The Rehabilitation Professional 18(4), pp. 207–212

Adjustment Disorder: Considerations for the Workers' Compensation System

Derrick C. Fowler and Chad J. Betters

This paper discusses Adjustment Disorder and how it may potentially affect return to work outcomes within the Workers' Compensation system. Adjustment Disorder, a psychiatric diagnosis, results from the onset of an identifiable psychological stressor and whose symptoms are acute by definition. A reasonable stressor could be a work-related injury resulting in occupational dysfunction. There is minimal research addressing the presence and impact of Adjustment Disorder within vocational rehabilitation, and no literature specifically regarding the Workers' Compensation system exists. Although psychological distress has been noted within the Workers' Compensation claimant population, it is critical to consider unrecognized or mis-diagnosed Adjustment Disorder and its possible effect on the return to work process.

There are many barriers that hinder the rehabilitation process within what some perceive to be a complicated Workers' Compensation system. The primary focus of the process consists of rehabilitating workers who are injured during the course of employment, specifically diagnosing and treating the physical injury sustained on the job. Consequently, special attention is warranted for the functional limitations that may present as a result of the work-related injury, especially when considering return to work options. Overall, the predominant concept maintained within the Workers' Compensation system reflects a sole prominence on the physical aspect of the claimant's injury and recovery.

Unfortunately, little to no emphasis is placed on the psychological aspects of the claimant's recovery (Betters & Shaw, 2009; Betters & Shaw, 2008; Sullivan & Stanish, 2003). Sullivan and Stanish state, "It has become increasingly clear that psychological and social factors are significant determinants of pain and disability." (p. 97). There is little evidence that supports the presence of a Workers' Compensation claimant's treatment plan considering physical and psychological needs equally in today's system (Sullivan & Stanish). Most states do not consider psychological distress as a potential work-related injury. However, many professionals within the rehabilitation arena recognize the psychological characteristics that frequently coexist with acquired physical disabilities, especially noted in pain management programs (Sullivan & Stanish). Unemployment caused by a work-related injury disrupts the daily routines of the individual, which in turn can create an upheaval in the structure of the claimant's life (Betters & Shaw, 2009). Additional factors, including economics, family dynamics, and social constraints can also weigh on injured workers as they navigate the Workers' Compensation rehabilitation process.

There is literature that suggests unmet psychological need can act as a barrier to vocational rehabilitation, including within the Workers' Compensation system (Boersma & Linton, 2005; Gatchel, 2004; Severeijns, Vlayen, van den Hout, & Weber, 2001; Sullivan & Stanish, 2003; Vowles & Gross, 2003). Much of the literature has addressed "mainstream" diagnoses, such as Major Depressive Disorder, Dysthymic Disorder, Somatization Disorder, and a variety of Anxiety Disorders. These diagnoses have been identified within the injured worker population, and consideration for psychological treatment accompanying physical rehabilitation has been argued. It is therefore logical and imperative to recognize Adjustment Disorder and its potential underlying presence in the Workers' Compensation rehabilitation system, especially when it is a condition that has yet to warrant attention within the rehabilitation literature.

Adjustment Disorder

The DSM IV-TR (APA, 2000) defines Adjustment Disorder as a psychological response to an identifiable stressor or stressors that result in the development of clinically significant emotional or behavioral symp-

toms. The symptoms of Adjustment Disorder emerge within three months of the onset of the stressor, and include a wide variety of impairments within social and occupational functioning. The DSM IV-TR also states that Adjustment Disorder is the appropriate diagnosis if symptoms fail to resolve within six months of the termination of the stressor or its consequences (APA). Psychosocial stressors, such as divorce, difficulties in child rearing, illness or disability, financial problems, conflicts with work colleagues, moving, and retirement are all possible triggers for Adjustment Disorder. Maladaptive extremes of anxiety, depression, and impulse control problems are also reoccurring themes of the diagnosis. According to DSM IV-TR, Adjustment Disorders are specified in various subtypes:

1) AD with depressed mood,
2) AD with anxiety,
3) AD with mixed anxiety and depressed mood,
4) AD with disturbance of conduct,
5) AD with mixed disturbance of emotions and conduct,
6) An unspecified subtype of AD.

The DSM IV-TR recommends that a diagnosis of Adjustment Disorder should not be made if symptoms for other more specific disorders, such as anxiety or depression, can be met (APA). This may contribute to a lack of identity within the rehabilitation arena, as it is conceivable to misdiagnose Adjustment Disorder as one of several previously mentioned conditions. However, Adjustment Disorder is a commonly used diagnosis among mental health clinicians, and it is among the top two most frequently coded diagnoses in specialty mental health claims (Azocar & Greenwood, 2007). Specifically, it is commonly used by clinicians belonging to managed behavioral health organization panels that bill outpatient services related to interpersonal relationships, family, or workplace issues when the patient does not display a definitive diagnosis for another Axis I disorder (Azocar & Greenwood). Therefore, failure to recognize this diagnosis may be related to the context in which it is being examined. Literature has noted that researchers are reluctant to perform further clinical analysis of Adjustment Disorder due to a lack of operational diagnostic specificity (Baumeister & Kufner, 2009). It is therefore understandable that certain environments, particularly those which operate under the scrutiny of service provision supported by literature arguing efficacious treatment, such as Workers' Compensation.

Empirical evidence also suggests that Adjustment Disorder is a transient disorder with a tendency for spontaneous remission (Maercker, Einsle, & Kollner, 2007). Because of this characteristic, clinicians providing services within the Workers' Compensation system may be reluctant to diagnose individuals with Adjustment Disorder. There are also studies that indicate that Adjustment Disorder can lead to a higher rate of psychiatric morbidity, e.g., increased suicide rates (Maercker et al.). Hesitancy to diagnose may also exist because of this noted feature of the condition.

Maercker and colleagues have suggested that research addressing AD lacks a concise definition of the condition, and note how most clinicians and researchers use the diagnosis as an exclusionary criterion for mood or anxiety disorders. Baumeister and Kufner (2009) agree, and argue that Adjustment Disorder is a "sub-threshold diagnosis." The most common sources of criticism regarding how AD is defined in the DSM IV-TR is the differentiation between Adjustment Disorder and normal adaption processes, as well as any overlap with other psychological disorders (Maercker et al., 2007). Adjustment Disorder shares commonalities with Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD), among other diagnoses, such a complicated grief (Horowitz, 1997). Baumeister and Kufner (2009) propose that a definitional revision of Adjustment Disorder be made even without sufficient empirical evidence due to the presence of unsubstantiated diagnoses made by health care providers without operational specificity. A precedent for a definitional revision was made in the early 1980s in the absence of empirical evidence when the DSM-III made categorical changes based only on expert opinion (Baumeister & Kufner).

Maercker and colleagues (2007) have developed new diagnostic criteria for Adjustment Disorder based on the central symptoms of intrusion, avoidance, and failure to adapt. Intrusion symptoms are recurrent, distressing, and involuntary recollections of the event. An individual experiences repetitive thoughts or constant rumination about the event, occurring most days for at least one month (Maercker et al.). The individual may also undergo stress if reminded of the event. Avoidance occurs as the individual attempts to avoid stimuli associated with the perceived stressful event. The client's efforts to avoid the thoughts associated with the event are usually in vain (Maercker et al.). Individuals avoid feelings associated with the distressing event. Attempts to avoid talking about the event and withdrawal from others are also consumer symptoms. Lastly, failure to adapt occurs when there is a loss of interest in work, social life, care for others, and leisure activities. Patients also experience difficulty concentrating, trouble sleeping, and lack of self-confidence when engaging in familiar activities (Maercker et al.).

Although there is a lack of a specific instrument for Adjustment Disorder diagnostics, the Hospital Anxiety and Depression Scale (HADS) is a common tool utilized for assessing Adjustment Disorder in outpatient settings (Mykletun, Stordal, & Dahl, 2001). The

HADS has been determined to be both a valid and reliable measure for symptoms indicative of Adjustment Disorder, as internal consistency measures has been noted via Cronbach's Alpha at r = 0.76 (Mykletun et al.) Treatment options for claimants who have been diagnosed with Adjustment Disorder along with other injuries may include psychotherapy, particularly cognitive behavioral therapy approaches, as well as pharmacological treatment, or a combination of both (Azocar & Greenwood, 2007). The fundamental goal of treatment is to utilize the claimant's stress-coping mechanisms to prevent Adjustment Disorder from developing into another more chronic condition, such as Generalized Anxiety Disorder or Major Depressive Disorder. Long-term effectiveness of treatment suggests appropriateness for Adjustment Disorder, and post-treatment relapse has been minimally noted (Azocar & Greenwood).

Considerations for Workers' Compensation

Treating the multiple aspects of the claimant's condition during the rehabilitation process after a work related injury appears to be the most cost-effective means to a successful long-term return to work. Carriers appear cautious not to incorporate psychiatric treatment, possibly to avoid a torrent of undesired costs. If carriers were to invest in the utilization of psychiatric care, including assessment, evaluation, and treatment, successful return to work outcomes may result, which is favorable to all parties.

Adjustment Disorder can manifest in various forms after the onset of a stressor, such as the life-changing experience of a work-related injury. It is very likely that individuals currently in the Workers' Compensation rehabilitation system are affected by this disorder's symptoms, which may interfere with their return to work process. Based on the previously mentioned literature, there are several reasons for why this condition may be overlooked. Regardless of whether the possible oversight is accidental or intentional, this diagnosis warrants specific attention, especially when considering the potential impact it can have on the injured worker and the rehabilitation process. Individuals with Adjustment Disorder may be less likely to fully participate in both medical and vocational rehabilitation. They may be perceived as uninterested in vocational development, noncompliant with rehabilitative therapeutics, and uncooperative with rehabilitation professionals throughout the process. Essentially, all of the perceived barriers that have been implied for other psychological conditions, such as depression, may be present. However, no explanatory diagnosis has been determined. These individuals may contribute to the "difficult client" stereotype, as they are within the system with no rationale for how and why they may behave. Consequently, the clients may be construed as adversarial, defensive, or apathetic.

Continued research focusing on Adjustment Disorder and its implications within vocational rehabilitation may change its status from an intermediate or transient disorder to that of a fundamental diagnosis that will assist in returning injured workers back to work. Additional research is needed examining the impact of psychological treatment, including costs associated with the care, effects return to work outcomes within the Workers' Compensation system. However, until such research is conducted and published, it is critical for parties providing Workers' Compensation rehabilitation services to deem Adjustment Disorder as a valid diagnosis and a potential barrier for the clients they serve.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: APA.

Azocar, F., & Greenwood, G. L. (2007). Service use for patients with adjustment disorder and short term treatment: A brief report. *Internet Journal of Mental Health, 4*, 1–3.

Baumeister, H., & Kufner, K. (2009). It is time to adjust the adjustment disorder category. *Current Opinion in Psychiatry, 22*, 409–412.

Betters, C. J., & Shaw, L. R. (2009). Establishing predictor variables of unmet psychological need in the Florida workers' compensation system. *Work, 32*, 145–154. doi: 10.3233/WOR-2009-800

Betters, C. J., & Shaw, L. R. (2008). The international classification of functioning model and untreated psychological need in workers' compensation. *The Rehabilitation Professional, 16*, 63–70.

Boersma, K. & Linton, S. J. (2005). Screening to identify patients at risk: Profiles of psychological risk factors for early intervention. *The Clinical Journal of Pain, 21,* 38–43.

Gatchel, R. J. (2004). Psychosocial factors that can influence the self-assessment of function. *Journal of Occupational Rehabilitation, 14,* 197–206.

Horowitz, M. J. (1997). *Stress response syndromes* (3rd ed.). Northvale, NJ: Aronson.

Maercker, A., Einsle F., & Kollner, V. (2007). Adjustment disorders as stress response syndromes: A new diagnostic concept and its exploration in a medical sample. *Psychopathology, 40*, 135–146. doi: 10.1159-000099290

Mykletun, A., Stordal E., & Dahl, A. (2001). Hospital anxiety and depression (HADS) scale: Factor structure, item analysis and consistency in a large population. *British Journal of Psychiatry, 179*, 540–544.

Severeijns, R., Vlaeyen, J. W., van den Hout, M., & Weber, W. E. (2001). Pain catastrophizing predicts pain intensity, disability, and psychological distress independent of the level of physical impairment. *The Clinical Journal of Pain, 17,* 165–172.

Sullivan, M. L., & Stanish, W. D. (2003). Psychologically based occupational rehabilitation: The pain disability prevention program. *The Clinical Journal of Pain, 19,* 97–104.

Vowles, K. E., & Gross, R. T. (2003). Work-related beliefs about injury and physical capability for work in individuals with chronic pain. *Pain, 101,* 291–298. doi: 10.1016/S0304-395900337-8

Author Notes

Derrick C. Fowler, BA, Rehabilitation Counseling Program, Winston-Salem State University. **Chad J. Betters, PhD,** CRC, CDMS, CVE, Rehabilitation Counseling Program, Winston-Salem State University.

Correspondence concerning this article should be addressed to Dr. Chad Betters, Anderson Center Room C024A, Winston-Salem State University, Winston-Salem, NC 27110.

CEU INFORMATION

This article has been approved for continuing education credits for CRC, CCM, and CDMS for IARP members through the IARP Certification Maintenance Program. At the time of printing we have requested approval of 1.0 credit. To obtain CEUs after reading the article, the following is required.

1. **Complete both the exam on page 211 and the evaluation form on this page.**
2. **Write a check to IARP for $15 (IARP professional members), $20 (IARP associate members), or $25 (non-members and subscribers) to process the request.**
3. **Send everything, including your name, address, phone/fax numbers, CRC, CDMS, and/or CCM number(s) to the address below.**

IARP CEU Processing
1926 Waukegan Rd., Ste. 1
Glenview, IL 60025-1770

This continuing education activity is provided by IARP and has been preapproved by the Commission on Rehabilitation Counselor Certification (CRCC), the Certification of Disability Management Specialists Commission (CDMS), and the Commission for Case Managers Certification (CCMC) for 1.0 clock hour of continuing education. Certificants must submit this completed quiz to IARP by mail by March 31, 2010 to receive a Verification of Completion form. IARP will be unable to issue credit for quizzes after this time.

Evaluation Form	Excellent	Very Good	Good	Average	Poor
1. The article was clearly written.	5	4	3	2	1
2. The article furthered my knowledge of the dissemination and utilization of disability information.	5	4	3	2	1
3. The article provided information which will be useful to me regarding the dissemination and utilization of disability information.	5	4	3	2	1
4. The issues addressed in this article were valuable.	5	4	3	2	1
5. The article furthered my career.	5	4	3	2	1

Your comments are appreciated. Please use a separate sheet of paper.