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Original article

Adjustment disorder with anxiety in old age: Comparing prevalence and clinical management in primary care and mental health care

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ABSTRACT

Purpose: Adjustment disorder with anxiety (AjD-A) is a common cause of severe anxiety symptoms, but little is known about its prevalence in old age.
Methods: This cross-sectional study examined the prevalence of AjD-A in outpatients over the age of 60 who consecutively consulted 34 general practitioners and 22 psychiatrists during a 2-week period. The diagnosis of AjD-A was obtained using the optional module for diagnostic of adjustment disorder of the Mini International Neuropsychiatric Interview (MINI). The study procedure also explored comorbid psychiatric conditions and documented recent past stressful life events, as well as social disability and current pharmacological and non-pharmacological management.
Results: Overall, 3651 consecutive subjects were screened (2937 in primary care and 714 in mental health care). The prevalence rate of AjD-A was 3.7% (n = 136). Up to 39% (n = 53) of AjD-A subjects had a comorbid psychiatric condition, mostly of the anxious type. The most frequently stressful life event reported to be associated with the onset of AjD-A was personal illness or health problem (29%). More than 50% of the AjD-A patients were markedly to extremely disabled by their symptoms. Compared to patients who consulted psychiatrists, patients who were seen by primary care physicians were older, had obtained lower scores at the Hamilton Anxiety Rating Scale, benefited less frequently from non-pharmacological management and received benzodiazepines more frequently.
Conclusions: AjD-A appears to be a significantly disabling cause of anxiety symptoms in community dwelling elderly persons, in particular those presenting personal health related problems. Improvement of early diagnosis and non-pharmacological management of AjD-A would contribute to limit risks of benzodiazepine overuse, particularly in primary care settings.

1. Introduction

According to classifications in both the DSM-IV-TR and the ICD-10, adjustment disorder is defined as subjective distress and emotional or behavioural disturbances that interfere significantly with social or personal functioning and that arise within 3 months after exposure to an identifiable psychosocial stressor, life change or stressful life event. Although the definition of significant stressful events differs between the DSM and the ICD (e.g., in the ICD-10 criteria, the stressor may affect the integrity of an individual's social network or social support or may represent a major developmental transition or crisis, such as bereavement, whereas in the DSM criteria, bereavement is an exclusion criterion), the description of adjustment disorder is similar within the two classification systems. In particular, both systems define subtypes of adjustment disorders with regard to the most prevalent symptoms, such as anxiety, depression or other conduct or behavioural disturbances. Adjustment disorder is often considered as a "sub-threshold" disorder [7] because patients should not meet criteria for any other Axis I condition to be diagnosed. However, the maintenance of adjustment disorder in the forthcoming revised versions of the DSM and the ICD is strongly debated, mostly because the current diagnostic criteria fail to clearly distinguish adjustment disorder from normal reactions to stressors [4,37]. Adjustment disorder has been associated with an increased risk of suicidality or suicide completion in the general

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population [15], army personnel exposed to combat [3] and individuals who have lived through major disasters [12]. Adjustment disorder has also been associated with personality disorders and substance abuse [40]. None of the major international epidemiological studies, such as the Epidemiological Catchment Area (ECA), the National Comorbidity Survey [19] or the National Comorbidity Survey Replication [20], have examined prevalence rates of adjustment disorders. Some preliminary studies have reported that the prevalence rate of adjustment disorders varies from 4 to 5% for patients in primary care [36] to 15 to 20% or higher for patients who were either referred to mental health care settings [11,35] or were admitted to general hospital settings [40]. Two recent studies rigorously examined the prevalence of adjustment disorder in the general population and found a prevalence rate ranging from 0.9% [26] to 2.94% [13], with a high frequency of mixed or anxious presentations. However, these two studies did not consider elderly people, who are a particularly frail and vulnerable group. Compared with younger individuals, adjustment disorder is more common in older people who are exposed to major disasters [42] and is strongly associated with an increased risk of suicide completion in older adults [33]. Moreover, anxiety symptoms are particularly disabling in activities of daily living for elderly people [30] and are associated with poor social and economic status as well as with severe chronic medical conditions [16]. Anxiety is also associated with the initiation of benzodiazepine treatment in the elderly [31]. Benzodiazepines are among the most inappropriately used medications in the elderly [6], and there is significant potential risk for severe adverse effects with these drugs [28].

The present observational study aimed to assess the prevalence of adjustment disorder with anxiety (AjD-A) in community dwelling elderly subjects (aged 60 years or older) who consulted primary care (general practitioners) or mental health care physicians (psychiatrists). As a secondary objective, it aimed at examining whether differences exist between primary care and mental health care AjD-A patients by comparing their demographic characteristics, associated comorbidities, stressors, functional impact and current or initiated pharmacological and non-pharmacological management.

2. Subjects and methods

2.1. Measures and assessments

Health professionals from primary care (general practitioners) and mental health care (psychiatrists in both private practice and public facilities) were randomly selected out of three metropolitan areas of France (Nice, Toulouse, Tours) and asked to complete an anonymous register of all consecutive patients over 60 years of age who consulted over 2 consecutive weeks (4 weeks for psychiatrists working in public mental health care facilities). Each newly referred patient was asked to answer the optional adjustment disorder section (Adjustment disorder) of the Mini International Neuropsychiatric Interview (MINI) [38], French version [21]. According to the DSM-IV criteria, patients who met the criteria for adjustment disorder were considered to have AjD-A when they reported anxiety as a predominant symptom. To confirm AjD-A, the subjects were asked to answer the MINI screening questions for major depressive episodes to ensure the absence of major depression. In the absence of a current major depressive episode, AjD-A subjects were invited to answer MINI questions regarding the diagnosis of other anxiety disorders and substance dependence or abuse. In addition, subjects were interviewed regarding the stressful life events they faced during the past 12 months and the potential impacts of these events (marital status and family life, social life, health and welfare, housing and home environment, leisure, and finance). The impact of AjD-A on global functioning was evaluated using the Sheehan Disability Scale [22] that provides a brief, simple, and sensitive self-assessment of the patient's disability in terms of work, social activities, and family relations. Subjects' levels of anxiety were characterised using the Hamilton Anxiety Rating Scale [18].

2.2. Ethics

All participants received information about the study conditions and consented to participate in the study. The protocol was approved by the consulting committee (Comité Consultatif sur le Traitement de l'Information en matière de la Recherche dans le domaine de la Santé [CCTIRS]) on July 9, 2009, and legal authorisation was obtained (by Commission Nationale de l'Informatique et des Libertés [CNIL], authorisation N° 909205) on July 29, 2009.

2.3. Study procedures

All primary care and mental health care physicians completed an intensive 4 hours training session within 4 weeks prior to the beginning of the screening period. Regular monitoring was performed daily during data collection to ensure consistency between the data collected in the registry and the CRF and to ensure high-quality data. According to the procedures established in the protocol (Data Handling Manual), clarification forms were completed when data were missing or inconsistent.

2.4. Statistical analysis

All analyses were performed using SAS® software version 9.1 (North Carolina, USA). Descriptive analysis was performed on the data collected from patients with AjD-A. Patients screened by primary care physicians were compared to those screened by specialist mental health care professionals in terms of their demographic data, associated comorbidities, the nature of their stressors and their functional impacts and therapeutic management. Differences between the two groups were tested with a Chi^2 test for qualitative parameters (using the Yates' correction if needed) and with Student's *t*-test for quantitative parameters.

3. Results

3.1. Investigators' profile

Thirty-four general practitioners and 22 psychiatrists participated in the study (mean age 49.8 ± 9.4 [SD] years, mean practice history 20.9 ± 9.5 [SD] years, mostly of male gender [90.7%] and based in urban areas [79.6%]).

3.2. Prevalence of AjD-A

As reported on Fig. 1, during the 2-week study period, a total of 3651 patients aged 60 years or older consecutively consulted the participating health care professionals (2937 in primary care, 714 in mental health care). According to the screening procedure, 337 patients (9.2%) were suspected of meeting the diagnostic criteria for adjustment disorder. Of these patients, 194 agreed to participate, and data were available for 189 of these patients. Ultimately, 14 patients were excluded during the data review (eight subjects' MINI data were erroneously coded by the investigator, five patients met criteria for major depressive episodes, and one patient had both adjustment disorder and major depression). Thus, a total of 175 patients were considered to