Psychotic (delusional) depression

The presence of delusional ideas and/or hallucinations during a major depressive episode defines psychotic (delusional) depression. Despite methodological problems, already in the first half of the previous century, most of the researchers agreed that depression accompanied by delusional ideas have a worse prognosis. During the last decades, the study of psychotic depression was intensified due to the observation that its response to the monotherapy with tricyclic antidepressants was poorer than those of non-psychotic depression. Until today several studies have investigated its characteristics in an effort to explore justifiable questions raised about the nature of the disorder and its relations to depressive and schizophrenic disorders.

In epidemiological studies, its prevalence in the community has been determined at 0.4%. Moreover, it is calculated that 14–18% of patients in the community suffering from major depressive episode manifest also psychotic features. Additionally, its frequency in hospitalized depressive patients is about 25%.

In clinical studies, it has been demonstrated that psychotic depression is a more severe form of depression, with a pronounced depressed mood, more psychomotor disturbance (agitation or retardation), more guilt feelings, and in most of the cases a depressive symptomatology of melancholic subtype coexists. The delusional ideas of psychotic depressives are mostly of paranoid, guilt and hypochondriacal content. The hallucinations, frequently auditory and visual, are present in 18–30% of the patients. The aforementioned psychotic symptoms are frequently mood-congruent. Otherwise, when they are mood-incongruent, attention should be paid to differential diagnosis with schizoaffective disorder of unipolar type.

In neuropsychological studies, psychotic depressives have been found to present lower scores in attentional tests, a finding correlating with psychotic symptomatology.

Findings regarding suicidal behaviour could be characterized as conflicting. It has been reported that the risk of committing complete suicides and suicide attempts is higher. However, several studies have not reported differences with non-psychotic depression.

In neurobiological studies, it has been found that the hypothalamic-pituitary-adrenal axis has been activated. Dexamethasone suppression-test is positive in psychotic depression more frequently than in any other subtype of depression, and also hypercortizolemia is hypothesized to constitute a basic parameter in the psychopathology of the disorder. Moreover, increased dopaminergic activity, decreased dopamine-beta-hydroxylase activity and serotonergic dysfunction have been found. The hypothesis that hypercortizolemia enhances dopaminergic dysfunction, and as a result psychotic symptoms emerge, remains predominant. Furthermore, in neuroimaging studies psychotic depressives have been found to have ventricle enlargement (possibly due to hypercortizolemia) compared to non-psychotic depression, whereas, in electro-encephalographic sleep studies shortened REM latency has been shown.

First-degree relatives of psychotic depressives manifest major depression, psychotic depression and bipolar disorder more frequently; findings that may be considered to lend further support to the hypothesis that psychotic features appear in the context of more "endogenic" depression.

The short-term (< 1–2 years) course and outcome of psychotic depression is poorer than those of non-psychotic, with more major depressive episodes, hospitalizations, economic burden and social impairment. The long-term (> 2 years) course and outcome of the disorder is similar to non-psychotic depression. However, the risk of recurrence may be greater.
Since antidepressants were introduced in therapeutics of psychotic depression it has become apparent that the response rates of monotherapy with tricyclics antidepressants are lower (35–40%) than those of non-psychotic depression (65–70%). Also, the response rate to the monotherapy with antipsychotics (20–40%) appears to be limited. However, it has been shown that the combination of an antipsychotic and an antidepressant is the therapy of choice, with higher rates of symptomatology remission (70–80%). Also favorable are the response rates of ECT (80–90%).

The issue of whether psychotic depression simply represents a more severe form of major depressive disorder or constitutes a distinct clinical entity warrants further investigation.

Psychotic depression in the elderly has constituted, mainly during the last decade, an interesting field of the research. It generally manifests a similar profile to psychotic depression in younger patients, though with some differentiations. There is evidence that psychotic depression becomes more frequent with greater age in hospitalized depressives and the hypochondriacal delusional ideas become more frequent, which can lead doctors to miss the diagnosis. Additionally, psychotic depressives present greater frontal atrophy and impaired working memory, which probably are involved in the formation of delusional beliefs. In addition, it has been shown that the short-term course and outcome of the disorder is dire, with greater mortality. Lastly, the response rates to the combination of an antipsychotic and an antidepressant are lower than those in younger patients (25–50%).

In conclusion, psychotic depression is common in inpatient settings; however, it is frequently under-diagnosed and overlooked. Its pathogenesis constitutes a matter of special interest of psychiatric research due to the coexistence of psychotic symptoms and depression.

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REFERENCES