Major Depressive Disorder Across the Lifespan: Children, Adolescents, and Adults — Comprehensive Clinical Guide (2025)

Definitions • Epidemiology • Etiology • Clinical Features • Diagnosis • Treatment • Prognosis • References
Compiled October 01, 2025

Definition & Diagnostic Criteria

- • MDD: persistent depressed mood and/or anhedonia with ≥5/9 DSM-5 symptoms for ≥2 weeks, causing impairment.
- • Symptoms: depressed/irritable mood, anhedonia, appetite/weight change, sleep disturbance, psychomotor changes, fatigue, guilt/worthlessness, poor concentration, suicidality.
- • In children/adolescents: irritability may substitute for depressed mood.
- • Chronic form: Persistent Depressive Disorder (≥2 yrs adults; ≥1 yr youth).

Epidemiology & Course

- • Prevalence: ~1–2% in children; up to 5–8% in adolescents; 6–7% annual in adults; lifetime prevalence ~16% adults.
- • Trends: rising youth depression, especially post-COVID-19.
- • Course: untreated episodes last 6–12 months; recurrence common (>60% adolescents within 5 yrs).
- • Early onset predicts adult recurrence and chronicity.

Etiology & Risk Factors

- • Multifactorial: genetic vulnerability (heritability ~40%), neurotransmitter dysregulation, HPA-axis, inflammation, neuroplasticity deficits.
- • Risk modifiers: early trauma, neglect, chronic stress, bullying, loss, parental psychopathology.
- • Cognitive: negative schemas, rumination.
- • Adolescents: developmental transitions and self-perception distress increase vulnerability.

Clinical Features

Children

- • Irritability, somatic complaints, school refusal, poor peer relations.

Adolescents

- • Anhedonia, academic decline, social withdrawal, suicidal ideation more common.

Adults

- • Depressed mood, anhedonia, psychomotor changes, fatigue, impaired concentration, guilt, suicidality.

Associated

- • Anxiety, ADHD, substance use, somatic symptoms, sleep problems.

Assessment & Diagnosis

- • Clinical interview: onset, duration, impairment, suicidality, comorbidity.
- • Tools: PHQ-9 (adults), PHQ-A/CDI (youth).
- • Collateral info from parents/teachers in youth.
- • Rule out: bipolar disorder, medical causes (thyroid, anemia), substance/medication effects.

Treatment — Psychotherapy

- • CBT: strong evidence across ages.
- • Interpersonal Therapy (IPT): effective, esp. in adolescents.
- • Behavioral activation, family therapy, supportive therapy.
- • Digital/online therapies emerging for youth.

Treatment — Pharmacotherapy

Children/Adolescents

- • Fluoxetine first-line; escitalopram also used.
- • Monitor closely for suicidal ideation (FDA black-box warning).

Adults

- • SSRIs, SNRIs, bupropion, mirtazapine, TCAs, MAOIs (latter less common).
- • Augmentation: antipsychotics, lithium, thyroid hormone.

General

- • Combine with psychotherapy for moderate-severe cases; continue treatment 6–12 months after remission.

Advanced/Resistant Cases

- • ~40% of youth show treatment resistance.
- • Options: ECT (adults, severe/refractory), rTMS, ketamine/esketamine, investigational neuromodulation.
- • Multimodal integration often needed.

Prognosis & Outcomes

- • Many remit, but relapse/recurrent risk is high.
- • Early onset associated with poorer prognosis.
- • Functional impairment: academic, occupational, social, increased suicide risk.
- • Treatment reduces relapse, improves QoL, decreases suicide and morbidity.

Clinical Snapshots

Child/Adolescent

- □ Depressed/irritable mood + ≥4 other symptoms, ≥2 wks
- □ Use PHQ-A/CDI; assess suicidality, comorbidity
- □ First-line: CBT/IPT; fluoxetine if moderate-severe

Adult

- □ Depressed mood/anhedonia + ≥4 others, ≥2 wks
- □ Rule out bipolar/medical/substance causes
- □ First-line: SSRI/SNRI or CBT; augment if resistant

References (selected, 2019–2025)

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