



<b>Title</b>	Adjustment disorder: implications for ICD-11 and DSM-5
<b>Authors(s)</b>	Casey, Patricia R., Doherty, Anne
<b>Publication date</b>	2012
<b>Publication information</b>	Casey, Patricia R., and Anne Doherty. "Adjustment Disorder: Implications for ICD-11 and DSM-5." Royal College of Psychiatrists, 2012. <a href="https://doi.org/10.1192/bjp.bp.112.110494">https://doi.org/10.1192/bjp.bp.112.110494</a> .
<b>Publisher</b>	Royal College of Psychiatrists
<b>Item record/more information</b>	<a href="http://hdl.handle.net/10197/5823">http://hdl.handle.net/10197/5823</a>
<b>Publisher's statement</b>	This is an author-produced electronic version of an article accepted for publication in the British Journal of Psychiatry. The definitive publisher-authenticated version is available online at <a href="http://bjp.rcpsych.org">http://bjp.rcpsych.org</a>
<b>Publisher's version (DOI)</b>	<a href="https://doi.org/10.1192/bjp.bp.112.110494">10.1192/bjp.bp.112.110494</a>

Downloaded 2026-05-02 00:27:27

The UCD community has made this article openly available. Please share how this access benefits you. Your story matters! (@ucd\_oa)



© Some rights reserved. For more information

## **Adjustment disorder: implications for ICD-11 and DSM-V**

Patricia Casey FRCPI, FRCPsych., MD  
Professor of Psychiatry,  
University College Dublin,  
Mater Misericordiae University Hospital,  
Eccles St,  
Dublin 7,  
Ireland.

Anne Doherty MBBCh, Med.S. MRCPsych.  
Senior Registrar in Liaison Psychiatry  
St. James Hospital,  
James St,  
Dublin 8,  
Ireland.

Declaration of Interest

None for PC or AD

Correspondence: Professor Patricia Casey, Mater Misericordiae University Hospital, Eccles St, Dublin 7, Ireland. Email: [apsych@mater.ie](mailto:apsych@mater.ie)

## **Summary**

Adjustment disorder (AD) has been a recognised disorder for decades but has been the subject of little epidemiological research. Now researchers have identified the prevalence of adjustment disorder in primary care, and found general practitioner recognition as very low but with a high rate of antidepressant prescribing. Possible reasons for the seemingly low prevalence, recognition rate and inappropriate management include its recognition as a residual category in diagnostic instruments and poor delineation from other disorders or from normal stress responses. These problems could be rectified in ICD-11 and DSM-V if changes according to full syndromal status, among others, were made. This would have an impact on future research.

## **Adjustment disorder: implications for ICD-11 and DSM-V**

The paper by Fernandez et al<sup>i</sup> is the first to specifically examine the prevalence of adjustment disorder (AD) in primary care. While a few other studies have included AD in primary care studies, this was not been their main focus. The historical lack of research interest is surprising since AD has been a recognised diagnosis in the International Classification of Diseases 9<sup>th</sup> edition (ICD 9)<sup>ii</sup> since 1978 and in the Diagnostic and Statistical Manual 11<sup>th</sup> edition (DSM 111)<sup>iii</sup> in 1980. Prior to that it was called transient situational disturbance. That this study found a prevalence of 2.94% is surprising since DSM says it is a common diagnosis. There are possible explanations for the discrepancy between expectations and the results of epidemiological studies that need to be considered before AD is dismissed as irrelevant due to its low prevalence.

### **The problem with the criteria**

Firstly AD is poorly delineated in both DSM-IV and ICD-10. The boundary between AD and normal adaptive stress is not addressed although the requirement that dysfunction must be present in the ICD descriptor is a tacit attempt to deal with this. The differentiation from other psychiatric disorders such as major depression and generalised anxiety is a further problem since the criteria are under-developed and rudimentary. Apart from specifying that AD requires a stressor and that the symptoms resolve within 6 months of termination of the stressor or its consequences, no assistance is offered with regard to the nature or configuration of the symptoms. Instead ICD-10<sup>iv</sup> and DSM-IV (TR)<sup>v</sup> state that the diagnosis cannot be made when the symptom threshold for another condition is reached. And in the case of major depression in DSM that threshold is reached after two weeks of certain symptoms, generally recognised as being a low threshold.

One of the consequences of the inadequate criteria of AD is that some of the structured diagnostic interviews have failed to include AD and those that have, such as SCID<sup>vi</sup> only diagnose only after other diagnoses have been excluded. In light of these considerations the low prevalence of AD found in the Fernandez et al study is not surprising since a structured diagnostic interview (SCID) was used, that derives from the principles of ICD-10 and DSM-IV which classify AD as a residual category. A similar problem also arose in the ODIN study which also found an unexpectedly low prevalence of AD ranging from 1 to 1.9% in the general population<sup>vii</sup>.

With regard to its seemingly low prevalence, some studies have found a discrepancy between AD when diagnosed clinically as compared to using a structured interview. Clinical diagnosis has identifies a higher prevalence for AD, which, when structured interviews are used is replaced by major depression. For instance among new psychiatric outpatients AD was diagnosed in 36% of those seen, but this dropped to just over 11% using SCID<sup>viii</sup> while among a population assessed following self-harm a clinical diagnosis of AD was made in

31.8% and major depression in 19.5% but using SCID the proportions were changed to 7.8% and 36.4% respectively <sup>ix</sup>.

This raises the questions as to the utility of the current crop of structured interviews in evaluating AD. While these are generally seen as the gold standard in psychiatric research, they are based simply on cross-sectional assessment of symptom numbers and their minimum duration while AD is a longitudinal diagnosis based on aetiology and outcome. So the construct of AD is not captured within the framework of the context-free, cross sectional approach of the current classifications and their associated diagnostic schedules. This is one issue that can only be addressed when due prominence is given to AD in the revisions to DSM and ICD that takes account of aetiology and course and new interview schedules are developed.

### **What are the research implications?**

Does it matter that AD is regarded as a subsyndrome, that it appears to be uncommon in epidemiological studies and that it is under researched? One of the consequences of regarding AD as a subclinical category is that it is viewed as mild in comparison to other full-blown conditions and less worthy of research than other disorders. While Fernandez and colleagues found that in terms of severity it lay between major depression and no psychiatric disorder, other studies have pointed to AD as a much more serious condition, particularly in respect of suicidal behaviour. One psychological autopsy study it was the most common diagnosis <sup>x</sup> while among those presenting to emergency departments following self-harm it was the most common psychiatric diagnosis <sup>ix</sup>.

One of the consequences of the lack of attention to AD in mental health research is that the condition is under recognised and may be mistaken for major depression <sup>xi</sup> and treated accordingly. As noted by others, AD is being eclipsed by major depression over time <sup>xii</sup> and the authors observe that this is not necessarily because of changes in its prevalence but due to a changed culture of diagnosis consequent upon a change in the “culture of prescribing” due to the wide availability of antidepressants.

The study by Fernandez provides evidence for both of these propositions. The authors point to the low recognition rate by general practitioners with only 2 of 110 cases identified by the general practitioner. In addition 45% of those diagnosed with AD by structured interview were prescribed an antidepressant. Furthermore, data on prescribing from the US <sup>xiii</sup> shows that antidepressants are the most commonly prescribed medications and their use in the general population has nearly doubled over a 10 year period from 5.84% in 1996 to 10.12% in 2005. This represents an increase from 13 million to 27 million persons. Their use in those with AD showed the biggest increase from a rate of 22.26/100 to 39.37/100 annually. Worryingly, the use of antidepressants in treating AD is not founded on any strong evidence and while there have been a few randomised trials, none are double blind and most of the focus has been on herbal remedies. The use of brief psychological therapies is the recommended treatment but studies are also limited in number and quality. Furthermore there is a possibility that no specific treatment is required since these are by definition self-limiting

conditions and one study comparing antidepressants, placebo, supportive psychotherapy and benzodiazepines found that all were associated with significant improvement<sup>xiv</sup>. Clearly, mistakenly offering services for a condition that may not require them has significant service planning and financial implications and warrants further study.

### **DSM-V and ICD-11**

The problems outlined above, such the low level of research interest in ADs, their conflation with other diagnoses, their inappropriate treatment and the inadequacy of the measurement of AD in the current diagnostic interview schedules could to be resolved in ICD-11 and DSM-V if a change to the current status of AD was initiated. This would involve a number of alterations to the criteria for AD. These have been detailed elsewhere<sup>xv</sup> but foremost among these is changing the status of AD from a residual category to a according it full syndromal status. A system of symptom weightings and directing more attention to the cognitive proximity between the stressor, the symptoms and mood reactivity should be considered. Regarding AD as a failure of adaptation is another avenue that has also been suggested<sup>xvi</sup>. A more difficult task will be deciding on diagnostic criteria that recognise the favourable longitudinal course that is generally the hallmark of AD. This may require a combined dimensional and categorical approach to classification, as suggested for other categories<sup>xvii</sup>.

A further challenge will be delineating AD from normal stress responses and this should take into consideration the impact of symptoms on functioning, based on the nature of the stressor, the personal and interpersonal context in which it has occurred and cultural norms with regard to such responses. Ultimately, the upgrading of AD into a full syndrome will entail the development of diagnostic criteria which will be incorporated into pre-existing structured interviews such as SCAN and SCID, allowing comparisons along the borders of AD while utilising specialised statistical tools to examine the latent structure of the construct.

At this point there is some information on the proposed changes to AD in DSM-V including its inclusion in a genre of stress related disorder<sup>xviii</sup> which would lead to harmonisation with ICD-11. The addition of a subtype of PTSD that does not meet all the criteria for this condition is also appropriate clinically. However, there would appear to be no plans to upgrade its subclinical status and without this the criteria will, most likely, continue to be poorly delineated. A recent editorial “Mental Illness – Comprehensive Evaluation or Checklist?”<sup>xix</sup> highlighted what its authors described as a “rote- driven essentially rule-of-thumb approach to the diagnosis and treatment of patients” that the tick-box approach of DSM fosters. Nowhere is this more apparent than in the approach to the classification and relegation of AD behind other disorders crossing a symptom threshold. This must be rectified so that the common condition is accorded appropriate recognition in the revised classifications. Thereafter a renewed interest in AD and its management will follow and ultimately inform service planning and treatment decisions, correcting the deficiencies noted by Fernandez and colleagues<sup>i</sup>.

---

<sup>i</sup> Fernandez A, Mendive JM, Salvador-Carulla L et al Adjustment disorders in primary care: prevalence, recognition and use of services. *British Journal of Psychiatry*. 2012. In press.

- 
- <sup>ii</sup> World Health Organisation. The ICD-9 classification of mental and behavioural disorders: Clinical description and diagnostic guidelines (ICD-10). 1978. Geneva, WHO.
- <sup>iii</sup> American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (3rd. edition). 1980. Washington DC:APA
- <sup>iv</sup> World Health Organisation. The ICD-10 classification of mental and behavioural disorders: Clinical description and diagnostic guidelines (ICD-10). 1992. Geneva, WHO.
- <sup>v</sup> American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (4th. Edition text revision). 2000. Washington DC:APA
- <sup>vi</sup> First MB, Spitzer RL, Williams JW et al Structured Clinical Interview for DSM-IV (SCID 1). 1995. New York Biometric Research Department, New York State Psychiatric Institute, USA.
- <sup>vii</sup> Ayuso-Mateos JL, Vazquez-Barquero JL, Dowrick C. et al Depressive disorders in Europe: prevalence figures from the ODIN study. *British Journal of Psychiatry*. 2001. **179**. 308-16.
- <sup>viii</sup> Shear KM, Greeno C, Kang J et al Diagnosis of non-psychotic patients in community clinics. *American Journal of Psychiatry*. 2000. **157**. 581-7.
- <sup>ix</sup> Taggart C, O'Grady J, Stevenson M et al. Accuracy of diagnosis and routine psychiatric assessment in patients presenting to an accident and emergency department. *General Hospital Psychiatry*. 2006. **8**, 330-5.
- <sup>x</sup> Manoranjitham SD, Rajkumar AP, Thangadurai P et al Risk factors for suicide in rural south India. *British Journal of Psychiatry*. 2010. **196**. 26-30.
- <sup>xi</sup> Casey P, Maracy M, Kelly BD et al. Can adjustment disorder and depressive disorder be distinguished? Results from ODIN. *Journal of Affective Disorders*. 2006. **92**: 291-7.
- <sup>xii</sup> Strain, J and Diefenbacher A. The adjustments disorders: the conundrums of the diagnoses. *Comprehensive Psychiatry*. 2008. **49**. 121-30.
- <sup>xiii</sup> Olfson M and Marcus SC. National patterns in antidepressant medication treatment. *Archives General Psychiatry*. 2009. **66,8**. 848-56.
- <sup>xiv</sup> de Leo, D. Treatment of adjustment disorders: a comparative evaluation. *Psychological Reports*. 1989. **64**, 51-4.
- <sup>xv</sup> Baumeister H, Maercker A and Casey P. Adjustment disorders with depressed mood: A critique of its DSM-IV and ICD-10 conceptualization and recommendations for the future. *Psychopathology*. 2009. **42**. 139-47.
- <sup>xvi</sup> Maercker A, Forstmeier S, Pielmaier L et al Adjustment disorders: prevalence in a representative nationwide survey in Germany. *Social Psychiatry and Psychiatric Epidemiology*. 2012. DOI 10.1007/s00127-012-0493-x
- <sup>xvii</sup> Slade T and Andrews G. Latent structure of depression in a community sample: a taxometric analysis. *Psychological Medicine*. 2005. **35**. 489-97.
- <sup>xviii</sup> Strain JJ and Freidman MS. Considering adjustment disorders as stress response syndromes. *Depression and Anxiety*. 2011. **28**. 818-23.
- <sup>xix</sup> McHugh PR and Slavney PR. Mental illness – Comprehensive evaluation or checklist? *New England Journal of Medicine*. 2012. **366**, 20. 1853-55.