Short Communication

BIOMEDICAL Journal of Scientific & Technical Research

ISSN: 2574 -1241

DOI: 10.26717/BJSTR.2025.63.009878

Psychotic Depression Conceptualization and Clinical Picture

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ARTICLE INFO

Received: August 22, 2025

Published: September 24, 2025

Citation: Ronaldo Chicre Araujo and Emilly Alves Martins e João Paulo Lopes Soares. Psychotic Depression Conceptualization and Clinical Picture. Biomed J Sci & Tech Res 63(2)-2025. BJSTR. MS.ID.009878.

Introduction

Major Depressive Disorder is characterized by a period of at least two weeks during which the individual experiences depressed mood or loss of interest and pleasure in most activities. For diagnosis, four or more additional symptoms must be present, such as changes in sleep or appetite, fatigue, feelings of worthlessness or excessive guilt, psychomotor slowing or agitation, difficulty concentrating, and recurrent thoughts of death or suicide. These symptoms must cause significant distress or functional impairment and cannot be attributed to substance use or another medical condition (DSM-5 [1]). When a major depressive episode is associated with psychotic symptoms, such as delusions or hallucinations, the condition is characterized as psychotic depression (DSM-5 [1]). Carrying out a complete and rigorous psychiatric and clinical examination is essential in the face of any depressive condition, as it allows, in some cases, the identification of other underlying mental conditions that present themselves behind typical symptoms of common depression or a disguised organic condition, directly influencing the therapeutic decisions adopted by the doctor (Dalgalarrondo [2]). Psychotic depression constitutes a particularly severe form of depressive disorder, characterized by the simultaneous presence of classic depressive symptoms and psychotic manifestations, such as delusions and hallucinations. The most frequently observed delusions involve feelings of doom, intense guilt, hypochondriasis, or organ denial, reflecting the patient's profound distortion of reality. Furthermore, auditory or visual hallucinations often have content congruent with the depressive state and may convey messages of incapacity, threat, or deserved punishment, such as "you are useless," "you will suffer," or "your children will be in need" (EY, et al. [3]). When psychotic symptoms present negative or depressive content, they are classified as mood-congruent, encompassing delusions of guilt, illness, death, organ denial, or deserved punishment. On the other hand, when they do not have a direct relationship with depressive mood, they are considered incongruent moods, including delusions of persecution, insertion of thoughts or self-referential ones (EY, et al. [3]). Delusions are present in 25% of depressive episodes and 15% of depression cases in outpatient clinics, such as primary care units and psychosocial care centers. Approximately 65% of cases are mood-congruent, and only 18% are mood-incongruent, with 9% presenting both types of delusions. Auditory delusions are twice as common as visual delusions, but there may be variations). In primary care, psychotic depression is rarely reported; in specialized outpatient clinics, the rates are intermediate, but in individuals hospitalized for depression, the rates are high. It is important to emphasize that psychotic depression presents greater pathophysiological severity and brain damage than other types of depression. Depressive states can also be associated with neurological and metabolic conditions, emerging as symptoms of infectious or organic brain disorders. Therefore, in cases of depressive symptoms, a complete examination of the individual should be performed to investigate the underlying cause. Brain tumors, meningoencephalitis, epidemic encephalitis, and multiple sclerosis are examples of diseases that can cause depression. Furthermore, depression can appear after head trauma, usually accompanied by neurotic or post-traumatic elements (Dalgalarrondo [2]). In the United States, individuals with depression exhibit a con-

siderably higher risk of suicide, 17 times higher than in the general population. The likelihood of suicidal behavior persists during severe depressive episodes, and a prior history of suicide attempts or threats constitutes the most consistent risk factor. Anhedonia is strongly linked to suicidal ideation. Other factors that increase the risk of death by suicide include being single, living alone, social isolation, life adversities, access to lethal means, sleep disorders, cognitive impairments, and feelings of hopelessness. Although women have a higher rate of suicide attempts, men are more likely to complete suicide (DSM-5 [4]).

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DOI: 10.26717/BJSTR.2025.63.009878

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Submission Link: https://biomedres.us/submit-manuscript.php