



ADOLESCENT DEPRESSION

Is your young patient suffering in silence?

This review of the GLAD-PC guidelines—specifically developed for primary care clinicians—can help you spot depressed teens. Next month we describe how GLAD-PC can help refine your treatment approach.

You've known Jane since infancy. Now she's 15 and in your office for her yearly checkup. As she comes into the exam room, you notice she's gained a lot of weight since you saw her a year ago. She's also missing the energy and sparkle that have always been such an engaging part of her personality. When you trot out your usual questions for teens—How's school? Keeping up your grades? Going out for a team?—her answers are disquieting. School's dull, her grades have gone downhill, and she's dropped out of gymnastics. Her mother says Jane is irritable and sleeping a lot, and that worries her.

Could Jane be going through a bout of clinical depression?

■ Teen depression: Common, and commonly untreated

In North America, about 9% of all teenagers meet the criteria for depression at any given time, and prevalence rates in primary care are very likely higher.¹ One study in the 1990s found approximately 28% of teens presenting to a primary care office met criteria for depression.²

Although adolescents with depres-

sion frequently seek care in the primary care setting, most are not identified or treated because of any number of barriers.^{3,4} First, mental illness continues to be highly stigmatized. As a result, many troubled teens (and parents of these teens) do not seek help.⁴ Second, mental health professionals trained to treat adolescents are in short supply, and most family physicians and other primary care clinicians feel inadequately trained, supported, or reimbursed for the management of this disorder.⁵ Third, the controversy over the safety and efficacy of antidepressants in the pediatric population has created an additional barrier to care.

In addition, while clinical guidelines for diagnosing and treating adolescent depression have been developed for specialty care settings,⁶ they are not easily transferred to primary care because of the significant differences between the primary and specialty care settings. Recognizing this gap in clinical guidance, a group of researchers and clinicians (including the authors of this report) from the United States and Canada established a collaborative to formulate primary care guidelines for adolescent depression (GuideLines for Adolescent Depression

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How teenage depression is different from that of adults

Teenage depression may not look like adult depression. Teens are more often irritable than sad, and their moods vary with their surroundings (ie, mood reactivity): They may be fine when they're hanging out with friends, and become depressed again at home or in school. The depressive symptoms they exhibit can range from complaints about stomach aches to fights with family and friends, skipping school, getting poor grades, or substance use.

in Primary Care, or GLAD-PC). Details about the collaborative's methods and recommendations were published in *Pediatrics* in 2007.^{7,8} The accompanying clinician toolkit is available at www.gladpc.org.

This review summarizes the collaborative's key findings and recommendations and includes evidence from additional research published since the completion of GLAD-PC in 2007. For simplicity's sake, we use the term "depression" to refer to what is more formally known as major depressive disorder (MDD).

■ Red flags that you are well positioned to spot

As a family physician, you have the advantage of knowing the families in your practice well and over a long time span. Drawing on that knowledge, you are well placed to spot the red flags that may signal depression in an adolescent patient.

Risk factors for the disorder are well known: a previous episode of depression, a family history of depression, the presence of other psychiatric disorders such as anxiety or attention deficit hyperactivity disorder (ADHD), substance abuse, or life stressors such as bereavement, abuse, or divorce. Teens with depression may complain of emotional problems, or turn up with repeated somatic complaints—headaches, stomach aches, fatigue—that have no apparent

physiologic explanation. Their responses to general questions, such as "How is your mood?" or "Have you been sad?" may be worrisome. Or they may screen positive on self-report checklists such as the Beck Depression Inventory (BDI) or the Kutcher Adolescent Depression Scale (KADS), available for download at www.cprf.ca/education/Openmind2006/KADS11.pdf and free for use with permission.^{9,10}

Routine screening of all adolescents for depression may be feasible, but the US Preventive Services Task Force concluded in 2002 that the evidence was insufficient to recommend for or against the practice.^{7,11,12} Expert opinion suggests that among adolescents at elevated risk for depression, depression checklists are useful during well-child and urgent care visits. However, families will likely find general questions more acceptable during acute care visits.¹⁰

GLAD-PC Recommendation I: Patients with depression risk factors such as history of previous episodes, family history, other psychiatric disorders, substance abuse, trauma, or psychosocial adversity should be identified (strength of recommendation [SOR]: **C**, expert opinion and cohort studies) and systematically monitored over time for the development of a depressive disorder (SOR: **C**, expert opinion and cohort studies).

GLAD-PC Recommendation II: Family physicians should consider the diagnosis of depression in high-risk adolescents and those who present with emotional problems as their chief complaints (SOR: **B**, cohort studies and randomized controlled trials [RCTs]).

"SIGECAPS" mnemonic can help as you evaluate the patient

When you suspect depression, take a detailed history. The diagnostic criteria for depression given in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) are shown in **TABLE 1**.^{7,10,13}

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Sometimes irritability is the major symptom in a depressed teen.

TABLE 1

Diagnostic criteria for major depressive episode (DSM-IV-TR)

- A.** Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least 1 of the symptoms is either depressed mood or loss of interest.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad or empty) or observation made by others (eg, appears tearful).
 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
 3. Significant weight loss when not dieting or weight gain.
 4. Insomnia or hypersomnia nearly every day.
 5. Psychomotor agitation or retardation nearly every day.
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt.
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
 9. 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.
- B.** The symptoms do not meet criteria for mixed episode.
- C.** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D.** The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, or a medication) or a general medical condition (eg, hypothyroidism).
- E.** The symptoms are not better accounted for by bereavement, that is after a loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Association; 2000.

Bear in mind, however, that adolescents who do not meet the full criteria may still be quite impaired and in need of help. The SIGECAPS mnemonic (sleep, interest, guilt, energy, concentration, appetite changes, psychomotor agitation or retardation, suicidality) can help you recall the neurovegetative symptoms in the depression criteria.

Ask about bereavement, manic symptoms (eg, feeling irritable/giddy/silly, hyperactive, racing thoughts), substance use, and life stressors. Ask, too, whether the teen has been treated for mental health problems in the past, and if there is any history of physical or sexual abuse or a family history of mental illness. Because depression is often comorbid with other conditions, you should also inquire

about other psychiatric disorders, such as ADHD and anxiety disorders.

The next step. When risk factors or checklists alert you to the possibility of depression, the next step is a more formal evaluation. Because teens and parents often feel uncomfortable disclosing information in the presence of the other, separate interviews are a good idea. Information crucial to the diagnosis may be available only from the adolescent or only from the parent or caregiver, and then only if they are interviewed separately.⁷

Parents may—or may not—pick up on their child's depression. On the one hand, parents will often have important clues to their child's diagnosis, such as recent withdrawal from social or extracurricular activities. On the other hand, they

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TABLE 2

Is a medical cause to blame for those symptoms of depression?

MEDICAL CAUSES	SYMPTOMS	INVESTIGATIONS
Hyper- or hypothyroidism	Insomnia, agitation, weight loss or gain	Thyroid function tests
Anemia	Fatigue, hypersomnia	Complete blood count
Sleep disorder	Fatigue, insomnia	Sleep assessment
Mononucleosis/viral infections	Fatigue, hypersomnia	EBV test
Medications		
Steroids	• Low mood, weight gain, increased appetite	Complete history of medication use (temporal relationship to onset of symptoms)
Albuterol sulfate (Ventolin)	• Irritability, insomnia	
Isotretinoin (Accutane)	• Low mood, suicidality	Medication re-challenge test
EBV, Epstein-Barr virus.		

may attribute their teen's behavior to normal adolescent moodiness. Or they might not recognize their teenager's depression because teens don't need to be "sad" to be depressed. Sometimes irritability is the major symptom in a depressed teen. (See "How teenage depression is different from that of adults" on page 188.)

Further compounding matters: Since depression is an internalizing disorder, teens may not share their innermost thoughts and emotions with their parents.

Is it MDD, or something else?

Although most of the literature on depression is focused on MDD, you should be aware that there are many subtypes of depression, including dysthymia (in which patients have longstanding depressive symptoms but with less functional impairment than major depression) and adjustment disorder (in which patients develop depressive symptoms in response to an acute stressor). As mentioned above, physicians should also assess for psychiatric disorders that are commonly comorbid with depression, because their presence can affect management. These include anxiety disorders, ADHD, eating disorders, and substance abuse.

Ruling out alternative diagnoses. In assessing potentially depressed teenagers like Jane, ruling out conditions with similar symptoms is essential. Medical conditions to be considered in the differential diagnosis are anemia, malignancies, hypothyroidism, and mononucleosis—as well as other viral conditions. There is, however, no evidence to support routine lab testing (including for hypothyroidism) of adolescent patients. Laboratory and other diagnostic evaluation should, instead, be guided by history and targeted physical exam. **TABLE 2** presents common medical causes of symptoms of depression that must be considered in the differential diagnosis.

Consider bipolar disorder. Depressive symptoms may also be part of a cycling mood disorder, such as bipolar disorder. In fact, most teens with bipolar disorder will first present with depressive symptoms. Adolescents with depression as part of a bipolar disorder are more likely to have adverse effects with antidepressants than are teens with depression alone. In order to adequately rule out bipolar depression, ask about:

- rapid onset of depressive symptoms: "She just woke up one day and couldn't stop crying," for instance

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TABLE 3

Grading the severity of depressive episodes

In both the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) and the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10), severity of depressive episodes is based on the number, type, and severity of symptoms, as well as the degree of functional impairment. The DSM-IV-TR guidelines are summarized in the table below.

DSM-IV-TR GUIDELINES FOR GRADING DEPRESSION SEVERITY

	MILD	MODERATE	SEVERE
Number of symptoms	5-6	*	Most†
Severity of symptoms	Mild	*	Severe
Degree of functional impairment	Mild impairment or normal functioning but with “substantial and unusual” effort	*	“Clear-cut, observable disability”

*According to the DSM-IV-TR, moderate episodes of depression “have a severity that is intermediate between mild and severe.”

†Cases should be considered severe if patients report all 9 symptoms. However, those who do not report all 9 symptoms but do report the key symptoms of depression (eg, sadness/irritability, loss of interest) along with active suicidality, psychosis, or significant impairment in functioning should be considered in the severe range.

In addition to the above framework, individual rating scales are associated with their own indicators of severity, as indicated in the GLAD-PC toolkit.

Source: Used with permission from GLAD-PC (www.gladpc.org).

- psychotic symptoms
- family history of bipolar disorder, especially in first-degree relatives
- previous symptoms of mania while on antidepressant treatment (eg, hyperactive, rapid speech, decreased need for sleep).

If a patient has these symptoms or a history of bipolar disorder, refer her or him for a mental health consultation before starting antidepressant treatment.

■ Help in classifying the severity of depression

The severity of depression can vary considerably from one patient to another, and distinguishing mild, moderate, and severe depression has significant implications for treatment. Guidelines for grading depression severity are given in TABLE 3. A common way to classify the severity of a depressive episode is to count the number of symptoms the teenager is displaying.⁷ If all 9 symptoms in the DSM-IV-TR criteria are present, the depression would

be classified as severe. But even with fewer symptoms, depression should be considered severe if the teenager is suicidal (has a specific suicide plan, a clear intent, or has made a recent attempt); has psychotic symptoms; or functioning is severely impaired (eg, patient is unable to go to school). The *Diagnostic and Statistical Manual of Mental Disorders: Primary Care Version* (DSM-PC) is also a useful resource for distinguishing between transient depressive responses and depressive disorders.

Ask yourself: Is this teenager impaired?

Symptoms, in themselves, are not enough to clinch the diagnosis. The fundamental question is whether the symptoms prevent your patient from normal functioning. To judge the extent of a patient's impairment, you need to assess overall functioning and ask about school, home, friends, and leisure activities. Impairment can be determined by asking the patient and parents the simple questions that ev-

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The key question is whether the patient's symptoms are interfering with normal functioning.

ery family physician is familiar with:

- How is Jane doing in school? Have her grades slipped lately?
- How is life at home? Does Jane's mood affect family relationships?
- Does Jane have good friends she can talk to?
- Has her mood affected her ability to maintain friendships?
- What does Jane do for fun? Has she been doing those things lately?

First and foremost, keep your patient safe. Even if you can't do a complete assessment, your evaluation must at least include the determination of acute risk of harm, either from self-inflicted injury or from impaired judgment. At minimum, assess for suicidality, self-injurious behavior, altered sensorium, substance use, and access to firearms.⁷ Again, this can be aided by the teen's answers to symptom checklists. ■

GLAD-PC Recommendation III: Family physicians should assess for depressive symptoms based on diagnostic criteria established in the DSM-IV or *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10) (SOR: **B**, epidemiological studies) and should use standardized depression tools to aid in the assessment (SOR: **A**, RCTs).

GLAD-PC Recommendation IV: Assessment for depression should include direct interviews with the patients and families/caregivers separately (SOR: **B**, cohort studies) and should include the assessment of functional impairment in different domains (SOR: **C**, expert opinion) and other existing psychiatric conditions (SOR: **B**, cohort studies).

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Disclosures

Dr. Cheung served on Eli Lilly's speakers' bureau between 2004 and 2005. Dr. Jensen serves as a consultant to Shire, Inc., Janssen-Ortho, Inc., McNeil Pharmaceuticals, and Best Practice, Inc. Drs. Ewigman and Zuckerbrot reported no conflict of interest relevant to this article.

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At minimum, assess for suicidality, self-injurious behaviors, altered sensorium, substance abuse, and access to firearms.

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