Professor Robert J Edelmann
r.edelmann@btinternet.com
+44 (0) 208 871 4219

The Misdiagnosis of Adjustment Disorder

By Professor Robert J Edelmann

Having undertaken medico-legal assessments, largely in relation to personal injury claims, for almost three decades I have seen numerous reports prepared by my psychology and psychiatry colleagues. In that time I have witnessed the diagnosis of Adjustment Disorder used with increasing frequency in relation to responses to a range of situations. These include minor road traffic accidents, trips and falls where physical symptoms have seemingly persisted in the absence of any identifiable physical pathology and negligence claims following surgical procedures, often for cosmetic purposes, where the person is unhappy or dissatisfied with the outcome.

Adjustment Disorder as a diagnostic category has had a rather chequered history with some being highly critical of its use (e.g. Casey et al., 2001). Indeed, Strain and Deifenbacher (2008) have described it as a subthreshold disorder "between normal behaviour and the major psychiatric morbidities". However, if one considers that behavioural and emotional difficulties lie along a continuum from slightly concerning to clinically significant conditions that warrant a psychiatric diagnosis then the key issue is discerning a slight difficulty from one which is disruptive to everyday functioning. There is obviously a difference between feeling somewhat down or sad and being clinically depressed, between being a bit anxious and being fearful to the extent of being phobic or suffering regular panic attacks, and being emotionally troubled after an accident rather than suffering from Post Traumatic Stress Disorder. One can also be reasonably certain that if the person's emotional and behavioural difficulties are such that a Psychiatric diagnosis is warranted then they will be struggling to cope with everyday life. In all these instances it is possible to derive evidence from diagnostic interview schedules and psychometric measures to augment one's clinical experience in order to diagnose Depression, an Anxiety Disorder or Post Traumatic Stress Disorder with a reasonable degree of certainty.

Unfortunately, as Strain and Deifenbacher (2008) note in relation to Adjustment Disorder: "secondary to the subjective nature of the diagnosis, diagnostic tools to aid clinicians in identifying this condition are significantly lacking". It is thus perhaps not surprising that prevalence rates are highly variable with between 5% and 20% of individuals in outpatient health treatment having a principle diagnosis of Adjustment Disorder while as many as 50% receive such a diagnosis in hospital psychiatric consultation settings (DSM-5). The key principle, however, should be that, as with a diagnosis of other psychiatric conditions, if a psychiatric diagnosis is warranted then the person will be struggling to cope with everyday life. This is alluded to in the diagnostic criteria as specified in both the DSM 5 and ICD10 as indicated below.

DSM 5 Diagnostic criteria for Adjustment Disorders

A. The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s)

B These symptoms or behaviours are clinically significant as evidenced
by one or both of the following:
(i) marked distress that is out of proportion to the severity and intensity of the stressor, taking into account the external context and the cultural factors that might influence symptoms severity and presentation.
(ii) significant impairment in social, occupational or other important areas of functioning

C The stress-related disturbance does not meet the criteria for another
mental disorder and is not merely an exacerbation of a pre-existing mental disorder.

D. The symptoms do not represent normal bereavement

E. Once the stressor or its consequences have terminated, the symptoms
do not persist for more than an additional six months.