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REVIEW ARTICLE

Depressive disorders in young people: phenomenology, prognostic features, and clinical outcome

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ABSTRACT

Depressive disorders with onset during adolescence and young adulthood are common, disabling, and often difficult to diagnose due to their heterogeneous and developmentally specific presentation. Compared with adult depression, young people more frequently display irritability, somatic complaints, and behavioural problems, which can obscure recognition and delay treatment. This narrative review aims to synthesize current evidence on depressive disorders in young people, while highlighting implications for treatment and prevention. The keywords ("youth" OR "adolescent" OR "childhood" OR "child" OR "young") AND ("depression" OR "depressive symptoms" OR "mood disorder" OR "depressed mood") were entered in the main databases and combined through Boolean operators. Findings confirm that youth depression presents with distinct clinical features and strong sociocultural influences, is frequently comorbid with other psychiatric disorders, and follows a recurrent and impairing course. Psychotherapy remains the most effective intervention, with selective serotonin reuptake inhibitors indicated for moderate-to-severe cases. Preventive and school-based strategies show promising results but are unevenly implemented. In conclusion, depressive disorders in young people require early detection and developmentally sensitive, multimodal treatment strategies. Future work should prioritize scalable interventions that integrate psychosocial, pharmacological, and digital tools, with special attention to prevention and to the influence of cultural and contextual factors.

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KEYWORDS
Youth depression; adolescent depression; youth mental health; developmental psychopathology; early onset depression

Introduction

Depressive disorders with onset during adolescence and young adulthood represent a major clinical challenge, given their high prevalence, early disruption of developmental trajectories, and strong association with chronic and recurrent illness across the lifespan (Zang, 2025). The precise age boundaries that define "youth" remain inconsistently applied across studies and diagnostic frameworks, with some considering adolescence as beginning around age 10 and others extending youth into the mid-twenties. This lack of uniformity complicates the comparison of epidemiological findings and may obscure developmental differences in onset and course (Zhang, 2025. While diagnostic frameworks are largely shared with adults, there are important developmental differences in presentation. For example, adolescents are more likely to present with irritability rather than overt sadness, alongside somatic complaints (e.g., headaches, abdominal pain) and academic or social withdrawal (Fusar-Poli et al., 2024; Menculini et al., 2024). Comorbidity is also particularly high, in particular with anxiety disorders, attention-deficit/hyperactivity disorder, and disruptive behaviour disorders, which often complicate diagnosis and treatment (Menculini et al., 2024).

In addition, the issue of diagnosis in this population deserves attention. As noted by Hankin and Griffith (2023), current diagnostic systems are largely derived from adult models and may inadequately capture youth-specific manifestations of depression. Widely used screening and assessment tools were not originally designed for adolescents, often failing to detect developmentally unique symptoms such as irritability, fluctuating mood, or interpersonal sensitivity (Hankin & Griffith, 2023). These limitations contribute to the under-recognition and diagnostic heterogeneity across clinical and research contexts.

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In younger populations, symptoms are often fluctuating, less specific, and strongly influenced by the social and developmental context, whereas adult depression more typically presents with sustained low mood, psychomotor alterations, guilt, and hopelessness (Racine et al., 2021). Another distinguishing feature is the long-term trajectory: depression that emerges in adolescence is more likely to recur, persist, and predict adverse outcomes across adulthood when compared with depression with later onset (Zang, 2025).

Youth depression has become a leading cause of disability worldwide. Global burden estimates show a continuous and steady rise in prevalence and disability-adjusted life years (DALYs) between 1990 and 2019 for depressive disorders in those aged 10–24, with the highest burden among females and late adolescents/young adults (20–24 years) (Zhang, 2025). Importantly, the COVID-19 pandemic magnified these concerns, with meta-analyses reporting prevalence rates of clinically elevated depressive symptoms reaching about 25%, meaning that one in four youths are affected by major depression. This is approximately twice the pre-pandemic levels (Racine et al., 2021; Ten Have et al., 2023).

The consequences extend beyond acute clinical impairment: depression in youth affects school performance, peer and family relationships and emotional development, and it is strongly associated with suicidal ideation and attempts – suicide is in fact the second leading cause of death in this age group globally (Zhang, 2025). Moreover, early-onset depression confers a higher risk of recurrence, chronicity, and comorbid psychiatric disorders across the lifespan, amplifying both personal suffering and societal costs (Menculini et al., 2024). Because of this combination of high prevalence, developmental vulnerability, and long-term consequences, youth depression is increasingly recognized as a critical target for clinical care and preventive strategies.

Despite its high prevalence and serious long-term consequences, youth depression remains a somewhat confusing and under-characterized entity in the literature. There is inconsistency in how the age range is defined, and differences from adult depression are not always clearly delineated (Menculini et al., 2024; Zhang, 2025). Furthermore, existing research tends to focus on specific domains, such as biological predispositions, psychosocial stressors, or developmental risk factors, without integrating these perspectives into a broader framework. Moreover, methodological variability, including inconsistent age boundaries, overlapping constructs, and limitations in diagnostic tools, further contributes to this fragmentation (Hankin & Griffith, 2023).

In this paper, we provide a synthesis of the literature on youth depression by highlighting different key areas. By weaving these domains together, we seek to clarify current knowledge, illuminate the unique features of depression during adolescence and young adulthood, and identify gaps that may guide future clinical innovation and research, also based on real-world clinical presentations.

Methods

We first performed a review to summarize and critically evaluate the current knowledge on youth depression. The process involved four main steps: definition of the problem, literature search, evaluation of relevant studies, and synthesis of findings.

The search terms ("youth" OR "adolescent" OR "childhood" OR "child" OR "young") AND ("depression" OR "depressive symptoms" OR "mood disorder" OR "depressed mood") were entered in PubMed, Scopus, Web of Science, PsycINFO, and Google Scholar, using the Boolean search technique to refine results. The literature search covered publications up to August 2025, with no lower time restriction, to include both classic and more recent works.

Articles were included if they were published in English and if they focused on depressive disorders in children, adolescents, and young people up to 25 years of age, addressing clinical features, risk factors, biological underpinnings, treatment, prevention, or burden of disease. Both original research and review articles were considered. Studies exclusively focusing on adult populations or unrelated psychiatric disorders were excluded. A total of nine key articles were used in the synthesis of results, including narrative and systematic reviews, meta-analyses, and major empirical studies addressing the phenomenology, risk factors, outcomes, and treatment of youth depression. The selected literature was critically examined and synthesized to highlight key findings and areas of ongoing uncertainty, with the aim of providing an updated overview of the clinical and research landscape regarding youth depression.

Results

The literature reviewed provides a multifaceted picture of youth depression, underscoring its complex clinical presentation, multifactorial origins, and significant personal and societal burden. Results are

presented across four main domains: the phenomenology of youth depression; risk factors and aetiopathogenesis; clinical outcomes and individual and social burden; and current approaches to treatment and prevention.

Phenomenology of youth depression

Core symptom domains in youth

Several studies confirm that the clinical presentation of depression in young people spans affective, cognitive, and somatic domains, often diverging from adult profiles. Liu et al. (2023) found that irritability was more frequently reported than sadness in children and adolescents, supporting its role as a core diagnostic feature in this age group. Negative self-referential symptoms, such as excessive guilt, hopelessness, and indecisiveness, were also observed across cohorts, together with cognitive impairments like reduced concentration, associated with academic decline and impaired decision-making (Menculini et al., 2024; Thapar et al., 2012).

Somatic and vegetative symptoms are also highly prevalent. According to Lovato and Gradisar (2014), up to 70% of adolescents with depression experience significant sleep disturbance, which was linked to greater symptom severity and suicidality. Liu et al. (2023) confirmed that both insomnia and hypersomnia were frequent early presentations. Changes in appetite and weight, in both directions, have been described by Allen et al. (2013) and more recently by Barone et al. (2023), who noted an overlap with emerging disordered eating. Psychomotor agitation and retardation were also documented (Liu et al., 2023).

Taken together, these findings indicate a marked clinical heterogeneity, underlining the diagnostic complexity of the disorder in this specific population.

Developmental specific symptoms

Several studies highlight that the expression of depression varies according to developmental stage. Liu et al. (2023) reported that in early adolescence depressive distress is more likely to manifest through externalising behaviours, including irritability, defiance, or somatic complaints, which can obscure recognition of the underlying disorder. By contrast, Klein et al. (2024) observed that, during late adolescence and emerging adulthood, presentations increasingly resemble the adult profile, with sadness, anhedonia, guilt, and suicidal ideation being more frequently endorsed.

Masked depression has also been documented across multiple cohorts. Liu et al. (2023) described adolescents presenting primarily with physical symptoms such as recurrent headaches, abdominal pain, or persistent sleep difficulties, which often resulted in referral to primary care rather than mental health services. Klein et al. (2024) further noted that behavioural manifestations, such as school refusal, irritability, or aggression, were commonly interpreted by parents and teachers as disciplinary problems, delaying an appropriate psychiatric evaluation.

Longitudinal studies have confirmed the prognostic implications of age of onset. Angold et al. (1999) reported that early-onset depression was strongly associated with a chronic and recurrent course; Thapar et al. (2012) added that older adolescents were more likely to display academic and social impairment, together with higher rates of suicidal ideation and number of attempts. These findings indicate that both the developmental stage and the initial presentation shape the recognition and long-term course of youth depression.

Contextual and culture-bound presentations

Digital environments have also been linked to emerging depressive patterns. Mukhra et al. (2019) examined the so-called *Blue Whale Challenge*, an online sequence of dangerous tasks culminating in suicide, and identified its role in exacerbating self-harm and suicidal behaviour among vulnerable adolescents. While relatively rare, the phenomenon illustrates the potential of online platforms to intensify maladaptive behaviours in those who are already at risk.

At a broader level, use of social media has been associated with depressive symptomatology in several population-based studies. Pedersen et al. (2023) found that rumination, negative self-comparison, and cyberbullying mediated the link between heavy social media engagement and depressive symptoms, supporting the role of digital culture as a negative reinforcing factor in adolescent vulnerability (Aboujaoude & Savage, 2023).

Substance use represents another recurrent contextual presentation. Wang et al. (2023) reviewed epidemiological data and concluded that depressed adolescents commonly use alcohol, cannabis, and stimulants as forms of self-medication. However, their use was consistently associated with increased symptom severity, higher risk of chronicity, and comorbidity with substance use disorders.

Together, these results suggest that, beyond traditional and known symptom profiles, youth depression may present through culturally and technologically mediated behaviours, complicating recognition and necessitating broader clinical awareness.

Prognostic features and risk factors

Youth depression emerges from the convergence of biological, psychological, and social vulnerabilities. Wang et al. (2023) confirmed that a family history of mood disorders is one of the strongest predictors of adolescent depression, reflecting both genetic liability and shared environmental exposures. Li et al. (2025) further reported that neurodevelopmental processes during adolescence, including pubertal hormone fluctuations and changes in brain maturation, interact with these pre-existing vulnerabilities to increase susceptibility (Cortese et al., 2023).

Several biological mechanisms are likely to be implicated. Wang et al. (2023) described how fluctuations in sex hormones during puberty influence serotonergic, dopaminergic, and glutamatergic systems, thereby altering mood regulation and stress sensitivity. Li et al. (2025) showed that subcortical structures involved in reward and threat processing mature earlier than prefrontal control regions, creating a temporary mismatch that heightens emotional reactivity. Imaging studies found disruptions in fronto-limbic connectivity in depressed adolescents, consistent with symptoms of sadness, irritability, and reduced capacity for pleasure (Li et al., 2025). Additional evidence linked atypical synaptic pruning and increased HPA axis reactivity to vulnerability, while inflammatory markers such as elevated cytokines are observed in subsets of depressed youth (Li et al., 2025; Wang et al., 2023).

Psychological factors also contribute meaningfully. Wang et al. (2023) found that depressive symptoms are predicted by maladaptive perfectionism, low self-esteem, and heightened sensitivity to criticism. Cognitive-affective styles such as dichotomous thinking and recurrent rumination were identified as mechanisms that maintain distress and amplify the impact of stressors. These findings were particularly salient in performance-oriented contexts; Sabik (2019) and Nesi & Prinstein et al. (2015) reported that adolescents linking self-worth exclusively to achievement were more likely to experience academic failure or social comparison as depressive triggers.

Environmental exposures interact with these vulnerabilities. Wahid et al. (2021) demonstrated that high academic pressure and performance expectations are associated with increased depressive symptoms, while Pedersen et al. (2023) showed that peer rejection, bullying, and cyberbullying contribute to symptom severity through chronic stress and impaired social belonging. Family-level adversities, including conflict, parental mental illness, and socioeconomic disadvantage, are also found to increase the risk (Wahid et al., 2021; Wang et al., 2023). Exposure to trauma and adverse childhood experiences, such as abuse, neglect, and witnessing domestic violence, emerged as particularly strong predictors, with longitudinal studies demonstrating persistent effects mediated by HPA axis sensitisation and disrupted attachment patterns (Pedersen et al., 2023).

Finally, digital-era influences have been increasingly examined as risk amplifiers. Wahid et al. (2021) reported that frequent social media use is linked to higher rates of depressive symptoms, with mechanisms including validation-seeking, social comparison, and exposure to online harassment. Late-night digital device use additionally disrupts sleep, which is a well-established risk factor for mood dysregulation (Firth et al., 2024). These results suggest that the digital environment not only introduces new stressors but also exacerbates pre-existing vulnerabilities, shaping both the onset and course of adolescent depression (Wasserman et al., 2023).

Clinical outcomes and burden

Epidemiological evidence consistently shows that depression is one of the most prevalent psychiatric conditions in adolescence. In a global meta-analysis of population-based studies, Racine et al. (2021) reported prevalence estimates around 25% for clinically significant depressive symptoms in youth. Liu et al. (2025) confirmed these figures in the Global Burden of Disease study, highlighting that rates rise steeply across adolescence. Gender differences were also observed: while prevalence is similar in boys and girls during childhood, females were found to be nearly twice as likely to develop depression from mid-adolescence onwards, a gap persisting into adulthood (Liu et al., 2025; Racine et al., 2021). Menculini et al. (2024) further noted that early-onset depression is associated with greater severity, higher comorbidity, and poorer functional outcomes compared to later-onset cases.

At the individual level, adverse outcomes are broad. Menculini et al. (2024) reported that academic decline is a recurrent consequence, with impaired concentration, absenteeism, and reduced motivation contributing to lower educational attainment. Mason et al. (2019) found that depressed adolescents were significantly more likely to engage in substance use, often as a maladaptive coping mechanism, which in turn exacerbated depressive symptoms and increased the risk of substance use disorders (Volkow et al., 2024). Suicidality is particularly concerning: Menculini et al.

(2024) summarised evidence showing that adolescent depression is linked not only to suicidal thoughts but also to earlier onset, higher frequency, and greater lethality of suicidal behaviours compared with other psychiatric conditions, positioning it as a central target for prevention efforts.

The chronic and recurrent course of adolescent depression has been documented in several longitudinal studies. Menculini et al. (2024) observed that adolescents with a first depressive episode had elevated risk of relapse and persistence into adulthood, often with comorbid anxiety and substance use disorders. These trajectories were associated with poorer occupational and social functioning, highlighting early-onset depression as a risk factor for long-term impairment (Mongan et al., 2023).

Beyond individual consequences, the societal burden is substantial. Liu et al. (2025) estimated that youth depression contributes significantly to healthcare utilisation, including emergency visits and psychiatric hospitalisations, as well as indirect costs related to school dropout, reduced workforce, and caregiver problems. These findings underscore that adolescent depression is not only a clinical challenge but also a major public health concern, demanding integrated approaches for prevention, early detection, and intervention.

Treatment approaches and prevention

The main areas of intervention for adolescent depression include psychotherapy and psychosocial interventions, pharmacological treatments, innovative digital approaches, and preventive strategies. Although each of these domains has been studied separately, increasing evidence suggests that the most effective management of youth depression relies on an integrated approach (March et al., 2004; Menculini et al., 2024). A synthesis of the main findings across psychotherapeutic, pharmacological, and preventive interventions is provided in Table 1.

Psychotherapy and psychosocial interventions

According to all trials and meta-analyses, cognitive-behavioural therapy (CBT) remains the most consistently supported first-line psychotherapy for adolescent depression, with adaptations that emphasise behavioural activation, cognitive restructuring, problem-solving, and relapse-prevention modules (Del Casale et al., 2021; Menculini et al., 2024). Interpersonal psychotherapy for adolescents (IPT-A), targeting role disputes, role transitions, and interpersonal deficits was indicated by comparative studies to have a similar efficacy to CBT, with particular benefit where interpersonal stressors and grief predominate (Menculini et al., 2024). Dialectical behaviour therapy for adolescents (DBT-A), originally developed for self-harm, has growing evidence for reducing depressive symptoms in youths with emotion-dysregulation and suicidality, especially when skills groups are combined with individual therapy and family involvement (Menculini et al., 2024).

Family-focused approaches (psychoeducation, communication/problem-solving training) improve engagement, adherence, and functioning, and are particularly useful when conflict, parental psychopathology, or low support are present (Branje, 2024; Del Casale et al., 2021; Menculini et al., 2024; Miklowitz, 2023). School-based programmes (from targeted CBT groups to whole-school mental-health education and resilience programmes) show small-to-moderate effects on depressive symptoms and help-seeking, with implementation quality and teacher training as key moderators (Del Casale et al., 2021).

Emerging peer-led and mentorship models can reduce stigma and increase uptake of support, although the evidence base is still developing and often embedded within broader school programmes (Menculini et al., 2024).

Pharmacological treatments

For moderate-to-severe depression, selective serotonin reuptake inhibitors (SSRIs) are recommended alongside psychotherapy. Fluoxetine and escitalopram have the most robust evidence and regulatory approval for adolescents. Response tends to be greater when they are combined with CBT/IPT (Menculini et al., 2024). Safety remains central: all antidepressants carry a warning for increased risk of suicidal thoughts/behaviours in youth, necessitating careful informed consent, close early monitoring (particularly in the first 2–4 weeks and following dose changes), and active safety planning (Menculini et al., 2024). Evidence on newer or rapid-acting options (e.g., ketamine/esketamine, glutamatergic modulators) in adolescents is preliminary; small studies suggest short-term symptom reduction in treatment-resistant cases, but data on durability and safety are limited and these approaches remain off-label or highly restricted in most settings (Ledesma-Corvi et al., 2024).

Innovative and digital interventions

Digital delivery of psychotherapy, psychosocial, and other interventions expands reach and adherence in

Table 1. Evidence on treatment approaches and prevention strategies for youth depression.

Approach	Findings	Strength of evidence	Sources
Psychotherapy and psychosocial interventions			
Cognitive-behavioural therapy (CBT)	Consistently associated with symptom reduction; moderate effect sizes	Moderate–High	Menculini et al. (2024); Del Casale et al. (2021)
Interpersonal psychotherapy for adolescents (IPT-A)	Comparable efficacy to CBT; particularly effective where interpersonal stressors are prominent	Moderate	Menculini et al. (2024)
Dialectical behaviour therapy for adolescents (DBT-A)	Reduces depressive symptoms and self-harm in small trials; requires replication	Moderate	Menculini et al. (2024)
Family-focused therapy	Improves adherence and outcomes in high-conflict families	Moderate-High	Del Casale et al. (2021); Menculini et al. (2024)
School-based programmes	Produces small-to-moderate symptom reductions; stronger effects in high-risk groups; quality of implementation crucial	Moderate	Del Casale et al. (2021)
Peer-led and mentorship initiatives	Pilot studies suggest reduced stigma and increased help-seeking, but evidence limited	Moderate	Menculini et al. (2024)
Pharmacological treatments			
Selective serotonin reuptake inhibitors (SSRIs: fluoxetine, escitalopram)	Fluoxetine and escitalopram effective; small increased risk of suicidality; fluoxetine FDA-approved	Moderate–High	Menculini et al. (2024); Ledesma-Corvi et al. (2024)
Combination treatment (CBT + SSRI)	Combination of CBT and SSRIs yields highest response/remission rates	Moderate–High	Menculini et al. (2024)
Novel pharmacological strategies (ketamine, esketamine)	Preliminary evidence of rapid but short-lived benefit; limited safety and durability data	Low–Moderate	Ledesma-Corvi et al. (2024)
Innovative and digital interventions			
Internet-delivered CBT (iCBT)	Small-to-moderate effects; stronger when guided by therapist; adherence limits unguided formats	Moderate	Menculini et al. (2024)
Teletherapy (video-delivered CBT/IPT)	Non-inferior to in-person therapy; improves access in underserved areas	Moderate	Menculini et al. (2024)
Mobile mental health apps	Improves self-monitoring and engagement; inconsistent impact on symptoms; quality heterogeneous	Low–Moderate	Menculini et al. (2024)
Prevention			
Universal prevention (school-based literacy, resilience)	Small reductions in symptoms and improved recognition of need	Moderate–High	Del Casale et al. (2021)
Selective prevention (children of depressed parents, bullied youth)	Larger effects in high-risk groups; CBT-based skills with parent components most effective	Moderate–High	Del Casale et al. (2021)
Indicated prevention (subthreshold depression interventions)	Brief interventions reduce progression to major depression	Moderate–High	Del Casale et al. (2021)
Community and parental involvement in prevention	Increases adherence and supports long-term outcomes	Moderate–High	Del Casale et al. (2021); Gladstone et al. (2011)
Digital platforms for prevention (psychoeducation, skills training)	Promising scalable option for psychoeducation and skills reinforcement	Moderate–High	Del Casale et al. (2021); Gladstone et al. (2011)

The strength of evidence column reflects a qualitative evaluation based on the methodological rigour and type of studies (e.g., randomized controlled trials, meta-analyses, pilot, or observational studies). When the source was a review, the quality and level of evidence of the references included in that review for each specific topic.

the young population. Therapist-guided and self-guided online CBT programmes demonstrate small-to-moderate effects on depressive symptoms, with guidance intensity and engagement driving outcomes; teletherapy (video-delivered CBT/IPT) shows non-inferiority to in-person care for many youths and improves access in underserved areas (Menculini et al., 2024). Mobile mental-health apps for mood tracking, behavioural activation, and skills practice are feasible adjuncts, even if heterogeneity in quality underscores the need for evidence-based, clinically integrated tools (Menculini et al., 2024).

Prevention

Preventive strategies operate at universal, selective, and indicated levels. Universal programmes in schools such as mental-health education, resilience training, problem-solving, and emotion-regulation programmes, yield small but meaningful reductions in depressive symptoms and improve the recognition of need (Del Casale et al., 2021). Selective prevention targeting high-risk groups (e.g., children of depressed parents, youth exposed to bullying or trauma) shows larger effects, particularly when CBT-based skills and parent components are included (Del Casale et al., 2021).

Indicated prevention for subthreshold depression, like brief CBT/IPT-informed interventions, reduces progression to major depressive disorder and can be delivered effectively in schools and primary care (Del Casale et al., 2021). Recent reviews emphasise the efficacy of multi-tiered systems that involve parents, teachers, and community organizations, with digital platforms used to diffuse psychoeducation and skills training and to maintain good results via booster sessions (Del Casale et al., 2021; Gladstone et al., 2011; Menculini et al., 2024).

Discussion and clinical experience

Our paper aimed to provide an updated synthesis of depressive disorders in the young population, focusing on phenomenology, prognostic features, and clinical outcomes. Findings consistently show that youth depression is a complex and heterogeneous condition, with developmentally specific features and strong sociocultural influences. These distinctive presentations, combined with frequent comorbidity, complicate recognition and contribute to diagnostic delays which, in turn, negatively affect prognosis and increase the likelihood of chronicity and recurrence into adulthood (Maalouf & Brent, 2012; Thapar et al., 2022).

Prognostic studies suggest both continuity and change: while many young people follow a recurrent course, developmental transitions often reshape symptom profiles, complicating the prediction of long-term outcomes (Rice et al., 2019). Risk factors are clearly multifactorial – biological, psychological, and social – but their interaction is insufficiently clarified, and robust predictors of poor outcome remain elusive (Patel et al., 2018). Clinical outcomes remain suboptimal, with persistent functional impairment even among those achieving symptomatic remission (Maalouf & Brent, 2012).

Evidence on treatment approaches indicates encouraging progress, though important challenges remain. Evidence supports psychotherapeutic, pharmacological, psychosocial, and emerging digital or innovative interventions. However, no single approach demonstrates unequivocal superiority. Instead, integrated and multimodal models appear most promising, aligning with a growing consensus that depression in young people requires coordinated, personalized, and developmentally sensitive care (Thapar et al., 2022). Yet, implementation in real-world settings is constrained by disparities in service availability, stigma, and limited preventive infrastructures.

The clinical experience supports recent evidence coming from the literature. In particular, young patients coming with emotional or relational difficulties, sleep or eating problems, or other externalizing (such as impulsivity) or internalizing (e.g., social withdrawal) behaviours are often affected by a masked depression. Thus, an in-depth clinical evaluation, exploring both antecedent and current factors that can explain the presence of an affective episode, is essential for a correct diagnosis and detailed treatment plan. An illustrative clinical vignette is reported in Figure 1.

Treatment should be initiated as soon as possible, in order to avoid treatment delays and long duration of untreated illness. The establishment of a good therapeutic relationship, particularly with young people, is very often the key for a successful therapy, whether it is pharmacological or psychosocial. Finally, preventive strategies can be extremely effective since most cases arise in particular situations, such as young people living in reformatories, migrants or others belonging to ethnic minorities, LGBTQI+, children of affected adults, and those who have been bullied or neglected.

Limitations

This paper has some limitations that should be acknowledged. First, the narrative style of the review does not guarantee exhaustive coverage of the literature and may be subject to selection bias. Second, most studies were very different in methodology, diagnostic criteria, and outcome measures, making direct comparison difficult. Third, the evidence base remains disproportionately weighted towards high-income countries, with fewer studies from low- and middle-income contexts where sociocultural factors may shape phenomenology and outcomes differently (Patel et al., 2018). Fourth, publication bias and the under-representation of negative or null findings in youth depression research may have skewed the available evidence. Finally, the clinical experience reported herein is based on one centre only and may not reflect the overall general practice.

Conclusion and future directions

Taken together, our paper indicates that depressive disorders in young people represent a multifaceted clinical and public health challenge. While considerable progress has been made in identifying clinical features, risk factors, and potential treatments, significant gaps remain. In particular, culturally bound syndromes and digital-age phenomena (e.g., hikikomori, online self-harm communities) remain under-studied and poorly integrated into existing care models (Maalouf & Brent, 2012; Kato et al., 2020). Further longitudinal and transdiagnostic studies are needed to disentangle the developmental

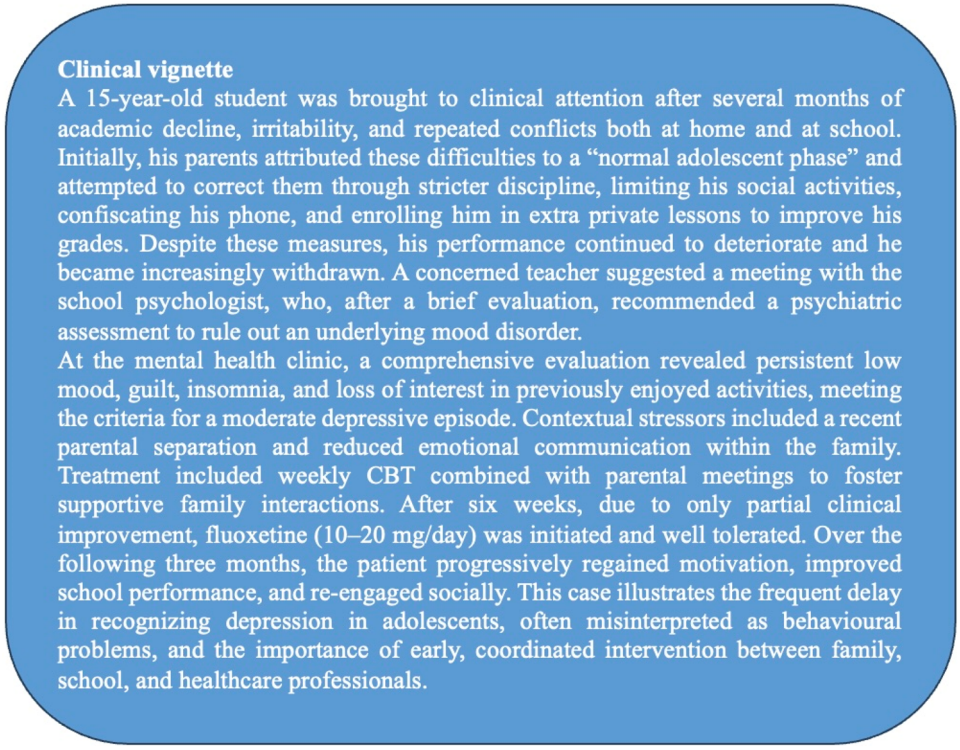


Figure 1. Illustrative clinical vignette of delayed recognition and multidisciplinary management of masked depression in adolescence.

trajectories of youth depression and to clarify which interventions best improve long-term outcomes.

Future research should prioritize prevention, early detection, and the development of scalable, multidisciplinary, and context-sensitive treatments. Integrated care models that combine psychotherapy, pharmacotherapy, family and school-based interventions, and innovative digital tools appear particularly promising for closing the gap between research and practice (Maalouf & Brent, 2012; Rice et al., 2019). Strengthening the evidence base for such approaches represents the most pressing challenge for this field.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used ChatGPT (OpenAI) in order to refine the language and improve readability. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

Disclosure of interest

No potential conflict of interest was reported by the authors.

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