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Review

Atypical depression, somatic depression and anxious depression in women: Are they gender-preferred phenotypes?

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Abstract

Background: Both depression and anxiety disorders affect women at rates significantly greater than men. Women also have a documented higher frequency of comorbid depression and anxiety disorders, and a three-fold higher prevalence of atypical depression. *Hypotheses:* These gender differences are mainly due to specific depressive phenotypes including anxious depression and atypical depression. The prevalence of comorbid anxiety and depression strongly suggests overlap of pathophysiological mechanisms—which in women are also affected by fluctuations in gonadal hormones. Similar efficacy of serotonergic antidepressants as treatment for anxiety disorders as well as depressions further underscores the blurred boundaries between these two descriptive entities. *Conclusions:* Symptoms of depression and anxiety may be a departure point for differential diagnosis in which dimensionally-based phenotypes substantiated by pathobiology would replace current descriptive entities. It is suggested that at least some biologically-based dysphorias may be specific to women, ensuing from the combination of specific vulnerabilities, and complex interactions between brain mechanisms and gonadal hormones.

Keywords: Atypical depression; Anxious depression; Comorbidity; Depression; Women

Contents

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1. Introduction

Current diagnostic systems in psychiatry have been described as atheoretical in their adherence to a descriptive phenomenology that does not consider the heterogeneous symptoms and course of mental disorders, nor their biological mechanisms, etiology and possible genotypes (Halbreich, 2006). This limitation is illustrated by the documented phenomenological heterogeneity of MDD, which may represent heterogeneous etiologies and constitute the end-result of several different pathophysiological pathways (Antonijevic, 2006; Halbreich, 2006). Inadequacies in current diagnostic criteria are also evidenced in questions surrounding psychiatric comorbidity: whether it is more accurate to recognize the complex overlap of clusters of psychiatric symptoms and conditions rather than the co-occurrence of two or more distinct psychiatric disorders based on diagnostic guidelines (Maj, 2005).

The heterogeneous symptomology and course of various depression subtypes, especially atypical depression, anxious depression, and somatic depression, suggest distinct etiologies and pathophysiological mechanisms. That these subtypes are more prevalent in women underscores the major role of gonadal hormones and their interactions with other hormonal systems (e.g. hypothalamic pituitary adrenal (HPA) system), as well as neurotransmitters.

An overview of gender differences in three depressive subtypes: atypical, anxious, and somatic depressions and the possible endocrine and neurological mechanisms underlying these discrete subtypes and their prevalence in women, may suggest distinct entities as well as biological markers which should be incorporated into current psychiatric diagnostic criteria and treatment approaches.

2. The prevalence of anxiety and depressive disorders in women

Although the overall lifetime risk for psychiatric illness is equal in men and women, women have a greater propensity to develop both anxiety disorders and depressions.

Generalized Anxiety Disorder (GAD) and Post-traumatic Stress Disorder occur twice as frequently in women as in men: 6.6% vs. 3.6% and 10.4% vs. 5.0%. Women develop panic disorder and simple phobia at rates far exceeding men: 5.0% vs.2.0% and 15.7% vs. 6.7%, respectively. Although the gender gap for obsessive–compulsive disorder (3.1% in women vs. 2% in men) and social phobia (15.5% in women vs. 11.1% in men) is not as wide, these disorders are still more prevalent in women (Kessler et al., 1994a,b, 1995; Wittchen and Hoyer, 2001; Yonkers and Ellison, 1996) (Fig. 1).

Women have a two-fold greater risk for recurrent unipolar depressive disorder (RUP) and major depressive disorder (MDD) in general, as compared with men (Weissman and Klerman, 1977; Weissman et al., 1991; Weissman and Olfson, 1995; Wolk and Weissman, 1995). The sex difference is also supported by the National Comorbidity Survey (NCS) (Kessler et al., 1994a,b) which found higher lifetime estimates for MDD (21% in women and 13% in men) with a preserved 2:1 women to men difference (Fig. 1). Epidemiological studies from other countries including Switzerland (Ernst and Angst, 1992; Preisig et al., 2001) Canada (Bland et al., 1988) and Germany (Wittchen et al., 1992), all report that women are at least twice as likely as men to suffer from MDD. In addition to MDD, dysthymic disorder occurs more often in women. Rates for dysthymic disorder in women and men were reported to be 4.1% and 2.2%, respectively (Weissman et al., 1991). In the NCS, the rates for dysthymic disorder were similarly skewed, with 8% women in 5% of men suffering from the illness (Kessler et al., 1994a,b).

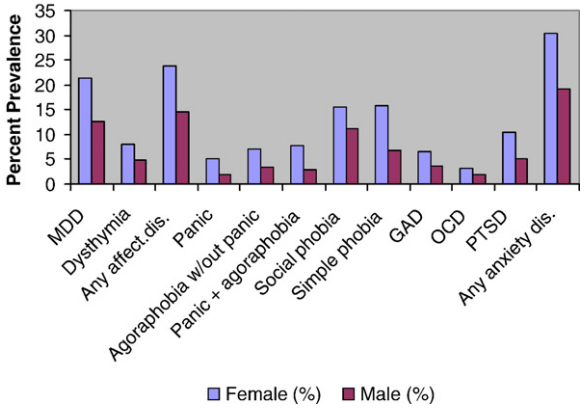

Fig. 1. Lifetime prevalence of depression and anxiety in men and women. Adapted from: Kessler et al., 1994a,b, 1995; Robins et al., 1984; Yonkers and Ellison, 1996.