Understanding Adjustment Disorder

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Learning Objectives

- The evolution of AD up to DSM-5 and ICD-11
- Controversies that continue in AD
- Diagnosing AD in research and clinical practice
- Treatments for AD

Why is it important?

- May be conflated with other diagnoses
- False claims of epidemics
- False premise regarding service development
- May lead to inappropriate treatment
- Labelled as “depressed”
- Impact on self-image
- Cost

Usage

- Global sample of 500 psychiatrists
- 7th most common diagnosis
- Ranked higher by psychologists (Reed et al 2013)

History

- DSM 1 1952 – transient situational personality disorder
- DSM 11 – acute situational disturbance
- DSM 111 1980 – adjustment disorder
- ICD-10 1994 – adjustment disorder
- Little change until 2015 when AD moved to stress/trauma category
- In ICD -11 (2022) specific criteria

Definition – DSM-5

- In response to a stressful event,
- Onset of symptoms is within 3 months of exposure to the stressor,
- Symptoms are distressing and in excess of what would be expected by exposure to the stressor or
- Significant impairment in social or occupational functioning,
- Symptoms are not due to another axis 1 disorder or bereavement,
- Once the stressor or its consequences is removed, the symptoms resolve within 6 months

DSM contd

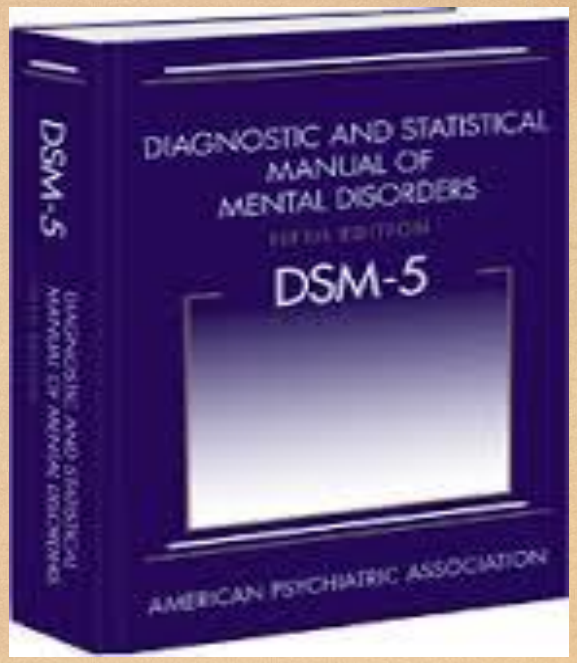
Acute – less than 6 months

Chronic – longer than 6 months

Six subtypes based on the predominant symptom pattern

- with depressed mood
- with anxiety
- with mixed depression and anxiety
- with disturbance of conduct
- with mixed disturbance of emotions and conduct
- and unspecified.

Move into trauma and stress related disorders



ICD-11 Proposal

Included in category of stress related disorders

Not full syndrome status

Characterised by:

- intrusive preoccupations
- inability to adapt
- emerging within 1 month of stressor
- resolving within 6 months (usually)
- Symptoms and dysfunction

Comparisons – ICD-11 and DSM-5

Differences

Function impairment in ICD-11

Differences in time specifier for onset

No subtypes in ICD-11

Similarities

Require stressful or traumatic event

Subthreshold status

Both in trauma and stress related group

Self-resolving

Conceptualisation of AD

Aetiology

Longitudinal

In these it differs from all other disorders

Problems with how AD are conceptualised and defined

- Sub-threshold – if criteria for another condition met then AD diagnosis trumped (low threshold) ie mild
- Differences from normal adaptive reactions unclear
- Differences from other axis 1 disorders unclear especially major depression or anxiety

Adjustment disorder or adaptive adjustment?

- Is functional impairment present?
- Expectability?
- Clinical significance criterion
- Does the symptom pattern and trajectory over time suggest that the person is adapting to the stressor?
- Has a similar reaction occurred in the past?
- Does this person exhibit resilience?

Overlap with other diagnoses

AD diagnosed clinically 31.8% and MDD in 19.5% of those in the Emergency Department. Changed to 7.8% and 36.4% respectively when SCID was used (Taggart et al 2006)

Cohen's kappa comparing clinical with SCAN diagnosis was 0.232 ($p<0.001$). Fair to poor level of concordance. The sensitivity and specificity of SCAN were 91.8% and 57.2% respectively (Doherty et al 2014).

Measuring AD

Adjustment disorder, new module (ADNM)

Self-rated questionnaire 29 or 20 statements (Ensile 2010).

Standardised Diagnostic Interview module for ICD-11 adjustment disorder (Perkonigg et al 2020)

Measuring AD contd.

Diagnostic Interview for Adjustment Disorder (DIAD)

29 questions that identify the stressful event (Cornelius et al 2014)

International Adjustment Disorder Questionnaire (IADQ)

11 items self-rating (Shevlin et al 2020)

Other schedules

Included in SCAN and in SCID based on DSM concept

Not included in CIDI, DIS or CID

The Gold Standard

Expert clinical evaluation remains the Gold Standard for assessing AD (Strain and Casey 2015)

Prevalence

Not measured in:

- the ECA (DIS) (Myers et al 1984)
- the National Co-morbidity Survey (CIDI) (Kesler et al 1994)
- the National Psychiatric Morbidity Survey (CIS) (Jenkins et al 1997)

Prevalence contd.

- ODIN – 1% of those with depressive disorder (Ayuso-Mateos et al 2001)
- 2.8% in GP consulter population (Fernandez et al 2012). Poor recognition
- Elderly people 2.3% of total population (Maercker et al 2008)
- Intake assessments 36% clinically diagnosed ,11% using SCID (Shear et al 2000) .
- AD diagnosed in 9% of consecutive admissions (Koran et al 2003).
- AD diagnosed in 18.8% of study population in Switzerland and 10.2" in Israel (Levin et al 2021)
- AD diagnosed in 15.9% of general population in UK in response to Covid Pandemic (Benezra 2021)

Prevalence in C-L Psychiatry

- 12% referrals (Strain et al 1998)
- Similar to figure from the European Consultation Liaison Workgroup (ECLW) study (AD primary diagnosis in over 12, 000 referrals to these services from 56 centres in 11 European countries) (Huyse et al 2001)
- Obstetric/gynaecology CL, AD vs mood disorder 41.8% vs 29%(Rigattelli 2002)
- AD in 15.4% of subjects in comparison to a pooled prevalence of 14.3% for DSM defined MDD (Mitchell et al 2011)

Changing diagnostic Culture

Frequency of AD diagnosis changing

- Major depression increasing from 6.4% to 14.7% in the period 1988 to 1997 while AD fell from 29.8% to 13.5% in the same period (Diefenbacher and Strain 2002).
- Change in the prevalence of these disorders as a change in the "culture of diagnosis" (Strain and Diefenbacher 2008)

Making the Diagnosis

- Context of stressor and culture

- **Avoid "rote-driven essentially rule-of-thumb approach to the diagnosis and treatment of patients" (McHugh PR and Slavney PR. New England Journal of Medicine. 2012. 366, 20.**

Diagnosis in Clinical practice

- Close proximity in time to onset of symptoms
- Cognitive proximity
- Relief on removal of person or of symptoms
- Absence of typical vegetative symptoms

Why AD and MDD are conflated

- Symptom overlap
- One is cross-sectional diagnosis, other is longitudinal (different parameters)
- MDD criteria doesn't take account of context
- "Tic box" approach

Evidence of treatment benefits

Difficult to assess because:

Self limiting

Few studies of pharmacological treatments for AD

Most in AD with anxiety

For psychological treatments, no placebo controls

Differential Diagnosis

- Normal adaptive reaction
- MDD / DE or in evolution
- GAD or in evolution
- PTSD
- Alcohol misuse
- Personality disorder – caution

Interventions- pharmacological

Lacking evidence for benefits of antidepressants because not studied adequately

(Casey, Kelly et al Cochrane Systematic Review Protocol 2020)

Pharmacological Treatments

Nguyen et al 2006	**Etifoxine vs Lorazepam**	**191 out-patients attending GP's**
Ansseau et al 1996	**Tianeptine vs alprazolam vs mianserin**	**152 patients**
Razavi et al 1999	**Trazadone vs clorazepate**	**18 cancer patients**
Hameed et al 2005	**Antidepressants in MD vs AD**	**96 primary care**
De Leo 1989	**Viloxazine vs placebo vs lormetazepam vs S-adenosylmethionine psychotherapy**	**85 out-patients**
Stein 2015	**Etifoxine vs alprazolam**	**202 GP patients AD**

Yet

Antidepressants most commonly prescribed medications in US

Proportion receiving them increased from 5.84% in 1996 to 10.12% in 2005.

An increase from 13 million to 27 million persons.

Those with AD showed the biggest increase from a rate of 22.26/100 to 39.37/100 annually (Olfson et al Arch Gen Psychiatry. 2009. 66,8. 848-56

Interventions - psychological

Best evidence for brief interventions but evidence limited except in DSH ? due to AD

No specific intervention may be necessary for most except general supportive measures

Treatments - psychological

Brief interventions
Cognitive approaches
Limited evidence base
AD specific treatments being developed

Van der Klink et al (2003) Work-related stress

Gonzales-Jaimes et al (2003) Post-myocardial infarction

Akechi et al (2004). Cancer patients

Summary of recent developments in AD

- Move to stress and trauma disorder group in DSM-5
- Symptom criteria in ICD-11
- Gap between 2 diagnostic systems
- Poor concordance between clinical and research interview diagnosis
- Screening schedules available
- Very limited evidence of pharmacotherapy

Thank You