TRAUMA- AND STRESSOR-RELATED DISORDERS

Adjustment Disorder

AjD

DSM-5-TR 309.0-309.9 | ICD-10-CM F43.2X

Clinically significant emotional or behavioral symptoms emerging within three months of an identifiable, non-catastrophic stressor.

PREVALENCE	ONSET	SEX RATIO	COURSE
5-20% outpatient MH visits	Within 3 months of stressor	~2:1 female:male in adults	Resolves <6 mo after stressor

CLINICAL PICTURE

- Depressed mood, worry, tearfulness, and hopelessness appear disproportionate to the stressor within weeks of its onset.
- Conduct disturbance predominates in adolescents, with truancy, fighting, vandalism, and reckless driving following family disruption.
- Common precipitants include job loss, divorce, relocation, a new medical diagnosis, financial crisis, and military deployment.
- Somatic complaints, insomnia, and declining work or academic performance often bring the patient in rather than any mood complaint.
- Symptoms typically remit within six months once the stressor and its downstream consequences have actually resolved.
- Suicidal ideation and attempts occur at rates approaching those in major depression despite the subthreshold framing of the diagnosis.

DIAGNOSTIC CRITERIA AT A GLANCE

- Emotional or behavioral symptoms develop within three months of the onset of an identifiable stressor or set of stressors.
- Distress is out of proportion to stressor severity when cultural context is accounted for, or it produces significant functional impairment.
- The disturbance does not meet criteria for another mental disorder and is not merely an exacerbation of a preexisting condition.
- Symptoms do not represent normal bereavement and resolve within six months after the stressor or its consequences have ended.
- Subtypes specify depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance, or unspecified.

NEUROBIOLOGY & PHYSIOLOGY

- Best conceptualized as a stress-response syndrome rather than a discrete neurobiological entity, and the research base remains thin.
- HPA axis reactivity, autonomic arousal, and inflammatory markers rise transiently and normalize once the stressor resolves.
- Allostatic load from cumulative prior stressors lowers the threshold at which a new event produces clinically significant symptoms.
- Genetic and temperamental vulnerability, including high neuroticism and low resilience, shapes who converts stress into disorder.
- Chronic unresolved stressors sustain cortisol and sympathetic activation, raising longer-term cardiovascular and metabolic risk.
- Sleep fragmentation induced by acute stress amplifies emotional reactivity and measurably slows the pace of symptom resolution.

PSYCHOLOGICAL MECHANISMS

- Diathesis-stress and transactional coping models frame symptoms as a failure of appraisal and coping capacity to meet situational demand.
- Rumination about the stressor and about one's own failure to manage it converts a time-limited reaction into a persistent syndrome.
- Loss of role, identity, and predictability, rather than the objective event itself, frequently drives the bulk of the distress.
- Avoidant coping, escalating substance use, and social withdrawal prevent problem solving and sustain the stressor's impact.
- Attachment security and available social support strongly moderate both the severity and the duration of the stress reaction.

DIFFERENTIAL & COMORBIDITY

- Rule out major depression, generalized anxiety disorder, PTSD, and acute stress disorder first, since this is a residual diagnosis.
- Prolonged grief disorder now covers persistent intense grief beyond twelve months in adults and should not be coded here.
- Normal stress responses lack proportionality or impairment, and culture shapes what counts as an expectable reaction to loss.
- Comorbid substance use frequently emerges as a coping strategy and should be screened for at every follow-up contact.
- Screen directly for suicide, since risk is substantial, particularly in adolescents and after job loss or relationship breakdown.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA-approved; psychotherapy and practical problem solving are first-line for nearly every presentation.
- A short course of a hypnotic or **trazodone 25-100 mg at bedtime** may be used briefly for stress-related insomnia.
- Avoid **benzodiazepines** beyond a few days, since dependence risk outweighs benefit in a largely self-limited condition.
- Consider an **SSRI** when symptoms persist past three months, worsen, or cross the threshold into a full depressive episode.
- Reassess the diagnosis before committing to long-term medication, because persistence usually signals a different disorder.

PSYCHOTHERAPY

- Brief **problem-solving therapy** and supportive counseling across 4-8 sessions are the best-supported interventions available.
- **CBT** targeting appraisal, avoidance, and behavioral activation reduces symptoms and speeds functional return to work or school.
- Stressor-specific work matters most: grief processing, occupational counseling, or structured adjustment to a medical diagnosis.
- Group and internet-delivered brief interventions show benefit in occupational, military, and disaster-exposed populations.
- Crisis intervention paired with concrete environmental change often outperforms purely symptom-focused therapy.

ADJUNCT & SUPPORTIVE

- Track with the **PHQ-9**, **GAD-7**, and a functional measure every 2-4 weeks to detect conversion to major depression.
- Mobilize practical resources including employee assistance programs, legal aid, financial counseling, and housing support.
- Sleep regulation, regular aerobic exercise, and reduced alcohol use accelerate recovery and lower conversion risk.
- Family and couples sessions address the interpersonal stressor directly rather than treating only the identified patient.
- Time-limited work modification or medical leave can resolve symptoms faster and more durably than any prescription.

CLINICAL PEARLS

- It is a residual diagnosis: rule out MDD, GAD, and PTSD before settling on it.
- Subthreshold does not mean low risk; suicide rates rival major depression.
- If symptoms outlast the stressor by six months, the diagnosis is wrong.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

O'Donnell, M. L., Agathos, J. A., Metcalf, O., Gibson, K., & Lau, W. (2019). Adjustment disorder: Current developments and future directions. *International Journal of Environmental Research and Public Health, 16*(14), 2537.

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

Stahl, S. M. (2021). *Stahl's essential psychopharmacology* (5th ed.). Cambridge University Press.

Strain, J. J., & Diefenbacher, A. (2008). The adjustment disorders: The conundrums of the diagnoses. *Comprehensive Psychiatry, 49*(2), 121-130.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

NOTE

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