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Etiology and epidemiology of depressive disorders in children and adolescents

Etiologia i epidemiologia zaburzeń depresyjnych u dzieci i młodzieży

Abstract

Issues related to depressive disorders in childhood and adolescence, including the aetiology of these disorders and their epidemiology, point to the enormous complexity of the problem, both in able-bodied individuals and those with disabilities. Based on a meta-analysis of existing research on the epidemiology of depressive disorders among children and adolescents in the general population, it can be assumed that they affect 2.6% of this group. Among children and adolescents with disabilities, the rate is usually significantly higher. Empirical research to date shows that the following factors are important in the aetiology of depressive disorders: genetic conditions, neurobiological factors, stressful life events, negative cognitive patterns, problems with self-regulation and the specificity of interpersonal relationships, as well as interactions between these factors, are also important.

Keywords: depressive disorders, children and adolescents, disability, aetiology, epidemiology

Streszczenie

Zagadnienia dotyczące zaburzeń depresyjnych w okresie dzieciństwa i adolescencji, w tym etiologii wspomnianych zaburzeń oraz ich epidemiologii, wskazują na ogromną złożoność prezentowanej problematyki, i to zarówno u osób pełnosprawnych jak i z niepełnosprawnościami. W oparciu o metaanalizę dotychczasowych wyników badań dotyczących epidemiologii zaburzeń depresyjnych wśród dzieci i młodzieży w populacji ogólnej można przyjąć, że dotykają one 2,6%. Wśród dzieci i młodzieży z niepełnosprawnościami wskaźnik jest zwykle wyraźnie wyższy. Z dotychczasowych badań empirycznych wynika, że w etiologii zaburzeń depresyjnych znaczenie mają: uwarunkowania genetyczne, czynniki natury neurobiologicznej. Istotne są również stresujące wydarzenia życiowe, negatywne schematy poznawcze, problemy w zakresie samoregulacji oraz specyfika relacji interpersonalnych, a także interakcje między wymienionymi czynnikami.

Słowa kluczowe: zaburzenia depresyjne, dzieci i młodzież, niepełnosprawność, etiologia, epidemiologia

Introduction

It is currently accepted that depressive disorders in children, adolescents and adults are essentially the same, and what distinguishes them is a certain specificity of symptoms resulting from the developmental period. Therefore, it is assumed that disorders in childhood and later in adolescence are an early manifestation of disorders occurring in adulthood. The specificity of disorders in earlier stages of development is limited to atypicality and clinical ambiguity of the disorder.[1] The current ICD-11 classification distinguishes the following depressive disorders: single episode depressive disorder (6A70), recurrent depressive disorder (6A71), dysthymic disorder (6A72), mixed depressive and anxiety disorder (6A73), other specified depressive disorders (6A7Y), depressive disorders, unspecified (6A7Z), symptomatic and course presentations for mood episodes in mood disorders (6A80), other specified mood disorders (6A8Y), mood disorders, unspecified (6A8Z).[2]

It should be noted that for a long time, the possibility of depressive disorders in children was not even considered, as in the early stages of development, children are unable to describe their own experiences, including symptoms reported later, such as low mood, lack of prospects, feelings of guilt and hopelessness.[3] However, observable behavioural indicators remain, which allowed, as early as the 1940s, for the distinction of so-called anaclitic depression, associated with the loss of support.[4] This anaclitic depression is a reaction to separation from significant others. This set of symptoms was also known in the past as psychological deprivation, orphan's disease or hospital disease. In general, it can be said that it is a state of the body resulting from a specific life situation in which a child is deprived of the opportunity to satisfy their basic psychological needs for a long period of time.[5] The described symptoms and mechanisms of the development of depressive disorders in infancy have been confirmed in later clinical studies, which observed the fundamental role of relationship disorders, especially in

[1] J. Bomba, *Depresja młodzieńcza* [in:] *Psychiatria dzieci i młodzieży*, ed. I. Namysłowska, Warszawa 2005, pp. 266–279.

[2] WHO, *ICD-11. International Classification of Diseases 11th Revision. The global standard for diagnostic health information*, 2022, https://icd.who.int/browse/2025-01/mms/en#1563440232 (4.01.2026).

[3] P. Majewicz, *Zaburzenia depresyjne w okresie dzieciństwa i adolescencji* [in:] *Kiedy boli dusza i życie traci sens: przełamywanie tabu: wspólne działanie w walce z depresją*, eds. W. Błażejewski, M. Leżucha, Jaroslaw–Łódź 2025, pp. 37–56.

[4] R.A Spitz, K.M. Wolf, *Anaclitic depression; an inquiry into the genesis of psychiatric conditions in early childhood, II*, "The Psychoanalytic Study of the Child" 1946, No. 2(1), pp. 313–342, DOI: https://doi.org/10.1080/00797308.1946.11823551.

[5] M. Suffczyńska-Kotowska, *Reakcje adaptacyjne u małych dzieci* [in:] *Psychiatria wieku rozwojowego*, eds. A. Popielarska, M. Popielarska, Warszawa 2000, pp. 96–100.

the first two years of life. As the results of the studies indicate, these problems precede the disorders in the child.[6]

Epidemiology of depressive disorders in childhood and adolescence

The literature on this subject presents varying results regarding the prevalence of mental disorders, including depressive disorders, among children and adolescents. These discrepancies have a number of sources, such as: the methodological procedure used, because it is not only important to select the right sample for the study, but also how the data is collected, whether it is a self-report study, whether individuals are examined by specialists, or whether it is a compilation of data obtained from reports from treatment centres. In addition, the age group covered by the research is important, as is the classification used as a basis, e.g. whether it is the DSM (Diagnostic and Statistical Manual of Mental Disorders developed by the American Psychiatric Association) or the ICD (International Statistical Classification of Diseases and Related Health Problems, which is also used in practice in Poland) and which version.[7]

A review of existing epidemiological reports shows that the prevalence of mental disorders in the general population in European Union countries is 17.3%.[8] However, it is most often indicated that approximately 10–20% of all children and adolescents have various mental disorders.[9] Based on a meta-analysis of 41 selected publications from 27 countries,[10] an attempt was made to determine the percentage more accurately, and it turned out that 13.4% of the population of children and adolescents suffer from mental disorders. A similar percentage is indicated by the results of the EZOP II project – "Comprehensive study of the mental health of the population and its determinants – EZOP II," which surveyed 15,000 people from all over Poland, including 3,000 children and adolescents. The results indicate that

[6] M.J. Cordeiro, P. Caldeira Da Silva, T. Goldschmidt, *Diagnostic classification: Results from a clinical experience of three years with DC: 0–3*, "Infant Mental Health Journal" 2003, No. 24, pp. 349–364, DOI: http://hdl.handle.net/10400.17/2487.

[7] P. Majewicz, J. Sikorski, *Uczeń z zaburzeniami psychicznymi. Wybrane zagadnienia wsparcia psychologiczno-pedagogicznego*, Kraków 2022, p. 36.

[8] IHME, *Global Health Data Exchange*, 2018, www.healthdata.org/, https://www.oecd-ilibrary.org/sites/health_glance_eur-2018-4-en/index.html?itemId=/content/component/health_glance_eur-2018-4-en (29.11.2021).

[9] WHO, *Child and adolescent mental health*, https://www.who.int/mental_health/maternal-child/child_adolescent/en/ (10.05.2020).

[10] G.V. Polanczyk, G.A. Salum, L.S. Sugaya, A. Caye, L.A. Rohde, *Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents*, "Journal of Child Psychology and Psychiatry, and Allied Disciplines" 2015, No. 56(3), pp. 345–365, DOI: https://doi.org/10.1111/jcpp.12381.

among children and adolescents aged 7–17, mental disorders occur in 13.4%, which is as many as 568,100 people.[11] Therefore, advanced statistical analyses of a range of results from different countries are consistent with the results of the Polish EZOP II study. It can therefore be assumed that mental disorders occur in slightly more than 13% of children and adolescents.

Against this background, an attempt can be made to determine the prevalence of depressive disorders in the child and adolescent population. Based on a meta-analysis of data from 27 countries, it can be concluded that the global prevalence of depressive disorders in children and adolescents is 2.6%.[12] It is worth adding that data collected from various sources in the USA between 2005 and 2011[13] indicate that 2.1% of children and adolescents aged 3–17 were diagnosed with depressive disorders. In contrast, the prevalence of depression in preschool children is estimated at around 2%.[14] Other authors[15] report that depression affects 1% of preschool children over the age of 2 and 3, while in the 6–12 age group, the percentage is already 2%. It should be added that in the group of children, symptoms of depression occur at a similar level in girls and boys. The incidence of depression increases between the ages of 13 and 18 and becomes similar to the prevalence of these disorders in adults. During adolescence, a higher incidence of depression is observed in girls than in boys.

The epidemiology of mental disorders, including depression, looks slightly different among children and young people with disabilities. In the case of neurodevelopmental disorders, such as autism spectrum disorder (ASD), as many as 70–80% of people also suffer from mental disorders. It is worth noting that 40–50% of adolescents and adults with ASD meet the criteria for two or more disorders.[16] In turn, in the population of children and adolescents with intellectual disabilities, the co-occurrence of mental, behavioural and neurodevelopmental disorders is 39%.[17] Other studies[18] observed that individuals with higher IQ or better academic

[11] K. Ostaszewski, M. Kucharski, J. Stokwiszewski, *Wyniki badania dzieci i młodzieży (wiek 7–17 lat)*, Konferencja projektu EZOP II, Warszawa, 15–16 listopada 2021.

[12] G.V. Polanczyk, G.A. Salum, L.S. Sugaya, A. Caye, L.A. Rohde, *Annual research*…, pp. 345–365.

[13] Centers for Disease Control and Prevention, *Key Findings: Children's Mental Health Report*, 2013, https://www.cdc.gov/childrensmentalhealth/features/kf--childrens-mental-health-report.html (10.05.2020).

[14] L. Popek, B. Remberk, *Zaburzenia depresyjne u dzieci i młodzieży* [in:] *Psychiatria dzieci i młodzieży*, Vol. 1, eds. M. Janas-Kozik, T. Wolańczyk, Warszawa 2022, pp. 472–493.

[15] P. Gałecki, A. Szulc, *Psychiatria. Rozpoznania według ICD-11*, Vol. 1, Wrocław 2023, p. 259.

[16] A. Słopień, A. Rynkiewicz, M. Janas-Kozik, *Zaburzenia ze spektrum autyzmu* [in:] *Psychiatria dzieci i młodzieży*,Vol. 1, eds. M. Janas-Kozik, T. Wolańczyk, Warszawa 2022, p. 284.

[17] E. Emerson, *Prevalence of psychiatric disorders in children and adolescents with and without intellectual disability*, "Journal of Intellectual Disability Research" 2003, No. 47(Pt 1), p. 54, DOI: https://doi.org/10.1046/j.1365-2788.2003.00464.x.

[18] M. Rutter, *Pathways from childhood to adult life*, "Journal of Child Psychology and Psychiatry, and Allied Disciplines" 1989, No. 30(1), p. 42, DOI: https://doi.org/10.1111/j.1469-7610.1989.tb00768.x.

performance are less likely to develop mental disorders later in life. Therefore, a higher IQ is a protective factor. It is therefore not surprising that as intellectual ability declines, the percentage of co-occurring mental disorders increases. There are more such disorders in people with mild intellectual disabilities than in the general population, with an estimated rate of 24–25%, while in people with an IQ below 50 on the Wechsler scale, the rate is already around 50%.[19]

In turn, among children and young people with hearing impairments, the prevalence of mental disorders is estimated to reach 50%. The ability to use speech appears to be a protective factor, followed by knowledge of sign language. In children and young people with visual impairments, the prevalence of mental disorders is estimated to be at a similar level, at around 45%. A similar percentage of children and adolescents with mental disorders is also reported among people with cerebral palsy, ranging from 40% to 60%.[20]

Depressive disorders occupy a significant position among the mental disorders listed above. This is particularly evident in people with autism spectrum disorders (ASD).The prevalence of mood disorders in the form of depression and dysthymia, depending on the study, ranges from 1% in children to over 30% in adolescents and adults.[21] As indicated by the results of a meta-analysis of numerous publications in this field, the lifetime prevalence of depressive disorders in people with ASD is 14.4%. Nevertheless, compared to typically developing individuals, people with ASD are at least four times more likely to experience depression during their lifetime.[22]

In the case of another neurodevelopmental disorder, namely intellectual disability, it is estimated that depressive disorders affect 1.5% of the population of children and adolescents.[23] Another study, conducted by Marielle Dekker and Hans Kooot,[24] showed a higher frequency, namely 4.4%.

In turn, research conducted by Irene Leigh[25] among young people with hearing impairments showed mild depression in 40% and moderate or severe depression in

[19] K. Bobińska, P. Gałecki, *Zaburzenia psychiczne u osób upośledzonych umysłowo*, Wrocław 2010, p. 17; J. Rola, *Współczesne podejście do problemu obecności depresji i zaburzeń zdrowia psychicznego u osób upośledzonych umysłowo*, "Psychiatria Polska" 2007, No. 41(2), p. 205.

[20] T. Wolańczyk, *Zaburzenia psychiczne w chorobach somatycznych* [in:] *Psychiatria dzieci i młodzieży*, ed. I. Namysłowska, Warszawa 2005, pp. 382–405.

[21] A. Słopień, A. Wojciechowska, N. Pytlińska, *Zaburzenia ze spektrum autyzmu* [in:] *Zaburzenia psychiczne dzieci i młodzieży*, eds. A. Gmitrowicz, M. Janas-Kozik, Warszawa 2018, p.43.

[22] C.C. Hudson, L. Hall, K.L. Harkness, *Prevalence of Depressive Disorders in Individuals with Autism Spectrum Disorder: A Meta-Analysis*, "Journal of Abnormal Child Psychology" 2019, No. 47(1), pp. 165–175, DOI: 10.1007/s10802-018-0402-1.

[23] E. Emerson, *Prevalence of psychiatric*…, p. 54.

[24] Ch. Stavrakaki, Y Lunsky, *Depresja, lęk i zaburzenia adaptacyjne* [in:] *Zaburzenia psychiczne i zaburzenia zachowania u osób niepełnosprawnych intelektualnie*, eds. N. Bouras, G. Holt, Wrocław 2010, p. 125.

[25] D. Podgórska-Jachnik, *Problem depresji wśród osób niesłyszących i niewidzących* [in:] *Nawracające zaburzenia depresyjne. Etiologia, diagnoza i terapia*, eds. A. Orzechowska, P. Gałecki, T. Pietras, Wrocław 2017, p. 138.

10% of the respondents. In contrast, in the group of students with hearing impairments, mild episodes of depression were recorded in 43% of cases and moderate depression in 8% of cases. Young people with visual impairments also showed a higher incidence of depressive tendencies, with an average level of 13.65, compared to 7.10 among sighted young people.[26] However, it is difficult to conclude on this basis that depressive disorders are more prevalent in this group of people, as there are also research results that do not confirm this difference. For example, studies conducted in Turkey[27] among visually impaired and sighted adolescents indicates that the level of depressive tendencies and self-esteem in both groups is similar, while the level of anxiety in adolescents with visual impairment is significantly higher than in sighted adolescents.

Etiology of depressive disorders

The factors determining and conditioning the occurrence of depressive disorders in children and adolescents, in general terms, do not differ from those in adults with similar problems, but the specificity of the period of intensive development is clearly visible here. Suffice it to mention, for example, attachment disorders in early childhood, the possible phenomenon of 'programming' of the HPA axis (hypothalamic-pituitary-adrenal), the dynamics of puberty, the development of the nervous system and the resulting different ways of responding in different periods, or the enormous importance of abnormalities in family and peer relationships for children and adolescents and the course of their development. It is highly likely that the influence of biological, psychological and environmental factors is mainly interactive in nature, and it is difficult to identify a single group of conditions that is responsible for the onset of depressive disorders in children and adolescents. The vulnerability-stress model, which also takes protective factors into account, seems to be the most appropriate here. As Archibald Hart[28] vividly put it, stress in childhood can be described using five terms:

a) "too much, too soon";
b) "too much of a good thing";
c) "too little good";
d) "too much stress – too little family";
e) "too much excessive stress."

[26] S.G. Koenes, J.F. Karshmer, *Depression: a comparison study between blind and sighted adolescents*, "Issues Ment Health Nursing " 2000, No. 21(3), pp. 269–279, DOI: https://doi.org/10.1080/016128400248086.

[27] N. Bolat, B. Doğangün, M. Yavuz, T. Demir, L. Kayaalp, *Depression and anxiety levels and self-concept characteristics of adolescents with congenital complete visual impairment*, "Turk psikiyatri dergisi = Turkish Journal of Psychiatry" 2011, No. 22(2), pp. 77–82.

[28] W. Pilecka, J. Fryt, *Teoria stresu dziecięcego* [in:] *Psychologia zdrowia dzieci i młodzieży. Perspektywa kliniczna*, ed. W. Pilecka, Kraków 2011, pp. 32–33.

In addition to the factors mentioned above that contribute to the onset of depressive disorders in children and adolescents, it is also worth mentioning the concept of bottom-up and top-down explanations of aetiopathogenesis.[29] In the first case, i.e. the bottom-up approach, biological processes, including, for example, neurotransmitter secretion disorders, are the cause of mental states such as low mood and anxiety. In the second situation, i.e. the top-down approach, a mental state, such as a feeling of hopelessness or anxiety, causes specific consequences in the functioning of the body, including various types of vegetative symptoms. These phenomena can interact with each other in a spiral manner, therefore leading to the development of disorders. Adopting this interpretation of the etiopathogenesis of depressive disorders, it can be assumed that they may already be present in the youngest age group, where bottom-up mechanisms will trigger the pathological process. Therefore, the presence of such disorders cannot be ruled out even in the youngest age group.

It is currently widely accepted that disorders in childhood and later in adolescence are early manifestations of disorders occurring in adulthood. The specificity of disorders in earlier stages of development is limited to atypicality and clinical ambiguity of the disorder.[30] Assuming that depression is essentially the same construct throughout development, similar or even identical causes should underlie the disorder at any age. Hence, most research on the aetiology of depressive disorders in children is based on extending theories developed to explain depression in adults. Empirical research to date suggests that the following groups of factors are important in this regard: genetic determinants, neurobiological factors, and within these: psychoneuroendocrinological determinants related to neurotransmitters, brain structure and function, and sleep disorders. In addition, stressful life events, negative cognitive patterns, problems with self-regulation, and the specifics of interpersonal relationships, as well as interactions between these factors, are also important.[31]

It is also worth noting additional possible factors contributing to the onset of depressive disorders in children and adolescents with disabilities. In the case of children with neurodevelopmental disorders in the form of intellectual disabilities, four different variants contributing to the co-occurrence of mental disorders are proposed.

Robert Goodman and Stephen Scott[32] indicate four possible variants justifying the co-occurrence of intellectual disability and mental disorders, including depressive disorders. It should be noted that each of these variants is possible in different cases, so one person may have variant "A", while another may have variant "B", "C" or "D."

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[29] M.E.P. Seligman, E.F. Walker, D.L. Rosenhan, *Psychopatologia*, Poznań 2017, p. 22.

[30] J. Bomba, *Depresja młodzieńcza*…, pp. 266–279.

[31] J. Garber, K.M. Gallerani, S.A. Frankel, *Depression in Children* [in:] *Handbook of depression*, eds. I.H. Gotlib, C.L. Hammen, New York 2009, pp. 405–443.

[32] R. Goodman, S. Scott, *Child and Adolescent*…, pp. 236–237.

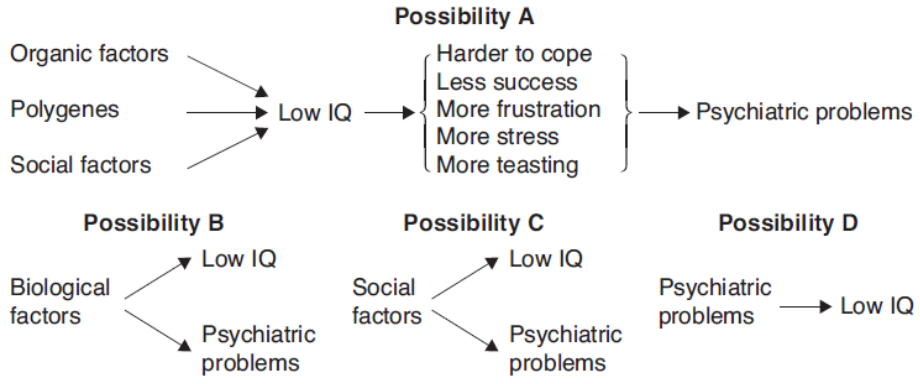

Figure 1. Why are intellectual disability and psychiatric disorder associated?

Source: R. Goodman, S. Scott, *Child and Adolescent Psychiatry*, Oxford 2012, p. 236.

Additional factors contributing to the development of depressive disorders in children and adolescents with sensory disabilities (visual and hearing) include, above all: the experience of disability itself, a frequent sense of loss (trauma), especially in the case of acquired hearing and visual impairments, and a sense of varying degrees of oppression, understood as experiencing the social consequences of disability, such as stigmatisation, discrimination, marginalisation, exclusion, suffering, violence, exploitation, and, in addition, increased restrictions on leaving the home, which results in limited social contact. It can therefore be assumed that in the case of people with impaired vision or hearing, the above-mentioned categories of secondary effects of disability may increase the subjective sense of disability and be a source of negative emotions and long-term distress, which in turn correlate with depressive disorders.[33]

Therefore, depressive disorders in children and adolescents with disabilities, apart from common factors such as those found in the general population, also have additional factors that increase the predisposition to the onset and development of these disorders.

Conclusion

Due to the significant prevalence of depressive disorders among children and adolescents, both able-bodied and disabled, it is necessary to take remedial action. In addition to traditional solutions such as psychotherapy and pharmacotherapy, it is worth supplementing any type of support provided with psychoeducation. Psychoeducational classes addressed not only to those directly affected, but also to their

[33] D. Podgórska-Jachnik, *Problem depresji*…, p. 132.

families and friends, currently constitute the third pillar of therapy. Currently, it is recommended that the treatment of depressive episodes in children and adolescents should begin with non-pharmacological measures and, if possible, be limited to psychoeducation and psychotherapy.[34] In the case of mild depressive symptoms, the main methods of intervention are psychoeducation and psychosocial support, which limit the impact of environmental stressors, and physical activity is also recommended.[35]

Therefore, contemporary treatment of depressive disorders in children and adolescents is based on three fundamental pillars: psychoeducation, psychotherapy and pharmacotherapy. It should be emphasised that non-pharmacological treatment, mainly in the form of psychoeducation and psychotherapy, is the first-line treatment and, in many cases, especially those involving mild disorders, it is sufficient.

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[34] L. Popek, B. Remberk, *Zaburzenia depresyjne u dzieci i młodzieży* [in:] *Psychiatria dzieci i młodzieży*, Vol. 1, eds. M. Janas-Kozik, T. Wolańczyk, Warszawa 2022, pp. 488–493.

[35] F. Rybakowski, *Zaburzenia depresyjne, choroba afektywna jednobiegunowa* [in:] *Zaburzenia psychiczne dzieci i młodzieży*, eds. A. Gmitrowicz, M. Janas-Kozik, Warszawa 2018, pp. 123–129.

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