02 - 11.2 Adjustment Disorders

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Panagioti M, Gooding PA, Tarrier N. Hopelessness, defeat, and entrapment in posttraumatic stress disorder: Their association with suicidal behavior and severity of depression. J Nerv Ment Dis. 2012;200:676. Ponniah K, Hollon SD. Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: A review. Depress Anxiety. 2009;26:1086. Sones HM, Thorp SR, Raskind M. Prevention of posttraumatic stress disorder. Psychiatr Clin North Am. 2011;34:79. Zantvoord JB, Diehle J, Lindauer RJ. Using neurobiological measures to predict and assess treatment outcome of psychotherapy in posttraumatic stress disorder: Systematic review. Psychother Psychosom. 2013;82(3):142–151. 11.2 Adjustment Disorders The diagnostic category of adjustment disorders is widely used among clinicians in practice. Adjustment disorders are characterized by an emotional response to a stressful event. It is one of the few diagnostic entities in which an external stressful event is linked to the development of symptoms. Typically, the stressor involves financial issues, a medical illness, or relationship problem. The symptom complex that develops may involve anxious or depressive affect or may present with a disturbance of conduct. By definition, the symptoms must begin within 3 months of the stressor. A variety of subtypes of adjustment disorder are identified in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). These include adjustment disorder with depressed mood, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct, features of acute stress disorder or posttraumatic stress disorder (PTSD), bereavement, and unspecified type. EPIDEMIOLOGY The prevalence of the disorder is estimated to be from 2 to 8 percent of the general population. Women are diagnosed with the disorder twice as often as men, and single women are generally overly represented as most at risk. In children and adolescents, boys and girls are equally diagnosed with adjustment disorders. The disorders can occur at any age but are most frequently diagnosed in adolescents. Among adolescents of either sex, common precipitating stresses are school problems, parental rejection and divorce, and substance abuse. Among adults, common precipitating stresses are marital problems, divorce, moving to a new environment, and financial problems. Adjustment disorders are one of the most common psychiatric diagnoses for disorders of patients hospitalized for medical and surgical problems. In one study, 5 percent of persons admitted to a hospital over a 3-year period were classified as having an adjustment disorder. Up to 50 percent of persons with specific medical problems or stressors have been diagnosed with adjustment disorders. Furthermore, 10 to 30 percent of mental health outpatients and up to 50 percent of general hospital inpatients referred for mental health

consultations have been diagnosed with adjustment disorders. ETIOLOGY

By definition, an adjustment disorder is precipitated by one or more stressors. The severity of the stressor or stressors does not always predict the severity of the disorder; the stressor severity is a complex function of degree, quantity, duration, reversibility, environment, and personal context. For example, the loss of a parent is different for a child 10 years of age than for a person 40 years of age. Personality organization and cultural or group norms and values also contribute to the disproportionate responses to stressors. Stressors may be single, such as a divorce or the loss of a job, or multiple, such as the death of a person important to a patient, which coincides with the patient's own physical illness and loss of a job. Stressors may be recurrent, such as seasonal business difficulties, or continuous, such as chronic illness or poverty. A discordant intrafamilial relationship can produce an adjustment disorder that affects the entire family system, or the disorder may be limited to a patient who was perhaps the victim of a crime or who has a physical illness. Sometimes, adjustment disorders occur in a group or community setting, and the stressors affect several persons, as in a natural disaster or in racial, social, or religious persecution. Specific developmental stages, such as beginning school, leaving home, getting married, becoming a parent, failing to achieve occupational goals, having the last child leave home, and retiring, are often associated with adjustment disorders. Psychodynamic Factors Pivotal to understanding adjustment disorders is an understanding of three factors: the nature of the stressor, the conscious and unconscious meanings of the stressor, and the patient's preexisting vulnerability. A concurrent personality disorder or organic impairment may make a person vulnerable to adjustment disorders. Vulnerability is also associated with the loss of a parent during infancy or being reared in a dysfunctional family. Actual or perceived support from key relationships can affect behavioral and emotional responses to stressors. Several psychoanalytic researchers have pointed out that the same stress can produce a range of responses in various persons. Throughout his life, Sigmund Freud remained interested in why the stresses of ordinary life produce illness in some and not in others, why an illness takes a particular form, and why some experiences and not others predispose a person to psychopathology. He gave considerable weight to constitutional factors and viewed them as interacting with a person's life experiences to produce fixation. Psychoanalytic research has emphasized the role of the mother and the rearing environment in a person's later capacity to respond to stress. Particularly important was Donald Winnicott's concept of the good-enough mother, a person who adapts to the infant's needs and provides sufficient support to enable the growing child to tolerate the frustrations in life. Clinicians must undertake a detailed exploration of a patient's experience of the stressor. Certain patients commonly place all the blame on a particular event when a

less obvious event may have had more significant psychological meaning for the patient. Current events may reawaken past traumas or disappointments from childhood, so patients should be encouraged to think about how the current situation relates to similar past events. Throughout early development, each child develops a unique set of defense mechanisms to deal with stressful events. Because of greater amounts of trauma or greater constitutional vulnerability, some children have less mature defensive constellations than other children. This disadvantage may cause them as adults to react with substantially impaired functioning when they are faced with a loss, a divorce, or a financial setback; those who have developed mature defense mechanisms are less vulnerable and bounce back more quickly from the stressor. Resilience is also crucially determined by the nature of children's early relationships with their parents. Studies of trauma repeatedly

indicate that supportive, nurturing relationships prevent traumatic incidents from causing permanent psychological damage. Psychodynamic clinicians must consider the relation between a stressor and the human developmental life cycle. When adolescents leave home for college, for example, they are at high developmental risk for reacting with a temporary symptomatic picture. Similarly, if the young person who leaves home is the last child in the family, the parents may be particularly vulnerable to a reaction of adjustment disorder. Moreover, middle-aged persons who are confronting their own mortality may be especially sensitive to the effects of loss or death. Family and Genetic Factors Some studies suggest that certain persons appear to be at increased risk both for the occurrence of these adverse life events and for the development of pathology once they occur. Findings from a study of more than 2,000 twin pairs indicate that life events and stressors are modestly correlated in twin pairs, with monozygotic twins showing greater concordance than dizygotic twins. Family environmental and genetic factors each accounted for approximately 20 percent of the variance in that study. Another twin study that examined genetic contributions to the development of PTSD symptoms (not necessarily at the level of full disorder and, therefore, relevant to adjustment disorders) also concluded that the likelihood of developing symptoms in response to traumatic life events is partially under genetic control. DIAGNOSIS AND CLINICAL FEATURES Although by definition adjustment disorders follow a stressor, the symptoms do not necessarily begin immediately. Up to 3 months may elapse between a stressor and the development of symptoms. Symptoms do not always subside as soon as the stressor ceases; if the stressor continues, the disorder may be chronic. The disorder can occur at any age, and its symptoms vary considerably, with depressive, anxious, and mixed features most common in adults. Physical symptoms, which are most common in children and the elderly, can occur in any age group. Manifestations may also include

assaultive behavior and reckless driving, excessive drinking, defaulting on legal responsibilities, withdrawal, vegetative signs, insomnia, and suicidal behavior. The clinical presentations of adjustment disorder can vary widely. DSM-5 lists six adjustment disorders, including an unspecified category (Table 11.2-1). Table 11.2-1 DSM-5 Diagnostic Criteria for Adjustment Disorders Adjustment Disorder with Depressed Mood In adjustment disorder with depressed mood, the predominant manifestations are depressed mood, tearfulness, and hopelessness. This type must be distinguished from major depressive disorder and uncomplicated bereavement. Adolescents with this type of adjustment disorder are at increased risk for major depressive disorder in young

adulthood. Adjustment Disorder with Anxiety Symptoms of anxiety, such as palpitations, jitteriness, and agitation, are present in adjustment disorder with anxiety, which must be differentiated from anxiety disorders. Adjustment Disorder with Mixed Anxiety and Depressed Mood In adjustment disorder with mixed anxiety and depressed mood, patients exhibit features of both anxiety and depression that do not meet the criteria for an already established anxiety disorder or depressive disorder. A 48-year-old married woman, in good health, with no previous psychiatric difficulties, presented to the emergency room reporting that she had overdosed on a handful of antihistamines shortly before she arrived. She described her problems as having started 2 months earlier, soon after her husband unexpectedly requested a divorce. She felt betrayed after having devoted much of her 20-year marriage to being a wife, mother, and homemaker. She was sad and tearful at times, and she occasionally had difficulty sleeping. Otherwise, she had no vegetative symptoms and enjoyed time with family and friends. She felt desperate and suicidal after she realized that “he no longer loved me.” After crisis intervention in the emergency setting, she responded well to

individual psychotherapy over a 3-month period. She occasionally required benzodiazepines for anxiety during the period of treatment. By the time of discharge, she had returned to her baseline function. She came to terms with the possibility of life after divorce and was exploring her best options under the circumstances. (Courtesy of Jeffrey W. Katzman, M.D., and Cynthia M. A. Geppert, M.D., Ph.D., M.P.H.) Adjustment Disorder with Disturbance of Conduct In adjustment disorder with disturbance of conduct, the predominant manifestation involves conduct in which the rights of others are violated or age-appropriate societal norms and rules are disregarded. Examples of behavior in this category are truancy, vandalism, reckless driving, and fighting. The category must be differentiated from conduct disorder and antisocial personality disorder. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct A combination of disturbances of emotions and of conduct sometimes occurs. Clinicians are encouraged to try to make one or the other diagnosis in the interest of clarity. Adjustment Disorder Unspecified

Adjustment disorder unspecified is a residual category for atypical maladaptive reactions to stress. Examples include inappropriate responses to the diagnosis of physical illness, such as massive denial, severe noncompliance with treatment, and social withdrawal, without significant depressed or anxious mood. DIFFERENTIAL DIAGNOSIS Although uncomplicated bereavement often produces temporarily impaired social and occupational functioning, the person’s dysfunction remains within the expectable bounds of a reaction to the loss of a loved one and, thus, is not considered adjustment disorder. See Section 34.1 for a further discussion of bereavement. Other disorders from which adjustment disorder must be differentiated include major depressive disorder, brief psychotic disorder, generalized anxiety disorder, somatic symptom disorder, substance-related disorder, conduct disorder, and PTSD. These diagnoses should be given precedence in all cases that meet their criteria, even in the presence of a stressor or group of stressors that served as a precipitant. Patients with an adjustment disorder are impaired in social or occupational functioning and show symptoms beyond the normal and expectable reaction to the stressor. Because no absolute criteria help to distinguish an adjustment disorder from another condition, clinical judgment is necessary. Some patients may meet the criteria for both an adjustment disorder and a personality disorder. If the adjustment disorder follows a physical illness, the clinician must make sure that the symptoms are not a continuation or another manifestation of the illness or its treatment. Acute and Posttraumatic Stress Disorders The presence of a stressor is a requirement in the diagnosis of adjustment disorder, PTSD, and acute stress disorder. PTSD and acute stress disorder have the nature of the stressor better characterized and are accompanied by a defined constellation of affective and autonomic symptoms. In contrast, the stressor in adjustment disorder can be of any severity, with a wide range of possible symptoms. When the response to an extreme stressor does not meet the acute stress or posttraumatic disorder threshold, the adjustment disorder diagnosis would be appropriate. PTSD is discussed fully in Section 11.1. COURSE AND PROGNOSIS With appropriate treatment, the overall prognosis of an adjustment disorder is generally favorable. Most patients return to their previous level of functioning within 3 months. Some persons (particularly adolescents) who receive a diagnosis of an adjustment disorder later have mood disorders or substance-related disorders. Adolescents usually require a longer time to recover than adults. Research over the past 5 years has disclosed a risk for suicide, especially in adolescent patients with adjustment disorder, not previously fully appreciated. A recent study of

119 patients with adjustment disorder indicated that 60 percent had documented suicide attempts in the hospital. Fifty percent had attempted suicide immediately prior to their hospital admission.

Comorbid diagnoses of substance abuse and personality disorder contributed to the suicide risk profile. A study of the background, pathology, and treatment-related factors of suicidal adolescents found that those with adjustment disorder and suicidality were more likely to have made attempts (up to 25 percent), to exhibit psychomotor restlessness and dysphoric mood, to have experienced a suicide of another person as a stressor, to have poor psychosocial functioning upon treatment entry, and to have received prior psychiatric care. A 16-year-old high school senior experienced rejection in his first serious relationship. In the weeks after the end of the relationship, he began to exhibit dysphoric mood accompanied by anxiety and psychomotor agitation. He had received counseling in junior high school when his parents divorced and he began using alcohol and marijuana and had been suspended during his freshman year for fighting. A month after the breakup, he began to tell his parents that life was no longer worth living without his former girlfriend. Two months later his parents came home from work and found him hanging in the garage with a note stating he could not go on alone. (Courtesy of J. W. Katzman, M.D., and C. M. A. Geppert, M.D., Ph.D., M.P.H.) TREATMENT Psychotherapy Psychotherapy remains the treatment of choice for adjustment disorders. Group therapy can be particularly useful for patients who have had similar stresses—for example, a group of retired persons or patients having renal dialysis. Individual psychotherapy offers the opportunity to explore the meaning of the stressor to the patient so that earlier traumas can be worked through. After successful therapy, patients sometimes emerge from an adjustment disorder stronger than in the premorbid period, although no pathology was evident during that period. Because a stressor can be clearly delineated in adjustment disorders, it is often believed that psychotherapy is not indicated and that the disorder will remit spontaneously. This viewpoint, however, ignores the fact that many persons exposed to the same stressor experience different symptoms, and in adjustment disorders, the response is pathological. Psychotherapy can help persons adapt to stressors that are not reversible or time limited and can serve as a preventive intervention if the stressor does remit. Psychiatrists treating adjustment disorders must be particularly aware of problems of secondary gain. The illness role may be rewarding to some normally healthy persons who have had little experience with illness’s capacity to free them from responsibility. Thus, patients can find therapists’ attention, empathy, and understanding, which are necessary for success, rewarding in their own right, and therapists may thereby

reinforce patients’ symptoms. Such considerations must be weighed before intensive psychotherapy is begun; when a secondary gain has already been established, therapy is difficult. Patients with an adjustment disorder that includes a conduct disturbance may have difficulties with the law, authorities, or school. Psychiatrists should not attempt to rescue such patients from the consequences of their actions. Too often, such kindness only reinforces socially unacceptable means of tension reduction and hinders the acquisition of insight and subsequent emotional growth. In these cases, family therapy can help. Crisis Intervention Crisis intervention and case management are short-term treatments aimed at helping persons with adjustment disorders resolve their situations quickly by supportive techniques, suggestion, reassurance, environmental modification, and even hospitalization, if necessary. The frequency and length of visits for crisis support vary according to patients’ needs; daily sessions may be necessary, sometimes two or three times each day. Flexibility is essential in this approach. Pharmacotherapy No studies have assessed the efficacy of pharmacological interventions in individuals with adjustment disorder, but it may be reasonable to use medication to treat specific symptoms for a brief time. The judicious use of medications can help patients with adjustment disorders, but they should be prescribed for

brief periods. Depending on the type of adjustment disorder, a patient may respond to an antianxiety agent or to an antidepressant. Patients with severe anxiety bordering on panic can benefit from anxiolytics such as diazepam (Valium), and those in withdrawn or inhibited states may be helped by a short course of psychostimulant medication. Antipsychotic drugs may be used if there are signs of decompensation or impending psychosis. Selective serotonin reuptake inhibitors have been found useful in treating symptoms of traumatic grief. Recently, there has been an increase in antidepressant use to augment psychotherapy in patients with adjustment disorders. Pharmacological intervention in this population is most often used, however, to augment psychosocial strategies rather than serving as the primary modality. REFERENCES Busch AB, Yoon F, Barry CL, Azzone V, Normand SL, Goldman HH, Huskamp HA. The effects of mental health parity on spending and utilization for bipolar, major depression, and adjustment disorders. Am J Psychiatry. 2013;170(2):180–187. Chen PF, Chen CS, Chen CC, Lung FW. Alexithymia as a screening index for male conscripts with adjustment disorder. Psychiatr Q. 2011;82:139. Daniels J. The perils of “adjustment disorder” as a diagnostic category. J Humanistic Counsel. 2009;48:77. Giltaij H, Sterkenburg P, Schuengel C. Psychiatric diagnostic screening of social maladaptive behaviour in children with mild intellectual disability: Differentiating disordered attachment and pervasive developmental disorder behaviour. J Intellect Disabil Res. 2013.

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