

Madigan Army Medical Center Referral Guidelines

Childhood Depression

Diagnosis/Definition

Definition

- Depression is defined as an illness when the feelings of unhappiness or sadness persist and interfere with a child or adolescent's ability to function.
- About 5 percent of children and adolescents in the general population suffer from depression at any given time.
- Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression.
- Depression also tends to run in families.
- Children and adolescents who are depressed may say they want to be dead or may talk about suicide.
- Depressed children and adolescents are at increased risk for committing suicide.
- Depressed adolescents may abuse alcohol or other drugs as a way to feel better.

Diagnosis

Primary care clinicians should consider depression in a child presenting with any of the following concerns:

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomach aches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

The DSM-IV diagnosis of a Major Depressive Episode requires:

- At least 5 symptoms of depression have been present during the same 1-week period and represent a change from previous functioning
- At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The symptoms are not due to the direct physiological effects of a substance or a general medical condition
- The symptoms are not better accounted for by bereavement

Initial Diagnosis and Management

- Perform standard history and physical examination focusing on the above mentioned features.
- Inquire about substance use: OTC, alcohol, smoking, caffeine, illicit
- Assess suicide risk: thoughts, plans, means, intent
- Assess family history of depression, response to medications, seasonal variation in symptoms, hormonal association of symptoms
- Consider laboratory tests to r/o common medical causes: anemia, hypothyroidism, diabetes, infectious mono, etc.
- May use self-report instruments: Child Depression Inventory (CDI), Beck Depression Inventory (BDI)

Ongoing Management and Objectives

- Collaborate with parents and child (and school) to specify appropriate target symptoms and functional outcomes to guide management. Common examples:
 - Improve mood
 - Improve sleep
 - Improve academic performance, particularly in volume of work, efficiency, completion, and accuracy
 - Improve self-esteem
 - Improve relationships with family members, teachers, and peers
- Decrease disruptive behaviors
- Recommend antidepressant medication* and/or cognitive behavior therapy, as appropriate, to improve target outcomes (*See Pharmacy's therapeutic guidelines for SSRIs)
- For mild to moderate depression, psychotherapy is considered equally effective to medications.
- Initiate antidepressant therapy in children 12 or older. (Starting pediatric dosages should be ½ that of adults to minimize side effects.)
- Inform parents and child of recent FDA warnings about SSRIs. Watch for worsening of depression or suicidality, agitation, irritability, hostility, impulsivity, akathisia (severe restlessness), or mania
- Titrate dosage every 2-4 weeks to maximum effect or limiting side effects
Recommend reading "Feeling Good: the new mood therapy" by Dr. David Burns
- Provide systematic follow-up and monitor target outcomes and adverse medication effects by obtaining specific information from parents, child and teacher.

Indications for Specialty Care Referral

Evaluation by a pediatric specialist (child psychologist, child psychiatrist, or child and adolescent social worker) is suggested for:

- Persistent suicidal ideation
- Plans or intent to commit suicide

- Psychotic symptoms: delusions, hallucinations
- Recurrent self-injurious behavior (SIB): e.g. cutting
- Persistent depression despite two adequate trials of antidepressants (4-6 weeks at adequate dose).

Referral to multidisciplinary care through TriWest

- Drug or alcohol abuse
- Eating disorder: anorexia or bulimia

Criteria for Return to Primary Care

- Completed specialty care evaluation with established diagnosis, evidence of co-morbid diagnoses, change in medication recommendations, etc. with recommendations that can be accomplished at a primary care level.
- A level of involvement that can be managed by a primary care manager with ongoing monitoring by subspecialists.

Please also see Depression Clinical Standard.

Last Review for this Guideline: **April 2010**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
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