1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:

    1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.

    1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA. However UK psychiatrists were consulted in its formulation.

2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable.

3. This appendix discusses the clinical features and aetiology of adjustment disorders. It is generally based on the ICD-10 system with any major comparisons and distinctions with DSM-IV being discussed where relevant. The ICD-10 codes (numbers usually prefixed with F) are also provided.

REACTIONS TO STRESSFUL EXPERIENCES: THE NORMAL RESPONSE

4. Most people react to stress with an emotional or somatic (physical) response. These are normal reactions and do not constitute mental disorders in themselves, although some people seek help from their doctor. What is interpreted as being stressful will vary from one individual to another and the ways in which they respond vary similarly. The response depends on personality variables, childhood experiences, family history and the resulting coping mechanisms developed as a result of these factors.

5. There are three components to the normal response:

    5.1. The emotional response to danger or threat is fear and anxiety. The response to loss is sadness or feeling "depressed".

    5.2. The somatic reactions to threat are those of autonomic arousal and include rapid pulse, dry mouth, increased muscle tension and gastro-intestinal sensations. The physical response to loss is reduced energy and physical activity.

    5.3. The third part of the response comprises those psychological mechanisms which reduce the impact of the emotions engendered. Everyone unconsciously develops a variety of these "defence mechanisms" to differing degrees in order to help them deal with mental conflict. Some of the most commonly employed psychological processes are

        5.3.1. **regression** which is adopting behaviour from an earlier stage of development, e.g. passively being taken care of like a child.

5.3.2. **denial** which is refusing to accept what someone would normally be expected to believe, for example someone is told they have terminal cancer but carries on as if unaware of the diagnosis.

5.3.3. **displacement** where the emotion is shifted onto to another less sensitive object, e.g. being angry with other people instead of the spouse.

5.3.4. **repression** where uncomfortable memories or emotions are kept out of awareness.

5.3.5. **identification** where the characteristics of another are incorporated in a person's own behaviour to reduce the sense of loss, e.g. carrying on a spouse's activities or hobbies following their death.

5.4. Other coping strategies include actual avoidance (so that the stressful situation is no longer encountered) and coming to terms with the situation. This latter involves working through the unpleasant idea and emotion by repeatedly recalling the event and finding a way of accepting it has happened. It is then possible to progress. Maladaptive strategies may be employed including the excessive use of alcohol or drugs, aggressive behaviour and deliberate self-harm.

6. These normal reactions to stressful experiences may lead the individual into contact with health and related services. However **they are not considered to be illnesses**, **mental disorders or personality disorders**. These adjustment reactions and behaviours are recorded in the ICD-10 under "Z" codes and the DSM-IV as "V" codes.

Some of the most common situations are outlined below:

6.1. **Accentuation of personality traits** Z73.1

This refers to the more florid appearance of personality traits under certain circumstances. For example when a shy, restrained and timid person is required to speak in public for the first time, anxiety builds as the day approaches and the performance may be hampered by blushing and difficulty in speaking, their demeanour being even more timid than usual. This person is obviously not mentally ill, nor do they have a personality disorder. Other examples include the histrionic personality's increase in ostentatious weeping when their demands are thwarted, or the low mood of a depressive personality when faced with disappointments.

6.2. **Phase of life problem** Z60

Most people find difficulties in adjusting to various changes during life including problems associated with starting school, changing jobs, starting a new career, marriage, divorce and retirement. Individuals with certain personality traits may have more difficulty than others; for example those with high dependency may find returning to work after a long break threatening. Similarly those with a strong need for structure may find difficulties in adjusting to retirement or change of career.

6.3. **Employment difficulties** Z56

Some may encounter problems more specifically relating to employment this including job satisfaction or dissatisfaction, "burn-out" and unemployment. Personality traits such as a lack of initiative may hamper efficient resolution of employment difficulties.

6.4. **Problems relating to lifestyle** Z72

This includes the effect of inappropriate diet and eating habits, lack of exercise, tobacco, alcohol and drug use and high-risk sexual behaviour.

6.5. **Bereavement** Z63

The normal grief reaction can include disbelief, shock, numbness, waves of grief, pining, anger, guilt, hearing the dead person's voice, feelings of exhaustion, despair and powerlessness. The normal response to bereavement may cause severe disruption to the person's functioning but only if it is exceptionally severe or prolonged is it considered to be a mental disorder.

6.6. **Intentional self harm** X60-84

Of those people who harm themselves for example by cutting or taking overdoses of various medications, few have a major psychiatric disorder. The motive behind some of these impulsive acts is obscure although quarrels or threats of rejection by partners are common antecedents of many acts of deliberate self harm. The reaction may represent a way of communicating in those people who have restricted internal resources, the behaviour being used to try and influence others. An isolated incident of this sort in the absence of other symptoms is a maladaptive response and does not constitute a mental disorder.

6.7. However if these acts are repeated or are accompanied by other symptoms, a mental disorder or personality disorder should be considered, the latter being diagnosed in one third of people who deliberately harm themselves.

THE ABNORMAL RESPONSE TO STRESSORS

7. A wide variety of behaviour falls within the normal range and most neurotic disorders are on a continuum with the normal. If a stressor is sufficiently severe and/or the person is vulnerable (see below) various mental disorders may develop. The stage at which symptoms constitute a disorder or disease depends on several factors including their severity and duration, whether treatment is required and various other social and cultural factors. The disorders most commonly associated with exposure to a stressful event include acute stress reaction, post-traumatic stress disorder, the adjustment disorders and depressive reactions, phobic and other anxiety disorders, and acute and transient psychotic disorders.

ADJUSTMENT DISORDERS

CLINICAL MANIFESTATIONS

8. These are disorders which are reactions to stressors or significant life events, occurring within a month prior to the onset of symptoms. The stressors need not be catastrophic or particularly unusual. The duration of the disorder depends on the duration of the stressor: symptoms do not usually persist for longer than six months after the cessation of the stress or its consequences. However in the case of prolonged depressive reaction this may be of the order of two years.

9. The individual manifests symptoms or behaviour disturbance of the type found in the affective, anxiety, somatoform and other neurotic disorders, **but the full criteria for these disorders are not met either in severity or quantity**.

10. The symptoms may include feeling worried, anxious, angry, depressed or irritable. These may be accompanied by physical symptoms such as tremor or shakiness and palpitations: subgroups may be thus identified.

11. The severity of the reaction relates more to the particular vulnerability of the individual than the severity of the stressor.

SUBTYPES OF ADJUSTMENT DISORDER

12. **BRIEF DEPRESSIVE REACTION** F43.20

This is a mild depressive state which occurs as a response to an event or situation and is relatively shortlived, lasting generally no more than a month. It is characterised by features such as low mood, thinking excessively about the stressful situation and subjective poor appetite but with no change in weight. Social and occupational function is not significantly affected.

13. **PROLONGED DEPRESSIVE REACTION** F43.21

This is a state characterised by depressed mood in response to a stressful situation which may last for two years after the cessation of the stressor or its consequences. A prolonged (i.e. abnormal) grief reaction may be classified here. The former diagnosis of "reactive depression" often now falls within this category.

14. **MIXED ANXIETY AND DEPRESSIVE REACTION** F43.22

Features of both anxiety and depression are present but not to such a degree as seen in mixed anxiety disorder and depressive disorders.

15. **ADJUSTMENT DISORDER WITH PREDOMINANT DISTURBANCE OF OTHER EMOTIONS** F43.23

The predominant symptoms may include anxiety, worry, "tension" and irritability.

16. **ADJUSTMENT DISORDER WITH PREDOMINANT DISTURBANCE OF CONDUCT** F43.24

The main manifestation in this category is that of behaviour such as aggressive or anti social conduct.

17. **ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT** F42.25

Both emotional and behavioural symptoms are present.

18. **ADJUSTMENT DISORDER WITH OTHER SPECIFIED PREDOMINANT SYMPTOMS** F43.28

This encompasses the very commonly encountered clinical condition in which the response to an identifiable stressor is a minor physical complaint or pain. **Adjustment disorder with physical complaints** may be the most appropriate label to use in this circumstance, especially if the symptoms are not sufficiently severe or long lasting to be classified as a somatoform or conversion disorder.

Comparison with DSM-IV

19. The general criteria for the adjustment disorders in DSM-IV are very similar to those for ICD-10, as are most of the subtypes. The main differences in DSM-IV are that brief depressive reaction is termed "adjustment disorder with depressed mood" and lasts for a maximum of six months. There is no equivalent for the prolonged depressive reaction.

AETIOLOGY

20. Exposure to a stressful event precipitates these disorders in susceptible individuals.

21. Pre-existing personality, coping mechanisms and previous experiences influence the presentation of these disorders to a greater extent than other types of reaction to stressors.

22. The types of stressful event or situation include:

    22.1. personal difficulties such as divorce, leaving home, a major change in domestic or work circumstances, retirement.

22.2. An ongoing situational difficulty such as marital difficulties, business problems, living in undesirable or deteriorating neighbourhood.

22.3. Groups who may be affected by a single stressful event such as a natural disaster.

CONCLUSION

23. **Adjustment disorders and depressive reactions** are disorders of relatively mild symptomatology. They are the result of exposure to a stressful event or situation and there duration is defined by the length of exposure to the stressor or its consequences.

24. Responses to a stressful event may either be a normal reaction, an exacerbation of pre-existing personality traits or a pathological reaction (a disorder).

25. In those cases of exposure to a stressor where there is a pre-existing personality disorder, any accentuation of personality traits should be predictable and in keeping with the previous personality traits. However, if the individual with a pre-existing personality disorder develops other symptoms not previously encountered then the episode may be classified as an adjustment disorder.

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