

## Case Report

# Treatment of Depression With Psychotic Features in Maltreated Adolescents: Evidence-Based Case Report

Feronia Augustine Setiawan<sup>1</sup>, Nicholas Kevin Phernando<sup>2</sup>, Zuhrotun Ulya<sup>3</sup>

<sup>1</sup>Medical Internship, Emanuel Banjarnegara General Hospital, Banjarnegara, Indonesia

<sup>2</sup>General Practitioner, Permata Cibubur General Hospital, Bekasi, Indonesia

<sup>3</sup>Psychiatric Department, Faculty of Medicine, University of Brawijaya, Malang, Indonesia

### Abstracts

Submitted : July 28, 2022  
Revised : March 5, 2023  
Accepted : May 22, 2023  
Published : November 10, 2023

You are free to:

Share — copy and redistribute the material in any medium or format

Adapt — remix, transform, and build upon the material for any purpose, even commercially.

The licensor cannot revoke these freedoms as long as you follow the license terms.



Correspondence Author:  
Email: [aferonia@gmail.com](mailto:aferonia@gmail.com)

**Introductions:** Depressive disorders are expected consequences of experiencing child maltreatment. Many depressive disorders can occur with or without psychosis, which has different implications for treatment and prognosis. This condition raises the challenge of treating depression in maltreated adolescents because the patient has inadequate family and social support. Consequently, it is difficult for the patient to undergo psychotherapy that involves family. The goal of treatment in psychotic depression should be complete remission of both depression and psychosis to improve functioning and quality of life and to reduce the risk of major relapse or recurrence. **Case:** A 17-year-old female was diagnosed with psychotic depression. The patient had symptoms of depression, accompanied by hallucinations, since five years ago. The patient was hospitalized for suicidal ideation and food refusal for days. Patient had a history of child maltreatment by family and experienced bullying since elementary school. Patient believes that her family, especially her mother, had hated her from the beginning. **Discussions:** After stabilization of the patient's general condition, psychopathology exploration was done together with selection of appropriate treatment. Combined Cognitive Behavioral Therapy (CBT), Selective Serotonin Reuptake Inhibitor (SSRI) and atypical antipsychotic treatment are the evidence-based treatments for psychotic depression in maltreated adolescents. Studies involving patients with psychotic depression which were treated by combination of sertraline and olanzapine showed significant improvement of depression and psychotic symptoms and reduced the risk of relapse over 36 weeks, compared to sertraline plus placebo. **Conclusion:** Combination of SSRI, atypical antipsychotic and CBT with a trauma-informed approach should be considered as treatment for psychotic depression in maltreated adolescents.

**Keywords:** Depression, Psychotic, Maltreated Adolescent, Antidepressant, Atypical Antipsychotic

**Cite this as:** Setiawan. F. A., Phernando. N. K., Ulya. Z. "Treatment of Depression With Psychotic Features in Maltreated Adolescents: Evidence-Based Case Report". *Jurnal Psikiatri Surabaya*, vol. 12, no. 2, pp.174-178, 2023. doi: [10.20473/jps.v12i2.37125](https://doi.org/10.20473/jps.v12i2.37125)

## Introductions

Depression is a significant contributor to the global disease burden, affecting people in all communities worldwide. Many depressions can be accompanied or not by psychosis, with varying implications for treatment and prognosis. Psychotic depression remains a common condition that is often underrecognized and inadequately treated [1]. Selective Serotonin Reuptake Inhibitor (SSRI) or mood stabilizer with Cognitive Behavioral Therapy (CBT), Trauma Focused – Cognitive Behavioral Therapy (TF-CBT), and Trauma Focused – Dialectical Behavioral Therapy (TF-DBT). Despite many available treatment options, childhood maltreatment has consistently been shown to be associated with poor treatment outcomes in depression, as assessed by lack of remission or response or longer time to remission [2]. In addition, the lack of family and social support prevents them from receiving psychotherapy involving families. Treatment goals for psychotic depression should be complete remission of depression and psychosis to improve functioning and quality of life and to reduce the risk of severe relapse or relapse.

This report describes an adolescent diagnosed with psychotic depression and a history of family maltreatment. Treatment decisions are challenging in this case. Therefore, further discovery of treatment options for psychotic depression in maltreated adolescents is required.

## Case Presentation

A 17-year-old female was brought by her grandmother to a psychiatric outpatient clinic. History taking was initially done through her grandmother. The patient had refused any food except water since ten days ago. The patient often spaced out on her thoughts. The patient was admitted to the psychiatric ward for stabilization and initial treatment. After stabilization, the patient was able to communicate. The patient felt sad, empty, and hopeless all the time. The patient men-

tioned frequent suicidal ideas wanting to reunite with her late father. She often had nightmares about death. The patient committed self-harm repeatedly by hitting her head on the wall. The patient felt anxious with strangers because she feared they might hurt her. The patient stated that she often heard a male voice from her left ear when she felt depressed. She also frequently had sensed a rotten smell since six months ago.

The patient assumed that her family resented her, especially her biological mother. The patient lived with her grandmother and her uncle. The patient had never been in her mother's care since birth, and her mother did not wish to be contacted. Although there is not enough information about family history of mental illness, the patient's uncle had an alcohol addiction issue and frequently mistreated her.

The patient had gone through physical and verbal bullying since primary school. The patient was frequently absent from class with various illnesses as an excuse. The patient could not endure the bullying and moved to a different school when she entered her senior year. The patient has not received any treatment related to her psychiatric condition. There is no data about the patient's regular non-psychiatric medications.

On admission, the patient appeared weak and pale with Glasgow Coma Scale (GCS) E4V5M6. Her appearance was disheveled yet still appropriate for her age. Her mood was described as depressed, with blunt and proper affect. Patient had psychomotor retardation. Her thought content was realistic with suicidal ideation. She also experienced auditory and olfactory hallucinations. Her cognitive sensory test showed normal orientation, memory, and slightly impaired insight. Her physical examination revealed typical vital signs.

Psychometric testing with the Psychotic Depression Assessment Scale (PDAS) revealed scores of 18 (Cut-off score =16, Moderate Psychotic Depression). The patient was diagnosed with Major Depressive Disorder

(MDD) with psychotic features. MDD tends to have a relapse-recurrent course, and each episode increases the risk of another relapse by 80%. She had a history of childhood maltreatment and was at an even greater risk of relapse. She also had multiple risk factors for suicide because patients with MDD have 20 times greater suicide risk than the general population. Moreover, she had a history of self-harm, which increased her suicide risk after being discharged.

Initial therapy was done with Risperidone (0,5 mg) b.i.d. and Sodium Valproate (250 mg). Evaluation of outcome was planned by comparing PDAS before and after initial therapy. PDAS testing before discharge revealed scores of 16 (Cut-off score = 16, Moderate Psychotic Depression), showing symptom improvement. After three days of admission, the patient was discharged and planned to continue outpatient treatment. There is no data regarding the adverse effects of medication the patient receives.

Following treatment, the patient was exhibiting good functionality. In order to look for a better academic environment, the patient and her family chose to transfer to a different school. The patient completed her six sessions of counseling, but she was unable to continue since she needed to prepare for her exam. She still had mood swings, however she could clearly understand how to cope with the symptoms, according to a subsequent evaluation by home visit. Additionally, the patient attempted to reach a mental health team in primary care settings who has been trained by a psychiatrist (Kader Lingkar Empati) of Psychiatry Department Faculty Medicine of Brawijaya University and Saiful Anwar General Hospital.

The patient and a family member gave informed consent to publish her case report. The signed papers are attached in a separate file.

## Discussions

Psychotic depression is a subtype of MDD with delusions or hallucination features [1]. Psychotic depression contributes to the inci-

dence of suicide in children/adolescents with depression aged 10-19 [3,4]. The increased prevalence of childhood depression could be explained by negative interpersonal relationships [5]. The strongest predictor of depression is the history of child abuse from the age of 10-17 years, especially in school and home [6].

The prominent risk factor in this case is the history of child abuse. The history of maltreatment could contribute to the psychopathology of psychotic depression. Additionally, it is known that a history of maltreatment was associated with poorer treatment outcomes. Evidence suggests a dose-response relationship between the history of child maltreatment and later psychotic development, and child maltreatment is related to the severity, persistence, and content of hallucinations and delusions in early and established psychosis. In addition, patients with history of child maltreatment have an earlier age of onset, lower social and occupational functioning, which are associated with worst treatment outcomes [7,8].

Patient was treated with Risperidone (0,5 mg) b.i.d. and Sodium Valproate (250 mg). Therefore, psychopharmacologic options lead to the administration of different drugs according to the patient's clinical condition, which leaned toward psychotic depression in maltreated adolescents.

The treatment of depression is divided into 3 phases: acute, continuation, and maintenance. Psychotherapy includes learning cognitive and behavioral strategies to prevent the recurrence of depression symptoms, stress management, and suicidality [9].

Recent studies of antidepressants and antipsychotics in psychotic depression involve second-generation antipsychotics and SSRIs [10-12]. In The Study of Pharmacotherapy of Psychotic Depression (STOP-PD) trial, which compared sertraline + olanzapine and sertraline + placebo as maintenance therapy, the former combination reduced relapse risk after 36 weeks [13,14]. Combination therapy of antipsychotics and antidepressants is

also commonly used by physicians in clinical settings. This fact shows that clinical practice aligns with treatment research evidence [15].

Non-pharmacological aspects of the treatment include psychological interventions. However, these were supported only by a few researches, and the efficacy of psychotherapy for adolescent psychotic depression remains unclear until now [16,17]. Trauma-focused CBT (TF-CBT) is a first-line treatment for depressed maltreated youth with an identified trauma. TF-CBT includes psychoeducation, learning parenting skills, relaxation training, affective modulation, cognitive restructuring, and behavioral coping skills [9,18].

Current evidence-based treatment of psychotic depression includes the combination of antidepressants, antipsychotics, and psychotherapy. Combining Fluoxetine + CBT and Fluoxetine alone was significantly more effective than placebo pills in children and adolescents with depression. Compared to other psychotherapy, Interpersonal Psychotherapy was found to be more effective than all psychological control groups; however, with very little evidence. Fluoxetine + CBT was associated with a higher decrease in symptoms than CBT or psychodynamic psychotherapy, with very low evidence. Regarding dropout rate, Nefazodone and Fluoxetine are associated with fewer dropouts than Sertraline, Imipramine, and Desipramine. Increased risk of suicidal ideation was associated with Venflaxine, compared with placebo and other interventions [19].

A combination of olanzapine and fluoxetine had a similar incidence of adverse events compared with fluoxetine or olanzapine alone. This was consistent with the findings of previous studies. Frequent adverse events include weight gain, increase in appetite, somnolence, fatigue, peripheral edema, sedation, and hypersomnia [20]. However, the patient has not complained of any adverse effects from our therapy.

## Conclusions

Treatment of adolescents with psychotic depression and a history of childhood maltreatment is associated with poor treatment outcomes. In adolescent psychotic depression with a history of child maltreatment, combining fluoxetine, olanzapine, and CBT is preferable to other antipsychotics and antidepressants.

## References

- [1] Dubovsky SL, Ghosh BM, Serotte JC, Cranwell V. Psychotic Depression: Diagnosis, Differential Diagnosis, and Treatment. *Psychother Psychosom* 2021;90:160–77. <https://doi.org/10.1159/000511348>.
- [2] Lippard ETC, Nemeroff CB. The devastating clinical consequences of child abuse and neglect: Increased disease vulnerability and poor treatment response in mood disorders. *Am J Psychiatry* 2020;177:20–36. <https://doi.org/10.1176/appi.ajp.2019.19010020>.
- [3] Alsaad AJ, Azhar Y ANY. Depression In Children - StatPearls - NCBI Bookshelf\_alsaad. *Depress. Child.*, 2022, p. 12.
- [4] Gournellis R, Tournikioti K, Touloumi G, Thomadakis C, Michalopoulou PG, Christodoulou C, et al. Psychotic (delusional) depression and suicidal attempts: a systematic review and meta-analysis. *Acta Psychiatr Scand* 2018;137:18–29. <https://doi.org/10.1111/acps.12826>.
- [5] Bernaras E, Jaureguizar J, Garaigordobil M. Child and adolescent depression: A review of theories, evaluation instruments, prevention programs, and treatments. *Front Psychol* 2019;10. <https://doi.org/10.3389/fpsyg.2019.00543>.
- [6] Dhamayanti M, Noviandhari A, Masdiani N, Pandia V, Sekarwana N. The association of depression with child abuse among Indonesian adolescents. *BMC Pediatr* 2020;20:1–6. <https://doi.org/10.1186/s12887-020-02218-2>.
- [7] Thomas S, Höfler M, Schäfer I, Trautmann S. Childhood maltreatment and treatment outcome in psychotic disorders: a



- systematic review and meta-analysis. *Acta Psychiatr Scand* 2019;140:295–312. <https://doi.org/10.1111/acps.13077>.
- [8] Toth SL, Handley ED, Manly JT, Sturm R, Adams TR, Demeusy EM, et al. The Moderating Role of Child Maltreatment in Treatment Efficacy for Adolescent Depression. *J Abnorm Child Psychol* 2020. <https://doi.org/10.1007/s10802-020-00682-z>.
- [9] De Bellis MD, Nooner KB, Scheid JM, Cohen JA. Depression in Maltreated Children and Adolescents. *Child Adolesc Psychiatr Clin N Am* 2019;28:289–302. <https://doi.org/10.1016/j.chc.2019.02.002>.
- [10] Thompson AR, Malhotra A, Rothschild AJ. Advances in the Treatment of Psychotic Depression. *Curr Treat Options Psychiatry* 2019;6:64–74. <https://doi.org/10.1007/s40501-019-0167-3>.
- [11] Kruizinga J, Liemburg E, Burger H, Cipriani A, Geddes J, Robertson L, et al. Pharmacological treatment for psychotic depression. *Cochrane Database Syst Rev* 2021;2021. <https://doi.org/10.1002/14651858.CD004044.PUB5/INFORMATION/EN>.
- [12] Gabriel FC, de Melo DO, Fráguas R, Leite-Santos NC, Mantovani da Silva RA, Ribeiro E. Pharmacological treatment of depression: A systematic review comparing clinical practice guideline recommendations. *PLoS One* 2020;15:1–16. <https://doi.org/10.1371/journal.pone.0231700>.
- [13] Flint AJ, Meyers BS, Rothschild AJ, Whyte EM, Alexopoulos GS, Rudorfer M V., et al. Effect of Continuing Olanzapine vs Placebo on Relapse Among Patients With Psychotic Depression in Remission: The STOP-PD II Randomized Clinical Trial. *JAMA* 2019;322:622–31. <https://doi.org/10.1001/JAMA.2019.10517>.
- [14] Bingham KS, Meyers BS, Mulsant BH, Rothschild AJ, Whyte EM, Banerjee S, et al. Stabilization treatment of remitted psychotic depression: the STOP-PD study. *Acta Psychiatr Scand* 2018;138:267–73. <https://doi.org/10.1111/acps.12937>.
- [15] Jami ES, Pritchard M, Shetty H, Stewart R, Young AH, Heslin M. Antidepressant and antipsychotic treatment of Psychotic Major Depression in a British mental healthcare setting. *J Ment Heal* 2021;0:1–7. <https://doi.org/10.1080/09638237.2021.1922632>.
- [16] Tompson MC, Sugar CA, Langer DA, Asarnow JR. A Randomized Clinical Trial Comparing Family-Focused Treatment and Individual Supportive Therapy for Depression in Childhood and Early Adolescence. *J Am Acad Child Adolesc Psychiatry* 2017;56:515–23. <https://doi.org/10.1016/j.jaac.2017.03.018>.
- [17] Eckshtain D, Kuppens S, Ugueto A, Ng MY, Vaughn-Coaxum R, Corteselli K, et al. Meta-Analysis: 13-Year Follow-up of Psychotherapy Effects on Youth Depression. *J Am Acad Child Adolesc Psychiatry* 2020;59:45–63. <https://doi.org/10.1016/j.jaac.2019.04.002>.
- [18] Weersing VR, Jeffreys M, Do MCT, Schwartz KTG, Bolano C. Evidence Base Update of Psychosocial Treatments for Child and Adolescent Depression. *J Clin Child Adolesc Psychol* 2017;46:11–43. <https://doi.org/10.1080/15374416.2016.1220310>.
- [19] Zhou X, Teng T, Zhang Y, Del Giovane C, Furukawa TA, Weisz JR, et al. Comparative efficacy and acceptability of antidepressants, psychotherapies, and their combination for acute treatment of children and adolescents with depressive disorder: a systematic review and network meta-analysis. *The Lancet Psychiatry* 2020;7:581–601. [https://doi.org/10.1016/S2215-0366\(20\)30137-1](https://doi.org/10.1016/S2215-0366(20)30137-1).
- [20] Luan S, Wan H, Wang S, Li H, Zhang B. Efficacy and safety of olanzapine/fluoxetine combination in the treatment of treatment-resistant depression: A meta-analysis of randomized controlled trials. *Neuropsychiatr Dis Treat* 2017;13:609–20. <https://doi.org/10.2147/NDT.S127453>.