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Research report

Distinguishing between adjustment disorder and depressive episode in clinical practice: The role of personality disorder

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ABSTRACT

Background: There is significant symptomatic overlap between diagnostic criteria for adjustment disorder and depressive episode, commonly leading to diagnostic difficulty. Our aim was to clarify the role of personality in making this distinction.
Methods: We performed detailed assessments of features of personality disorder, depressive symptoms, social function, social support, life-threatening experiences and diagnosis in individuals with clinical diagnoses of adjustment disorder ($n=173$) or depressive episode ($n=175$) presenting at consultation-liaison psychiatry services across 3 sites in Dublin, Ireland.
Results: Fifty six per cent of participants with adjustment disorder had likely personality disorder compared with 65% of participants with depressive episode. Compared to participants with depressive episode, those with adjustment disorder had fewer depressive symptoms; fewer problems with social contacts or stress with spare time; and more life events. On multi-variable testing, a clinical diagnosis of adjustment disorder (as opposed to depressive episode) was associated with lower scores for personality disorder and depressive symptoms, and higher scores for life-threatening experiences.
Limitations: We used clinical diagnosis as the main diagnostic classification and generalisability may be limited to consultation-liaison psychiatry settings.
Conclusions: Despite a substantial rate of likely personality disorder in adjustment disorder, the rate was even higher in depressive episode. Moreover, features of likely personality disorder are more strongly associated with depressive episode than adjustment disorder, even when other distinguishing features (severity of depressive symptoms, life-threatening experiences) are taken into account.

1. Introduction

Adjustment disorder is a state of "subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event" (World Health Organisation [WHO], 1992; p. 149). Onset of symptoms is usually within one month of the onset of the stressful event according to the *International Classification of Diseases (Tenth Edition)* (ICD-10) (WHO, 1992) or within three months according to the *Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition)* (DSM-5) (APA, 2013).

Both classification systems identify a subtype of adjustment disorder which features depressed mood as a central component. Diagnosing this subtype of adjustment disorder is especially challenging owing to the possibility of overlap with normal distress on the one hand, and depressive episode on the other (Casey et al., 2001); this renders the relationship between adjustment disorder and depressive episode both complex and difficult for clinicians to unravel. There have been suggestions that the questionable validity of the sub-categories of adjustment disorder add further to the lack of diagnostic clarity (Zimmerman et al., 2013).

The relationship between adjustment disorder and personality disorder is similarly complex. In 1952, DSM-I (APA, 1952) contained a condition described as "transient situational personality disorder" as well as "adult situational reaction" and "gross stress reaction". In DSM-II, the term "transient situational disturbance" was used instead, referring to a transient mental disturbance

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provoked by stress (APA, 1968). Adjustment disorder as it is currently understood first appeared in DSM-111 (APA, 1980).

Today, DSM-5 includes "adjustment disorder" under the heading of "trauma-and stressor-related disorders" but notes that "some personality features may be associated with a vulnerability to situational distress that may resemble an adjustment disorder" (APA, 2013; p. 288). In addition, "stressors may also exacerbate personality disorder symptoms" but a diagnosis of adjustment disorder should not be made unless the "stress-related disturbance exceeds what may be attributable to maladaptive personality disorder symptoms" (p. 288).

Similarly, ICD-10 classifies adjustment disorder under "neurotic, stress-related and somatoform disorders", and acknowledges that while "individual predisposition or vulnerability plays a greater role in the risk of occurrence and the shaping of manifestations of adjustment disorder" than it does in other "neurotic, stress-related and somatoform disorders", it is still "assumed that the condition would not have arisen without the stressor" (WHO, 1992).

Thus, the relationship between adjustment disorder and personality is both acknowledged in international classification systems yet somewhat unclear clinically. It is also under researched with few studies to inform clinical practice. Strain and colleagues found that personality disorder was commonly co-morbid (15%) with adjustment disorder (Strain et al., 1998). The ODIN study found no difference in prevalence of personality disorder between adjustment disorder and depressive episode (Casey et al., 2006). A study of 86 young male conscripts with adjustment disorder with depressed mood and 86 healthy controls confirmed the strong associations between adjustment disorder and certain personality traits by showing significantly higher scores on harm-avoidance and lower scores on self-directedness, cooperativeness, and self-transcendence (Na et al., 2012).

Overall these findings suggest a relationship between adjustment disorder and personality, and point to role for specific aspects of personality and temperament in shaping features of the disorder. There remain, however, significant deficits in the literature regarding the precise relationship between personality disorder and adjustment disorder, and, even more so, regarding their relationships, if any, with depressive episode, which is a common differential diagnosis for adjustment disorder.

This paper aimed to explore these relationships further in a consultation-liaison psychiatry setting in Ireland. More specifically, we hypothesised that (a) adjustment disorder would be associated with a high level of personality disorder; and (b) personality disorder would have a stronger association with adjustment disorder than with depressive episode.

2. Methods

2.1. Study setting

This multi-centre study was set in 3 inner-city hospitals in Dublin, Ireland: the Mater Misericordiae University Hospital (MMUH), The Rotunda Hospital and St James's Hospital (SJH).

The MMUH is a general hospital with 570 beds providing secondary and tertiary care, with a public (i.e. non-fee-paying) consultation-liaison psychiatry service at the hospital providing (a) psychiatric consultations to the emergency department, outpatient clinics, and medical and surgical inpatient wards; and (b) inpatient psychiatric care for patients with complex combinations of medical and psychiatric need.

The Rotunda Hospital is one of Ireland's 3 National Maternity Hospitals, and provides psychiatry consultation-liaison services to inpatients and outpatients at the hospital, via the MMUH consultation-liaison service.

SJH is a 900 bed general hospital providing secondary and tertiary care. It has a multi-disciplinary liaison psychiatry team and a multidisciplinary psycho-oncology team, which provide a liaison psychiatry service to the emergency department, outpatient clinics, and medical and surgical wards. It provides a specialist service to the Oncology Service, the National Burns Unit and the Haematology Service.

2.2. Participants

This was an observational study with a longitudinal design. Participants were recruited at the MMUH from 12 May 2009, at Rotunda Hospital from 3 December 2010 and at SJH from 28 November 2011, until close of the study on 30 June 2012. At all 3 sites, participants were recruited from all areas covered by the psychiatry

Table 1
Socio-demographic features of study participants by clinical diagnosis.

Variable		Adjustment disorder $n=185$	Depressive episode $n=185$	All participants $n=370$
Age (mean years, SD)		43.5 (14.5)	44.1 (13.9)	43.8 (14.2)
Gender (n, %)	Male	66 (35.7)	69 (37.3)	135 (36.5)
	Female	119 (64.3)	116 (62.7)	235 (63.5)
Marital status (n, %)	Never married	65 (35.5)	66 (36.5)	133 (36)
	Married	67 (36.6)	74 (40.9)	141 (38.7)
	Separated or divorced	30 (16.4)	24 (13.3)	54 (14.8)
	Widowed	10 (5.5)	6 (3.3)	16 (4.4)
	Cohabiting	11 (6)	11 (6.1)	22 (6)
Living arrangement (n, %)	Lives alone	42 (23.2)	39 (21.5)	81 (21.8)
	Lives with others	139 (76.8)	142 (78.5)	281 (78.2)
Place of birth (n, %)	Ireland	155 (84.7)	151 (84.4)	316 (85.4)
	Overseas	28 (15.3)	28 (15.6)	54 (14.6)
Employment status (n, %)	Employed outside the home	66 (35.7)	59 (33.5)	125 (35.5)
	Works in the home	29 (15.7)	36 (20.5)	65 (18.5)
	Unemployed	23 (12.4)	19 (10.8)	42 (11.9)
	Medically unfit	36 (19.5)	46 (26.1)	82 (23.3)
	Other	22 (11.9)	16 (9.1)	38 (10.8)
Setting	Emergency department	44 (24)	43 (23.6)	87 (23.5)
	Ward	60 (38.2)	46 (25.3)	106 (28.6)
	Outpatient clinics	79 (43.2)	93 (51.1)	172 (46.5)

SD: Standard deviation.
There were no significant differences between the groups in any of these variables.