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A CASE STUDY IN THE TREATMENT APPROACHES AND OUTCOMES
OF ADJUSTMENT DISORDER

By
Tobiellen Care

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
Rowan University
May 14, 2004

Approved by _____
Professor

Date Approved 10/6/04

ABSTRACT

TOBI ELLEN CARE A CASE STUDY IN THE TREATMENT APPROACHES AND OUTCOMES OF ADJUSTMENT DISORDER

2004

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Mental Health Counseling

This case study evaluated the effectiveness of cognitive-behavioral therapy in the treatment of an adolescent female in a community agency. The client was diagnosed with adjustment disorder with mixed with anxiety and depression. A psychosocial history of the client was presented emphasizing the psychosocial stressors that contributed to the adjustment disorder. A review of empirically supported treatment approaches for adjustment disorders was conducted. The Beck Depression inventory and the Trait Anxiety scale were used as outcome measures. Pre and post comparisons of both measures indicated clinically significant decreased in both anxiety and depression. However, further treatment was needed to extend the improvement in symptoms and to reduce the risk of future relapse. A comparison between the client's current treatment and what might be considered "best" treatment was presented.

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Chapter 1 Psychosocial Assessment

Identifying Information

Name of client: Zoe

Age of Client: 15 years old

Presenting Problem

Zoe was a fifteen year-old Hispanic female who currently resides in a residential shelter. She was living in the shelter for three months. On interview Zoe stated she was very sad. She felt sad every day almost all day long. Although she reported that her sadness had gotten worse since coming to the shelter, she had been sad for as long as she could remember. She reported that she rarely felt happy and if she had to think of a time when she was happy it was when she went out to a bookstore, which was not very often. She presented with poor concentration and feelings of hopelessness as evidenced by the statement " I feel like I will be sad for the rest of my life".

Zoe also reported feelings of worry and anxiety. She had been feeling this way for many years while living with her uncle. She stated that a large part of her worrying came because she never knew when he might explode. Although she felt safe at the shelter she found it difficult to control her anxiety because of the uncertainty she faced with her future. She also felt that being worried all the time made her more tired. Her high levels of anxiety made it more difficult for her to focus, especially at school. These feelings were present more days than not. Zoe also presented with some anger management issues. She expressed that she often became angry and had a difficult time controlling it. Her anger was sometimes accompanied by impulsive behavior; including hitting other

people. Zoe had the insight that hitting people will not solve her problems. She tried to cope with the impulses by retreating to her room. This was somewhat successful and she reported she did not hit anyone over a 2-month period. Her episodes of anger lasted about a day and occurred approximately 2-3 times a week. The problem became worse after she was admitted to the shelter. Staff observations of Zoe confirmed that she was angry and depressed much of the time.

Zoe was living in a shelter after being removed from her aunt's house by the child welfare agency. The agency substantiated reports that Zoe and her two brothers were physically abused while they lived with their aunt and uncle.

History of Presenting Problem

Zoe's feelings of depression, anxiety and anger began 11 years ago at the funeral of her mother. Since then, the feelings have gotten worse due to the dysfunctional family environment she was placed in through the foster care system. Her lack of a secure, stable and nurturing environment was a major contributor to her symptoms of anxiety, depression and anger. Zoe reported feelings of happiness after leaving the foster home to go live with her aunt and uncle however, she said these feelings did not last long. Upon arriving at her uncle's, she was subjected to both physical and emotional abuse lasting approximately nine years. This ended only she was removed by the child welfare agency and placed in the shelter.

Prior Efforts to Address the Problem

Zoe has never received any prior counseling or treatment.

Family Relationships

Current Family

Zoe was living in the shelter with her two brothers, John age sixteen and Tom age twelve. All three of the siblings had been removed from the home of their aunt and uncle. Zoe describes her relationship with her brothers as very close. They were the primary support system for each other. They were extremely protective of each other and very affectionate. They interacted in a positive manner on a daily basis and encourage each other to be strong. Besides her brothers, Zoe did not have contact with any other family members.

Family of Origin

Zoe was raised until the age of four by Ann, her biological mother. It was at this age that her mother died and Zoe was placed in foster care with her two siblings. Zoe's father has never been a part of her life. She has never had a relationship with him and does not know where he lives. Zoe and her brothers were placed in a foster home for two years after their mother's death because they had no relatives willing to take them. She remembered very little about the time with her mother but when asked questions about what her mother was like she stated, "very nice and pretty." She remembered her mother cooking meals and cleaning the house. She did report that her Aunt Barbara and Uncle Frank described her mother as abusive to Zoe and her brothers. According to the Aunt and Uncle, Zoe's mother was arrested for abuse. It appears likely then, that Zoe was abused in her mother's home. Zoe's mother died of cancer at the age of twenty-eight.

Zoe described her foster mother as old. During the placement, which lasted about two years, Zoe experienced severe physical and emotional abuse. She remembers being locked in a dark basement with her brothers while being given little food or water for long periods of time. Zoe also stated that her foster mother would pull her hair and hit her. Zoe could not report what precipitated any of these incidents. She and her brothers were again removed by the child welfare agency and placed with her Aunt Barbara and Uncle Frank. Uncle Frank is her mother's biological brother. She recalled being very happy the day that she left the foster home.

Zoe's uncle's house was very crowded. Her aunt and uncle had three children to care for in addition to Zoe and her brothers. She reports that the happiness she originally felt didn't last long. The uncle was a very strict disciplinarian. Zoe remembers feeling like a prisoner. From her account, her uncle abused alcohol. She was not allowed to use the phone or go out unless it was with her aunt. In addition, her uncle would call her derogatory names and would use excessive physical discipline. She stated he would hit her with a belt. She also said her uncle would throw things at her when he got angry. She denied any sexual abuse. Overall, it appeared that this placement was also an abusive environment for Zoe and her brothers.

Drugs, Alcohol and Addictive Behavior

Zoe denied any alcohol use, drug use or any other type of addictive behavior. There was no evidence in her file of substance abuse. Zoe understands the negative impact drugs and alcohol have on a person's life because of the experiences she had with her uncle when he drank too much.

Early Development / Neurological History

Zoe was not aware of any problems during her mother's pregnancy. Case files available to the shelter contained no reports of any developmental or neurological problems. When asked about normal developmental milestones Zoe stated that she attended a normal school and had no difficulties while growing up. No further information was available.

Medical and Psychiatric History

Zoe reported that she has difficulty seeing the blackboard and often gets headaches. She was seen by the doctor at the residential facility and by a school doctor. She was given a prescription for glasses but will not wear them. She also reported that she has allergies. She was not taking any medications. Zoe reported that before coming to the shelter she did not get regular medical and dental check-ups. Zoe gets her period twice a month. She had reported this to the doctor who examined her at the shelter. Zoe had difficulty giving an accurate account when reporting any psychiatric history in her family due to her frequent changes in placements. As mentioned previously, her maternal uncle abused alcohol and became extremely aggressive toward Zoe during the times when he was drinking. Due to this aggressiveness he was required by the child welfare agency to attend anger management training.

Education and Job History

Zoe was in her sophomore year of high school. She enjoyed school and reported that she received good grades. When asked what good grades were she stated "mostly B's and C's". She performed best in art and computers classes and had the most difficulty with math. She reported positive relationships with her teachers and had made some friends at the school. These relationships made school enjoyable for her. In the future she would like to pursue a career in Japanese imitation art. Zoe continues to stay focused in school and while she has had some difficulties with her peers in the shelter she has reported no problems with her peers in school. The client has no work experience.

Social Supports and Pattern of Relationships

Zoe's primary social supports were her siblings. She reports having a close bond with them even though they fight occasionally. Living in the shelter caused each of them an extreme amount of stress. She also viewed her mother's sister and her stepsister as supports for her, although she had not been able to see them recently. She did belong to a church that she attended on a regular basis when she lived with her uncle. The family went to church six days a week and this was a positive outlet for her. She has lost this support since being placed in the shelter. Zoe has one best friend with whom she trusts very much. Zoe has never dated and denied ever being sexually intimate with anyone. Zoe was able to make friends with some of the other girls at the shelter. She has been able to maintain her friends from school since she was attending the same high school that she went to when placed with her uncle. Despite her multiple placements then, Zoe has been able to develop a fairly strong support network.

Situational Stressors

Zoe's main source of stress was being placed in the shelter. She had realistic fears about her future and the future of her brothers. When asked if she would rather be living with her uncle she stated, "no". However, she recognized that the shelter was not a permanent placement for her.

Coping Mechanisms and Strengths

Zoe's primary coping mechanism was to isolate herself during difficult times. When she is not able to do that, she might fight, argue or hit people. She has some understanding that these coping mechanisms were not effective. She reported trying to work on the computer, listen to Japanese music, draw or talk to staff as alternative ways to cope. She wanted talk to staff more but had difficulty asking for support.

Zoe would like to change her negative reactions to stress, anger and sadness. She has a positive self-image as evidenced by her response on the BDI exam "I feel satisfied with myself". Zoe was compliant with all aspects of treatment.

Other Agency Involvement

Zoe was under the supervision of the child welfare agency. No other agencies were involved.

Summary

Zoe was a 15 year-old girl with symptoms of anxiety, anger and depression. She had been in multiple placements where she was physically and emotionally abused. Zoe has never had a long- term placement where her physical and emotional needs were met. Zoe has realistic concerns about her long-term placements and legitimate anger regarding her maltreatment. She has a number of strengths including good insight and the ability to maintain social support networks.

Chapter 2 Differential Diagnosis

Axis 1

309.28

Adjustment Disorder Mixed with Anxiety and Depression, Chronic

R/O Dysthymia

According to the DSM-IV TR, the diagnosis of Adjustment Disorder requires a strong and dysfunctional response to an identified stressor. The response needs to be either excessive compared to what could be normally expected, or severe enough that the individual has significant difficulty in functioning.

Zoe meets the major criterion of adjustment disorder because she was exposed to a significant stressor; her placement in a homeless shelter. Prior to that, she had chronic exposure to stressors in the form of abusive home environments. In addition, she meets the specific diagnostic criteria for the disorder as detailed below:

Criterion A

Development of emotional or behavioral symptoms in response to an identified stressor. The response needs to occur within 3 months after the onset of the stressor.

Zoe developed emotional and behavioral symptoms as a result of being taken from her home and placed in a shelter for adolescents. Symptoms of depression and anxiety existed previously due to the chronic absence of a stable home life. However, Zoe had an increase in the frequency, duration and intensity of these symptoms after arriving at the shelter. She reported strong feelings of depression and anxiety. She had realistic

concerns about her future. This increase in symptomatology occurred within 3 months of the stressor, therefore meeting the core diagnostic feature of adjustment disorder. Other indications of impaired functioning include a loss of concentration, poor school performance and anger management problems.

Zoe also engaged in impulsive and aggressive behavior, including hitting other clients in the shelter. She reported having difficulties in interpersonal relationships. Taken together, these symptoms indicate a significant impairment in function that occurred after a major stressful event.

Criterion B

This stress related disturbance did not meet the criteria for any other Axis I or II disorder.

While Zoe manifested some symptoms of acute stress disorder she did not meet the full diagnostic criteria. She did not report a numbing, detachment or absence of emotional responsiveness. There was no derealization or depersonalization. She never had dissociative amnesia. There was never a report of recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event. She had no marked avoidance of stimuli that aroused recollections of the trauma. Finally, her symptoms have persisted for more than four weeks.

While Zoe also manifests some symptoms of Major Depressive Disorder she did not meet the full diagnostic criteria for this disorder either. Zoe presented with a depressed mood and feelings of sadness. Her inability to concentrate was evident in her

lack of participation in school that resulted in poor grades. However, these symptoms would dissipate when Zoe was visiting her relatives or if she was taken on an outing to a favorite place. Zoe had no weight loss or weight gain during this period. She did not report any feelings of worthlessness or excessive inappropriate guilt. There was no psychomotor agitation or retardation. There were no reports of insomnia or hypersomnia. Zoe had no recurrent thoughts of death, suicidal ideation or suicide attempts. Due to these factors Zoe did not meet the criteria for this diagnosis on the basis of duration and severity.

The disturbance did not meet the criteria for Generalized Anxiety Disorder because symptoms did not meet the full criteria needed to apply this diagnosis. Her symptoms of anxiety and worry were only associated with her current situation; that is, living in the youth shelter not any other events or activities. It is important to note that her high levels of anxiety did not exist prior to her placement in the shelter.

These symptoms were also not representative of PTSD. While she did manifest some of the symptoms, she did not meet the full diagnostic criteria. She did not report recurring memories of the event including images, thoughts or perceptions. She did not have recurrent distressing dreams of the event. She did not act or feel as if the event was recurring and there was no reenactment. There were no reports of intense psychological distress at the exposure to internal or external cues that symbolized or resembled an aspect of the traumatic event. There was also no psychological reactivity on exposure to internal or external cues that symbolized or resembled an aspect of the traumatic event. There was no persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.

Criterion C

These symptoms did not represent bereavement due to the fact that they are not related to the death of a loved one. Zoe had no recent deaths in the family. Zoe did not have any guilty feelings associated with the death of her mother 11 years ago. She did not wish she was dead and did not think she should have died when her mother died. She had no morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

The specifier of chronic was given because the stressor was still present. Since Zoe's long-term placement had not been resolved, she was continually subjected to a difficult living environment and uncertainty about her future.

The specifier of mixed anxiety and depressed mood was given since Zoe reported symptoms of both anxiety and depression. It should be noted that it is common for adolescents to manifest symptoms of depression by being irritable. Some of Zoe's irritability and anger could be symptomatic of her depressed state.

Axis 2

V71.09

Axis 3

Headaches

Axis 4

1. Problems with Primary Support:

Multiple foster home placements

Mother deceased, no contact with father

Exposure to chronic abuse and neglect

2. Problems related to social environment:

Low levels of support from family

3. Housing Problems:

*Zoe is currently homeless and living in a shelter.

Axis 5

Current GAF: 70

A GAF of 70 was given because Zoe has difficulty functioning in school and social settings. She did have a number of strengths. She attended school regularly, maintained peer relations, and completed her homework and chores. Given the nature of her chronic abuse, Zoe was functioning at a relatively high level.

Rule Out

Dysthymia

Zoe did present with many of the same symptoms associated with Dysthymic Disorder. She had depressed mood, feelings of hopelessness and poor concentration. However, the symptoms had not been present for a year at the time of treatment. It will be important to rule this diagnosis out after Zoe is removed from the shelter and placed in a stable home environment. If symptoms continue to persist or become worse, then this diagnosis may be appropriate.

Chapter 3 Literature Review

“Adjustment Disorder occurs due to the development of emotional or behavioral symptoms in response to an identifiable stressor occurring within three months of the onset of the stressor. These symptoms or behaviors must be clinically significant as evidenced by either a marked distress that is in excess of what should be expected from an exposure to the stressor, or significant impairment in social or occupational (academic) functioning. The symptoms must not be due to a preexisting mental disorder. The symptoms must not be due to bereavement and must terminate once the stressor is no longer present” (APA 2003 4th Ed. p. 679). “ By itself, the term ‘adjustment disorder’ means that a specific stressor has found the point of vulnerability in a person of otherwise considerable ego strength” (Mishne & Turner, 1984 pp 356-357). “The basis of the disorder lies in the concept of trauma as psychic overload, with a subsequent partial or complete feeling of helplessness, accompanied by regression and inhibitions”(Kaplan and Sadock, 1981 p.581).

Between 5% and 20% of patients receiving outpatient mental health treatment have a primary diagnosis of AD (Adjustment Disorder). Individuals whose socioeconomic status is low are more at risk to AD due to the fact that they are more likely to experience a high rate of stressors. Other risk factors for AD may be a recent diagnosis or an exacerbation of physical illness, changes in work responsibilities, recent loss and family discord (Sampang, 2003). AD should not be regarded as a minor mental disorder because suicide ideation may be high (Horowitz, 1986). How an individual reacts to a specific stressor may be due their ability to cope with change. The overall

treatment goal of the professional should include relief as soon as possible, development of more effective coping strategies in response to the current stressor and preparation for coping in the future (Araoz & Carrese, 1997).

Self- Help Groups

An important initial goal would be to remove the stressor whenever possible. Many individuals who experience an acute amount of stress will turn to family and friends for support first. They also may go to a family doctor or clergy for additional support if needed. Most individuals with adjustment disorders manage it on this informal level. People who do not find this method of coping effective may then seek to find support through self- help groups. These self-help groups can serve as a source of interpersonal support in which many clients may respond too (Seligman, 2001; Counseling treatment for children and adolescents, 2004).

There are three types of self-help organizations:

1. Self -Help Groups. Activities like yoga or biofeedback are dedicated to self-improvement. Trained facilitators usually run these groups.
2. Mutual-Help Groups. Organizations such as AA, or associations formed by parents of handicapped children. Participants usually cooperatively run these groups.
3. Peer-Help Groups. Trained peers who work with identified target populations. Examples include, hotlines where peers make themselves available to respond to calls from suicidal adolescents (Noshpitz & Coddington 1990).

A number of studies have explored the therapeutic benefit of these groups. Several mechanisms appear to be at work:

1. The shared identity with others in like circumstances is a powerful buffer against self-devaluation, social isolation, and sense of alienation that follow in the wake of many human vicissitudes. Within the group, instead of being a social reject, one acquires a sense of belonging. The former feeling of being different and alone is transformed into an experience of communication, mutual understanding and sharing.
2. The client is given a chance to help others with similar difficulties; this is often enormously rewarding and converts a state of passive vulnerability to one of active effectiveness.
3. A group ideology that amounts to a belief system often emerges; this functions as an effective rallying point and instills a sense of mission and positive goal seeking that does much to dissipate anxiety and depression.
4. The client characteristically finds an immediate place within a social network of people who may interact supportively and remain in contact between group meetings. Newsletters, parties, informal social visits, and numerous phone calls serve to enhance the sense of connectedness and participation; fairs and annual conventions extend the reach of the network enormously.
5. Many projects, often in the form of public relations or educational efforts, bring people together in common participation, with old timers setting the tone and newcomers offering to help any way they can.

6. Within the group the characteristic emphasis is usually one of the overcoming obstacles, achieving mastery, or, at any rate, keeping a positive outlook. Collectively, these factors make for hope and lessen the helplessness/hopelessness component of the Adjustment Disorder.
7. There is an associated active cognitive component to the group experience. Where applicable the members often feed the latest scientific information into the pattern of group exchange, and in any case, they can always share individual experiences and coping efforts to enhance their array of adaptive possibilities (Noshpitz & Coddington, 1990 pp. 630-633).

While these informal forms of interventions may be useful to some they are not effective with all individuals. Some people will need more formal therapeutic approaches that may include brief individual psychotherapy, group therapy, crisis intervention, family therapy, and psychopharmacology. In a comparative evaluation of the treatment of AD, Diego De Leo from the University of Padua School of Medicine (De Leo, 1989) set out to test four forms of therapy with adjustment disorder outpatients. Subjects were randomly assigned to the following treatments: supportive psychotherapy, viloxazine, (an antidepressant), lorazepam (a benzodiazepine), and S-adenosylmethionine (a methyl donor with antidepressive properties). An additional group of 15 subjects received a placebo, orally administered. The trial lasted four weeks. None of the treatments had superior effects over others on scores on the Zung Self-rating Depression Scale, although all produced a significant improvement. However, groups given S-adenosylmethionine and supportive psychotherapy had the highest mean scores (De Leo, 1989).

Crisis Intervention

Crisis intervention is a form of treatment designed to engage a client who has been subjected to acute stress and is emotionally overwhelmed by it. Crisis intervention is helpful, but should be followed by a thorough psychological evaluation (Treatment of psychiatric disorders, 1989). The goal of crisis intervention is to reduce symptoms immediately and bring relief to the individual. Crisis intervention works to help the individual cope more successfully in the future. AD typically responds well to crisis intervention (Seligman, 2001). It is cost-effective, brief and helps the individual understand his or her situation (Sampang, 2003). The approach is built upon the theory that individuals struggle to maintain a homeostatic balance. In normal circumstances this results in a steady state. When an individual experiences a period of stress, extra effort is required to regain homeostasis. However, if a person undergoes a period of extreme stress, for example, due to a natural disaster or rape experience he or she may have difficulty returning to a homeostatic state. It is during this period that an individual is considered to be in a state of crisis. The individual responds to this crisis by using their coping skills and seeking support from their family and friends. If these strategies do not work, they may seek the services of a professional psychotherapist.

If a therapist is sought, the existence of the crisis state may allow the individual to be more open to treatment opportunities. Crisis intervention as a form of treatment has different characteristics that set it apart from other kind of therapy. Crisis intervention therapy is very brief and can be quite intensive. The primary goal is to resolve the present crisis. The therapist will work to explore the realities of the situation and build on the person's strengths so that he or she may work to resolve the issues at hand. The therapist

will also focus on evaluating the individual's support system so that it may be strengthened and utilized in the treatment process. As with most psychotherapies, it is helpful if the individual is a willing participant in the treatment (Noshpitz & Coddington, 1990).

There are four stages in crisis intervention therapy. In the first stage, the therapist reviews what the client states is the crisis and discusses what they have done to cope with it. The therapist also explores what supports the client has utilized and if there is a danger of violence or suicide. Stage two is about developing goals. The therapist works with the client to establish clear attainable goals that will work to bring the client some relief. The therapist will make it clear at this point that once the goals are reached therapy will end. Stage three involves action. The therapist will begin to give the client tasks to perform. The therapist might also work with the client's social support system and give referrals to community resources for extra support. During the final stage the therapy is terminated. The client has made it through the crisis and has returned to the pre-crisis state. The therapist will need to take the time to thoroughly process the therapy and review what was learned. Even though crisis intervention therapy is brief, the therapist must follow the same termination procedure as if it had been a course of long-term therapy (Noshpitz & Coddington, 1990).

Brief Psychotherapy

Kaplan and Sadock (1981) argued that psychotherapy is the treatment of choice in adjustment disorders. "Individual psychotherapy offers the opportunity to explore the meaning of the stressor to the patient, so that the earlier traumas can be worked through"

(Kaplan & Sadock, 1981 p.582). Horowitz (1989) stated that, "...as with all treatment for Adjustment Disorder, the goal of psychotherapy is to relieve symptoms by improving client's adaptations (Noshpitz & Coddington, 1990 p. 634). Adaptations are presumed to have failed if the individual could not cope with the crisis. "Brief psychotherapy for adjustment disorder rests on the assumption that the symptom pattern is linked to earlier modes of attempted adaptation" (Noshpitz & Coddington, 1990 p.634). Supportive psychotherapy is helpful in enabling individuals to learn new adaptations and develop coping skills while dealing with emotional turmoil engendered by a crisis (Kaplan & Sadock, 1981).

Cognitive therapy is also a widely used approach when treating adjustment disorders. It attempts to correct cognitive distortions, particularly negative conceptions of one's self (Kaplan & Sadock, 1981). This approach is mainly used to treat depression while relaxation programs and stress management may be used to treat individuals presenting with anxiety (Counseling treatment for children and adolescents, 2004).

Solution Focused Therapy

Solution focused therapy is another brief treatment approach that has shown some promise in treating adjustment disorder. Solution- based therapy assumes that people are doing the best that they can at any given time. Treatment focuses on increasing peoples' hope and optimism by creating an expectancy for change no matter how small. It is believed that small behavioral changes lead to larger changes that have ripple effects on the whole system (Seligman, 2001). A therapist may use reframing or re-labeling with the client to help the individual view their concerns differently and see the hopeful

possibilities. The therapist and client should develop realistic and measurable goals that focus on current problems. One way a solution-based therapist can do this is to use the "miracle question". This enables the client to imagine the possibility that their problems have been solved, which continues to instill hope and optimism in the individual.

Solution focus therapy is known to be effective and efficient with a broad range of problems. It is generally well received by clients, is encouraging and empowering, and offers new ways of thinking about helping people (Seligman, 2001).

Solution-based therapy does have limitations. Solution-focused therapy can co-create problems between the therapist and client if they do not work together to identify problem definitions. The approach may cause clinicians to focus prematurely on a presenting problem and thereby miss an issue of greater importance. Solution-based treatment should not be used as the primary method of treatment for severe or urgent emotional difficulties. Some therapists, clients and managed care organizations feel that brief treatment is the only thing needed to treat clients successfully. However, they should exercise caution when using this treatment approach to be sure it is going to meet the needs of the client.

Pharmacotherapy

There is some evidence that antidepressants and anxiolytics can be beneficial in the treatment of adjustment disorder, although some evidence suggests medication should only be used for a brief amount of time (Kaplan & Sadock, 1981). Additionally, a careful assessment should be done to avoid missing relevant symptoms, affects, moods, or underlying disturbances (Mishne & Turner 1984). Kelly and Frosch, (1989) have stated

that the treatment of adjustment disorders should be essentially psychological, and the use of psychotropic agents must be regarded as supportive and symptom focused. In children, psychotropic medications are used less frequently and the effects are often less certain (Enzer & Cunningham, 1991). Pharmacological interventions may help symptom relief to facilitate addressing other issues involved in adjustment (Enzer & Cunningham, 1991).

The use of medication should facilitate psychotherapy rather than impair it (Noshpitz & Coddington, 1990). The therapist will need to determine whether the use of pharmacotherapy is appropriate depending on the nature of the symptoms and their severity. One empirical study concluded that treatment with psychotropic medications was as effective as supportive psychotherapy (DeLeo, 1989). Sampang (2003) has stated that pharmacological treatment is indicated for adjustment disorder when symptoms continue or worsen, even with concurrent or previous counseling and psychotherapy. However, she cautions that medications should never be used as the primary treatment of adjustment disorder.

A number of strategies integrating psychotropic medications into the treatment of adjustment disorders have been utilized with clients who are acutely stressed. The therapist may give tiny doses of some active pharmacological agent for the placebo effect. Sometimes many people will feel relief from the simple comfort of knowing that they have medication at hand, even though they may never use it. The general rule of thumb in prescribing medications is usually to give them in the smallest dose possible for the shortest amount of time. The therapist should beware of any person who may use the medications for non-medicinal purposes. The therapist should also consider any suicidal

tendencies that a person may have or anyone else that the person may be associated with before offering such treatment to ensure the clients safety (Noshpitz & Coddington, 1990).

If severe depressive symptoms predominate the clinical picture than an antidepressant may be what is needed to relieve the symptoms. Where depressive symptoms occur in direct response to stress, medication should not be given immediately so that the psychological work can be implemented. If outbursts of panic or other symptoms of anxiety dominate the clinical picture, then a benzodiazapine will work to decrease the symptoms (Noshpitz & Coddington, 1990).

Group Therapy

Group therapy can be useful for clients who are experiencing the same clinical symptoms (Kaplan & Sadock, 1981). This is particularly true for clients who are having difficulty in coping with stress. When individuals have a shared stress (handicap, medical illness or catastrophe of some kind) this can offer an immediate focus for the group. Clients are likely to be willing to share and have a sense of belonging to the group. People are eager to share their experiences with others and gain a new perspective in terms of social skills and coping tactics (Noshpitz & Coddington, 1990).

In these stress related groups, it is important to avoid blaming or allowing participants to blame themselves for their misfortunes. The responsibility begins with how they react to the event, and what they do with the feelings it provokes. A leader can reframe these stressful experiences for group members by redefining the difficulties as challenges. This presents opportunities for an individual to master a variety of painful

issues and discover his or her own unrecognized resources. It is the essential work of the group therapist that is dealing with Adjustment Disorder to apply crisis intervention techniques (Noshpitz & Coddington, 1990).

The structure of stress related groups are highly variable. The groups can take the form of a class, or be defined as group therapy but limited to two participants. Group therapy sessions may only last two to three sessions or may be open ended with no predetermined termination date. The groups may be structured to include formal instructional components or can be an interactive open exchange. As in all therapies, the process of termination must be discussed. The therapist facilitating the group must give the group members an adequate amount of time to process the ending of group and provide support needed to all members. The therapist must be careful to avoid any counter transference when working in the group setting. It may be very easy for the therapist to over-identify with one's pain. That can be intrusive and distort the nature of the work (Noshpitz & Coddington, 1990). Although group therapy is used in many settings, there is no supportive empirical evidence showing the effectiveness of it.

For many people, coping means utilizing supports such as family and friends as they move through a period of crisis with no more than minor adjustments. Other people may turn to self-help groups in search of people that they can identify with and get support from because they are experiencing the same thing. Others choose to seek a more formal approach to treatment. These approaches include crisis intervention, brief psychotherapy, pharmacotherapy, group therapy, and psychopharmacological treatments. While there has been a fair amount of discussion regarding theoretical approaches to treatment, there are very few empirical studies. Some empirical support exists for

cognitive- behavioral, solution focused, supportive expressive and behavioral therapies. Medications may be particularly useful when symptoms worsen or persist for long periods of time. It remains unclear whether medications are effective when used as the sole source of treatment. Overall, more rigorously designed research is needed to determine the most effective treatment for adjustment disorder.

Chapter 4 Normative Practice/ Outcomes

General Information

Treatment was conducted at the homeless shelter where Zoe lived and consisted of 30 individual sessions. Each session lasted 1 hour and was conducted on a weekly basis. Zoe was not being treated by anyone else at the time. Zoe was not on any medication but had been seen by the medical doctor that visited the shelter.

Outcomes

The client complained of experiencing symptoms of depression and anxiety. The measures used to assess these symptoms were the Beck Depression Inventory (Beck, 1996) and the Trait Anxiety Scale (Spielberger, 1968).

The Beck Depression Inventory (BDI) (Beck, 1996) is a self-report measure designed to assess the severity of depression in adolescents and adults. It consists of 21 items rated in a scale ranging from 0-3 in terms of severity. Clients are asked to pick the statement which best describes the way they have been feeling during the past two weeks.

Zoe was assessed with the BDI on three separate occasions. She was given a pre-test, post-test and was also assessed about half way through treatment at week 10. During the first assessment, given at week two, Zoe scored a 14, which placed her on the low end of mild depression, (Beck, 1996). Her highest score was on item # 10 " I feel like crying

but I can't". On item # 16 she had a moderate score because she felt that she was sleeping more than usual. She also had a moderate scoring on item # 19 in which she felt that she had a hard time keeping her mind on anything for very long. While Zoe is feeling more tired than usual and has difficulty concentrating she still has positive self worth and does not feel like a failure. This information was useful in developing a treatment plan that focused on increasing social supports and decreasing her feelings of sadness.

The second assessment, at week 10, found Zoe's symptoms had increased on 10 out of the 21 items. This information suggested that Zoe was having increased difficulties in adapting to the residential placement.

The last assessment was given at week 26. Zoe scored a 2 that placed her within the normal range. These results indicated that Zoe had been able to more effectively cope with her stressors and her depressive symptoms were ameliorated.

The Trait Anxiety Scale (Spielberger, 1968) is a self-report measure designed to assess the severity of anxiety in adolescents. The test consists of 20 items, with a responses range from 1 "almost never" through 4 "almost always". Participants are asked to rate each item based upon how they "generally" feel.

Zoe was given a pre-test and a post-test. During the initial assessment, Zoe scored a 47 on the Trait Anxiety Scale (Spielberger, 1968) that places her on the "high" end of the anxiety. Her highest score was on Item # 24 " I wish I could be as happy as others seem to be". She scored moderately high on Item # 32 "I lack self confidence" and Item # 40 " I get in state of tension or turmoil as I think over my recent concerns and

interests". In response to item # 31 "I have disturbing thoughts" She answered "almost never". When asked in therapy Zoe also stated she never had disturbing thoughts.

The results of both measures during the initial assessment indicated a mild level of depression and high level of anxiety. Therefore, it was necessary to develop a treatment plan in which the goals would focus on these two areas.

Initial Goal

Zoe will show a decrease in depressive symptoms.

Strategies

- Zoe will identify three occasions during the week when feelings of sadness were experienced.
- Zoe will identify at least three precipitants, (significant persons or potential sources) which are related to feelings of sadness.
- Zoe will identify any unresolved feelings of sadness that any have been experienced in childhood, which were contributing to her symptoms.
- Zoe will express negative feelings through artistic modalities.
- Zoe will implement positive self -talk to strengthen feelings of self-acceptance, self-confidence and hope.

Long Term Goal

Zoe will reduce the overall frequency and intensity of the anxiety response so that daily functioning is not impaired.

Strategies

- Zoe will explore in therapy current life stressors that form the basis for present anxiety.
- Zoe will learn and implement in therapy positive self talk to be used to decrease the levels of anxiety.
- Zoe will identify and process in therapy areas of conflict that precipitate the anxiety and worry.
- Zoe will learn and apply in therapy deep breathing techniques to be used during times of stress and anxiety.

Techniques

Journaling:

Zoe was asked to record feelings of sadness through journal writing so that she may begin to openly express her thoughts and feelings related to her underlying feelings of sadness, hurt and disappointment. These were reviewed during session. Possible ways of coping with these feelings were discussed along with activities that may help to reduce the symptoms.

Reattribution

Zoe was asked to identify all the potential precipitants, persons or sources that may contribute to her feelings of sadness. In therapy these precipitants, persons and

sources were discussed so that the client could express the pain associated with them. The aim of this technique was to work with the client in redistributing some of the responsibility from her to the other possible sources. Through supportive expressive techniques and cognitive behavioral techniques the client was given the opportunity to work through resolving the causes of the sadness.

Letter Writing

Zoe was asked to identify any unmet emotional needs from her past that may be contributing to these feelings. Zoe expressed her sadness at the loss of her mother and verbalized her feelings of hopelessness because of this loss. Zoe was asked to write a letter to her mother where she would describe her thoughts and feelings and read it to the therapist. Zoe was very young at the time of her mother's death and has never fully accepted her loss. This would allow Zoe to process her feelings of sadness and focus on her memory in a more positive manner.

Expressive Therapy

Zoe was asked to use her artistic ability as a tool when feelings of sadness were present and paint her emotions on paper. Zoe would bring her artwork to sessions where she would describe her thoughts and feelings associated with each picture. This would help her to elaborate on the emotions and together with the therapist process the causes. Zoe was asked to bring pictures of her mother to sessions where she was able to reminisce about the good things she remembers.

Cognitive restructuring

Zoe was introduced to the concept of "automatic thoughts". The relationship between thoughts, emotions and feelings were discussed. She was educated on the importance of eliciting and changing her "automatic thoughts" and her reactions to them. Zoe had a continual feeling of hopelessness as evidenced by her automatic thought "No matter what happens, my life is never going to be good". Cognitive restructuring is a technique used to raise a client's understanding of the cognitive approach to anxiety and depression and their treatment.

Decatastrophizing was used to help Zoe identify the most negative possible outcome or interpretation of the cognition and then assess the likelihood, impact and possible solution.

Identify Stressful Situations

Zoe was asked to recognize and explore current stressful situations that cause her anxiety. Through this technique Zoe could learn the triggers associated with her anxiety and develop the necessary coping strategies to effectively deal with them.

Positive Self-Talk

Zoe was asked to explore in therapy her distorted cognitive messages. Some examples of those messages were "I am never going to get out of here" or "No one likes me in here". Zoe was able to recognize how these negative statements increased her fears and made her more anxious. With statements such as "I am going to make it through this"

and "I am a good person" Zoe was able to begin to think more positively about the current challenges she was facing in her life.

Problem Solving

Zoe was asked to write down all possible triggers that she felt contributed to her current feelings of anxiety and process them in session. Through this process Zoe was able to explore possible resolutions that would decrease her feelings of anxiety. This enabled Zoe to feel in control of her situation because she thought about solutions to problems before they happened.

Deep Breathing Exercise

Through this behavioral technique Zoe learned a relaxation exercise that would help decrease her feelings of stress and stabilize the anxiety. Zoe was asked to use this technique during times in which she felt anxiety. Zoe also learned a technique called positive imagery. This technique allowed Zoe to dream of a place where she felt safe, content, happy and peaceful. These techniques increased Zoe's ability to cope with stressful situations she faced on a daily basis.

Treatment Outcomes

On the BDI assessment given at week 10, Zoe scored a 27 placing her on the high end of moderate depression. Her highest score was on Item # 6 " I feel that I am being punished" Item # 20 " I am too tired or fatigued to do a lot of things I used to do" and Item # 19 "I find I can't concentrate on anything." She rated moderately high on Item 1 "I

feel sad all the time", Item # 2 "I do not expect things to work out for me", Item # 3 "As I look back, I see a lot of failures", Item # 4 " I get very little pleasure from the things I used to enjoy", Item # 5 " I feel guilty most of the time", and Item # 16 " I sleep a lot more than usual". She had low scores on Item # 13 " I find it more difficult to make decisions than usual", Item # 15 " I have less energy than I used to have", Item # 17 "I am more irritable than usual", and Item # 18 "My appetite is somewhat greater than usual".

Zoe was given the BDI again on week 26 She scored a 34 that placed her below the median on this scale. Significant responses included Item # 23 "I feel satisfied with myself", Item 26 "I feel rested" and Item # 33 "I feel secure" in which her response was "almost always". She responded often to Item # 21 "I feel pleasant", Item # 27 "I feel calm, cool and collected", Item # 36 "I feel content" and Item # 39 "I am a steady person". She gave a response of "sometimes" to Item # 24 "I wish I could be as happy as others seem to be", Item # 25 "I feel like a failure", Item # 28 "I feel that difficulties are piling up so that I can't overcome them", Item # 34 "I make decisions easily", Item # 35 "I feel inadequate", Item # 38 "I take disappointments so keenly that I can't put them out of my mind" and Item # 40 "I get in a state of tension or turmoil as I think over my recent concerns and interests".

Comparison of the pre and post- test scores suggested a clinically significant reduction in depression and anxiety.

At the six- month measurement point, Zoe obtained a score of 2 on the BDI that placed her within normal range for depressive symptoms. This compares with a score of 14 obtained during the initial assessment and 27 during the mid treatment phase. These results support the conclusion that Zoe had a significant increase in depressive symptoms

during the middle phase of treatment. This spike may have been the result of her adjusting to the realities of living in a shelter and her concerns about her future placements. The final score of 22 indicates that Zoe's depressive symptoms were no longer clinically significant. At this point in the treatment, she had made significant progress and her long-term placement plans were clear. Zoe obtained a score of 34 on the Trait Anxiety Scale (Spielberger, 1968) at the six-month follow up. The score represents normal levels of anxiety. This compares with an initial score 47 which represents a higher than average anxiety level. These results support the conclusion that Zoe had a significant reduction in anxiety levels. Most items at the six-month follow-up either stayed the same or improved by one or two rating intervals. Behavioral observations of Zoe also supported the conclusion that her mood and anxiety levels improved. Over the course of treatment she looked more relaxed and happy. She also reported feeling better now that she was out of the shelter and living with her aunt. Zoe continued to have feelings of sadness and hopelessness, but the feelings are not as frequent as reported during the initial and mid-phase of treatment. She reported feeling more secure and calm now that she is living with her aunt. She also reported feeling more rested and satisfied since her move.

While Zoe stated that she her feelings of anxiety and sadness have lessened, her home life continues to be filled with instability. The relationship that Zoe has developed with her aunt is not as secure and safe as she would have hoped. Zoe has maintained that she is much happier than before and is willing to take the "good" with the "bad". Zoe would definitely benefit from further treatment that could help her to resolve some of

these conflicts she faces in her home. Without treatment Zoe's symptoms could increase once again and further develop into a more chronic disorder.

Chapter 5 Comparison of Normative and Best Practice

The purpose of this case study was to determine the best practice of empirically supported treatment approaches for adjustment disorder, mixed with depression and anxiety. Research has shown that the empirically supported treatment approaches for adjustment disorder were solution focused therapy, cognitive-behavioral therapy, supportive expressive therapy and behavioral therapy. Cognitive-behavioral and solution-focused therapies have been shown to be effective in the treatment of depression. In the current case study, cognitive-behavioral approaches were used to treat the client through cognitive restructuring and positive self-talk to eliminate negative thoughts. By eliminating these thoughts, the client was able to develop more adaptive ways of thinking. Letter writing was implemented to identify and resolve feelings associated with her mother's death. Journaling was implemented so that the client could learn to openly express her thoughts and feelings related to her underlying feelings of sadness, hurt and disappointment. Deep breathing exercises were used to improve stress management skills. In terms of supportive expressive techniques, the client was asked to use her artistic ability to paint her emotions on paper so that she may continue to learn how to identify and cope with them.

The current case study then used a number of techniques and approaches that have been identified as best practice. The current therapeutic techniques were adjusted to the client's needs and abilities during the treatment process. The techniques used seemed helpful as evidenced by the clinically significant reduction in depression and anxiety as rated by the outcome measures.

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