Background Information

Male aged 54 called K. Married, father of 2: son 19, daughter 15. General health excellent. Occasional back problem (musculoskeletal) corrected by Chiropractic treatment, and swims several times a week to avoid recurrence. Likes to walk.

Employed full-time in the same job since his late teens. Same job at same location for 35 years. K’s employment relocated on 14th February 2016 to company headquarters, resulting in longer commute to and from work. Occupational demands for him to acquire knowledge of new technological systems, work-flow processes and engage more as part of a team.

Family history: Couple of broken bones before the age of twenty (sports-related). Otherwise healthy. Death of Grandmother coincided with nervous breakdown of his Mother (1982). Mother, history of anxiety and depression; took benzodiazepines; died of Dementia in 2009. His Father is 77, alive and healthy and has three siblings alive and well.

Describes himself as ‘easy going’. Coping skills for day to day life are good, though admits having difficulty adjusting to bigger life changes e.g. moving house/changing job.


Description of the Presenting Problem

Unable to go to work for last week. Since job relocation, K has experienced significant impairment in ability to function in new occupational environment: meet employer demands and expectations. Has relocated from a solitary, working situation where he was largely his own boss: “just me in my department”, into a large open-plan, technologically, process driven environment. He likes people, is generally chatty and “enjoys a laugh”.

Adjustment Disorder – Case Study

Date: 26th March, 2017
Presenting Symptoms

Struggling to cope with occupational move. Difficulty sleeping, feeling anxious because he is unsure of how to navigate computerised system. Feels he was expected to ‘hit the ground running’ and is under pressure from boss to be on top of things. Feels unable to cope, has lost weight and generally ‘out of sorts’. Does not want to go to work. Used to pop in and see his father weekly at ‘old’ work location, but now feels unable to contact him or other family members; is not responding to calls/texts/emails. Is aware of social withdrawal but unable to assert himself. Ashamed he cannot adjust and progress, as usually works to high standards. General sense of hopelessness. Can get some relief from these symptoms (less ‘troubled’) by taking the dog for a walk and adjusting his level of cognition in relation to work. (Baumeister, Maercker and Casey: 2009). Has the presence of mind to admit the new environment is a ‘culture shock’, but fears his ability to adjust. Is keen to ‘get back to normal’.

Diagnosis


Apart from AD being referred to as an ‘ambiguous diagnostic category’ Daniels (2009, p. 88) alludes to the problem of differentiating AD from a Major Depressive Disorder (MDD) (APA: 1994, p.167). When symptoms for MDD were eliminated: experiencing daily depressed
mood / reduced ability to concentrate or think throughout the day, a Diagnosis of AD was recorded. D had not reported, nor been treated for any single episodes of MDD (APA: 1994). Casey (2008, p.1203) argues that this delineation between MDD and AD is essential, not just for research purposes, but to increase the clinical knowledge of the condition. She advocates this clinical relevance because diagnosis ‘determines treatment’ and emphasises the important role of the clinician in being able to view the symptoms within their cultural context, relative to the patient’s life. It is also crucial to avoid ‘pathologizing’ (Casey: 2008, p.1203) regular levels of stress which occur as a response to everyday stressful events.

Casey (2009 p. 931) is emphatic that an essential requirement for diagnosing AD is that ‘the symptoms must be triggered by a stressful event’, but critically must not be misdiagnosed as Post Traumatic Stress Disorder (NICE: 2005, p.12). Consequently, diagnosis was reached by acknowledging specific timing of the onset of K’s excessive emotions and behaviours in response to the event or ‘stressor’ (Rhoads: 2011, p.146). In K’s case, the stressor was clearly identified as the maladaptive adjustment to a job relocation incorporating three factors: change of location, occupation environment and employer’s expectations. This functional impairment is severe enough for K to visit to the surgery. It is also congruent with the diagnostic criteria for AD in that: symptoms have occurred within three months of the identified stressor (job relocation mid February 2016, about five weeks ago); symptoms are more severe than would normally be expected for job relocation; and are interfering with K’s normal functioning e.g. does not want to go to work. This is exacerbated by the cultural context in which they are occurring i.e. as the major breadwinner in the family he believes he ‘should’ be able to adjust.

According to Casey (2009) ADs are not uncommon both in primary and secondary care, with prevalence ranging from 11 to 18% of the population and from 10 to 35% respectively.
**Intervention**

Despite the lack of pharmacological and psychological trials for AD (Casey, Dowrik and Wilkinson: 2001), the main focus for treatment has been on Psychological intervention, with ‘brief’ therapy identified as the most appropriate (Casey: 2009, p.). This is supported by the National Institute for Clinical Excellence (NICE) at primary care level (Bennett: 2011) which advocates Cognitive Behavioural Therapy (CBT) as the ‘optimal treatment’ (Bennett: 2011, p.8) over and above prescriptive drugs. Unlike other ‘talking therapies’ e.g. psychotherapy, CBT aims to deal with a current problem instead of focusing on issues from the past; and seeks practical, effective solutions to improve a person’s state of mind. (NHS: 2013)

In K’s situation, as the stressor could not be removed (occupational move), adaptive strategies had to be employed. Despite NICE guidelines, Casey (2008) argues that AD has clinical relevance because treatment is required, however, antidepressants are not necessary, nor do they work. Daniels (2009) recommends that for AD specific symptoms, pharmacology may be used in conjunction with a talking therapy as a way of reducing acute physical symptoms to enable the person to be able to focus on the changes they want to make in their life. This combination is appropriate in K’s acute circumstances: consequently his treatment involved a course of solution-focused, goal-orientated CBT (with support from his employer) and as suggested by Daniels (2009) a short-term, targeted medical intervention of a mild hypnotic to address this short-term insomnia (3 x times a week, for 2 weeks: NHS, 2013).

Carta et al (2009) propose that as AD’s are short-lived and resolve over time, CBT will enable D to restructure his thinking and develop coping skills regarding his occupational situation. Reinforcing this thesis, van der Klink et al’s (2003) findings indicate that cognitive behavioural intervention techniques are particularly effective for work-related stress. As D
has indicated his willingness to ‘get back to normal’ quickly, CBT has the potential to facilitate the process of adaptation and adjustment, with the best possible outcome.

**Current Debates**

In terms of classification, Casey (2001, p.479) described AD as being ‘controversial’, and suffering from academic and scientific neglect. Her (2008) central argument is that ADs are under-researched and without a stable diagnosis in the DSM-IV or International Classification of Diseases (ICD)-10. The latter diagnosis incorporates symptoms and impaired function, and the former argues for impairment or symptoms for an AD diagnosis (Casey and Doherty: 2012).

Apart from this dilemma, the crux of the debate appears to be whether to medicate or not. O’Keeffe and Ranjith (2007) question whether what appear to be temporary depressive reactions to stressful, life events need medical intervention (O’Keeffe and Ranjith: 2007). Part of the problem appears to be the over-elasticity of depression as a disorder (Casey et al: 2001) which marginalises those with AD. Consequently because of potential misdiagnosis, corrective action may include drug therapy. Ayuso-Mateos et al’s (2001) Europe-wide study on depressive disorders, highlighted that only 1% of participants with depressive disorders were diagnosed as having AD. This parallels Casey’s (2009: p. 933 & 934) emphatic considerations for drug treatment in favour of ‘brief therapies’ or in the case of chronic ADs-extended therapy.

Conversely, O’Keeffe and Ranjith argue (2007 p.479) that Casey’s (2009) advocated treatment potentially undermines the seriousness of the symptoms for AD by assuming that it can only be ‘transient’. Consequently, insufficient action by clinicians, (whilst reducing the stigma of a mental disorder), has the potential to ‘lull’ them into ‘therapeutic inactivity’ (O’Keeffe and Ranjith: 2007, p. 479) and may minimise the misery suffered by patients.
Regier et al (1993) contribute further to the debate by suggesting that those with existing mental problems, not seeking medical attention maybe be having ‘appropriate homeostatic responses’ needing no medical intervention or other treatment.

This in turn leads on to the political, economic argument put forward by Casey et al (2001) who pose that AD, as a clinical concept, has been obscured by policy makers and researchers and categorised as a mood disorder. This concurs with the argument that AD can be over-medicalized, and unnecessary drug interventions introduced for a problem which has the potential to resolve itself naturally (i.e. when the stressor is removed and/or adaptations strategies have been established).

In light of the arguments presented, it is imperative that the focus must be on the severity of the patient’s presenting symptoms, and the meaning of events in the patient’s life. The danger in following the prescriptive thresholds of the DSM/ICD may mean a diagnosis is made automatically without sufficient attention made to the person and the causal events of their particular situation.
References


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