

THE EDUCATIONAL IMPACT OF CHILDHOOD DEPRESSION AND THE NEED OF EARLY IDENTIFICATION

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KEYWORDS

Mental health,
Hyperactivity,
Psychologists,
Education, Children.

Received on: 03-06-2025

Accepted on: 08-07-2025

Published on: 9-07-2025

ABSTRACT

Background: Ten to twenty percent of kids and teens have mental health issues. Attention deficits, cognitive problems, low motivation, and depression hinder academic progress. It's sometimes unclear how psychologists affect kids' mental development and what school therapies and prevention efforts work.

Methods: The foundation of this brief statement is the systematic reviews, meta-analyses, and randomized and non-randomized controlled trials found through a selective search in the PubMed and Google Scholar databases—ScienceDirect, Elsevier, ResearchGate, and others.

Results: Impulsive conduct, a lack of focus, and hyperactivity in the motor areas are the hallmarks of this disorder. Depression affects 4-5% of children and adolescents, with a double prevalence that of males compared to girls. Learning impairments, including dyslexia and dyscalculia, impact 4-6% of children. Repeated grades, chronic absenteeism, and dropping out of school are all associated with mental health issues. Incorporating evidence-based school programs and making adjustments to the school environment can reduce the likelihood of students developing internalizing or externalizing mental health problems.

Conclusion: Doctors, school social workers, and psychologists must help educators identify and address mental health issues in their students to quickly identify school stressors and implement necessary interventions. School-entrance tests and risk factor testing can help. Schools must implement evidence-based preventative activities and enhance the school climate.

INTRODUCTION

During adolescence and other formative years, mental health issues are common. Untreated neuropsychiatric disorders are a major contributor to youth impairment and may have far-reaching consequences for a person's personal, academic, and social development. Between

ten percent and twenty percent of the world's population suffers from a mental illness while they are young [1]. The majority of them manifest by the time a person reaches the age of fourteen [2]. As one of the most worrisome "new morbidities" [3,4], depression is among the most common mental health issues among adolescents. Recognizing the early warning signs and symptoms of depression is crucial, since it usually begins in the middle to late adolescent years. Early management can often avert a serious depressive condition. For example, more than half of the teenagers who committed suicide had a diagnosable depressive condition when they passed away, and depression is a strong predictor of suicide in this age group [5]. Serious social and educational maladjustments, including an uptick in smoking, drug abuse, eating disorders, and obesity, are associated with depression in this age group [6, 7]. We write this opinion to alert physicians to the challenges and risks teenagers face when they suffer from depression. More specifically, we stress the need to include novel morbidities in pediatrics curricula throughout the world. Such an approach will help future generations of physicians identify and treat these pathologic illnesses more effectively [8].



Figure-1 Building better mental health reducing the burden of depression ^[8]

Definition, Classification, and the Alarming Predictive Signs of Depression in Adolescents

Symptoms of depression are characterized by a set of interrelated problems. There are comparable diagnostic and clinical features in adults and adolescents [8,9]. Although the frequency of depression in adolescents increases significantly, it is still uncommon in youngsters; most studies estimate a rate of less than 1% [10]. Many variables explain why the prevalence of depression increases after puberty, as they are associated with the significant social and biological changes that occur during this time [11]. Commonly mentioned are the changes that occur in the brain and cognitive abilities throughout puberty, as well as the increased sensitivity, self-awareness, and social understanding that are hallmarks of this developmental stage [12]. Anxieties and stress levels rise, especially in teenage females, and this is associated with alterations in neurophysiology that contribute to imbalanced reactions to reward and danger [13]. A revised categorization that provides a list of diagnostic symptoms,

as well as a cross-cultural evaluation of depression, is included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [14]. Depressed mood, loss of interest or pleasure, or changes in affect and emotions, cognition, and neurovegetative functions are the hallmarks of major depressive disorders, according to the DSM-5 [15]. These episodes must last at least two weeks [16]. In certain situations, a single episode may be enough to confirm the diagnosis; however, most people with this illness experience remissions followed by episodes. Although irritability, not sadness, is recognized as a key diagnostic symptom in the DSM-5, the two major categorization systems (DSM-5 and the International Classification of Diseases-11) agree on a common definition of depression [17]. Adolescent depression is often undiagnosed because, unlike in adults, symptoms such as irritability, mood instability, reactivity, and oscillation are more common in this age group [18]. Substance abuse, unexplained medical symptoms, anxiety, misbehavior, school refusal, declining academic performance, and eating disorders are some of the primary issues that could make depression go unnoticed [19].

Beginnings of Depression During Formative Years

Possible explanations for the large discrepancy in estimates of depression prevalence among populations in different studies and nations include variations in diagnostic criteria, research designs, and categorization systems [20]. Similar to adult prevalence rates, median 12-month rates in mid-to-late adolescence range from 4% to 5% [21]. But when you add together all the available statistics, you'll see that the likelihood of depression increases from around 5% in early adolescence to 20% by the end of this time [22]. Isolation from loved ones and risky behaviors, including drunk driving, drug misuse, and sexually inappropriate actions, are common outcomes of depression [23]. The negative effects of depression on teenage mental health and social functioning may last a lifetime [24]. All too frequently, family members and primary care physicians fail to notice, discount, ignore, or intentionally neglect symptoms of depression, particularly in younger children and adolescents [25]. This issue might provide a significant challenge when it comes to implementing effective preventative measures in a timely manner [26].

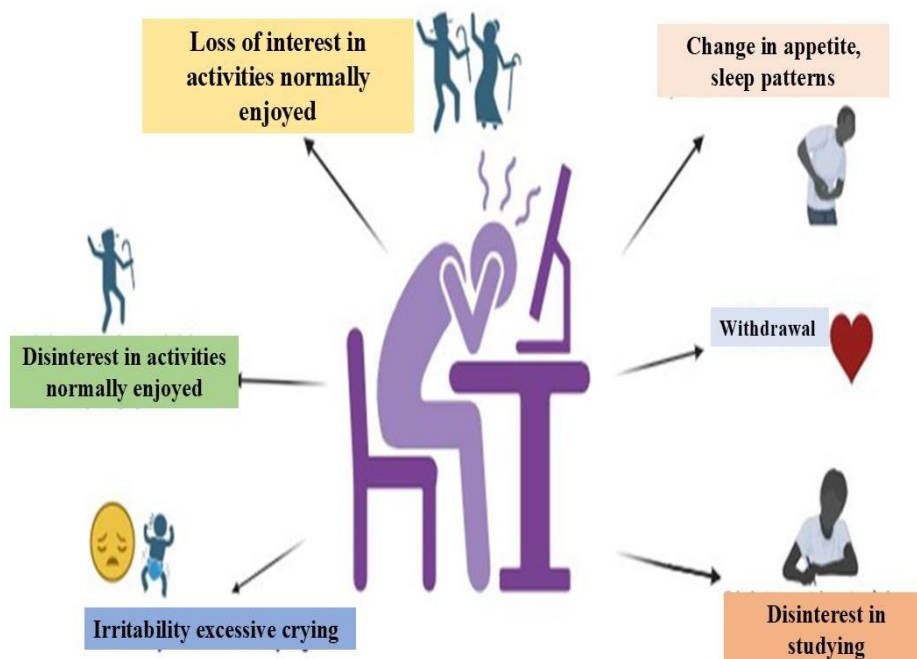


Figure-2 Child showing the symptoms of depression [27]

The value of being alert to depressive symptoms in their early stages

Symptoms of depression in children less than six years old tend to be subtle or unnoticeable [29]. In some instances, the persistent symptoms are related to the psychosomatic realm, and they may include issues with diet and the sleep-wake cycle, as well as skin and respiratory issues. A kind of depression known as interpersonal dependence may affect infants as early as six months old [30]. Extreme emotions of weakness and helplessness, coupled with strong anxieties of abandonment, characterize this type of melancholy [31]. Typically, a family affective condition, such as a parent's illness, death, or the lack of a close adult figure, is the foundation of this type of depression. Extended hospital stays and the child's illness can both lead to affective loss as a result of being apart from loved ones [32]. When a child's emotional states stabilize via family interactions, kindergarten, and elementary school, they may be able to build compensating mechanisms that lessen the impact of an initial depressed condition [33].

Rapid changes in mood, accompanied by powerful affect oscillations and an inability to control one's behavior in response to these fluctuations (e.g., going from laughing to crying), are major warning signs of depression in children in elementary school [34]. An important factor in how a sad child's personality develops is the family's surroundings. If a child grows up with one parent who struggles with depression, it sets a negative example for the rest of the family [35]. As a means of developing relationships and attracting the attention of their caregivers, youngsters often want to please them. Pediatric healthcare providers can foretell outcomes by learning their patients' personal and familial histories and by being alert to symptoms that may indicate depression [36].

The Benefits of a Collaborative Team Strategy

The complicated disorder of depression has an uncertain cause [37]. Some research suggests that neurotransmitter deficiencies may have a role in the development or worsening of depressive symptoms. Research on mediators has primarily focused on serotonin, but it has also considered several other chemicals, including norepinephrine and dopamine [38]. However, current thinking suggests that depression can be caused not only by neurotransmitter deficiency, but also by a combination of genetics, physical illness, chemical imbalance, social factors, and life-changing events. Thus, it is common practice to employ a multidisciplinary team approach when dealing with depression in children and adolescents. These teams should include pediatric primary care providers, mental health specialists, psychologists, social workers, occupational therapists, and other disciplines such as counsellors, art therapists, drama therapists, advocacy workers, and care workers [39].

School screenings

There has been a lot of research on the efficacy of psychological stress screenings in schools. These screenings can identify issues including emotional difficulties, ADD/ADHD, social anxiety, and deviant behaviors [40]. One common screening tool utilized in the aforementioned contexts by educators, parents, and healthcare providers is the strengths and difficulties questionnaire (SDQ). Compared to the ICD-10 diagnosis, the SDQ was more accurate in diagnosing conduct disorders, hyperactivity, depressive symptoms, and anxiety disorders in 70% of the 7984 kids in the 5–15 age group who participated in the epidemiological study. There was a sensitivity of 63.3% (ranging from 59.7% to 66.9%) and a specificity of 94.6% (95% CI [94.1%; 95.1%]) for mental health issues [38]. When looking at ratings given by both parents and teachers, it was shown that parents were more likely to spot anxiety disorders and sadness, while teachers were more likely to notice HKD. Combining the ratings from parents and teachers yielded the best screening result. For specialized medical care, questionnaires are a quick and valid way to determine if a teen or kid at risk with unexplained symptoms is suffering from a depressive disorder or HKD.

Table-1 Scenario of school level [40]

Sr.no.	Statements	Strongly disagree	Disagree	Agree	Strongly agree	Total
1.	Parent involvement is important for a good school.			1.8%	11.92%	12
2.	Parent involvement can help teachers be more effective with more students.			2.17%	10.83%	12
3.	Every family has some strengths that could be tapped to increase student success in school.			5.42%	7.58%	12
4.	Parent involvement is important for student success in school.			2.17%	10.83%	12
5.	All parents could learn ways to as-sist their children on school work at home, if shown how.			2.17%	10.83%	12
6.	Mostly when I contact parents, it's about problems or trouble.	2.17%	7.58%	3.25%		12

Screening tools for the school entrance test might help uncover potential risk factors for mental health issues in young people. For the 7– 8-year-old test, we should expand the screening categories to include emotional stress and indications of depression. By doing so, we may identify the child's early stress sources, which can happen at school in certain circumstances, and start providing the necessary aid and therapy right away [39]. Only school psychologists or school physicians should administer school surveys; based on the results, they will be able to prescribe and implement appropriate interventions. Intervention and prevention in educational settings Efforts to improve the mental health of children and adolescents have been carried out in schools across the globe under the umbrella term "mental health program or promotion." These programs have included prevention and intervention strategies aimed at the entire school, individual classes, or at-risk populations. Despite growing popularity, global school ideas that incorporate changes in school life (such as atmosphere/climate, architectural characteristics, extracurricular support systems, and acceptability in the community or municipality) have demonstrated minimal or no impact. Reasons might include goals that aren't well-defined or focused, rules that aren't well-defined or implemented, manuals that aren't well-written, people in charge of the program not being well-instructed or trained, and a lack of controls to ensure quality [40].

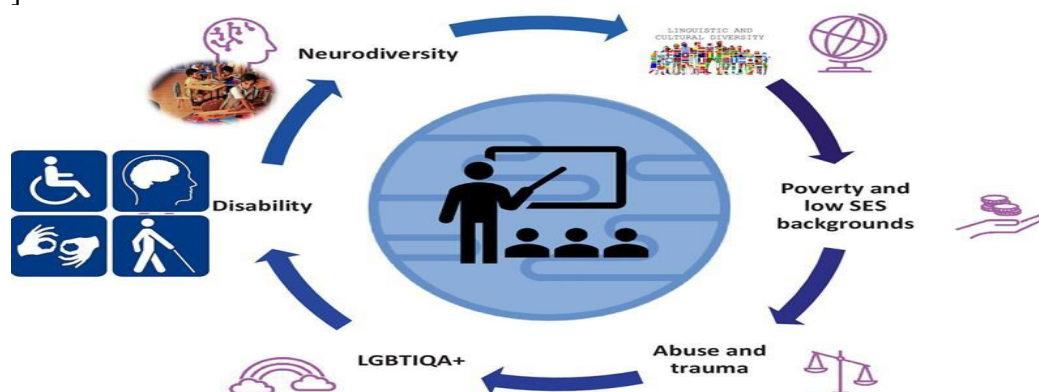


Figure-3 Screening tools for the school entrance test might help uncover potential risk factors [40]

The school-based preventative and intervention programs have moderate to low impact sizes when it comes to improving mental health, decreasing psychological pressures and stress, decreasing bullying and mobbing, and encouraging prosocial conduct. In the setting of bullying and mobbing, the impact size of universal programs to decrease violence and increase dispute resolution was extremely low. When strategies for prevention and intervention focus on groups of kids who exhibit violent behaviors or on children who are at a higher risk for mental health issues like anxiety or depression, the impact becomes significantly more apparent. School preventive and intervention programs will be successful in the long run if they are implemented with quality assurance measures, program directors undergo certified advanced and prolonged training, and the school climate is improved [41].

Challenges and solutions

Early identification of risk factors for mental health problems and reduction of those risks through preventative measures are needed because of the high rates of mental health problems in kids and teens, the importance of these problems for their academic growth, and the low use of the right healthcare system services. Improved access to healthcare services and more education about those alternatives should be priorities for children, adolescents, and their families. pp. 34–35 Implementing the following measures can be done by the school, which is a central institution in the education system, in collaboration with the healthcare system (general practitioners, outpatient, part-inpatient, and inpatient child and adolescent psychiatric and psychosomatic services; psychotherapeutic and medical services for children and adolescents; and school psychologists and social workers): Screenings preventive actions [42]. There have been changes in the atmosphere of the classroom and the school as a whole, along with enhanced professional development opportunities for educators.

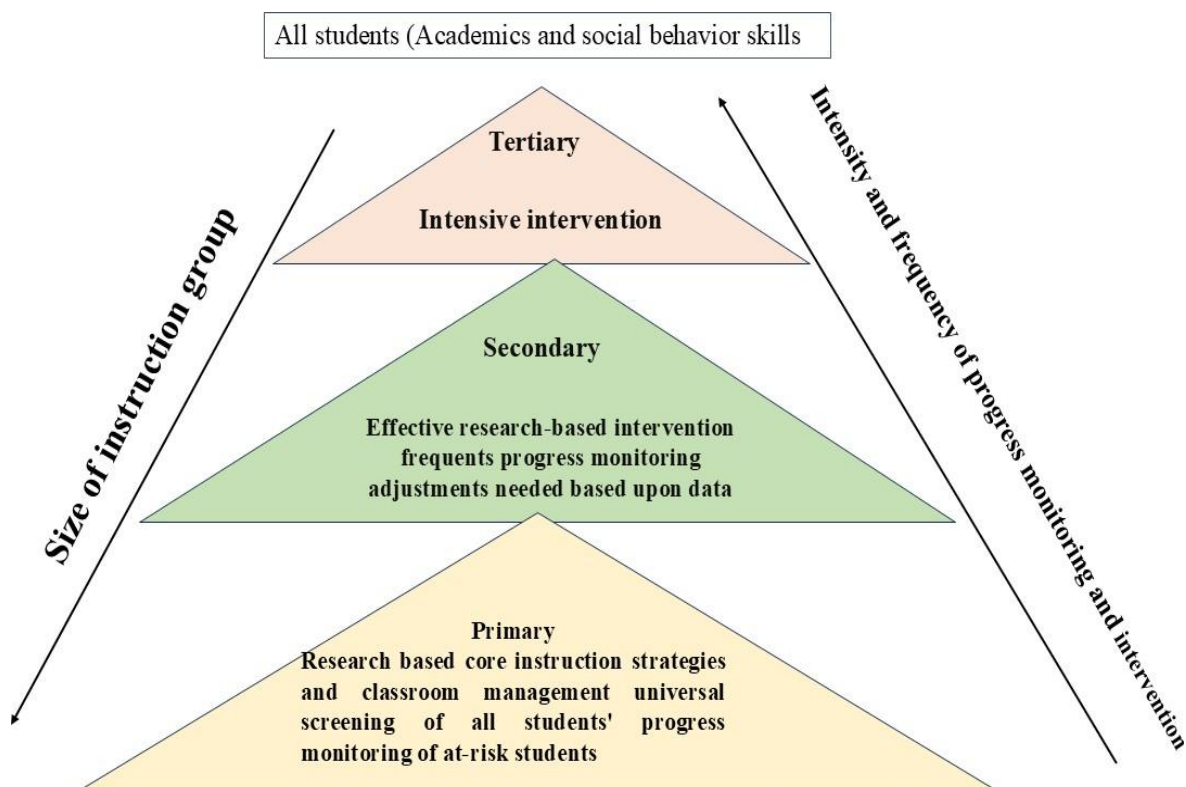


Figure-4 Types of education provided by various groups [40]

Table 2. Numerous neurotransmitters have been implicated in the pathophysiology of depression [42].

S. No	Psychoactive chemicals	Actions	References
1	ACH	Aids in learning and remembering, and it improves memory as a whole.	[36,40]
2	5HT	Affects mood, hunger, and sleep. Removes the sensation of pain. Evidence suggests that serotonin transmission is impaired in depressed individuals. Hypothyroidism is associated with an increased risk of	[36, 40]
3	NE	Medicates hypertension by narrowing blood vessels. Norepinephrine may affect mood, which in turn affects motivation and reward, and it may trigger some types of anxiety and depression.	[37, 40]
4	DA	Basic to movement. It impacts reality perception and motivation. Psychosis and severe cognitive distortion with	[38, 40]
5	Glutamate	As an excitatory neurotransmitter, it may contribute to bipolar illness and schizophrenia.	[39, 40]
6	Lithium carbonate	It often treats bipolar disorder and regulates mood. Studies show it protects neurons in glutamate-exposed rats. Further animal in vivo experiments suggest lithium regulates glutamate reuptake, explaining how it reduces mania and	[40]
7	Gamma-aminobutyric acid	This amino acid controls anxiety by behaving like an inhibitory neurotransmitter.	[41]

CONCLUSIONS

Social stigma, prejudice, and isolation frequently confront children suffering from depression, posing significant challenges for them [43]. The severity of these diseases is exacerbated by inadequate access to educational and medical resources. Teenagers are still in the process of forming their identities within the context of their families. At the same time, they may be struggling with emotions of independence and making difficult choices regarding their schooling and future jobs. All of these factors can contribute to the development of depression without a diagnosis being made. Instruction on newly emerging disorders has to be incorporated into a comprehensive curriculum for paediatrics [44]. According to the working committee on social paediatrics and public health that is part of the European Paediatric Association (UPA), this is the case. To effectively combat the increasing morbidities, it is vital to provide training to newly graduated paediatricians so that they can view themselves not only as doctors at the bedside but also as community champions [45].

LIST OF ABBREVIATIONS

DSM -Diagnostic and Statistical Manual of Mental Disorders

SDQ-Strengths and difficulties questionnaire

Cl- Chloride

ICD-International Classification of Diseases

HKD-Hyperkinetic disorder

ACH- Acetylcholine

5HT- 5-hydroxytryptamine

NE-Norepinephrine

DA- Dopamine

CONSENT FOR PUBLICATION

Not applicable.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

ACKNOWLEDGEMENTS

The authors are very much grateful to Prof. Vikram Kumar Sahu, principal of Maharana Pratap College of Pharmacy Kanpur for his inspiration and facilities.

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