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BJPsych Advances (2021), vol. 27, 179–180 doi: 10.1192/bja.2020.74

Adjustment disorder or adaptive adjustment?

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REFRESHMENT

SUMMARY

The differentiation of pathological stress responses from responses that are appropriate and adaptive is a challenge with little to guide the clinician. This refreshment considers adjustment disorder and possible approaches to distinguishing those who have the disorder from those who are responding 'normally' to stressful events.

KEYWORDS

Pathological; stressor; adaptive; classification; adjustment disorder.

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First received 15 Jul 2020
Final revision 7 Sep 2020
Accepted 14 Sep 2020

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Adjustment disorder is defined as a response to a stressor that is excessive and maladaptive. It sits on a boundary. On one side are common mental disorders such as depressive episodes and on the other are normal adaptive responses to stressors. But clear demarcations between the sadness of the human condition and recognised psychiatric disorders such as adjustment disorder, known as zones of rarity (Kendell 2003), are non-existent. Instead, there is symptom overlap that blurs the lines of demarcation between responses to stressors that are pathological and those that are adaptive.

This refreshment will concern itself with how clinicians judge whether an individual exposed to financial ruin, for example, is experiencing an understandable emotional response to their plight or one that is disproportionate and appropriately described as an adjustment disorder.

DSM and ICD diagnostic criteria

The approach of DSM-5 (American Psychiatric Association 2013), and to a lesser extent ICD-10 (World Health Organization 1992), is that the number and duration of symptoms determine whether a disorder is present. Yet the tick-box approach to symptoms can hardly be considered scientific, particularly if it is applied in a contextual vacuum. It is all the more problematic in adjustment disorder, since there are no specific diagnostic criteria apart from the dominant subtypes of anxiety, depression, mixed anxiety/depression and 'other'.

'Expectability' and 'clinical significance'

The DSM-5 attempts to deal with the pathological/non-pathological question by specifying that the response 'must not merely be an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one'. But 'expectable' is vague and for many stressful events there is no indication as to what is expectable in each incidence owing to individual variation in coping, personality and resilience. And even when reactions to stressors are culturally sanctioned, they may still be overwhelming and protracted, thus arguably making them pathological.

Echoing the 'expectability' consideration, Maj (2012) has called for a refinement of the diagnostic system that would include a description of ordinary responses to major stressors (such as bereavement, economic ruin, exposure to disaster or war, disruption of family by divorce or separation) and also to life-cycle transitions (e.g. adolescent emotional turmoil), so as to aid clinical judgement. While this is appealing, the types of event to which people are exposed are legion. Apart from bereavement, there are few descriptions of the adaptive responses to the myriad other events that confront human beings.

The 'clinical significance' criterion is applied by DSM (but not ICD) as a means of reducing the likelihood of medicalising appropriate distress. This is hardly a robust definition, since help-seeking is culture bound and there is also between-person variation, stemming from familial influences (Frances 1998). Moreover, some with recognised psychiatric disorders do not consult at all, whereas others experiencing normal reactions seek professional help in the form of hypnotics and anxiolytics for a brief period and may also request 'counselling'.

'Normal' stress responses

Meanwhile the approach of ICD-10 and DSM-5 is to simply state that the symptomatic response to a stressor must not represent a normal stress response. This is a tautological definition.

One way of examining this would be to consider whether there are any qualitative differences between the symptoms themselves or the manner in which they present together that would assist in

https://doi.org/10.1192/bja.2020.74 Published online by Cambridge University Press

differentiating adjustment disorder from adaptive stress responses. Although not studied in respect of adjustment disorder, this has been studied in those with normal sadness compared with those with a depressive episode (Clarke 2002). Those with the clinical diagnosis were more likely to experience lethargy and an inability to do things because of tiredness or difficulty summoning up the energy, problems envisaging the future and a sense of detachment, along with physical changes that the individual says are similar to a viral illness.

Biological differentiators

Turning to the psychobiology, this could theoretically provide some assistance were investigators to compare cohorts exposed to various stressful events who do and do not show adverse responses. So far none have been carried out. The hypothalamic–pituitary–adrenal (HPA) axis is a potential area for differentiation but this has not been examined in the context of adjustment disorder and adaptive responses to stressors.

Practical suggestions

In practice the decision on whether the symptoms represent an adaptive or abnormal response is a clinical one. Box 1 lists a few clinical considerations that will assist in making this judgement. A particularly useful distinguishing feature between those who are distressed and those who are more broadly affected is likely to be functional impairment (Baumeister 2009). Both the ICD-10 and the new ICD-11 (World Health Organization 2018) criteria require functional impairment. By comparison, in DSM-5 either symptoms or distress are required, setting a lower threshold than ICD, thereby increasing the risk of false positives.

The new ICD-11 criteria for adjustment disorder (World Health Organization 2018) may further assist in making the distinction between adaptive and pathological responses to stressors. While the symptoms included in the criteria, namely excessive concern about the stressor, distressing thoughts about it or constant 'rumination' about the implications of the stressor, are present to varying degrees in those who worry, it is the failure to adapt manifested by poor concentration and sleep reduction leading to impaired functioning that sets adjustment disorder apart. Careful history taking and examination of the severity and progress of symptoms over time will assist in evaluating whether the adaptative process is in train or not. A history of previous episodes will also increase the likelihood that this is a pathological reaction. Finally, consideration of the person's resilience, evaluated in terms of social supports, coping skills, beliefs and attitudes, will also confirm whether this is likely to be a short-lived and appropriate response.

At this point much more research is necessary to provide certainty and the clinical considerations suggested above could form the basis for hypothesis testing.

BOX 1 Distinguishing pathological from adaptive responses

- Is functional impairment present?
- 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?

Declaration of interest

P.C. is Editor of *BJPsych Advances*. She had no role in the reviewing process for this article.

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https://doi.org/10.1192/bja.2020.74 Published online by Cambridge University Press