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When Depression Persists: Diagnostic and Therapeutic Complexity of Early-Onset Treatment-Resistant Depression in an Adolescent

Y. Bohsina[1]*, Z. El Maataoui[1], H. Kisra[1]

[1]Department of Child and Adolescent Psychiatry, Ar-Razi Hospital, Ibn Sina University Hospital Center, Faculty of Medicine and Pharmacy of Rabat, Salé, Morocco

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***Corresponding author:** Y. Bohsina
Department of Child and Adolescent Psychiatry, Ar-Razi Hospital, Ibn Sina University Hospital Center, Faculty of Medicine and Pharmacy of Rabat, Salé, Morocco

Abstract **Case Report**

Early-onset depressive disorders may evolve into chronic, severely disabling conditions and become diagnostically challenging when trauma-related symptoms, historical psychotic manifestations, and deficit-like features coexist. We report the case of a 17-year-old male adolescent with an almost continuous depressive syndrome since approximately age 11, characterized by anhedonia, emotional numbing, fatigue, clinophilia, sleep-wake cycle inversion, social withdrawal, psychomotor and cognitive slowing, and major academic and social impairment. At age 14, after discovering the body of a close cousin who had died by hanging, he developed post-traumatic stress disorder. Auditory and visual hallucinations were reported during that period and resolved after approximately three months of risperidone; no established delusions or disorganized behavior were documented, and psychotic symptoms have not recurred for approximately three years. Trichotillomania subsequently emerged. Multiple pharmacological strategies were ineffective, only transiently effective, poorly tolerated, or limited by treatment availability. At the last follow-up, sertraline and lamotrigine had been initiated without reported adverse effects, but efficacy could not be assessed because the patient was lost to follow-up. This case highlights the difficulty of distinguishing severe chronic depression from negative symptoms of a schizophrenia-spectrum disorder, interpreting remote psychotic symptoms and psychomotor agitation, and monitoring possible bipolar evolution without premature diagnostic reclassification. Comorbid post-traumatic stress disorder and trichotillomania further complicated management. Longitudinal reassessment and individualized multimodal treatment are essential in severe early-onset treatment-resistant depression.

Keywords: Adolescent depression; treatment-resistant depression; persistent depressive disorder; post-traumatic stress disorder; trichotillomania; differential diagnosis; child and adolescent psychiatry.

INTRODUCTION

Depressive disorders in children and adolescents are associated with substantial psychological distress, academic and psychosocial impairment, and suicidal morbidity. Assessment becomes particularly challenging when onset is early, the course becomes chronic, and response to evidence-based interventions remains insufficient. Current guidance emphasizes comprehensive diagnostic and functional assessment, identification of psychiatric and medical comorbidities, systematic suicide-risk assessment, and evidence-based psychotherapy and pharmacotherapy for moderate-to-severe presentations [1].

Treatment resistance adds further complexity. In adolescents who do not respond to an adequate first selective serotonin reuptake inhibitor (SSRI) trial, the TORDIA study found that switching antidepressants combined with cognitive behavioral therapy (CBT) produced a higher response rate than medication switching alone [2]. Evidence becomes considerably more limited after multiple treatment failures.

Severe depression may also overlap phenomenologically with bipolar, schizophrenia-spectrum, and neurodevelopmental disorders. Social withdrawal, blunted affect, reduced speech, anhedonia, avolition, irritability, and cognitive difficulties are not diagnostically specific. We report a 17-year-old adolescent with early-onset persistent treatment-resistant depression complicated by post-traumatic stress disorder (PTSD), remote psychotic manifestations, and trichotillomania.

CASE REPORT

A 17-year-old male adolescent from Sidi Taïbi, Morocco, had been out of school for approximately one year and was the eldest of three children. His father was a taxi driver and his mother a homemaker. Pregnancy was monitored and carried to term in a context of family and marital conflict. Vaginal delivery was uncomplicated; birth weight was 3 kg. Early psychomotor, language, and toilet-training milestones were reportedly achieved within expected timeframes. Medical history was limited to allergic rhinitis. His mother was receiving psychiatric care for a depressive disorder.

During childhood, his mother described marked motor hyperactivity, distractibility, difficulty remaining seated, attentional difficulties, emotional dysregulation, and low frustration tolerance. These features later raised the possibility of childhood attention-deficit/ hyperactivity disorder (ADHD), although retrospective information was insufficient for confirmation. He had always been quiet and reserved, maintained some friendships, and often preferred solitary activities. He was particularly close to a paternal cousin six years his senior.

At approximately age 11, his family observed progressive withdrawal, reduced participation in family activities, increasing time alone, loss of interest in previously pleasurable activities, persistent fatigue, and loss of motivation. Academic performance deteriorated, resulting in three repeated school years. His sleep-wake cycle progressively inverted, with prolonged nighttime phone use, daytime sleep, and increasing clinophilia; appetite remained preserved. Thus, the depressive syndrome preceded the subsequent trauma by nearly three years.

At age 14, his close paternal cousin died by suicide by hanging, and the patient discovered the body immediately after the act. Approximately 20 days later, intrusive images, recurrent nightmares, near-daily thoughts about the death, avoidance, increasing irritability, and worsening sleep emerged and persisted, supporting a diagnosis of PTSD. During the following weeks, social withdrawal intensified. His mother reported self-directed speech and unmotivated laughter. Retrospectively, he recalled hearing voices without being able to describe their content and repeatedly seeing the silhouette of a man. His previous clinician had also noted some persecutory ideas but did not consider them established delusions. The patient currently had no recollection of these ideas. No disorganized behavior or established delusional syndrome was documented. Hallucinations resolved after approximately three months of risperidone and had not recurred for approximately three years.

At approximately age 15, repetitive pulling of scalp hair, eyebrows, and pubic hair developed, producing visible alopecic areas that he attempted to conceal with a cap. Over subsequent years, functioning continued to deteriorate. He rarely left home, spent much of the day lying down, and showed little engagement in activities. He described profound emotional numbing, stating that he felt neither happiness nor sadness and perceived only his “primary needs.” He expressed no future plans. Outside periods of clinophilia, his family described repeated aimless pacing. Noise and sibling conflict triggered irritability, anger outbursts, and occasional hetero-aggressive behavior toward his brothers.

Mental status examination showed psychomotor slowing. Grooming and clothing were appropriate; he wore a cap or hood during almost all interviews. Contact was difficult to establish and poorly spontaneous, although cooperative. Speech was sparse, responses brief, and prosody monotonous. Thought processes were slowed, with marked response latency and frequent need for repetition. Consciousness was clear and orientation preserved. Attention was distractible and memory globally preserved. Thought content included pessimistic thoughts about death, hopelessness, a sense of incurability, and very passive suicidal ideation. There was no active suicidal intent or formulated plan, no history of suicide attempt, and no psychiatric hospitalization. Suicide risk was assessed as low, and a safety plan was established with the family. No current perceptual disturbance or overt delusion was identified. Affect was impoverished and poorly modulated but congruent with the reported emotional numbing; judgment and insight were preserved.

Depression severity was quantified using the Children’s Depression Rating Scale–Revised (57), Patient Health Questionnaire-9 (15/27), 33-item Mood and Feelings Questionnaire (29/66), and 17-item Hamilton Depression Rating Scale (25/52). Autism-focused assessment yielded Autism Diagnostic Interview–Revised scores of 8/10 for social interaction, 6/8 for communication, and 0/3 for restricted behaviors, below the diagnostic thresholds used in the evaluation; the Autism Spectrum Quotient was 27/50. Adaptive functioning on the Vineland-II was preserved. No etiological somatic or paraclinical investigations were performed because of financial constraints.

The primary diagnosis was persistent depressive disorder with persistent major depressive episodes, with comorbid PTSD and trichotillomania. Childhood ADHD remained to be reassessed. Intellectual developmental disorder appeared unlikely given the developmental history and preserved adaptive functioning, and autism spectrum disorder was not retained. Bipolar and schizophrenia-spectrum disorders remained important longitudinal differential diagnoses.

In 2022, escitalopram 20 mg/day was administered for approximately four months without meaningful improvement. Risperidone 1 mg/day, increased to 1.5 mg/day, was associated with resolution of hallucinations within approximately three months, without sustained improvement in depressive symptoms. Sertraline 50 mg/day was subsequently prescribed but not optimized; treatment was interrupted and the patient was lost to follow-up for nearly three years.

When care resumed in 2025, fluoxetine was titrated from 20 to 60 mg/day. A partial mood improvement lasting approximately one month occurred without sustained remission. Olanzapine 2.5 mg/day augmentation was discontinued because of marked sedation. A switch to aripiprazole was planned but could not be initiated because of a nationwide stock shortage in Morocco. Quetiapine 50 mg/day was poorly tolerated because of sedation, nightmares, increased appetite, and nervousness, leading to poor adherence and discontinuation. At the last follow-up, sertraline 50 mg/day had been reintroduced with planned titration and lamotrigine 50 mg/day added as an individualized augmentation strategy. No adverse effects were reported, but efficacy could not be assessed because the patient was subsequently lost to follow-up.

Psychoeducation and trauma-focused CBT principles were initiated, but marked trauma avoidance, psychomotor slowing, and attentional difficulties limited trauma narration and cognitive restructuring; mood stabilization was therefore prioritized. For trichotillomania, CBT incorporating habit reversal training was proposed. Scalp hair pulling ceased with regrowth, although pulling shifted to pubic hair.

Table 1: Standardized assessment scores

Instrument	Score
Children's Depression Rating Scale–Revised (CDRS-R)	57
Patient Health Questionnaire-9 (PHQ-9)	15/27
Mood and Feelings Questionnaire, 33-item version (MFQ-33)	29/66
Hamilton Depression Rating Scale, 17-item version (HDRS-17)	25/52

DISCUSSION

This case illustrates the longitudinal complexity of severe early-onset treatment-resistant depression. The depressive syndrome began around age 11, clearly before the traumatic exposure, and became chronically disabling before being complicated by PTSD, transient psychotic manifestations, and trichotillomania. The chronology is clinically important: the trauma aggravated the presentation but does not explain the onset of the depressive disorder.

The treatment course supports a clinically resistant presentation while also requiring nuance because adherence was inconsistent during some periods and follow-up was interrupted. The patient received two adequate antidepressant trials—escitalopram 20 mg/day for four months and fluoxetine up to 60 mg/day for six months—without sustained remission. In TORDIA, 334 adolescents with SSRI-resistant depression had a higher response rate when medication switching was combined with CBT than with medication switching alone (54.8% vs. 40.5%); venlafaxine was not more effective than switching to another SSRI and produced more adverse effects [2]. In this patient, augmentation was additionally constrained by tolerability and access: olanzapine caused marked sedation, quetiapine was poorly tolerated, and planned aripiprazole could not be initiated because of a nationwide shortage.

Possible bipolar evolution warrants surveillance but is not established. Early onset, treatment resistance, irritability, historical psychotic manifestations, and psychomotor agitation prompted consideration of bipolarity; however, no manic or hypomanic episode was identified, and there was no decreased need for sleep, elevated or expansive mood, grandiosity, pressured speech, flight of ideas, increased goal-directed activity, or risk-taking behavior. Van Meter *et al.,*[3] found that the prodrome before an initial bipolar mood episode averaged 27.1 ± 23.1 months across 11 studies involving 1,078 participants, with substantial heterogeneity. Such findings support longitudinal monitoring rather than assigning predictive value to nonspecific symptoms in an individual patient. Repetitive aimless pacing also resembles descriptions of agitated or mixed depressive states, although psychomotor agitation alone is insufficient to establish bipolarity [4].

A second diagnostic challenge is the overlap between severe depression and negative symptoms of schizophrenia-spectrum disorders. The patient displayed marked social withdrawal, reduced verbal spontaneity, monotonous prosody, impoverished affect, loss of motivation, anhedonia, and severe functional decline. These may resemble avolition, alogia, anhedonia, asociality, and blunted affect. Krynicki *et al.,*[5] showed that depressive and negative symptoms substantially overlap in schizophrenia: low mood, suicidal ideation, and pessimism are more specific to depression; alogia and blunted affect are more specific to negative symptoms; and anhedonia, anergia, and avolition may occur in both. Historical hallucinations and profound functional decline justify continued surveillance, but no established delusions, behavioral disorganization, or persistent psychosis have been documented. The poorly characterized persecutory ideas at age 14 were not

considered delusional by the treating clinician, and the patient no longer recalls them. The available data therefore do not support a current schizophrenia-spectrum diagnosis, although longitudinal reassessment remains warranted.

The remote hallucinations should also be interpreted cautiously because their content, frequency, mood congruence, relationship to trauma re-experiencing, and degree of insight were insufficiently documented. Their resolution under risperidone does not retrospectively determine their nosology, and no current psychotic symptoms were present.

PTSD was superimposed on a pre-existing depressive disorder. Trauma-focused CBT is supported in pediatric PTSD [6,7], but in this case marked avoidance, psychomotor slowing, and attentional difficulties limited engagement, leading clinicians to prioritize stabilization of the depressive syndrome.

Autism spectrum disorder was considered because of longstanding preference for solitude, poor spontaneous contact, impoverished affect, and noise intolerance, but developmental history, preserved friendships and reciprocal attachment, absence of stereotyped behavior or restricted interests, preserved adaptive functioning, and subthreshold autism-focused assessments did not support the diagnosis. Social-cognitive impairment may itself occur during major depression; Bora and Berk [8] found significant theory-of-mind impairment in major depressive disorder, associated with depressive severity.

Trichotillomania constituted an additional comorbidity. Behavioral therapy is supported in pediatric trichotillomania [9]. The disappearance of scalp hair pulling with regrowth but migration of pulling to pubic hair suggested partial behavioral improvement rather than remission.

Lamotrigine augmentation requires particular caution. It is not a first-line evidence-based augmentation strategy for unipolar treatment-resistant depression in adolescents. A systematic review identified seven pediatric mood-disorder studies including 319 patients with bipolar disorder and only 43 with major depressive disorder; the evidence was insufficient for definitive recommendations, particularly in unipolar depression [10]. Its use here was individualized after previous augmentation strategies were ineffective, poorly tolerated, or inaccessible. Because the patient was lost to follow-up, no conclusion regarding efficacy is possible.

The case is limited by retrospective reconstruction of some childhood and psychotic symptoms, incomplete phenomenological characterization of the historical psychotic experiences, variable adherence across treatment periods, absence of etiological somatic or paraclinical investigations because of financial constraints, and loss to follow-up after the most recent treatment change.

CONCLUSION

Severe early-onset treatment-resistant depression in adolescence may present substantial diagnostic overlap with trauma-related, bipolar, psychotic-spectrum, and neurodevelopmental conditions. In this patient, the depressive syndrome preceded the traumatic event and later became complicated by PTSD, transient historical psychotic manifestations, trichotillomania, and profound functional impairment. Psychomotor agitation and historical psychotic symptoms justify longitudinal surveillance but do not establish bipolar or schizophrenia-spectrum disorders in the absence of defining syndromic features. Repeated diagnostic reassessment, suicide-risk monitoring, family involvement, structured psychotherapy, functional rehabilitation, and cautious individualized pharmacotherapy remain central to management.

Consent for Publication and Confidentiality

Written informed consent for presentation and publication of this case was obtained from the patient and/or his legal representative. Directly identifying information has been omitted to preserve confidentiality.

REFERENCES

1. Walter, H. J., Abright, A. R., Bukstein, O. G., Diamond, J., Keable, H., Ripperger-Suhler, J., & Rockhill, C. (2023). Clinical practice guideline for the assessment and treatment of children and adolescents with major and persistent depressive disorders. Journal of the American Academy of Child & Adolescent Psychiatry, 62(5), 479–502. https://doi.org/10.1016/j.jaac.2022.10.001
2. Brent, D., Emslie, G., Clarke, G., Wagner, K. D., Asarnow, J. R., Keller, M., Vitiello, B., Ritz, L., Iyengar, S., Abebe, K., Birmaher, B., Ryan, N., Kennard, B., Hughes, C., DeBar, L., McCracken, J., Strober, M., Suddath, R., Spirito, A., … Zelazny, J. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: The TORDIA randomized controlled trial. JAMA, 299(8), 901–913. https://doi.org/10.1001/jama.299.8.901
3. Van Meter, A. R., Burke, C., Youngstrom, E. A., Faedda, G. L., & Correll, C. U. (2016). The bipolar prodrome: Meta-analysis of symptom prevalence prior to initial or recurrent mood episodes. Journal of the American Academy of Child & Adolescent Psychiatry, 55(7), 543–555. https://doi.org/10.1016/j.jaac.2016.04.017
4. Koukopoulos, A., & Sani, G. (2014). DSM-5 criteria for depression with mixed features: A farewell to mixed depression. Acta Psychiatrica Scandinavica, 129(1), 4–16. https://doi.org/10.1111/acps.12140

5. Krynicki, C. R., Upthegrove, R., Deakin, J. F. W., & Barnes, T. R. E. (2018). The relationship between negative symptoms and depression in schizophrenia: A systematic review. Acta Psychiatrica Scandinavica, 137(5), 380–390. https://doi.org/10.1111/acps.12873
6. Goldbeck, L., Muche, R., Sachser, C., Tutus, D., & Rosner, R. (2016). Effectiveness of trauma-focused cognitive behavioral therapy for children and adolescents: A randomized controlled trial in eight German mental health clinics. Psychotherapy and Psychosomatics, 85(3), 159–170. https://doi.org/10.1159/000442824
7. Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & Clark, D. M. (2007). Cognitive-behavioral therapy for PTSD in children and adolescents: A preliminary randomized controlled trial. Journal of the American Academy of Child & Adolescent Psychiatry, 46(8), 1051–1061. https://doi.org/10.1097/CHI.0b013e318067e288
8. Bora, E., & Berk, M. (2016). Theory of mind in major depressive disorder: A meta-analysis. Journal of Affective Disorders, 191, 49–55. https://doi.org/10.1016/j.jad.2015.11.023
9. Franklin, M. E., Edson, A. L., Ledley, D. A., & Cahill, S. P. (2011). Behavior therapy for pediatric trichotillomania: A randomized controlled trial. Journal of the American Academy of Child & Adolescent Psychiatry, 50(8), 763–771. https://doi.org/10.1016/j.jaac.2011.05.009
10. Kumar, R., Garzon, J., Yuruk, D., Hassett, L. C., Saliba, M., Ozger, C., Oztosun, C., Ahern, K., Athreya, A. P., Singh, B., Croarkin, P. E., & Vande Voort, J. L. (2023). Efficacy and safety of lamotrigine in pediatric mood disorders: A systematic review. Acta Psychiatrica Scandinavica, 147(3), 248–256. https://doi.org/10.1111/acps.13500