Adjustment disorder with depressed mood and

Adjustment disorder with mixed anxiety and depressed mood

At A Glance*

Introduction

Adjustment disorder—a subthreshold diagnosis—has undergone a major evolution since DSM-I, in which it was considered a "transient situational personality disorder" (American Psychiatric Association 1952)

In DSM-IV-TR, adjustment disorder was reduced to six types that again are classified according to their clinical features: with depressed mood, with anxiety, with mixed anxiety and depressed mood, with disturbance of conduct, with mixed disturbance of emotions and conduct, and unspecified. In their study, Despland et al. (1995) suggested reducing the subtypes even further, demonstrating identical profiles for adjustment disorder with depressed mood and adjustment disorder with mixed anxiety and depressed mood and proposing assimilation of mixed anxiety and depressed mood into the depressed mood category. These two groups represented 57% of their adjustment disorder sample; the remainder was classified as adjustment disorder with anxiety and other categories.

TREATMENT

Psychotherapy

Treatment of adjustment disorder rests primarily on psychotherapeutic measures that enable reduction of the stressor, enhanced coping with the stressor that cannot be reduced or removed, and establishment of a support system to maximize adaptation. The first goal is to note significant dysfunction secondary to a stressor and to help the person served moderate this imbalance. Many stressors may be avoided or minimized (e.g., taking on more responsibility than can be managed by the individual or putting oneself at risk by having unprotected sex with an unknown partner). Other stressors may elicit an overreaction on the part of the person served (e.g., abandonment by a lover). The person served may attempt suicide or become reclusive, damaging his or her source of income. In this situation, the therapist would attempt to help the person served put his or her rage and other feelings into words rather than into destructive actions and assist more optimal adaptation and mastery of the trauma–stressor. The role of verbalization cannot be overestimated in an attempt to reduce the pressure of the stressor and enhance coping. The therapist also needs to clarify and interpret the meaning of the stressor for the person served. For example, a mastectomy may have devastated a person's feelings about her body and herself. It is necessary to clarify that the person served is still a woman, capable of having a fulfilling relationship, including a sexual one, and that the person can have the cancer removed or treated and not have a recurrence. Otherwise, the person's pernicious fantasies—"all is lost"—may take over in response to the stressor (i.e., the mastectomy) and make her dysfunctional in work and/or sex and precipitate a painful disturbance of mood that is incapacitating.

Counseling, psychotherapy, medical crisis counseling, crisis intervention, family therapy, and group treatment may be used to encourage the verbalization of fears, anxiety, rage, helplessness, and hopelessness related to the stressors imposed on a person served. The goals of treatment in each case are

to expose the concerns and conflicts that the person served is experiencing, identify means to reduce the stressors, enhance the person's coping skills, and help the person gain perspective on the adversity and establish relationships (i.e., a support network) to assist in the management of the stressors and the self. Cognitive-behavioral therapy, for example, was successfully used in young military recruits (Nardi et al. 1994).

Pharmacotherapy

Although psychotherapy has historically been the mainstay of treatment for the adjustment disorders, Stewart et al. (1992) emphasized the importance of including psychopharmacological interventions in the treatment of minor depression. These authors argued that pharmacotherapy is generally recommended, but data do not support this contention. Despite the lack of rigorous scientific evidence, Stewart and colleagues advocated successive trials with antidepressants in any depressed person (major or minor disorders), particularly if he or she has not benefited from psychotherapy or other supportive measures for 3 months. In a recent randomized, controlled trial in the treatment of minor depressive disorder, fluoxetine proved superior to placebo in reducing depressive symptoms, improving overall psychosocial functioning, and alleviating suffering (Judd 2000). The question remains, does this also apply to adjustment disorders with depressed mood?

Conclusion

The etiological and dynamic attributes of the diagnosis of adjustment disorders make them a fascinating diagnostic category that constitutes a linchpin between normality and pathology, between subthreshold psychiatric morbidity and more serious mental disorders. Appropriate and timely treatment is essential for persons with adjustment disorders so that their symptoms do not worsen, their important relationships are not further impaired, or their capacity to work, study, or be active in their essential interpersonal pursuits is not compromised. In a nutshell, treatment must attempt to forestall further erosion of the person's capacity to function, which could ultimately have grave consequences. Maladaptation may impede the person served to a point at which irreversible losses in important sectors of his or her life occur. The cost to the person served and to society as a whole in terms of disability and lost productivity is enormous. Future research should encompass systematic clinical trials aimed at pure cohorts of persons with adjustment disorders. Cost-benefit analyses of the various treatment modalities must also be undertaken. Although this diagnosis lacks rigorous specificity, its treatment is no less challenging or less important.

The issues of diagnostic rigor and clinical utility seem at odds for the adjustment disorders. Clinicians need a "wild card," and field studies need to use reliable and valid instruments (e.g., depression or anxiety rating scales, stress assessments, length of disability, treatment outcome, family patterns) to determine more exact specification of the parameters of the diagnosis. Identification of the time course, remission or evolution to another diagnosis, and evaluation of stressors (characteristics, duration, and nature of adaptation to stress) would enhance the understanding of the concept of a stress-response illness.

Studies with adequate symptom checklists rated independently from the establishment of the diagnosis would help clarify the threshold between major and minor depression and anxiety, as well as help guide an entry cutoff point for adjustment disorder. Although the upper threshold is established by the criteria for the major syndromes, the lower threshold between an adjustment disorder and problems of living/normality is bereft of operational criteria that would define an entry "boundary." The careful

examination of associated demographic and treatment outcome variables also would enable clinicians to describe more specifically the boundaries between diagnoses. Associated features such as family history, biological correlates, treatment response, and long-term course are all critical to establishing the authenticity of a diagnosis—that is, construct and criterion validity. The theory and practice of medicine have documented the need for a comprehensive multidimensional formulation of multiple physiological and functional variables and mechanisms to describe an illness.

Regardless of their position on the diagnostic tree, subthreshold syndromes can encompass significant psychopathology that must be not only recognized but also treated (e.g., suicidal ideation or behavior). Cross-sectionally, adjustment disorder may appear to be the incipient phase of an emerging major syndrome. Consequently, adjustment disorder, despite its problems with reliability and validity, serves an important diagnostic function in the practice of psychiatry. Problem- and subthreshold-level diagnoses are critical to the function of any medical discipline. Because this disorder may be the initial phase, or a mild form, of a dysfunction that is not yet fully developed, the relation between the incipient and the developed and between the subthreshold and the defined must be described. This apparent chaos, lack of specificity, and questionable reliability and validity are the hallmark of interface disorders and subthreshold phenomena, whether they are in diabetes mellitus, hypertension, or depression.

Combined with the remaining problem of the certainty of the diagnosis, the question prevails: Should drugs be used in the treatment of adjustment disorders? The solution to this dilemma demands a caution with regard to pharmacological intervention; the pharmacological studies are currently inconclusive. The diagnostic uncertainty of adjustment disorder presents sufficient difficulty in and of itself, with its mixed features, frequent combination with medical comorbidity, and placement in the gray area of diagnosis (Hosaka et al. 1994; Hugo et al. 1996; Oxman et al. 1994). It is better to be cautious and delay psychotropic drug administration rather than subject the person served to the risk of unfavorable other drug–psychotropic drug interaction(s). The condition may resolve, or it may evolve into a major psychiatric illness that needs to be treated accordingly, which could include pharmacological agents.

Perhaps secondary to the subjective nature of the diagnosis, diagnostic tools to aid clinicians in identifying this condition are significantly lacking. Many widely used screening instruments (e.g., Clinical Interview Schedule—Revised, Composite International Diagnostic Interview) found in psychiatric research today fail to incorporate the diagnosis (Casey 2001; Casey et al. 2001). Although the Hospital Anxiety and Depression Scale, a commonly used self-report screen for psychological distress in hospitalized patients, does not screen for adjustment disorders specifically, a recent study of terminally ill cancer patients found it to be a useful predictor of adjustment disorders and major depression in persons who did not show clinical evidence of psychological distress at baseline (Akechi et al. 2004). Brief screening instruments have also recently been developed to help in the detection of adjustment disorders in cancer patients. The one-question interview and the impact thermometer are two such instruments that appear efficacious in identifying cases (Akizuki et al. 2003, 2005). Although they have shown to be valid tools, they lack the ability to distinguish between adjustment disorder and other depressive disorders, thus limiting their usefulness in promoting the concept of adjustment disorder as a separate and meaningful diagnostic entity.

The characteristics of a mental disorder vary over the life cycle, and this variation is clearly illustrated by the adjustment disorders. Certain developmental epochs may be associated with a particular symptom

profile, as seen with acute myocardial infarction and appendicitis. The effect of the stressor may vary, and the assessment of functioning must be "measured" according to the demands of the developmental stage (e.g., school [youth], work [adults], self-care and maintenance [elderly]). The symptom characteristics and functional assessment of other diagnoses also may vary along the developmental schema from birth to senescence. Illnesses such as major depressive disorders, organic mental disorders, sexual dysfunctions, and eating disorders need to be reformulated in another hierarchy to incorporate the vicissitudes of the stage of the life cycle extant at the time of the assessment. Considering normal variations across developmental epochs would make adjustment disorder and other DSM-IV-TR disorders much more reliable and valid and less vulnerable to being characterized as "unfair" in regard to the aged, children and youth, or the medically ill (L. George, personal communication, May 1981; Strain 1981). The result would be a taxonomy accommodating to the vicissitudes of development, gender, age, and medical illness.

Such an effort also may make adjustment disorder, and DSM-IV-TR and future editions of DSM, more useful to child psychiatrists, pediatricians, geriatricians, geriatric psychiatrists, and primary care specialists, who currently believe that too often their persons' problems do not conform to psychiatry's lexicon. In fact, a significant number of persons served remain at the problem level of diagnoses with their somatic complaints as well. It is common for a fever of unknown origin not to be diagnosed or for chest pain to remain unspecified. It is the art of medicine that makes it a profession, and it is a most difficult one at the interface of medicine and psychiatry, or at the interface of normality and pathology. Anna Freud (1968) emphasized the difficulty of understanding normality and pathology in her assessments of childhood. This important advice would prevail across the life cycle and be an important challenge to the developers of the subthreshold diagnoses (e.g., adjustment disorder) and future editions of DSM.

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