FOLIA MEDICA CRACOVIENSIA
Vol. LXV, 4, 2025: 113–123
PL ISSN 0015-5616 eISSN 2957-0557
DOI: 10.24425/fmc.2025.156702

Occurrence and severity of depressive disorders in people aged 18–25

Alicja Kamińska[1], Kinga Dziedzic[2], Patrycja Zurzycka[3], Katarzyna Wojtas[3]

[1] Department of Nursing Theory and Fundamentals, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Medical College, Kraków, Poland
[2] Graduate of the second degree in Nursing Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Medical College, Kraków, Poland
[3] Department of Specialist Nursing, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Medical College, Kraków, Poland

Corresponding author: Katarzyna Wojtas, Ph.D.
Department of Specialist Nursing, Institute of Nursing and Midwifery
Faculty of Health Sciences, Jagiellonian University Medical College
ul. Kopernika 25, 31-501 Kraków, Poland
Phone: +48 12 421 41 60; E-mail: katarzyna.wojtas@uj.edu.pl

Abstract: Introduction: The occurrence of depressive disorders with a varied clinical picture and intensity of symptoms among young people has been confirmed by numerous studies. Their dynamic development during a period of life full of changes and related activities directs efforts towards their early detection, identification of risk factors, and preventive measures.
The aim of this study was to assess the prevalence and severity of depressive disorders among people aged 18–25.
Material and Methods: The study was conducted using a diagnostic survey among 236 young people using the Beck Depression Inventory and the author's questionnaire.
Results: 15.68% of the respondents admitted to having diagnosed depressive disorders, while the results based on the Beck Depression Inventory indicated moderate depression in 54.66% of the respondents and severe depression in 13.98%. The severity of depressive symptoms was associated with the presence of mental and somatic symptoms, female gender, stress related to family and social life, studying or working remotely due to the COVID-19 pandemic, and substance abuse.
Conclusions: Depressive disorders of varying severity occur among young people in the study and are associated with many factors. Due to the consequences of depressive disorders, there is a need for preventive measures aimed at promoting knowledge and therapeutic measures to facilitate recovery.

Keywords: depressive disorders, young people.

Submitted: 28-Aug-2025; **Accepted in the final form:** 30-Nov-2025; **Published:** 31-Dec-2025.

Introduction

Depressive disorders, which are among the most common mental disorders in developed countries [1], occur regardless of age, gender, place of residence, or marital status [2] and are most commonly diagnosed in people aged 20–40. Young people diagnosed with depressive disorders account for approximately 46 million patients [3]. The most common symptoms of these disorders are sadness, loss of interest, low self-esteem, circadian rhythm sleep and wakefulness disorders, cognitive disorders, and somatic symptoms [4]. The issue of depressive disorders points to the need to raise awareness in this area, including factors that reduce the risk of developing the disorder, such as healthy social relationships, coping skills in stressful situations, seeking help, a healthy lifestyle, healthy self-esteem, and optimism [5, 6].

The aim of this study was to assess the prevalence and severity of depressive disorders in people aged 18–25.

Material and Methods

The diagnostic survey was conducted via the Google Forms online platform in 2021, and the online tools were made available on selected internet forums and social media sites. Before participating in the study, participants were informed about its purpose and complete anonymity. The criteria for inclusion in the study were age between 18 and 25 years and voluntary consent. The research tools included the author's questionnaire and the Beck Inventory (BDI). The Beck Inventory, adapted in Polish by Parnowski and Jernajczyk, is a self-report screening tool that assesses the severity of depressive symptoms in adults on a scale where 0 means no symptoms and 3 means severe symptoms. The number of points that can be obtained ranges from 0 to 63. A score of ≤10 points indicates no depression, 11–27 points indicates moderate depression, and ≥27 points indicates severe depression [7–9]. Questions in the author's survey questionnaire, which were addressed to people with diagnosed depressive disorders and those who suspected that they might be suffering from them, concerned risk factors for depressive disorders, treatment, support and well-being over the last month, as well as the effects of the COVID-19 pandemic on mental health and sociodemographic variables.

Statistical analysis was conducted using the Statistica v.13.1 PL statistical package from StatSoft, Inc. The results were considered statistically significant at $p < 0.05$.

Characteristics of the study participants

The study covered 236 participants, including 74.8% women, 22.88% men, and 2.54% of other genders. The majority of participants were aged 23 (22.03%), while the smallest group were aged 18 (2.97%). Sociodemographic variables showed that the study group was dominated by residents of large cities (56.36%), single people (70.34%), and persons with higher education (52.97%).

Results

Health status and course of depressive disorders

The respondents admitted to drinking alcohol (58.08%), smoking tobacco, drinking coffee, and taking medication (12.71%). One in ten of them took drugs, while 97.03% considered themselves

non-addicted. The stress experienced by the respondents was related to school/university (65.68%), work (35.17%), family life (33.47%) and social life (27.54%), being in a relationship/marriage (20.34%) and other factors (9.32%). The respondents admitted that they struggled with personality disorders (9.68%), eating disorders (9.68%), adjustment disorders (6.45%), chronic lymphocytic thyroiditis (6.45%), anxiety disorders (32.26%) or other disorders (38.71%).

Among the respondents, 15.68% admitted to having diagnosed depressive disorders, which lasted for more than 5 years in 37.84% of cases, while no one had been suffering for less than 4 weeks. Treatment began several years after diagnosis in 29.73% of the respondents, and 24.32% had been treated since the time of diagnosis. Adverse drug reactions were reported by 68.0% of the respondents. The sources of psychological support were friends (63.14%), partners (50.0%), psychotherapist (14.41%), physicians (4.24%), and the most preferred method of treatment for 71.61% was individual psychotherapy.

During the last month, the respondents most often felt sadness/depression (72.88%), fatigue (68.64%), low self-esteem (59.75%), headaches (47.03%) and back pain (37.29%), heart palpitations (25.42%), abdominal pain and decreased libido (24.58% each), and experienced sleep disturbances (55.93%). Well-being over the past week was rated as average (41.95%) and poor (17.37%), with winter and autumn identified as the seasons that worsen well-being — 76.80% vs 70.40%, respectively.

A deterioration in mental health due to the COVID pandemic was confirmed by 70.34%, and in the opinion of 13.14%, it made it difficult to contact a psychiatrist, psychologist, or psychotherapist. Psychological (remote) assistance was used by 11.02% of the respondents, but for 64.0% of them it was less effective than face-to-face contact. Factors related to the COVID-19 pandemic that had the most negative impact on the mental health of the respondents were limited social contact (75.0%), isolation (69.49%), remote learning/working and epidemiological restrictions (59.75%), and concern about their own health and/or that of their loved ones (46.61%).

Results of the Beck Depression Inventory

The scores obtained by the respondents ranged from 0 to 50 points. Half of the respondents scored at least 16 points, and one in four scored at least 23 points (Table 1). After converting the raw data into ranges, it turned out that moderate depression affected 54.66% of the respondents, and severe depression affected 13.98%.

Table 1. Results based on the Beck Depression Inventory obtained by the respondents.

Beck Depression Inventory	Descriptive statistics					
	Mean ± SD	Median [Q25–Q75]	Min.–Max.	Confidence interval		Standard error
				–95.00	+95.00	
	16.88 ± 10.51	16 [9–23]	0	15.53	18.22	0.68

Relationship between the severity of depressive disorders and selected variables related to physical and mental health, lifestyle, and socio-demographics

Respondents for whom remote learning or work had a negative impact on their mental health scored higher on the Beck Depression Scale than those for whom this factor had no negative impact ($p < 0.05$).

Respondents who noticed mental symptoms scored higher on the Beck Depression Inventory (Table 2).

Table 2. Mental symptoms and the severity of depressive symptoms in the study participants.

Mental symptoms		Descriptive statistics — Beck Depression Scale						Mann-Whitney U test
		Mean ± SD	Median [Q25–Q75]	Min.–Max.	Confidence interval		Standard error	
					–95.00	+95.00		
Sadness / depression	Yes (n = 172)	20.22 ± 9.8	19 [13–26]	3–5	1	21.7	0.75	Z = 8.57; p <0.001
	No (n = 64)	7.89 ± 6.21	6.5 [2–11.5]	0–23	6.34	9.44	0.78	
Decreased self-esteem	Yes (n = 141)	21.43 ± 9.74	20 [15–27]	4–50	19.8	23.05	0.82	Z = 8.51; p <0.001
	No (n = 95)	10.13 ± 7.6	9 [4–15]	0–35	8.58	11.67	0.78	
Indifference	Yes (n = 134)	21.09 ± 10.24	19.5 [14–27]	2–50	19.34	22.84	0.88	Z = 7.17; p <0.001
	No (n = 102)	11.34 ± 8.02	10 [5–19]	0–38	9.77	12.92	0.79	
Decreased activity	Yes (n = 137)	19.23 ± 10.27	18 [12–25]	1	17.5	20.97	0.88	Z = 4.09; p <0.001
	No (n = 99)	13.62 ± 10	11 [5–21]	0	11.62	15.61	1	
Fatigue	Yes (n = 162)	19.2 ± 10.44	18 [11–26]	0	17.58	20.82	0.82	Z = 5.08; p <0.001
	No (n = 74)	11.78 ± 8.76	11 [4–17]	0	9.75	13.81	1.02	
Withdrawal from social life	Yes (n = 99)	21.53 ± 10.45	20 [14–28]	1	19.4	23.61	1.05	Z = 5.59; p <0.001
	No (n = 137)	13.52 ± 9.22	12 [6–20]	0	11.96	15.08	0.79	
Feeling of anxiety / unease	Yes (n = 124)	20.87 ± 10.33	20 [14–26]	1	19.04	22.71	0.93	Z = 6.34; p <0.001
	No (n = 112)	12.46 ± 8.84	11 [6–18]	0	10.80	14	0	
Guilt	Yes (n = 95)	23.07 ± 10.2	21 [15–29]	3–5	21	25	1.05	Z = 7.37; p <0.001
	No (n = 141)	12.7 ± 8.48	11 [6–19]	0–39	11.29	14.1	0.71	
Loss of appetite	Yes (n = 42)	26.88 ± 11.19	26.5 [18–7]	8–50	23	30.37	1.73	Z = 5.95; p <0.001
	No (n = 194)	14.71 ± 9.02	15 [8–21]	0–43	13.43	15.99	0.65	
Self-injurious behaviour	Yes (n = 30)	27.13 ± 11.04	24 [18–37]	9–50	23	31.26	2.02	Z = 5.06; p <0.001
	No (n = 206)	15.38 ± 9.58	15 [8–22]	0	14.07	16.7	0	
Suicidal thoughts	Yes (n = 56)	28.07	27 [21–4.5]	7–50	25.48	30.66	1.29	Z = 8.56; p <0.001
	No (n = 180)	13.39 ± 8.05	13 [8–19]	0–38	12.21	14.58	0.60	

The somatic symptoms also had a significant correlation with the severity of depressive symptoms in the study participants (Table 3).

Table 3. Somatic symptoms and severity of depressive symptoms in the study participants.

Somatic symptoms		Descriptive statistics — Beck Depression Scale						Mann-Whitney U test
		Mean ± SD	Median [Q25–Q75]	Min.–Max.	Confidence interval		Standard error	
					–95.00	+95.00		
Headaches	Yes (n = 111)	19.87 ± 10.34	20 [12–27]	0	17.9	21.82	0.98	Z = 4.37; p <0.001
	No (n = 125)	14.22 ± 9.97	13 [7–21]	0	12.45	15.98	0.89	
Back pain	Yes (n = 88)	21.38 ± 10.86	20.5 [14–28.5]	0	19.07	23	1.16	Z = 4.92; p <0.001
	No (n = 148)	14.2 ± 9.35	13 [8–20]	0	12.68	15.7	0.77	
Mucosal dryness	Yes (n = 37)	21.22 ± 11.05	18 [13–27]	5–47	17.5	24.90	1.82	Z = 2.36; p <0.05
	No (n = 199)	16.07 ± 10.23	16 [8–23]	0–50	14.64	17	0.73	
Shortness of breath	Yes (n = 44)	23.18 ± 11.48	20.5 [15–33]	7–50	19	26.67	1.73	Z = 3.87; p <0.001
	No (n = 192)	15.43 ± 9.75	15 [8–21]	0–45	14.05	16.82	0.70	
Heart palpitations	Yes (n = 60)	22.27 ± 9.3	20 [16.5–27]	5–47	19	24.67	1.20	Z = 4.92; p <0.001
	No (n = 176)	15.04 ± 10.29	13 [8–21]	0	13.5	16.57	0.78	
Abdominal pain	Yes (n = 59)	19.54 ± 10.17	18 [12–26]	3–47	16	22.19	1.32	Z = 2.31; p <0.05
	No (n = 177)	15.99 ± 10.5	15 [8–22]	0–50	14.43	17	0.79	
Nausea / vomiting	Yes (n = 37)	23.11 ± 10.82	22 [15–30]	4–4	19	26.71	1.78	Z = 3.8; p <0.001
	No (n = 199)	15.72 ± 10.06	15 [8–21]	0	14.31	17.12	0.71	
Dizziness	Yes (n = 39)	25.67 ± 10.92	27 [18–33]	4–47	22	29	1.75	Z = 5.33; p <0.001
	No (n = 197)	15.14 ± 9.53	15 [8–21]	0	13.8	16.48	0.68	
Diarrhea	Yes (n = 35)	21.74 ± 10.18	19 [15–27]	3–47	18.25	25	1.72	Z = 3.05; p <0.01
	No (n = 201)	16.03 ± 10.36	15 [8–22]	0	14.59	17.47	0.73	
Constipation	Yes (n = 27)	20.74 ± 9.36	20 [13–27]	8–43	17	24.44	1.80	Z = 2.25; p <0.05
	No (n = 209)	16.38 ± 10.57	16 [8–22]	0	14.94	17.82	0.73	
Decreased libido	Yes (n = 58)	22.03 ± 9.9	20.5 [15–27]	7–50	19.4	24.64	1.30	Z = 4.46; p <0.001
	No (n = 178)	15.2 ± 10.17	14.5 [8–21]	0–47	13.69	16.7	0.76	
Weight loss	Yes (n = 32)	21.31 ± 11.2	21.5 [15–27]	2–47	17.2	25.35	1.98	Z = 2.66; p <0.01
	No (n = 204)	16.18 ± 10.25	15 [9–22]	0	14.77	17.6	0.72	
Weight gain	Yes (n = 56)	19.11 ± 9.69	20 [11.5–25]	1–45	16.5	21.7	1.30	Z = 2.17; p <0.05
	No (n = 180)	16.18 ± 10.68	15 [8–22]	0–50	14.61	17.75	0.80	

Table 3. Cont.

Somatic symptoms		Descriptive statistics — Beck Depression Scale						Mann-Whitney U test
		Mean ± SD	Median [Q25–Q75]	Min.–Max.	Confidence interval		Standard error	
					–95.00	+95.00		
Muscle/joint pain	Yes (n = 53)	21.75 ± 11.79	20 [12–30]	1–47	18	25	1.62	Z = 3.35; p <0.001
	No (n = 183)	15.46 ± 9.69	15 [8–21]	0	14.05	16.88	0.72	
None	Yes (n = 39)	8.36 ± 7	6 [2–13]	0	6	10	1.12	Z = –5.84; p <0.001
	No (n = 197)	18.56 ± 10.28	18 [11–24]	0–50	17.12	20.01	0.73	

People who did not use stimulants were characterized by a higher severity of depressive disorders ($p < 0.05$). Among stimulants, only alcohol significantly differentiated the severity of depressive symptoms. Beck Depression Inventory scores were lower in the group of individuals who consumed alcohol than in the group of individuals who did not use this stimulant ($p < 0.01$).

The severity of depressive symptoms was significantly differentiated by gender. Results based on the Beck Depression Inventory were higher in the group of women than in the group of men. This difference was statistically significant (Table 4).

Table 4. Gender of respondents and severity of depressive symptoms.

Gender	Descriptive statistics — Beck Depression Scale						Mann-Whitney U test
	Mean ± SD	Median [Q25–Q75]	Min.–Max.	Confidence interval		Standard error	
				–95.00	+95.00		
Women (n = 176)	17.45 ± 9.99	17 [10–23.5]	0	15.96	18.94	0.75	Z = 2.78; p <0.01
Men (n = 54)	13.2 ± 9.73	13.5 [5–19]	0–43	10.55	15.86	1.32	

The place of residence and marital status of the respondents did not affect the severity of depressive symptoms ($p > 0.05$). However, family and social life were significantly related to the severity of depressive symptoms. Individuals for whom family and social life were a source of stress scored higher on the Beck Depression Inventory ($p < 0.01$) and ($p < 0.001$), respectively.

Discussion

The age criterion adopted for the study group qualifies as young adulthood/early adulthood (the period of development between the ages of 20 and 30 or 35) [10, 11] associated with the pursuit of ambitions and needs in combination with professional, family, and social challenges (often in the face of pressure from the environment), which may contribute to mental crisis and mental health problems [12, 13]. Early adulthood requires the ability to balance work and student activities, develop independence, and form meaningful new relationships [14]. It is worth noting that meeting the age criterion for early adulthood is not always synonymous with fulfilling or not fulfilling the roles characteristic of this life stage [15], and moreover, their fulfillment is always individual [13].

According to some researchers, this stage of life is when stress is felt most strongly, negative emotions are revealed (more strongly than in other age groups), and risky behaviors are undertaken [12]. An analysis of available data suggests that the incidence of depressive disorders among adolescents and young adults (aged 15–39) is on the rise, especially after 2019. [16]. Research results confirm the general trend of emotional difficulties and mental disorders in people under 29 [17], and the particular risk of depressive disorders in young people is associated with threats and stressful situations in the face of new life activities [11]. The report Mental Health of Polish People (2021) show that concern about mental health is a "relatively new phenomenon" in the 18–24 age group [18], while the results of the 2025 National Health Test of Polish People indicate that 31% of young people in the same age group rated their mental health as poor or very poor [19].

When asked in the author's questionnaire, "Do you have a diagnosis of depression?", 15.0% of the respondents answered affirmatively. However, these results turned out to be different from the Beck Inventory results — over half of the respondents showed symptoms of moderate depression, and 13.98% showed symptoms of severe depression. Perhaps those who scored higher did not participate in a psychiatric consultation (thus no diagnosis) because they believed it was unnecessary, due to long waiting times for appointments, or lack of knowledge about the symptoms that may indicate depression. Higher scores may also have been due to the current assessment of own situation dictated by various circumstances. It should be emphasized that the results of the Inventory do not constitute a clinical diagnosis, but allow for an assessment of the severity of depressive symptoms [7–9]. Given that student activities predominate in this age group, the studies presented in the discussion mainly refer to this group of respondents. The results of studies conducted by Jurkiewicz and Kołpa in a group aged 20–35 confirmed the risk of depression in 20% of them [20], and the results of studies by Dymowska and Nowicka-Sauer in a group aged 18 showed a risk in 25.7% of the subjects [21]. Franczok-Kuczmowska and Kuzian showed that the subjects aged 24–26 were characterized by higher levels of depressive and anxiety symptoms than the group aged 27–30 (postgraduates) [12]. The respondents admitted that they experienced negative emotions, decreased activity (including social activity), appetite disorders, pain, digestive, circulatory and respiratory complaints, and decreased libido, and the severity of depressive symptoms was significantly associated with the above symptoms. For comparison, Kluczyńska *et al.* showed that negative mental health indicators most often included fatigue, pain, sleep disorders, irritability, and unjustified fears and, very alarmingly, suicidal thoughts, which are reported, among others, in situations of mood disorders and anxiety [17]. Participants in the study conducted by Czyżowicz *et al.* experienced loss of interest, sadness, depression, low self-esteem, anxiety, and fatigue [22], which, similarly to our study, were associated with the severity of depressive disorders.

Mental health is also affected by circumstances related to the global situation. An example is the recent pandemic. Participants in our own research admitted that they felt their mental health had deteriorated as a result, experiencing restrictions in contact with mental health professionals (remote psychological support did not meet most of their needs) and their environment. Remote learning/working in such an unfamiliar area could have been associated with uncertainty and anxiety. The results of a study by Gambin *et al.* showed the highest levels of depression and anxiety symptoms in the 18–24 age group during the epidemic. The severity of anxiety and depression symptoms in this age group was associated with limited freedom, boredom, difficult family relationships, feelings of loneliness, fatigue with the situation, while the feeling of threat to own health and life and that of loved ones was not associated with the severity of depression symptoms [23]. The COVID-19 pandemic contributed to depressive disorders in adolescents

and young adults not only due to social isolation and family conflicts, but also due to greater educational pressure and limited access to mental health services [16]. Sokół-Szawłowska's research showed that stress related to the COVID-19 pandemic had a major impact on the occurrence of anxiety and depression [24].

In our own survey, respondents admitted to drinking alcohol, smoking tobacco, drinking coffee, taking medication, and using drugs. The Beck Depression Inventory scores were lower in the group of people who consumed alcohol compared to the non-drinking group. Questions regarding alcohol did not concern quantity, frequency, or type. Studying the relationship between the severity of depressive disorders and alcohol consumption requires taking into account the manner of consumption. According to the Report from the National Health Test of Polish People (2025), this age group smokes traditional tobacco products (81.0%), has experience with heated tobacco (50.0%), e-cigarettes (liquids) (92.0%), and designer drugs (8.0%) [19]. Alcohol, tobacco, and marijuana are the most commonly used psychoactive substances among students, which, combined with the stress of studying, contribute to the occurrence of depressive disorders [14]. The results of a study conducted by Hashem *et al.* showed that female students who smoked cigarettes had significantly higher depression scores than male students who smoked [25].

The severity of depressive symptoms in our study differed significantly by gender (women scored higher), but not by place of residence or marital status. In comparison, among students in Zhuang's study, depression — based on the DASS-21 — it was more common among students and those living in cities [26]. In the study by Jurkiewicz and Kołpa, symptoms of depression were not significantly related to the participants' gender (although they were more common in women) or marital status, but only to place of residence (the larger the city, the lower the risk of depression) [20]. The results of a study by Gambin *et al.* showed lower severity of depressive symptoms in married people than in single or those in informal relationships [23]. The severity of depressive symptoms in the study group was significantly associated with family and social stress, possibly resulting from a lack of support, conflicts, family disagreements, and difficulties in relationships with people outside the family circle.

It is emphasized that the lack of loved ones and interpersonal problems reinforce negative self-esteem and predispose individuals to depression [27].

Depressive disorders are present among young people, and issues related to them should be further researched. Screening for their occurrence and analysis of risk factors provide a basis for broadly defined measures to promote and prevent mental health in this population. However, such research and therapeutic interventions should be carried out at an earlier age. Research results confirm the occurrence of depressive disorders in adolescents, the consequences of which are present in middle adulthood in relation to the social dimension [28], and studies among younger groups experiencing age-related depressive disorders confirm a higher risk of suicide in adulthood [29].

It is worth noting that mental health issues are increasingly present in the media with an aim to break the taboo that still exists in Polish society, and given the age of the respondents, reference can also be made to initiatives undertaken at universities or as part of social campaigns. The campaigns and social initiatives undertaken not only serve to raise public awareness of mental disorders, but also to show that experiencing a mental crisis does not deprive a person of their dignity and value or their ability to return to social activities. Some studies among young people concern not only the prevalence of depressive disorders, but also the phenomenon of stigmatization in relation to people experiencing depressive disorders [30], which is extremely important with regard to the above considerations.

Conclusions

1. Our study confirmed the occurrence of depressive disorders of varying severity in people aged 18–25.
2. The severity of depressive symptoms was associated with substance use. Individuals who used any substances (especially alcohol) reported less severe depressive symptoms.
3. The severity of depressive symptoms was significantly differentiated by gender as well as family and social life — women and individuals for whom family and social life was a source of stress scored higher on the Beck Depression Inventory.

Contribution statement

Research design: A.K., K.D.; Analysis and writing the article: A.K., K.W., P.Z.; Critical evaluation: A.K., K.W., P.Z.

Conflict of interest

None declared.

Financing

Source of financing — none.

References

1. *Kiejna A., Pluta J., Bohater P.* (ed.): Depresje [Depression]. Wrocław: MedPharm Polska 2013.
2. *Osińska M., Kazberuk A., Celińska-Janowicz K., Zadykowicz R., Rysiak E.*: Depresja — choroba cywilizacyjna XXI wieku [Depression — the civilization disease of the 21st century]. Geriatria. 2017; 11: 123–129.
3. *Bielawska-Batorowicz E.* (ed.): Depresja [Depression]. Łódź: Wydawnictwo Uniwersytetu Łódzkiego 2020.
4. *Jarema M.*: Depresja w praktyce lekarza POZ [Depression in the practice of a primary care physician]. PZWL, Warszawa 2017.
5. *Kielan A., Gorostiza D., Mosiołek A., Chodkiewicz J., Święcicki Ł., Walewska-Zielecka B.*: Depresja u mężczyzn — specyfika, etiologia i związki z tendencjami samobójczymi oraz używaniem substancji psychoaktywnych: przegląd piśmiennictwa [Depression in men — specificity, etiology and associations with suicidal tendencies and psychoactive substance use: a literature review]. Adv Psychiatry Neurol. 2020; 29 (1): 54–66. doi: https://doi.org/10.5114/ppn.2020.94695.
6. *NFZ*: O depresji [About depression]. Warszawa 2020. https://ezdrowie.gov.pl/portal/home/badania-i-dane/zdrowe-dane/raporty/nfz-o-zdrowiu-depresja. Accessed online on 12.01.2021.
7. *Łopuszańska M., Szklarska A., Jankowska E.A.*: Ocena nasilenia objawów depresyjnych z zastosowaniem polskiej wersji IA Inwentarza Depresji Becka u zdrowych mężczyzn, mieszkańców Wrocławia [Assessment of the severity of depressive symptoms using the Polish version of the Beck Depression Inventory IA in healthy men, residents of Wrocław]. Psychiatria Polska. 2013; 47 (6): 1001–1009.
8. *Kokoszka A., Jastrzębski A., Obrębski M.*: Ocena psychometrycznych właściwości polskiej wersji Kwestionariusza Zdrowia Pacjenta-9 dla osób dorosłych [Evaluation of the psychometric properties of the Polish version of the Patient Health Questionnaire-9 for adults]. Psychiatria. 2016; 13 (4): 187–193.

9. *Humeniuk E., Dąbska O., Krupa A.*: Nasilenie zaburzeń depresyjnych wśród pacjentów onkologicznych [The severity of depressive disorders among oncology patients]. Rozprawy Społeczne. 2018; 12 (3): 55–63.
10. *Rosiński D.*: Wczesna dorosłość — wybrane aspekty z perspektywy psychologii społecznej [Early adulthood — selected aspects from the perspective of social psychology]. Polityka Społeczna. 2013; 12 (2 thematic): 8–14.
11. *Piestrzyński W., Sarzała D.*: Depresyjność osób we wczesnej dorosłości [Depression in people in early adulthood]. Konińskie Studia Społeczno-Ekonomiczne. 2020; 6 (1): 45–54. doi:10.30438/ksse.2020.6.1.4.
12. *Franczok-Kuczmowska A., Kuzian M.*: Psychospołeczne uwarunkowania funkcjonowania i zdrowia psychicznego w okresie wczesnej dorosłości [Psychosocial determinants of functioning and mental health in early adulthood]. In: Annales Universitatis Paedagogicae Cracoviensis Studia Psychologica 11, Kossewska J. (ed.). Kraków: Wydawnictwo Naukowe UP 2018; 115–134. doi: 10.24917/20845596.11.8.
13. *Wołk Z.*: Praca i edukacja na tle zadań rozwojowych wczesnej dorosłości w obliczu czwartej rewolucji przemysłowej [Work and education in the context of developmental tasks of early adulthood in the face of the fourth industrial revolution]. Annales Universitatis Mariae Curie-Skłodowska. Sectio J Paedagogia-Psychologia. 2021; 34 (4) 53–66. doi: 10.17951/j.2021.34.4.53-66.
14. *Rodríguez-Sáez J.L., Martín-Antón L.J., Salgado-Ruiz A., Carbonero-Martín M.Á.*: Academic Performance, Absenteeism, and Drug Use in Emerging Adulthood. Cureus. 2025; 17 (2): e78325. https://doi.org/10.7759/cureus.78325.
15. *Oleszkiewicz A., Misztela A.*: Kryteria dorosłości z perspektywy starszych adolescentów i młodych dorosłych [Criteria of adulthood from the perspective of older adolescents and young adults]. Psychologia Rozwojowa. 2015; 20 (1): 41–55. doi:10.4467/20843879PR.15.002.3474.
16. *Zhao L., Lou Y., Tao Y., Wang H., Xu N.*: Global, regional and national burden of depressive disorders in adolescents and young adults, 1990–2021: systematic analysis of the global burden of disease study 2021. Front. Public Health. 2025; 13: 1599602. doi: 10.3389/fpubh.2025.1599602.
17. *Kluczyńska S., Witkowska E.M., Zabłocka-Żytka L. Sokołowska E.*: The mental health of polish students — selected positive and negative indicators. Adv Psychiatry Neurol. 2019; 28 (4): 233–240. doi: https://doi.org/10.5114/ppn.2019.92484.
18. *CBOS*: Zdrowie psychiczne Polaków [Mental Health of Poles]. Komunikat z Badań. 2021; 154: 1–7. https://www.cbos.pl/SPISKOM.POL/2021/K_154_21.PDF.
19. *Medonet*: Narodowy Test Zdrowia Polaków. Raport 2025 [National Health Survey of Poles. 2025 Report]; 1–164. https://ocdn.eu/medonet/medonet/Narodowy_Test_Zdrowia_Raport_2025.pdf.
20. *Jurkiewicz B., Kołpa M.*: Stres, a ryzyko wystąpienia depresji u ludzi młodych w przedziale wiekowym 20–35 lat [Stress and the risk of depression in young people aged 20–35]. Problemy Pielęgniarstwa. 2015; 23 (1): 13–19. doi: 10.5603/PP.2015.0003.
21. *Dymowska A., Nowicka-Sauer K.*: Depresja wśród młodzieży — problem wciąż aktualny [Depression among young people — a still current problem]. Forum Medycyny Rodzinnej. 2015; 9 (2): 124–126.
22. *Czyżowicz K., Sitarz J., Wojtas K.*: Occurrence of depressive disorders among students of the Faculty of Health Sciences of the Jagiellonian University Medical College. Nursing Problems. 2020; 28 (3–4): 136–142. doi: https://doi.org/10.5114/ppiel.2020.103534.
23. *Gambin M., Sękowski M., Woźniak-Prus M., et al.*: Uwarunkowania objawów depresji i lęku uogólnionego u dorosłych Polaków w trakcie epidemii Covid-19 — raport z pierwszej fali badania podłużnego [Determinants of symptoms of depression and generalized anxiety in adult Poles during the Covid-19 epidemic — report from the first wave of the longitudinal study]. Wydział Psychologii Uniwersytetu Warszawskiego 2020 [online]. Available from: https://psych.uw.edu.pl/wp-content/uploads/sites/8/2022/08/Uwarunkowania_objawow_depresji_leku_w_trakcie_pandemii_raport.pdf [Accessed: 10.12.2025].
24. *Sokół-Szawłowska M.*: Wpływ kwarantanny na zdrowie psychiczne podczas pandemii COVID-19 [The impact of quarantine on mental health during the COVID-19 pandemic]. Psychiatria. 2021; 18 (1): 57–62. doi: 10.5603/PSYCH.a2020.0046.

25. *El Hashem A., Bou Saba A., Bou Madi A.M., et al.*: Patterns and prevalence of depression, tobacco, and caffeine use among university students from different majors in Lebanon: a cross-sectional study. Front Public Health. 2025 Jun 4; 13: 1605086. doi: 10.3389/fpubh.2025.1605086.
26. *Zhuang H., Zhao H., Liu M.*: Depression, anxiety, stress symptoms among overweight and obesity in medical students, with mediating effects of academic burnout and internet addiction. Scientific Reports. 2025; 15: 16566. doi.org/10.1038/s41598-025-01793-7.
27. *Michalska-Leśniewicz M., Gruszczyński W.*: Czynniki psychologiczne w depresji [Psychological factors in depression]. Psychiatry. 2010; 7 (3): 95–103.
28. *Alaie I., Ssegonja R., Philipson A., et al.*: Adolescent depression, early psychiatric comorbidities, and adulthood welfare burden: a 25-year longitudinal cohort study. Soc Psychiatry Psychiatr Epidemiol. 2021; 56 (11): 1993–2004. doi: 10.1007/s00127-021-02056-2.
29. *Wang C., Tong Y., Tang T.:* Association between adolescent depression and adult suicidal behavior: A systematic review and meta-analysis. Asian J Psychiatr. 2024; 100: 104185. doi: 10.1016/j.ajp.2024.104185.
30. *Musa A., Ashraf J., Tsai F.J., et al.*: Depression Severity and Depression Stigma Among Students: A Survey of Universities in Five Countries. J Nerv Ment Dis. 2020; 208 (11): 884–889. doi: 10.1097/NMD.0000000000001226.