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Editorial

Physician's Role in Depression among Children

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Without either, the diagnosis of depression among children is rare, increased knowledge has shown through the study of its prevalence it is not uncommon [1] and despite the problems presented between different researchers in the scientific community for it to be accepted, due to the different types of population studied, the lack of agreement to define depression (symptom, syndrome or disorder) and to establish the diagnostic criteria; the different methods of evaluation used; the influence of the level of development and age and the presence of comorbidity; they were given the task of finding their symptoms and characteristics [2,3].

The studies of Akerson&spitzshowed criteria for diagnosis (presence of at least five of the following symptoms for a period of two weeks, almost all day, almost daily: depressed mood or loss of interest or pleasure in almost all activities once enjoyed; changes in appetite or weight, sleep disorders and psychomotor activity, lack of energy, feelings of worthlessness or guilt, difficulty thinking, concentrating or making decisions, and recurrent thoughts of death or suicide plans or attempts), accepted by the National Institute of Mental Health United States in 1977 and in 1980 by the DSM-III [4,5]. Finding a prevalence of 2% among children [6].

In addition, cohort studies have shown that depression at an early age interferes with the development of social, academic and interpersonal skills, affecting the child's adjustment to their environment and promoting the deterioration in various aspects of their life [7].

So what is the role of the physician to this problem? While it has evidence of instruments that have been used for screening as DIGA (Diagnostic Interview for Children and Adolescent) of Herjanic and his group, the CAS (Child Assessment Schedule) of Hodges, Kline, Fitch, Mckrew and Cytrym (1981), the DISC (Diagnostic Interview Schedule for Children) of Costello et al. (1982), the CBCL (Child Behavior Check list) of Achenbach and Edelbrock (1983) [8], the CBTD (Brief Screening and Diagnosis) of Caraveo (2007) [9], the Depression Inventory for Children (CDI, its acronym in English), which it was developed by Kovacs et al. (1983) [10], among others, when and to whom these instruments should be applied? Is it necessary to apply to children in general?

Research findings show risk factors such as family history of depression, poor school performance and impaired family functioning [11,12]. Likewise, the identification of constituent elements of childhood depression, within which are brought to the low self-esteem, sleep disturbances, social withdrawal, changes in appetite and weight, hyperactivity, dysphoria, anhedonia and suicidal ideation as symptoms more consensus among experts [13]. Therefore, these risk factors and the constituent elements may be the criteria to consider screening for depression among children. Situations that both the primary care physician, specifically the family physician, as the pediatrician, must be considered in cases of recurrent diseases or lack of response to treatment and other data that they can be identified during the physician-patient-family as suggestive of a pattern of depression.

If parents or guardians manifest behavioral and emotional changes such as mood instability, obsessions, somatic problems, nervousness, insecurity, fears, phobias, sadness, apathy, dysphoria, anxiety, tension, worry and guilt; [14] note that clinical depressive presented in childhood usually under masks irritability, difficulty concentrating and address [15] and that, given the complexity of their symptomatology manifestations (age and sex), multicausality own children characteristics and possible comorbidity with other problems [16], you must refer the child to a psychiatrist, psychologist or family therapist to determine the degree and type of depression [17] and give appropriate treatment.

Early detection and treatment of risk factors reduce the presence of depression, early diagnosis and timely treatment; reduce the presence of complications, considering that one that begins in childhood is a more severe form in the adulthood [18]. Therefore, the implementation of strategies for early detection and identification help improve the future quality of life in children with risk factors [19].

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