

Adjustment Disorder in Patients with Serious Illness

Background Diagnosis of any life-threatening condition creates challenges of self-identity and orientation to the world in profound ways. It is common for patients with such illnesses to grieve the person they used to be, their former activity levels, their functional capacity, and their sense of control over their lives. A period of significant adjustment is to be expected. Identifying when that adjustment period evolves into a clinical disorder for a patient can be fluid and very challenging for clinicians. This *Fast Fact* aims to help clinicians recognize adjustment disorder (AD), which is a common psychiatric diagnosis seen in patients with various serious illnesses, including cancer, heart failure, and pulmonary disease (1-5).

Definition DSM-V TR defined AD as the presence of emotional or behavioral symptoms (sadness of mood and/or anxiety) in response to an identifiable stressor that begins within 3 months of stressor onset and is expected to resolve within 6 months after the stressor or its consequences have ceased (6). In the setting of a terminal illness the stressor is unlikely to resolve, hence, the DSM-V TR allows for the diagnosis of persistent (chronic) adjustment disorder (2). AD is characterized by preoccupation with the stressor or its consequences, including excessive worry, distressing thoughts about the stressor, and/or constant rumination (7). The inability to adapt to the stressor often leads to significant impairment in the patient's life and functioning (7). If symptoms escalate to meet the criteria of another psychiatric disorder (e.g., major depressive disorder), the diagnosis should be changed (6).

Subtypes The DSM-V TR divides AD into subtypes depending upon presenting symptoms: *with depressed mood, with anxiety, with mixed anxiety and depressed mood, with disturbance of conduct, and with mixed disturbance of emotions and conduct* (6).

Prevalence Most published prevalence data in patients with serious illness pertains to cancer for whom AD prevalence rates range from 12% to 25% (8-12). It is more often seen among young individuals, in those with a lack of support, increased disease and symptom burden, female gender, and in individuals with competing caregiving and work obligations (11-13).

Making the diagnosis While AD is common, the fact that it sits between the spectrum of expected response to more severe diagnoses like major depressive disorder (MDD) and/or generalized anxiety disorder (GAD) makes it difficult to identify. Therefore, AD is often missed by clinicians. Unaddressed AD has been associated with treatment nonadherence, suicidal thinking or attempts, and progression to a more serious psychiatric diagnosis (6,8). Two distinct features can help clinicians identify AD better:

- AD occurs in response to an identifiable event (6) such as a new diagnosis, treatment setback, or disease progression. Unlike MDD or GAD, its symptoms are directly linked to that stressor.
- Although AD symptoms can cause significant distress and impairment, they are not severe enough to meet the full criteria for another disorder (1). The presence of symptoms like anhedonia, hopelessness, guilt, and/or persistent worry should hint that another diagnosis is more likely.

Applying the diagnosis How the diagnosis of AD is applied varies from clinician to clinician. Some use AD as a billable label to describe presenting symptoms that do not meet the level of other diagnoses (i.e. MDD or GAD). Others use the term only if the patient meets a certain symptom severity threshold. While the DMS-V TR is an excellent AD guide, considering how complex, variable, and nuanced the definition and subtypes of AD are, clinicians should consult a mental health specialist whenever there is doubt.

Assessment AD screening and continuous reassessment are crucial as needs can vary with disease progression (14-16). Clinicians can use the Hospital Anxiety and Depression Scale (HADS) for this purpose. It is a brief, self-report, 14-item instrument that can be used to assess for AD and monitor distress (17). A HADS score of ≥ 10 suggests clinically significant distress consistent with AD, whereas scores ≥ 17 raise concerns for MDD criteria (17).

Management Early recognition and ongoing monitoring is probably more important than any specific therapeutic approach (18). It is key to establish a trusting relationship with the patient and allow them to openly express their emotions (18). Compassionate and transparent communication about prognosis, therapeutic alliance, and empathetic listening are all instrumental in AD care. An interdisciplinary team combining the complementary expertise of clinicians, psychologists, social workers, chaplains, and other health professionals is often needed (19).

If mental health professionals are available, encourage patients to consider a referral when an AD diagnosis is made. Cognitive behavioral therapy (CBT) (including internet-delivered CBT) is the treatment of choice for AD (20). If symptoms persist despite CBT, pharmacologic treatment may be appropriate. When depressive features predominate, antidepressants (e.g. sertraline 25-75 mg daily) are first line. Short-term anxiolytics (e.g. hydroxyzine 50 mg or clonazepam 0.5 mg for 10 days) may be considered for anxiety-predominant AD, although they usually carry a greater risk (21).

Summary Early recognition of an adjustment disorder can help a patient cope with a serious illness. Even brief psychological interventions may help patients regain a sense of control and meaning.

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