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Depression in children and adolescents

Agnieszka Słopień https://orcid.org/0000-0001-7821-8972

Department of Child and Adolescent Psychiatry at the Poznań University of Medical Sciences

Address for correspondence: Klinika Psychiatrii Dzieci i Młodzieży, Szpitalna 27/33, 60-572 Poznań, asrs@wp.pl

Abstract

In recent years, the situation of child and adolescent psychiatry in Poland has dramatically deteriorated. 24-hour psychiatric wards dedicated to minors are overcrowded and it is almost exclusively patients who are a direct threat to their own health or life that are hospitalised. About 20% of children and adolescents have symptoms of various mental disorders, of which 10% (about 400,000) require specialist care. Depression is one of the most common health problems among children and adolescents and its prevalence increases with age and puberty. Depression can be chronic, with constant severity, or recurrent, when symptoms return in the form of mild, moderate or severe episodes. The mood disorders occurring in the developmental period carry many negative consequences in the emotional, social and educational functioning of the patient. They increase the risk of self-destructive behaviours, suicide, abuse of psychoactive substances, as well as later difficulties in many areas of life during adulthood.

Key words: **children and adolescents, depression, mood disorders**

Słowa kluczowe: **depresja, dzieci i młodzież, zaburzenia nastroju**

Ministerstwo Nauki i Szkolnictwa Wyższego

Przygotowanie do wydania elektronicznego finansowane w ramach umowy 637/P-DUN/2019 ze środków Ministerstwa Nauki i Szkolnictwa Wyższego przeznaczonych na działalność upowszechniającą naukę.

Introduction

In recent years, the situation of child and adolescent psychiatry in Poland has dramatically deteriorated. 24-hour psychiatric wards dedicated to minors are overcrowded and it is almost exclusively patients who are a direct threat to their own health or life that are hospitalised. In other situations, the waiting time for admission to hospital ranges from 7 to 720 days [1, 2]. The number of specialists in child and adolescent psychiatry is still low and amounts to approx. 419. The fact that the specialisation was included in the list of priority specialisations has not significantly increased the interest in this field of education. Therefore, per 1 (child and adolescent) psychiatrist there are about 1,000 people in mental crisis aged 18 or below, which more than doubles the recommendations of the World Health Organization. In 2018, the Minister of Health appointed a team for mental health of children and adolescents, whose tasks include preparation of recommendations concerning improvement of care of children and adolescents in psychiatric health care. However, the effects of the introduced changes are not to be seen for the next few years. As of now, the waiting time for psychiatric, psychological and psychotherapeutic consultations is very long. That is mainly why more and more often young people in mental crisis are reported to family doctors or paediatricians, school counsellors or psychologists. For these reasons, basic knowledge of the symptoms, causes, risks and management practices of patients is becoming essential for an increasing number of professional groups that come into contact with children or adolescents and their families.

About 20% of children and adolescents have symptoms of various mental disorders, of which 10% (about 400,000) require specialist care [3]. The growing prevalence of depressive disorders in children and adolescents and their often serious consequences are a significant medical problem. Depression is one of the affective disorders (moods), which can be chronic, with constant severity, or recurrent, when symptoms return in the form of mild, moderate or severe episodes. *The Manual of International Statistical Classification of Diseases and Related Health Problems*, currently in its 11th edition, ICD-11 [4] and the *Diagnostic and Statistical Manual of Mental Disorders* [5] list a number of items with depressive symptoms, including: depressive episode, recurrent depressive disorders, bipolar disorder, dysthymia, mixed depression and anxiety disorders, adjustment disorders

and post-traumatic stress syndrome. These disorders differ in etiology, clinical picture, intensity of symptoms, course, prognosis, but also in therapeutic needs. It should be remembered that depressive symptoms may also accompany or precede characteristic symptoms of mental disorders and diseases (e.g. schizophrenia), as well as be caused by somatic issues (e.g. autoimmune diseases, hypothyroidism, CNS damage) or medication (e.g. steroids).

Epidemiology

Depression is one of the most common health problems among children and adolescents and its prevalence increases with age and puberty [6]. Among teenagers aged 13–18, the incidence of depression ranges from 2.9 to 5.8% [7], while lifetime prevalence ranges from 11.7 to 20.4% [8]. It is estimated that the prevalence of MDD (major depressive disorder, according to DSM-5) among children in the prepubertal period is 1–2%, and in adolescence 5–8% [9]. However, in recent years we have observed a worrying decline in the age of the onset the disease and serious consequences of depression in the younger age group below 13 years of age. MDD in children is equally common in both sexes, whereas in adolescence, similarly as in adulthood, higher morbidity is observed in girls and women. This may be related to hormonal, neurobiological and socio-cultural differences in the development of both sexes [10]. Early in life, the disease is at a high risk of relapse. On average, half of children and adolescents experience second (or subsequent) episodes of depression before the age of 18, and in many of them recurrent depressive disorder (RDD) [11] is present in adulthood. This is particularly the case with multiple risk factors. These include family mood disorders, co-occurring neurodevelopmental or mental disorders, negative cognitive style, or unfavourable life experiences.

Another disease in which depressive symptoms are observed is the persistent depressive disorder (PDD). Its prevalence in childhood is 0.6–1.7%, whereas in teenage years it amounts to 1.6-8%. In the course of dysthymia, the mood is mildly or moderately reduced. The disorder is diagnosed and treated only when depressive symptoms intensify and meet the criteria of a depressive episode. The majority of patients with the onset of dysthymia before 21 years of age experience MDD during their lifetime [12].

The DSM-5 classification for the first time presents the criteria of disruptive mood dysregulation disorder (DMDD) in children and adolescents, in which irritability and anger eruptions are the dominant symptom. The prevalence of DMDD is about 2–5%. This disorder most often occurs in school-age boys between 6 and 18 years of age, and its occurrence increases the risk of developing depressive or anxiety disorders in adulthood [5].

Depressive symptoms are also observed in the course of the bipolar disorder. Its very early onset is when the symptoms appear before 13 years of age, and its early onset when the first symptoms appear before 18 years of age [13]. The risk of developing bipolar disorder between 14 and 18 years of age is 0.94–0.99%, while below 10 years of age it reaches 0.3–0.5% [14]. The most important risk factors for the development of disorders in childhood include family history of affective disorders and attention deficit hyperactivity disorder (ADHD).

Causes, clinical picture and course

The causes of depressive disorders are complex and depend on the interaction of many variables, including genetic, family, and personality factors, as well as experiences acquired throughout the patient's life. Population studies show that the incidence of depression in parents increases threefold the risk of depression in their offspring. Almost half of the parents of teenagers with depressive symptoms were treated for various mental disorders [10]. Genetic and environmental factors play an important role in the development of depressive disorders. The gene-environment interaction may explain the important role of the former in the development of depression and anxiety predisposition, which results in a greater sensitivity to stress factors.

Family factors influencing the emergence of depressive disorders include: chronic mental illness of the caregiver, or any other chronic illness, conflicts within the family, low socio-economic status, death of the caregiver(s), physical and psychological abuse, sexual abuse, neglect, abuse of psychoactive substances by parents, distrustful bond with parents (related e.g. to their unavailability or insufficient sensitivity to the child's needs), negative parental attitudes (cold, rejective, controlling), lack of support, and disorganization of family life [15].

Other factors that may contribute to the development of depressive disorders are the psychological properties of young people. These include high levels of anxiety, low self-esteem, self-criticism, perfectionism, cognitive distortions, negative attributional style, poor school achievement or insufficient social skills.

The cause of depressive symptoms appearing in the course of adjustment disorders or post-traumatic stress syndrome are stressful life events, which may also have a triggering effect on affective disorders (depressive episode, recurring depressive disorders or bipolar affective disorders) in most patients. These include the death of a parent/family member/guardian/friend, parents' divorce, suicide of a close person, loss of relationship with a person important for the young person, physical and psychological abuse by peers or adults, sexual abuse. More and more often children (even the youngest ones between 7 and 10 years of age) and adolescents use various forms of psychological abuse, insults, humiliation against each other, e.g. by taking denigrating photos or videos and posting them on social networking sites, setting up false accounts and impersonating the bullied person. Children are bullied or humiliated by their peers when they are children who do not stand out in the group in any special way, and are consequently teased by peers, older or younger children, boys and girls alike. Neither learning outcomes nor material situation differentiates

the environment of the victims and perpetrators. Aggression can affect any child. However, any type of 'otherness', or weakness, is conducive to finding oneself in the role of a victim. "One scathing remark is enough. Cyberbullying is one of the main causes of depression and suicide among schoolchildren. If you have a smartphone, use it with caution. Don't kill anyone's self-esteem" (UNICEF). Based on the nationwide diagnosis of the scale and determinants of child abuse carried out on a representative group of children and youth aged 11–17 ($N = 1155$), it follows that 16% of children were mutilated, 7% attempted suicide, 7% had no person to turn to in a difficult situation, 15% of children lived with a family member who abused alcohol, and 5% lived with a family member who had attempted suicide (Empowering Children Foundation 2018) [2].

The first episode, but often also the following ones, of the bipolar disorder and recurring depressive disorder can be triggered by various psychological, social and biological factors. Strong or prolonged stress may be associated with negative events, but also with positive ones. These include mourning, experiences of rejection and separation, failures in relationships with peers, somatic disease, sleep deprivation, but also life successes and falling in love. However, a good pre-existing adaptation is considered a factor alleviating the impact of stress, and so exerting some influence on the course of the bipolar disorder or recurring depressive disorder [5, 16].

The affective disorders occurring in children and adolescents are diagnosed on the basis of the same diagnostic criteria that we use in diagnosing adults. However, especially in children under 10–12 years of age, the clinical picture of mood disorders is different from that observed in adolescents or adults. Depressive symptoms occurring in children, but also in teenagers, do not always indicate a depressive episode, because we often find them in the course of mixed behavioural and emotional disorders, post-traumatic stress syndrome, adjustment disorders or abnormally formed personality. Depression may take the form of a single episode (major depressive disorder, MDD), recurrent depressive disorders (several depressive episodes; RDD) or dysthymia (persistent depressive disorder, PDD; in persons below 18 years of age – monotonous, shallow mood reduction or irritability lasting at least 1 year. For many years it was believed that due to the immaturity of mental processes, serious mood disorders did not occur in the discussed age group. In 1946, Spitz described the so-called anaclitic depression in children under the age of 1, which was associated with separation from the loved ones and placement in a care facility [17]. At present, there is a dominant opinion that separating children before the age of 5 from people important to them causes despair, considered in the past as an indicator of depression and now understood as a manifestation of adjustment disorders with a depressive component [16]. The manifestation of depressive symptoms depends on the stage of development of the child. The younger the patient, the less typical the symptoms are. In contrast to adults, children and adolescents are dominated by irritable rather than depressive mood, which is reflected in the current classifications. Younger children often find it difficult to describe their emotional state, and so it is important to observe their behaviour and functioning. A child can easily fall into anger or despair, show their hostility towards the environment, in this way discouraging others from making contact with them. He or she often refuses to attend school, withdraws from playing, and their academic performance deteriorates. Disturbances of sleep and appetite in the course of depressive disorders are usually less frequent in children under 10–12 years of age than in adolescents and adults, but lack of expected weight gain may be observed. Guilt and hopelessness are less common in younger children than in adolescents and adults. According to many authors, the clinical picture of depression in children is characterized by numerous somatic complaints, e.g. abdominal pain, headaches. In the course of a depressive episode observed in children, suicidal plans and intentions less frequently lead to death (actual suicides) than in the case of adolescents [16]. Psychotic symptoms in the course of depressive disorders in children are rarely observed, but they may occur in adolescents. In this case, we observe symptoms both in line with the mood (e.g. depressive delusions) and out of line with the mood (more common in schizophrenia). This is the reason for the erroneous classification of symptoms and initial diagnosis of schizophrenia in a young person (according to literature, an average of 30% of first occurrences of the disease). In 20–40% of teenagers with symptoms of severe depressive episode, especially with psychotic symptoms, a manic or hypomanic episode occurs most often within 5 years, which results in the diagnosis of the bipolar disorder [18]. The appearance of MDD before the age of 12 is associated with a high risk of the bipolar disorder in the future [19].

Depressive disorders in adolescents often occur in the form of atypical depressive syndrome. Its symptoms include: excessive sleepiness (hypersomnia), increased appetite and significant weight gain, feeling of heaviness in the limbs, and sometimes also psychomotor arousal [20]. Adolescents more often than children perceive themselves, their past and future negatively and manifest self-destructive behaviours. The risk of suicide attempt is very high in this age group, especially among girls. According to some authors, seasonal depressive disorders are rarely diagnosed in the developmental period, whereas children and adolescents develop mild depressive symptoms quite often in winter.

The bipolar disorder in the developmental period most often begins in boys with a manic phase (bipolar disorder – type I) or hypomaniacal phase (bipolar disorder – type II), whereas in girls with a depressive episode. There are no separate diagnostic criteria for people under 18 years of age. This developmental period is conducive to the development of incomplete symptoms of mania or depression, more frequent diagnosis of type II disorders (hypomaniacal and depressive episodes) or cyclothymia. Particularly often, even in 81% of patients, the course is observed with rapid cycling (4 episodes per year), ultra rapid cycling (5–365 episodes per year), or

ultradian (phases change during the day, last 4 or more hours) [21]. Teenagers in particular have a high suicide risk of 19–20%. At preschool and younger school age (up to 12 years old), more psychosomatic symptoms are usually found in the course of a depressive episode. Above the age of 15, depression is similar to that observed in adults. In some patients we observe various prodromal symptoms (atypical symptoms occurring before the onset of the typical symptoms of the disease), which include anxiety, short-term mood disorders, irritability, feeling of energy loss or intensification, disorders of control of impulses. A manic episode in children is characterized by variability of manifested symptoms, such as: increased mood, disordered thoughts, increased psychomotor drive. Imprudent behaviours take the form of fights, school negligence, dangerous games and inappropriate sexual activity (in the youngest children it may be e.g. touching intimate areas of adults). In adolescents, more often than in adults occur psychotic symptoms, mental disorders, significant deterioration of functioning and mixed features (e.g. during a depressive episode there are at least 3 out of 7 manic symptoms). The different picture of the disease in children and adolescents makes it difficult to make a correct diagnosis in this age group.

The diagnosis of disorders with destructive mood regulation is made in the case of intense and repeated outbursts of anger (temper outbursts) manifested verbally and/or through behaviour (e.g. physical aggression towards people or objects), which are inadequate in their intensity, proportion or duration to the stage and level of development, as well as the situation or stimulus that caused them. Outbursts of anger occur on average three or more times a week. The mood between them is irritable or angry for most of the day, almost daily, and is noticed by parents, caregivers, peers or teachers. Symptoms must be present for one year or more, observed in at least two environments, and between them there must not be a 3-month or longer period without symptoms [5].

Self-destructive behaviour, suicide

Self-destructive behaviour is a significant problem in the age group below 18 years of age, both in the course of depressive disorders and in the case of abnormally formed personality. Self-aggression is an action or a series of actions aimed at causing psychological or physical harm to oneself. In the case of direct self-aggression, patients hurt themselves in various ways, cut the skin with various objects (e.g. nails – causing 'scratches'), bite cheeks, pour acid over the skin or wounds made earlier (in order to feel pain for a longer period of time), rub the skin with an eraser, hit themselves. In indirect auto-aggression, patients force or provoke others to use aggression against them. This includes conscious careless driving, going into dangerous places at night, endangering one's life and health (including, for example, not following the doctor's instructions). Sometimes patients themselves cause various ailments and simulate symptoms of many diseases. Self-injurious behaviour has a number of functions. In this way, patients try to regain control 'over their lives', events and relationships. Many times they report that it is the only way to perceive reality more strongly, because they usually feel empty. In this way they also try to attract the attention of other people, 'call for help', in the case of depression, loneliness, misunderstanding, anxiety, fear, helplessness, lack of support, problems at home, with peers, cyber-violence. These behaviours also result from an inadequate sense of guilt and impact on a given event, e.g. parents' divorce. In this way young people punish themselves for being insufficiently perfect, for being bad, for causing trouble to someone they love, for letting others hurt them. Self-aggression can also be a punishment for others for hurting the patient. Self-aggression initially brings emotional relief to patients, replacing 'mental pain with physical pain', but often repeated, this way of coping with difficulties leads to the perpetuation of the behaviour. In this case, self-injurious behaviour ceases to have its original function, but becomes a compulsion, and the failure to perform it begins to bring suffering.

Suicidal behaviour covers all phenomena from suicidal thoughts, suicide threats, and suicide attempts to committed suicides. A suicide attempt is an attempt to commit suicide that includes activities that can lead to death. According to the WHO definition, suicide is "a deadly act that the deceased person, knowingly and with the expectation of such an effect, planned and executed herself/himself". The risk of suicide attempts in the course of depressive disorders is very high, especially among girls. However, suicide is more common among boys.

Suicides occur in every age group, but it is rare in small children. The frequency of suicides increases rapidly with age, reaching a peak between 19 and 23 years of age. They are one of the most common causes of death in the developmental period and the fourth main cause of death in children between 5–14 years of age, and the third in the 15–24 age group [22].

According to police statistics, the suicide rate in Poland is steadily increasing. The number of deaths in Poland in the 15–19 age group is one of the highest in the European Union. On average, there are 10 suicides per 100,000 people. We are currently ranked 2nd in Europe in terms of the number of suicides committed in the age group below 18. Unfortunately, in recent years in Poland we have observed a decrease in the age of juvenile suicides. This resulted in the introduction of the age group of 7–13 into the police statistics, which means that suicides of 7-year-old children were recorded [2]. It should be remembered that police statistics do not fully reflect the number of deaths caused by suicide.

Treatment

Psychotherapy, pharmacotherapy and psycho-education of patients and their families should be included in the treatment of depressive disorders in children and adolescents. The primary aim of the treatment is to alleviate symptoms, but equally important are interventions aimed at shaping peer relationships, coping with stress, and building a positive image of oneself. It is also

important to consider coexisting mental and somatic disorders in management. The choice of treatment method (psychotherapy or pharmacotherapy) should take into account the severity of symptoms and the resulting risks (suicidal plans and intentions, psychotic symptoms), as well as the age of the child. The basic methods of treatment, especially in the case of mild depression, minor disorders of the child or teenager's functioning and in the youngest patients, are non-pharmacological interactions – psycho-education and psychotherapy. During psycho-education, patients and their parents/guardians are provided with information on symptoms, their causes, treatment methods, undesirable effects of the drugs used and methods of management in relapse situations.

In the event of violence, you should always react and never be passive. This also applies to young people who are often afraid to react because they do not want to become the victims. Often the key people are the witnesses of violence, who are the most likely to change the situation and stop it. Young people often do not realise how much depends on them and their reaction to the violence that happens to them or their peers. They often forget that persistent harassment is not without legal consequences, it is a punishable act, and juveniles may be subjected to educational or corrective measures.

Psychotherapy can be carried out in the form of individual, group or family therapy. The latter plays a very important role in the psychotherapy of children and adolescents due to the specificity of the patient's functioning in the family system. Group psychotherapy is especially recommended for people experiencing difficulties in social relations. Cognitive behavioural therapy (CBT) is an effective form of psychotherapy for mood disorders. It is based on the assumption that emotions and behaviour are largely the result of a patient's abnormal beliefs, and their change may affect their better functioning. In severe depression, the combination of CBT and pharmacotherapy is the fastest and most effective solution [23].

Pharmacotherapy should be considered when the intensity of symptoms makes it difficult for the child to function and the psychotherapeutic effects alone do not bring sufficient results. However, pharmacological treatment is necessary when the symptoms of depression are so severe that they make it impossible to start psychotherapy, depression occurs in the course of bipolar disorder, when it is accompanied by psychotic symptoms, and when there is a high risk of suicide [24].

The most commonly used antidepressants in children and adolescents are selective serotonin reuptake inhibitors (SSRI). They are relatively well tolerated, and side effects are usually not very severe and resolve within a dozen or so days of treatment. Fluoxetine 20 mg/day seems to be well tolerated and effective in the treatment of MDD in children and adolescents in outpatient conditions, as confirmed by controlled, randomized placebo studies [25]. Fluoxetine is also the only SSRI group drug registered for the treatment of depression in children under 18 years of age and recommended by the Food and Drug Administration (FDA). The use of any other SSRI medicine requires the written consent of the child's guardian. Because of the higher risk of side effects (especially cardiotoxicity), tricyclic antidepressants (TLPDs) are used less frequently. For bipolar disorders, mood stabilisers (valproate, carbamazepine, lithium, lamotrigine) are the basis for treatment, and antidepressants or antipsychotics are used if symptoms are severe.

Prognosis

The prognosis of depression depends on a number of factors, including the developmental phase, severity of symptoms and duration of the disorder. The younger the age of the person experiencing the onset of the disease and the more chronic and recurrent nature of the disorder, the greater the impact on the overall development of the child. Persistent symptoms of depression affect i.a. the patient's self-esteem, personality development, acquisition of information about the surrounding world and social functioning. In the case of depressive symptoms accompanying behavioural disorders, the risk of criminal behaviour in adulthood increases. In the case of mood disorders, the risk of suicide increases. In some patients, anxiety, excessive fatigue, attention deficit, difficulty in making decisions, guilt and persistent thoughts of death may persist despite the improvement in mood. The factors worsening the prognosis include worse pre-existing adaptation, low intellectual capacity of the patient, and consequently worse stress management skills, rapid phase change, psychotic symptoms, as well as poor family functioning. Very often, the course of depression is complicated by the co-occurring mental disorders, including: ADHD, eating disorders, behavioural disorders, abuse of psychoactive substances, obsessive-compulsive disorders, or anxiety disorders. The above mentioned factors may influence the deterioration of prognosis, the shortening of remission, longer treatment, worse response to drugs, greater recurrence, worse cooperation, as well as worse quality of life of patients. Due to the above information, it is important to pay attention to symptoms appearing in a young person (often only behavioural changes) and to take appropriate early therapeutic measures to counteract the delayed effects of affective disorders.

Summary

The mood disorders occurring in the developmental period carry many negative consequences in the emotional, social and educational functioning of the patient. They increase the risk of self-destructive behaviours, suicide, abuse of psychoactive substances, as well as later difficulties in many areas of life during adulthood. The care provided currently for children and adolescents is insufficient. At every level, from prevention of mental disorders to hospital care, there is a lack of specialists, appropriate programmes and centres, adequate funding and coordination of all activities. The planned reform envisages improvements in all these areas. However, these changes will still be insufficient if we do not deepen our knowledge of the causes of the increasing number of patients requiring such care.

References

1. Maślankiewicz R., Bójko M., *Raport Watchdoga – Jak źle jest w polskiej psychiatrii dzieci i młodzieży?*, 2019; https://siecobywatelska.pl/raport-watchdoga-jak-zle-jest-w-polskiej-psychiatrii-dzieci-i-mlodziezy/ (accessed: 23.08.2019).
2. Szredzińska R., *Dzieci się liczą. Raport o zagrożeniach bezpieczeństwa i rozwoju dzieci w Polsce*, "Dziecko Krzywdzone. Teoria, Badania, Praktyka" 2017; 16 (1): 112–117.
3. Kieling C., Baker-Henningham H., Belfer M., Conti G., Ertem I., Omigbodun O., Rohde L.A., Srinath S., Ulkuer N., Rahman A., *Child and adolescent mental health worldwide: Evidence for action*, "Lancet" 2011; 378 (9801): 1515–1525.
4. *Manual of the International Statistical Classification of the Diseases and Related Health Problems, 10th Edition*, World Health Organization, Geneva 2002.
5. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), American Psychiatric Association, Washington, DC 2013.
6. Costello E.J., Mustillo S., Erkanli A. et al., *Prevalence and development of psychiatric disorders in childhood and adolescence*, "Arch. Gen. Psychiatry" 2003; 60: 837–844.
7. Olsson G.I., von Knorring A.-L., *Adolescent depression: prevalence in Swedish high-school students*, "Acta Psychiatr. Scand." 2007; 99: 324–331.
8. Merikangas K.R., Jian ping-He, Burstein M. et al., *Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A)*, "J. Am. Acad. Child Adolesc. Psychiatry" 2010; 49: 980–989.
9. Jellinek M.S., Snyder J.B., *Depression and suicide in children and adolescents*, "Pediatr. Rev." 1998; 19: 255–264.
10. Richardson L.P., Katzenellenbogen R., *Childhood and adolescent depression: The role of primary care providers in diagnosis and treatment*, "Curr. Probl. Pediatr. Adolesc. Health Care" 2005; 35 (1): 6–24.
11. Birmaher B., Arbelaez C., Brent D., *Course and outcome of child and adolescent major depressive disorder*, "Child Adolesc. Psychiatr. Clin. N. Am." 2002; 11 (3): 619–637.
12. Klein D.N., Schwartz J.E., Rose S., Leader J.B., *Five-year course and outcome of dysthymic disorder: A prospective, naturalistic follow-up study*, "Am. J. Psychiatry" 2000; 157 (6): 931–939.
13. McClellan J., Werry J., *Practice parameters for the assessment and treatment of children and adolescents with bipolar disorder*, "J. Am. Acad. Child Adolesc. Psychiatry" 1997; 36 (1): 138–157.
14. Lewinsohn P.M., Klein D.N., Seeley J.R., *Bipolar disorders in a community sample of older adolescents: Prevalence, phenomenology, comorbidity, and course*, "J. Am. Acad. Child Adolesc. Psychiatry" 1995; 34 (4): 454–463.
15. Greszta E., *Rodzinne czynniki ryzyka rozwoju depresji u dorastających*, "Psychiatr. Pol." 2006; 4: 719–730.
16. Rabe-Jabłońska J., *Zaburzenia afektywne u dzieci i młodzieży*, in: Pużyński S., Rybakowski J., Wciórka J. (eds.), *Psychiatria. Psychiatria kliniczna*, Elsevier Urban & Partner, Wrocław 2011: 377–380.
17. Spitz R.A., *Anaclitic depression: An inquiry into the genesis of psychiatric conditions in early childhood*, "Psychoanal. Study Child" 1946; 2: 313–342.
18. Namysłowska I., *Zaburzenia psychiczne dzieci i młodzieży. Wybrane zagadnienia*, Polskie Towarzystwo Psychologiczne, Kraków 2000.
19. Benazzi F., *Is there a link between atypical and early-onset "unipolar" depression and bipolar II disorder?* "Compr. Psychiatry" 2003; 44 (2): 102–109.
20. Carr A., *Depresja i próby samobójcze młodzieży. Sposoby przeciwdziałania i reagowania*, Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2004.
21. Geller B., Zimerman B., Williams M., Bolhofner K., Craney J.L., Delbello M.P., Soutullo C.A., *Six-month stability and outcome of a prepubertal and early adolescent bipolar disorder phenotype*, "J. Child Adolesc. Psychopharmacol." 2000; 10 (3): 165–173.
22. Heron M., *Deaths: Leading causes for 2010*, "Natl. Vital Stat. Rep." 2013; 62 (6): 1–96.
23. *Treatment for Adolescents with Depression Study (TADS) Team: Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression. Treatment for adolescents with depression study (TADS) randomized controlled trial*, "JAMA" 2004; 292: 807.
24. Lambert M., Niehaus V., Correll C., *Pharmacotherapy in children and adolescents at clinical-high risk for psychosis and bipolar disorder*, "Pharmacopsychiatry" 2016; 49 (6): 229–244.
25. Emslie G.J., Heiligenstein J.H., Wagner K.D. et al., *Fluoxetine for acute treatment of depression in children and adolescents: A placebo-controlled, randomized clinical trial*, "J. Am. Acad. Child Adolesc. Psychiatry" 2002; 41 (10): 1205–1215.