diagnosis of a bipolar disorder often gets misclassified as one of a unipolar etiology. Most evidence-based literature states the complexity of this diagnosis due to the subtlety of the presenting symptoms, and it is usually only with a thorough patient history that a clinician can diagnose a patient with bipolar II disorder when the chief complaint is atypical depression.

An integrative approach to classifying the depression in terms of polarity requires the clinician to consider the longitudinal course of the patient’s illness; the tendency for depression to recur; the onset, prominence, and severity of depressive episodes; and whether there is a family history of bipolar disorder. It is essential to distinguish between unipolar and bipolar depression in order to treat current episodes and prevent further depressive episodes. The first-line treatment for unipolar depression with atypical features is monoamine oxidase inhibitors (MAOIs), whereas first-line treatment for bipolar depression is a mood stabilizer that may be augmented with an antidepressant.

CASE
A 42-year-old white woman carries the diagnoses of panic disorder with agoraphobia and major depressive disorder with atypical features. She has been following up at the outpatient clinic for more than 2 years with stable and baseline depression without suicidal intent or behavior. The patient’s medication had originally been stabilized on sertraline and aripiprazole, which was initiated for augmentation of unipolar depression. However, the patient’s unipolar depression had not improved during the past 2 years, prompting her current psychiatrist to ask further questions to categorize her depressive symptoms with the hope of finding a better treatment plan. The patient had reported some features of atypical depression (hypersomnia, hyperphagia, and mood reactivity) without leaden paralysis.

The current first-line therapy for atypical depression is an MAOI, but because of the many dietary and drug restrictions and rate of treatment failure for this class of drugs,1 it was decided not to place the patient on this therapy. After doing a literature review of evidence-based medicine, the outpatient psychiatrist recognized that atypical features are more common in bipolar depression (versus unipolar depression) and that these features may lie on the spectrum of bipolar disorder. Thus,
the psychiatrist decided to prescribe a mood stabilizer to treat the atypical features in this patient. The dosage of aripiprazole was up-titrated to a dose that was indicated for bipolar disorder.

The patient responded well to the medication adjustment, reporting a marked decrease in depressed mood and a reduction of the parameters of the aforementioned atypical features. The psychiatry resident continued to follow-up with the patient on a monthly basis in the outpatient setting and continued her on the same pharmacotherapy. At the time of this writing, the patient was doing well, was compliant with treatment, and has experienced a step-wise reduction of symptoms.

DISCUSSION

The relationship among atypical depression, bipolar II disorder, and borderline personality disorder remains unclear. A significant body of knowledge suggests a considerable overlap in clinical manifestations and psychotherapeutic responses, and also the difficulty among psychiatrists in making distinct diagnostic entities.

The category “atypical depression” includes a large subset of depression states characterized by reactive mood, a pattern of stable interpersonal sensitivity (exaggerated vulnerability to feeling hurt by criticism or rejection that leads to difficulties in interpersonal relationships, creating a personal life characterized by being easily hurt, having many romantic partners, and experiencing frequent breakups), and reverse vegetative symptoms such as increased appetite and hypersomnia.

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) defines atypical depression as a subtype of major depressive disorder with atypical features, characterized by:

- Mood reactivity (ie, mood brightens in response to actual or potential positive events).
- At least two of the following:
  - Significant weight gain or increase in appetite;
  - Hypersomnia (sleeping too much, as opposed to the insomnia present in melancholic depression).
  - Leaden paralysis (ie, heavy, leaden feelings in arms or legs)
  - Long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.
- Criteria are not met for melancholic depression or catatonic depression during the same episode.

Other significant facts about atypical depression include the following:

- It tends to cause greater functional impairment than other forms of depression. Women are more likely to be affected.
- It is a chronic syndrome and tends to begin early in life, usually in teenage years.
- Patients with atypical depression are more likely to suffer from other psychiatric syndromes (eg, panic disorder, social phobia, body dysmorphic disorder).
- Patients often have intense cravings for carbohydrates. A mineral supplement (chromium picolinate) assuages these cravings.

CONCLUSION

It is evident that effective therapeutic response in patients with atypical depression depends on the diagnostic accuracy of the clinician. Although MAOIs have been the prescribed drugs of choice, their use is limited by their dietary restrictions and safety profiles. A consensus exists that because atypical depression lies on the spectrum of bipolar disorder and may predict the future diagnosis of bipolar disorder, mood stabilizers should be considered as therapy for atypical depression. Psychosocial interventions, such as behavioral activation, should also be assessed as a non-psychotherapeutic option for patients with atypical depression.

REFERENCES

Statement of Ownership, Management, and Circulation
(Required by 39 U.S.C. 3685). Title of publication: Psychiatric Annals. Publication no.: 054-830. Date of filing: October 1, 2013. Frequency of issue: Monthly. Number of issues published annually: 12. Annual subscription price: $254. Complete mailing address of known office of publication: 6900 Grove Road, Thorofare, Gloucester County, New Jersey 08086-9447. Complete mailing address of the headquarters of the general business offices of the publisher: PNS & WSS Inc., t/a SLACK Inc., 6900 Grove Road, Thorofare, New Jersey 08086-9447. Publisher: Joan-Marie Stiglich, SLACK Inc., 6900 Grove Road, Thorofare, New Jersey 08086-9447. Editor: Jan Fawcett, MD, SLACK Inc., 6900 Grove Road, Thorofare, New Jersey 08086-9447. Managing Editor: Stephanie Portnoy, SLACK Inc., 6900 Grove Road, Thorofare, New Jersey 08086-9447. Owner: PNS & WSS, Inc., t/a SLACK, Inc., 6900 Grove Road, Thorofare, NJ 08086-9447; Peter N. Slack, 6900 Grove Road, Thorofare, New Jersey 08086-9447. Known bondholders, mortgagees, and other security holders: None. Issue date for circulation data: August 2013. Extent and nature of circulation: A. Total Number of Copies: Average number of copies each issue during preceding 12 months (hereinafter “Average”), 34,448. Actual number of copies of single issue published nearest to filing date (hereinafter “Most recent”), 34,418. B. Legitimate paid and/or requested circulation. B1. Outside county paid/requested mail subscriptions stated on Form 3541: Average, 33,946. Most recent, 33,951. B2. In-county paid/requested mail subscriptions stated on Form 3541: Average, 0. Most recent, 0. B3. Sales through dealers and carriers, street vendors, counter sales, and other paid or requested distribution outside USPS: Average, 25. Most recent, 25. B4. Requested copies distributed by other mail classes through the USPS: Average, 0. Most recent, 0. C. Total paid/requested circulation (sum of B1, B2, B3, and B4): Average, 33,971. Most recent, 33,976. D. Nonrequested distribution. D1. Outside county nonrequested copies stated on Form 3541: Average, 130. Most recent, 129. D2. In-county nonrequested copies stated on Form 3541: Average, 0. Most recent, 0. D3. Nonrequested copies distributed through the USPS by other classes of mail: Average, 0. Most recent, 0. D4. Nonrequested copies distributed outside the mail: Average, 34. Most recent, 2. E. Total nonrequested distribution (sum of D1, D2, D3 and D4): Average, 164. Most recent, 129. F. Total distribution (sum of C and E): Average, 34,135. Most recent, 34,105. G. Copies not distributed: Average, 313. Most recent, 313. H. Total (sum of F and G): Average, 34,448. Most recent, 34,418. I. Percent paid/requested circulation (C divided by F times 100): Average, 100%. Most recent, 100%. This Statement of Ownership will be printed in the November 2013 issue of this publication. I certify that the statements made by me above are true and complete. Joan-Marie Stiglich, Senior Vice President. Date: October 1, 2013.

AD INDEX

SLACK INCORPORATED
6900 Grove Road
Thorofare, NJ 08086
Healio.com/Psychiatry..........................C4

SUNOVION PHARMACEUTICALS INC.
84 Waterford Dr.
Marlborough, MA 01752
Lutudia............................................C2,473-482

While every precaution is taken to ensure accuracy, Psychiatric Annals cannot guarantee against occasional changes or omissions in the preparation of this index.