CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

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Pediatricians regularly care for children who have experienced child maltreatment. Child maltreatment is a risk factor for a broad range of mental health problems. Issues specific to child maltreatment make addressing emotional and behavioral challenges among maltreated children difficult. This clinical report focuses on 2 key issues necessary for the care of maltreated children and adolescents in pediatric settings: trauma-informed assessments and the role of pharmacotherapy in maltreated children and adolescents. Specific to assessment, current or past involvement of the child in the child welfare system can hinder obtaining necessary information or access to appropriate treatments. Furthermore, trauma-informed assessments can help identify the need for specific interventions. Finally, it is important to take both child welfare system and trauma-informed assessment approaches into account when considering the use of psychotropic agents because there are critical diagnostic and systemic issues that affect the prescribing and discontinuing of psychiatric medications among children with a history of child maltreatment.

INTRODUCTION

Child maltreatment includes physical, sexual, and psychological abuse as well as neglect experienced by children and adolescents. Approximately 700 000 children and adolescents are substantiated victims of maltreatment in the United States each year.[1] The actual number is likely higher because nationally reported child welfare statistics greatly underestimate the prevalence of child maltreatment.[2] Pediatric health care providers routinely care for maltreated children and adolescents, and a disproportionate number of children and adolescents with a history of

abstract

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Drs Keeshin, Forkey, Fouras, and MacMillan were equally responsible for conceptualizing, writing, and revising the manuscript and considering input from all reviewers and the board of directors, and all authors approved the final manuscript as submitted.

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To cite: Keeshin B, Forkey HC, Fouras G, et al. AAP AMERICAN ACADEMY OF PEDIATRICS, COUNCIL ON CHILD ABUSE AND NEGLECT, COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, COMMITTEE ON CHILD MALTREATMENT AND VIOLENCE, COMMITTEE ON ADOPTION AND FOSTER CARE. Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication. *Pediatrics.* 2020;145(2): e20193751

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maltreatment are likely to experience emotional, behavioral, and developmental problems.[3,4]

Addressing mental health conditions in children and adolescents who have experienced maltreatment involves a comprehensive assessment that is used to guide the provision of follow-up care and treatment. When maltreated children receive treatment of emotional and behavioral problems, emphasis may be placed on pharmacotherapy rather than on a broad range of interventions, including psychotherapy.[5] Each child's case will have its own individual features, and there are situations in which medications are necessary; however, irrespective of mental health diagnosis, maltreated children and adolescents receive more psychotropic medications than comparable populations receiving psychiatric care, suggesting overtreatment.[6,7] Children and adolescents involved with the child welfare system are 2 to 3 times more likely to be treated with psychotropic medication compared with those without such involvement.[8,9] In addition, 33% of all foster children are prescribed a psychotropic medication. Among Medicaid-eligible children, foster children are approximately 4 times more likely to be prescribed a second-generation antipsychotic than children not in foster care,[10] with 10% of foster children receiving 3 or more psychotropic medications at any given time.[11]

The purpose of this clinical report is to provide guidance for pediatric health care providers on the assessment and treatment of mental health conditions commonly experienced by maltreated children and adolescents in both foster care and in-home placement with a particular focus on the appropriate use of psychotropic medication. The report reviews: (1) the potential impact of the child welfare system on mental health assessment and treatment; (2) methods for assessing children and adolescents for traumatic experiences, including trauma- and non–trauma-related symptoms; and (3) approaches to the use of psychotropic medication among maltreated children and adolescents. The latter will include principles and recommendations for the prescribing and discontinuing of psychotropic medications.

ASSESSMENT

Child Welfare System

Understanding key aspects of the child welfare system and how it serves children is important for the assessment of child maltreatment experiences and traumatic stress symptoms as well as treatment planning. Although there is variability among jurisdictions, many of the key decision points are consistent across systems. Contact with child protective services (CPS) begins with a report filed by a mandated reporter, a concerned citizen, or a family member. For substantiated cases with an identified safety or risk issue, a court petition may be filed, which may result in the child becoming a court dependent. In court-dependent cases, service plans or reunification requirements ordered by the court determine the services or "reasonable efforts" that CPS must provide to the family and caregivers of the child. Cases are reviewed periodically to check on the progress of the parents or caregivers as they work toward achieving service plan goals with the aim of eventual reunification of the dependent child with his or her family, if safe to do so.

In court proceedings, the concept of "best interests of the child" is typically used to guide decisions. In addition, the principles of least restrictive settings, maintenance of family or kinship relations, and permanency are important considerations. For children who cannot safely stay at home, placement with a foster or kinship family will be the next step. It is not uncommon in the foster care system for living circumstances to be disrupted and to experience multiple moves within the system. Half of children in foster care are moved to other homes or more restrictive settings while in foster care because of behavioral concerns.[12] After multiple failed placements or when specialized services are needed, children may be moved to residential or congregate care (ie, group homes).

Emotional, Behavioral, and Developmental Problems

A recent clinical report from the American Academy of Pediatrics (AAP), "Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment,"[13] recognizes that children and adolescents who have been exposed to one or more types of maltreatment may experience a broad range of emotional, behavioral, and developmental problems.[14–17] The clinical report provides a comprehensive overview of these signs and symptoms as well as some of the most commonly associated conditions, such as posttraumatic stress disorder (PTSD).[13] Young children are overrepresented in the maltreated population and may also have emotional and behavioral problems as a result of maltreatment. These clinical problems may include changes in mood, anxiety, sleep, eating or feeding, and behavioral patterns and require that the pediatric health care provider be vigilant for the changes, given developmental stage and limited verbal interactions.[18] Because pediatricians, child psychiatrists, and other health care professionals encounter children in their practices who have been abused and/or neglected, it is important for these pediatric providers to assist children and their families in addressing impairments associated with maltreatment.

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Child maltreatment is an experience and not a symptom or disorder. A focused and trauma-informed assessment should be conducted before initiating treatment including referral of a child and/or family to a specific intervention and/or medication. The broad range of conditions and symptoms associated with different forms of child maltreatment show little specificity by type of experience.[2,19] Furthermore, children and adolescents are often exposed to more than one type of maltreatment,[20] and the effects of maltreatment can overlap or be comorbid with non–trauma-related conditions. When available, review of CPS court reports or court reports filed by an assigned court-appointed special advocate can provide valuable assessment information for the pediatric provider. Determination of which aspects of a child's emotional, behavioral, or developmental condition are directly related to specific episodes of child maltreatment versus chronic exposure to maltreatment or other biological, familial, and social factors can be difficult and is generally not possible in the pediatric setting.

Developing a comprehensive picture of a child's exposure to and effects from maltreatment is important because of the pervasive consequences that maltreatment can have on the developing child. Multiple domains of functioning can be affected, including attachment, cognition, self-image, emotional responses, social interactions, and behavior.[21] Affected children and adolescents and their families often interact with professionals from multiple service sectors, including health care, mental health, child welfare, law enforcement, education, and juvenile justice. A number of specific factors may be considered, including the type and timing of exposure to maltreatment as related to developmental stage, the range of symptoms, functional impairment including developmental delay, and how behaviors and symptoms may be related to triggers and reminders of the maltreatment.

Medical, Social, and Trauma Histories

Medical, social, and trauma histories are particularly important in determining the intervention needs of a child and family when history includes child maltreatment. Emphasis on history helps to change the conversation from "What is wrong with you?" to "What happened to you?" This trauma-informed approach is critical to destigmatize and validate the patient and family. The approach will differ depending on the child's living arrangements and access to caregivers. The goal is for the clinician to communicate to the child and family an openness to hearing about past and present events and convey the message that the information is important in formulating decisions about treatment in the present and future. Children and/or family do not necessarily have to provide all details about past injuries, traumas, social services involvement, or foster care placements because this information may be gathered from other sources. Child welfare, school, and previous medical records, when available, can be obtained to inform the history.

Pediatricians should obtain a comprehensive social history to inform a child's treatment needs after exposure to abuse and/or neglect.[22] They should attempt to determine the child's current living arrangements, including any contact with the biological family, foster care placement, residential treatment, or involvement with juvenile justice. The assessment of any ongoing violence, including exposure to intimate partner violence among caregivers, is not only the responsibility of CPS; the pediatrician should be alert to these issues as well as parental mental health problems, including substance use disorder. Pediatricians must emphasize safety as a paramount consideration. It should be made clear that if a child or family is unsafe at any time, an emergency report will be made to CPS.

Assessment of Current Trauma, Social Determinants of Health, and Resilience

Increasingly, pediatric literature supports the practice of being aware of and alert to children's traumatic experiences and social determinants of health because these are important considerations when making decisions about diagnoses and treatments. Traumatic events, including maltreatment, can have a multiplicative effect,[23] and stressors beyond maltreatment, such as poverty and community violence, can contribute to the harm experienced by the child.[24,25] Increasingly, pediatric literature supports taking resilience into account, which allows the pediatric provider to address these issues with a more positive and potentially empowering perspective.[26] Yet, there are no outcome studies indicating benefits of one assessment approach over the other.[27]

It is important for pediatricians to be alert to the possibility of ongoing trauma in children who have experienced past trauma and to demonstrate openness to hearing about ongoing or recurrent experiences of maltreatment. The pediatric provider can spend time with the older child or adolescent individually and ask questions such as, "How are people in the family getting along?" and "Sometimes kids are worried about their safety or the safety of someone at home. What about you?" In some settings, the pediatrician may not be the only professional in a position to ask these questions of the child and may collaborate with another professional, such as a social worker or mental

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health clinician. Regardless, questions should be open-ended and appropriate for the child's age and developmental stage and ability to respond appropriately.[28] If the child discloses information about ongoing maltreatment or new exposures not disclosed previously, it is important that the pediatric provider acknowledge and validate the child's disclosure. Information that is critical to providing medical care should be obtained and documented. Medical providers are not investigators like CPS and law enforcement; thus, although medically relevant information should be obtained, questions regarding nonmedical details are not necessary. If the child reveals ongoing or new information, the clinician should support the child, document the disclosure, and tell the child that this information needs to be shared with a child protection worker to help keep the child safe. Children should not be assured of absolute confidentiality when there are safety concerns. Stating this to a child in simple terms early in the visit with a phrase such as, "What you say will be just between you and me unless you are hurting yourself, someone is hurting you, or you are hurting someone else" will help avoid a situation in which a child feels that his or her confidence has been betrayed.

Caregivers can also provide useful information about social determinants of health and safety. Questions about food insecurity and parental mental health provide an opportunity for the practitioner to assess important risk factors but require a practitioner to have a plan to respond to identified family needs. It is essential that such inquiry not put the caregiver at risk; for example, in asking about intimate partner violence, caregivers should only be asked this question during individual interviews.[29] Caregivers should also not be assured of absolute confidentiality because they may provide information that raises concerns about the safety of the child.

Certain questionnaires and instruments have been developed to gather detailed information about exposure to child maltreatment; the National Child Traumatic Stress Network (www.nctsn.org) and the Child Welfare Information Gateway (https://www.childwelfare.gov) maintain updated databases of such tools. These tools have generally been used in research studies; there is no indication that the administration of these measures through screening leads to better outcomes for children.[30] Furthermore, such measures often involve considerable time, making them not feasible for use in the general pediatric setting, and their use may lead to the collection of information that overlaps with what a CPS worker needs to ask about in conducting an assessment.

Trauma-Related Symptoms

Along with screening tools for depression, anxiety, and attention-deficit/hyperactivity disorder (ADHD), specific tools to identify traumatic stress symptoms are available for use in the pediatric setting. The UCLA PTSD Reaction Index Brief Form[31] utilized in a primary care settings is one option for traumatic stress screening that is freely available. Familiarity of the pediatric provider with the tools chosen, specific symptoms or diagnoses screened by each tool, protocols to incorporate their use into office flow, and ability to address patient or family responses are all important. One example of how this can be done is the Intermountain Healthcare Pediatric Traumatic Stress Care Process Model.[32] As discussed in the AAP clinical report on the behavioral manifestations of child maltreatment, psychiatric diagnoses, including PTSD; internalizing problems, such as depression and anxiety; externalizing problems, including disruptive behavioral disorders (oppositional defiant and conduct disorders); substance use disorder; suicidal behavior; and ADHD are associated with maltreatment.[13] The term "complex trauma" is used to describe the effects of multiple or chronic traumatic experiences, which result in a wide range of cognitive, emotional, and behavioral changes that do not fit easily into common diagnostic categories. For children and adolescents who have suffered from severe, pervasive, or prolonged maltreatment, symptoms of complex trauma can result. These include intense emotional distress; disturbed sleep; attention and concentration problems; anger; aggressive, destructive, or reckless behavior; withdrawal; intrusive thoughts; exaggerated emotional response to stimuli; hypervigilance; risk-taking; and difficulty with emotional regulation.

For the symptoms of complex trauma noted above, trauma-specific measures, such as the Trauma Symptom Checklist for Children,[33] or broad behavioral assessment tools, such as the Child Behavior Checklist, may be used. The need for additional and improved tools in primary care or specialty settings to assess for complex trauma and distinguish it from other diagnoses has been noted. However, until new methods are developed and validated, children and adolescents at risk for complex trauma require comprehensive evaluations that lead to thoughtful and parsimonious formulations rather than a laundry list of diagnoses. The National Child Traumatic Stress Network (www.nctsn.org) has commonly used standardized measures for providers to assess these patients, along with specifics regarding the domains evaluated by the measure, targeted age, format, completion time, and source of more information.

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The purpose of any measures used during the assessment should be discussed with the child and caregiver. Where appropriate, feedback to the child and/or family that highlights the child's strengths should be provided. Areas in which the caregiver and child agree or disagree can be discussed during the feedback. If opinions are consistent, this is a potential strength, indicating that child and caregiver are "on the same page." Discussing discrepancies may help family members to understand that children and caregivers have different perceptions of the same symptom. The feedback process can be used to provide some psychoeducation to families and patients. It can be helpful to explore the past strategies used to address behaviors, such as strong emotions. The family can be educated about triggers of certain behaviors and advised about how treatment can potentially relieve those symptoms. These approaches assist families to consider a child's actions using a "trauma lens," which can help families and children to understand behaviors and reduce stress. The National Child Traumatic Stress Network has a number of resources specifically for families and caregivers to further their understanding of the effects of trauma.

Although beyond the scope of this clinical report, information and practical guidance in integration of these components into pediatric practice, including preparing the practice, difficult conversations, managing office flow, and coding and billing, are available in the AAP guide "Helping Foster and Adoptive Families Cope with Trauma," the AAP's "Trauma Toolbox for Primary Care" (both available at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx), and Johns Hopkins University's "Improving the Capacity of Primary Care to Serve Children and Families Experiencing Trauma and Chronic Stress: A Toolkit" (available at http://web.jhu.edu/pedmentalhealth/PICC%20TOOLKIT%201.pdf).

TREATMENT

A stable home environment with responsive and nurturing caregiving is most important for children who have experienced maltreatment with resultant emotional and behavioral difficulties. In addition, such children need to receive evidence-based treatments (EBTs) demonstrated effective in this population. An overview of the evidence-based individual and family-based psychotherapeutic interventions for maltreated children and adolescents is provided in the AAP clinical report on the behavioral manifestations of child maltreatment.[13] A 2016 AAP technical report, "Addressing Early Childhood Emotional and Behavioral Problems," outlines services for the treatment of young children[18] because young, even nonverbal, children can be significantly affected by child maltreatment–related trauma. Because access to such interventions may be limited and, even when available, may be accessed only after long waitlists, pediatric providers should provide guidance and strategies to help families bridge the time until EBT can begin. Psychoeducation, relaxation training, encouraging parent-child communication, and parenting supports are features common to EBTs. Through pediatric anticipatory guidance, pediatric providers may support families with such approaches while waiting for EBT to become available. Helping nonoffending caregivers and patients learn relaxation techniques such as using belly breathing, guided imagery, meditation, yoga, stretching, and massage can be useful in dealing with traumatic stress symptoms after maltreatment.[34]Providing guidance on the importance of adequate sleep and exercise is also important. Referrals to community resources for mindfulness programs and parenting support can be useful in supporting children and families.

Sometimes, in an attempt to preserve existing foster care placements and reduce failure of caregiving arrangements, providers will turn to psychotropic medication in an attempt to control disruptive behaviors that threaten a placement. A Government Accounting Office report from 2011 reviewed Medicaid claims data for children and adolescents both in foster care and not in foster care in 5 states: Florida, Massachusetts, Michigan, Oregon, and Texas.[35] In this report, children and adolescents in foster care were found to be prescribed psychotropic medications at rates 2.7 to 4.5 times higher than those who were not in foster care. The report also cited high rates of polypharmacy, high doses of medications, and young age at initiation of medication therapy.[35] A follow-up report from 2012 examined Medicaid and private insurance claims data and found that children and adolescents enrolled in Medicaid were more likely to be on psychotropic medication without psychosocial interventions, such as psychotherapy. In response to the increased use of psychotropic medications in foster care, child welfare agencies have adopted programs to provide psychotropic medication oversight.[36] Detailed discussion of these programs is beyond the scope of this clinical report, but they commonly include a review by a medical practitioner with a recommendation to the child welfare agency and/or the courts for action. In some jurisdictions, parents or other stakeholders may also be given the opportunity to contest the administration of medication during a court hearing.

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General Pharmacotherapy Considerations

Ideally, pediatricians work closely with therapists and psychiatrists when treating maltreated children in need of pharmacotherapy. Some pediatricians work in integrated care settings that may provide colocated or collaborative care. These models tend to enhance coordination and continuity of care and are well suited to address the clinical and system-level complexity of children exposed to child maltreatment.[37] However, primary care providers are often not in a position to provide integrated mental health care, nor do they necessarily have access to evidence-based trauma-focused interventions for maltreated children. This lack of access may lead to underuse of trauma-informed, evidence-based psychotherapies and may be one of many factors leading to the increased prescription of psychotropic medication among maltreated children and adolescents.

Having to consider the use of a medication to treat symptoms in maltreated children is a reality faced by primary care providers. Therefore, it is critical for pediatric providers to remember the following key concepts when considering the use of medications:

1. Maltreated children are more likely to have complex trauma including multiple or chronic traumatic experiences that result in a wide range of cognitive, emotional, and behavioral changes that do not easily fit into common diagnostic categories. Unidentified complex trauma may lead to children and adolescents being given multiple psychiatric diagnoses in an effort to capture the many manifestations of the trauma.[38]
2. Even when phenotypically similar to common disorders, individuals with a history of child maltreatment constitute a distinct "ecophenotype" (as described by Teicher and Sampson[4]) with different underlying biological changes and, thus, may not respond in predictable ways to treatments traditionally prescribed for mental health conditions.[4] This phenomenon may be especially true for young children.[18]
3. Maltreated children and adolescents may be more susceptible to adverse effects associated with psychotropic medication, such as excessive weight gain and suicidality.[39,40] It is essential that pediatricians are cautious when considering the use of psychotropic treatments in maltreated children.
4. Accurate diagnosis of both trauma- and non–trauma-specific conditions is crucial for choosing a treatment plan to alleviate symptoms in maltreated patients.
5. When starting, continuing, or discontinuing a medication, shared decision-making and informed consent are used for the child's given placement (home, kinship, or foster care) with the appropriate caregiver or proxy (which may vary by state in foster placements) as well as assent, when indicated. Before prescribing, providers will need to consider, identify, and obtain the consents required in their locality according to the placement status of the child.[41]

Ongoing Trauma Exposure

The biological aspects of trauma-specific disorders are discussed in the AAP clinical report on the behavioral manifestations of child maltreatment.[13] When considering treatment options, it is important to remember that behaviors such as increased reactivity, hyperarousal, and poor attention to stimuli (such as school work) in the presence of ongoing danger are not pathologic but a normal stress response.[42] Furthermore, in situations in which maltreated children continue to be at risk, there is little value in a pharmacotherapy trial for possible comorbidities until the danger has been mitigated.[43] Medication trials for the child's developmentally normal response to an ongoing threat are inappropriate and invalidating to the child. In addition, focusing on medication rather than the family distracts from approaches aimed at collaboration with child welfare and other community agencies to enhance overall safety and develop enhanced safety skills for the child, which is a core component of most evidence-based trauma psychotherapies.[43]

Sleep Disturbances

Children and adolescents who have experienced maltreatment often have sleep problems that can be a manifestation of specific trauma-related symptoms or may result from poor sleep hygiene and inadequate environmental and family supports for healthy sleep.[44] When maltreated children present with sleep problems, pediatricians should begin with providing psychoeducation on the connection between traumatic exposures and sleep difficulties.[45] Along with general sleep guidance (hygiene), such as limiting screen time and decreasing caffeine intake, other strategies specific to a history of trauma may include encouraging the family to reestablish routines around bedtime that calm the child (eg, warm bath, chamomile tea, story time), enhancing the child's feelings of safety at night (eg, parent staying in room at first while child falls asleep, use of a night light), and actively decreasing distress experienced by the child through use of techniques such as focused breathing and guided imagery.[34]

There is little evidence on effective medications for the treatment of sleep problems in children and adolescents.[46] Sleep problems should prompt the clinician to assess for disorders common in maltreated

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children, including PTSD, anxiety, depression, and behavioral problems. Referral to mental health providers should be made if there is an inadequate response to primary sleep interventions, sleep problems that are frequent or severe and/or worsening over time, or the identification of psychiatric comorbidity that has persisted after trauma (eg, PTSD, anxiety, depression, behavioral issues). After attempting nonpharmacologic interventions, concurrent with or before a mental health referral for persistent sleep difficulties, a trial of melatonin can be considered.[46] Melatonin has been found to be efficacious in pediatric populations at risk for insomnia, such as those with ADHD and autism spectrum disorders.[47,48] Additionally, treatment of comorbidities should be considered to avoid the risk of polypharmacy.[49] Because of the lack of evidence and the option of safer alternatives, as well as significant adverse effects and risks, first- and second-generation antipsychotics and benzodiazepines are not recommended for the treatment of sleep problems in children and adolescents.[43]

PTSD

Evidence-based psychotherapies are the most effective treatment of children with PTSD[50] and should always be considered first before initiating medication trials.[13,34] To date, no medication is approved by the US Food and Drug Administration (FDA) for treatment of trauma-specific symptoms or PTSD in children and adolescents.[43] In 2 separate randomized controlled trials evaluating the efficacy of sertraline (an FDA-approved selective serotonin reuptake inhibitor [SSRI] for PTSD in adults) in the treatment of PTSD among pediatric patients, no benefit was found, either as monotherapy or in combination with evidence-based psychotherapy.[51,52] In adults with PTSD, prazosin has been demonstrated as effective in treating nightmares and sleep disturbances.[53] Prazosin may be considered for children and adolescents with PTSD and severe sleep difficulties, according to expert consensus guidelines such as the "Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents," on the basis of a review of retrospective data (Table 1).[54] However, given the substantial evidence supporting the efficacy of certain psychotherapeutic approaches for the treatment of trauma-exposed children and the paucity of rigorous studies evaluating pharmacologic agents in children with PTSD,[34,50] there is at present no evidence to support the use of medications without first providing evidence-based psychotherapies in the treatment of pediatric PTSD.

Other Diagnostic Considerations

Children and adolescents with a history of maltreatment are at increased risk of disorders that are not trauma specific and for which judicious use of medication may be indicated. Common disorders such as anxiety, depression, and ADHD are overrepresented in children with histories of child maltreatment and other types of adversity.[3,4,55,56] Depending on the experience and expertise of the pediatric health care provider, the provider should use standardized measures to assess the wide array of possible psychiatric diagnoses or refer to a child psychiatrist.[49]

Although some of the information that follows may seem outside the scope of practice for pediatricians, in fact, pediatric health care providers may be the only resource available for this type of care because of the limited availability of psychiatrists. It is often difficult to distinguish between anxiety, depression, disruptive behavior, and trauma-specific disorders, especially when the symptoms could be indicative of comorbidity or syndromic overlap (Table 2). For example, the intrusive and hyperarousal symptoms of PTSD can appear similar to symptoms of anxiety or ADHD in a child brought to primary care for possible psychotropic medication management. Assessing for additional traumatic stress symptoms, inquiring about the temporal relationship between maltreatment experiences and the onset and exacerbation of symptoms, and poor responses to previous pharmacologic interventions may provide important insights. For example, symptoms initially identified by caregivers as related to anxiety or ADHD may be better explained by PTSD and, therefore, may not be appropriate for pharmacotherapy, as described in the preceding section on PTSD. The revised PTSD criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, include negative or decreased cognition and mood with many specific symptoms, such as negative beliefs toward self, self-blame, negative emotional state, loss of interest in previously enjoyable activities, and feeling detached.[57] Determining symptoms of depression versus PTSD and possible comorbidity has significant treatment implications. Over time, when disorders such as anxiety, depression, and ADHD are clearly identified, monotherapy trials of psychotropic medications may be warranted (Table 1).

Suicidal ideation and suicide attempts are often related to the presence of mental illness generally[58] and not limited to depression alone. Older children and adolescents who have been maltreated are at increased risk of suicidality and self-harm.[59] Asking questions regarding self-harm and suicidal ideation is critical because patients may not appear suicidal in the clinical setting. Measures such as the Columbia Suicide Severity Rating Scale[60] can assist practices in standardizing their approach to

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TABLE 1 Pharmacologic Treatment Considerations in Maltreated Children and Adolescents

Disorder	Initial Considerations	Ongoing Monitoring Strategy	Second-Line Considerations	Treatments Pitfalls To Avoid
General pediatric mental health concerns	Start with psychosocial treatment. Nonoffending parental involvement is essential, with involvement of other caregivers and school-based interventions as needed. In mild cases, attempt at least 12 wk of psychosocial interventions before medication.	Monitor response to treatment by using reliable and valid measures. If medications are being considered, first reassess the diagnosis and diagnostic formulation. Weigh the risks and benefits of initiating treatment with psychotropic medications.	When starting medication: • Initiate with monotherapy • When using medication, initiate at a low dose and slowly titrate (start low, go slow) • Continue psychosocial treatment during treatment with medication • Monitor for suicidality • Monitor for adverse effects of medications	• Polypharmacy • Antipsychotics should be restricted to schizophrenia, mania or bipolar disorder, psychotic depression, drug-induced psychosis, tic disorders, and severe aggression.
PTSD	The greatest level of evidence supports exposure-based therapies, of which, TF-CBT has the most data and is the most widely used. In children <6 y, may consider TF-CBT (4 mo) or CPP (6 mo) as first-line treatment.	Monitor for treatment response. When TF-CBT is not readily available or effective, consider: • Prolonged exposure therapy • Eye movement desensitization and reprocessing • Trauma and grief components therapy for adolescents • Child and family traumatic stress intervention (PTSD prevention therapy)	• For PTSD symptoms that impair sleep (eg, nightmares, nighttime hyperarousal), may consider psychotherapy augmentation with prazosin • For persistent intrusive or arousal or reactivity, may consider psychotherapy augmentation with clonidine or guanfacine	• Pharmacotherapy-absent trauma-focused psychotherapy • Polypharmacy • Antipsychotics • Benzodiazepines • Multiple antihypertensive medications
Depression	Psychoeducation and psychosocial interventions including but not limited to self-help materials, active listening or relationship building, school involvement, mood monitoring, opportunities for play and recreational activities, cognitive restructuring, family conflict reduction, sleep hygiene, and exercise.	• Psychotherapy for mild to moderate depression • For moderate to severe depression, fluoxetine or combination of CBT or IPT with fluoxetine • May consider escitalopram for patients 12 y and older	• If no clinical response to the medication in first trial, switch to other SSRI • Reassess diagnosis or medication adverse effects • Increase psychosocial intervention and medication dose if tolerated • Augment with alternate psychosocial intervention (either CBT or IPT)	• Polypharmacy • Antipsychotics • Benzodiazepines
Anxiety	Initiate treatment with exposure-based CBT. If CBT is not available, consider other evidence-based psychosocial interventions.	• If moderate to severe anxiety disorder or inadequate response to CBT, initiate treatment with fluoxetine or sertraline alone or with CBT • Treatment with CBT has been shown to be more effective than medication alone	• If first trial with fluoxetine or sertraline is not effective and/or there are treatment-limiting adverse effects, switch to the other SSRI not previously used and initiate or continue CBT	• Polypharmacy • Antipsychotics • Benzodiazepines
ADHD	When clinically feasible, observe for potential traumatic stress symptom overlap in children exposed to maltreatment. If unsafe, or if ADHD symptoms persist with EBTs for traumatic stress and home stabilization, proceed with ADHD treatment.	• Psychostimulant monotherapy (methylphenidate class or amphetamine class, either short- or long-acting) • If first choice is ineffective, try monotherapy with another stimulant or alpha-2 agonist	• Combination of extended-release alpha-2 agonist with psychostimulant or trial of atomoxetine	• Antipsychotics • Multiple concurrent antihypertensive medications

Adapted from 2018–2019 Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents (Available at: http://www.medicaidmentalhealth.org/_assets/file/Guidelines/2018-19%20FL%20Best%20Practice%20Medication-Child-Adolescent_Online1.pdf). CBT, cognitive-behavioral therapy; CPP, Child-Parent Psychotherapy; IPT, interpersonal psychotherapy; TF-CBT, trauma-focused cognitive-behavioral therapy.

identifying and then assessing suicidality. Although most suicide screening and assessment processes have been validated for adolescents, they can be adapted for older children. When there is indication of suicidal ideation or suicidal behavior, using a standardized clinical approach may be helpful. Evidence-based approaches, such as the Family Intervention for Suicide Prevention, use behavioral assessments and family-based considerations when determining risk and protective factors for suicide and have been shown to increase linkage with ongoing mental health care for suicidal adolescents.[61] Although

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TABLE 2 Potential for Diagnostic Overlap With Trauma- and Non–Trauma-Specific Symptoms

	Traumatic stress and depression	
PTSD symptom clusters may mimic symptoms commonly considered indications of depression	**Negative cognition and mood sypmtoms** of PTSD include depressive similar symptoms: negative belief toward self, self-blame, negative emotional state, loss of interest, detachment	**Hyperarousal and increased reactivity** in PTSD include depressive similar symptoms[a]: irritable and angry, reckless and self-destructive behavior, poor concentration, sleep disturbances
	Traumatic stress and anxiety	
Panic attacks may not indicate panic disorder if attacks are triggered by trauma reminders, better explained as intrusive and hyperarousal symptoms of PTSD	Separation challenges may be similar to **separation anxiety** but could be trauma specific depending on context of traumatic experience(s) and association with trauma reminders	**Generalized and social anxiety** are often independent of trauma-specific context and reminders; however, still important to consider symptoms in context of traumatic experiences
	Traumatic stress and ADHD	
Many overlapping symptoms make differentiating trauma and ADHD symptoms in the presence of traumatic stress nearly impossible, especially in younger children	**Collateral information** from multiple settings may help clarify if symptoms are specific/exacerbated by certain relationships/settings or are more universal	**Reevaluation after treatment for traumatic stress** and reduction of trauma symptoms for possible ADHD may be needed to make diagnosis

[a] Suicidal ideation is a well-recognized symptom of major depressive disorder. However, suicidal ideation and nonsuicidal self-injurious behavior can be observed in a number of conditions in addition to depression that disproportionally affect maltreated children, including, but not limited to, PTSD, anxiety, substance use disorder, and personality, mood, and psychotic disorders.

many maltreated adolescents with significant suicidality or self-harm ideation may benefit from evidence-based therapies, such as Trauma-Focused Cognitive Behavior Therapy,[62] stabilization and enhancing safety must occur before the child can receive trauma-specific therapies in the outpatient setting. When indicated, more intensive levels of care, such as inpatient hospitalization, day treatment, or intensive outpatient treatments (such as Dialectical Behavior Therapy), are necessary before the initiation of trauma-specific outpatient therapies.[63] Of note, crisis interventions like the Family Intervention for Suicide Prevention or more intensive interventions as described above are, as of now, intended for adolescents and nonoffending family and caregivers and should be an important consideration when working with maltreated adolescents.

Discontinuing Medication

In 2009, the American Academy of Child and Adolescent Psychiatry (AACAP) identified principles to follow, including developing a specific plan, when discontinuing psychiatric medications.[49] Over the last 2 decades, there has been interest among some child psychiatrists in refinement of processes for appropriate discontinuation of medications, reflecting the frequency of psychotropic prescriptions given to children and adolescents as well as the rate of psychotropic polypharmacy.[64] Especially in vulnerable populations, such as maltreated children and adolescents, it is a priority to identify the reasons for the use of psychotropic medications.[35] The AACAP and other organizations indicate that if evidence-based prescribing practices were used and systems of care were strengthened, the use of psychotropic treatment and medication burden among maltreated children and adolescents could be lessened.[65,66]

Discontinuing medications is the process of identifying and then tapering off medications that are no longer indicated or when the existing or potential risks outweigh the existing or potential benefits.[64] Safe medication discontinuation is an area in need of further research and clear policies and practice guidance because it pertains to children and adolescents. However, pediatricians are often confronted with challenging clinical issues for which clear guidelines or definitive evidence about how to respond is absent. For example, the use of a psychotropic medication may be necessitating the administration of another psychotropic to address effects of the first medication (ie, the addition of a sleep medication to treat insomnia that has developed after beginning a psychotropic medication).[29,49] Additionally, children, adolescents, and/or families may be advocating for a simplification of the pharmacotherapy and desiring guidance as to how best to proceed.

A practical and safe approach to medication discontinuation is not simply medication cessation but rather assessing for the minimal effective dose and number of medications. Because there can be multiple reasons for prescribing psychotropic medications to children with a history of maltreatment, a broad and thoughtful approach is crucial. When a complete clinical picture is not available, pediatricians may be hesitant to reduce even substantial medication regimens because of a concern about escalation in symptoms.[67] However, it is

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important to recognize that discontinuing medication is not necessarily a static, one-time event but should be considered part of an ongoing treatment plan.[64] Periodic reassessment of the diagnosis, formulation, and treatment plan is necessary as new information becomes available and in response to the currently provided treatment.[64]

Unfortunately, for many psychotropic medications, there is no standardized approach to determining when psychotropic medications are no longer required. However, Bellonci et al[64] have provided guidance and considerations on the process:

1. Ascertaining the complete medication history, which requires a comprehensive assessment in which a review of previous records is essential to assess what has been tried in the past and the basis for the current regimen.
2. Considering the risk and adverse effect profile of the current medication regimen.
3. Assessing each medication currently being prescribed in light of the comprehensive assessment.
4. Creating an order priority for each medication to be either decreased or discontinued.
5. Implementing the treatment plan.
6. Monitoring treatment plan effects and reassessing.

Additionally, when selecting medications to decrease or discontinue, factors to consider include (1) medications for which there is no clear or valid indication; (2) medications that are part of a prescribing cascade, which may occur when an adverse effect of a medication(s) is used as the basis for another diagnosis and a new medication added; (3) when actual harm or potential harm is greater than the benefits; (4) medications that appear to be duplicative, redundant, or ineffective or the symptoms have resolved; (5) medications that are preventive (prophylactic) in nature; and (6) medications that are imposing an unacceptable treatment burden for the patient and family.[64] The off-label use of medication may pose a concern to pediatric providers and their patients in clinical practice. However, the off-label use of medication is not synonymous with a lack of evidence to support its use. Levels of evidence, ranging from a lower level, such as a case series, to a higher level, such as a randomized controlled trial or a meta-analysis, provide the basis of support or indication for the off-label use of a medication. With regard to medication discontinuation, it is the level of evidence of support for the treatment, in addition to the other factors noted, that should drive the decision-making process, rather than simply basing it on whether a medication is FDA approved.[49]

As suggested by Bellonci et al,[64] this process of discontinuing psychotropic medication may be operationalized by (1) beginning with a medication that has the least evidence of efficacy or has the greatest evidence for adverse effects, (2) focusing on medications that are being prescribed at supratherapeutic doses with no reasonable justification, (3) focusing on medications that are being given in subtherapeutic doses with no evidence of effectiveness, and (4) addressing only 1 medication at a time so that there is clarity, should an adverse effect develop or symptoms return.

When to Refer to Child Psychiatry

Access to mental health assessments by psychiatrists can be difficult, often because many regions do not have enough child psychiatrists to meet the demand. Child psychiatry referrals should be made for children with diagnostic uncertainty and for those in whom multiple trials of medications have failed or who are taking 2 or more psychotropic medications (or 1 medication, if the medication is an antipsychotic).[49] Referral to child psychiatry should be considered when parents or guardians of maltreated children are advocating for treatment regimens beyond the pediatrician's regular scope of practice or the pediatrician believes that addressing the needs of child and family are beyond his or her capability.[49] Furthermore, it is important for pediatricians to routinely monitor for adverse effects from psychiatric medications. Monitoring is not limited to medications that pediatricians initiate because adverse effects of a medication initiated by a mental health provider may prompt a medical, rather than psychiatric, visit. Referral to child psychiatry should not take the place of referral to a trained therapist who can evaluate and initiate evidence-based therapies for traumatic stress.[45]

CONCLUSIONS

Children and adolescents who experience maltreatment are at great risk of revictimization and mental health sequelae, and it is incumbent on the pediatric primary care provider to work collaboratively with families and the child welfare system and to participate in the assessment, management, and appropriate referral for trauma-related conditions common among maltreated children and adolescents. Although no studies to date demonstrate that early intervention with EBT mitigates the long-term sequelae associated with child maltreatment, reducing symptoms and promoting return to healthy functioning at school and at home have important implications for quality of life and overall well-being. It is, therefore, essential that pediatric providers conduct comprehensive assessments whenever feasible to determine where EBT strategies apply and avoid the use of medications that have little or no likely benefit. There is a clear need for controlled trials of interventions

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including pharmacologic agents to help determine evidence-based approaches to reducing impairment in children and adolescents exposed to maltreatment. Although medications have a role, the evidence to date is limited, and nonpharmacologic approaches are preferred.

Clinical Considerations for the Pediatrician

1. Children who experience child maltreatment are best served by providers and systems that use trauma-informed approaches to care.
2. Interactions with child welfare can be complex and can result in treatment barriers and issues.
3. When assessing traumatic experiences and symptoms, ensure that there are approaches in place to respond to the information obtained so that children who have experienced maltreatment and their families can be supported. This support could be provided by the pediatrician and/or by referrals, depending on the setting and context.
4. Treatment that is primarily focused on psychosocial interventions rather than medications and tailored to the unique needs of the child is often of greatest value and least risk to children with a history of child maltreatment.

Key Action Statements

- Pediatricians should communicate to the children and families an openness to hearing about past and present events and convey the message that the information is important in formulating decisions about treatment in the present and future.
- The pediatrician should obtain a comprehensive social history to inform a child's treatment needs after exposure to abuse and/or neglect.
- The pediatrician must be alert to ongoing trauma and violence, including exposure to intimate partner violence among caregivers, and parental mental health problems, including substance use disorder.
- Pediatricians must emphasize safety as a paramount consideration and make it clear that if a child or family is unsafe at any time, an emergent report will be made to CPS.
- Pediatricians should not assure children or caregivers of absolute confidentiality.
- Before the initiation of psychosocial or medication interventions, a focused assessment of the child should be conducted by a clinician trained in the assessment of children exposed to maltreatment.
- Children who have experienced maltreatment with resultant emotional and behavioral difficulties should receive evidence-based psychotherapies and treatments with demonstrated effectiveness.
- Pediatric providers should provide resources to bridge the period until EBT can begin, including psychoeducation, relaxation training, encouraging parent-child communication, and parenting supports.
- Pediatricians should refer children with sleep disorders after trauma to mental health providers if there is an inadequate response to primary sleep interventions.
- First- and second-generation antipsychotics and benzodiazepines should not be used for the treatment of sleep problems in children and adolescents and are not generally indicated for the treatment of the most common disorders found among maltreated children, specifically, PTSD, anxiety, depression, and ADHD.
- When anxiety, depression, or ADHD is suspected, pediatric health care providers should consider that traumatic stress may better explain the symptoms of concern and use standardized measures to assess the possible psychiatric diagnoses or refer to a child psychiatrist.
- Pediatricians should ask maltreated children and adolescents questions regarding self-harm and suicidal ideation, even if patients may not appear suicidal, preferably using standardized tools such as the Columbia Suicide Severity Rating Scale.
- Pediatricians who are considering discontinuing medications should employ evidence-based protocols that incorporate principles of optimizing the medication regimen (ie, focusing on medications with significant risk, limited evidence, or no clear clinical or symptom improvement).
- Pediatricians should make referrals to child psychiatry (if available) for children when there is diagnostic uncertainty and for those in whom multiple trials of medications have failed or who are taking 2 or more psychotropic medications (or 1 medication, if the medication is an antipsychotic).

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ADHD: attention-deficit/hyperactivity disorder
CPS: child protective services
EBT: evidence-based treatment
FDA: US Food and Drug Administration
PTSD: posttraumatic stress disorder
SSRI: selective serotonin reuptake inhibitor

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

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DOI: https://doi.org/10.1542/peds.2019-3751

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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