Psychotic depression: Types, Causes, Symptoms, Diagnosis

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Abstract

Psychotic depression, also referred to as depressive psychosis, may be a major depressive episode that's amid psychotic symptoms. It can occur within the context of manic depression or major clinical depression. It are often difficult to differentiate from schizoaffective disorder, a diagnosis that needs the presence of psychotic symptoms for a minimum of fortnight with none mood symptoms present. Unipolar depressive disorder requires that the psychotic features occur only during episodes of major depression. Diagnosis using the DSM-5 involves meeting the standards for a serious depressive episode, alongside the standards for "mood-congruent or mood-incongruent psychotic features" specifier.

Signs and symptoms

Individuals with depressive disorder experience the symptoms of a serious depressive episode, alongside one or more psychotic symptoms, including delusions and/or hallucinations.[2] Delusions are often classified as mood congruent or incongruent, counting on whether or not the character of the delusions is keep with the individual's mood state.[2] Common themes of mood congruent delusions include guilt, persecution, punishment, personal inadequacy, or disease.[5] half patients experience quite one quite delusion.[2] Delusions occur without hallucinations in about one-half to two-thirds of patients with depressive disorder .[2] Hallucinations are often auditory, visual, olfactory (smell), or haptic (touch), and are congruent with delusional material.[2] Affect is gloomy , not flat. Severe anhedonia, loss of interest, and psychomotor retardation are typically present

Cause

Psychotic symptoms tend to develop after a private has already had several episodes of depression without psychosis. However, once psychotic symptoms have emerged, they have a tendency to reappear with each future depressive episode. The prognosis for depressive disorder isn't considered to be as poor as for schizoaffective disorders or primary psychotic disorders. Still, those that have experienced a depressive episode with psychotic features have an increased risk of relapse and suicide compared to those without psychotic features, and that they tend to possess more pronounced sleep abnormalities.

Family members of these who have experienced depressive disorder are at increased risk for both depressive disorder and schizophrenia.

Most patients with depressive disorder report having an initial episode between the ages of 20 and 40. like other depressive episodes, depressive disorder tends to be episodic, with symptoms lasting for a particular amount of your time then subsiding. While depressive disorder are often chronic (lasting quite 2 years), most depressive episodes last but 24 months. A study conducted by Kathleen S. Bingham found that patients receiving appropriate treatment for depressive disorder went into "remission". They reported a top quality of life almost like that of individuals without PD.

Pathophysiology

There are variety of biological features which will distinguish depressive disorder from non-psychotic depression.

The foremost significant difference could also be the presence of an abnormality within the hypothalamic pituitary adrenal axis (HPA). The HPA axis appears to be dysregulated in depressive disorder , with dexamethasone suppression tests demonstrating higher levels of cortisol following dexamethasone administration (i.e. lower cortisol suppression).[2] Those with depressive disorder even have higher ventricular-brain ratios than those with non-psychotic depression

Treatment

Several treatment guidelines recommend either the mixture of a second-generation antidepressant and atypical antipsychotic or tricyclic monotherapy or electroshock (ECT) because the first-line treatment for unipolar depressive disorder. there's some evidence indicating that combination therapy with an antidepressant plus an antipsychotic is simpler in treating depressive disorder than either antidepressant treatment alone or placebo.

Pharmaceutical treatments can include tricyclic antidepressants, atypical antipsychotics, or a mixture of an antidepressant from the newer, more well tolerated SSRI or SNRI categories and an atypical antipsychotic. Olanzapine could also be an efficient monotherapy in depressive disorder , although there's evidence that it's ineffective for depressive symptoms as a monotherapy; and olanzapine/fluoxetine is simpler. Quetiapine monotherapy could also be particularly helpful in depressive disorder since it's both antidepressant and antipsychotic effects and an inexpensive tolerability profile compared to other atypical antipsychotics. the present drug-based treatments of depressive disorder are reasonably effective but can cause side effects, like nausea, headaches, dizziness, and weight gain. Tricyclic antidepressants could also be particularly dangerous, because overdosing has the potential to cause fatal cardiac arrhythmias.

In the context of depressive disorder, the subsequent are the foremost well-studied antidepressant/antipsychotic combinations

First-generation

Amitriptyline/perphenazine
Amitriptyline/haloperidol

Second-generation

Venlafaxine/quetiapine
Olanzapine/fluoxetine
Olanzapine/sertraline

References

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