Diagnosis of Major Depression in the Primary Care Setting

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Major depression is one of the most prevalent psychiatric disorders in children and adolescents, occurring in approximately 2% of children and 4-8% of adolescents. Pediatric primary care providers are in a unique position to identify depression early in its course. Without early identification and treatment, pediatric depression has a profound effect on social and emotional development and leads to many adverse outcomes including suicide, substance abuse, school failure, family conflict, and antisocial behavior. Primary care providers often feel that the formal diagnosis of depression can only be made by a specialist. Actually, the diagnosis of major depression in children does not require esoteric knowledge or particularly sophisticated interviewing techniques. Establishing rapport with children and families is usually the most challenging aspect of psychiatric interviewing and primary care providers often have the foundation of a well-established relationship. After a careful history from both the patient and caregiver and an assessment of mental status, primary care providers can readily apply standardized diagnostic criteria (DSM IV TR) in order to make a definitive diagnosis of depression. The following overview of the criteria for major depression from the DSM IV-TR is offered for review and future reference:

Five or more of the following symptoms must be present during the same 2-week period in addition to a depressed mood nearly every day:

- Decreased interest or pleasure in activities
- Significant weight loss (without diet) or weight gain, or change in appetite. In children, this may be noted as a failure to make expected weight gains
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- For an accurate diagnosis of Major Depression, you must also establish that the symptoms have caused clinically significant distress or impairment in social, occupational, or other important areas of functioning and that the symptoms occur nearly every day.

It is very important to keep in mind that children with depressive symptoms will not always clearly report them upon interview. The evaluator must include observations of caretakers, additional providers, family members, teachers, etc. as part of their diagnostic process. It is essential to look for common signs of depression such as tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry and somatic complaints. Children and adolescents in particular often express depression through irritability, separation anxiety, anger and oppositional behaviors.

Although each of the above-mentioned symptoms may be found in depressed patients, they are non-specific. There are many differential diagnoses to consider when assessing depression, including Bipolar Disorder, Substance Abuse Disorders, Adjustment Disorders, Bereavement,

ADHD and Anxiety Disorders. Manic symptoms in Pediatric Bipolar Disorder can include irritable mood, rapidly changing moods, explosive/aggressive outbursts, defiance, hyperactivity, agitation, distractibility, sleep irregularity, impulsivity, racing thoughts, impaired judgment, separation anxiety, and delusions and/or hallucinations. Adjustment Disorders can occur with depressive, behavioral and anxious symptoms and can be differentiated from depression primarily by the ability to clearly identify a psychosocial stressor underlying the adjustment difficulty. By definition, symptoms of adjustment disorder must develop within 3 months of the onset of the stressor and typically last up to 6 months after the termination of the stressor. Substance disorders must be considered in any adolescent presenting with depressive symptoms. All of the above differential diagnoses can also be comorbid with depression.

To help with an accurate diagnosis of Major Depression, primary care providers can use rating scales for purposes of assessment. One highly recommended tool is the Children's Depression Inventory (CDI) which can be purchased for screening purposes. The CDI can be ordered through www.mhs.com/ecom/ or additional sites can be located online. Other depression rating scales may be found at
www.massgeneral.org/madiresourcecenter/schoolpsychiatry/screeningtools_table.asp
Or alternatively at it's parent web-site www.schoolpsychiatry.org
Once the primary care provider is confident of a diagnosis of Major Depression, a treatment plan should be formulated immediately for the child/adolescent in need. An effective treatment plan should include a referral for psychotherapy and antidepressant medication may be considered to as part of a comprehensive treatment plan. It is vitally important for any patient with depression to be screened for suicide risk at the time of the initial diagnosis and throughout the course of treatment. Parents and adolescents should be educated that suicidal thoughts and feelings are commonly associated with depression and that this can emerge in the course of treatment. Advance planning for emergency access to treatment should be made. Consultation with a child psychiatrist, either through the MCPAP program or to a community provider, should be considered in the case of severe depression, treatment refractory depression, depression that is associated with significant suicidality and/or depression associated with psychosis or problems with reality testing.