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Original article

Adolescent adjustment disorder: Precipitant stressors and distress symptoms of 89 outpatients

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Abstract

Objective. – Research on adolescent adjustment disorder (AD) is scarce. We characterized adolescent outpatients with AD in psychosocial background and treatment received compared with patients with other non-psychotic disorders (OND). Furthermore, we explored precipitant stressors, distress symptoms and behavioral problems among males and females with AD.

Method. – Data were collected prospectively on 290 consecutive psychiatric outpatients, aged 12–22 yrs, at a secondary care clinic in Finland. DSM-III-R diagnoses were assigned, based on all available information, at the end of treatment.

Results. – AD was the second most common diagnosis among non-psychotic patients (31% of 290). Compared to OND-patients, those with AD were predominantly female and had less severe psychosocial impairment. In multivariate comparisons school-related stressors, problems with law and restlessness characterized males, and parental illness and internalizing symptoms females with AD. Intensity and duration of treatment of AD-patients varied widely.

Conclusions. – Adjustment disorder comprised a common clinical entity among adolescent outpatients. Psychiatric assessment and treatment should be individually targeted by taking into account gender-specific stressors and distress symptoms among young people with AD.

Keywords: Adolescence; Adjustment disorder; Psychiatric treatment; Precipitant stressors; Distress symptoms

1. Introduction

Adjustment disorder (AD), defined as a stress-induced maladaptive reaction and not meeting specific criteria for other mental disorders [4], is a common diagnosis assigned to adolescent psychiatric patients [5,13]. In contrast to most other DSM-III-R and DSM-IV-disorders the AD criteria have no clear and specific symptom profile that defines the condition. The level of symptomatology and impairment in AD has been found to be intermediate between comparison groups of all-age patients with major syndromes and other sub-threshold disorders [7,10,20,34]. Despite the clinical appeal of this diagnostic category [17,18,22,23,39], AD has been seen as a ''wastebasket'' or transitional diagnosis [12].

Youth AD has been reported to be a potentially severe clinical condition [19,26,27,33], to have poor outcome more often than adult AD [6], to be associated with suicidal behavior [32] and subsequent suicide [25]. However, some research suggest a relatively favorable course of youth AD [22].

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Cumulative or multiple risk factors (e.g. parental divorce, parental illness, and school problems) are reportedly associated with adolescents' adjustment problems with gender-specific features [15,21,22]. The clinical manifestation of AD seems to present with sub-threshold symptomatology across multiple symptom domains, and risk factors and the nature of stress-induced maladaptive reactions need to be assessed when planning treatment for AD-patients.

Although a common diagnosis, AD has received little scientific attention. Systematic characterization of adolescent patients – particularly outpatients – with AD is scarce [7,20]. Our previous reports using this data set on a large consecutively referred adolescent outpatient sample have dealt with suicidality [28,32], psychosocial functioning [29] and treatment adherence [30] in adolescent outpatients. In the present report we specifically investigated clinical characteristics of AD in adolescents.

The first aim of the present study was to investigate background and clinical features of adolescent AD outpatients compared with patients having other non-psychotic disorders (OND). We expected AD-patients to be less severely impaired and their treatment to be less intensive compared with OND-patients. Secondly, we explored precipitant stressors, psychic distress symptoms and behavioral problems among males and females with AD.

2. Method

2.1. Sample

The subjects of this study were adolescents aged 12–22 yrs referred for their first treatment at a psychiatric outpatient secondary care clinic for adolescents in Finland during the five-year period 1990–1994. The index treatment was completed by the end of May 2000. Of the 481 adolescents referred during the study period, 95 were recommended to other outpatient services or for inpatient treatment, and telephone consultations only were given to 42 adolescents. Of the 344 adolescents accepted for outpatient treatment, 42 missed their initial appointment and were not included in the study. A total of 302 adolescents started their treatment [30]. Of these, 12 suffered from a psychotic disorder, and were excluded from the present study. The number of patients included in the study thus totalled 290, of whom 138 (47.6%) were males. All patients were of Caucasian origin. There were no statistically significant differences in mean age (16 yrs), sex distribution (48% males) or reasons for referral (internalizing symptoms in 81% of 290 vs. 75% of 179) between included and excluded subjects.

The catchment area of the clinic covers approximately 220 000 inhabitants (15% adolescents) of Vantaa and Kerava, an urban and suburban area close to Helsinki, the capital of Finland. The clinic offers eclectic psychiatric treatment, including individual psychotherapy, family consultations, and psychotropic medication when appropriate. Adolescents are initially screened by a psychiatric staff member in one or more telephone interviews, lasting 15–45 min. Semi-structured phone data coding sheets are used. Information on the major problems reported during the initial phone call were classified as externalizing symptoms (e.g. stealing and aggressive behavior) or internalizing symptoms (e.g. depressive feelings, interpersonal problems, and anxiety), and were based on the semi-structured phone data coding sheets.

2.2. Data collection

Systematic data collection was developed at the clinic as a part of clinical practice for research purposes [28–30]. All four treating persons (a psychiatrist specialized in adolescent psychiatry, a clinical psychologist, a nurse specialized in psychiatry and a social worker) were trained for data collection. Data were coded systematically in medical records using structured coding sheets during the treatment and checked by the treating psychiatrist at the end of treatment. Thereby there were no missing data in the variables used in the analyses of this report. The treating persons were blind to the hypotheses of the present study. Data collection was conducted as part of ordinary clinical practice and thereby the number of interviews parallels the number of total appointments of each subject.

During the first two treatment appointments information was gathered on family-related characteristics, the adolescents' previous psychiatric treatment, current life situation, previous and current suicidal ideation and suicide attempts, and on the referring person. The level of the patients' psychosocial functioning was assessed with the Global Assessment Scale [11], applying 10-class version used in Finland [24], proven to be a reliable measure of psychosocial functioning in adolescents [30].

At the end of treatment, data on the number of scheduled and kept individual and family appointments, psychotropic medication, level of psychosocial functioning, suicidal ideation and suicide attempts during treatment and recommended after-care were gathered. Best estimate diagnoses of current mental disorders according to DSM-III-R criteria [3] were assigned at the end of the treatment, based on all available information on the patient, by the treating psychiatrist. The research diagnoses were confirmed by a senior psychiatrist (MM) carefully integrating clinical diagnoses and all available data. Multiple diagnoses on DSM-III-R axes I and II were allowed [28,30,32].

2.3. Variables

Adolescents who had been arrested, charged or convicted of an offence were classified as having had problems with the law. Subjects with previous or current suicide ideation or suicide attempts were coded as suicidal. If the treatment did not continue after the evaluation phase and need for care was still evident, or if key problems had not been worked through and need for care was still evident, the patient was considered as having terminated treatment prematurely [29]. All data collected during the treatment were recorded in the patients' case files.

Among the patients with adjustment disorder stressors were considered in the diagnostic procedure, and the final classification was made by one researcher (MP) based on all data in the