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**Adjustment disorders with depressed mood: A critique of its DSM-IV and ICD-10
conceptualization and recommendations for the future**

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Abstract

Background: The volume of research involving adjustment disorders (AD) is limited. The scientific neglect of AD seems to result from the inadequate operationalisation of AD in DSM-IV and ICD-10. The aim of the present proposal is to discuss the shortcomings of AD and to present recommendations for the future. **Sampling and Methods:** This conceptual paper is based on an iterative process of debate between the authors. **Results:** The current operational definition of AD is characterised by three main limitations: a) the inadequately defined clinical significance criterion, b) the relegation of AD behind other diagnoses and c) the missed recognition of the importance of contextual factors such that normal human adaptive processes might be pathologised. Furthermore, subtypes of AD lack operational clarity. Based on a discussion of the limitations, recommendations for DSM-V are presented including the addition of new subtypes. **Conclusions:** The revision of AD criteria will reduce the likelihood of false positive and false negative diagnoses. These changes will enable the scientific exploration of this common and relevant disorder and will make epidemiological studies, and ultimately service planning based on these, more reliable than at present.

Keywords: adjustment disorders; depression; critique; classification; DSM-V

Adjustment disorders with depressed mood: A critique of its DSM-IV and ICD-10 conceptualization and recommendations for the future

There has long been a recognition that individuals at times react to stressful events with symptoms and behaviours that are excessive. These symptoms might include emotions and behaviours such as low mood, tearfulness, anxiety, self harm, withdrawal or irritability.

However, they often spontaneously resolve over time without any specific intervention.

Adjustment disorder (AD) is the term that is used to describe such conditions. This concept was included in DSM-I [1] as transient situational personality disorder and evolved to transient situational disturbance in DSM-II [2]. In DSM-III [3] the latter was replaced by AD and this taxonomy has continued in DSM-IV [4] and DSM-IV TR [5]. The World Health Organisation suit by incorporating AD into ICD-9 [6] and it continues to be a recognised category in ICD-10 [7]. Our paper aims to delineate shortfalls in the current conceptualization of AD by focusing on its most prominent subtype: AD with depressed mood. Other subtypes of AD [8] are only briefly touched upon.

Before the inclusion of AD there existed a diagnostic category that was especially beloved in some psychiatric traditions (e.g. Germany, Austria) but muddied the waters and was source of confusion for many clinicians in other traditions (e.g. UK, USA). Reactive depression was a depressive condition that also had a trigger and perusing the older textbooks [9] it is clear that this descriptive label caused considerable uncertainty for clinicians not least because of doubts about the value of antidepressants in this condition, a view recently reinforced by others [10].

Over time there was a move to become atheoretical as regards aetiology while basing the diagnostic criteria on psychopathology only. So both DSM and ICD moved to merge the aetiologically constructed “reactive” and “endogenous” depressions, into a single, criterion based dimension called major depression in DSM and depressive episode in ICD. DSM is more specific in the criteria laid down and according to the preamble it should be calibrated “to the

lowest level of inference”. Yet in a self-contradictory move the classifications retained the aetiological requirement for AD.

The importance of AD

The removal of reactive depression and its replacement with AD reflects the clinical reality that many individuals exhibit abnormal emotional responses to stressful events that mimic depressive illness due to their symptoms, severity and/or duration yet may not require a specific treatment, especially those of a pharmacological nature, as they spontaneously resolve on removal of the stressor or as adjustment develops over time although short-term symptomatic treatment may necessitate pharmacotherapy, on occasion. More usually, less invasive interventions such as monitoring, psycho-education and empowerment programs or stepped care models may be more appropriate for those patients [11;12]. The utility of the concept has been recognised for over 50 years, in the specific diagnosis of AD and also in the now defunct category known as “reactive depression”. Moreover the category of AD is of particular clinical relevance and arguably is central to the complex debate on the respective merits of antidepressant or psychological treatments for “depression” [10].

In spite of its conceptual and clinical utility critics have not been deterred and have described AD as a “wastebasket diagnosis” and as a “cryptic form of disease entity” [13]. Proponents have answered by pointing to its predictive validity and have demonstrated that it is a stable diagnosis seldom transmuting into any other category [14].

Conceptually AD lies in the hinterland between normal stress responses on the one hand and illness on the other. The question is now, not if this is a valid or clinically useful category, but whether the current criteria as constituted in DSM and ICD achieve the differentiation from normal reactions to stressful events on the one hand and from other axis 1 disorders on the other?

- Table 1 near here -

This paper is an attempt to critique the current diagnostic criteria for AD with depressed mood and based on our iterative discussion to make recommendations for the DSM-V criteria.

Critique of DSM criteria

Criterion A – temporal relationship to a stressor

AD's are defined by DSM-IV as comprising emotional or behavioural symptoms occurring within 3 months of exposure to an identifiable stressor. The close proximity in time is necessary to ensure that the condition is in fact a reaction to a stressor and a time period of three months seems reasonable based on the limited information available on the temporal relationship between events and symptom onset. Some have recommended an extension in the time period to allow for delayed onset AD [15] but as this is very uncommon even in PTSD, a condition in which arguably the stressors are much more severe, an extension would in our opinion increase the likelihood of false positive diagnoses due to erroneous aetiological associations being made between symptoms and distal events.

Concerning the type of events, there is little to assist the clinician in distinguishing AD from major depression. While 100% of those with a diagnosis of AD have recent life events, 83% of those with major depression also experience such events [16], with more related to marital problems and fewer to occupational or family stressors in the AD as compared to the major depression group. Such differences while statistically significant are unlikely to be clinically meaningful in an individual patient so specification of the type of events would be inappropriate.

With regard to the second element of this criterion, there is no definition of what constitutes a stressor and it is presumed that this is whatever the person says it is. Usually it means an event that is external to the person and the range could span those that are generally perceived to be mild, such as having a row with a boyfriend, through to a life threatening illness being diagnosed and the vagueness in this regard might be subject to question. However, applying a rigid definition might lead to the counter-criticism that some very vulnerable people, who have pathological reactions to events generally regarded as mild, would fail to be diagnosed with AD even when significant symptoms and functional impairment were present. A simple linear model between stressor and depressive symptom response is too simplistic since individuals vary in their reaction to events due to modifiers such as individual vulnerability, expectations, personality and genetic liability to depression [17-19]. Hence, the development of symptoms in response to a stressor can be regarded as the interaction of stressors and personal, environmental and biological factors. We therefore believe that no operational definition of what a stressor is should be provided. Thus, the only requirement relating to the stressful event is that it must be regarded as causing the emotional or behavioural symptoms. This distinguishes the stressors of an adjustment disorder from psycho-social and environmental stressors such as classifiable on axis 4 of the DSM-IV or within the ICD-10-Z classification, which may provoke or aggravate a disorder but not cause the disorder.

Criterion B - The clinical significance criterion

Having established that the dysfunctional reaction is closely related in time to an event, the second requirement is that the symptoms are clinically significant. This criterion is an attempt to delineate the border between normal stress reactions and AD. However, it can validly be criticised as being vague and tautological [20] simply being that what doctors decide is clinically significant. This criterion has been broken into two components; distress in excess of

what would normally be expected (criterion B1) or significant impairment in social or occupational functioning (criterion B2).

With regard to the first of these (criterion B1), distress in excess of what would be expected poses some problems since what is normally expected varies hugely. For example, some cultures are naturally more emotionally expressive than others and some social groups are more likely to consult with symptoms than are others, so the mere fact of visiting a doctor should not necessarily be deemed to be a proxy measure of severity. There are individuals who are more emotional than others and there are some for whom a particular event, such as having losing a job, has devastating consequences, factors that might be expected to produce responses that are in excess of what would normally be expected. For these reasons, if the excessive reaction were simply a statistical requirement then a high proportion of those experiencing normal stress reactions might be classified as disordered, running the risk of pathologizing normal human adaptive processes [21;22;23]. So the presence alone of a greater number or severity of symptoms does not necessarily imply disorder since this depends on the social and cultural context in which the symptoms occur.

But what of the internal context? It has been suggested that individual meanings, values and temperament might also make the person's reaction to a stressor greater without being disordered [24]. While we agree that cultural and other external factors provide an important backdrop against which the severity of the response should be evaluated, we believe that individual factors such as temperament and personality are not since it is precisely these inherent attributes that make for vulnerability and trigger such excessive reactions. Hence we believe that individual personality factors should not be weighted in evaluating context but that culture and stressor severity should.

The alternative criterion of significant impairment (criterion B2) in social or occupational function as it stands poses problems also. Responses to stress are often associated with impairment in functioning both in themselves and secondary to symptoms. For example a

serious illness in a child might be associated with a re-evaluation of life's goals and purpose so that prior hobbies seem irrelevant and are not pursued while poor concentration associated with worry might impair one's ability to function at work. So of itself functional impairment is not necessarily indicative of disorder although of course it might be. This line of reasoning suggests that function should be removed as a criterion. But what of the opposite consideration – is it possible to have a disorder yet exhibit no functional impairment?

While it may be possible in some mild disorders to conceal impairment, it is unlikely that all areas of functioning will be spared. For example, while some might continue to work either through tenacity or of necessity, it is unlikely that all roles e.g. social, interpersonal or academic would be unimpaired. So we believe that functional impairment should be retained as one of the criteria for AD since it is this which other people notice, and leads to treatment-seeking behaviour.

We propose to include a requirement that both criteria i.e. distress and dysfunction rather than either on its own are present, so as to reduce the risk of normal reactions being recorded as pathological.

Criterion C - The disturbance must not meet the criteria for another axis 1 disorder

The second border dispute concerns the distinction between AD and other axis 1 disorders, most commonly major depression. To what extent do the symptom criteria, as presently detailed in DSM-IV, separate those with AD from major depression? Studies comparing one with the other have failed to identify distinguishing symptom profiles in those being rehabilitated following physical illness [25] or in those with depressive disorders in the general population [26,27]. The latter also failed to identify differences in social supports or personality disorder. Some have described differences in symptom severity and in the nature and severity of stressors as well as more rapid improvement in those with AD as compared to major depression [16]. However no

study has identified specific distinguishing symptoms and the current criteria do not mention any specific symptoms apart from the current sub-categorisation of AD (see below) based on presumptive symptoms. Thus the symptom criteria as presently constituted do not assist in differentiating AD with depression from major depression. And the most likely explanation for this is that the diagnosis of AD is a longitudinal one, based both on aetiology (a causal stressor) and longitudinal course (resolution over time or when the stressor or its effects are removed) while the diagnosis of depressive illness is based on symptom duration, severity and number. Another reason for the failure to identify distinguishing symptoms may be that research is focused on depressive symptoms as defined in DSM-IV and these are too non-specific to allow such distinctions to be made. For example, based on our clinical experience, affect modulation as a characteristic of depressed mood seems to be typically impaired in non-reactive depressive disorders but not in adjustment disorders notwithstanding the fact that both are associated with depressed mood. Typically, the mood state of those with AD depends more on the cognitive presence of the stressor so that immediate impairment of mood is observed when the stressor is mentioned, while followed by a more pronounced mood recovery when the patient is distracted as compared to those with major depression. Moreover, the presence of diurnal mood change or a decrease in mood reactivity might increase the likelihood that this was a depressive episode rather than an AD [28]. Hence, a system of weighting, in which some symptoms assume greater diagnostic importance than others, may become a possible way forward to allow for the differentiation between AD and major depression.

The salience given to other diagnoses over AD is arguably the most important problem in the current AD criteria and results in the conflation of AD with major depression, since a patient with five or more depressive symptoms owing to an identifiable stressor will get a major depression diagnosis regardless of the context in which symptoms have developed. Yet the 5 symptom diagnostic window is easily crossed. Consider a man with a family who loses his job and as the sole earner has to continue to finance the running of the household and the mortgage.

Such a person might easily describe sleep and appetite disturbance, poor concentration secondary to worry, low mood and withdrawal from social contacts due to embarrassment.

Taking the context in which the symptoms developed into consideration it is likely that when he finds a new job his symptoms will improve spontaneously. Yet adopting the symptom checklist approach of DSM-IV he will be diagnosed with major depression and probably prescribed antidepressants even though conceptually his symptoms would be best classified as an adjustment disorder.

Evidence that this criterion brings about the conflation of AD with major depression, and consequently to over-diagnosis of the latter, comes from a recent study of those presenting to accident departments with self-harm [29]. It demonstrated that a clinical diagnosis of AD was made in 31.8% and major depression in 19.5% while using SCID the proportions were 7.8% and 36.4% respectively. There is an obvious gap between the diagnostic process in clinical practice, which takes account of symptoms, context, and duration and is dynamic compared to diagnosis using standardized methods which restricts the process and rigidly applies the specified criteria in “cook book” fashion. Nowhere is this more obvious than with AD.

Further supportive evidence that this criterion results in major depression being over diagnosed either at the expense of AD or of non-pathological stress responses comes from a study that re-analysed the ECA and NCS data taking account of the clinical significance imperative [30]. It scaled downwards the prevalence of all disorders, by 17% in the ECA and 32% in the NCS. The authors speculated that the high prevalence of disorder, coupled with the low rate of service use in those studies, might not so much indicate unmet need as the absence of the need for treatment. Ultimately inflated prevalence estimates lead to mistrust of mental health planning based on such studies.

So simply separating AD from major depression on the basis of symptom numbers alone is insufficient. This view is supported by calls for a return to the older classification based on endogeneity and reactivity [31], based on studies showing that patients with reactive depressive

disorders are more likely than patients with endogenous symptoms to improve with various types of psychotherapy [10]. This echoes the view of others [32] that the range of therapies beneficial in treating major depression is so diverse, spanning counselling, assisted bibliotherapy, cognitive therapy, placebo and antidepressants, that it strongly suggests major depression is so diverse as to be meaningless and that a return to a more nuanced approach should follow.

For these reasons i.e. the failure to distinguish AD from major depression, the over diagnosis of major depression at the expense of AD and the heterogeneity of major depression as currently constituted, we suggest the removal of criterion C. This implies a nosological redefinition of AD and major depression based on distinct inclusion and exclusion criteria for each, rather than one subsuming the other.

Criterion D - The bereavement exclusion

Symptom severity: The current AD criteria state that the symptoms do not represent bereavement and the criteria for major depression also have bereavement exclusion. We believe that the exclusion of normal reactions such as bereavement while including those that are pathological is the essence of AD. But by specifying bereavement there is a danger that dysfunctional bereavement reactions will also be excluded when in some instance they might best be included as AD's. For example a person who was excessively emotionally dependent on their spouse will reach the criteria for major depression easily and their reaction might appropriately be construed as an AD.

Duration: Inherent in bereavement is the recognition that the person is “permitted” to have significant symptoms for a longer period than following other events without being classified as disordered. Yet, depending on other environmental factors, it might take a person who is also

physically ill longer to adapt to an adverse event than if he/she was in full health. So, the context in which the event occurs, be it bereavement or otherwise, is important both in relation to symptom severity and duration.

We believe the criteria for this section should change to reflect this complexity and that this should extend the bereavement exclusion to other events also. This would continue to recognise the special place of bereavement in the wider emotional world as ordinarily being non-disordered but would also prevent other reactions that are currently misclassified as pathological from being so categorised e.g. the response to a diagnosis of serious illness.

Similar changes have been urged in relation to the major depression criteria [21] so that too the bereavement exclusion should extend to other events in recognition of the importance of context. For example, reactions triggered by loss of employment, serious physical illness, broken relationships may sometimes lie within the boundaries of an uncomplicated reaction if the context is serious even when the 5 symptom threshold has been reached. We support extending the bereavement exclusion to these other events in the major depression criteria in recognition of context and the narrow diagnostic window between a reaction that is considered of no real consequence for patients' health and one that justifies the diagnosis of major depression. This would have the effect of reducing false positives for major depression, some of which would move into the AD category while others would continue to constitute normal reactions, which are not in need for treatment.

When considering the revision of the bereavement criterion however, one should keep in mind that the aforementioned reflections may be redundant if complicated grief will be classified separately. Recently, the new diagnostic concept of a complicated grief disorder has been intensively studied. It showed that a noteworthy minority of bereaved individuals experience persistent distressing and disabling symptoms of grief [33-37]. Research on this condition indicates that major loss can cause a substantial amount of psychiatric morbidity. Explicit proposals to include a Complicated Grief Disorder into DSM-V are on the way [38].

Other AD subtypes

Six subtypes of AD have been described based on the prominent emotional/behavioural symptoms (table 1). Although these have not been fully operationally defined, attempts have been made in the DSM-IV-TR to outline a few associated symptom patterns more fully. However, subtypes other than those currently listed in DSM-IV and ICD-10 should also be considered for inclusion. Maercker and colleagues [8] proposed an AD subtype that resembles subsyndromal posttraumatic stress disorder (PTSD). Here, the stressor is of lesser magnitude than those seen in PTSD yet leads to PTSD like symptoms (avoidance, intrusion symptoms and failure to adapt). This might incorporate the AD anxiety subtype, often diagnosed following a diagnosis of major medical illnesses, financial losses or other unpredictable life events [8;39]. Others [40] have suggested that post-traumatic embitterment disorder (PTED) should be included as AD subtype, characterized by its predominant emotional mixture of despair, anger and accusations. These orphaned groups could find a home as subgroups within the AD category.

The grouping of AD into acute (< 6 months) and chronic (\geq 6 months) is in keeping with clinical experience and evidence [16] and should not be changed.

Inadequate ICD criteria

If there are problems with the DSM criteria for AD, then they are even more pronounced with the ICD criteria. As shown in table 1, the ICD-10 criteria can all be grouped according to the DSM-IV-TR criteria, while there remain DSM criteria which are not mentioned within the ICD-10. Thus, the critique of DSM criteria is also applicable to AD defined by ICD-10.

The main differences between DSM and ICD are a more restrictive time period during which symptoms must develop in response to a stressor (3 vs. 1 month), the missed incorporation of an explicated clinical significance criterion and the bereavement criterion which is not mentioned in the ICD-10. As aforementioned, a close proximity in time is necessary to ensure that the condition is in fact a reaction to a stressor. There is hardly any evidence which time period is appropriate for AD. However, since some life events such as work relocation entail a long period of organizational change following the event, emotional reactions may be time-delayed. Since these delayed reactions are “in response to a stressor”, a time period of 3 months seems to be more appropriate. But further differences such as the failure to include a criterion of clinical significance leads to an even vaguer concept of AD in ICD-10 as compared to DSM-IV-TR.

The impact of inadequate criteria

Does it matter that AD criteria are inadequate? One of the resulting problems is that the volume of research involving AD is limited. A search of Medline reveals only 108 titles comprising the term “adjustment disorder(s)” up to June 2008. The discrepancy between practice and research raises the issue of why research activity does not focus on this diagnostic group especially as they are said to be very common, particularly in general medical settings [41]. Most of the research tools used in epidemiological research such as the Composite International Diagnostic Interview (CIDI [42]) do not include AD presumably because they are restricted to use by lay interviewers. The Schedule for Clinical Assessment in Neuropsychiatry (SCAN [43]) includes AD in the section 13 dealing with inferences and attributions yet provides no guidelines on its application. With the exception of the ODIN study [44], none of the major international community based epidemiological studies, such as the NCS-(R) [45;46], the British National Household Survey [47] or the German GHS-MHS [48] have included AD [49]. Thus in the research community, it is no surprise that research into AD is sparse. This results in a unique

situation in which a very frequent disorder with a high economic impact is not accompanied by any treatment guidelines.

- Table 2 near here -

Recommendations for DSM-V

It is our belief that the neglect of AD stems from the inadequate operationalisation of AD in DSM-IV and ICD-10 and also from its relegation behind other diagnoses, particularly major depression. On the basis of the current difficulties with a diagnosis that has clinical relevance yet is imprecisely conceptualised and under-researched, we recommend major changes to the DSM-V (and ICD-11) criteria for AD in an attempt to improve the status of AD with depressed mood (table 2).

Criterion A

No changes are recommended to this criterion

- *The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).*

Criterion B

The definition of “clinical significance” should be changed so as to reduce the proportion of those experiencing normal reactions that are misclassified as having disorders. Thus both the distress and functioning wording should be modified and the emphasis placed on the context in which the symptoms have developed.

- *These symptoms or behaviours are clinically significant as evidenced by **both** of the following:*

- *Marked distress that is in excess of what would be proportionate to the stressor taking account of the external context and the cultural factors that might influence symptom severity and presentation.*

AND

- *Significant impairment in social or occupational (academic) functioning.*

Criterion C

Remove the subordination of AD to other diagnoses such as major depression. This also implies a revision of the criteria for the corresponding specific disorders:

- *Stressors may also trigger adverse reactions that symptomatically resemble major depression, anxiety or conduct disorders but are better classified as AD, particularly when there is a close temporal relationship between the event and the onset of symptoms and spontaneous recovery is anticipated after a period of adaptation or when the stressor is removed.*

Additionally symptoms should be identified which are likely to distinguish AD from depressive episode. As mentioned above the presence of diurnal mood change or changes in mood reactivity seem to contribute to a better differentiation between depression with external as compared to endogenous causes [28]. However there is insufficient research on the discriminative power of these or other symptoms to propose criteria based on them at this point.

Criterion D

The bereavement exclusion should be extended to other events.

- *The diagnosis does not include normal bereavement.*

- *Other events may also require a longer period for adaptation to occur, similar to bereavement, and yet not be classified as pathological. This is most likely if the stressor is uncommon or severe.*

Criterion E

No changes are recommended to this criterion

- *Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months*

This criterion for AD is important in distinguishing AD from other disorders. An AD diagnosis requires the presence of a stressor or the consequences of a stressor and if this is not present the symptoms should not be labeled as AD.

Other Subtypes

The subtypes should continue to be split with attempts made to define the symptoms present in each.

The following subtypes are worthy of further investigation

- *With PTSD like symptoms (not meeting the PTSD stressor and/or symptom criterion)*
- *With (posttraumatic) embitterment symptoms*

Conclusion

The current criteria for AD require significant refining for inclusion in DSM-V and ICD-11. Some will have implications for the criteria for major depression. The result will reduce the false positive and false negative diagnoses. These changes will enable the scientific exploration of this common and relevant disorder and will make epidemiological studies, and ultimately service planning based on these, more reliable than at present.

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Table 1: DSM-IV and ICD-10 criteria for adjustment disorders

Diagnostic criteria for adjustment disorders	
DSM IV	Corresponding ICD 10 Criteria (ICD-10 numbering)
<p>A. Emotional/behavioral symptoms in response to identifiable stressor(s)</p> <p>Occurring within 3 months</p>	<p>Symptoms in response to an identifiable stressor (A)</p> <p>Symptoms can vary in severity and form (B)</p> <p>Occurring within 1 month (A)</p>
<p>B. Clinically significant as evidenced by either of the following:</p> <p>(1) distress is in excess of what would be expected from exposure to the stressor</p> <p>(2) significant impairment in social or occupational (academic) functioning</p>	Not mentioned
<p>C. Disturbance</p> <p>- does not meet the criteria for another Axis I disorder and is not merely an exacerbation of preexisting Axis I /Axis II disorders</p>	The criteria for another specific disorder are not fulfilled (B)
<p>D. The symptoms do not represent bereavement</p>	Not mentioned
<p>E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months (ICD-10 Criterion C)</p>	
<p>Subtypes:</p> <p>Acute: < 6 months</p> <p>Chronic: ≥ 6 months</p> <p>309.0 With depressed mood</p> <p>309.24 With anxiety</p> <p>309.28 With mixed anxiety and depressed mood</p> <p>309.3 With disturbance of conduct</p> <p>309.4 With mixed disturbance of emotions and conduct</p> <p>309.9 unspecified</p>	<p>Subtypes:</p> <p>F 43.20 Brief depressive reaction: < 1 month</p> <p>F 43.21 Prolonged depressive reaction: < 2 years</p> <p>F43.22 Mixed anxiety and depressive reaction</p> <p>F 43.23 Predominant disturbance of other emotions</p> <p>F43.24 Predominant disturbance of conduct</p> <p>F43.25 Mixed disturbance of emotions and conduct</p> <p>F43.28 With other specified predominant symptoms</p>

Table 2: Recommendations for DSM-V

Diagnostic criteria for adjustment disorders	
DSM IV	Recommendations for DSM V
A. - Emotional/behavioral symptoms in response to identifiable stressor(s) - Occurring within 3 months	
B. Clinically significant as evidenced by either of the following: (1) distress is in excess of what would be expected from exposure to the stressor (2) significant impairment in social or occupational (academic) functioning	Clinically significant as evidenced by both of the following: (1) Marked distress is in excess of what would be proportionate to the stressor (2) significant impairment in social or occupational (academic) functioning
C. Disturbance - does not meet the criteria for another Axis I disorder and is not merely an exacerbation of preexisting Axis I /Axis II disorders	<i>Note: To be removed</i>
D. The symptoms do not represent bereavement	The symptoms do not represent bereavement or normal sadness due to similar types of loss
E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months	
Subtypes: Acute: < 6 months Chronic: ≥ 6 months 309.0 With depressed mood 309.24 With anxiety 309.28 With mixed anxiety and depressed mood 309.3 With disturbance of conduct 309.4 With mixed disturbance of emotions and conduct 309.9 unspecified	Additionally to be proved for inclusion: • With PTSD like symptoms • With (posttraumatic) embitterment symptoms