Journal of Psychiatry
ISSN: 2378-5756

Ali, J Psychiatry 2015, 18:5
DOI: 10.4172/2378-5756.1000324

Short Communication Open Access

Adjustment Disorders (Stress Related or Psychiatric Disorder)

Ismail Ali*

Al Azhar University, consultant of psychiatry, KJOH, KSA, chief of CME, KJOH, Saudi Arabia

Adjustment disorder is a stress-related, short-term, nonpsychotic disturbance associated with impairment in some element of general functioning of patients because their emotional or behavioral response to an identifiable stressful event or change in the person's life [1]. The disorder usually begins within 3 months of the stressful event and should subside when the stressor resolves or the person has adapted to the change, usually within 6 months [1]. Adjustment disorders constitute a diagnostic category that lies between health and pathology. Adjustment disorders are located on a continuum between normal stress reactions and specific psychiatric disorders. A number of studies have reported rates around 12% across a variety of populations. In clinical patient populations, rates as high as 23% have been recorded [2-8]. Depressed mood was the most common subtype assigned (11.6%), followed by anxious mood, mixed anxiety and depressed mood, and disturbance of conduct [9-15]. According to *DSM-5,* a principal diagnosis of adjustment disorder is made in approximately 5-20% of individuals undergoing outpatient mental health treatment. In the setting of a hospital psychiatric consultation service, adjustment disorder is often the most common diagnosis, with frequencies as high as 50% [1]. Most studies report no significant differences in prevalence among age groups [5,16-19]. Approximately half of the patients with adjustment disorder suffered from depressed/irritable mood (59%), sleep disturbances (48%), and poor performance in school (48%).

Pathophysiology

The pathology of adjustment disorders is not clear. Human life involves constant adaptation to change. Distress and disorder occur when the need to adapt exceeds the person's capacity to maintain psychological or physiological equilibrium. Adaptation at the physical level involves the activity of monoamine neurotransmitters, hormones, and other neuromodulators. Rao et al. observed that patients with adjustment disorders had a significantly higher maximal binding capacity of the platelet serotonin-2A receptor [17]. Factors that contribute to the meaning of a stressor and, thus, to adjustment disorder, include the patient's genetic endowment, preexisting personality, past personal history, stage of development, psychological qualities (cognitive capacities, typical coping patterns,), and overall constitution [7,20-23]. A vast majority of patients with adjustment disorders defined themselves as "insecurely attached" and tended to "keep a larger interpersonal distance from self-images, family members, and significant others," in addition to having "low self-esteem, self-efficacy, and poor social support from family, friends, and significant others" [10] .

The most important factor in the development of adjustment disorder in a child is his or her degree of vulnerability, which depends on the characteristics of both the child and the child's environment.

Social Factors Related to Suicidality

Patients experiencing suicidal intent with adjustment disorders had less education and lower social status than the patients with major depression; in addition, they were more likely to be unmarried. There is no significant differences in suicide methods between the patients with adjustment disorders and patients with major depression the patients with adjustment disorders who made suicide attempts were characterized by previous psychiatric treatment, poor psychosocial functioning at treatment entry, suicide as a stressor, dysphoric mood, and psychomotor restlessness Mitrev et al. found that suicide risk was higher in patients with chronic adjustment disorder and in individuals with previous suicide attempts [12]. Patients aged 15-19 years demonstrated the highest suicide risk. The suicide risk for women increased with age. Polyakova et al. found that the interval from the first symptoms to the suicide attempt was shorter in the group with adjustment disorder than in the group with major depression. An emergency department (ED) study of individuals who engaged in deliberate self-harm determined that a clinical diagnosis of adjustment disorder was made in 31.8% of those interviewed [6,12,13,14,24].

Prognosis

As many as 70% of patients with adjustment disorder in adult medical settings of general hospitals receive comorbid psychiatric diagnoses, such as personality disorders, anxiety disorders, affective disorders, and psychoactive substance abuse disorders. 59% of individuals diagnosed primarily with adjustment disorder were relabeled on discharge with a primary diagnosis of substance abuse [9]. Andreasen and Hoenk reported that in children and adolescents, more serious mental illnesses were present at 5 years' follow-up [2].

Approach Considerations

In the absence of controlled trials comparing different modalities of treatment, selection of treatments remains a clinical decision, influenced by consensus and common practice. No particular treatment may be considered "optimal" or the "treatment of choice" [23]. For instance, clinicians should consider both psychotherapy and pharmacotherapy for patients who have adjustment disorder with depressed anxious mood [3,18,23,25,26]. Most studies acknowledge that brief, rather than long-term, psychotherapy is most appropriate for persons with adjustment disorder because this disorder tends to be time-limited [5,6,11,21]. Accordingly, treatment of adjustment disorders entails psychotherapeutic counseling aimed at reducing the stressor, improving the ability to cope with stressors that cannot be reduced or removed, and developing emotional states and support systems that enhance adaptation and coping. The goal of pharmacotherapy is to ameliorate the debilitating symptoms of the adjustment disorder, reduce morbidity, and prevent complications rather than treatment of the disorder itself. The agents most commonly prescribed for individuals with this disorder are benzodiazepines and antidepressants [4,5,20,22,25,27].

***Corresponding author:** Ismail Ali, Al Azhar University, consultant of psychiatry, KJOH, KSA, chief of CME, KJOH, Saudi Arabia, Tel: 00966563000721; E-mail: alysmail4@gmail.com

Received July 28, 2015; **Accepted** August 29, 2015; **Published** September 05, 2015

Citation: Ali I (2015) Adjustment Disorders (Stress Related or Psychiatric Disorder). J Psychiatry 18: 324 doi:10.4172/2378-5756.1000324

References

1. American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, (5thedtn). Arlington, VA: American Psychiatric Association 286-9.
2. Andreasen NC, Hoenk PR (1982) the predictive value of adjustment disorders: a follow-up study. Am J Psychiatry 139: 584-90.
3. Beck JC (1998) Legal and ethical duties of the clinician treating a patient who is liable to be impulsively violent. Behav Sci Law Summer. 16: 375-89.
4. Brown RL, Brown RL, Saunders LA, Castelaz CA, Papasouliotis O (1997) Physicians' decisions to prescribe benzodiazepines for nervousness and insomnia. J Gen Intern Med 12: 44-52.
5. Casey P, Bailey S (2011) Adjustment disorders: the state of the art. World Psychiatry 10: 11-8.
6. Casey P (2009) Adjustment disorder: epidemiology, diagnosis and treatment. CNS Drugs 23: 927-38.
7. Despland JN, Monod L, Ferrero F (1995) Clinical relevance of adjustment disorder in DSM-III-4 and DSM-IV. Compr Psychiatry 36: 454-60.
8. Grassi L, Mangelli L, Fava GA, Grandi S, Ottolini F, et al. (2007) Psychosomatic characterization of adjustment disorders in the medical setting: some suggestions for DSM-V. J Affect Disord 101: 251-4.
9. Greenberg WM, Rosenfeld DN, Ortega EA (1995) Adjustment disorder as an admission diagnosis. Am J Psychiatry 152: 459-61.
10. Kienlen KK, Birmingham DL, Solberg KB, O'Regan JT, Meloy JR (1997) A comparative study of psychotic and nonpsychotic stalking. J Am Acad Psychiatry Law 25: 317-34.
11. Kisely S, Preston N, Rooney M (2000) Pathways and outcomes of psychiatric care: does it depend on who you are, or what you've got?. Aust N Z J Psychiatry 34: 1009-14.
12. Mitrev I (1996) A study of deliberate self-poisoning in patients with adjustment disorders. Folia Med (Plovdiv) 38: 11-6.
13. Pelkonen M, Marttunen M, Henriksson M, Lönnqvist J (2005) Suicidality in adjustment disorder--clinical characteristics of adolescent outpatients. Eur Child Adolesc Psychiatry 14: 174-80.
14. Polyakova I, Knobler HY, Ambrumova A, Lerner V (1998) Characteristics of suicidal attempts in major depression versus adjustment reactions. J Affect Disord 47: 159-67.
15. Ponizovsky AM, Levov K, Schultz Y, Radomislensky I (2011) Attachment insecurity and psychological resources associated with adjustment disorders. Am J Orthopsychiatry 81: 265-76.
16. Presicci A, Lecce P, Ventura P, Margari F, Tafuri S, et al. (2010) Depressive and adjustment disorders-some questions about the differential diagnosis: case studies. Neuropsychiatr Dis Treat 6: 473-81.
17. Rao ML, Hawellek B, Papassotiropoulos A, Deister A, Frahnert C (1998) Upregulation of the platelet Serotonin2A receptor and low blood serotonin in suicidal psychiatric patients. Neuropsychobiology 38: 84-9.
18. Schatzberg AF (1990) Anxiety and adjustment disorder: a treatment approach. J Clin Psychiatry 51: 20-4.
19. Schnyder U, Valach L (1997) Suicide attempters in a psychiatric emergency room population. Gen Hosp Psychiatry 19: 119-29.
20. Shaner R (2000) Benzodiazepines in psychiatric emergency settings. Psychiatr Ann 4: 268-75.
21. Sifneos PE (1989) Brief dynamic and crisis therapy. Kaplan HI, Sadcock BJ, eds. Comprehensive Textbook of Psychiatry. 5th ed. Baltimore, Md: Williams & Wilkins 2: 1562-7.
22. Stewart JW, Quitkin FM, Klein DF (1992) The pharmacotherapy of minor depression. Am J Psychother 46: 23-36.
23. Strain JJ, Smith GC, Hammer JS, McKenzie DP, Blumenfield M, et al. (1998) Adjustment disorder: a multisite study of its utilization and interventions in the consultation-liaison psychiatry setting. Gen Hosp Psychiatry 20: 139-49.
24. Taggart C, O'Grady J, Stevenson M, Hand E, Mc Clelland R, et al. (2006) Accuracy of diagnosis at routine psychiatric assessment in patients presenting to an accident and emergency department. Gen Hosp Psychother. 28: 330-5.
25. Uhlenhuth EH, Balter MB, Ban TA, Yang K (1995) International study of expert judgment on therapeutic use of benzodiazepines and other psychotherapeutic medications: III. Clinical features affecting experts' therapeutic recommendations in anxiety disorders. Psychopharmacol Bull 31: 289-96.
26. Uwakwe R (2000) Psychiatric morbidity in elderly patients admitted to non-psychiatric wards in a general/teaching hospital in Nigeria. Int J Geriatr Psychiatry 15: 346-54.
27. Wai BH, Hong C, Heok KE (1999) Suicidal behavior among young people in Singapore. Gen Hosp Psychiatry 21: 128-33.