



Title	Adjustment disorder considered
Authors(s)	Casey, Patricia R., Jabbar, Faraz
Publication date	2013
Publication information	Casey, Patricia R., and Faraz Jabbar. "Adjustment Disorder Considered." The Royal College of Psychiatrists, 2013. https://doi.org/10.1192/apt.bp.111.010058 .
Publisher	The Royal College of Psychiatrists
Item record/more information	http://hdl.handle.net/10197/5736
Publisher's statement	This is an author-produced electronic version of an article accepted for publication in Advances in Psychiatric Treatment. The definitive publisher-authenticated version is available online at http://apt.rcpsych.org/content/19/2/99.short
Publisher's version (DOI)	10.1192/apt.bp.111.010058

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Adjustment Disorder Considered

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Declaration of Interest

None for PC or FJ

Summary

Adjustment disorders have been included in the psychiatric classifications for over 40 years but have received little attention from the research community. They are particularly common in consultation liaison psychiatry. Evaluation is problematic since they may be mistaken for major depression, generalised anxiety or alternatively for non-pathological reactions to stress. Their measurement by structured interview is problematic since they are not included in many instruments and, in others, cannot be diagnosed once the threshold for another disorder is reached. There are few evidence based treatments and it is possible that these transient reactions may not require any formal intervention. They generally carry an excellent prognosis but in some individuals they are associated with self-harm and suicide.

Adjustment Disorder Considered

Adjustment disorder (AD) is not a new diagnostic category. It was incorporated into DSM-111 in 1980 into ICD-9 in 1978 (World Health Organisation 1978), having been called transient situational disturbance in earlier editions. It represents a maladaptive but temporary reaction to life stressors. There are no detailed diagnostic criteria in either DSM-IV TR (American Psychiatric Association 2000) or ICD-10 (WHO 1992) but the main clinical features are summarised in Box 1.

Box 1 Features of adjustment disorder in ICD-10 and DSM-IV

- the presence of a stressor is essential to making the diagnosis
- the onset of symptoms must proceed the stressor
- the symptoms begin within 1 month (ICD-10) or 3 months (DSM-IV) of the stressor
- the symptoms resolve within 6 months of the termination of the stressor
- symptoms may be prolonged beyond this if there are continuing consequences resulting from the stressor
- the diagnosis cannot be made in the presence of another mental state diagnosis
- the subtypes refer to the predominant symptoms (with depression, with anxiety, with disturbance of conduct, mixed types and other)
- neither system of classification specifies diagnostic criteria in terms of symptom severity or numbers, apart from general principles, thus deviating from the approach used for other diagnoses

The condition may be acute or chronic

AD differs from other diagnoses in which life events are common, such as depressive episode in that the event is not essential to making a diagnosis while it is a pre-requisite in AD. Apart from PTSD and substance use disorders, AD is the only other diagnosis based on aetiology in the current classifications. In ICD-10, AD is classified under the category termed “neurotic, stress-related and somatoform disorders” and in DSM-IV it is grouped with the anxiety disorders.

Borders and boundaries

The boundaries of AD are not well defined in the current classifications. On the one hand the distinction for normal adaptive reactions is not defined and on the other the distinction from other diagnoses such as mood and anxiety disorders is a matter of debate.

The distinction from normal adaptive reactions is not dealt with explicitly in either classification. ICD-10 specifies that social impairment should be present in order to make the diagnosis, while there is no such requirement in DSM-IV. This raises the possibility that

using DSM-IV the diagnosis could be applied in the face of proportionate and adaptive reactions to stressful events. This issue was raised when AD was first introduced into DSM-1 (Fabrega and Mezzich 1987) when it was argued that it represented an attempt at medicalising problems of living. ICD-10 has to some extent recognised this danger and applied more rigorous criteria. DSM, on the other hand requires that the symptoms should be clinically significant although what this means is not specified.

On the other side of the AD border lie the major diagnoses seen in psychiatric practice. The difficulty of distinguishing AD from major depression, in particular, has been identified (Casey et al 2006) with few differences between the two in terms of symptom severity, personality disorder or social functioning. It has been suggested that the expansion in the prevalence of “depression” in community based epidemiological studies has come about because transient reactions are misdiagnosed and mopped up by the category of major depression (Regier et al 1998), a diagnosis that has expanded beyond clinical utility (Parker 2005).

The difficulty distinguishing major depression from AD using structured interviews should hardly be surprising since these base the diagnosis on symptom numbers and duration and assess symptoms cross-sectionally while AD represents a diagnosis that is inherently aetiological and longitudinal. So the conceptual framework of major depression and AD differ significantly yet both classifications deal with this simplistically by stating that the diagnosis cannot be made once the threshold for another diagnosis is reached, relegating AD to subsyndromal status.

The distinction between AD and minor depression, mild depression, subclinical depression or subsyndromal depression has not been formulated either and it is possible that these terms are used interchangeably.

See case vignette 1 for consideration of the boundaries of AD between normal reactions and major depression.

Case vignette 1 near here

Epidemiology

In population studies AD has not been considered in the National Comorbidity Survey Replication (Kessler et al, 2005), National Psychiatric Morbidity Surveys (Jenkins et al, 1997) or Epidemiological Catchment Area Study (Myers et al, 1984). By way of contrast, the Outcome of Depression International Network (ODIN) did include AD (Ayuso-Mateos et al, 2001) and the prevalence varied between countries and by gender, with females in rural Finland having the highest prevalence (1.9%) and other groups having a prevalence of less than 1.0% (e.g. males in urban Ireland). Maercker et al (2008) studied a representative sample of elderly persons from Switzerland (aged 65 to 96 years) and found a prevalence rate of 2.3% for adjustment disorder, compared to 2.3% for major depressive disorder and

0.7% for post-traumatic stress disorder. Using a narrow definition of AD, similar in symptoms to PTSD but triggered by day to day events rather than major traumas Maercker et al (2012) found a prevalence of 0.9% and 1.4% with and without the impairment criteria, in the general population.

Adjustment disorder is a notably common diagnosis in emergency department populations. Amongst individuals who undergo psychiatric assessment following deliberate self-harm, AD was the clinical diagnosis in 31.8% and major depression in 19.5% (Taggart et al, 2006) but when SCID was used the figures changed with AD dropping to 7.8% and major depression increasing to 36.4%. Brakoulias et al (2010) studied patients referred to a new "Psychiatric Emergency Care Centre" and found adjustment disorder to be the most common diagnosis, present in 35.9% of cases and Kropp et al (2007) using data on all individuals treated or assessed for mental illness in the emergency department over one year and diagnosed AD in 6.7% of patients, after acute alcohol intoxication (20.2 %) and paranoid schizophrenia (14.2%).

Adjustment disorder accounts for a significant proportion of referrals to consultation-liaison psychiatry services in general hospitals in the IS making up about 12% of cases (Strain et al, 1998).

In Europe, too, adjustment disorder accounts for a significant proportion of psychiatry morbidity in hospitals: one study of fifty-six consultation-liaison psychiatry services in eleven European countries found that while deliberate self-harm was the most common reason for seeking psychiatric assessment (17%), adjustment disorder and post-traumatic stress disorder accounted for 12.4% of referrals (Huyse et al, 2001). Further studies in consultation-liaison psychiatry indicate that adjustment disorder is almost three times as common as major depression in acutely ill medical inpatients (13.7% as opposed to 5.1%) (Silverstone, 1996) and almost twice as common as mood disorders in obstetric and gynaecological liaison services (Rigatelli et al, 2002). The contribution of additional psychosocial and environmental stressors to AD in this setting has also been recognized (Snyder et al 1990).

However a changing pattern has been reported with the diagnosis of AD declining in tandem with an increase in the diagnosis of major depression (Diefenbacher and Strain 2002). This may not so much reflect a change in their prevalence as a change in the "culture of diagnosis" (Strain and Diefenbacher 2008) stimulated by the availability of newer antidepressants for the treatment of major depression.

Yet the continuing salience of AD is evident from a recent meta-analysis (Mitchell et al 2011) which identified AD as the diagnosis in 15.4% and major depression in 16.5% of cases among studies conducted in palliative care settings while in oncological and haematological settings AD was the diagnosis in 19.4% of cases and major depression in 16.3% of cases.

Among those in contact with the psychiatric services studies are scarce. Among intake assessments at a rural and an urban clinic AD was the most common clinical diagnosis, made in 36% of those seen, but this dropped to just over 11% using SCID. Concordance between clinical and SCID diagnoses was lower for this than for any other diagnosis (Shear et al 2000) while among in-patients AD was the diagnosis in 9% of patients (Koran et al 2003).

ADs are said to be very common in primary care where family practitioners deal with the long-term impact of physical illness as well as the consequences of social and interpersonal problems. Prevalence rates of 11% to 18% among those consulting with mental health problems have been described in studies that are now old (Blacker and Clare 1988 ; Casey et al 1984). A recent study identified AD in 2.84% of the population of consulters using the SCID interview (Fernandez et al 2012) but only 2 of the 110 so diagnosed were identified by the general practitioner.

Psychobiology of AD

Biological studies are scarce in adjustment disorders but some are slowly emerging that showing differences between AD and major depression. In those expressing suicidal ideation post-dexamethasone suppression of cortisol levels were negatively correlated with symptom scores only in those with a diagnosis of major depression and not with AD (Lindqvist et al 2008). Among those with AD in the context of workplace bullying (Rocco et al 2007; Di Rosa et al 2009)), DST and other aspects of the hypo-thalmo-pituitary axis were found to be normal. While limited in number and scope, these studies point to a distinction between major depression/depressive episode and AD.

Making the Diagnosis

– structured interview

It is generally assumed that structured diagnostic interviews are the gold standard for making diagnoses in epidemiological settings. It is unclear if this is true for AD since it is not incorporated into many of the commonly used instruments such as the Clinical Interview Schedule (CIS) (Lewis et al 1992) or the Composite International Diagnostic Interview (CIDI) (Kessler et al 2004). The Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (Wing et al; 1990) does include AD, in the section on Inferences and Attributions. This comes after the criteria for all other disorders have been completed and there are no specific questions to assist the interviewer in making the diagnosis. The Structured Clinical Interview for DSM-IV (SCID) (First et al 1995) and the Mini International Neuropsychiatric Interview (M.I.N.I.) (Sheehan et al 1998) both incorporate a section on AD but in both it is trumped by the presence of any another diagnosis.

This problem with structured interviews has been highlighted by a number of studies in clinical settings showing that when structured interviews are used major depression is the predominant diagnosis while in those same patients when clinical diagnosis is used AD is the more common (Taggart et al 2006; Shear et al 2000).

Attempts to develop a screening instrument for AD based on the Hospital Anxiety and Depression Rating Scales (HADS) (Akechi et al 2004) or on the 1-Question Interview and Impact Thermometer (Akizuki et al 2003) have been shown to measure a general dimension of low mood but not to distinguish AD from major depression.

At this point is it arguable that clinical diagnosis which takes account of the context of symptoms and of the likely longitudinal course is superior to structured interviews, when diagnosing AD for research purposes.

-Clinically

The individual

Events that are not exceptional can trigger AD but also events of a magnitude that could lead to PTSD can be responsible for a cluster of symptoms that do not encapsulate the full PTSD spectrum and are best considered as ADs.

When assessing an individual's reaction to a stressful event, it is important to take four key aspects into account, to help distinguish AD from normal responses to stressors; these variables are:

- The individual's personal circumstances and the context of the stressful event e.g an event such as redundancy that might be devastating for one individual might be welcomed for others depending on their financial circumstances
- The proportionality between the triggering even and symptom severity e.g. a minor event is unlikely to have a significant impact on a person with well-developed coping skills whereas a vulnerable person could have a severe reaction.
- Cultural and sub-cultural norms for emotional expression and emotional responses e.g some cultures allow for the expression of emotion very openly and noticeably and such manifestations might be considered normal in one culture while in another this might be regarded as indicating pathology
- Severity and duration of resultant functional and social impairment e.g brief reactions to stressful events including functional impairment can occur in non-pathological reactions such as bereavement, but when the impairment persists the reaction might be considered abnormal.

ICD-10 (WHO 1992) opines that personal vulnerability plays a greater role in AD than in other psychiatric conditions. So, what is the evidence for this?

The frequency of personality disorder among those with AD in comparison to those with other depressive disorders seems to be no different (Casey et al 2006) although studies are

scarce. Other investigators have focussed on personality dimensions, especially neuroticism (For-Wey et al 2006) and attachment style (For Wey et al 2002). Using subjects chosen from the military with a diagnosis of AD, neuroticism emerged as one of the dimensions predisposing to AD. Attachment style, maternal over protection and paternal abuse were also identified as risk factors for later AD as was paternal abuse. (Giotakos and Konstantakopoulos 2002). However no comparisons were made with those having other psychiatric disorders so the relevance of these findings is unclear.

The presence of social supports has been seen as buffering the impact of adverse events in those with depressive disorders and while not studied specifically in AD, may be relevant in in this condition also.

The stressor

The essential requirement for diagnosing AD is that the symptoms must be triggered by a stressful event and the maximum time lag between the events and the onset of symptoms is 1 month in ICD-10 and 3 months in DSM-IV. According to ICD-10 "The stressor may have affected the integrity of an individual's social network (through bereavement or separation experiences) or the wider system of social supports and values (migration, refugee status). The stressor may involve only the individual, or also his group or community" (World Health Organization, 1992).

The type of event varies from those that are considered everyday such as a row with a friend, to those that are more serious for example being bullied in the workplace. A study comparing those with major depression to those with AD identified a higher proportion of events related to marital problems and fewer to occupational or family stressors in the AD group (Despland 1995) but as there are not specific they are unlikely to be helpful in making the diagnosis. There may be multiple simultaneous stressors, which may further complicate the clinical picture. So a relatively minor stressor, which appears to have little effect on its own, may have an additive effect on earlier, major stressors, and thus precipitate AD.

Another of the key features of AD is that the symptoms resolve spontaneously after the stressor is removed. This feature may help distinguish AD from other disorders, although this point of distinction requires a longitudinal perspective on the course of the symptoms. Clinically it presents as mood reactivity. Experimentally removing the person from the stressful environment might help clarify the diagnosis as improvement is likely to be significant in AD but more transient and superficial in those with major depression/depressive episode. Additionally the closer the temporal proximity between stressor and symptoms the more likely is the diagnosis to be one of AD. Symptoms may recur when there is cognitive proximity to the stressor such as speaking about it e.g. in the context of litigation.

Symptoms and behaviour

AD is generally regarded as a “mild” condition although the evidence for a distinction based on severity is ambiguous. One study in a general population sample (Casey et al 2006) failed to find any distinction in symptom severity or in social functioning between depressive episode and AD with depression subtype. On the other hand a recent study (Fernandez et al 2012) identified some differences, notably better quality of life in those with AD (depressed or anxious subtypes) as compared to those diagnosed with major depression or generalised anxiety.

The absence of melancholic features might also be of assistance in separating those with AD. Yates et al (2004) examined a group of patients with major depression with and without physical illness. Those with physical illness were less likely to display melancholic features raising the possibility that the greater the role of environmental factors the less likely are the typical melancholic symptoms to be present. Since AD represents, par excellence, a disorder in which environmental factors are prominent, it is possible that these symptoms might help distinguish those with AD from those with more biologically determined depression. Only further studies will demonstrate if these symptoms have sufficient specificity. This has led to recommendations (Baumeister et al 2009) that this should be encapsulated in the revisions for DSM-V and ICD 11.

Suicidal behaviour such as self-harm is common in those with AD and 25% of adolescents with a diagnosis of AD engage in this behaviour (Pelkonen et al 2005) while among adults this rises to 60% (Kryzhananovskaya and Canterbury 2001). Moreover, suicidal behaviour emerges several months earlier in those with AD in comparison to major depression (1 versus 3 months respectively) (Runeson et al 1998).

See case vignette 2 for an illustration of a case of AD with depressed mood.

Case vignette 2 near here

Differential diagnosis

The differential diagnoses to be considered in those with AD are listed in box 2.

Box 2

Normal reaction to stress

Major depression (or other symptom related disorder e.g. GAD)

Major depression (or other symptom related disorder e.g. GAD) in evolution

Emotionally unstable personality disorder (EUPD).

PTSD and acute stress reaction

Substance misuse

Dysthymia

The differential diagnosis includes the common differentials for anybody with either depressive or anxiety symptoms. The closeness in time between the occurrence of the stressor and the onset of symptoms is very useful in deciding between AD and say either depressive episode or GAD. The fact that there is cognitive proximity between the symptoms and the stressor e.g. talking about the event worsens the symptoms while at other times the individual is symptom free, is also more suggestive of AD rather than other axis 1 disorders.

Emotionally unstable personality disorder is included because shifts in mood in EUPD can occur in response to stressful events. In this context, the transient changes that occur should not be labelled as AD since these are inherent in EUPD. With regard to PTSD, events that are of such magnitude as to cause PTSD can also lead to AD and this may be the more appropriate diagnosis when the full criteria for PTSD are absent. Shifts in mood can occur in those who misuse substances, particularly alcohol, and these should not be labelled as AD unless there are co-occurring events driving the mood changes.

The possibility that the symptoms constitute a sub-threshold condition such as mild depression or subclinical depression must also be considered. A problem however is that these are poorly defined and delineated and apart from the requirement that AD is preceded by a stressor there is nothing in the scientific literature to assist the clinician in separating these from each other. While mild depression is recognised in ICD-10 and has 4 symptoms the distinction from AD, apart from the requirement for a stressor to trigger the latter and a judgement that it will resolve when the stressor is removed, there is nothing additional to assist in deciding on one above the other. Similar problems arise with respect to sub-syndromal and subclinical depression, terms that seem to have arisen without any clarity as to their meanings (Snaith 1997). There is a case to be made for either defining or abandoning such terms.

When both the stressor and the symptoms persist it is possible that a diagnosis of dysthymia will be made. However, a history of fluctuations in responses to changes in the stressor will tend towards a diagnosis of chronic AD while changes in symptom severity that are independent of the stressor will point in the direction of dysthymia (with associated double depression). The prior history may also be illuminating in that those with AD usually have no prior history while those with dysthymia have a history of persistent low mood often lasting many years and beginning usually in early adulthood.

Evidence Based Management

There is very little to assist the clinician in making treatment decisions for this condition since randomised controlled trials are scarce. No Guidelines from NICE exist either. Indeed it is questionable if specific interventions are even required since generally the symptoms

resolve spontaneously, unless there are continuing stressors or reminders that maintain the symptoms.

In so far as treatment is required, brief psychological treatments are the preferred option (Strain and Diefenbacher 1998). This seems appropriate given the, usually, time limited nature of the disorder. There are few randomised controlled trials and an array of psychological interventions and pharmacological have been tried with some success, both individually and in groups and underpinned by different theoretical models (Casey 2008).

Pharmacological treatments have a limited role apart from symptomatic treatment of anxiety and insomnia with benzodiazepines (Shaner 2000). In AD a number of placebo controlled trials of herbal remedies have been evaluated with kava-kava (Voltz and Keiser 1997) and valerian plus other extracts (Bourin et al 1994) showing some benefit in AD with anxiety symptoms.

There have been no RTC's on antidepressants in the treatment of AD with depression yet they are frequently prescribed for those with this condition and 45% of those with a diagnosis of AD received an antidepressant in a recent study (Fernandez et al 2012). In addition between 1996 and 2005 the use of antidepressants in the treatment of psychiatric disorders increased in the US and was most marked in those with AD, changing from 22.26/100 to 39.37/100 (Olfson and Marcus 2009).

Finally, one study comparing antidepressants, placebo, supportive psychotherapy and benzodiazepines found that all were associated with significant improvement (de Leo 1989), lending further credence to the possibility that no specific intervention may be required.

Outcome and Prognosis

There is very little information on the diagnostic stability of AD in comparison to other diagnoses. For example does AD augur some more sinister diagnosis or does it recur albeit retaining the same taxonomic diagnosis. For the ICD-10 group of neurotic and stress related disorders combined a low level of diagnostic stability (37%) has found in contrast to a level of 73% for depressive disorders. However numbers were small and AD was not examined separately (Daradkeh et al 1997). Another study found that adjustment and anxiety disorders were the least stable at around 34% but again AD was not examined on its own (Huquelet et al 2001). Greenberg (1995), a vociferous critic of the diagnosis, reported that 59% of those with an admission diagnosis of AD were relabelled as having a primary diagnosis of substance misuse. Based on the paucity of information, it is not possible to describe the frequency or direction of diagnostic change in those with an initial diagnosis AD in comparison to other categories..

By contrast, a definite point of departure from other common mental disorders is the better prognosis in those with AD. Not only does symptom improvement occur more quickly in those with AD but re-admission rates are lower (Jones et al 2002) than other diagnostic

groups sharing the same symptoms, most likely due to the temporal character of the stressor. Whether a diagnosis of AD places the person at risk of some other disorder subsequently has not been examined but the answer is likely to be negative since this is a condition that is exclusively stressor induced and has a lower re-admission rate.

However AD is neither benign nor mild as some suggest. It is the diagnosis in up to one third of young people who die by suicide (Lonnqvist et al 1995) and among all suicide deaths in the developing world it is the most common diagnosis (Manoranjitham et al 2010).

ICD-11 and DSM-V

A major concern for those framing ICD-11 and DSM-V is how and where to include AD in these new classifications. It is recommended that all the trauma related disorders including AD should move from the anxiety disorders section in DSM-V to a new section incorporating disorders that are stress related (Freidman et al 2011) in recognition of the common aetiology of some disorders rather than their common phenomenology. This would align ICD and DSM.

Of further relevance is whether AD should continue to be a sub-syndrome that cannot be diagnosed when the threshold for another disorder is reached. Acceptance of AD as a full blown disorder would inevitably lead to greater clarity in its diagnosis and would stimulate research into its many facets. But for this to happen AD must be accorded specific diagnostic criteria as detailed by some (Baumeister et al 2009).

Screening and diagnostic tools that can be used in research in AD need to be developed. These must not only distinguish AD from normal adaptive reactions but must also separate AD from other possible diagnoses. However, such developments are unlikely to occur until AD becomes a fully accepted syndrome in its own right. It remains to be seen if radical steps such as these are considered for the forthcoming editions of ICD and DSM.

CONCLUSION

AD is an under utilised diagnosis in clinical practice. It lacks any well developed criteria in the current classifications and is poorly conceptualised. For these reasons it is under researched. It is conflated with other axis 1 diagnoses and many of the treatments offered are not evidence based. The development of ICD-11 and DSM-V will be an opportunity to develop diagnostic criteria for this condition, thus enabling research to answer the myriad questions yet to be answered.

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Case Vignette 1

Ms. X, aged 50, was recently diagnosed with Parkinsons' disease. She was referred with low mood, tearfulness, poor concentration, hopelessness, loss of interest and insomnia since the diagnosis 1 month earlier. She was showing no response to treatment for her physical condition at the time of referral. She had no prior psychiatric history and had worked as a nurse up to the time of diagnosis - was the only breadwinner. She had two teenage children and her husband was recently made redundant.

Comment: Given this lady's circumstances it could be argued that her distress response, as the only breadwinner with two dependent children and insight into the prognosis, was proportionate and appropriate. On the other hand she had symptoms that have lasted for four weeks and she meets the criteria for depressive episode. Alternatively it could be argued that she had an adjustment disorder given the close time relationship between the onset of symptoms following the neurological diagnosis and the absence of any response to treatment to date. This vignette illustrates the boundary disputes surrounding the diagnosis of AD.

Case vignette 2

Mr. X was a 45 year old man admitted to a psychiatric unit having been rescued when he was observed trying to drown himself by a walker on a beach. He had left a suicide note in his car. He reported increasingly low mood since his marriage broke up 6 months earlier. Shortly thereafter he was made redundant, although he had since got a job but with a much reduced salary. This had resulted in mounting debt. When he moved out of his home he rented a small flat in a run-down part of the city, being all that he could afford. He was embarrassed to meet his friends and siblings because of his situation. His evenings were spent in the pub where he drank and ate, usually on his own, because his accommodation was so poor. He returned home only to sleep. He experienced initial insomnia. He had no interest in his previous hobbies such as watching football and he saw

no hope for the future. He continued to go to work and was satisfied that he was doing it well. Seeing no solution to his debts or accommodation problems he decided to end his life

During his stay in hospital he was not given any medication apart from hypnotics for the first two nights. He was reported to be eating well, attending all activities and engaging in conversation with staff and fellow-patients. His mood improved within a few days and he reported relief that his life had been saved. He also felt happy to be away from his situation and to be receiving help for same.

He received visits from close friend and siblings who made offers of accommodation which he accepted. He was referred to a free financial advice service for help in addressing his debts and to the local council for help with housing. He began to discuss his problems more openly and was discharged two weeks post-admission. Throughout the three month period of follow-up he remained symptom free and continued the process of resolving his debt and accommodation problems. He did not require medication at any point up to his discharge to his GP some 3 months after his admission.

Comment: This gentleman's history showed that the onset of symptoms was closely related in time to the breakup of his relationship and was maintained and eventually worsened by a number of factors that included financial difficulties and housing problems. In addition he was socially isolated and so had no supports from those who might have been able to help him, either emotionally or practically. Although his mood was low he continued to work. His use of alcohol may have contributed to his low mood. His increasing hopelessness and sense of helplessness led to him making a serious suicide attempt. Once he was in an environment that removed him from his adverse circumstances and offered practical assistance and emotional support his symptoms resolved rapidly with the minimum of pharmacotherapy. This case study indicates that AD can persist while adverse social circumstances continue and also that it can in some instances be associated with serious suicidal behaviour. This history illustrates the possible conflation of AD with depressive episode since this man might easily have been prescribed antidepressants, when in fact his symptoms were driven exclusively by his circumstances.

Multiple choice questions

Select the single best option for each stem

A diagnosis of adjustment disorder cannot be made unless

- 1. a stressor is identified**
- 2. the individual is vulnerable**

3. the individual has a personality disorder
4. the symptoms persist beyond 6 months
5. marked anxiety is present

Correct answer 1

Adjustment disorder and major can be distinguished from each other by the presence of the following symptoms

1. Insomnia
2. Low mood
3. Poor concentration
4. Suicidal ideation
5. None of the above

Correct answer 5

Adjustment disorder is best treated with

1. Antidepressants
2. Psychodynamic psychotherapy
3. Interpersonal therapy
4. Any of the above
5. None of the above

Correct answer 5

Adjustment disorder may be diagnosed using the following interview schedules

1. SCID
2. CIDI
3. CIS
4. Hospital anxiety depression scale
5. Hamilton depression rating scale

Correct answer 1

The following controversies concerning adjustment disorder have been resolved

1. The distinction from normal stress reactions
2. The distinction from major depression
3. Their categorisation as a trauma based diagnosis in DSM-5
4. The good prognosis in most circumstances
5. Their diagnosis by interview schedule

Correct answer 4