Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Depression Treatment Guide

DSM V Criteria for Major Depressive Disorders

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 one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1) Depressed mood most of the day, nearly every day, as indicated by either subjec tive report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

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).

3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month}, or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4) Insomnia or hypersomnia nearly every day.

5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6) Fatigue or loss of energy nearly every day.

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

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 cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a nat ural disaster, a serious medical illness or disability) may include the feelings of intense sad ness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understand able or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss. [1]

D. The occurrence of the major depressive episode is not better explained by schizoaf- fective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders. There has never been a manic episode or a hypomanic episode.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

DSM V Criteria for Major Depressive Disorders

296.2x Major Depressive Disorder, Single Episode

A. Presence for a single Major Depressive Episode.

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. Note: This exclusion does not apply if all the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition

If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:

- Mild, Moderate, Severe Without Psychotic Features/ Severe with Psychotic Features
- Chronic
- With Catatonic Features
- With Melancholic Features
- With Atypical Features
- With Postpartum Onset

If the full criteria are not currently met for a Major Depressive Episode, specify the current clinical status of the Major Depressive Disorder or features of the most recent episode:

- In Partial Remission, In Full Remission
- Chronic
- With Catatonic Features
- With Melancholic Features
- With Atypical Features
- With Postpartum Onset

SOURCE: National Institute of Mental Health. *BiPolar Disorder.*

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

DSM V Criteria

300.4 Persistent Depressive Disorder (Dysthymia)

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least1 year.

B. Presence, while depressed, of two (or more) of the following:

1) Poor appetite or overeating
2) Insomnia or hypersomnia
3) Low energy or fatigue
4) Low self-esteem
5) Poor concentration or difficulty making decisions
6) Feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major de pressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

With anxious distress
With mixed features
With melancholic features
With atypical features
With mood-congruent psychotic features
With mood-incongruent psychotic features
With peripartum onset

Specify if:

In partialremission In full remission

Specify if:

Mild Moderate Severe

Specify if (for most recent 2 years of persistent depressive disorder):

With pure dysthymic syndrome:Full criteria for a major depressive episode have not been met in at least the preceding 2 years.

With persistent major depressive episode: Full criteria for a major depressive epi sode have been met throughout the preceding 2-year period.

With intermittent major depressive episodes,with current episode:Full criteria for a major depressive episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full major depressive episode.

With intermittent major depressive episodes, without current episode: Full crite ria for a major depressive episode are not currently met, but there has been one or more major depressive episodes in at least the preceding 2 years.

Specify if:

Early onset: If onset is before age 21 years. Late onset: If onset is at age 21 years or older

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Differential Diagnosis of Depressive Symptoms

In Adolescents

Below is a comprehensive list of disorders that can either be comorbid or mimic the symptoms of depression.

Some patients may have a medical etiology for their symptoms and ruling out medical causes of depressive symptoms should be done prior to any mental health treatment or referral. However, no lab tests or imaging is routinely required. The medical work-up should be guided by the history and physical.

Along with ruling out normal mood changes of adolescence which is generally not associated with changes in functioning (e.g., drop in grades), clinicians should assess for any symptoms of bipolar disorder. Bipolar disorder is less common in teens than adults. In addition, many teens that may go on to have bipolar disorder will be presenting first with a depressive episode in adolescence and thus diagnosing bipolar disorder at this point will not be possible. However, since teens with bipolar disorder can have significant adverse effects when treated with antidepressants, obtaining any history of past or current bipolar symptoms is critical. The symptoms of bipolar disorder including an extended period (at least a few days) of elevated mood (either happy or irritable or both), decreased need for sleep, high energy, increased speech, increased thoughts, acting silly or inappropriate, poor judgment, and grandiosity. Others around the teen will often comment on this behavior – noting it as unusual. In addition, teens with a first degree relative with bipolar disorder are at increased risk of bipolar disorder (although they are at even a greater increased risk for unipolar depression). If clinicians suspect bipolar disorder, a referral should be made to mental health services before initiating treatment.

Differential Diagnosis

Normal Moodiness of Teens
Major Depressive Disorder
Dysthymic Disorder
Substance induced mood disorder
Adjustment disorder with depressed mood
Adjustment disorder with depressed mood and anxiety
Depressive Disorder NOS
Subthreshold Depression
Anxiety disorders
PTSD Depressive episode of Bipolar Disorder
Eating Disorders
ADHD
Conduct Disorder
Anemia
Mononucleosis
Thyroid disorders
Other Medical disorders
Medication adverse effects

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Assessing Severity

In both the DSM and the ICD-10, severity of depressive episodes is based on the number, type and severity of symptoms, as well as degree of functional impairment. The DSM guidelines are summarized in the table below.

Category	Mild	Moderate	Severe
Number of Symptoms	5-6	*	"most"
Severity of Symptoms	Mild	*	Servere
Degree of Functional Impairment	Mild impairment or normal functioning but with "substantial and unusual" effort	*	"Clear-but, observable disability"

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

- See also Patient Health Questionnaire (PHQ-9).

Medication Management

The Depressive Disorder Not Otherwise Specified category includes disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood, or Adjustment Disorder With Mixed Anxiety and Depressed Mood. Sometimes depressive symptoms can present as part of an Anxiety Disorder Not Otherwise Specified.

Examples of Depressive Disorder Not Otherwise Specified include

- Selective serotonin re-uptake inhibitor (SSRI) Antidepressants are considered the first line of pharmacological treatment for pediatric depressive disorders. SSRIs have a superior safety, tolerability and effectiveness profile and a stronger knowledge base than is currently available for newer antidepressants.
- **Fluoxetine** and **Escitalopram** are currently the only drugs approved by the FDA for treating MDD among youth.
- Other SSRIs are sometimes used to treat depression in youth (see table below).

Tips for Prescribing SSRIs in Primary Care

- "Start low and go slow" - Begin with suggested starting dose for the first 3 to 7 days.
- If tolerated, increase to initial target dose.
- Re-evaluate response and increase dose incrementally if partial response.
- If no response at target dose or higher at 4 to 6 weeks, consider consultation with PPN/specialist.
- Also see: GLAD-PC Clinical Management Flowchart.
- See table on next page for medication guidance.

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Medication Management

	SSRI₸	Available Doses	Starting Dose	Max Daily Dose	SSRI Titration Schedule* Every 5-7 days increase dose by:
First Line	Fluoxetine (Prozac)** FDA approved for ages 6-17	10mg tablets 10, 20, 40mg pulvules 90mg weekly pulvule and liquid form	10mg qd****	60mg	10-20mg
	Escitalopram (Lexapro)*** FDA approved for ages 12-17	5, 10, 20mg tablets and liquid form	5mg qd	20mg	5mg
Second Line	Sertraline (Zoloft)**	25, 50, 100mg tablets and liquid form	25mg qd	200mg	12.5-25mg
	Citalopram (Celexa)**	20, 40mg tablets and liquid form	10mg qd	40mg	10mg
	Escitalopram (Lexapro) ***	5, 10, 20mg tablets and liquid form	5mg qd	20mg	5mg
	Paroxetine (Paxil)**	10, 20, 30, 40mg tablets and liquid form	10mg qd	60mg	10mg
	Fluvoxamine (Luvox)**+	25, 50, 100mg tablets and liquid form	25-50mg qdthen bid	300mg	25-50mg

₸Patients who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Parents should be advised of the need for close observation and communication with the prescriber.

* Initiate medicine at lowest possible dose. Titrate weekly until the mid-point of the dose range is reached depending on patient reported side effects, tolerability, and effectiveness.

** Generic medication available *** Generic medication not available **** qd = once a day

+ Not indicated for treatment of depression in U.S.

Note: Contra-indicated medications (NOT exhaustive-please check PDR): MAOIs must not be used with SSRIs listed above plus terfenadine, astemizole, and pimozide for Fluvoxamine (Luvox).

SOURCE: Adapted from American Academy of Pediatric Guidelines for Adolescent Depression in Primary Care (Glad-PC) Toolkit, Version 1, 2007 by Child Health and Development Institute of Connecticut.

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Evidence-Based Psychosocial Therapies

- A growing body of evidence suggests that the combination of an SSRI antidepressant and Cognitive Behavior Therapy (CBT) is superior to either treatment alone. This is important information for patients and families to understand when they are making treatment decisions.

- **Best support:** Cognitive behavior therapy (CBT), CBT and medication, CBT with parents (includes parent and child, focusing on the child's concerns), family therapy.

- **Good support:** Client-centered therapy, cognitive behavioral psychoeducation, expressive writing/ journaling/diary, interpersonal therapy, relaxation.

Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Practice Guidlines

American Academy of Pediatrics

Phase 1

1. Clinicians should educate and counsel families and patients about depression and options for the management of the disorder. Clinicians should also discuss limits of confidentiality with the adolescent and family.
2. Clinicians should develop a treatment plan with patients and families and set specific treatment goals in key areas of functioning, including home, peer, and school.

Phase 2

3. Clinician should establish relevant links/collaboration with mental health resources in the which may include patients and families who have dealt with adolescent depression and are willing to serve as resources to other affected adolescents and their family members.
4. All management must include the establishment of a safety plan, which includes restricting lethal means, engaging a concerned third party, and developing an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors, especially during the period of initial treatment when safety concerns are highest. [1]
5. After initial diagnosis, in cases of mild depression, clinicians should consider a period of active support and monitoring before starting other evidence-based treatment.

Phase 3

6. If a PC clinician identifies an adolescent with moderate or severe depression or complicating factors/conditions such as coexisting substance abuse or psychosis, consultation with a mental health specialist should be considered
7. Appropriate roles and responsibilities for ongoing management by the primary care and mental health clinicians should be communicated and agreed upon.
8. Clinicians should recommend scientifically tested and proven treatments (ie, psychotherapies such as CBT or IPT and/or antidepressant treatment such as SSRIs) whenever possible and appropriate to achieve the goals of the treatment plan.

Ongoing

9. Clinicians should monitor for the emergence of adverse events during antidepressant treatment (SSRIs).
10. Systematic and regular tracking of goals and outcomes from treatment should be performed, including assessment of depressive symptoms and functioning in several key domains: home, school, and peer settings.
11. Diagnosis and initial treatment should be reassessed if no improvement is noted after 6 to 8 weeks of treatment and mental health consultation should be considered.
12. For patients who achieve only partial improvement after PC diagnostic and therapeutic approaches have been exhausted (including exploration of poor adherence, comorbid disorders, and ongoing conflicts or abuse), a mental health consultation should be considered.
13. Clinicians should actively support depressed adolescents who are referred to mental health to ensure adequate management. Clinicians may also consider sharing care with mental health agencies/professionals when possible. Appropriate roles and responsibilities regarding the provision and coordination of care should be communicated and agreed upon by the primary care clinician and the mental health specialist.[2]

SOURCES:

1. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, Assessment, and Initial Management. PEDIATRICS Vol. 120 No. 5 November 1, 2007 pp. e1299 -e1312.

2. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management. PEDIATRICS Vol. 120 No. 5 November 1, 2007 pp. e1313 -e1312.