Matt (host): Welcome back to the Nimble Youth Podcast. I'm your host, Matt Butterman, and today we're beginning a four part series on depression across childhood, adolescence, and into young adulthood. Breaking this topic down by age because depression looks very different depending on where a child is developmental. Today we're starting at the beginning of that spectrum elementary age children. This is a group where depression is often missed, misunderstood, or mistaken for something else entirely.

I'm really glad to be joined again by Doctor. Gretchen Hoyle, a pediatrician with twenty five years of experience, who has spent the last decade focusing heavily on pediatric mental health. Before we start, we remind you that this podcast is intended for informational purposes only and does not substitute for medical advice from a qualified mental health or medical provider. Please visit a healthcare professional with any questions about your child's health. Doctor.

Hoyle, thanks again for joining us for what is an increasingly common, but so often misunderstood behavioral health concern for young people and their parents today.

Dr. Gretchen Hoyle: Thanks, Matt. I'm really glad we're starting here. Depression in young children is one of the most overlooked areas in pediatric mental health.

Matt (host): Yeah. So let's start with that. Why is depression in elementary age kids so often missed?

Dr. Gretchen Hoyle: Yeah. There, there are a few reasons. I mean, first of all, people don't really expect young children to be depressed. We associate depression with like teenagers or adults, not elementary age kids. And then secondly, you know, young children often don't have the language to say what their feelings are.

So saying I feel depressed would be a stretch for a six, seven, eight year old. Instead their distress shows up through behavior or physical symptoms like stomach aches, headaches, feeling really irritable, trying to avoid school, super clingy to the parents, loss of interest in play, things that used to make them happy. And so those are kind of the ways that they'll often present. So it's not as clear as somebody being able to actually articulate what's going on for them mood wise. And then a lot of times these symptoms will get labeled more as like behavior problems rather than being recognized as emotional distress.

Matt (host): Yeah. So when clinicians talk about depression in children, what are we actually talking about diagnostically?

Dr. Gretchen Hoyle: Right. So generally we mean one of two diagnoses. The first is major depressive disorder or MDD, and this involves a distinct episode of depression. It's a clear change from the child's baseline mood and functioning. That's a that's lasted at least two weeks.

The second is persistent depressive disorder or PDD, sometimes called dysthymia. And this is more of a chronic low grade depression that can last like a year in children or more. So the

difference is major depression is episodic, persistent depression is ongoing and chronic. Both can be impairing, especially if they're not recognized.

Matt (host): How common is depression at this age?

Dr. Gretchen Hoyle: Right. So, it's less common than it is in adolescence for sure, but it absolutely occurs. So about one to two percent of elementary age children would meet a criteria for a depressive disorder. That number may sound small, but when you consider how many kids are in an elementary school, it's fairly significant. And because it's so often missed, many children don't get the help that they need until their symptoms are much worse.

Matt (host): So we often talk on this podcast about anxiety and depression overlapping. And does that apply here as well at this young age?

Dr. Gretchen Hoyle: Yeah, for sure. I mean, typical scenario, like in young children, is that they tend to present more with anxiety because that condition usually shows up first developmentally. Many children who eventually develop depression start out with anxiety symptoms, so they're having worries and fears and sort of hyper perfectionistic thinking, or they're trying to avoid school. Then over time, you know, anxiety and being sort of hypervigilant can become pretty exhausting and demoralizing. And that can tend to lead into depressive symptoms, sort of the negative symptoms of not wanting to engage in things that you used enjoy.

And that's why we almost always assess for both anxiety and depression together, in young kids.

Matt (host): Yeah. And so how do you actually assess these things in elementary age kids?

Dr. Gretchen Hoyle: Right. So we use our, structured questionnaires along with, you know, the typical like history and physical. For anxiety, I typically will use the SCAD questionnaire. And so this is a questionnaire we talked about at LinkedIn previous podcast on anxiety in young children. The SCAD, it stands for SCREEN for child anxiety and related emotional disorders.

And it has both a parent and a child version. And it helps us understand the different types of anxiety. So it stratifies their anxiety into like generalized anxiety, separation anxiety, social anxiety, panic symptoms, and school avoidance. And so, for folks who want to dig in more to that, you know, would potentially link that previous podcast. For depression, we use a tool called the Short Mood and Feelings Questionnaire or the SMFQ.

Matt (host): You said before that it's really helpful for parents to actually hear the questions. Can you walk us through them?

Dr. Gretchen Hoyle: Yeah, sure can. I think that this is really important. And so, I'm going to sort of tell you about these items on this questionnaire, and it'll give us insight into how a child sees themselves in their world. And so, what happens here is I'll read a sentence and the child can

tell me that it's not true, sometimes true or true for them. And it's about how they have been thinking and feeling over the previous two weeks.

Okay. So the items are like this. Number one, I felt miserable or unhappy. Number two, I didn't enjoy anything at all. Number three.

I felt so tired. I just sat around and did nothing. Number four. I was very restless. Number five.

I felt I was no good anymore. Number six. I cried a lot. Number seven. I found it hard to think properly or concentrate.

Number eight. I hated myself. Number nine. I was a bad person. Number 10.

I felt lonely. Number 11. I thought nobody really loved me. Number 12, I thought I could never be as good as other kids. And number 13, I did everything wrong.

So when you listen to those items, can hear how they're sort of different from the anxiety questions, which are things like, I don't like to be with people I don't know well, or I follow my mom or dad wherever they go. Those questions are more fear based. These questions are more about mood, self worth, hopelessness, and whether or not they can enjoy things.

Matt (host): Yeah. So, so how do you interpret the results that you get from, from the questionnaire?

Dr. Gretchen Hoyle: Right. So each of these are scored zero to two. So not true is zero, then sometimes is one, and then true is two. And so the total score could be as much as 26, If you had a two on everything, really we're looking at for scores of eight or higher makes us think to ourselves, oh, we probably need to dig a little deeper here and try to figure out if that diagnosis makes sense for this child. But it's also importantly used as a measurement in measurement based care.

So, in measurement based treatment to target where you make a diagnosis, have a questionnaire and you measure the symptoms and then you do interventions and you measure it again later to see if that, the symptoms scores has come down. And so that's really what we're wanting to see is downward trending scores, which tells us that whatever our interventions are is helping.

Matt (host): And so you've mentioned before that kids can have more than one diagnosis.

Dr. Gretchen Hoyle: Oh, absolutely. I mean, oftentimes kids with depression, you know, have another diagnosis. Mean, often anxiety, sometimes ADHD, sometimes all three ADHD can en risk. It can increase the risk for anxiety and depression because kids with ADHD often repeat often experience a lot of repeated frustration. They're getting criticized a lot.

They have academic struggles and those emotional things, emotional burden can really add up. So it's like, you know, emotional paper cuts, little tiny things that happen all the time, every day for them that is sort of adding to their mood being, you know, decreased. And that's why, you know, assessment needs to be comprehensive and longitudinal. Like you're looking at it over time. It's not just a snapshot.

Matt (host): So you use something called a biopsychosocial framework. It's kind of a mouthful, but, you use that, that framework in your evaluations. Can you explain that for us?

Dr. Gretchen Hoyle: Yeah. So, is what we call the four P's to understand depression in children. This probably works for anyone. But first of all, we think about what are the predisposing factors? And so most of the time we're thinking about these, these are the biological things that might be going on with this child.

And probably our best indication of that is family history of mood disorders or difficulty with temperament. And so those would be considered like predisposing factors. Then there's this precipitating factors. So those tend to be contextual. So like what's going on in the child's life.

There may be stressors or events that happen around the time that the symptoms begin. Things like school stress, bullying, illness, family changes, or loss. For the grandparents, a classic one. And, but then changing schools or having, you know, parenting parents divorcing. I mean, of different things that can be sort of precipitating factors that are like in the context of their life.

The third P is the perpetuating factor. So these are things that keep the depression going. So things like ongoing stress, difficulty with sleep, sort of ongoing like academic struggles and, you know, family conflict. So having a lot of perpetuating factors in a child's life makes it harder to get this to turn around. So we need to think about those factors.

And then the fourth is kind of goes the opposite direction. So these are protective factors. So these are the strengths that are in of that child or that family or that community that can help mitigate the symptoms of depression. So supportive caregivers, access to therapy, positive relationships, supports in school, kids who have developed certain interests that they enjoy and skills that can help the child sort of buffer those previous predisposing, precipitating, and perpetuating factors. So this framework sort of helps us understand not just what's happening, but why and where we can intervene.

Matt (host): Yeah. So let's talk about treatment options. What does management usually look like?

Dr. Gretchen Hoyle: Yeah. Treatment, like most things will include therapy, medication, or both. Always love the both answer. Sometimes that is more doable than others. It sort of depends on access.

First of all, would say for elementary age kids, you know, we really love for them, especially if they're they meet criteria for depression, is to get into a therapist. Many therapists at this age will start doing some version of cognitive behavioral therapy. This needs to be typically adapted for younger children. CBT helps kids understand how thoughts and feelings and behaviors. We've talked about that triad in previous episodes, but thoughts, feelings, behaviors are connected.

For younger kids, this often involves a lot of concrete examples and having the parents involved and building a

Matt (host): lot of skills. Yeah. And that medication as well?

Dr. Gretchen Hoyle: Yep. I do feel like this makes a huge difference. And sometimes this is the jumpstart we need to be even able to really participate in therapy effectively. And it's certainly faster. So that's just one of the practical nature of how we're going to intervene with a kid who has pretty significant depression symptoms.

The medications that we use first line in kids are the typical SSRIs that we think of. So fluoxetine, escitalopram, or sertraline. So that would be Prozac, and Zoloft. And basically what's happening there, there's selective serotonin reuptake inhibitors. It's just a really fancy way of saying that we're going to slow down how quickly the serotonin gets cleared from the space that connects neurons in the brain so that there's more serotonin activity available.

And when we do that, we can often see pretty substantial improvement within a few weeks. I feel like kids respond quicker than the manufacturers will often say it's a four to six week thing before you're going see a response. And that's probably true for adults. But I do feel like with kids, especially depending on how symptomatic they are, we can see some improvements within, you know, three to four weeks a lot of times. As far as choosing which of those medications, I will take a look back and see if we've ever had them on a medication before.

That's certainly a big clue. Sometimes we would start it for anxiety and then we sort of stopped it and now we're sort of back of more depression symptoms and we'll try to take into account whether or not that medicine was a good fit for them. Family history is super important. I think that if I have a family member who had a good or bad response to one of those medicines, I can take that into account as well. Sometimes that can help me make the choice.

Whether or not they have comorbid conditions like anxiety or ADHD, there are some nuances about which medicines I would potentially choose for a kid who has depression and also has ADHD. Then there's also always the issues of how we're going to deliver that. So the formulation, can they swallow a pill or do we need to do liquid? You know, that's a part of our thinking. And then as with everything, insurance has a say.

So insurance has formularies and they decide what things they're going to pay for. So I need to pick something that's on their insurance so that we can reliably get them. But we monitor things

closely, especially early on, and then we adjust based on their response and whether or not they're having side effects.

Matt (host): Yeah. So if parents take away one thing from this episode, what do you think it should be?

Dr. Gretchen Hoyle: Right. So that depression in elementary age children is very real, but it's also very treatable, but it's can be hard to recognize. And so early recognition and thoughtful intervention can really change the outcome for children. That trajectory of having a child who sort of has disengaged in the things that they used to enjoy, or, you know, is not wanting to spend time with family or, not really wanting to spend time with friends. When that's happening, then they're missing out on some of the key, not just fun things.

And, you know, we want them to have fun. We also need their brains to go through the developmental stages that are appropriate for that age and missing out on things because their mood is poor is, is not, is not good for them. And so we want to help put them back on a trajectory where they can fully engage in life and be able to take those skills into the next stage. This is for sure not about blame. It's about understanding and support, for sure.

Like there's most kids that I see that have this condition diagnosis. This is true for most kids with any mental health diagnosis is there's always a lot of those predisposing factors kind of in the mix for that kid. And those are things that are, you know, there's no blame in any of that. It's just a matter of saying, well, you know, the way that your brain is wired up, you may be a little more likely to be anxious or even get really sad or depressed. And so it's important for us to recognize that in the same way that what we used to consider, you know, the difference of medical conditions like asthma or diabetes, you know, those are medicines that we use to help treat those conditions.

The brain is also an organ that responds to medicine if there's something that's off. And so, so I think it's important to recognize that we really do want to intervene. We want to intervene in the best way possible. We might do that with as limited as side effects as possible. And, and then there's also lots of really good work that the therapists do with kids in this age group.

And a lot of times what they're focusing on is identifying those activities that the child enjoys and really try to get them activated in June. Because that in and of itself, you know, we talk a lot about serotonin and trying to balance that neurotransmitter, but like our own, if we're doing things that are good for our brains in general, so a lot of times for kids, it's going to be things like making sure that they're getting enough sleep and playing outside and being in the sunshine and being with their friends and all the things that the human brain needs to be regulated, you know, really paying attention to those lifestyle things can be extremely helpful. And that's where sort of like additional help with coaching parents and looking for other opportunities for children to be involved in, again, like, you know, the embodied experiences of life. I think, I think there's some concern that as kids are often kind of getting down a rabbit hole a bit with their devices and with like their digital lives, that that's just not really the same thing for your brain. And so we

really want to try to identify ways to help them engage in embodied experiences, real world experiences.

And that really helps sort of keep from falling into a place where the mood is really depressed. And you know, kids are really resilient, which is good. And so a lot of times if there's some predisposing factors and then we have a significant precipitating factor, that is not uncommon, but it is, there are ways to engage and help kids just get to a place where they're enjoying life again and being able to do all their developmental tasks at the same time.

Matt (host): Right. We're all dealt a complex hand of cards sometimes and we just have to learn how to play them the best we can I guess?

Dr. Gretchen Hoyle: Correct.

Matt (host): Want to ask again to Doctor. Hoyle for her perspective on this and insight on this pervasive concern for young people today. Thank you to our listeners for joining us whether on the audio podcast found on all major podcast platforms or via our video broadcast on YouTube. We remind you to please rate our content and offer comments or questions at our website which is www.nimbleyouthpodcast.com it helps us to keep providing you with the content you want to see and listen to. Also, follow us on social media, Facebook and Instagram especially nimble youth podcast.

Until next time, please take care of yourselves and the young people in your lives.