Journal of Affective Disorders 182 (2015) 91–94

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Anxious, irritable and hostile depression re-appraised

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ARTICLE INFO

Article history:
Received 11 December 2014
Received in revised form
23 April 2015
Accepted 24 April 2015
Available online 2 May 2015

Keywords:
Depression
Classification
Personality
Temperament
Spectrum model

ABSTRACT

Background: While classification of the depression disorders currently favors a dimensional model, this study considered the empirical support for a spectrum model linking personality with phenotypic depressive features, specifically examining patients with 'irritable', 'hostile' and 'anxious' depression.
Methods: Pearson correlations were performed for Temperament and Personality (T&P) scales and state depressive patterns (irritable, hostile and anxious) for patients clinically diagnosed with unipolar melancholic and non-melancholic depressive conditions.
Results: Irritable depression was most strongly associated with T&P irritability and anxious depression with T&P anxious-worrying – although these associations lacked specificity and were also correlated with other T&P scales. Hostile depression was most strongly correlated with T&P irritability suggesting that hostile and irritable depression are synonymous patterns. There were no clear indications for more distinct associations for the non-melancholic, compared to the melancholic, subset.
Limitations: Study findings are limited in that measures of state depressive patterns were relatively minimalistic and assignment to melancholic and non-melancholic conditions was measured by clinician judgment and may be subjective in nature.
Conclusions: Findings offer little support in the positioning of anxious and irritable/hostile depression as meaningfully differing patterns, nor for the spectrum model being more specific to the non-melancholic depressive conditions. There would appear to be little utility in preserving these depressive patterns as diagnostic constructs.

1. Introduction

Classification of the depressive disorders currently weights a dimensional model albeit complemented by some sub-typing nuances. Thus, the DSM-5 'major depression' category has melancholia, catatonia and atypical specifiers, while ICD-10 has dimensional severity, recurrency and persistency parameters for depressive disorders, with sub-type decisions dependent on the presence or absence of somatic and psychotic symptoms.

Historically, the dominant view within psychiatry for the classification of the depressive disorders was a subtyping binary model. This model contrasted 'endogenous/psychotic' depressions (viewed to be more biological in origin) with those depressions stemming from the impact of personality factors and proximate and distal life stressors – termed 'neurotic' or 'reactive' depressions (Parker and Hadzi-Pavlovic, 1996). As a result of various studies employing multivariate analyses, a second-order sub-typing variant emerged which generated 'hostile/irritable' and 'anxious' depressive patterns. For example, Paykel's (1971) study employing a cluster analysis identified four groups of patients, defined as those showing "typical psychotic or endogenous symptoms," 'young depressives with personality disorders', and 'anxious' and 'hostile' depressive groups. A similar pattern was obtained by Grinker et al. (1961) who used Q-sort factor analysis and identified an 'anxious depressive' group as having significant depression and marked anxiety, and a 'hostile depressive' group as characterized by provocative, demanding and hostile behaviors. Using factor analytic techniques, Overall et al. (1966) derived three groups of patients with depression, which they labeled as 'retarded', 'anxious' and 'hostile' and with patients in these three groups subsequently shown to respond differentially to tricyclic and other antidepressant medications (Hollister et al., 1967). Findings such as these argue for differing biological underpinnings for these three depressive 'phenotypes' and thus advance their status as distinct depressive sub-types.

In line with these studies, hostile depression has long been viewed as an "unofficial" subtype of depression (Paykel and Henderson, 1977; Overall and Zisook, 1980). While "irritable" depression is less often viewed as a distinct subtype, some researchers position it as synonymous with hostile or 'agitated'

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http://dx.doi.org/10.1016/j.jad.2015.04.041
0165-0327/

depression (Benazzi et al., 2004). However, others have argued that irritability is more closely linked with hypomania during mixed episodes in bipolar disorder. For example, Kraepelin (1913, 1921) described irritability as being present in depressive episodes during a depressive mixed state and, more recently, Benazzi and Akiskal (2005) have hypothesized that irritable–hostile depression is linked to a depressive mixed state in adults with bipolar disorder. In the last few decades, there has been little reference to such depressive 'types' – particularly relating to unipolar depression – and raising questions as to their validity and utility.

We have previously positioned a spectrum model for conceptualizing the non-melancholic depressive disorders, whereby personality traits both predispose to non-melancholic depressive conditions and also shape their phenotypic picture (Parker and Manicavasagar, 2005). This model addressed the three depressive patterns (i.e. 'anxious', 'irritable' and 'hostile' depression) considered in this research study. Specifically, our model proposed that those with high trait anxiety either internalize their anxiety (by anxious worrying) or externalize it (via irritability) and differ from those who are more hostile in their interactions with others (e.g. lacking in empathy, taking advantage and/or blaming). According to this spectrum model, such personality styles shape phenotypic the picture of 'anxious', 'irritable' and 'hostile' depression respectively.

In this paper we pursue components of such a spectrum model. If valid, we would anticipate some specificity between the personality style (i.e. anxious, irritable, hostile) and equivalent symptom features as well as some independence between the symptom patterns. Secondly, as melancholia is positioned as a quintessential 'biological' condition, in contrast to the non-melancholic conditions, and which are more viewed as having psychosocial origins (Parker and Hadzi-Pavlovic, 1996), we hypothesize that the spectrum model should show specificity to the non-melancholic depressive conditions.

2. Methods

2.1. Research patients

Sample members were recruited from patients attending the Black Dog Institute (BDI) Depression Clinic (a state-wide tertiary service for those with a primary mood disorder) from 2010 to 2013. All patients received a detailed clinical assessment by one of five assessing psychiatrists – and with a percentage of patients having diagnostic and management issues reviewed by a second psychiatrist interviewing the patient. Both psychiatrists contribute to a 'consensus diagnostic decision' and with high inter-rater agreement in differentiating bipolar and unipolar diagnoses quantified in an earlier study (Parker et al., 2008a). Eligible study patients were those obtaining a clinical diagnosis of a primary unipolar depressive condition meeting DSM-IV criteria for a major depressive disorder, and who had also completed the Mood Assessment Program (MAP). Patients were excluded if significant cognitive or language difficulties were present, if they were under 18 years of age or if there was another substantive alternative primary diagnosis. Allocation to melancholic or non-melancholic sub-sets was undertaken by clinician assessment, and with a diagnosis of melancholia requiring the presence of prototypic melancholic features such as psychomotor disturbance, a non-reactive and anhedonic mood, anergia, and diurnal variation of mood and energy (Parker et al., 2013).

The total sample comprised 569 patients – with 292 diagnosed with melancholic and 277 diagnosed with non-melancholic depression. All patients provided informed written consent and the study was approved by the University of New South Wales Ethics Committee.

2.2. Study measures

All 569 patients completed the computerized MAP (Parker et al., 2008b) prior to clinical assessment and so providing socio-demographic and clinical information. Within the MAP, patients completed the 32-item Severity of Depressive Symptoms or SDS (Parker et al., 2009), so quantifying the presence and severity of depressive symptoms during their worst depressive episode. They also completed the Temperament and Personality Questionnaire or T&P (Parker et al., 2006) which measures personality style at multiple levels – including two molar constructs (i.e. neuroticism and introversion) and eight facet constructs (i.e. social avoidance, irritability, perfectionism, anxious worrying, personal reserve, self-criticism, interpersonal sensitivity and self-focused). Thus, relevant T&P facets (i.e. irritability, anxious worrying and self-focused) were selected to quantify those personality styles most likely to contribute to phenotypic syndromes of irritable, anxious and hostile depression respectively. The respective T&P 'irritability' scale measures personality features such as impatience and being snappy and hot-tempered, the 'anxious worrying' scale measures levels of being nervy/tense, worrying and taking things personally, while the 'self-focused' scale measures hostility, volatility, blaming and intolerance of others.

State 'irritable' and 'hostile' depressive patterns were generated by quantifying scores returned by patients on respective "irritable when depressed" and "angry when depressed" SDS symptom items and with scores for each ranging from 1 to 4. Quantification of any 'anxious depressive' pattern was undertaken from patients' scores on the MAP-embedded 10-item Depression in the Mentally Ill or DMI-10 (Parker et al., 2001) item – "stewing over things" when currently depressed – and with possible scores ranging from 0 to 4. Thus, each patient received a numeric score for irritable, hostile and anxious depression rather than being assigned categorically to mutually exclusive groups, and so allowing examination of any independence of constructs.

2.3. Principal analyses

Data analyses were conducted using SPSS, version 22.0 (SPSS, Inc., Chicago). Primary analyses included Pearson correlation coefficients (two-tailed) and were calculated for the total sample and separately for the non-melancholic and melancholic patient sub-sets. Our principal analyses sought to examine whether scores on relevant T&P facets correlated with related depressive pattern scores, and demonstrated some independence of anxious, irritable and hostile depression.

3. Results

3.1. Sample data.

The total sample ($n=569$) had a slight female preponderance (52%), a mean age of 42.7 years and an average age of depression onset of 22.0 years. For the non-melancholic ($n=277$) and melancholic ($n=292$) subsets, there was a slight female preponderance (51% vs. 54%), average respective ages of 43.4 and 41.9 years and a mean depression onset of 21.7 and 22.3 years, respectively.

Prior to undertaking principal analyses, we examined associations between state depressive pattern scores. For the total sample, anxious depression scores correlated 0.24 ($p<0.001$) with irritable depression scores and 0.23 ($p<0.001$) with hostile depression scores, while irritable and hostile depression scores correlated 0.68 ($p<0.001$) with each other, indicating little cleavage between our definition of irritable and hostile depression, and with coefficients in a similar order in the melancholic and non-melancholic sub-sets.