

## Adjustment Disorders in DSM-5: Implications for Occupational Health Surveillance

Francesco Chirico

Institute: State Police Health Service  
Department, Ministry of Interior, Italy

Corresponding author: Chirico F

✉ medlavchirico@gmail.com

Institute: State Police Health Service  
Department, Ministry of Interior, Italy.

Tel: 3346904194

**Citation:** Chirico F. Adjustment Disorders in DSM-5: Implications for Occupational Health Surveillance. *Acta Psychopathol.* 2015, 1:1.

### Abstract

Work-related stress is experienced when the demands of the work environment exceed the employees' ability to cope with (or control) them. Recently, in DSM-5, disorders which are precipitated by specific stressful and potentially traumatic events in the workplaces are included in a new diagnostic category, "Trauma and Stress-related Disorders", which includes both Adjustment Disorders (Ads) and PTSD. Adjustment disorder is a common diagnosis in psychiatric settings and carries a significant rate of morbidity. Nevertheless, until now, despite its relative frequency, adjustment disorder has been poorly covered in the literature; this diagnostic category has been the subject of criticism. Occupational Health Surveillance could reduce the misdiagnosis of AD and, simultaneously, improve the research on "work-related stress disorders".

**Keywords:** Adjustment disorder; Work-related stress disorders; DSM-5; Occupational health surveillance

**Received:** September 25, 2015; **Accepted:** October 05, 2015; **Published:** October 11, 2015

### Adjustment disorders in DSM-5: implications for occupational health surveillance

Over the last decade a consistent increase in stress-related psychological consequences at the workplace has been seen. Stress isn't a disease, but if it is intense and goes on for some time, it can lead to mental and physical ill-health. The Health and Safety Executive in the UK defines work related stress as being 'the process that arises where work demands of various types and combinations exceed the person's capacity and capability to cope' [1]. According to EU-OSHA it is convenient to summarize the possible health and health-related effects of work-related stress under two headings: psychological and social effects, and physiological and physical effects [2]. From, often cross-sectional, studies it can be deduced that an association exists between work-related psychosocial risk factors and distress symptoms. Reviews have examined the association of work-related psychosocial factors and depressive disorders [3] and all common mental disorders combined [4, 5]. Mental disorders attributed to work-related stress include post-traumatic stress disorder, burn-out, adjustment disorder (AD), depression and anxiety [6]. However, it is not always clear whether such risk

factors lead to clinically significant work-related stress disorders. Interestingly, Cox and Griffiths reported that the literature which describes the translation from a normal psychological reaction to events to *psychological* illness is not well formed, except in the case of post-traumatic stress and related disorders [2]. The term "work-related stress disorders" has been applied to many overlapping stress-related concepts and diagnoses such as neurasthenia, AD and burnout. Unfortunately, there is no consensus based on these concepts, terms, and diagnoses or on criteria that can be used in practice for employees with serious work-related problems or disorders [7]. For example, Burnout is not a psychiatric diagnosis but a concept of the occupational psychology concerning the impact of working conditions on the psyche of affected persons. Depression and burnout appear to be interrelated. Research reported the overlap of job-related burnout and depressive disorders, i.e., major depressive disorder, dysthymia, and minor depressive disorder and the need for their differential diagnosis has been highlighted in many reviews [8]. A group of Canadian psychiatrists has argued that burnout can be considered a particular mental adjustment disorder as described by DSM [9]. Moreover, according to Dutch guidelines on DSM-IV TR, adjustment disorders (Ads) were classified into the categories of distress, nervous breakdown, and burnout [7]. In Italy, the

Italian Workers Compensation Authority (INAIL) recognizes and identifies the Post-Traumatic Stress Disorder (PTSD) and the Chronic Adjustment Disorder as professional illnesses referable to situations of Mobbing and task-related Bullying [10-12]. Moreover, INAIL recognizes the Chronic Adjustment Disorder such as the most frequently diagnosed psychiatric disorder caused by work-related stress. AD is an abnormal and excessive reaction to an identifiable life stressor. The reaction is more severe than would normally be expected, and can result in significant impairment in social, occupational or academic functioning. AD occurs when an individual is unable to cope and develops behavioural or emotional symptoms. According to DSM 5, ADs are common, although prevalence may vary widely as a function of the population studied and the assessment methods used. The percentage of individuals in outpatient mental health treatment with a principal diagnosis of an adjustment disorder ranges from approximately 5% to 20%. In a hospital psychiatric consultation setting, it is often the most common diagnosis, frequently reaching 50% [13]. AD is a very common diagnosis in clinical practice, but we still lack data about its rightful clinical entity, because it has found little place in the scientific literature. SCID interview for DSM IV TR was rarely used for scientific research. By contrast, research on work-related stress very often used self-reported instruments such as questionnaires for reporting anxiety, depression, burnout or other outcomes such as job satisfaction, sickness absence, presenteeism and ill health retirement [14]. Nevertheless, "adjustment disorder" is an accepted medical diagnosis and is consistent with experience in occupational health practice. This diagnosis, which includes impaired functioning and marked distress, seems most appropriate because it covers the work-related problems seen in daily practice [7]. According to Casey's review [15], since its introduction the category of AD has been the subject of criticism on three fronts. The first was that it constituted an attempt to medicalize problems of living and did not conform to the criteria for traditional disorders such as having a specific symptom profile [16]. The second was that it was a "wastebasket diagnosis" which was assigned to those who failed to meet the criteria for other disorders [17]. The third was on its diagnostic instability and that its main utility was to serve as a "justification" for diagnosis-based reimbursement operating in the healthcare system of the US [18].

Diagnostic criteria by DSM IV TR are vague and lead to many difficulties in terms of validity and reliability. Moreover, one of the most insightful critics of the DSM-IV, J. Wakefield [19], points out that it would allow the top third in the normal distribution of mood reactivity to be classified as disordered, and that it does not take into account the contextual factors that might cause this excess in distress. Casey has pointed out that AD is poorly delineated in both DSM IV TR and ICD-10. The boundary between adjustment disorder and normal adaptive stress is not addressed and the differentiation from other psychiatric disorders such as major depression and generalized anxiety is difficult since the criteria are underdeveloped and rudimentary [20]. Therefore AD is common in medical and psychiatric settings but is frequently misdiagnosed [21]. Some studies have found a discrepancy between AD when diagnosed clinically as compared to using a structured interview. Clinical diagnosis has identified a higher

prevalence for adjustment disorder, which, when structured interviews are used, is replaced by major depression [20]. In DSM IV TR, structured diagnostic instruments (SCID), having been designed for use by lay interviewers, for a diagnosis such as adjustment disorder, which relies heavily on clinical judgement, context and presumptive longitudinal course rather symptoms alone, was considered an overly rigid diagnostic instrument [24]. Recently, the DSM IV TR system has been replaced with a more simplified, non-axial documentation approach in the DSM-5. In DSM-5, disorders which are precipitated by specific stressful and potentially traumatic events in the workplaces are included in a new diagnostic category, "Trauma and Stress-related Disorders", which includes both ADs and PTSD [13]. The Structured Clinical Interview for DSM 5 (SCID-5) is a semi-structured interview guide for making DSM-5 diagnoses such as AD and has replaced the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). According to American Psychiatric Association, the SCID-5 can be used also in comprehensive forensic diagnostic evaluation. Moreover, the diagnostic data that have been obtained using the SCID-5 interview can be utilized by researchers, practitioners, policy makers, and the general public that are interested in prevalence and incidence estimates of psychiatric disorders among certain populations [13]. In DSM 5 AD have been classified under the trauma and stress related disorders for the first time. In addition, differently from DSM IV-TR, to diagnosing AD, marked distress must take into account the external context and the cultural factors that might influence symptom severity and presentation and significant impairment is in social, occupational or in other important areas of functioning. Therefore, differently from "normative stress reactions", the diagnosis "adjustment disorder" should only be made when the magnitude of the distress (e.g., alterations in mood, anxiety, or conduct) exceeds what would normally be expected (which may vary in different cultures) or when the adverse event precipitates functional impairment [13]. Friedman assert that there is heuristic value in grouping this set of disorders in a specific stress-related category as it enables clinicians to differentiate between normal (non-pathological) distress, from acute, diffuse clinically elevated stress reactions indicative of AD, to more severe and chronic psychopathology (including PTSD) [22, 23]. Nevertheless, despite this positive step, there are still problems with the classification of ADs. According to Casey [24] there is no guidance on the distinction from normal stress reactions, it remains a subthreshold category, and the subtypes are not strongly underpinned by research. Moreover, there are no specific diagnostic criteria in terms of symptom numbers or combinations of these, unlike most conditions classified in DSM. Occupational health surveillance is the process of monitoring the health of employees exposed to specific health risks during the course of their work. It's a control measure that may be needed in some situations where health risks cannot be eliminated or adequately controlled. When health surveillance for work-related stress is needed, occupational physicians, psychiatrists, psychologists, experts in work organization should operate in strict cooperation for diagnosing Chronic Adjustment Disorder in the workplace. In occupational health practice, questionnaires could be useful in the first step medical examination (occupational physician), but it is necessary a second step for the organizational analysis

(expert in work organization) and the third step psychiatric and psychological examination [11, 12]. This latter phase needs both clinical examination and SCID-5. Moreover, occupational health surveillance can give an advantage, because AD is a longitudinal

diagnosis based on aetiology and outcome [24]. This procedure could reduce the misdiagnosis of AD and, simultaneously, improve the research on “work-related mental disorders”.

## References

- 1 Health and Safety Executive (2009) 'Stress-related and psychological disorders', Health and Safety Executive (2009) 'Work Related Stress' (2009).
- 2 Cox T, Griffiths A (2010) Work-related stress: A theoretical perspective. In: Leka S, Houdmont J, editors. *Occupational Health Psychology*. Oxford: Wiley-Blackwell 31-56.
- 3 Bonde JP (2008) Psychosocial factors at work and risk of depression: a systematic review of the epidemiological evidence. *Occup Environ Med* 65: 438-445.
- 4 Nieuwenhuijsen K, Bruinvels D, Frings-Dresen M (2010) Psychosocial work environment and stress-related disorders, a systematic review. *Occupational Medicine* 60: 277-286.
- 5 Stansfeld S, Candy B (2006) Psychosocial work environment and mental health—a meta-analytic review. *Scand J Work Environ Health* 32: 443-462.
- 6 Australia Government- Australian Safety and Compensation Council- Work-related mental disorders in Australia, 2006.
- 7 Van der Klink JLL, van Dijk FJH (2003) Dutch practice guidelines for managing adjustment disorders in occupational and primary health care. *Scand J Work Environ Health* 29: 478-479.
- 8 Ahola K, Honkonen T, Isometsa E, Kalimo R, Nykyri E, et al. (2005) The relationship between job-related burnout and depressive disorders—results from the Finnish Health 2000 Study. *J Affect Disord* 88: 55-62.
- 9 Schaufeli WB, Leiter MP, Maslach C (2009) Burnout: 35 years of research and practice. *The Career Development International* 14: 204-220.
- 10 Signorelli MS, Costanzo MC, Cinconze M, Concerto C (2013) What kind of diagnosis in a case of mobbing: post-traumatic stress disorder or adjustment disorder? *BMJ Case Reports*.
- 11 Sed B, Magrini A, Livigni L, Pietroiusti A, Somma G, et al. (2006) Evaluation approach to chronic stress, organizational constrictivity, and mobbing. *G Ital Med Lav Erg* 28: 3
- 12 Taino G, Pizzuto C, Pucci E, Imbriani M (2014) Reactive anxiety crisis and chronic adjustment disorder: a unique case of work injury and suspected occupational disease. *G Ital Med Lav Ergon* 36: 118-123.
- 13 American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington.
- 14 Henderson M, Harvey SB, Overland S, Mykletun A, Hotopf M (2011) Work and common psychiatric disorders. *J R Soc Med* 104: 198-207.
- 15 Casey P, Bailey S (2011) Adjustment disorders: the state of the art. *World Psychiatry* 10: 11-18.
- 16 Fabrega H, Mezzich J (1987) Adjustment disorder and psychiatric practice: cultural and historical aspects. *Psychiatry* 50: 31-49.
- 17 Fard F, Hudgens RW, Welner A (1979) Undiagnosed psychiatric illness in adolescents: a prospective study. *Arch Gen Psychiatry* 35: 279-281.
- 18 Greenberg WM, Rosenfeld D, Ortega E (1995) Adjustment disorder as an admission diagnosis. *Am J Psychiatry* 152: 459-61.
- 19 Wakefield J (1997) Diagnosing DSM-IV. Part 1: DSM-IV and the concept of disorder. *Behav Res Ther* 35: 633-649.
- 20 Casey P, Doherty A (2012) Adjustment Disorder: implications for ICD-11 and DSM-5. *Br J Psychiatry* 201: 90-92.
- 21 Shay Gur MD, Haggai Hermesh MD, Neil Laufer MD, Michal Gogol BA, Ruth Gross-Isseroff DSc (2005). Adjustment Disorder: A Review of Diagnostic Pitfalls. *Isr Med Assoc J* 7: 726–731.
- 22 Friedman MJ, Resick PA, Bryant RA, Brewin CR (2011) Considering PTSD for DSM 5. *Depress Anxiety* 28: 750-769.
- 23 Kangas M (2013) DSM-5 trauma and stress-related disorders: implications for screening for cancer-related stress. *Frontiers in psychiatry* 4: 1-3.
- 24 Casey P (2014) Adjustment disorder: new developments. *Curr Psychiatry Rep* 16: 451.