Depression in Maltreated Children and Adolescents

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INTRODUCTION

Depressive disorders are common consequences of experiencing child maltreatment. Depressive disorders herein termed depression, are defined in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), under the chapter “Depressive Disorders,” as major depressive disorder, persistent depressive disorder (formerly dysthymia), disruptive mood dysregulation disorder, other specified depressive...
disorder, and unspecified depressive disorder. The diagnostic criteria for a major depressive disorder did not change from the DSM fourth edition text revision (DSM-IV-TR). This critical review of depression in maltreated youth includes literature from DSM-IV-TR and DSM-5. Maltreated youth may also have 3 types of depressive disorders listed under the chapters “Anxiety Disorders” in DSM-IV-TR and “Trauma- and Stressor-Related Disorders,” in the DSM-5, namely adjustment disorder with depressed mood, adjustment disorder with mixed anxiety and depressed mood, and adjustment disorder with mixed disturbance of emotions and conduct. Adjustments disorders do not have enough symptoms to meet other DSM diagnostic criteria and occur in response to an identified stressor. Adjustments disorders can be acute, with symptoms occurring less than 3 months, or chronic, with symptoms occurring more than 3 months.

A literature search of PubMed and PsychINFO articles published from 2000 to 2018 using keywords and MeSH terms “depression” (and DSM-5 terms for depressive disorders), “maltreatment” “emotional, physical or sexual abuse,” “neglect,” “childhood,” “child,” and “adolescence” were crossed individually with “incidence,” “prevalence,” “assessment,” “practice parameters,” “evidence-based treatment,” “psychopharmacology,” “psychotherapy,” “medications,” “suicide, and ” self-injury,” which were limited to the English language, were reviewed and selected for this article. Our criteria were that the articles be peer reviewed and methodologically sound. When reviews were needed to summarize important information, meta-analyses or peer-reviewed reviews published by depression or maltreatment researchers were cited.

CHILD MALTREATMENT

Child maltreatment is defined by law (The Child Abuse Prevention and Treatment Act) and investigated by Child Protective Services (CPS) as physical, sexual, or emotional abuse, and/or neglect by a caregiver that results in harm, potential for, or threat of harm to a child. CPS usually codes emotional abuse or physical neglect in youth who witness interpersonal or domestic violence. According to the National Child Abuse and Neglect Data System, each year 3 million referrals are made to CPS, involving 6 million children. Of these, fewer than 700,000 youth, about 9.1 of every 1000 children, are identified as victims, with 75% classified as neglect, 16% as physical abuse, and 9% sexual abuse. Perpetrators are mainly biological parents (88%), and about half of the perpetrators are female. Parental factors such as substance use disorder (SUD), history of maltreatment, and depression are the strongest risk factors for abusing or neglecting a child. At greatest risk are children, aged 0 to 4 years, because 80% of the 1545 maltreatment-related fatalities in 2011 resulted from neglect, physical abuse, or their combination.

The actual US child abuse and neglect rates are likely higher than official reports. The National Incidence Study of Child Abuse and Neglect 4 estimated rates of child abuse and neglect by US caretakers in 2005 to 2006 to be 17.1 of every 1000 children (approximately 1.25 million children). The National Incidence Study applied 2 definitional standards: a harm standard, restricted to children who were harmed by child abuse and neglect, and the endangerment standard, for children not yet harmed, but at high risk of being harmed. Most states apply only the harm standard in their official reports.

CHILD MALTREATMENT IS A MAJOR RISK FACTOR FOR YOUTH AND ADULT DEPRESSION

Maltreated children have greater rates of depression, posttraumatic stress disorder (PTSD), behavioral problems, suicidal thoughts, suicide attempts, self-injury, and
SUDs compared with nonmaltreated youth. In a meta-analysis of adults with histories of child maltreatment, all forms of abuse and neglect increased the odds ratio of having depression from 2 to 3.00. Emotional abuse, with an odds ratio of 3.53, most strongly increased depression risk. Although the 12-month prevalence rate of depression in the United States is 7%, the depression rate in maltreated individuals is estimated to be 24.7%. In the Longitudinal Studies of Child Abuse and Neglect, a study of 638 at-risk youth, emotional abuse also showed the strongest association to depression in girls, whereas emotional neglect was the strongest predictor of depression in boys. Widom and colleagues (2007) found that child abuse and neglect before age 11 years was associated with an increased risk for depression in young adulthood (odds ratio, 1.51) compared with those without maltreatment histories from similar sociodemographic backgrounds. Depression in abused and neglected youth had a much earlier age of onset (between ages 5 and 10 years) than depression in nonmaltreated youth. A challenge for detecting depression in maltreated youth is that emotional abuse or emotional neglect may not be reported to CPS or the police. Thus, it is important for clinicians to screen their young patients for past or ongoing maltreatment. When maltreatment is identified, prompt referral to early evidence-based trauma-focused treatment (described later) may be a potent strategy for curtailing or preventing the onset of later depression in those youth for whom it is not already present.

Another challenge in identifying depression in maltreated youth is that core symptoms of depression are similar to the core symptoms of distress that are commonly seen in maltreated youth. Even though the symptoms overlap, it is important to account for maltreatment exposure when diagnosing and treating depressive disorders. A major depressive episode includes having depressed/irritable mood or loss of interest or pleasure, for the same 2-week period for most of the day/nearly every day, along with at least 4 of the following symptoms:

1. Significant decreased or increased appetite with weight loss, or failure to make expected weight for developmental stage or weight gain
2. Insomnia or hypersomnia early every day
3. Psychomotor agitation or retardation
4. Fatigue or loss of energy
5. Feelings of worthlessness or inappropriate guilt
6. Poor concentration or indecision
7. Recurrent thoughts of death, suicidal ideation, plan, or attempt

Core symptoms of a persistent depressive disorder (dysthymia) include having clinically significant depressed/irritable mood for 1 year or more along with at least 2 symptoms of depressive disorder or 1 symptom of depressive disorder and chronic feelings of hopelessness. Core symptoms of a disruptive mood dysregulation disorder (DMDD), include a period of 12 months or more of severe temper outbursts that are inconsistent with developmental stage and occur on average 2 to 3 times a week, along with persistent irritable mood in at least 2 settings. Although there are few published studies on the incidence or prevalence of DMDD in maltreated youth, there is significant overlap of DMDD with oppositional defiant disorder (ODD) and
attention-deficit/hyperactivity disorder (ADHD). Some maltreatment researchers posit that DMDD is similar in clinical presentation to developmental trauma disorder, not present in the DSM-5, and may represent PTSD symptoms of reenactment and irritability. There are no evidence-based treatments for either disorder, so treatment should focus on evidence-based treatments for depression along with PTSD, ODD, and ADHD, as appropriate.

ASSESSING MALTREATMENT AND TRAUMA IN YOUTH

Depressed maltreated youth should be assessed for current and past maltreatment experiences and other traumas. One method for asking about adverse experiences is to normalize the question as can be found in structured clinical interviews, which includes informing youth and parents separately that good and bad things happen to everyone and asking what each believes is the worst thing that happened in the youth’s life and why. For young children, asking them to draw a picture of the best and worst things in their lives may be helpful. In maltreated youth, depression is commonly comorbid with PTSD, ODD, ADHD, separation anxiety disorder (particularly in cases of intimate partner violence toward primary caregiver) in children, as well as conduct disorder and alcohol use disorder (AUD) and SUD in adolescents. There are many structured clinical interviews (some are free of charge) and self-reports listed in Table 1 that outline methods of asking questions about maltreatment, other adverse child experiences, and DSM-5 axis I disorders. In maltreated youth, multiple trauma exposures may be present. It is important to document the age of onset, duration, and offset of these events and identify the impact of these events on the child’s emotional, cognitive, and behavioral development.

RISK FACTORS FOR DEPRESSION IN MALTREATED CHILDREN

Children of depressed parents have a 2-fold increased risk for depression and those with at least 1 parent and grandparent with depression are at highest risk. Parental depression, PTSD, and SUDs increase the risk of having a child who is reported for maltreatment. Other direct risk factors for depression in youth with high familial depression risk include irritability, fear behaviors, externalizing symptoms or anxiety before first depressive episode, economic disadvantage, and recent psychosocial adversity (eg, being bullied, death in family, parental conflict). These risk factors for depression are commonly seen in maltreated youth.

REPORTING CHILD MALTREATMENT

When assessing the impact of potential maltreatment during a comprehensive clinical examination, it is important to first outline the limits of confidentiality. If a child or adolescent responds in the affirmative to the maltreatment or other traumatic stress questions, the clinician must follow up appropriately according to the clinical guidelines of the setting that the child is in and in full accordance with mandatory child abuse reporting laws. It is recommended that clinicians identify resources in the community to address any urgent concerns associated with trauma disclosure as part of setting up clinical services (eg, child abuse reporting lines, domestic violence shelters, emergency room access). In cases in which a clinician is mandated to report maltreatment, the youth’s safety is the first concern. In most cases, clinicians can make a report in a transparent way. Reporting maltreatment after explaining the laws, the clinician’s legal obligations, and the need for youth and family safety does not have to result in ending the clinician’s treatment relationship with the youth and the family.
<table>
<thead>
<tr>
<th>Measure</th>
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<tr>
<td>National Child Traumatic Stress Network Measure</td>
<td>This user-friendly Web site lists a database for trauma-informed mental health screenings, assessments for clinicians to use with parents, children, and adolescents, including interviews and self-reports</td>
<td>Interviews and self-reports</td>
<td>Infancy to 18</td>
<td><a href="https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews/all-measure-reviews">https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews/all-measure-reviews</a></td>
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<td>Review of assessment instruments</td>
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<td>The Preschool Age Psychiatric Assessment</td>
<td>Structured interview that assesses different types of traumas and adverse life events, including various types of child abuse and neglect and the age at which each event was experienced, as well as developmentally sensitive version of PTSD and for diagnosing psychiatric disorders in preschool children</td>
<td>Child’s caregiver</td>
<td>2–5</td>
<td><a href="http://devepi.duhs.duke.edu/papa.html">http://devepi.duhs.duke.edu/papa.html</a></td>
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<td>Kiddie Schedule for Affective Disorders and Schizophrenia – Present and Lifetime Version for DSM-5</td>
<td>Semistructured interview that assesses 12 different types of trauma, including various types of child abuse and neglect and the age at which each event was experienced, as well as PTSD, and all major axis I disorders</td>
<td>Caregiver and youth as interview or computerized self-report</td>
<td>3–18</td>
<td><a href="https://www.kennedykrieger.org/patient-care/faculty-staff/joan-kaufman">https://www.kennedykrieger.org/patient-care/faculty-staff/joan-kaufman</a></td>
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<td>Child PTSD Symptom Scale for DSM-5</td>
<td>Self-report instrument or clinical interview that assesses DSM-5 symptoms for PTSD</td>
<td>Youth self-report or interview</td>
<td>7–18</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pubmed/28820616">https://www.ncbi.nlm.nih.gov/pubmed/28820616</a></td>
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<td>UCLA PTSD Reaction Index for DSM-5</td>
<td>A comprehensive trauma history profile for many discrete forms of trauma, including abuse, neglect, bullying, and community violence, and the age at which each event was experienced. Includes a PTSD scale for DSM-5</td>
<td>Caregiver and youth as interview or self-report</td>
<td>7–18</td>
<td><a href="https://www.reactionindex.com/index.php/">https://www.reactionindex.com/index.php/</a></td>
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<td>Trauma Symptom Checklist for Children</td>
<td>Self-report instrument that assesses PTSD and related problems, such as depressive, anxiety, and dissociative symptoms.</td>
<td>Youth self-report</td>
<td>8–16</td>
<td><a href="https://www.parinc.com/Products/Pkey/461">https://www.parinc.com/Products/Pkey/461</a></td>
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<td>The Child and Adolescent Psychiatric Assessment</td>
<td>Structured interview that assesses different types of trauma and adverse life events, including various types of child abuse and neglect and the age at which each event was experienced, as well as PTSD and all major axis I disorders</td>
<td>Caregiver and youth interview</td>
<td>9–18</td>
<td><a href="http://devepi.duhs.duke.edu/capa.html">http://devepi.duhs.duke.edu/capa.html</a></td>
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<td>Childhood Trauma overall mental health Questionnaire</td>
<td>Assesses childhood physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect</td>
<td>Youth self-report</td>
<td>12 to adulthood</td>
<td><a href="http://www.pearsonclinical.com/psychology/products/10000446/childhood-trauma-questionnaire-a-retrospective-self-report-ctq.html">http://www.pearsonclinical.com/psychology/products/10000446/childhood-trauma-questionnaire-a-retrospective-self-report-ctq.html</a></td>
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Abbreviation: UCLA, University of California, Los Angeles.
Youth may not disclose ongoing maltreatment until a therapeutic alliance is built, which may take place many months after treatment initiation. Educating caregivers and their youth about these systems and the urgent need for child safety usually leads to cooperation with CPS investigations and maintaining the youth and family in treatment.

ESTABLISHING THE DIAGNOSIS OF DEPRESSION AND TREATMENT PLAN

Depressed maltreated youth should be screened for symptom severity and assessed for safety pertaining to child abuse and neglect, suicide, and homicide, which could indicate the need for CPS/police involvement or a higher level of care. Clinicians can use the mood disorder sections of the interviews or depression, irritability or anxiety, self-reports, or other rating scales listed in Table 1 to serve as a baseline that can be used to examine the effectiveness of the treatment plan. Hospitalization is a short-term stabilization strategy for youth whose level of function is severely impaired, who may be suicidal or homicidal (eg, secondary to severe irritability), who have depressive symptoms with psychosis, or would benefit from an inpatient environment because of unstable family support and inability to adhere to outpatient treatment.

Given that maltreated youth are more likely to have medical issues than nonmaltreated youth,17 it is important for depressed youth to have a medical evaluation to rule out medical causes of depression. The American Academy of Child and Adolescent Psychiatry has a practice parameter for the assessment and treatment of children and adolescents with depressive disorders.18 Medical disorders (eg, hypothyroidism, sleep disorders, mononucleosis, anemia, cancer, autoimmune diseases, premenstrual dysphoric disorder, chronic fatigue syndrome, vitamin deficiencies involving folic acid, and side effects of medications) should be ruled out as part of the treatment plan. If there is a history of physical abuse or head injury involving loss of consciousness, head computed tomography or MRI of the brain may be indicated to rule out an organic cause for depression. The medical evaluation can be completed as inpatient or outpatient depending on the youth’s severity of depression and individual needs.

The treatment of depression is usually divided into 3 phases: acute, continuation, and maintenance.18 The acute phase involves stabilization of dangerous behaviors, and initial evaluation, which includes an assessment of child maltreatment and other ongoing stressors, family support, family conflict, parental mental disorder, school function, and peer relationships. These factors should be assessed because they can contribute to persistence or desistence of depression and may need to be addressed in the youth’s treatment. The aim of the acute phase is full remission of depression (a period of ≥2 weeks and <2 months with no or few depressive symptoms) or recovery (a period of >2 months with no depressive symptoms). Continuation treatment is required for depressed youths to secure a successful treatment response during the acute phase and prevent depression relapses. New stressors can put maltreated youth with a history of depression at high risk for relapse or recurrence of depression, including suicidal, homicidal, and self-injurious thoughts and behaviors. Maintenance treatment is used to prevent recurrences in youth who have had a more severe, recurrent, and chronic depressive disorder. Because maltreated youth are more likely to have a severe and recurrent form of depression with poor prognosis,19 treatment planning should include all 3 phases, including psychotherapy that includes learning cognitive and behavioral strategies to manage ongoing stressors to prevent the recurrence of depression symptoms, including suicidality. Fig. 1 represents a working guideline for the treatment of maltreated youth with depression.
COMBINED PSYCHOTHERAPY AND PSYCHOPHARMACOLOGY TREATMENT ARE THE EVIDENCE-BASED TREATMENTS FOR DEPRESSION IN YOUTH AND SHOULD BE THE FIRST APPROACH FOR MALTREATED DEPRESSED YOUTH

A landmark study, The Treatment for Adolescents with Depression Study (TADS), showed that, in adolescents (aged 12–17 years), combined treatment with fluoxetine (a selective serotonin reuptake inhibitor [SSRI]) and cognitive behavior therapy (CBT) with an 86% response rate, compared with 81% for fluoxetine alone and 81% for CBT alone, was judged to be superior to either treatment alone at 36 weeks after treatment initiation, and the combination treatment was also associated with decreased suicidal ideation compared with fluoxetine treatment alone.20 Maltreated depressed youth in the TADS study showed better outcomes with combined treatment than with CBT alone.21 According to a meta-analysis of 13 pediatric trials involving 3004 children and adolescents that examined the SSRIs fluoxetine, paroxetine, sertraline, citalopram, and escitalopram, SSRIs showed the greatest benefits within the first 4 weeks of treatment initiation and then had a smaller benefit compared with studies in adults thereafter.22 Another meta-analysis compared 34 antidepressant trials, including 5260 children and adolescents and 14 antidepressant treatments (amitriptyline, citalopram, clomipramine, desipramine, duloxetine, escitalopram, fluoxetine, imipramine, mirtazapine, nefazodone, nortriptyline, paroxetine, sertraline, and venlafaxine) and found that only fluoxetine was statistically significantly more effective than placebo.23 Fluoxetine was better tolerated and imipramine, venlafaxine, and duloxetine had more discontinuations because of adverse events compared with placebo.

The Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) trial defined treatment-resistant depression as clinically significant depression that has not responded to acute treatment with a SSRI.24 In this randomized controlled trial of a clinical sample of 334 patients aged 12 to 18 years with a primary diagnosis of major depressive disorder who had not responded to 2 months of SSRI treatment, patients were randomized to 12 weeks of (1) switch to a second, different SSRI (paroxetine, citalopram, or fluoxetine, 20–40 mg); (2) switch to a different SSRI plus CBT; (3) switch to venlafaxine (150–225 mg); or (4) switch to venlafaxine plus CBT. The combination of...
CBT and a switch to another antidepressant resulted in a higher rate of clinical response than did a medication switch alone, and venlafaxine was not tolerated as well as other SSRIs.24 By 24 weeks, patients in the TORDIA study, who showed remission of depression, also showed reductions in symptoms of anxiety, ADHD, disruptive behavior disorders symptoms,25 and parent–child conflict.26 The patients with a history of physical abuse had a lower rate of response to combination treatment in the TORDIA study, and those without maltreatment histories showed the best outcomes.27

There are several evidence-based therapies for the treatment of depression: CBT, whose focus is on increasing behavioral activation and decreasing negative cognitive distortions; interpersonal psychotherapy, whose focus is on shifting the patient’s outlook and interaction in key relationships and interpersonal life events; and supportive therapy. All show improvement in youth depression, with a moderate effect size.28 Data from a recent meta-analysis of 13 randomized trials of 796 children and adolescents showed that computer-based and Internet-based cognitive behavioral treatments decreased anxiety and depressive symptoms and may be an attractive treatment alternative to regular face-to-face treatment.29 Although all of these treatments have been used with maltreated youth with depression, maltreated youth are less likely to access psychotherapy resources and have more limited computer access than nonmaltreated youth.30

TREATMENT OF DEPRESSED MALTREATED YOUTH WITH POSTTRAUMATIC STRESS DISORDER SYMPTOMS

Child maltreatment becomes biologically embedded in the stress systems of its victims, leading to cognitive deficits, high rates of depression, PTSD, other mental disorders, immune dysregulation, and adverse brain development.31–33 Clinicians may consider treating depressed maltreated youth with PTSD symptoms and an identified trauma with a trial of trauma-focused CBT (TF-CBT) as a first-line treatment. TF-CBT includes psychoeducation, learning parenting skills, relaxation training, affective modulation, cognitive restructuring, and behavioral coping skills. After these skills are mastered, trauma narration and processing to correct cognitive distortions and in vivo mastery of traumatic reminders are implemented. Then conjoint child and parent sessions and safety planning skills are addressed. A critical review suggests that TF-CBT is the best evidence-based treatment of maltreated youth.34 Behavioral management strategies can easily be integrated with TF-CBT to treat the behavioral regulation problems that commonly occur in traumatized children (ADHD, ODD) (see Ref.35). Information about therapist training and certification in TF-CBT is available at https://tfcbt.org. The National Child Traumatic Stress Network Learning Collaboratives (NCTSN), whose mission is “to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States” (www.nctsn.org) is an excellent trauma-informed resource for clinicians working with maltreated youth with depression. If depression is severe, SSRIs can be offered, with careful monitoring of suicidality.

TREATMENT OF DEPRESSED MALTREATED YOUTH WITH SELF-INJURY AND SUICIDALITY

Dialectical behavior therapy (DBT), a cognitive behavioral, evidence-based, multi-modal, outpatient treatment that involves individual, group treatment, and life skills coaching, is effective for reducing self-injury and suicidality as well as depression and PTSD.36 DBT was modified for adolescents with borderline personality disorder
traits and was found to be more effective than enhanced usual care in reducing self-harm, suicidal ideation, and depression. DBT is a promising treatment of maltreated adolescents with depression, self-injury, and suicidality.

TREATMENT OF DEPRESSED MALTREATED YOUTH WITH EXTERNALIZING DISORDERS

There are important evidence-based interventions for disruptive behavioral disorders and for antisocial behaviors in youth with early trauma (eg, multisystemic therapy). The American Academy of Child and Adolescent Psychiatry established practice parameters for the assessment and treatment of children and adolescents with ADHD, ODD, and conduct disorder. Many of these interventions can be integrated into TF-CBT or evidence-based treatments for depression and undertaken concurrently as part of a community treatment approach. Psychostimulants have a moderate to large effect and the alpha-2 agonist, guanfacine, a small to moderate effect on oppositional behavior, conduct problems, and aggression in youth with ADHD, with and without ODD or conduct disorder. Stimulants may improve mood and decrease irritability, outbursts, and DMDD symptoms. The Center for Education and Research on Mental Health Therapeutics Treatment of Maladaptive Aggression in Youth consensus guidelines include the possibility of using second-generation antipsychotic medications for psychosis or severe aggression only after a comprehensive assessment, treatment as indicated for underlying disorders, in combination with evidence-based behavioral interventions and with regular monitoring and planned taper/discontinuation as soon as feasible. Intensive case management may be necessary to address significant behavioral symptoms.

TREATMENT OF DEPRESSED MALTREATED YOUTH WITH ALCOHOL AND SUBSTANCE USE DISORDERS

Maltreatment is a strong risk factor for developing AUD and SUD in adolescents and adults. Depression in maltreated youth is highly comorbid with AUD and SUD. It is important to ask about tobacco, alcohol, marijuana, and other drug use as described in the assessments outlined in Table 1. Adolescents may “self-medicate” symptoms (eg, sad/irritable mood, insomnia) of depression with substances. Toxicology tests are indicated in an assessment of depression if the clinician is concerned about AUD/SUD. The American Academy of Child and Adolescent Psychiatry has a practice parameter for the assessment and treatment of child and adolescents with substance use disorders. This practice parameter has detailed descriptions on the types of formal screening tools that can be helpful in AUD/SUD assessment. These recommendations for the formal evaluation and the ongoing assessment of SUD include toxicologic tests of bodily fluids, such as urine, to detect the presence of specific substances. Toxicologic tests may assist in making a differential diagnosis because some substances (eg, cannabis, alcohol) may cause depressive symptoms and, once an individual is sober, the depression may remit. According to this practice parameter, treatment of AUD/SUD must be evidence based, should be done in the least restrictive setting that is safe and effective, should involve family/caregivers and family therapy, should be comprehensive (eg, including treatment of comorbid disorders, educational/vocational issues, or addressing legal issues), and may involve medications to treat cravings or the underlying depression that may have led to AUD/SUD.

Seeking Safety is an evidence-based treatment model that emphasizes safety, integration of trauma and AUD/SUD issues, coping skills, and hope, and consistently shows positive outcomes in adolescents and adults with interpersonal trauma.
histories. If a depressed adolescent has these problems, then referral for this evidence-based treatment is appropriate. Further information can be sought at www.seekingsafety.org. A modified version of TF-CBT, Risk Reduction through Family Therapy, has been shown in a small randomized controlled trial to significantly reduce substance abuse and trauma symptoms in traumatized youth with significant substance use.

FACTORS TO EXPLORE IF EVIDENCE-BASED TREATMENTS ARE NOT ALLEVIATING DEPRESSION IN MALTREATED YOUTH

Caregivers and youth may complain about ineffectiveness of medications that were previously effective. It is always important to reevaluate the target symptoms and differential diagnosis when this occurs. There are several possible reasons for treatment resistance:

1. Noncompliance with drug regimen as prescribed
2. Unrealistic expectations of what a medication will and will not do to change mood and behaviors
3. New onset of maltreatment or increase in chronic stressors that may lead to increased depression
4. Significant side effects, such as akathisia or sleepiness
5. A medical issue
6. Growth spurts/increased drug metabolism during adolescence may require dose increase
7. The need to change to another medication, drug class, or type of CBT may be indicated
8. PTSD/trauma symptoms that have not been addressed or that emerge during treatment

SUMMARY

This article outlines approaches for the treatment of depression in maltreated children and adolescents. At the time of this writing, combination treatment with SSRIs and CBT with a trauma-informed approach should be considered for depressed maltreated youth. Behavioral management can be integrated with TF-CBT to treat the externalizing disorders that commonly occur in maltreated depressed youth. However, randomized clinical trials of depressed maltreated youth are needed to make progress and help guide maltreated youth to recovery.

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