Review Article

Adjustment Disorder: Current Diagnostic Status

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ABSTRACT

Adjustment disorder is a common diagnosis in psychiatric settings and carries a significant rate of morbidity. However, diagnostic criteria are vague and not much helpful in clinical practice. Also there has been relatively little research done on this disorder. In this article, we review the information that is available on the epidemiology, clinical features, validity, and current diagnostic status of adjustment disorder. In this article, the controversy surrounding the diagnosis is also highlighted. It also discusses the differential and comorbid diagnosis. The various recommendations for DSM-V and ICD-11 conclude the article.

Key words: *Adjustment disorder, current nosology, epidemiology, validity*

INTRODUCTION

The adjustment disorder is a diagnostic category characterized by an emotional response to a stressful event. It is a state of subjective distress and emotional disturbance, which arises during the course of adapting to stresses of significant life changes, stressful life events, serious physical illness, or possibility of serious illness. Stress is ubiquitous and a person learns to deal with stress over time. However, when coping mechanisms fail to ameliorate stress effectively, adjustment disorder is precipitated. At a variance from the largely atheoretical model of International Classification of Diseases and Health Related Conditions (ICD) 10 and Diagnostic and Statistical Manual (DSM) IV TR, adjustment disorder is one of the few disorders that take into account the potential cause of the disorder.

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Adjustment disorder is a psychiatric diagnosis that falls between normal behavior and the major psychiatric disorders and thus produces taxonomical and diagnostic dilemmas.[1]

EVOLUTION OF THE CONCEPT

The first clinical description of an adjustment disorder came in the 11th century writings of physician-philosopher Avicenna. Severe war time stress during World War II and the evolution of crisis-intervention theory and practice led to further work upon stress-related conditions including adjustment disorder. The DSM-I in 1952 described this as "Transient Situational Personality Disorder" which is the vulnerability in personality during stressful situations. The subtypes of this entity were gross stress reaction, adult situational reaction, adjustment reaction of infancy, adjustment reaction of childhood, adjustment reaction of adolescence, and adjustment reaction of late life. In DSM-II (1968) it was changed to Transient Situational Disorder and the subtypes were adjustment reactions of infancy, adjustment reaction of childhood, adjustment reaction of adolescence, adjustment reaction of late life, and adjustment reaction of adult life. The DSM-III (1980) introduced

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the term adjustment disorder in which developmental periods of diagnostic categorization were eliminated and subtypes were based upon affective experience. These were adjustment disorder with depressed mood, anxious mood, mixed emotional features, disturbance of conduct, mixed disturbance of emotions and conduct, work inhibition, withdrawal and atypical features. DSM-III-R (1987) added an additional subcategory of involvement of physical complaints, and specified that symptoms could not last longer than 6 months. In DSM IV (1994), subtypes of mixed emotional features, work inhibition, withdrawal, and physical complaints were eliminated. The stressor was allowed to persist for indefinite period of time and a descriptor of chronicity (of more than 6 months) was specified.[2]

In the ICD diagnostic system, adjustment disorder was incorporated in 1978 in ICD 9.

CURRENT NOSOLOGICAL STATUS

According to ICD-10 classification, adjustment disorder is classified under the category of reaction to severe stress and adjustment disorders (F43). This category includes acute stress reaction (F43.0), post-traumatic stress disorder (F43.1) (PTSD), adjustment disorder (F43.2), other reactions to severe stress (F43.8), reaction to severe stress unspecified (F43.9). As per DSM IV, adjustment disorder (309) is a separate diagnostic category. Acute stress disorder and PTSD are given separate diagnostic categories in DSM IV TR. The conceptualization of adjustment disorder according to various diagnostic systems is shown in Table 1 and the various subtypes of the disorder are shown in Table 2.

While considering a diagnosis of adjustment disorder, a few differential diagnoses should be kept in mind [Table 3]. Normal nonpathological reaction to stress which is appropriate to the stressful situation should be looked for to avoid over diagnosis of adjustment disorder. Personal circumstances and context of the stressor, relation between symptom severity and stressor, persistence beyond the expected time period, cultural norms for emotional response/expression and duration and severity of dysfunction can be useful guide to make a diagnosis of adjustment disorder.[3] Major depression should be considered as the diagnosis when symptoms meet the diagnostic threshold of depression. Exacerbation of maladjustment in personality disorders when faced with severe stress can result in symptoms of adjustment disorder. The premorbid functioning and coping patterns may help to discern personality disorders. Acute stress reaction occurs in response to extreme stressor in which specific constellation of symptoms is encountered, i.e., daze, withdrawal or agitation. A mixed and changing pattern is seen and the symptoms abate after 3 days.

Table 1: ICD 10 and DSM IV TR conceptualization of adjustment disorder

ICD-10 (F43.2)	DSM-IV TR (309)
Onset of symptoms within 1 month of stressor	Onset of symptoms within 3 months of stressor
Presence of a stressor to be clearly established	These symptoms or behaviors are clinically significant as evidenced by either
Symptoms of any of affective disorders, disorders in F4-and conduct disorders	Marked distress that is in excess of what would be expected from exposure to the stressor
Should not fulfill criteria of an individual disorder	Significant impairment in social or occupational (academic) functioning
The symptoms <6 months, except prolonged depressive reaction	Should not fulfill criteria of an individual disorder
	Not merely an exacerbation of a preexisting Axis I or Axis II disorder
Symptoms persisting beyond 6 months warrant change in diagnosis	The symptoms do not represent bereavement
Bereavement reactions should not be included	Once the stressor has terminated, the symptoms do not persist >6 months
Grief reactions of any duration considered to be abnormal or intense and last >6 months	Marked distress that is in excess of what would be expected by significant impairment in social or occupational functioning
Stress can be coded in Z codes	
Some degree of disability in the performance of daily routines and usually interfering with social functioning and performance	

ICD – International classification of diseases; DSM – Diagnostic and statistical manual

Table 2: Subtypes of adjustment disorder

ICD-10	DSM-IV
Brief depressive reaction (F43.20)	With depressed mood (309.0)
Prolonged depressive reaction (F43.21)	With anxiety (309.24)
Mixed anxiety and depressive reaction (F43.22)	With mixed anxiety and depressed mood (309.28)
With predominant disturbance of other emotions (F43.23)	With disturbance of conduct (309.3)
With predominant disturbance of conduct (F43.24)	With mixed disturbance of emotion and conduct (309.4)
With mixed disturbance of emotions and conduct (F43.25)	Unspecified (309.9)
With other specified predominant symptoms (F43.28)	

ICD – International classification of diseases; DSM – Diagnostic and statistical manual

Table 3: Differential diagnosis of adjustment disorder

Major depressive disorder
Personality disorder
Mixed anxiety depression
Acute stress reaction
Post traumatic stress disorder
Bereavement
Normal nonpathological reaction to stress

PTSD occurs as a consequence of extreme stressor and has characteristic symptoms of re-experiencing like flashbacks and nightmares, associated with autonomic arousal and avoidance of stimuli.[4]

VALIDITY AND RELIABILITY

Studies have also been conducted to establish validity of the diagnosis. In the outpatient setting, the adjustment disorder group was seen to be much closer to depressive disorder than to those with no diagnosis in the form of association with substance use and the presence of stressor.[4] Differences from depression were observed with respect to the nature of stressor and the duration of treatment. A study of medical inpatients found that patients with adjustment disorders were older, widowed, living alone, had less severe symptoms and rapid improvement compared to those with major depression.[5] As per the findings of a recent study,[6] patients with adjustment disorders had higher mental quality-of-life scores than patients with major depressive disorder but lower than patients without mental disorder. The self-perceived stress was higher in adjustment disorders when compared with those with anxiety disorders and those without mental disorder. The 10-year readmission rate of adjustment disorder was less than that for those with depressive disorder.[7] In a crisis intervention unit with 5-year follow-up, 17% developed a chronic course of primarily depressive symptoms.[8] Those with adjustment disorder had shorter duration of hospitalizations, more presented suicidality, fewer psychiatric readmissions, and rehospitalization days 2 years after discharge.[9] Thus attempts have been made to validate adjustment disorders as a separate entity.

Reliability studies of adjustment disorder have been found to be lower than some other psychiatric disorders. Inter-rater agreement for adjustment disorder was not found to be significant in a survey of psychiatrists and psychologists using 27 child and adolescent case histories. The results of the UK-WHO study of reliability of the ICD-9 categories were also consistent with such a finding. The inter-rater reliability for adjustment disorder was 0.23, which was lower than that for many other categories.[2]

CRITIQUE OF CURRENT DIAGNOSTIC CRITERIA

The criteria of adjustment disorders have been subjected to several questions, shadowing concern over the diagnosis *per se* and the process of making this diagnosis.

The first criterion of adjustment disorder is temporal relationship to a stressor. The psychological symptoms are etiologically related to the stressor. The etiological concept is similar to organic mental disorder which is at a variance with the atheoretical approach of ICD 10 and DSM IV TR, which are based on phenomenological observations. Also, what constitutes a 'stressor' is not clearly defined, and quantifiable and qualifiable criteria of this stressor are lacing.[1] Moreover, the presence of stressor is not restricted to adjustment disorder. Despland *et al*.[4] found that 100% patients of adjustment disorder had recent life events, while 83% of those with major depression also had associated recent life events. There was recommendation for extension in time period, to allow for delayed onset AD, but this is uncommon even in PTSD.

The second criterion is clinically significant symptoms (in excess what would be expected). The concept of normalcy is vague. What constitutes a normal response varies greatly across culture and social groups. Seeking treatment should not be a proxy measure of severity of illness to decide about the clinical diagnosis. Considering socially inevitable human adjustment problems as pathological may lead to medicalization of problems of living.[10]

The next criterion for diagnosing adjustment disorder is exclusion of other psychiatric disorders. A study comparing adjustment disorder and depressive episode failed to identify distinguishing symptom profiles and differences on any specific variable.[11] The disorder lacks a specific symptom profile as its own, and at times is used as a waste basket diagnosis.

The adjustment disorder diagnosis excludes bereavement reaction. Special consideration has been given to bereavement reaction, but not to other stressors which may have equally distressing impact, for example, being diagnosed with a terminal illness. It also does not cater to a prolonged or complicated grief where the symptoms may emerge later, last longer or have severe symptoms. The category of complicated grief disorder has been proposed as a separate entity.[12]

ICD-10 lacks a criterion of "clinical significance," though some disability in performing daily routine is mentioned. Hence the threshold of making the diagnosis may widely vary from center to center and person to person. Also, the symptoms should arise within 1 month of stressor for a diagnosis of adjustment disorder. Some life events take a longer period of organizational change, and emotional reactions may be delayed. Which time period is appropriate and adequate to make a diagnosis is not clear.

Due to the abovementioned issues and inadequacy of criteria, the research on adjustment disorder is fairly limited. This disorder is also not included in widely

used psychiatric diagnostic instruments like Mini International Neuropsychiatric Interview (MINI) and Composite International Diagnostic Interview (CIDI). In Schedule for Clinical Assessment for Neuropsychiatry (SCAN), there is a provision for coding of adjustment disorder but no guidelines on application have been provided. Limited research has been reflected in lack of treatment guidelines.[13]

EPIDEMIOLOGY

Large population based data about adjustment disorders have been sparse. Methodologically rigorous large epidemiological surveys like those of Epidemiological Catchment Area, National Co-morbidity Survey, and National Psychiatric Morbidity Survey do not evaluate adjustment disorder. However, some effort has been made to assess the prevalence of adjustment disorder. The Outcome of Depression International Network (ODIN) project shows adjustment disorder in less than 1% of population.[14] A recent study[15] in the general population found the prevalence of adjustment disorder to be 0.9%, when the criterion of clinically significant impairment was considered. A further 1.4% of the sample was diagnosed with adjustment disorder without fulfilling the impairment criterion.

Adjustment disorders are commonly seen in primary care settings in which the 1-year prevalence varies from 11% to 18% of those with any clinical psychiatric disorder.[16,17] A recent cross-sectional survey of 3815 patients from 77 primary healthcare centers found the prevalence of adjustment disorders to be 2.94%.[6] A study of patients admitted through the psychiatric emergency showed that 7.1% of the adults and 34.4% of the adolescents had adjustment disorders at time of admission, though the diagnosis in some patients changed during rehospitalization.[9] A study from Belgium by Bruffaerts *et al*.[18] found adjustment disorder in 17.1% of patients presenting to psychiatric emergency setting. Among patients admitted to a public sector psychiatric inpatient unit during a 6-month period, adjustment disorder was diagnosed in 9% of patients (third most common diagnosis after psychotic illness in 62% and mood disorders in 24%).[19]

Adjustment disorders have also been widely studied in consultation liaison practice. A multisite study in consultation psychiatry services of seven teaching hospitals in the United States, Canada, and Australia examined 1039 consecutive referrals.[20] A diagnosis of adjustment disorder was made in 12.0% of psychiatric consultations, being the sole diagnosis in 7.8% and comorbid with other Axis I and II diagnoses in 4.2%. In further 10.6% patients, it was also considered as a rule-out diagnosis. Among the subtypes, adjustment disorder with depressed mood was the most frequent. AD was diagnosed in 15%, 7%, and 7% of those with personality disorder, organic mental disorder, and psychoactive substance abuse disorder respectively. Two older studies on the general hospital population found the prevalence rate of adjustment disorder with depressed mood to be 13.77% in inpatients, and 11.5% of psychiatric referrals.[5,21] Adjustment disorder was found to be the most common diagnosis (7.1%) among 127 postsurgery breast cancer patients.[22] Another study from Japan shows the prevalence of adjustment disorder to be 35% in case of recurrence on breast cancer.[23] In the acutely ill medical inpatient unit, adjustment disorder was found to be the most common axis-1 disorder (13.7%) followed by anxiety disorder (5.8%), alcohol abuse (5.4%), and major depressive disorder (5.1%) according to DSM-IV diagnostic criteria.[24] A recent large meta-analysis shows the prevalence of adjustment disorder to be 15.4% in adults with cancer in oncological, hematological, and palliative-care settings.[25]

The course and outcome have also been studied for adjustment disorders. After 5-year follow-up of 100 patients, 71% adults and 44% adolescents with adjustment disorder were well. The adult group developed major depressive disorder and alcohol abuse while adolescents developed a wider range psychiatric disorder like schizophrenia, bipolar disorder, antisocial personality disorder, drug abuse, and major depressive disorder. The predictors of poor outcome were chronicity and behavioral disturbances.[26] The risk of suicide in adjustment disorder was found to be 4%, mostly along with presence of alcohol abuse. The interval between suicidal communication and act was less than 1 month in adjustment disorder, which was lesser compared with other disorders (depression 3 months, bipolar disorder 30 months, and schizophrenia 47 months).[27] One recent study on psychological autopsy of suicide found that 15% had adjustment disorder.[28]

Future recommendations

The DSM V work group on adjustment disorders proposes some revisions to the diagnostic criteria.[29] The disorder requires symptoms starting within 3 months in response to identifiable stressor (longer duration of onset for bereavement). The external context and cultural factors also need to be assessed additionally while evaluating the severity and impact of stressor. Additional specifiers have suggested that include those with features of acute stress disorder or posttraumatic stress disorder, and those related to bereavement. For the bereavement subtype, symptoms may arise within 12 months for adults and 6 months for children after the death of a close relative or friend. The severity criterion in view of the shift toward dimensionality

in DSM V is still to be finalized as of writing of this text. The work group also proposes persistent complex bereavement disorder for further study in Section III, which encompasses conditions that require further research.

It has been suggested to remove the subordination of adjustment disorder to other psychiatric diagnosis. Though stressors may trigger any other specific axis 1 disorder, adjustment disorder diagnosis to be made when there is a clear temporal relationship to the stressor and a spontaneous recovery is anticipated when stressor is removed. It has been suggested that the bereavement exclusion should be extended to other events when stressor is severe.[12] A system of symptom weighting and paying more attention to the cognitive proximity between the stressor, the symptoms and mood reactivity can be considered to reduce diagnostic ambiguities. A combined dimensional and categorical approach to classification may help to identify the longitudinal course of adjustment disorder.[30]

Some authors have proposed other subtypes and variants of adjustment disorder. Post-traumatic embitterment symptoms has been suggested to consist of mixture of despair, dysphoria, aggression, accusation, feeling of injustice, disturbed sleep and appetite, and intrusive memory. These symptoms are precipitated after an exceptional negative life event. The main emotional response is embitterment and feeling of injustice. Emotional modulation is unimpaired and the duration is more than 3 months.[31,32] Another entity, psychosomatic characterization is accompanied with demoralization, irritable mood, health anxiety, and denial. This may offer more specific clinical indication.[33]

CONCLUSION

Adjustment disorder is a common psychiatric disorder, but has received limited attention in research settings. Many pitfalls in diagnostic criteria need to be addressed, though the concept has fair utility in the clinical setting. In both psychiatric and general medical setting, the diagnosis of adjustment disorder is a useful clinical construct, especially when patients are faced with considerable physical and psychological stresses. Further systematic research about this disorder may help in strengthening evidence base and enabling better clinical decisions.

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