“If the person is maintaining all aspects of their life in exactly the same manner as prior to the index event, then, although they may be upset by the index event, it would seem highly unlikely that the distress they are experiencing is clinically significant”

ICD10 F43.2 Adjustment Disorder

States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine.

Unfortunately, in both the DSM 5 and ICD10 definitions, disruption to social functioning is only a possible and not an essential element of the disorder. This means that symptoms of marked or subjective distress can be taken as an indicator of Adjustment Disorder. How though does one assess ‘marked distress’? In essence Adjustment Disorder can be taken as simply implying that the person has not adjusted or coped well with an identifiable stressor. However, such distress must be “out of proportion to the severity and intensity of the stressor” (DSM-5) and should “usually interfere with social functioning and performance” (ICD10). Interestingly, the SCID-5, a diagnostic interview schedule developed specifically to aid in the diagnosis of DSM5 defined psychiatric conditions, specifies questions “as needed” relating to any affects of symptoms on relationships, work, taking care of things at home or in relation to other important parts of the person's life to facilitate the diagnosis of an Adjustment Disorder. If the person is maintaining all aspects of their life in exactly the same manner as prior to the index event, then, although they may be upset by the index event, it would seem highly unlikely that the distress they are experiencing is clinically significant. In such contexts one would have to assume that a diagnosis of Adjustment Disorder is inappropriate. Unfortunately minimal emotional or behavioural difficulties often seem to be taken as indicating Adjustment Disorder and one would have to assume that the disorder is being diagnosed too frequently and erroneously.

In any research based study where patients with psychiatric diagnoses are compared then rigorous methods, including diagnostic interview schedules to aid diagnoses or key evidence to support a particular diagnosis is expected. Simply referring to clinical experience on its own is not considered to be a sufficient basis for a diagnosis. Such rigour is not expected for therapy purposes in clinical contexts where clinical experience is sufficient to offer a possible diagnosis. One would assume that in terms of diagnostic rigour a medico-legal assessment should be more akin to a research study than an assessment for purposes of therapy. It is a great pity then that evidence based rigorous assessments in relation to Adjustment Disorder in medico-legal contexts often seems to be sadly lacking.

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