TABLE 19.4. Medications Used in the Treatment of Posttraumatic Stress Disorder (*continued*)

Medication Category	*Examples Commonly Used in Pediatric Populations*	*Target Symptoms/Comments*
Benzodiazepines	Lorazepam, diazepam, clonazepam	Brief use for insomnia. Probably underutilized in children because of worries of abuse or dependence. Short-term use would minimize this risk. Watch for disinhibition. Considered second line by many.
Mood stabilizers	Valproate, carbamazepine, oxcarbazepine	Carbamazepine, shown to be effective in decreasing flashbacks, nightmares, intrusive memories, and sleep dysregulation in children and adults. Considered second line by some because of side-effect profile and the need for blood testing.
Antipsychotics	Risperidone, olanzapine, quetiapine, aripiprazole, ziprasidone, haloperidol	Should be reserved for youth with associated psychotic symptoms, or extreme aggression or self-injurious behaviors.

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20 Adjustment Disorders

Essential Concepts
Screening Questions
- Has there been something that happened recently that has caused you to feel particularly upset?
- What was it? When did it happen?
- What type of response have you had to that event?

Every new adjustment is a crisis in self-esteem

—Eric Hoffer

CLINICAL DESCRIPTION

Life is full of events that cause upset and stress. At times a particular stress may precipitate a significant decline in ability to cope. When this happens, a child, adolescent, or adult may experience extreme distress, depression, anxiety, or behavioral symptoms as a consequence. We diagnose an adjustment disorder when the symptoms are not specifically related to bereavement and do not meet criteria for another Axis I or II disorder, but have resulted in significant impairment in functioning within 3 months of the stressor. In children and adolescents, divorce or separation of parents, a move to a new school or home, or being teased at school may result in a distress reaction. When the reaction is excessive and interferes with daily life tasks, it becomes an adjustment disorder.

CLINICAL VIGNETTE

Brittany is a 13-year-old seventh-grade girl presenting with symptoms of anxiety, crying spells, and recent shoplifting, which was quite uncharacteristic, as she was described by her parents as an honor student who had been very well behaved. Her parents have been arguing a great deal, and last month announced to Brittany and her 7-year-old sister that

they are divorcing. Her father will be taking a new job and moving 2 hours away. Brittany speaks freely to you and relates that she "had a perfect life, and now it is totally ruined!" She is quite close to her father and feels abandoned by his move. Her parents, although well meaning, tried to shield the issues from the children by stating, "It will all work out." They subtly and not so subtly let the children know that this was not a topic for discussion. Brittany tells you that she has begun to hang out "with other kids from broken homes, since I am one now." The shoplifting and other behaviors are a manifestation of her distress (and possibly an attempt to reunite her family).

KEY POINT

An adjustment disorder is an appropriate diagnosis to make for a child or adolescent who is responding acutely to a stressor. If the stressor is significant, consider posttraumatic stress disorder (PTSD) as a diagnosis. If there is a more chronic disorder that does not resolve with the resolution of the stress, rethink the diagnosis.

Epidemiology

Adjustment disorders tend to be common. It is estimated that between 2 and 8% of youth in community samples suffer from this disorder. For clinical samples, the rate is higher.

Etiology and Risk Factors

The diagnosis of adjustment disorder assumes a stressor. However, as with PTSD, some children and adolescents respond more negatively to stress than others. There are important intrinsic factors that modulate the impact of a distressing event. Cognitive and emotional development and pre-stress self-esteem and level of psychosocial support all mediate the reaction the child has to the stress. Because children often link unrelated events as cause-and-effect phenomena, they may feel guilt and distress over uncontrollable events that they did not cause.

TIP

Children with chronic illnesses will often meet criteria for an adjustment disorder. New diagnoses of juvenile diabetes or epilepsy commonly lead to adjustment difficulties. The child and family need a great deal of support to prevent more significant and permanent psychiatric disability.

Assessment

The primary issue in assessment is determining if there is a pre-existing psychiatric disorder that has been exacerbated by stress, or if the stress reaction constitutes PTSD, a major depressive episode, or other psychiatric disorder.

Treatment

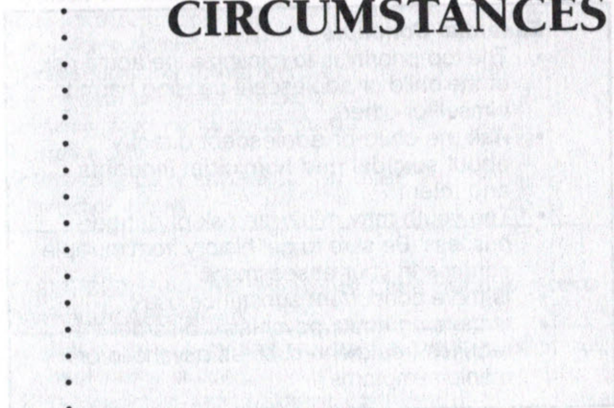
Treatment of children and adolescents with adjustment disorders is focused on two primary issues—resolving the acute stressor and shoring up coping mechanisms. Family intervention is typically the treatment of choice—helping the family cope with the stress, helping the family support the child, and decreasing the "sick role" labeling of the child.

Psychoeducation of children, adolescents, and families about reactions to stress is the first aspect of treatment. Supportive psychotherapy, family counseling, and brief, focused treatment of the presenting symptoms are indicated. Pharmacological treatment to target the child's reactive symptoms and alleviate immediate stress may be useful in specific situations. In general, there is very little research around the efficacy of medications for the treatment of adjustment disorder.

CLINICAL VIGNETTE

Sharelle is a 10-year-old girl who tends to be a perfectionist and does very well in school. There is a strong family history of anxiety disorders and obsessive-compulsive personality in her biological father and grandfather. Sharelle had no significant symptoms until approximately 1 month ago, when she was at a sleepover at a friend's home and became ill in the night (vomiting). She now presents a month later, fearful of going to school for fear of the humiliation of vomiting in public. In fact,

it has been a week since spring break (a week of school vacation) and she has only gone to school once. When she got to school, she went immediately to the nurse stating she was ill and needed to go home. She has started eating less and is losing weight. You diagnose an adjustment disorder and begin psychoeducation, supportive psychotherapy, relaxation treatment, and medication to target her phobic reaction to going to school. With some low-dose benzodiazepines and the psychosocial treatments, she is able to get back to school. Ongoing anxiety symptoms (continued preoccupation about vomiting) suggest that she may require a longer-term treatment with an SSRI and cognitive-behavioral therapy as well. In this case, the stressor (vomiting) may be the first symptom of the onset of a longer-term anxiety disorder.



SPECIAL CLINICAL CIRCUMSTANCES