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Adjustment Disorder in Adolescence: A Case Study from a Juvenile Custodial Setting

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Abstract: This clinical case study explores the psychological evaluation and therapeutic management of a 16-year-old male, Mr. A, diagnosed with adjustment disorder with Depressed Mood following his detainment in a juvenile center due to a false legal accusation. The case presents a detailed account of the client's psychosocial background, emotional struggles, and the adverse impact of abrupt environmental changes during adolescence. Emphasis is placed on the interplay between family dynamics, academic aspirations, and the client's emotional response to the stressor. A comprehensive, developmentally sensitive treatment plan was implemented, incorporating cognitive-behavioral therapy, emotional regulation strategies, family engagement, and supportive therapy. The intervention aimed to alleviate distress, foster resilience, and facilitate reintegration into normal life. This case highlights the importance of early psychological support for adolescents facing legal and emotional turmoil and underscores the value of structured interventions within custodial settings to prevent long-term psychological sequelae.

Keywords: *Adjustment Disorder, Adolescents, Juvenile Detention, Cognitive Behavioral Therapy, Family Therapy, Emotional Regulation, Psychosocial Stressors*

1. Introduction

Emotional or behavioral signs that appear within three months of the triggering event characterize adjustment disorder with depression, a psychological reaction to a major stressor or life transition. In contrast to other mental illnesses, adjustment disorders have a temporal limit and is strongly associated with a recognizable exterior stressor, such a marital breakdown, legal issues, or significant life changes. Such stressors can have extremely destabilizing effects on young people and teens, particularly those going through crucial stages of identity creation and social integration. These effects frequently show up as protracted sadness, withdrawal symptoms, hopelessness, and poor performance in social, school, or familial situations. The stressor in the instance of Mr. A, a 17-year-old teenager kid from Saharanpur, was a grave legal charge brought by the girl's family, with whom he had dated for two years. Despite being denied, the charges have resulted in his incarceration in a juvenile facility, which is a far cry from his former existence as a dedicated student with close family ties. Mr. A has suffered from severe mental distress ever since his imprisonment, which includes frequent episodes of sobbing, trouble acclimating to the unfamiliar surroundings, and difficulties interacting socially with classmates. His hopes of succeeding academically and as a doctor had to be dashed, which has made him feel even more alone and powerless.

Teenagers like Mr. A are particularly susceptible to emotional turmoil when they experience public humiliation, abrupt loss of independence, or interpersonal betrayal. Young individuals are developing their sense of self, independence, and moral principles throughout this developmental stage. In addition to endangering Mr. A's future goals, the abrupt allegation and his family's split have damaged his faith in other people and left him emotionally confused. This phenomenon, which manifests as depressed symptoms, withdrawal, and trouble coping with the perceived unfairness or loss of control, is more common in teenagers who experience significant impact social or legal pressures. According to research, adolescents with adjustment problems are frequently disregarded or mistaken for normal adolescent moodiness, especially in settings where mental health facilities are few or stigmatized. Untreated adjustment problems, however, have the potential to develop into more serious illnesses like anxiety disorders or major depressive disorder. The symptoms may raise the risk of using drugs or self-harm, interfere with peer interactions, and affect academic achievement. These vulnerabilities are frequently exacerbated in institutional

settings, such as juvenile homes, because of a lack of personal autonomy, trust, and emotional safety.

Being wrongly accused can have a severely painful psychological effect, particularly in a romantic setting during adolescence. The emotional reaction that results from institutionalization might be too much for the teenager to handle on their own. For young people like Mr. A, early psychological intervention, sympathetic support, and trauma-informed therapy approaches are therefore essential to navigating their anguish, regaining their sense of self-worth, and reestablishing faith in their future.

A framework for comprehending Mr. A's psychological discomfort is provided by his diagnosis of adaptation disorder with Depressed Mood, which is appropriate in this instance. It also emphasizes how important it is to treat the developmental sensitivity and psychosocial environment specific to teenage mental health.

2. Case Study

Sociodemographic Details

Name	Age	Gender	Marital Status	Occupation	Family Type	Education	Socio-Economic Status	Address
Mr. A	16 years	Male	Unmarried	Student	Joint	9th grade	Middle class	Saharanpur

Chief Complaints

1) Complained of mental anguish, sobbing fits, and ongoing stress (duration: a month and 20 days).
2) Reports of social disengagement and trouble acclimating to the juvenile facility.
3) A history of being wrongfully accused of wrongdoing by the girlfriend's relatives.

Onset, Course, And Precipitating Factors

1) Acute Mode of Onset
2) Course: Ongoing
3) Precipitating factors include detention in a juvenile home and false accusations under IPC Section 376.

History Of Present Illness

Due to mental anguish after a legal accusation, Mr. A, the 16-year-old male learner of Saharanpur, U.P., was taken to the clinic by his appointed guardian for a psychiatric examination. Mr. A claims to have had a two-year consensual relationship with a classmate. He was placed in a juvenile home after being accused of inappropriate behavior after an event that was documented by the girl's family. Mr. A has shown symptoms of poor mood, frequent sobbing fits every two to three days, impatience, despair, trouble adapting to his surroundings, and social disengagement since his arrest.

Mr. A comes from a close-knit unit that places a strong emphasis on family ties and traditional values. His mother stays at home while his father works as a teacher. His grandparents and paternal uncle reside in the same home and have close emotional bonds. Since his grandpa had a significant impact on his moral growth and upbringing, Mr. A hold him in high regard. He was very close to his mom, whom he views as his emotional support system. Although the court processes startled the family, they still provide him with emotional support, visit him frequently, and believe he is innocent. One of the main protective factors in his mental health is the warmth, direction, and emotional support he receives from his family. Mr. A is quite worried about how the issue would affect his family's well-being and social standing, and he has often voiced helplessness and remorse about upsetting them.

Despite his circumstances, he is driven to finish his degree and maintains optimism about when he will be released.

Past History

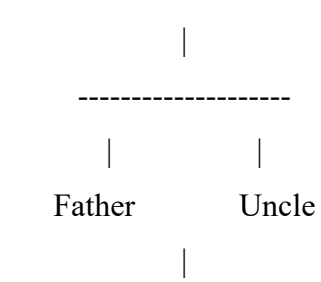
1) No prior hospitalizations or medical or mental health history has been disclosed.

Family History

1) There is no known family history of mental illness.

2) Family structure: a joint family with parents who are helpful.

Genogram



Mother

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Mr. A (Client)

Personal History

1) Perinatal/Natal History: Not available.
2) Early Childhood: Described as extroverted and outgoing.
3) Middle Childhood: Academically focused with aspirations to become a doctor.
4) Late Childhood/Adolescence: Consistently high academic performance; scored 75% in 10th grade.

Educational History

1) Currently enrolled in school; earned a 75% grade in the tenth grade.
2) Showed promise academically; aimed for a 12th grade score above 90%.

Occupational History

1) Student. No previous employment.

Sexual And Marital History

1) Unmarried. No prior sexual activity reported.

Premorbid Personality

1) Interests: Studying and working for a medical degree.
2) Attitude: Prior to the incident, it was mostly positive.
3) Personality: Family-oriented and diligent.
4) Workplace Attitude: Motivated and serious.
5) Interpersonal Relationships: experienced a long-term love relationship and was emotionally connected to family.
6) Initiative and Energy: Strong; self-motivated.
7) Fantasy Life: Not documented.
8) No history of substance abuse or usage.
9) History of Suicide: Shows signs of emotional dysregulation but has never attempted suicide.

Mental Status Examination (MSE)

1) Appearance: Young male appropriately dressed.
2) Behavior: Cooperative, though initially guarded.

3) Eye Contact: Maintained.
4) Speech: Relevant and coherent, normal tone and rate.
5) Mood: Subjectively sad.
6) Affect: Restricted.
7) Thought Process: Goal-directed.
8) Thought Content: Denies hallucinations/delusions. Mild hopelessness noted.
9) Perception: No perceptual disturbances.
10) Cognition: Alert and oriented.
11) Insight: Partial.
12) Judgment: Intact.

Diagnostic Formulation

Behavioral and emotional indicators that point to an adjustment disorder with Depressed Mood (F43.21, DSM-5) are displayed by the client. A major psychosocial stressor (false court accusations and family separation) set off these symptoms, which resulted in noticeable functional deficits.

Differential Diagnosis

1) Major Depressive Disorder (ruled out because of the time duration and contextual stressor)
2) PTSD (hyperarousal, lack of reliving)

Psychological Assessment

1) Beck Depression Inventory (BDI)
2) Strengths and Difficulties Questionnaire (SDQ)
3) Clinical Interview

Diagnosis: Adjustment Disorder with Depressed Mood

Treatment Plan

In order to address Mr. A's teenage developmental stage, custodial setting, and psychosocial backdrop, a comprehensive and integrated treatment plan was created. Cognitive behavioral therapy (CBT) will be the main modality used to treat Mr. A's maladaptive thinking patterns and encourage adaptive coping strategies. Cognitive reframing, thought restructuring exercises, and recognizing negative automatic thoughts linked to pessimism and guilt will all be part of the sessions. In order to build a solid therapeutic partnership, improve resilience, and validate feelings, supportive treatment will be used. Throughout the sessions, techniques for

regulating emotions such as progressive muscle relaxation, deep breathing, guided journaling, and mindfulness exercises will be used. His parents will be involved in family therapy to improve support networks, define responsibilities, and lessen family strife. Psychoeducation will be crucial, with an emphasis on normalizing Mr. A's emotional reactions, gaining understanding of adjustment issues, and raising knowledge of healthy coping mechanisms. Techniques from problem-solving therapy will also prepare him to deal with social challenges in the juvenile facility. To promote interaction in a non-threatening way, creative treatments will also be used, such as narrative activities or emotional expression via painting. Recovery will be further supported by environmental interventions, such as working with center officials to offer a scheduled regimen and safe emotional outlets. Treatment effectiveness will be ensured and adjustments will be guided by ongoing monitoring via sessional feedback and recurring use of tests such as the BDI and SDQ. The ultimate goals of the strategy are to improve family ties, stabilize mood, restore functioning, and get Mr. A ready for a smooth transition back into society and education.

Therapeutic Sessions Outline

Session 1: First Assessment and Relationship Building

Establishing trust is the aim. Acknowledge and validate emotional discomfort. Bring up treatment.

Method: Ask open-ended questions and pay attention. Explain the framework of treatment and confidentiality.

Session 2: Psychoeducation

The purpose of psychoeducation is to normalize symptoms and teach Mr. A about mental responses to stress.

Procedure: Explain the stress reaction system and the consequences of trauma using worksheets and visual aids.

Session 3: Expression and Control of Emotions

Goal: Introduce skills for emotion management and assist the client in recognizing and expressing their feelings.

Procedure: Grounding activities, prolonged breathing exercises, and an emotion wheel exercise.

Session 4: Restructuring Cognitively

Objective: Recognize and combat unhelpful beliefs about one's value and future.

Method: Assigning thought logs and reorganizing cognition using the ABC paradigm (Activating event, Beliefs, Consequences).

Session 5: Skills for Coping and Solving Problems

Teaching problem-solving techniques and improving adaptive coping mechanisms are the objectives.

Methods: Creation of a coping toolkit, role-playing, and ideation of flexible solutions.

Session 6: Participation of the Family

Goals: Discuss support networks, highlight strengths, and include family members in treatment.

Procedure: Hold a family session, encourage candid discussion, and examine dynamics using a genogram.

Session 7 – Creating Hope and Making Plans for the Future

Reconnecting the client with academic objectives while fostering optimism and structure is the aim.

Procedure: worksheet for creating goals and a graphic timeline for learning and development.

Session 8: Closure and Prevention of Relapses

Objective: Evaluate acquired abilities and create a strategy to handle upcoming pressures.

Procedure: Draft a strategy to prevent relapses, write a reflection letter, and arrange for follow-up assistance.

3. Review of Literature

Kazlauskas and Zelviene (2018) thorough analysis examined how adjustment disorder (AD) is conceptualized and treated, emphasizing the disorder's clinical significance and common underdiagnosis. According to Zelviene and Kazlauskas, AD frequently develops in reaction to abrupt changes in a person's life, such as relationship problems, legal troubles, or environmental displacement—factors that are especially pertinent in Mr. A's situation. The analysis highlights how early treatments are crucial since teenagers are particularly vulnerable owing to their developing coping systems and increased emotional reactivity. To lessen the intensity and

frequency of symptoms, the authors suggest psychotherapy techniques such cognitive behavioral therapy, emotion management techniques, and family involvement.

Härter and Baumeister (2007) In spite of its high incidence in clinical settings, particularly among adolescents dealing with interpersonal, academic, or legal stress—adjustment disorder is noticeably unrepresented in large-scale surveys, according to this meta-analysis that assesses the prevalence of mental illnesses across a variety of demographics. The evaluation backs up the clinical significance of AD and how it affects functioning, reflecting Mr. A's declining emotional stability and academic drive. The authors propose improved screening in educational institutions and youth detention facilities, as well as a larger integration of AD in epidemic frameworks.

Doherty and Casey (2012) The definition and diagnosis of adjustment disorder are examined critically in this article, with special attention to the ICD and DSM systems. According to the authors, AD is particularly pertinent for teenagers who undergo abrupt psychosocial upheavals, such as Mr. A., because it is often brought on by a clearly recognized stressor and manifests as a combination of depressed and anxious symptoms. The study emphasizes the significance of context-sensitive therapeutic techniques, such as story therapy or building resilience in juveniles, and argues for more sophisticated diagnostic criteria to differentiate AD from major depression and PTSD.

4. Discussion

The story of Mr. A illustrates the complex connection between psychosocial pressures and teenage emotional well-being. As seen in Mr. A, adjustment disorder with depression frequently results from recognizable stresses such relationship problems, legal issues, or significant environmental changes. In Mr. A's case, a false legal accusation coupled with the sudden change from a controlled family setting to the juvenile court system caused severe mental turmoil. Due to their stage of growth, adolescents are especially vulnerable to these outside forces since their identity formation and coping mechanisms are still developing.

The signs of adjustment disorder, such as social disengagement, despair, and periods of sobbing, are present in Mr. A. An important protective factor in reducing the likelihood of long-term psychopathology is the existence of a nurturing family structure. Resilience is also demonstrated by his future goals and retained cognitive abilities. In order to address emotional regulation, dysfunctional cognitions, and overall assistance through family participation, the

therapy method incorporates cognitive-behavioral and supportive strategies specifically designed for adolescents in custodial settings. Moreover, goal-setting and future planning sessions are essential to helping him regain his feeling of agency.

The case emphasizes the necessity of developmentally appropriate and sensitive assistance for young people involved in judicial procedures. Long-term psychological effects can be avoided by addressing the stigma, encouraging emotional expression, and strengthening support networks through treatment. To guarantee therapeutic continuity and effectiveness, treatments must be specifically tailored to the adolescent's environment, particularly if it is restricted or custodial.

5. Conclusion

In summary, Mr. A's case illustrates how acute psychosocial stresses can affect teenage mental health and how adjustment disorder manifests in a forensic context as depressed mood. The most effective way to treat his contextual emotional symptoms—which arise in reaction to a recognizable stressor—is through organized, evidence-based psychotherapy that incorporates personal and family-based therapies.

Mr. A can restore his mental health and academic drive by establishing a solid therapy connection and stressing the value of cognitive restructuring, emotional validation, and future-focused planning. The prognosis is greatly strengthened when the family unit is involved. Teenagers like Mr. A may overcome severe psychological anguish and progress toward healing, durability, and integration into society with prompt and comprehensive psychological therapy, as this example illustrates.

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