Diagnosis and Treatment of Adjustment Disorders in People With Intellectual Disability

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The adjustment disorders are a group of conditions in which a person suffers mild emotional and behavioral symptoms as the result of a stressor. Although common, there is little research on these conditions compared to other disorders, such as schizophrenia or major depression. For people with intellectual disability, there is very little research. We review what is known, and present two cases of adjustment disorder in people with intellectual disability.

**Keywords:** adjustment disorders, anxiety, conduct disorder, depression, developmental disability, intellectual disability, mental retardation, psychiatric diagnosis, psychiatric disorder

The adjustment disorders are a group of conditions characterized by the development of mild emotional or behavioral symptoms in response to an identifiable or presumed psychosocial stressor or stressors (see Table 1). The stressor can be related to any life situation. The symptoms, however, must be significant enough to cause a functional impairment in personal relationships, work, or school.1

Because people experience mild symptoms as the result of a stressor, they are unlikely to seek psychiatric help. Intellectually typical individuals may understand the relationship between their symptoms and the stressor. For example, if a woman loses her employment, severely stressing the family economically, she may be irritable, anxious, and sleepless. This is seen as a “normal” reaction to her situation. Because her symptoms are not severe, and she understands that they are a reaction to a situational stressor, she is unlikely to seek help.

The diagnostic criteria today require that the stressor be judged within the context of a person’s culture and living situation. The meaning and experience of the stressor to the person must be taken into account in judging the intensity of the stressor and the intensity of the symptomatic response.

The key concept of the adjustment disorder is that removal of the stressor would relieve or remove the psychiatric symptoms. Andreasen and Wasek2 stated that “the disorder was defined as both transient and acute, the precipitating stress was defined as overwhelming, and the diagnosis could only be made in individuals without any apparent underlying mental disorder.” Today, an adjustment disorder is still thought to be a definable entity, because these patients differ significantly from people with no diagnosis, and from those with mood and anxiety disorders, in several ways including differences in the nature of causal stressors, in vulnerability related to social isolation, and in overall life functioning.3

Intellectually typical patients with adjustment disorders may suffer from mild depressive symptoms such as sadness, crying, sleep and appetite disturbance. Patients who are mainly anxious present with worry and inability to concentrate on tasks. A small percentage of patients have a behavioral or interactional change termed a “disturbance of conduct.” For example, truancy from school, vandalism, and fighting can be reported. Less typical reactions include physical complaints and social withdrawal.

Research on the adjustment disorders shows that generally patients improve within a reasonable time, with quick resolution of symptoms.19 There is thought to be 79% remission after five years in affected adults1 and development of a chronic course in less than 17%,5,10 evidence that the disorder is a reaction to events and that it resolves with time or changing environmental supports. Thus, one might view the disorder as within the human spectrum of a “normal” response to an “abnormal” situation: increase in anxiety, depression, and overall functioning are a typical reaction to severe stressors.

The major psychiatric disorders, such as bipolar disorder, schizophrenia, and the more frequent major depression and anxiety disorders are often treated and studied. Because ordinary

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Table 1: Summary of Key Relevant Diagnostic Symptoms From DSM-IV-TR With Intellectual Disability Equivalents

<table>
<thead>
<tr>
<th>DSM Criteria</th>
<th>Intellectual Disability Equivalents</th>
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<tr>
<td>Depressed mood</td>
<td>Sad appearance</td>
</tr>
<tr>
<td></td>
<td>Not interested in others</td>
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<tr>
<td></td>
<td>Insomnia, loss of appetite, mild</td>
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<td></td>
<td>Statements consistent with depression, e.g. “I am bad.”</td>
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<tr>
<td></td>
<td>Clinging</td>
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<tr>
<td></td>
<td>Withdrawal</td>
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<tr>
<td>Anxiety</td>
<td>Nervous, fidgeting</td>
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<td></td>
<td>Frightened appearance</td>
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<td></td>
<td>Statements of worries</td>
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<tr>
<td></td>
<td>Clinging</td>
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<tr>
<td></td>
<td>Self-talk</td>
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<tr>
<td>Conduct</td>
<td>Mild aggressive demeanor or behavior</td>
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<tr>
<td></td>
<td>Destructiveness</td>
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<tr>
<td>Unspecified</td>
<td>Withdraws from family, friends</td>
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<tr>
<td></td>
<td>Increase in self-injury</td>
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<tr>
<td></td>
<td>Increase in compulsions</td>
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Adjustment Disorders; DSM-IV-TR criteria

- Symptoms must develop within 3 months of the onset of the stressor (Criterion A).
- Subtypes are defined by the predominating symptoms. Adjustment Disorder may be Acute (duration of symptoms less than 6 months) or Chronic ("longer than 6 months in response to a chronic stressor, or to a stressor that has enduring consequences").

**Subtypes**

- Adjustment Disorder With Depressed Mood
- Adjustment Disorder With Anxiety
- Adjustment Disorder With Mixed Anxiety and Depressed Mood
- Adjustment Disorder With Disturbance of Conduct
- Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
- Unspecified

People experiencing adjustment reactions consider them normal reactions, and are, therefore, unlikely to seek psychiatric help, these diagnoses are infrequently made by mental health clinicians and are not the subject of great study in psychiatry. For example, Casey et al. found "fewer than 30 publications in peer-reviewed journals exclusively devoted to" adjustment disorder from 1975 to 2000.

It is not possible to obtain a realistic incidence and prevalence of adjustment disorders in the general population because so few people recognize the condition and seek help. Studies of outpatient mental health populations have estimated prevalences of 5 to 20%, and between 2 and 8% in children and adolescents; in 12% of general hospital patients referred for psychiatric consultation, 10 to 30% of those referred from outpatient health settings, and up to 50% in populations that have experienced particular stressors (e.g., cardiac surgery). The data for these studies were based on patients who sought treatment or who were brought for treatment, and may not at all reflect a true prevalence of adjustment disorders in the general population, or in the population of those with intellectual disability (ID). Further, people who live in lower socioeconomic groups, or groups suffering racial
and ethnic prejudice, are thought to experience a high rate of stressors and therefore, are thought to be at greater risk for adjustment disorders. However, people from all backgrounds suffer from these conditions.\textsuperscript{1,2} It is known that patients who have an adjustment disorder have a higher likelihood of suicide than the general population.\textsuperscript{1,2}

Patients who experience an adjustment disorder with depressed mood have a generally favorable outcome overall, compared to the prognosis for a major depressive episode.\textsuperscript{2,12,20} However, the outcome of adjustment disorders in persons with ID may not be as favorable as for intellectually typical patients with the same disorders. Intellectually normal individuals will for the most part come for care when they are in distress; persons with ID will be brought for evaluation when their behavior distresses others. Thus, people with ID brought for treatment may be more likely to display subtypes of adjustment disorder involving disturbance of conduct. This may in turn be only after longer exposure to the causal stressor and longer suffering, and perhaps more severe effects than those seen in most intellectually typical individuals.

Major psychiatric disorders must not only be sought for in the diagnostic process, but must also be ruled out when the phenomena displayed do not meet DSM-IV diagnostic criteria.\textsuperscript{16} Casey et al.\textsuperscript{6} warn against “mechanistic application” of diagnostic criteria, e.g., diagnosis of a major depressive episode “if five or more depressive symptoms have been present for longer than two weeks, irrespective of the close temporal relationship between an identifiable stressor and symptoms.” They note this and reliance on formal diagnostic instruments in epidemiologic studies (eliminating, as they inevitably do, clinical judgment of the significance of possible causal stressors) for the possible underdiagnosis of adjustment disorder and overdiagnosis of mood and anxiety disorders.

The definition of stressors in DSM-IV includes single events or multiple stressors, such as business and martial problems at the same time. Stressors can consist of a single event or continuous long-term exposure. Some may be linked to developmental milestones such as getting married. Lastly, DSM-IV requires that adjustment disorders resolve within six months of the termination of the stressor (or its consequences). It does allow for diagnosis of adjustment disorder, however, if there is in fact a chronic stressor, such as a chronic disabling general medical condition, or a stressor that has enduring consequences.

**USE OF DSM-IV CRITERIA FOR ADJUSTMENT DISORDER FOR PATIENTS WITH INTELLECTUAL DISABILITY**

Existing diagnostic criteria must be modified for use in people with intellectual disability, especially for use with persons functioning in the severe and profound range of ID. Clinicians must be familiar with this population in order to use this diagnostic category accurately and avoid mistaking an adjustment disorder for more serious psychiatric disorders. However, clinicians may also minimize the symptoms of major mental illness in patients with ID by mistakenly thinking behavioral symptoms are merely an adjustment disorder. Thus, the “subculture” in which many patients with ID live is a key concept in understanding adjustment disorders in this patient group.

For people with ID, developing an adjustment disorder as the result of a stressor comprises an entirely novel situation. First, the majority of individuals with ID are unable to connect their emotional and behavioral reactions to the stressor itself. Second, due to limited insight and coping skills, their mild reactions may be unusual and will cause undue distress to caregivers. Thus, people with ID are more likely to be brought to psychiatry for help when suffering an adjustment disorder but, because of unusual reactions and little insight or ability to describe the stressor, they are more likely to be diagnosed with other disorders such as major depression, bipolar disorder, even psychotic disorders. For example, if a man with severe ID and autistic disorder has a major change in staff at his work program, his former low rate of self-injurious behavior may increase in frequency and intensity. His reaction is unusual, and without specific training in or experience of patients with ID, his psychiatric provider for an initial evaluation is apt to diagnose his condition as a major mental illness, for example worsening of obsessive compulsive symptoms of the autism. Further, it is also likely that the family or staff bringing him to the appointment would not understand that losing staff at a work program is a severe psychosocial stressor for a person with ID.
Assessing Emotional and Behavioral Reactions in Patients With Intellectual Disability

DSM-IV secondly requires that “the clinical significance of the reaction is indicated either by marked distress that is in excess of what would be expected given the nature of the stressor, or by significant impairment in social or occupational (academic) functioning.” The clinician must be aware of signs of distress in persons with ID, and of the patient’s actual premorbid level of comfortable, anxiety-free function. Anxiety and depression may manifest in persons with ID as they would in intellectually normal individuals, but may also present differently, with, for example, clinging, loss of skills, withdrawal, or, in persons with autism spectrum disorders, as increases in obsessive-compulsive behaviors or rituals. Disturbance of conduct and unusual reactions in patients with ID may include the emergence of new maladaptive behaviors or an increase in frequency or intensity of preexisting maladaptive behaviors such as aggression, skin-picking, or self-injury. The increase in intensity of severity of a previous maladaptive behavior, such as self-injury, may be dismissed by family, staff, and clinicians, who may see it as behavioral when in fact the person is having an adjustment reaction to a severe stressor.

DSM-IV also requires the absence of signs of more serious disorders such as mood disorders (sleep and appetite changes), anxiety disorders (signs of autonomic arousal), or psychotic disorders (hallucinations and delusions).

Assessing the Stressor in Patients With Intellectual Disability

To diagnose an adjustment disorder, the stressor must be identifiable. Adjustment disorder is an extremely valuable diagnostic concept for it correctly identifies environmental sources of mental distress, which are in all our lives, but are rampant in the lives of people with ID who have so little power to make choices and effect change in their home and work settings. These environmental stressors are potentially correctable, or are able to be amended in ways that make them less stressful, if family and support staff understand the connection between a “stressor” and resulting emotional and behavioral reactions.

Intellectually typical adults can articulate the stressors fairly clearly and see them as the defining event. Often, during administrative intake for a first psychiatric appointment, a patient states, “My husband said he is leaving me,” “I was fired from my job last month,” or “I have been in severe pain since the operation.” Thus, it is fairly simple for the clinician to then explore the severity and range of symptomatology, and formulate a diagnosis. Further, intellectually typical patients can easily identify the required time line of three months, whereas this may not be possible for patients with ID. People with ID rarely ask for an appointment and are typically brought by family or direct support professionals. Further, even if able to verbalize adequately, they rarely make a connection between stressors and change in emotion or behavior. Unfortunately, caregivers are often equally unable to see that connection.

When considering this diagnosis for patients with ID, the clinician must apply the concept of cultural context. People with ID frequently live within a specific subculture. Most are very dependent on others, compared to the lives of intellectually typical individuals, and they may have day and/or residential programs that have their own unique cultures. For example, the high turnover of staff in these settings creates a culture of great instability. Imagine for a moment, the life of a clinical psychologist with a different department director every year, with changes in support staff and administrators every few months. The “culture” of the organization would be in chaos, a lack of trust would develop, peers would always be on guard and unable to cope with changes in policy as well as interpersonal relationships and changing alliances. Many peers would leave for more stable jobs, creating constant “loss” of personal relationships and support at the job. This is what life is like for many persons with ID due to the economic organization of most support systems.

To identify the particular stressor in the patient’s life the clinician must have a reliable source for history. The clinician must be aware of the expected sources of stress in the lives of persons with ID. This requires looking at the world through the patient’s eyes. A stressor might be mild for someone of normal intelligence, but will be major for someone who is dependant on others throughout life. Levitas and Gilson proposed that, in principle, a stressor can be anything in the life of a person with ID beyond the person’s power to resolve alone. The clinician might therefore need to be aware of the smallest...
details in the life of a patient who may or may not be able to provide such a history, necessitating a search for caregiver or documentary history.

Some might consider that ID itself is a chronic stressor under this definition. This implies, however, that ID can never be integrated into a successful life, that it is a constant and unending source of pain and disability in the same way as is, for example, juvenile rheumatoid arthritis. Such an argument strains the definition of adjustment disorder without adding anything useful to the mental health care of persons with ID. Nevertheless, ID and its consequences render these individuals more prone to certain types of stressors, most prominently those calling for novel responses or responses calling for more than comfortable levels of autonomy. All individuals with ID have deficiencies in problem solving and share executive function deficits (the ability to analyze a situation, compare strategies, shift set, and execute a solution). For example, if during work a supervisor criticizes an intellectually typical worker, he or she might think, “Oh, I will try to do this a better way,” or “He always criticizes everyone,” or, “He is the worst boss I have ever had, better keep my mouth shut,” etc. If one is concrete, such criticism is taken literally; thus the worker with ID thinks, “I am so terrible, I am doing a bad job.” This deficit in intellectual coping skills can be the route to significant depression, anxiety, and dysfunctional behavior indicative of an adjustment disorder.

For persons with ID, because each new life event may demand more novel or autonomous responses than the individual is comfortable with, the stressor does not accompany, but rather consists of, the developmental event. For example, graduation from school to work may be stressful in and of itself, not because the work setting is particularly stressful.

Bereavement as a stressor is treated differently, as transient depressive symptoms due to the death of a loved one are considered normal. For people with ID, the death of a family member or other caregiver may be not only a symbolic loss, but the loss of a person active in the care of and advocacy for the patient. Further, the loss of favored staff, house mates and friends are losses that can cause significant grief for people with ID. Conventional responses to loss may be undetectable in a person with an autism spectrum disorder, except as, for example, catastrophic reactions to cessation of routine or scheduled parental visits. Tears may not be evident in persons with Down syndrome with blocked or maldeveloped tear ducts.

A stressor might go unnoticed by caregivers, especially by those who have known the patient for only a limited time, and go unreported by a person with ID who does not want to “rock the boat” or disappoint caregiver expectations. Stressors that reflect poorly on caregiving programs or individual caregivers may not be reported—may, indeed be actively hidden—by caregivers.

Many stressors in the lives of persons with ID are beyond the power of the person to change. For example, a stressful job or a threatening roommate might only be escaped after prolonged negotiation with caregivers and a caregiving bureaucracy, a process stressful in itself for a person inexperienced with self-advocacy or thwarted by an inadequate caregiving system. It is a process that might be experienced as more stressful than the precipitating stressor. All of this adds a layer of complication to the detection, diagnosis and treatment of adjustment disorders.

In summary, stressors in the lives of persons with ID can include any need for an increase in autonomous functioning beyond the individual’s level of comfort. The limited behavioral repertoire should not lead one to assume that exacerbations of symptoms of severe ID or autism spectrum disorders do not merit diagnosis of an adjustment disorder when there is clear relation to a stressor.

It is recommended that the clinician engage in extensive leading questions such as:

- Were there any significant changes in staff recently?
- Is there great conflict among staff in any settings?
- Is family life stable, or are there stressors for the family?
- Have there been any medical illnesses or changes lately?
- Is there change in the work setting duties?
- Is someone new living with the patient?
- Has there been a change in friendship?
- Have any family members died or otherwise left the patient’s life recently?

Unfortunately, both authors have had multiple experiences during staff interviews where it is attested that there are no stressors. Upon such questioning, however, staff have said for example,
"Oh, his father died three months ago, but he did not seem upset. I don’t think it bothered him.”
(Second author)

**RESEARCH IN THE POPULATION WITH INTELLECTUAL DISABILITY**

Despite the difficulties in diagnosis, there is some (limited) data on adjustment disorders in persons with ID. A survey of psychiatric disorders in a sample of patients with del22q- syndrome (Velocardiofacial syndrome, VCFS) found several cases of adjustment disorder. The patient database of the Division of Prevention and Treatment of Developmental Disorders, Department of Psychiatry, UMDNJ/SOM, identified 64 patients with a diagnosis of an adjustment disorder in its first 2,144 patients (3%). A study of outpatients comparing those with normal intelligence to those with mild ID and moderate to profound ID yielded the corresponding percentages: 2%, 1%, 2%. Thus, the reported prevalence in patients brought to outpatient care is similar to that seen in intellectually typical populations. Demb and Chang reported on the use of psychostimulants in children with ID and disruptive behavior disorders. In their sample, 3 of 115 children had a comorbid adjustment disorder. Raitasuo and colleagues concluded that adjustment disorder was probably underdiagnosed in the intellectually disabled population, and research might focus on the effects of stressors.

**TREATMENT OF ADJUSTMENT DISORDERS**

The concept of adjustment disorder is a very useful one for persons with ID as it offers the opportunity to remove or ameliorate stressful elements of their lives. Knowledge of the events in the lives of persons with ID that can precipitate a crisis and a mental health consultation can result in accurate diagnosis and more rapid therapeutic resolution. One challenge of treatment is to determine the best way to relieve the stressor.

It must be recognized that challenging the family or the caregiving system can be as stressful for the person with ID as the original stressor. At the same time, either through encouragement, support, or psychotherapy, to challenge the family or caregiving system, or to grieve a loss, may be the best preventive for a recurrence of adjustment disorder in response to a later stressor. The needs and capacities of both the patient and the family and/or other caregivers for change, and for tolerance of grief in the patient, must be carefully weighed before undertaking the task.

For persons with severe and profound ID and the majority of persons with autism spectrum disorders, the task of relieving the stressor may be beyond the abilities of the patient, and the clinician and allied caregivers may have to become advocates for change. Since patients often cannot really improve until the stressor has somehow been reduced in its effects or eliminated, the treating clinician is put in the position of having to intervene with a family, school, or caregiving system, a task for which an increasing number of clinicians are poorly trained, and for which there is scant time and fewer resources. It is necessary to enlist the caring aspects of the systems themselves—family members, case managers, advocates—and to help the patient as much as possible to relieve the stressor.

When the stressor is an irreplaceable loss of a parent, sibling, friend, important caregiver, or life situation, the task becomes one of helping the individual to turn an adjustment disorder into normal grief.

Medication is at best an adjunct to the therapeutic process, even for persons with moderate to profound ID. Anxiety and depressive symptoms can and should be relieved to the extent necessary to facilitate psychotherapy, for which specific serotonergic reuptake inhibitors (SSRIs) in small doses are well suited. Disturbances of conduct involving explosive aggression may respond to mood stabilizers. Since the symptoms of adjustment disorder may be exacerbation of existing problems, this may mean increases in doses of an existing medication regimen. Consideration can be given to returning to the pre-existing doses when the stressor is relieved.

When a stressor can be but is not relieved, either because of an intransigent caregiving system or a helpless family, the clinician is presented with the agonizing ethical problem of continuing a medication regimen to decrease the suffering caused by an intractable stressor. The clinician must then be always watchful for opportunities to relieve the stressor (and presumably decrease or discontinue medication) when the situation changes.
Case Examples

Case 1

Mr. B was a 65-year-old man with delayed developmental milestones; limited history could be supplied by a younger sibling, who recalled diagnosis of mental retardation at age 8, but a longstanding indulgence of the patient throughout their shared childhoods, with his being very demanding with a poor tolerance for frustration. He attended special classes in a church-affiliated school through age 21, then lived at home with parents until their deaths when he was 46. An attempt to live with the sibling ended when the sibling was hospitalized, possibly for depression. Two adult foster home placements were ended by the patient due to possible neglect and abuse, which the patient acknowledged but would not describe further. A third placement in a group home, part of a large comprehensive disability agency, was a great success; he lived happily, if with limited activity participation, with well-liked peers for over 15 years, despite hospitalization for a painful cellulitis, and later need for frequent catheterization due to atonic bladder. Throughout this time there was no psychiatric contact, nor any need seen for it.

Between three and six months before consultation, in the wake of the deaths of two peers (both his roommates) and the move to a nursing home of another, he became more withdrawn, less sociable, and irritable to the point of verbal outbursts with caregivers. He expressed sadness at the friends’ deaths. The sibling informed caregivers that there had been similar behavior following the alleged abuse years before. Psychiatric consultation was sought, but scheduled for three months later; in the intervening three months he had two episodes of physical aggression against a very demanding peer whose seizure disorder had progressed, and of whom the patient expressed fear.

At interview he was warm, humorous, but readily acknowledged sadness at his multiple losses, saying, “Everybody’s dying on me, starting with my parents, now my friends.” He acknowledged his fear of the intrusive peer, but noted that he might also be leaving the house (a fact confirmed by caregivers), and that he too had been a friend before the progression of his seizures. He denied sleep disturbance, appetite loss, suicidal ideation, hallucinations or delusions, and was completely oriented. There was no sign of thought disorder or restriction of affect.

Case Discussion

The family history of possible depression yielded a differential diagnosis of major depressive disorder vs. adjustment disorder. The absence of vegetative signs (sleep and appetite disturbance) and the onset of symptoms in close proximity to stressors, with worsening as the stressors progressed, strongly suggested a diagnosis of adjustment disorder. Had the consultation occurred immediately upon referral, the patient would have met DSM-IV diagnostic criteria for adjustment disorder with depressed mood. With progression of symptoms to aggression, he met criteria for adjustment disorder with disturbance of emotions and conduct. This highlights not only the fluidity of symptoms, but the evolution of severity of symptoms, with consequences for the diagnosis and for the patient’s life, of such a common factor as a long clinic waiting period, or a long wait to make a referral for evaluation.

Treatment is properly directed at the underlying depressive mood and the effects of the losses, not at the aggression (which was in any case minor). Psychotherapy would have a goal of accomplishing appropriate grief; depending upon the depth of suffering, the presence of anxiety about his own health, and the ability to participate in therapy, use of an SSRI could be considered. Meanwhile, the staff of this group home, involved as they are specifically with aging residents, could benefit from help in dealing with their own grief and other feelings caused by the inevitable losses in this setting, and in using these feelings to help residents through the next losses. With caregivers prepared to respond, the patient and his housemates could be encouraged to approach staff, or respond to staff approaches, to verbalize responses to future losses. The residential agency might require consultation to develop such a staff approach, or might require encouragement to direct its professional staff to this need.

The situation is thus an opportunity not only to help the patient, but to prevent future episodes and possibly improve the quality of life of an entire group home. Both individual psychotherapy for the patient and T-Group for staff and other residents were recommended to the agency.
Case 2

Ms. A was a 23-year-old woman with mild ID. She was the product of normal birth and delivery, and slow development, compared to her older sister, was evident by age 2. She received early intervention services, and special education services beginning at age 3. During her high school years, she had vocational training in a special education classroom, with some mainstream experiences in art and gym classes. Her family was intact and supportive. She was described as a quiet, polite and kind young woman who had never had a notable adjustment difficulty or emotional disturbance.

When she finished her entitlement to education, there was a lapse in obtaining a work situation funded by the state disability agency. After two months without a daily routine, she began to show symptoms of anxiety. She worried, and paced much of the day. She asked her parents often about getting a job. Given her intellectual level, it was difficult for her to understand how these processes “take time,” and she began to blame herself, saying that there must be something “wrong with me.” Further, her parents would hear her in her room talking to herself out loud at times, and the content of this was negative and self-deprecating.

Her parents brought her for a psychiatric evaluation when she began to stay in her room alone for most of the day unless asked to join the family. She presented as depressed, anxious, nervous, and verbalized many worries. She could not directly connect her loss of education and transition to adult services as a stressor. During the interview, however, she made statements related to specific questions of the examiner, such as, “No one wants to hire me.”

Ms. A and her parents engaged in psychotherapy as they preferred not to try any medication. In addition, the local disability agency was contacted and the clinician aided in presenting the case as a possible psychiatric emergency caused by the lack of work supports. In psychotherapy, the young woman was given coping statement cards, and rehearsed these in sessions. She was given a perspective of waiting for work which she could understand. For example, in one session, the psychotherapist read the newspaper headlines about unemployment, and how many people did not have jobs. These were pasted on cardboard that she could then post on a bulletin board at home. Her mother helped in a homework assignment to meet with a local state representative to talk about unemployment, and her daughter’s specific unemployment. These tasks helped her to shift her belief system to a societal problem rather than a personal deficiency in her.

After several months, the young woman began to visit sheltered workshops, and most had a division that helped try to find work in the community. This caused a setback, as these sites were vastly different from her school setting, which was exceptionally well-staffed, physically appealing, and integrated into the school mainstream. The low caregiver to worker ratio, work site physical setting, and the many individuals in a small space were not what she expected. This may be similar to the adjustment of many college students to work settings after finishing school. For my patient, this also led to a new phase of helping her address the nature of her disability and to not look down on others who were similarly disabled.

She recovered from her symptoms within nine months, and accepted placement at the site that was the most physically pleasing with a promise of finding some work in the community.

Case Discussion

This woman presented with an adjustment disorder with depressive and anxious symptoms. Through the interview with her parents and herself, a major recent stressor was identified. Her talking out loud to herself, making self-deprecating statement was not psychotic, but rather a more childlike open speaking that occurs prior to the private speech of adults (although everyone talks out loud to themselves during times of stress). She responded well to supportive and cognitive-behavioral psychotherapy. The major stressor was finally eliminated, although her symptoms resolved during the therapy prior to obtaining a work placement. She was able to see that her “unemployment” was not her fault, but rather a societal problem.

Final Comments

The adjustment disorders are a family of mild psychiatric conditions that are responses to environmental stressors. For people with ID, they are most likely undiagnosed and underappreciated. First, mild emotional and behavioral responses to a stressor may be unrecognized because the person with ID cannot label them as verbal as the result of a stressor. Secondly, the responses may be labeled
as a “behavior” problem or may present as an increase in the frequency and intensity of a preexisting behavioral aberration. Thirdly, if brought for a psychiatric evaluation, the clinician will most likely default to diagnosing a major mental illness, because the patient cannot verbalize the link of his or her reaction as a response to a stressor.

Two problems result. People with ID are not brought for treatment in a timely fashion when it might help their problem considerably. Secondly, without this recognition, the source of the stress is never addressed. The majority of life situations that are causing stress for people with ID can either be ameliorated, changed, or the person’s natural support system could provide modifying emotional support. It is critical that this concept be discussed and publicized through developmental disability agency support systems.

REFERENCES


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