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# Early Warning Signs of Depression in Adults and Adolescents: A Clinical Review

*Narrative Literature Review*

**Abstract—**Depression commonly becomes recognizable through an accumulation of changes rather than one unmistakable event. Earlier recognition may reduce the interval during which sleep, motivation, concentration, relationships, and daily functioning deteriorate, but ordinary sadness, grief, developmental change, stress, and medical illness must not be recast automatically as a depressive disorder. This narrative review examines early signs in adults and adolescents, including differences in presentation, recurrence, irritability, somatic complaints, withdrawal, functional decline, and suicide risk. A clinically useful signal is a sustained deviation from the person's own baseline that persists across settings, clusters with changes in mood or interest, and carries functional or safety consequences. In adolescents, irritability, school disengagement, altered peer contact, risk behavior, and unexplained physical complaints may be prominent, although none is specific. Screening instruments can structure inquiry and follow change, but they do not determine cause, bipolarity, or risk and must be followed by clinical assessment. A useful early-warning plan translates personal prodromes into observable markers, named supports, review intervals, and explicit thresholds for escalation. Early recognition is therefore best understood as a longitudinal, revisable clinical inference rather than a checklist exercise.

**Index Terms—**depression, adolescents, adults, early signs, recurrence, screening, suicide risk, differential diagnosis

## I. INTRODUCTION

Depression is often recognized only after daily life has noticeably contracted. Earlier changes may have been attributed to laziness, ordinary stress, adolescence, a difficult personality, or lack of effort. Retrospective certainty is misleading, however, because fatigue, poor concentration, sleep disturbance, withdrawal, and irritability occur in many psychological, social, and medical states. The clinical task is to improve sensitivity without surrendering specificity.

A useful early sign is more than a symptom on a list. It is a sustained and meaningful departure from the person's usual pattern that converges with other changes and affects participation, recovery, or safety. In this review, an early sign is treated as a working clinical signal rather than a distinct diagnostic entity. Earlier JPPC articles on treatment-resistant depression and communication in depression likewise emphasized revisiting the formulation instead of assuming that persistent low mood has one explanation (Haverkampf, 2016; Haverkampf, 2017a). Questions should enlarge the inquiry rather than force an early conclusion (Haverkampf, 2017b).

## II. SCOPE AND REVIEW METHOD

This narrative review draws on targeted searches of PubMed and professional guideline websites completed on 30 November 2023. Search topics included adult and adolescent depression, prodromal and early signs, recurrence, screening, functional impairment, irritability, suicide risk, and differential diagnosis. Priority was given to guidance available at the cutoff date, systematic reviews and meta-analyses, longitudinal studies, diagnostic research, and clinically informative original studies. Bibliographic details were checked against PubMed, DOI records, or the issuing organization's website. Relevant JPPC articles were reviewed in the journal archive when they materially informed the clinical question.

The review was not registered as a systematic review, did not use a formal risk-of-bias protocol for every included source, and does not estimate pooled effects. Its purpose is to support recognition, formulation, and shared clinical reasoning. Application to an individual depends on developmental stage, culture, medical status, exposure, setting, and the quality of the assessment. Recommendations are described as they stood at the literature cutoff and should be checked for later revision before clinical use.

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**Core propositions (author-developed clinical synthesis; not a validated prediction tool)**

- Treat early signs as sustained deviations from personal baseline, not isolated symptoms.
- Loss of interest and reduced positive engagement may be more revealing than reported sadness.
- In adolescents, irritability, school change, altered peer contact, risk behavior, and somatic complaints require developmental interpretation.
- Screening opens an assessment; it does not establish diagnosis, cause, polarity, or risk.
- A personalized warning plan should name observable markers, responders, review timing, and escalation thresholds.

## III. WHAT COUNTS AS AN EARLY SIGN?

The phrase early warning sign can refer to a nonspecific change that prompts review, a personal pattern preceding recurrence, or evidence that an episode is already developing. These are not interchangeable. Early detection means recognizing clinically meaningful change and may occur after a syndrome has begun; it is not proof that an episode was predicted. A prodrome is a change that precedes a later confirmed episode, often identifiable only retrospectively and seldom specific to depression. After previous episodes, a personal recurrence signature—such as sleep disruption followed by withdrawal, self-critical rumination, missed meals, or unanswered messages—may guide monitoring, but it remains an individualized hypothesis rather than a validated prediction. Diagnosis still requires syndromal, longitudinal, functional, and differential assessment.

Major depression is syndromal: symptoms co-occur over time and are accompanied by distress or impairment. Depressed mood and diminished interest or pleasure are central, while changes in energy, sleep, appetite, psychomotor activity, concentration, decision-making, guilt, worthlessness, and thoughts of death shape severity and risk. Depression is heterogeneous in presentation, course, and mechanism, and no single biomarker identifies an episode in routine practice (Malhi & Mann, 2018).

Clinical value usually lies in direction and sequence. A person who normally enjoys music no longer starts it; a reliable employee begins missing small deadlines; an adolescent withdraws from a valued peer group; ordinary setbacks are interpreted as global and permanent. The first task is to describe what changed, when it changed, where it occurs, and what followed. Interpretation should come after observation, not replace it.

***Domains of possible early change (author-developed clinical synthesis; not a validated instrument)***

| Domain | Possible observations | Important alternatives |
|---|---|---|
| Interest | No longer anticipates or starts valued activities | Pain, exhaustion, loss, restricted opportunity |
| Mood | Sadness, irritability, numbness | Grief, trauma, mixed or activated state |
| Sleep | Insomnia, early waking, oversleeping | Schedule, substances, sleep disorder |
| Energy/action | Slowing, agitation, reduced initiation | Medical illness, medication, ADHD |
| Thinking | Indecision, concentration loss, hopelessness | Anxiety, sleep loss, neurodevelopmental factors |
| Connection | Withdrawal, conflict, stopped communication | Bullying, unsafe relationship, social anxiety |
| Self-evaluation | Guilt, burdensomeness, worthlessness | Abuse, discrimination, realistic loss |

## IV. ADULT PRESENTATIONS

Adults may first report reduced efficiency, indecision, bodily discomfort, insomnia, irritability, or a sense of functioning on automatic. Continued employment does not rule out depression: familiar routines may be maintained while domestic tasks, relationships, nutrition, and recovery deteriorate. Conversely, work difficulty may reflect an unhealthy workplace rather than a depressive disorder. Assessment should compare change across roles and ask how much effort and external support are required to sustain visible performance.

Anhedonia deserves more specific questions than "Are you enjoying things?" Ask what the person previously anticipated, initiated, and became absorbed in. Anticipatory pleasure, motivation to begin, and enjoyment during an activity can diverge. A loss of positive engagement may therefore appear as flatness, effortfulness, or disconnection rather than as explicit sadness.

Cognitive changes may include global self-criticism, reduced confidence in decisions, selective recall of failure, and a future experienced as closed. These patterns can sustain inactivity, but they may also reflect genuine loss or a hostile environment. Cognitive language should not be used to invalidate financial, relational, occupational, or health adversity. Because bipolar depression may initially be managed as unipolar depression, the history should also examine previous activation, reduced need for sleep, and episodic change (Smith et al., 2011; Hirschfeld, 2014; Daveney et al., 2019).

## V. ADOLESCENT PRESENTATIONS

Adolescent depression unfolds during rapid changes in sleep timing, autonomy, identity, schooling, peers, and family

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relationships. Irritability may be more visible than sadness; withdrawal may occur online as well as offline; and academic decline may reflect depression, anxiety, sleep loss, bullying, ADHD, learning difficulty, substance use, or an unsafe environment. Developmental context, comorbidity, recurrence, and suicide risk are therefore integral to assessment rather than secondary considerations (Thapar et al., 2012).

Possible warning signs include sustained loss of interest, marked change in sleep or appetite, unexplained physical complaints, abandonment of valued activities, increasing hopelessness, school refusal, pronounced self-criticism, risk-taking, substance use, or a sudden change in peer contact. None is diagnostic in isolation. Disclosure is more likely when the young person is offered private time, developmentally appropriate language, a clear explanation of confidentiality and its limits, and more than one opportunity to speak.

Family and school information can clarify baseline and function, but collateral accounts remain perspectives rather than verdicts. The young person's account should remain central, and collateral contact should not create additional danger. Guidance available at the review cutoff supports systematic identification, assessment, management, and monitoring, with age-appropriate family involvement and explicit attention to safety (Zuckerbrot et al., 2018; Cheung et al., 2018; National Institute for Health and Care Excellence, 2019; Walter et al., 2023). Consent, autonomy, safeguarding, and local legal requirements require careful handling.

## VI. COURSE, RECURRENCE, AND PERSONAL PRODROMES

Depression can recur, and an episode in adolescence may be followed by further episodes in young adulthood. Community follow-up studies document recurrence while also showing substantial variation in course; not every episode becomes chronic or follows the same sequence (Lewinsohn et al., 2000). Pettit et al. (2013) examined whether liability to recurrence can be detected before a first adolescent episode, illustrating both the appeal and the limits of prediction.

After recovery, a personal relapse signature can be reconstructed from records and recollection. Which changes came first? Which were consequences rather than precursors? Which were observable to others? Did sleep shorten or lengthen? Did language become more absolute? Were messages left unanswered? Which protective routines disappeared? The resulting plan should link early markers to actions, such as contacting a named person, restoring appointments, reviewing medication adherence with a prescriber, or arranging assessment.

Monitoring should not become hypervigilance. Continuous checking can magnify anxiety and turn ordinary low days into evidence of inevitable relapse. Brief scheduled review, several converging indicators, and explicit thresholds are preferable. Repeated measurement can reveal different symptom trajectories rather than one linear recovery curve, but monitoring data remain descriptive unless interpreted in clinical context (Pfeiffer et al., 2015). Current prognostic models for relapse are not sufficiently validated for routine individual prediction (Moriarty et al., 2022).

## VII. SCREENING AND DIAGNOSTIC FOLLOW-UP

The PHQ-9 is a brief, validated measure that can support identification of depressive symptoms and estimation of severity in clinical populations (Kroenke et al., 2001). Its items can structure a conversation and track change, but the total score does not establish cause, bipolarity, psychosis, trauma, bereavement, substance effects, or medical contributors. An affirmative response concerning death or self-harm requires direct follow-up regardless of the total score.

Screening is most useful within a defined pathway. A positive result should lead to assessment of duration, impairment, previous episodes, activation or reduced need for sleep, psychotic symptoms, anxiety, trauma, attention and developmental history, eating, substances, medications, pregnancy or postpartum context, and medical contributors. A negative result should not end inquiry when function has clearly changed or when language, literacy, shame, fear, or cognitive difficulty limits use of the measure.

At the literature cutoff, NICE guideline NG134 addressed depression in children and young people, while NG222 addressed depression in adults (National Institute for Health and Care Excellence, 2019, 2022a). Instruments and thresholds differ by age, population, and setting. Clinicians should use validated versions, understand the population in which a measure was studied, and explain that a screen estimates symptom burden or probability; it does not identify a disorder or settle the diagnosis.

## VIII. HOW TO ASK AND HOW TO RESPOND

Concern is best expressed through observation and invitation: "I have noticed that you have stopped coming to football and seem awake most nights; how have things been?" This is more useful than "You are depressed" or "You have nothing to be depressed about." The person may not use psychiatric language, may fear burdening others, or may expect punishment. Listening for change, hopelessness, shame, and disconnection matters more than extracting a preferred label.

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Questions about suicide should be direct and unambiguous. A review found no evidence that asking about suicide increases suicidal ideation (Dazzi et al., 2014). Ask about wishes not to wake up, thoughts of death or self-harm, intent, planning, access to means, rehearsal, and previous acts, as well as what has prevented action and who can help now. Risk formulation is a clinical process; NICE advises against using risk scales to predict future suicide or repetition of self-harm (National Institute for Health and Care Excellence, 2022b). A collaboratively developed safety plan can specify coping steps, supportive contacts, and routes to care, but it is not a substitute for assessment or follow-up (Stanley et al., 2018).

The initial response should match urgency and functional change. It may include practical support, restoration of sleep opportunity and regular meals, reduction of immediate load, primary-care or mental-health assessment, and involvement of a trusted adult when appropriate. Formal treatment decisions should reflect severity, duration, recurrence, age, preference, comorbidity, risk, and access, in keeping with age-appropriate guidance (National Institute for Health and Care Excellence, 2019, 2022a; Walter et al., 2023). Practical measures are adjuncts, not substitutes for indicated treatment or urgent care.

***A personalized early-warning plan (author-developed clinical synthesis; not a validated instrument)***

| Level | Illustrative pattern | Agreed response |
|---|---|---|
| Baseline variation | One low day after a setback | Ordinary support; review if the pattern persists |
| Early cluster | Sleep change + withdrawal + self-criticism | Tell named person; restore routine; arrange review |
| Functional decline | Missed school, work, care, or meals | Prompt clinical assessment and practical support |
| Escalating risk | Hopelessness, burdensomeness, increased substance use | Direct risk assessment; increase contact and safety measures |
| Imminent danger | Intent, plan, means, inability to stay safe | Emergency or crisis pathway; do not leave unsupported |

## IX. CONTEXT, EQUITY, AND ACCESS

Clinical thresholds are not socially or culturally weightless. Opportunity, exposure, power, language, disability, service design, and previous treatment shape both symptoms and the evidence available to an assessor. Equity does not require less rigorous assessment; it requires better contextual evidence and care not to mistake structural constraint for individual pathology.

**Adolescent voice.** Collateral information can clarify change and function, but it can also overshadow the young person's experience. Privacy and the limits of confidentiality should be explained before sensitive questions, and the adolescent's account should remain central unless an immediate safety duty requires action.

**Somatic expression.** Sleep disturbance, pain, fatigue, and other bodily complaints may be the first language of distress. They warrant medical as well as psychological inquiry, with attention to timing, context, and the meaning the person gives them. Bodily language should not be treated as less informative merely because it is not explicitly emotional.

**Adversity.** Poverty, racism, bullying, disability, unsafe relationships, and caregiving strain can precipitate or maintain symptoms and require practical response alongside treatment. The plan should identify who can change the relevant condition and what support is genuinely accessible. Unavailable care and unaffordable advice should not be interpreted as poor motivation or treatment resistance.

## X. MEASUREMENT, FOLLOW-UP, AND REVISION

Before intervention, define what will be observed, at what interval, and by whom. Symptom measures can be useful, but they should be paired with function, safety, adverse effects, context, and the person's priorities. The purpose is not to accumulate scores but to determine whether the working formulation anticipates the course and whether the agreed action produces a benefit that is meaningful and proportionate to its burden.

***A balanced outcome dashboard (author-developed clinical synthesis; not a validated instrument)***

| Domain | Article-specific outcome |
|---|---|
| Symptoms and course | Interest, anticipatory pleasure, mood, sleep, appetite, and energy |
| Function | School or work, self-care, relationships, and responsibilities |
| Safety | Hopelessness, self-harm thoughts, intent, and protective contact |
| Context | Pain, medication, substances, adversity, and changing exposure |
| Formulation and response | Fit of the personal warning signature and effect of the agreed action |

## XI. CLINICAL INTERVIEW: DOMAINS AND QUESTIONS

Begin with what has changed from the person's usual way of living. A patient may report sadness; another may describe numbness, irritability, bodily symptoms, lost interest, or effort that has become invisible to others. Reconstruct timing, function, sleep, activation, medical and substance factors, and social context. With consent, a parent, partner, teacher, or friend may contribute observations, but collateral information should not replace a private conversation. End by asking directly about death wishes, self-harm, intent, means, previous

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action, protective relationships, and what help the person could accept now.

The domains below can alter diagnosis, urgency, intervention, or interpretation of outcome. They are not a script that must be completed in one sitting. Information should be gathered at a pace compatible with safety, development, capacity, consent, and the clinical setting. When collateral information is sought, its purpose and limits should be explained, and the source's opportunity to observe, relationship to the person, and possible bias should be considered.

**Baseline and change. Begin with what was usual before the current change—for example, several weeks or months earlier—and identify the first sustained departure.** Compare interest, sleep, energy, concentration, self-care, communication, school or work, and recovery across settings rather than relying on one adjective. Ask when the change is absent, who noticed it, and what consequence followed. An adult may preserve visible work while domestic life contracts; an adolescent may remain online while withdrawing from valued peers or activities. Record whether information comes from the patient, observation, records, or consented collateral history and how confident each source is. Change from personal baseline is more informative than comparison with a stereotype.

**Core symptoms.** Explore mood and irritability, interest and pleasure, energy, movement, sleep, appetite, cognition, guilt, worthlessness, and thoughts of death in the person's own language. Clarify onset, persistence, daily variation, and whether symptoms cluster. Ask separately about wanting to begin an activity, being able to initiate it, and enjoying it once engaged. Bodily and cognitive symptoms deserve the same attention as reported sadness, especially when development, culture, shame, or fear of disclosure affects wording. When a questionnaire item is endorsed, obtain an example and its meaning; when it is denied despite clear functional change, continue inquiry without assuming concealment.

**Function.** Describe what has stopped, what occurs less often, and what continues only through disproportionate effort. Ask about school or work attendance, care responsibilities, relationships, hygiene, meals, sleep, appointments, and activities that previously provided interest or connection. Grades and employment can conceal deterioration when relatives or colleagues are carrying additional work, so identify the conditions sustaining performance. For adolescents, ask about online as well as offline participation and obtain private time to speak. Concrete examples provide a baseline for follow-up and help distinguish recovery from withdrawal from demands.

**Course.** Reconstruct previous episodes, recovery, seasonal or menstrual patterns, reproductive context, family history, and periods of activation or reduced need for sleep. Determine whether changes clustered into distinct departures from baseline and what others observed. Irritability, increased activity, unusual confidence, rapid speech, risk-taking, or markedly reduced sleep can change the differential, but no single feature settles polarity. Ask what treatment or contextual change preceded recovery without treating response as proof of one cause. When recall is incomplete, records or collateral history may add evidence with consent; their absence should lower confidence rather than produce a confident conclusion.

**Context.** Ask about loss, bullying, abuse, discrimination, conflict, financial pressure, caregiving strain, school demands, and unsafe relationships. A visible stressor neither proves nor excludes depression: understandable distress can become severely impairing, while a diagnostic label can obscure conditions that still require direct action. Clarify the sequence among adversity, withdrawal, hopelessness, sleep change, and loss of interest, and identify who has authority to improve the environment. Differences between accounts should be documented as questions to investigate, not as proof that one source is unreliable.

**Differential diagnosis.** Review medical illness, pain, sleep disorder, substances, medication, trauma, anxiety, ADHD, learning needs, psychosis, and bipolar activation against the same timeline. Fatigue, poor concentration, irritability, and sleep change occur across these states, so ask which symptoms began together, what persists during preferred activities, and what changes with recovery or exposure. New neurological or systemic signs, medication change, intoxication or withdrawal, or an atypical course may alter urgency and the order of assessment. More than one explanation may remain; specify whether the next step is examination, prescriber review, targeted investigation, developmental history, or observation over time.

**Risk and protection.** Ask directly about death wishes, self-harm, intent, planning, access to means, rehearsal, and previous action, then ask what has prevented action and who can help now. A total questionnaire score cannot replace this conversation. Assess psychosis, severe agitation, intoxication, self-neglect, safeguarding, and the ability to eat, drink, take necessary medication, and remain safe. With adolescents, explain confidentiality and its safety limits before disclosure and identify an appropriate adult or service without exposing the young person to retaliation. Record current confidence, immediate actions, and the threshold for urgent escalation.

**Consent and follow-up.** With adolescents, explain what may remain private, what must be shared for safety, who will receive information, and how the young person can participate in that conversation. Collateral reports should answer a defined question about change or function, not become a vote on credibility. Name a review date, a responsible clinician or service, and the observations that should trigger earlier contact.

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Interpret these domains longitudinally and in combination. One answer may support several hypotheses, while silence may reflect absence, memory, shame, language, fear, or the way a question was asked. Record the source and confidence of material observations and state what evidence would strengthen or weaken the working formulation. When findings conflict, choose a defined next step—clarification, consented collateral information, targeted medical review, or scheduled observation—and set a review date. Early recognition becomes clinically useful when it leads to an explicit next step while preserving diagnostic alternatives and the person's participation in decisions.

## XII. CRITICAL APPRAISAL AND EVIDENCE TRANSFER

Clinical application depends on what each study design can support. Professional guidance integrates evidence and expert judgment for defined populations, services, and dates; it does not remove the need to examine exclusions and later updates. Systematic reviews reduce selective citation but inherit the definitions and biases of their included studies. Original studies can provide chronology and clinical detail while remaining vulnerable to sampling, measurement error, confounding, and chance.

Measurement choices also matter. Diagnostic interviews, symptom questionnaires, single risk items, behavioral records, and administrative outcomes capture different aspects of early depressive change and are not interchangeable. A statistically reliable group difference may be imperceptible to an individual, while a meaningful functional change may be missed by a narrow symptom total. The measure should therefore be named when it affects interpretation and read alongside personal baseline, course, participation, and direct risk assessment.

Causal language should follow the design. Cross-sectional association cannot establish which variable came first. Longitudinal association improves temporal ordering but may retain confounding and measurement error. Random allocation supports causal inference for the tested intervention under trial conditions, not for every mechanism proposed to explain the result. Mechanistic accounts in this review are therefore treated as models that organize testable observations rather than as facts about one person's hidden cause.

Heterogeneity is clinically relevant. Average effects can conceal people who benefit, do not respond, deteriorate, or cannot access the intervention. Trials often exclude medical complexity, active substance problems, acute risk, unstable housing, language barriers, or multiple diagnoses. Before applying an estimate, the assessor should compare the study population, treatment competence, dose, outcome, and setting with the decision at hand.

The search was closed on 30 November 2023, and guidance is cited in the version available at that date. Later safety warnings, revised diagnostic systems, updated recommendations, retractions, or comparative evidence may change clinical application. The cutoff is therefore a transparent boundary, not a claim that the evidence base is complete.

Assessment and treatment carry burdens as well as benefits. Assessment can stigmatize, alarm, expose sensitive information, or delay more appropriate care. Treatment can involve adverse effects, opportunity costs, financial strain, or deterioration. Monitoring should include unwanted effects and reasons for discontinuation; absence of benefit should prompt review of fit, implementation, diagnosis, and context rather than an accusation that the person did not try hard enough.

Local JPPC articles are used as prior clinical and theoretical work, not as substitutes for external evidence. Their communication-oriented propositions should be interpreted at the level their methods support. Where they generate useful questions, this review places those questions alongside professional guidance, systematic evidence, or original research and discloses the author's interest in Communication-Focused Therapy.

## XIII. DEVELOPMENTAL INTERPRETATION IN ADOLESCENCE

In adolescence, the baseline itself is changing. Comparison with peers is therefore less informative than comparison with the young person's own trajectory. Genetic, developmental, cognitive, and environmental influences interact with school, family, peer, online, and identity contexts (Thapar et al., 2012). Irritability may be prominent but remains nonspecific. Assessment should consider anhedonia, sleep, appetite, concentration, guilt or hopelessness, self-harm, risk-taking, bullying, trauma, neurodevelopmental history, substances, physical health, and the quality of available support.

Confidentiality should be explained rather than assumed. A clear explanation of confidentiality may facilitate disclosure of self-harm, abuse, sexuality, substance use, or family conflict by clarifying what can remain private and what must be shared for safety. Caregiver and school information can clarify change and function, but it should not erase the adolescent's account or expose the young person to retaliation. Guidance from GLAD-PC, NICE, and the American Academy of Child and Adolescent Psychiatry (AACAP) supports developmentally appropriate collaboration, systematic assessment, treatment planning, and monitoring (Zuckerbrot et al., 2018; Cheung et al., 2018; National Institute for Health and Care Excellence, 2019; Walter et al., 2023).

School decline is a signal, not a diagnosis. Attendance and grades may deteriorate because of depression, anxiety,

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ADHD, learning difficulty, bullying, caregiving, poverty, sleep disruption, chronic illness, or an unsafe environment. Assessment should ask what changed first, whether concentration fails during preferred as well as nonpreferred activities, and whether interest has been lost or displaced. Safeguarding, workload adjustment, learning support, sleep protection, or family assistance may be justified before diagnostic certainty is complete.

## XIV. FROM RECOGNITION TO PROPORTIONATE ACTION

Concern should be raised with observations rather than an imposed label: "I have noticed that you stopped coming to training and seem exhausted; how has the last month been?" Open questions allow sadness, numbness, irritability, shame, bodily distress, or another explanation to emerge. Silence, disagreement, and difficulty finding words are clinical information, not noncompliance. Direct questions can clarify current risk and, in the available review evidence, did not increase suicidal ideation (Dazzi et al., 2014); the response should examine intent, planning, means, recent behavior, protective relationships, intoxication, agitation, psychosis, and the ability to use support.

Early warning is not the same as predicting every episode. Group-level predictors cannot predict an individual's future course with certainty. A personal warning plan is more modest: identify two or three markers that have preceded deterioration, specify who can observe them, and link them to actions and review points. This caution is supported by a systematic review that found 12 studies of 11 prognostic models for relapse or recurrence; 11 studies were at high risk of bias, external validation was limited, and none assessed clinical utility (Moriarty et al., 2022).

Proportionality links evidence to action. One nonspecific change justifies curiosity and scheduled review; a persistent cluster with functional decline justifies assessment and practical support; escalating risk justifies urgent safety action. Earlier JPPC work on treatment-resistant depression, Communication-Focused Therapy (CFT) for depression, and questions in therapy highlights how symptoms and help-seeking are communicated (Haverkampf, 2016; Haverkampf, 2017a; Haverkampf, 2017b). That perspective can inform inquiry, but it does not replace developmental evidence, medical assessment, or guideline-based care.

## XV. MONITORING AND FORMULATION REVISION

Follow-up should measure outcomes that matter to the person: return of interest, sleep regularity, energy, school or work participation, self-care, social contact, hopelessness, and safety. Symptom scales add comparability, but functional recovery may lag behind or precede score change. An adolescent may resume school before enjoyment returns; an adult may report less distress only because responsibilities have been abandoned. Review should therefore examine symptoms, participation, and the hidden support that makes current functioning possible.

The plan should name thresholds for escalation. Rapid deterioration, inability to eat or drink, severe self-neglect, suicidal intent, psychotic depression, catatonic features, marked agitation, or possible mania require urgent assessment. Less acute but persistent change warrants scheduled review even when a full syndrome is not yet clear. Risk scales should not be used to predict individual suicide or to decide access to care (National Institute for Health and Care Excellence, 2022b).

Formulation revision is expected. If mood improves after contributing factors such as sleep disruption, pain, medication effects, bullying, or excessive workload are addressed, the initial depressive formulation may narrow; if anhedonia, hopelessness, and impairment persist, confidence may increase. New periods of reduced need for sleep, elevated or irritable activation, psychosis, substance change, or cyclical course can reorder the differential. The record should preserve the original observations while updating their interpretation, allowing diagnostic learning without implying that earlier distress was unreal or undeserving of care.

## XVI. EARLY INTERVENTION WITHOUT PREMATURE LABELING

Support can begin before diagnostic confidence is complete. Restoring sleep opportunity, reducing an acute school burden, addressing bullying, arranging primary-care review, reconnecting a supportive adult, and scheduling follow-up may all be justified by impairment or risk. The rationale should be explicit: the change is real and warrants help, while the diagnosis remains open. This avoids the false choice between doing nothing and assigning a permanent label after one difficult week.

For adolescents, family involvement should be specific. Caregivers can reduce criticism, protect routines, restrict access to lethal means when risk is present, support attendance at appointments, and notice worsening withdrawal or agitation. They should not become constant mood monitors or interrogators. The young person needs a private route to care, a clear explanation of safeguarding limits, and developmentally appropriate participation in decisions. When home is unsafe, other protective adults or services must be engaged.

Adults may need temporary workplace or caregiving adjustments while assessment proceeds. A clinician can describe functional limitations without disclosing unnecessary diagnostic detail and can distinguish short-term protection from a long-term occupational conclusion. Social withdrawal

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should be addressed gently: one reliable point of contact may be more achievable than a demand to resume every activity. Early action is most useful when it reduces risk and preserves connection without converting ordinary fluctuation into a medical emergency.

The decision to begin formal treatment should integrate severity, duration, recurrence, previous response, preference, access, comorbidity, and safety. Active monitoring is justified only when it includes a review date, defined outcomes, and an escalation route (National Institute for Health and Care Excellence, 2019, 2022a; Cheung et al., 2018). If follow-up is missed, the degree of outreach should be proportionate to risk and service responsibility. The aim of early recognition is to shorten unsupported deterioration and improve entry into appropriate care, not to maximize the number of people given a diagnosis.

## XVII. SAFETY, URGENCY, AND BOUNDARIES

Depression may involve suicide risk, self-neglect, psychosis, severe agitation, substance-related risk, or safeguarding concerns. Any marked or unexpected behavioral change should be interpreted in context and may warrant direct inquiry, but no single change, factor, or scale accurately predicts an individual's action. Risk formulation integrates current intent and means, previous behavior, dynamic stressors, protective factors, access to care, and the person's ability to collaborate with immediate safety steps (National Institute for Health and Care Excellence, 2022b).

**Urgent and safeguarding considerations**

- Ask directly, when clinically indicated, about suicidal thoughts and self-harm, intent, plans, means, rehearsal, previous attempts, violence, exploitation, severe intoxication or withdrawal, inability to meet basic needs, and current ability to stay safe.
- For a child or adolescent, address abuse, exploitation, bullying, access to lethal means, and who can provide immediate supervision and support.
- Escalate urgently for severe self-neglect, psychotic depression, mania or mixed activation, intoxication, a new focal neurological sign, delirium, catatonia, marked behavioral change, severe medical symptoms, or rapidly deteriorating function or mental state.
- This educational review cannot determine an individual diagnosis, fitness for work, medication plan, or level of care; those decisions require an appropriately qualified clinician with access to the person and relevant records.

## XVIII. LIMITATIONS AND RESEARCH NEEDS

Prediction before a first depressive episode remains imprecise because early changes are nonspecific, retrospective accounts are shaped by memory and current mood, and studies vary in age, setting, measures, and outcomes. Cultural and developmental factors also influence mood, behavior, and somatic expression. This review therefore supports a monitored formulation rather than individual prediction and does not provide an exhaustive suicide-risk protocol or an age-specific treatment guideline.

Social support is associated with lower depression risk, but heterogeneous measures and weaker cohort effects constrain causal interpretation (Gariépy et al., 2016). Future studies should follow individual warning sequences prospectively, distinguish changes reported by the person from those supplied by family, school, services, or administrative records, and test whether actions linked to early signals improve time to care, function, and safety without increasing unnecessary labeling. Research should report both benefit and burden, including false alarms and missed episodes.

## XIX. CONCLUSION

Early recognition of depression is best understood as a longitudinal inference rather than a checklist exercise. Diagnostic confidence increases when a sustained deviation from personal baseline converges across interest, mood, cognition, bodily rhythms, relationships, and function. Screening scores can organize inquiry but cannot establish cause, polarity, or suicide risk. A personalized warning plan has clinical value only when it translates previous prodromes into observable markers, named supports, a review interval, and explicit thresholds for escalation. Adults may preserve visible occupational roles while life contracts elsewhere; adolescents may present through irritability, school change, altered peer contact, risk behavior, withdrawal, or physical complaints that require developmental interpretation. The practical aim is not maximal case finding, but a shorter interval between meaningful change and proportionate, revisable care.

## XX. CONFLICTS OF INTEREST AND DISCLOSURES

**Conflicts of interest—**The author developed and writes about Communication-Focused Therapy (CFT). CFT is presented here as a formulation perspective, not as a substitute for established diagnostic assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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**Patient material—**No identifiable patient material is presented. Brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

Haverkampf, C. J. (2023). Early Warning Signs of Depression in Adults and Adolescents: A Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Dec 31;12(4):91-100

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