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Adjustment Disorder: History and Future

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Abstract: This paper looks at the diagnosis of adjustment disorder (AD), its history as well as arguments for and against its continued use. AD is shown to fit in a special place in the taxonomy of psychiatric disturbances or difficulties people experience and this special position is both one of its strengths and one of the reasons it has been a frequently maligned diagnosis. Other strengths and weaknesses of the AD diagnosis are discussed as well the expected future growth and usefulness of the diagnosis in a variety of areas where it may be overlooked or under utilized today.

key words: adjustment disorder, diagnosis, stress, adjustment

Adjustment disorder (AD) has been one of the most widely diagnosed psychological disorders since its inclusion under that name in the *Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM–III)* in 1980 (Casey, 2009). It is also a diagnosis which creates a variety of negative reactions from counsellors and others within the mental health profession (Casey, Doric & Wilkinson, 2001; Daniels, 2009). The popularity of the diagnosis can be seen in the estimates which show between 5–21% of adults seeking consultation being diagnosed with a form of adjustment disorder (Jones, Yates, Williams, Zhou & Hardman 1999). Despite its popularity as a diagnosis, it has also been the target of much criticism for a variety of reasons (see Daniels, 2009; Casey, 2009; Strain, Wolf, Newborn & Fulop, 1996). Among the primary criticisms are the position of AD in the diagnostic continuum as well as the lack of clarity in how it is diagnosed. This lack of clarity may lead to its being used in place if a more robust diagnosis and therefore its being used in cases where no diagnosis might be better. There are likely many other reasons for both the popularity of adjustment disorder as a diagnosis among practitioners as well as the negative views that many take toward the diagnosis overall. Today, however, there are a variety of issues which suggest that adjustment disorder should continue to play an important role in the treatment of psychological difficulties and may in fact grow in importance in the coming years.

History

The earliest official form of adjustment disorder first appeared in *Diagnostic and Statistical Manual of Mental Disorders, First Edition* (*DSM–I)*, released in 1952, under the name ‘Transient situational personality disorder’. Initially The diagnostic categories were based on developmental stages such as: ‘Adjustment reaction of infancy,’ ‘Adjustment reactions of childhood’ and so on up to ‘Adjustment reactions of late life.’ *DSM–I* also included more general diagnostic categories such as ‘Gross stress reaction’ and ‘Other transient situational personality disturbance.’ In total, *DSM–I* recognized seven categories of dysfunctional responses to stressful life events (Strain and Diefenbacher, 2008). *Diagnostic and Statistical Manual of Mental*

Disorders, Second Edition (*DSM−II*) which was released in 1968 recognized five categories of 'Transient situational disturbances' according to the developmental stage that the sufferer is going through. These five stages were: Infancy, childhood, adolescence, adult, life and late life.

In 1980, with the release of *DSM−III*, adjustment disorder was finally recognized in a form based on the experiences an individual is experiencing rather than the age or developmental stage they are going through. The name was changed to adjustment disorder with this release as well. In *DSM−III* there were eight categories such as: 'AD with depressed mood,' 'AD with anxious Mood,' 'AD with mixed emotional features,' 'AD with work or academic inhibition' and 'AD with withdrawal.' *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM−III R)*, saw the categories increased to nine with the category 'AD with atypical features' removed and replaced with 'AD with physical complaints' and the category 'AD NOS' or ' AD Not Otherwise Specified.' *DSM−IV* and *DSM−IV−TR* (*Text Revision*) both saw the categories of AD reduced to six. The category 'AD unspecified' was added to replace the categories 'AD with work (or academic) inhibition,' 'AD with withdrawal,' 'AD with physical complaints,' and 'AD NOS.'

Up to the final release of *DSM−IV−TR* a diagnosis of adjustment disorder remained quite easy to obtain in some ways. One of the reasons was the broad range of categories into which a client's symptoms or experiences could fit. More importantly however, the core criterion for an AD diagnosis was that a sufferer not meet the criteria to be diagnosable with any other psychiatric condition (Casey, 2009). According to Casey (2009) *DSM−IV−TR* was specific however in indicating that an instance of adjustment disorder can only be considered to have occurred:

- In responses to a stressful event.
- When the symptoms occur within 3 months of exposure to the stressful event.
- When symptoms are distressing and in excess of what would be expected by exposure to the stressor.
- When there is significant impairment in social or occupational functioning
- When the symptoms are not due to another axis I disorder or bereavement.
- When, once the stressor or its consequences is removed, the symptoms resolve within 6 months (p.928).

Criticisms of Adjustment Disorder

Adjustment disorder has been widely diagnosed and widely criticized essentially since it became recognized as a disorder. One of the underlying criticisms of the disorder is that sufferers experience low levels of impairment. As a result, one of the frequently cited complaints is that the problems experienced by those diagnosed with AD are simply normal events and should not be 'pathologized.' From this point of view the reactions of people having difficulties adjusting to life events should not be seen as pathological. The argument is essentially that the suffering caused by a relatively normal, though potentially traumatic or otherwise stress inducing event, should not be seen as a disorder. Those that argue this believe that the suffering or difficulties one experiences are natural responses and, though they may require some care or treatment of some kind, the response need not be labeled as a disorder. By labeling natural reactions as a disorder it is held, the natural response becomes a disease of sorts, a medical condition to be treated with medicine and seen as a problem rather than the natural response that it is (Daniels, 2009; Casey, 2009, p.931).

The complaint that AD is an unnecessary diagnosis is a part of a deeper criticism of the adjustment disorder put forward by Daniels (2009). Daniels asserts that the position of adjustment disorder on the Human Mental Health continuum places it strategically between health and disorder. This position is seen by Daniels as completing the scale of mental health so that all categories of behavior are labeled ranging from 'normal' behavior to 'severe' impairment. Adjustment disorder serves as a keystone in this continuum of mental health so that all human responses to life events are able to be diagnosed

ranging from normal to clinically impaired. With all human mental reactions to life events thusly anchored, Daniels asserts, the focus becomes simply ‘diagnosis’ and short term ‘treatment’ of the identified disorder. This is done under the DSM system instead of working toward longer term mental health goals that are provided by more traditional counseling and working toward a better psychological life. With the goal of diagnosing and treating becoming set, with AD providing the anchor between emotional health and sickness, the mental health of individuals becomes secondary which he Daniels expects will lead to a decline in mental health overall.

The vagueness of the diagnosis requirements for adjustment disorder is also frequently cited as one of its important weaknesses (Casey, 2009, Strain, Wolf, Newcorn and Fulop, 1996). Partly this can be explained by the classification of AD as a sub-syndrome within the overall diagnostic schema. Being a sub-syndrome, the core criterion for diagnosis is that the individual being considered for diagnosis must not meet conditions for any syndrome on the spectrum of disorders. This allows for application of AD in a wide variety of apparently unrelated and poorly defined situations. According to Strain, Wolf, Newcorn and Fulop (1996) three of the diagnostic criteria are especially problematic. The first is what Strain, Wolf, Newcorn and Fulop (1996) basing their discussion on DSM−III−R, refer to as a ‘maladaptive reaction’ (p.1034) Casey, (2009), discussing DSM−IV−TR calls ‘…distressing and in excess of what would be expected by exposure to the stressor.’ In this case, though it is implied by the criteria, there are no clear guidelines provided in deciding whether the distress is either ‘maladaptive’ or ‘in excess’ of what would normally be expected. Whether a response is appropriate or not is likely to be quite objective and more clarity here would be helpful.

The second problematic criterion is regarding the definition of ‘Psychosocial stressor’ according to Strain, Wolf, Newcorn and Fulop (1996) and referred to by Casey (2009) simply as a ‘stressful event.’ Again, neither version of the *DSM* discussed by these authors clearly examines how these terms or phrases should be defined (Casey, 2009, p.931, Strain, Wolf, Newcorn and Fulop, 1996, p.1034). No guidance is provided, according to Casey, (2009) as to how the stressor or stressor should be measured or identified in order to be considered appropriate for AD. Further problems arise when attempting to differentiate between the possibility of the stressor being considered an event more appropriately a trigger for post-traumatic stress disorder or an adjustment disorder. As a result, the application of AD or perhaps some other diagnosis is again, is very much up to the diagnostician.

Finally, the vagueness of symptoms expected and the duration of those symptoms are less clear than they could be (Casey, 2009; Strain & Diefenbacher, 2008). The duration of the symptoms have been problematic until DSM−IV−TR established acute (less than 6 months) and chronic (longer than 6 months) designations. The onset of symptoms should also be within three months of experiencing the stressor but other diagnoses are similar and clarity in differentiating is not provided. The types of symptoms to be expected have also been left unclear according to Casey (2009) despite the fact that clarity between melancholic and depressive features could greatly help in the clarification between AD and depression.

The vagueness of AD in these and other areas leads to difficulty in differentiating AD from other diagnostic categories. One such area of difficulty that has been researched by Casey *et al.* 2006 is the similarity between AD and the diagnosis of ‘depressive episode.’ In their work, they found that there were few ways in which the two diagnoses could be distinguished using methods available at the time of the completion of the study. This suggests that the two diagnoses are in need of refinement or that further diagnostic tools should be developed more appropriate to be used with AD especially. Other areas of confusion between diagnoses include PTSD, major depression, generalized anxiety and others (Casey, 2009). Without more clarity in how to apply the AD diagnosis, confusion and potential danger in getting the diagnosis wrong remain possible.

The Strengths of the Adjustment Disorder Diagnosis

According to Strain and Diefenbacher (2008) an important strength of AD is that it fits very nicely into the overall taxonomy of psychiatric disorders (p.121). It does this by occupying a strategic gap between the initial stages of suffering that some experience prior to their symptoms progressing on to higher levels of morbid states where a more severe diagnosis might result. In being positioned at this middle point between the normal and the pathological, it gives clinicians the opportunity to begin treatment in situations which might otherwise not be treatable due to the lack of a clear diagnosis. This is helpful in a number of ways. Most importantly, AD also allows clinicians to begin treatment before cases become more severe and perhaps more difficult to treat. It may also be important in situations where a diagnosis is required before an individual's health insurance can alleviate some of the financial burden of treatment. The lower threshold for diagnosis will certainly encourage sufferers to get treatment rather than waiting for more severe symptoms to arise.

In other cases, having the AD diagnosis available may help alleviate the social and personal stress that individuals are likely to feel when they are concerned about receiving a psychological diagnosis. Concerns of this type have been shown to lead to stress regarding being stigmatized in society and has lead subjects to underutilize care despite the apparent need (Kushner & Sher, 1989). If only the more severe diagnoses were available, sufferers might fear being stigmatized, might fear the treatment itself or might feel that their future will be burdened by the difficulty they are facing at the time. With the milder diagnosis available, those that suffer from it might be more willing to get needed treatment and move forward from their difficulties.

The value of the AD diagnosis is especially important when the sufferers are young people. Work by Portzky, Audenaert and van Heeringen (2005) suggests that the prevalence of AD among young people is higher than for most other age groups. It may also be more dangerous. Portzky, Audenaert and van Heeringen show that a high association exists between adjustment disorder and suicide attempts among young people. Fortunately, fatal suicides occur more frequently in those suffering from major depressive episodes and substance abuse than in those diagnosed with AD. Despite sufferers of these more serious diagnoses being more frequently successful in committing suicide, estimates of those who suffer from adjustment disorder that successfully commit suicide range between 5%−36% a smaller yet hardly insignificant number. Having the AD diagnosis in the mental health professional's arsenal is therefore important for these young people who might be prone to attempt suicide.

This tendency toward high levels of suicide attempts also shows the importance of the AD diagnosis in another way. Unlike other, more severe diagnoses such as bi-polar or even depressive episode disorder where sufferers are likely to have repeated or occasional difficulties, adjustment disorder sufferers are generally free of relapse five years following initial diagnosis (Bisson & Sakhuja, 2006). Short-term prognosis is also good so, once the initial dangerous period where sufferers are more prone to attempt suicide, where proper care will likely be very helpful, sufferers can be relatively assured that their future will not be significantly effected by their brief period of difficulty.

Discussion

Despite its weaknesses, adjustment disorder is a useful and important weapon against mental distress in the arsenal of mental health professionals. The strengths that it offers, far outweigh the weaknesses discussed above, in terms of providing a valuable asset for the mental health of clients that might find themselves on the border between mental health and mental pathology. The overall usefulness of AD can be seen through the number of diagnoses that continue to be made as discussed above as well as the wide variety of situations where it has been applied.

In the field of medicine for example, adjust-

ment disorder has been found and studied in patients suffering from a range of medical issues. A common topic of adjustment disorder research has been in patients suffering from cancer and other longterm and terminal illnesses (see Akechi, et al. 2004, Derogatis, et al 1983, Massie & Holland, 1990 among others). Young patients recently diagnosed with insulin-dependent diabetes mellitus (see Kovacs, Ho & Pollack, 1995) have been examined as well. In these and other studies of patients facing important and frequently life-changing diagnoses, adjustment disorder is shown to be useful. In most of these cases, no other available disorder can be identified according to the *DSM* or other diagnostic manuals and yet the patients require some sort of treatment for the psychological difficulties they are experiencing. This suggests that adjustment disorder is playing a vital role in helping individuals in need of treatment, often for short periods of time, to get the treatment they need.

While these uses of adjustment disorder to treat hospitalized patients or patients facing significant changes in their medical conditions have been fairly common for a number of years, there appears to be a need for the application of this disorder to a variety of cases. As discussed above and outlined by both *DSM−IV−TR* and the *International Statistical Classification of Disease* (*ICD−10*), AD can occur in cases where someone is reacting to a life event that causes stress. The level of reaction to that stress is the main deciding factor in whether or not an individual is suffering from AD or adjusting to the life event in a normal manner. For reactions to traumatic stress the diagnosis has traditionally been PTSD. Reactions in need of treatment that have come as a result of organic disorders are seen as having physical causes. Agents causing distress may be agent induced such as drug or alcohol dependence. Other factors, some of which may not obviously be the causes of a diagnosable mental disorder, may be better treated if clinicians are encouraged to identify the difficulties people are experiencing as instances of adjustment disorder.

Some of the cases in which AD may be useful moving forward include culture-shock and reverse-culture-shock. Both of these problems are likely to continue to grow as more and more students, professionals and others are spending significant parts of their lives living in cultures other than their own. The literature in these fields is rife with discussion of ‘adjustment’ and ‘adjustment difficulties’ related to individual's time abroad and upon their return, yet no articles have been found to date suggesting that the problems people experience adjusting to different cultures should be viewed as examples of AD. The reaction is generally identified as having been caused by the stress of living in a different culture or returning to one’s home culture as the case may be. Having this diagnosis available to those living and working overseas for extended periods or upon their return home, may help those that suffer from these difficulties to be treated more effectively and more quickly. Understanding adjustment disorder as a possible source of the difficult may also help prepare for preventative steps to be taken.

People experiencing difficulties that may be best looked at through the adjustment disorder view point include those adjusting to life as a senior citizen as well. This will include a growing number of individuals in the future in many countries and cultures around the world. Approaching the problems these people experience from the AD point of view, should allow for a healthier reaction to the difficulties involved. Facing the problems as the result of AD rather than simply a result of aging may make it easier to counteract some of the problems related to the changes involved in the process of growing older. These changes may involve an adjustment to loss of physical strength, a loss of hearing or eyesight or other problems (see Blazer, Hughes & George, 1987, Koenig, Meador, Cohen, & Blazer, 1988) but when dealt with from the viewpoint of AD, treatment may be more successful.

Despite the fact that adjustment disorder is a diagnosis with many uses today and moving forward, many see it as a diagnosis in need of change. As a result, more research is needed to ensure that any changes made to this useful diag-

nosis do not remove the benefits it now has. Until that research has been completed and validated, not enough is known about the disorder and those that suffer from it, to really make many major changes. As discussed above, the current system allows for people suffering from psychological difficulties to have treatment begun before reaching a more severe threshold at which point treatment may be more difficult, or more time consuming. With the relatively high number of suicides among sufferers of AD which have been fairly well documented (see Portzky, Audeaert and van Heeringen, 2005 among others) changing the diagnosis too soon may be more dangerous than helpful.

Conclusion

Adjustment disorder is both a widely used and a widely debated diagnosis. Its weaknesses include vagueness and lack of clarity as well as difficulty in differentiating it from other diagnoses such as depressive episode. Nonetheless, AD is widely diagnosed and sufferers of AD show a higher level of suicidal attempts than would otherwise be expected for a sub-syndrome disorder. Together these suggest that AD serves an important purpose within the field of psychological care. It is likely to continue to grow in the future as well with more people traveling overseas for extended periods being forced to adjust to life in different cultures. People also generally face major life adjustments as society changes and increased life expectancy results in a number of changes and adjustments throughout one's life. As nearly all who examine AD repeatedly call for more research to help in the overall understanding of the disorder and the diagnosis, this is not the time to undertake major changes in the criteria or the diagnosis itself (Strain & Diefenbacher, 2008). Instead, this important diagnosis should be researched more comprehensively so that any changes that are made to this important, little understood diagnosis are done in a way that benefits those that are experiencing the difficulties that it was designed to encompass.

References

Akechi, T., Okuyama, T. Sugawara, Y., Nakano, T., Shima, Y., & Uchitomi, Y., (2004). Major depression, adjustment disorders, and post-traumatic stress disorder in terminally ill cancer patients: Associated and predictive factors. *Journal of Clinical Oncology 22*(10), 1957−1965.

Blazer, D., Hughes, D. C., & George, L. K. (1987). The Epidemiology of Depression in an Elderly Community Population. *The Gerontologist*, *27*(3), 281−287.

Bisson, J. & Sakhuja, D. (2006). Adjustment disorders. *Psychiatry, 5*(7), 240−242.

Casey, P. (2009). Adjustment disorder: Epidemiology, diagnosis and treatment. *CNS Drugs, 23*(11), 927 −938.

Casey, P., Dowrick, C. & Wilkinson, G. (2001). Adjustment disorders: Fault line in the psychiatric glossary. *British Journal of Psychiatry, 179*, 479−481.

Casey, P., Maracay, M. Kelley, B. D., Lehtinen, V., Ayuso-Mateos, J.-L., Dalgard, O. S., & Dowrick, C. (2006). Can adjustment disorder and depressive episode be distinguished? Results from ODIN. *Journal of Affective Disorders*, *92*, 291−297.

Daniels, J. (2009). The perils of "adjustment disorder" as a diagnostic category. *Journal of Humanistic Counselling, Education and Development. 48*, 77−90.

Derogatis, L. R., Morrow, G. R., Fetting, J., Penman, D., Piasetsky, S., Schmale, A. M., Henrichs, M., & Carnicke C. L. M. (1983). The Prevalence of Psychiatric Disorders Among Cancer Patients. *Journal of the American Medical Association, 249*(6) 751−757.

Greenberg, W.M., Rosenfield, D.M., & Ortega, E.A., (1995). Adjustment disorder as an admission diagnosis. *American Journal of Psychiatry 152*, 459−461.

Jones, R., Yates, W.R., Williams, S., Zhou, M., & Hardman, L., (1999). Outcome for adjustment disorder with depressed mood. Comparison with other mood disorders. *Journal of Affective Disorders, 55*, 55−61.

Koenig, H. G., Meador, K. G., Cohen, & H. J., Blazer, D. G., (1988). Depression in Elderly Hospitalized Patients With Medical Illness. *Archives of Internal Medicine*. 148(9) 1929−1936.

Kovacs, M., Ho, V., & Pollock, M. H., (1995) Criterion and predictive validity of the diagnosis of adjustment disorder: A prospective study of youths with new-onset insulin-dependent diabetes mellitus. *The American Journal of Psychiatry*, *152*(4), 523−528.

Kushner, M. G. & Sher, K. G. (1989) Fear of psychological treatment and its relation to mental health service avoidance. *Professional Psychology: Research*

and Practice, 20(04) 251−257.

Massie, M. J. & Holland, J. C. (1990) Depression and the cancer patient. *Journal of Clinical Psychiatry, 51*(Suppl), 12−19.

Newcorn, J. H., Strain, J., 1992. Adjustment disorder in children and adolescents. *Journal of American Academy of Child and Adolescent Psychiatry 31*, 318 −327.

Portzky, G., Audenaert, K., & van Heeringen, K., (2005). Adjustment disorder and the course of the suicidal process in adolescents. *Journal of Affective Disorders, 87*, 265−270.

Strain, J. J. & Diefenbacher, A. (2008). The adjustment disorders: The conundrums of the diagnoses. *Comprehensive Psychiatry*, *49*, 121−130.

Strain, J. J., Wolf, D., Newcorn, J. & Fulop, G. (1996). Adjustment disorder. In *DSM−IV Sourcebook, Vol. 2.* T.A. Widiger, A. J. Frances, H.A. Pincus, et al. Washington DC: American Psychiatric Association, pp.1033−1049.