



Clinical guideline Adjustment disorders

Description

An adjustment disorder is a severe behavioral response to a stressful event or variation in an individual's life that is a more serious response to the event or change than would be expected given the situation. Symptoms usually begin within three months of the event and usually last no longer than six months. Triggering stressors commonly include family or marital conflict, academic and work issues, financial difficulties, major life changes or health problems.

Adjustment disorders are thought to be among the most common psychiatric disorders, although exact prevalence is unknown (American Psychiatric Association, 2000). While the symptoms may be milder and/or of briefer duration than in other disorders, adjustment disorder (AD) can have lethal consequences. The progression from suicidal ideation to behavior has been found to be faster in adjustment disorder than in major depression (Benton and Ifeagwu, 2009). AD is particularly common among people with medical illnesses (Schatzberg, 1990). Despite the prevalence of AD, there is a paucity of controlled clinical trials specific to AD (Benton and Ifeagwu, 2009). Similarly, there are few available guidelines specific to treating AD.

Diagnostic criteria

1. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s).
2. These symptoms or behaviors are clinically significant as evidenced by either of the following:
 - a. Marked distress that is in excess of what would be expected from exposure to the stressor
 - b. Significant impairment in social or occupational or academic functioning
3. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
4. The symptoms do not represent bereavement.
5. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional six months.

Specify if:

Acute: if the disturbance lasts less than six months

Chronic: if the disturbance lasts for six months or longer

(source: DSM-IV-TR)



Note: By definition, symptoms cannot persist for more than six months after the termination of the stressor or its consequences. The chronic specifier therefore applies when the duration of the disturbance is six months or longer in response to a chronic stressor or a stressor that has enduring consequences.

Assessment

Assessment should include an evaluation of the following dimensions:

- Identification of specific stressors causing impairment
- Assessment of current symptoms, including use of a validated symptom inventory or outcomes measurement tool
- Risk factors such as suicidal or homicidal ideation
- Social support
- Mental status examination
- Psychosocial history, including premorbid functioning
- Previous treatment history
- Substance use
 - Use of a standardized assessment such as CAGE or AUDIT is recommended
 - Referral for a formal substance abuse evaluation is recommended if the CAGE or AUDIT produces a positive result
- Patient's strengths and coping abilities

Treatment planning

Treatment planning for individuals with adjustment disorder should include:

- Specific interventions aimed at reducing symptoms and improving patient's functioning
- A plan for reassessing the patient's symptoms and functioning on a regular basis
- A plan for terminating treatment

Treatment goals should include establishing adaptive coping skills and a return to baseline functioning. Remission and relapse prevention are not only acceptable, but appropriate targets. Realistic short-term goals should be made at the start of therapy, as the course of adjustment disorder is generally short-term in nature. Treatment should include:



- Improving the individual's coping and problem-solving skills
- Identifying and enacting social supports
- Teaching methods of stress reduction (e.g., relaxation techniques, self-soothing, etc.)

Treatment

As noted above, there is a paucity of controlled clinical trials regarding treatment specifically for AD. Specific recommendations must therefore be drawn from clinical consensus and from application of broader studies regarding treatment effectiveness.

Therapists may choose from a variety of effective treatment approaches, including brief psychodynamic, cognitive behavioral, interpersonal, family, or group therapy. Treatment may aim to reduce the stressor as well as improve the patient's ability to cope with the stressor. (Benton and Ifeagwu, 2009). Coordinating care with the patient's medical providers is of particular importance given the association between AD and other medical disorders (Schatzberg, 1990).

Improvement should be identifiable through ongoing monitoring of the patient's scores on a validated symptom inventory or outcomes measurement tool (Lambert, 2003). Validated outcomes measures include the ACORN and the Session Rating Scale/Outcomes Rating Scale, which are available to clinicians free of cost. (See www.psychoutcomes.org and www.talkingcure.com.)

If no improvement is noted by the third session, further assessment is needed and the treatment plan should be modified. Brown, Dreis, and Nace (1999) found that on average, if there was no improvement by the third session, no improvement occurred throughout the entire course of treatment and patients were more likely to drop out. The re-assessment should include consideration of:

- Patient's subjective experience of the treatment sessions
- Possibility of an underlying Axis II condition or other Axis I conditions
- Need for psychosocial interventions (e.g., support groups)
- Reassessment of possible co-occurring conditions (e.g., medical conditions, substance abuse)
- Possible need for medication evaluation
- "Goodness of fit" between the therapist's style and interventions with the patient's expectations, and consideration of a change in approach or referral to different provider when appropriate.



The revised treatment plan should identify which issues have impeded progress in treatment and identify what actions will be taken to address these issues.

Prior to termination it is appropriate to address potential relapse and help the patient build skills and supports which can assist in minimizing the impact of an ongoing or recurrent stressor. Therapists may decrease the frequency of sessions as the patient's condition and coping improve. It is also important to communicate the availability of a return to treatment and/or "booster sessions" if the patient should experience a recurrence of symptoms.

References

- Benton, Tami and Ifeagwu, Judith (2009). Adjustment Disorders. *emedicine from WebMD*. On-line article at <http://emedicine.medscape.com/article/292759-print>.
- Brown, J., Dreis, S., and Nace, D. K. (1999) What Really Makes a Difference in Psychotherapy Outcome? Why Does Managed Care Want to Know? In M.A. Hubble, B. L. Duncan, and S. D. Miller (eds.). *The Heart and Soul of Change: What Works in Therapy*. Washington, D.C.: American Psychological Association Press, 389-406.
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (2000). Washington: American Psychiatric Association.
- Lambert, M. J., Whipple, J. L., Hawkins, D.A., Niewlsen, S. L., Smart, D. W. (2003). Is it Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis. *Clinical Psychology: Science and Practice*, 10, 3, 288-301.
- Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D.A., Nielsen, S. L. (2001). The Effects of Providing Therapists with Feedback on Patient Progress During Psychotherapy: Are Outcomes Enhanced? *Psychotherapy Research*, 11, 1, 49-68.
- Schatzberg, Alan (1990). Anxiety and Adjustment Disorder: A Treatment Approach. *J. Clinical Psychiatry*, 51, 11, 20-24.