Background: ICD-11 adjustment disorder (AjD) is characterized by two main symptom clusters; preoccupation with the stressor and failure to adapt to the stressor. The network analytic approach provides important information on the structural validity of a disorder and reveals which symptoms are most prominent. To date, no study compared the network structure of AjD symptoms in clinical and non-clinical samples, which could potentially inform our understanding of psychopathological mechanisms that underlie AjD and identify core targets for therapy. Methods: A network analysis was conducted on AjD symptoms as assessed by the adjustment disorder –New Module (ADNM-8) using data from 330 clinical participants from the UK and a non-clinical sample of 699 participants from Switzerland. Results: Comparisons of network structure invariance revealed differences between the network structure of the clinical and the non-clinical samples. Results highlight that in terms of both edges strength and centrality, failure to adapt symptoms were more prominent in the clinical sample, while the preoccupation symptoms were more prominent in the non-clinical sample. Importantly, global strength was similar across networks. Discussion: Results provide evidence of the coherence of AjD in the ICD-11 as assessed by the ADNM questionnaire. They tentatively suggest that subclinical AjD may be characterized by emerging preoccupation symptoms that may result in failure to adapt and functional impairment in clinical manifestation of AjD. However, there is a need for replication and longitudinal research to further validate this hypothesis.
Dear Prof. Sophia Frangou, MD, PhD

European Psychiatry

Ms. Ref. No.: EURPSY-D-22-00031

Title: The network structure of ICD-11 adjustment disorder: A comparison of clinical and non-clinical samples

European Psychiatry,

We would like to thank you for making efforts to improve our manuscript entitled "The network structure of ICD-11 adjustment disorder: A comparison of clinical and non-clinical samples " (Manuscript No. EURPSY-D-22-00031). We thank you for believing in the potential of our paper to contribute to the understanding of adjustment disorder. We were thankful during the process of the revision and we made our best to clarify the manuscript according to your comments. We were doing our best to thoroughly address each of the reviewers’ comments and our responses appear below each comment in bold (in the manuscript all changes are in red).

In addition to the reviewers’ comments, we found a mistake in the discussion: "Third, the stressor referred to when administering the ADNM was different in the two samples (the COVID-19 pandemic in Switzerland; general traumatic events in the UK)". This was changed to “Third, the stressor referred to when administering the ADNM was different in the two samples (the COVID-19 pandemic in Switzerland; general stressors in the UK)”.

Sincerely,
Yafit Levin, PhD,

On behalf of all authors.
Dear reviewers,

European Psychiatry

Ms. Ref. No.: EURPSY-D-22-00031

Title: The network structure of ICD-11 adjustment disorder: A comparison of clinical and non-clinical samples

European Psychiatry,

We would like to thank you for making efforts to improve our manuscript entitled "The network structure of ICD-11 adjustment disorder: A comparison of clinical and non-clinical samples " (Manuscript No. EURPSY-D-22-00031). We thank you for believing in the potential of our paper to contribute to the understanding of adjustment disorder. We were doing our best to thoroughly address each of the reviewers’ comments and our responses appear below each comment in bold (in the manuscript all changes are in red).

Sincerely,

Yafit Levin, PhD,

On behalf of all authors.

Reviewer #2:

Comment #1:

What method/tool was used to diagnose adjustment disorders in the clinical sample?

Response: Thank you for this comment. The same adjustment disorder tool (ADMN-8) was used to screen for adjustment disorder in both samples. In the discussion, we declared that
"data collected relied on a self-report measure rather than clinician-administered interviews, which may have biased the reports".

**Comment #2:**

Were clinical participants consecutively recruited? How was the non-clinical sample recruited? What was the participation rate?

**Response:** Thank you for this comment. We added the following to the paper: "Participants were a consecutive sample of adults who self-referred to an NHS trauma service in Scotland (N = 330). All new patients over the 8-month recruitment period were asked to complete a set of standardized measures as part of their initial assessment with the service. Eligibility criteria for participation were as follows: Having self-referred to the service for psychological therapy within the recruitment period, being aged 18 years or over, possessing adequate competency in written English to allow for the completion of self-report questionnaires. Ethical approval for the collection and use of these data was provided by NHS Lothian Clinical Governance and Edinburgh Napier University Research Ethics Committee."

**Comment #3:**

Could you translate the y-axis label in Figure 2?

**Response:** Done.

**Comment #4:**

Discuss the limitations of having clinical and non-clinical sample come from distinct population geographically/culturally.
Response: Thank you for this comment. We added the following to the limitations section: "even though both samples are Western-European, we cannot negate the alternative explanation that cultural differences are associated with differences between the samples".

Reviewer #3:

Comment #1:

I believe that in the methods section, the a priori considerations made by the investigators for the eligibility of the participants should be noted. In the results section, the characteristics of the patients who met the eligibility criteria should be noted.

Response: Thank you for this comment. We added the following to the paper:

Clinical sample: "Participants were a consecutive sample of adults who self-referred to an NHS trauma service in Scotland (N = 330). All new patients over the 8-month recruitment period were asked to complete a set of standardized measures as part of their initial assessment with the service. Eligibility criteria for participation were as follows: Having self-referred to the service for psychological therapy within the recruitment period, being aged 18 years or over, possessing adequate competency in written English to allow for the completion of self-report questionnaires. Ethical approval for the collection and use of these data was provided by NHS Lothian Clinical Governance and Edinburgh Napier University Research Ethics Committee."

Non-clinical sample: “Inclusion criteria were being above the age of 18 and being fluent in German.”

Comment #2:
It is important to note the characteristics of the trauma clinic from which the UK sample was drawn.

**Response:** Thank you for this comment. We added the following to the manuscript: "The clinic is receiving referrals from GPs, psychiatrists and other mental health services of people who have experienced psychological trauma. Individual and group treatments for psychological trauma are being offered by qualified therapists".

**Comment #3:**

How was the diagnosis of AD made in the patients? Who evaluated them?

**Response:** Thank you for this comment. All data for this sample were collected as part of an initial assessment using self-report measures. The same adjustment disorder tool (ADMN-8) was used to screen for adjustment disorder. ADNM-8 was used in both samples.

**Comment #4:**

At what points in time were the patients assessed, and did the COVID-19-related stressors also operate on them?

**Response:** These data were collected prior to the pandemic.

**Comment #5:**

**Methods - In the non-clinical sample**

5.1. What were the eligibility criteria?

**Response:** Inclusion criteria were being above the age of 18 and being fluent in German.

This was added to the manuscript.
5.2. How was recruitment and data collection done?

**Response:** We added to the manuscript that “Participants were recruited via social media (e.g., Facebook), using a snowball technique. The study was advertised through personal and professional networks and included a Facebook advertisement targeting ages 30 and above.”

5.3. How many subjects were invited to participate and how many finally participated?

**Response:** As we used a snowball technique for recruitment, unfortunately, we do not know how many participants heard about the study but did not participate. We added a limitation specifying that “the Swiss sample is a convenience sample and, therefore, is not representative of the Swiss population.”

**Comment #6:**

**Discussion** - Could origin (UK versus Switzerland) explain the differences, i.e., the possibility to consult clinical centers? Can cultural differences explain the ability to continue "functioning" in the non-clinical sample?

**Response:** Thank you for this comment. We cannot exclude the possibility that cultural differences are related to the pattern of our results and added the following to the limitations section: "even though both samples are Western-European, we cannot negate the alternative explanation that the samples differ in culture". However, as the Swiss study recruited participants from the general population whereas the Scottish sample included only treatment-seeking individuals we believe that potential cultural explanations are unlikely to explain the differences in functioning.

**Reviewer #4:**

**Comment - Abstract:**
Claiming that a network analysis has never been done is not enough to justify the research. Authors should better focus on why this analysis is interesting maybe to assess the core symptoms and identify targets for therapy as you say further.

**Response:** Thank you for this comment. We added and adapted the following to the abstract: "To date, no study compared the network structure of AjD symptoms in clinical and non-clinical samples, which could potentially inform our understanding of psychopathological mechanisms that underlie AjD and to assess the core symptoms and identify core targets for therapy ".

**Comment - Introduction:**

Page 2 L2: Please precise what is "Adj" the first time you use the abbreviation in the text: "adjustment disorder (Adj)".

**Response:** Done as suggested (see the first sentence of the introduction).

**Comment:**

Page 5 L4: I understand what you said. However, I would find clearer that you mention that the first network analyses have been performed among non-clinical samples and that therefore, the analysis should be perform on a clinical sample to identify the organization of the symptoms within a clinical sample. Then, you talked about the comparison.

**Response:** Thank you for this comment. Done as suggested.

Page 5: When you say: "We analyzed the symptoms network of ICD-11 AjD using the ADNM-8 in a clinical dataset from the UK, as compared to the network structure of ADNM-8 in a non-clinical sample from Switzerland. » This should be removed or in the method section. You already presented your objectives.
Response: This was moved to the methods section.

Comment - Method:
I did not see ethical evaluation. I think this should be mentioned in the method section. You said that the non-clinical participants consented to participate but not the clinical sample, if I am right.

Response: Thank you for this comment. We added the following to the paper: "The study was approved by the Institutional Review Board of the University of Zurich. The participants provided their written informed consent to participate in this study."

Comment - Discussion:
Page 11: L 2: I wonder if the greatest connections between symptoms can be interpreted as the central symptoms. Maybe some explanations and/or references would be relevant in the data analysis section. I agree that the centrality of the node can actually be interpreted as the centrality of a symptom. I am less sure about the strength of the symptoms with only another symptom.

Response: We apologize for not adding enough literature that can shed light on the different indicators. The greatest connections between symptoms cannot be interpreted as the central symptoms. There is a strength centrality indicator that is known as reflective of the overall strength of each symptom in activating the network. As stated in the results section, "the standardized strength centrality estimates are presented in Figure 2. Item 2 ('sense of burden') was the node with the highest strength centrality in the non-clinical sample's network. The node with the smallest centrality was the impairment in functioning (item 8). In the clinical sample's network, the node with the highest centrality was the impairment in functioning item 8 and the least central item was item 2 ('sense of burden')". This report is based on the indicator of strength centrality which was not described in the methods section. Therefore, we added the following to the data analysis section in the methods: "Network..."
inference: The centrality index node strength and the predictability of each node. Strength refers to the sum of all edges connected to a specific node (Opsahl, Agneessens, & Skvoretz, 2010). Strength provides information on the connectedness of each node within the symptom network and it is considered a relative metric."


Comment –

Page 14: You could be more specific when you talk about clinical interventions. What do we do? Cognitive reframing, rumination focused therapy, problem solving interventions”.

Response: Thank you for this comment. We added the following to the text: " The results of the current study suggest that exercises focused on handling preoccupation could be useful as preventive measures and potentially inhibit later failure to adapt symptoms as well as the full clinical picture of AjD. Specifically, psychoeducation in a preventive setting should portray preoccupation as a natural process that supports the integration of the life event into one's biography. Supportive measures should guide clients to reprocess and understand their experiences in a meaning-making process. Clients must not develop avoidance strategies because attempts to suppress distressing thoughts about the event are often doomed to failure and can perpetuate the disorder in the long term (29,31)."

Comment:

You do not mention the cultural differences as a limit. This is an important limit. If you would like to conclude that the only difference is the clinical/ non-clinical aspect, you should exclude everything else. I was therefore wondering why the non-clinical sample has
not been gathered in the UK as well. Maybe mentioning the invariance analysis of the ADNM-8 within countries would be interesting in the method section if such analysis exists. Then, performing group comparison between clinical and non-clinical sample would also be interesting to be sure that the samples are only different from the clinical/non-clinical aspect as you say.

Response: Thank you for this comment. We added the following to the limitations section: "even though both samples are Western-European, we cannot negate the alternative explanation that the samples differ in culture". We also added the following comparisons as requested by the reviewer: " Groups did not differ in age and gender. In both the Swiss (73.8%) and the UK 64.1%) samples there were more women than men (p = .212). Age also did not differ significantly between groups (p=.583). In both groups the proportion of retired and unemployed participants was similar. "

Comment:

In the introduction, you go quickly in the statistical and psychometric considerations. Maybe adding few lines about why Adj is a relevant problem may be useful. Talking briefly about the prevalence, the use of the diagnostic, the fact that patients suffering from Adj, can at the end go the psychiatric urgencies, may be relevant.

Response: Thank you for this comment. We added the following to the manuscript: "

Adjustment disorder (AjD) is one of the most frequently diagnosed mental health conditions in clinical practice (1,2) and is prevalent in the general population. For example, 15.6% of participants in a nationally representative sample of Ireland screened positive for AjD (3) whereas 16.5% in the general population of Lithuania fulfilled the diagnostic criteria (4). Even though AjD is defined as a self-resolving condition, it can be protracted if the stressor continues, resulting in a substantial decline in quality of life and an increased risk of suicide.
Recently, the International Classification of Diseases, 11th revision (ICD-11) (8) has revised the diagnostic conceptualization of AjD and for the first time represents it by specific symptom groups. 

**Comment:**

Why did you use the ADNM-8 and not the ADNM-20. It would have been even more interesting to identify if preoccupations and failures to adapt are as central as the ICD proposes?

**Response:**

We agree with the reviewer, however, the focus of the study was on the core symptoms. According to ICD-11, preoccupation and failure to adapt are the core symptoms of adjustment disorder and are covered by the ADNM-8.
The network structure of ICD-11 adjustment disorder: A comparison of clinical and non-clinical samples

Yafit Levin¹,², Thanos Karatzias, PhD³,⁴, Mark Shevlin, PhD⁵, Menachem Ben-Ezra, PhD², Andreas Maercker⁶ Rahel Bachem⁶

¹ University of Ariel, Education Department, Kiryat HaMada 3, Ariel, 40700 Israel
² University of Ariel, School of Social Work, Ariel, Israel
³ Edinburgh Napier University, Sighthill Ct, Edinburgh, Scotland, EH11 4BN, UK
⁴ NHS Lothian, Rivers Centre for Traumatic Stress, Edinburgh, Scotland, UK
⁵ Psychology Research Institute, School of Psychology, Derry, Northern Ireland
⁶ University of Zurich, Institute of Psychology, Psychopathology and Clinical Intervention, Binzmühlestrasse 14, 8050 Zurich, Switzerland

Corresponding Author: Yafit Levin, Ph.D.: University of Ariel, Education Department and Social-Work school, Kiryat Hamada 3, 40700, Ariel, Israel. Tel: 972-547957276. Email: yafitl@ariel.ac.il

Sortened title:
Symptoms network of ICD-11 AjD in a clinical sample

Word count: 3969
Abstract

**Background:** ICD-11 adjustment disorder (AjD) is characterized by two main symptom clusters; preoccupation with the stressor and failure to adapt to the stressor. The network analytic approach provides important information on the structural validity of a disorder and reveals which symptoms are most prominent. To date, no study compared the network structure of AjD symptoms in clinical and non-clinical samples, which could potentially inform our understanding of psychopathological mechanisms that underlie AjD and identify core targets for therapy. **Methods:** A network analysis was conducted on AjD symptoms as assessed by the adjustment disorder –New Module (ADNM-8) using data from 330 clinical participants from the UK and a non-clinical sample of 699 participants from Switzerland. **Results:** Comparisons of network structure invariance revealed differences between the network structure of the clinical and the non-clinical samples. Results highlight that in terms of both edges strength and centrality, failure to adapt symptoms were more prominent in the clinical sample, while the preoccupation symptoms were more prominent in the non-clinical sample. Importantly, global strength was similar across networks. **Discussion:** Results provide evidence of the coherence of AjD in the ICD-11 as assessed by the ADNM questionnaire. They tentatively suggest that subclinical AjD may be characterized by emerging preoccupation symptoms that may result in failure to adapt and functional impairment in clinical manifestation of AjD. However, there is a need for replication and longitudinal research to further validate this hypothesis.

**Keywords:** Symptoms network analysis; Adjustment Disorder; ICD-11; ADNM-8
The network structure of ICD-11 adjustment disorder: A comparison of clinical and non-clinical samples

Adjustment disorder (AjD) is one of the most frequently diagnosed mental health conditions in clinical practice (1,2) and is prevalent in the general population. For example, 15.6% of participants in a nationally representative sample of Ireland screened positive for AjD (3) whereas 16.5% in the general population of Lithuania fulfilled the diagnostic criteria (4). Even though AjD is defined as a self-resolving condition, it can be protracted if the stressor continues, resulting in a substantial decline in quality of life and an increased risk of suicide (6,7). Recently, the International Classification of Diseases, 11th revision (ICD-11) (8) has revised the diagnostic conceptualization of AjD and for the first time represents it by specific symptom groups.

According to ICD-11, AjD is a maladaptive reaction to a stressful life event, ongoing psychosocial adversities or a combination of stressful life situations that usually emerges within a month of the occurrence of a stressor and tends to resolve within six months, unless the stressor persists for a longer duration. In ICD-11, AjD is characterized by two main symptom clusters: 'preoccupations with the stressor', which includes symptoms such as recurrent and distressing thoughts or rumination about the stressor or its implications, and 'failure to adapt', which includes difficulties concentrating, sleep disturbances and an inability to recover emotionally. For a diagnosis of AjD, the symptoms must be associated with significant impairment in functioning (8).

In parallel to the development of the AjD symptom criteria, a scale to assess AjD has been developed for validation of the newly proposed concept. Maercker,
Einsle and Kollner (2007) introduced and initially validated a 29-item self-report questionnaire, the adjustment disorder–New Module (ADNM), which was later condensed to 20 items (10). The ADNM-20 can be used to assess the two core symptom clusters of AjD in ICD-11 (preoccupation with the stressor and failure to adapt). Several validation studies of both ADNM versions indicated good psychometric properties (11,12). More recently and in line with the conceptualization of AjD in the ICD-11, an 8-item brief version, consisting of only the core symptoms (13) was produced and validated.

Factor analytic models assume a pre-determined set of factors (14) which means they are less efficient in providing the full complexity of relations among the different symptoms of AjD. The network approach, on the other hand, conceptualizes mental disorders as systems of connected symptoms rather than reflecting an unobservable disorder. A network structure consists of "nodes" that represent the symptoms studied and edges that represent the relationship between nodes. Edges have thicknesses corresponding to the strength of the association between the nodes they connect (15). The symptoms co-occur because they reciprocally reinforce each other, not because they arise from a common underlying cause (14).

Another advantage of the network approach is the index of central symptoms which are having many strong connections to other symptoms and greater numbers of connections (16). Identifying central symptoms of a disorder is of crucial importance to clinicians in order to guide intervention efforts. Central symptoms can also guide prognosis of patients and inform the development of care plans accordingly. Preliminary findings suggest that symptom centrality is related to the longitudinal course of a disorder (17). In the case of AjD, very few disorder-specific interventions have been developed to date (18) and thus, obtaining information on symptom
centrality may be particularly relevant for improving future treatment efforts in clinical samples.

To the best of our knowledge, no study has yet examined the network analysis of AjD in a clinical sample. The network of AjD was examined recently for the first time, in the general population of three African countries, and revealed important insights into the complex relations among its symptoms (19). Results highlighted preoccupation symptoms as the more prominent symptoms in terms of edges strengths and had the highest centrality in all networks. Scrutinizing the nature of both preoccupation and failure to adapt symptoms and their importance in clinical populations as compared to general population samples could help us to understand psychopathological mechanisms that underlie AjD and broader psychopathologies.

Furthermore, while the new conceptualization of AjD in ICD-11 suggests a two-factor structure (19), there is evidence to suggest that AjD could be perceived as a unidimensional construct (20). It would be of interest to examine the differences in network structure between clinical and non-clinical samples and the pattern of connections across different symptoms. The first network analyses have been performed among non-clinical samples and that therefore, the analysis should be perform on a clinical sample to identify the organization of the symptoms within a clinical sample. The current study thus aimed to compare the network structure of AjD in a clinical sample and a non-clinical sample.

We aimed to explore whether the networks are different in terms of global strength and structure. We aimed specifically to compare networks on (1) conceptual validity by exploring which of the symptoms are strongly associated with one another and are located adjacently; (2) which symptoms are most central and whether they belong to the preoccupations or the failure to adapt clusters.
Methods

Participants and Procedure

The study sample included 330 participants from Scotland \((n = 330)\), and Switzerland \((n = 699)\).

Clinical – UK sample

Data were collected from a trauma clinic as part of routine initial assessments \((n = 330\) participants). The clinic is receiving referrals from GPs, psychiatrists and other mental health services of people who have experienced psychological trauma. Individual and group treatments for psychological trauma are being offered by qualified therapists. Participants were a consecutive sample of adults who self-referred to an NHS trauma service in Scotland \((N = 330)\). All new patients over the 8-month recruitment period were asked to complete a set of standardized measures as part of their initial assessment with the service. Eligibility criteria for participation were as follows: Having self-referred to the service for psychological therapy within the recruitment period, being aged 18 years or over, possessing adequate competency in written English to allow for the completion of self-report questionnaires. Ethical approval for the collection and use of these data was provided by NHS Lothian Clinical Governance and Edinburgh Napier University Research Ethics Committee. The mean age of the participants was 38.97 years \((SD = 12.46,\) range 18–78 years), 62.1% were female \((n = 205)\). Almost the entire sample was of British ethnicity \((n = 297, 92.5\%)\) while 4.7% \((n = 15)\) were from other European nations, and 1.2% \((n = 4)\) were Asian. Less than half of the sample was employed at the time of assessment \((40.0\%, n = 132)\). In addition, 6.7% were students \((n = 22)\), 7.8% \((n = 25)\) were home keepers, 29.8% \((n = 95)\) were unemployed or retired, 9.1% \((n = 29)\) were not working due to illness, and 1.4% \((n = 13)\) were retired. The majority of the
sample were not having an in-patient care history \( (n = 279, 87.2\%) \), while 12.8\% \( (n = 41) \) had an in-patient care history.

The entire sample endorsed the full criteria of AjD according to ICD-11 as tested by the ADMN-8. The most frequently endorsed stressful life events were family conflicts (58.5\%), financial problems (50.5\%), and too much/too little work (48.0\%). See Table 1 for more information.

*Non-clinical – Switzerland sample*

Participants \( (N = 699) \) consented to participate in a study aiming to uncover psychosocial coping with challenges regarding COVID-19. We considered the pandemic as a global stressor which satisfies the criteria for exposure to a stressful life event that could potentially trigger AjD, as has been suggested in previous research (21,22). The study was approved by the Institutional Review Board of the University of Zurich. Data collection took place from April 24 to May 23 while Switzerland was in a partial lockdown. Inclusion criteria were being above the age of 18 and being fluent in German. Participants were recruited via social media (e.g., Facebook), using a snowball technique. The study was advertised through personal and professional networks and included a Facebook advertisement targeting ages 30 and above. Questionnaires were distributed electronically in German using Unipark Software. The participants provided their written informed consent to participate in this study. The mean age of the participants was 43.45 years \( (SD = 15.09, \text{range } 18–87 \text{ years}) \), 73.8\% were female \( (n = 516) \). Regarding education, 28.18\% \( (n = 197) \) completed primary/middle school, 16.01\% \( (n = 114) \) completed high school and 55.51\% held a bachelors or master’s degree. The majority of the sample was working \( (67.00\%, n = 468) \), 12.73\% were students \( (n = 89) \), 11.87\% were retired \( (n = 83) \), 5.72\% \( (n = 40) \)
were homemakers, and 22.58% \((n = 18)\) were unemployed. Among the entire sample, 32.9% \((n = 230)\) endorsed the full criteria of AjD according to ICD-11.

**Groups comparison**

Groups did not differ in age and gender. In both the Swiss (73.8%) and the UK 64.1% samples there were more women than men \((p = .212)\). Age also did not differ significantly between groups \((p = .583)\). In both groups the proportion of retired and unemployed participants was similar.

**Measurements**

The Adjustment Disorder–New Module-8 (ADNM-8) \((13)\) assesses the preoccupation and failure to adapt similarly to the ICD-11. Participants first rate a list of stressors, indicating which stressors they experienced during the previous two years. Then, they rate the presence of AjD symptoms during the last two weeks. Four items refer to preoccupation with the stressor(s) and four items assess failure to adapt symptoms (see Table 2). Each item is scored on a 4-point Likert-type scale \((1=\text{never}, 2=\text{rarely}, 3=\text{sometimes}, 4=\text{often})\). The total score of the ADNM-8 is the sum of responses to all items, and higher scores are indicative of greater severity of AjD. The internal reliabilities \((\text{Cronbach's alphas})\) of the ADNM-8 were satisfactory for the UK \((.812)\), and Swiss \((.850)\) samples for the total scores as well as for the preoccupation and the failure to adapt subscales, in the UK \((.686, .780)\), and Switzerland \((.816, .711)\), respectively.

**Statistical analysis**

We analyzed the symptoms network of ICD-11 AjD using the ADNM-8 in a clinical dataset from the UK, as compared to the network structure of ADNM-8 in a non-clinical sample from Switzerland.
Regularized partial correlation networks across the three samples

More information regarding network estimation and stability and accuracy of both edges and the centrality index techniques can be found in the data analysis section in the supplementary materials.

**Network estimation and visualization:** We estimated partial pairwise correlations parameters between all nodes, through a Gaussian Graphical Model (GGM). The methodology is described in detail in the data analysis section in the supplementary materials section. We used the graphical least absolute shrinkage and selection operator (Graphical Lasso; implemented in qgraph), which visualizes sparse networks using part correlations and considered the ordinal scale of the questionnaire.

**Network inference:** The centrality index node strength and the predictability of each node. Strength refers to the sum of all edges connected to a specific node (23). Strength provides information on the connectedness of each node within the symptom network and it is considered a relative metric.

**Network stability:** We examined the stability of the individually estimated networks, including estimating 95% confidence intervals around the edge weights and estimating a correlation-stability coefficient for strength centrality. More information regarding the network analysis techniques can be found in the data analysis section in the supplementary materials, and in a tutorial (24).

**Network comparisons:** To compare differences between networks, we estimated network differences between each pair of networks using the *NetworkComparisonTest* (NCT) package in R (25). More information regarding the network comparisons techniques can be found in the data analysis section of the supplementary materials.

**Results**
Regularized partial correlation networks across the two samples

Network estimation

To enhance visual comparability of edges, we estimated the average layout of the two networks and presented all networks using this layout (Fig. 1). In the clinical sample network, 12 of 28 possible edges (42.9%) while 19 of 28 possible edges (67.9%) in the Swiss non-clinical network, were nonzero. This designates that the symptoms had extensive connections with each other in both samples. The visual inspection of the networks exhibited many inconsistent edges across the samples.

The ADNM-8 symptoms Network in the UK Clinical sample

In the clinical network, the most robust connection was found between the 'difficulties doing work/tasks' (item 6) and the impairment in functioning item (item 8), both represent the failure to adapt factor. Next in the hierarchy of edges strength is the association between the 'repeated thoughts' (item 1) and 5 ('thoughts often revolve') both belong to the preoccupation factor. Then, strong associations were found between the preoccupation items 4 ('constant memories') and 5 ('thoughts often revolve'), as well as between item 4 and item 1 ('repeated thoughts'). Equal strength of association was found between item 3 ('difficulties concentrating') which is a part of the failure to adapt factor and 5 ('thoughts often revolve') which is a part of the preoccupation factor. Weaker but yet significant associations were found between item 3 ('difficulties concentrating') on the one hand, and the 'difficulties doing work/tasks' (item 6) and the impairment in functioning item (item 8), of the failure to adapt factor, on the other hand. The 'sense of burden' (item 2) was distant from all other symptoms and weakly connected to the network.

The ADNM-8 symptoms Network in the Swiss Non-Clinical sample
The strongest association was found between the preoccupation items 4 ('constant memories') and 5 ('thoughts often revolve'), followed by a robust connection between the preoccupation items: 'repeated thoughts' (item 1) and 'sense of burden' (item 2). Next in the hierarchy of edges strength was the association between the preoccupation items 1 ('repeated thoughts') and 5 ('thoughts often revolve'). Then, there were strong connections between the failure to adapt items 7 ('sleep difficulties') on the one hand and items 3 ('difficulties concentrating') and 6 ('difficulties going to work/doing daily tasks'), on the other hand. Equally strong was the association between items 2 ('sense of burden') and 3 ('difficulties concentrating'). Finally, there were strong associations, though less substantial between the preoccupation 'sense of burden' (item 2) and item 4 ('constant memories'). Item 4 was equally associated with item 3 ('difficulties concentrating') of the failure to adapt factor. Item 8 was less connected to other symptoms in the network.

**Network stability**

To confirm the visual similarity of networks, we used Spearman correlations of edge-weights for all combinations of networks, which are presented in the data analysis section in supplementary materials. Analysis shows that the accuracy of the edges was satisfactory. The results of the confidence interval showed that edge-weights were moderately large. In addition, the results showed moderate accuracy of the centrality strength index (see supplementary material text, results: Network accuracy and stability and Fig. SM2-SM3).

**Network inference**

The standardized strength centrality estimates are presented in Figure 2. Item 2 ('sense of burden') was the node with the highest strength centrality in the non-clinical sample's network. The node with the smallest centrality was the impairment in
functioning (item 8). In the clinical sample's network, the node with the highest centrality was the impairment in functioning item 8 and the least central item was item 2 (‘sense of burden’).

**Network comparisons**

Results from the network comparison test showed that global strength values per group were 3.41 and 2.87 for Scotland (clinical data) and Switzerland (non-clinical data), respectively (S statistics was .53 and p value was .14). The network structure differed between the two samples (M=.33, p=.03).

**Discussion**

This was the first study to compare the symptom network structure of the ICD-11 AjD in a clinical sample compared to a non-clinical sample. In both samples, extensive connections were found between the symptoms with particularly strong associations within each core symptom cluster (i.e., preoccupation with the stressor and failure to adapt symptoms). While global strength was similar between networks, the networks’ structures differed. In the clinical network, the most robust connections were found between items representing failure to adapt, including the ‘impairment in functioning’ item. Conversely, in the non-clinical sample, the strongest associations were found between preoccupation items. Regarding centrality of symptoms, in the clinical sample's network, the node with the highest centrality was ‘impairment in functioning’ and the least central item was the preoccupation item ’sense of burden’. Interestingly, the non-clinical sample showed the opposite trend, with 'sense of burden' being the most central item while the ‘impairment in functioning’ being the least central item.

**Conceptual validity and central symptoms**
This study aimed to assess the conceptual validity by exploring which of the symptoms strongly associate with one another and are located adjacently and to identify and compare the most central symptoms in the networks. Our findings indicate that the global strength of the clinical and non-clinical networks was similar. This finding lends support to the overall intensity of connections (weighted absolute sum of all edges) between symptoms in both networks of ICD-11 AjD, which indicates that the overall strength of associations between symptoms in the two networks was similar. Specifically, in both samples, extensive connections were found among the symptoms within each core symptom cluster (i.e., preoccupation with the stressor and failure to adapt). This provides further evidence for the conceptual validity of this newly defined condition.

However, the structure of the networks of the clinical and non-clinical samples and the most central symptoms differed significantly. In the non-clinical sample, it was found that preoccupation symptoms were the most connected nodes in the AjD network and that the preoccupation item 'sense of burden' was the node with the highest strength centrality. The node with the lowest centrality was ‘impairment in functioning’. This is in line with a recent study that conducted symptoms network analysis among three population-based African samples and found similarly strong associations between preoccupation symptoms (19), supporting the notion that preoccupation is the most prominent indicator of AjD in non-clinical samples. Moreover, in the population-based African samples, the ‘sense of burden’ item also had the highest strength centrality in all three non-clinical networks (19). This could be explained by the fact that failure to adapt symptoms are more heterogeneous than preoccupation symptoms, describing symptoms such as sleep disturbances,
concentration difficulties, loss of interest in positive activities, and reduced self-confidence (26).

Interestingly, among the clinical cases, for whom the adjustment difficulties are more substantial, failure to adapt items were more intensively connected and ‘impairment in functioning’ played a distinctive role. The least central item was the preoccupation item 'sense of burden', which was the most central item in the non-clinical sample. Results indicate that in the clinical sample impairment in functioning was a core symptom of the disorder. While functional impairment represents global malfunctioning in broader domains of life, the specific failure to adapt symptoms can be understood as subjective difficulties with work/tasks and other related psychopathological variables such as sleeping problems and concentration difficulties. The high centrality of failure to adapt in respect to functioning is also consistent with other studies conducted with clinical samples. For example, the symptoms network research conducted among clinical samples with schizophrenia showed that functioning and difficulties with tasks of daily life were most central and highly interconnected nodes in networks of schizophrenia (27).

The pattern of the current results raises the tentative assumption that there may be temporal development according to which AjD is first characterized by emerging preoccupation symptoms and less substantial failure to adapt symptoms (i.e., the pattern prevalent in non-clinical populations). If the preoccupation symptoms persist, it could be assumed that they result in failure to adapt and functional impairment, which represents the clinical manifestation of AjD (i.e., the pattern prevalent in clinical populations). This assumption is in line with the theoretical stress-response model of Horowitz (1997), which proposes that AjD can be located on a stress response continuum, along with other stress response syndromes such as PTSD and
prolonged grief. The model proposes four consecutive phases of stress response, starting with a first phase of realization that is accompanied by negative emotions such as fear, sadness or rage. The second phase is characterized by denial and refusal to face the implications of the event, which in the third phase results in alternating intrusions (i.e., preoccupations) and suppression of these unbidden thoughts and memories. In its final fourth phase, the stress response process results either in adapting to the stressor and its consequences or in problems to adapt, the latter of which represent a mental disorder such as AjD.

In line with this model, it was recently argued that preoccupation may represent a generic risk factor for the development of psychopathology (29). The current study lends further support for the transdiagnostic potential of preoccupation. Preoccupation may provide the grounds for the development of AjD which gradually enables the development of failure to adapt and functioning difficulties as observed in clinical cases. This hypothesis, however, requires further investigation in longitudinal studies with multiple assessments.

The study has several limitations. First, even though both samples are Western-European, we cannot negate the alternative explanation that cultural differences are associated with differences between the samples. Second, the data collected relied on a self-report measure rather than clinician-administered interviews, which may have biased the reports. Third, the cross-sectional nature of the data does not allow for any inferences on causality. Moreover, the centrality measures may be high because the nodes strongly influence the rest of the system but also because they are influenced by other nodes. Fourth, the stressor referred to when administering the ADNM was different in the two samples (the COVID-19 pandemic in Switzerland; general stressors in the UK). This discrepancy renders the samples not directly
comparable. Fifth, the Swiss sample is a convenience sample and, therefore, is not representative of the Swiss population. Despite these limitations, the current findings provide an initial estimation of the network structure of AjD in clinical and non-clinical samples with important insights that can guide future research and practice.

**Clinical implications**

Comparing the symptom networks of a clinical and a non-clinical sample provided some initial thoughts regarding the temporal development of the disorder which also have implications for psychosocial interventions. This is particularly important considering that relatively little is known about the treatment of AjD. It has been suggested that adjustment difficulties after stressful life events should be addressed with a stepped care approach (30), whereby low-intensity interventions such as bibliotherapy, behavioral activation and e-mental-health interventions are suitable in the early stress-response stage (26). The results of the current study suggest that exercises focused on handling preoccupation could be useful as preventive measures and potentially inhibit later failure to adapt symptoms as well as the full clinical picture of AjD. Specifically, psychoeducation in a preventive setting should portray preoccupation as a natural process that supports the integration of the life event into one's biography. Supportive measures should guide clients to reprocess and understand their experiences in a meaning-making process. Clients must not develop avoidance strategies because attempts to suppress distressing thoughts about the event are often doomed to failure and can perpetuate the disorder in the long term (29,31).

The prominence of functional impairment in the clinical sample's network suggests prioritizing failure to adapt and functional capacity as treatment targets for AjD in clinical settings. The high centrality of functional impairment in the network supports approaches to AjD that consider the ability to perform daily tasks in
everyday life as a primary target of recovery programs (30). A failed adjustment to
the stressor is often accompanied by feelings of personal incompetence and thus a
resource-strengthening approach is indicated. It can be useful to guide patients to
recall past crises and to identify personal qualities and strengths that helped them deal
with difficult situations in the past. Subsequently, it should be elaborated on how
these resources can be used purposefully in the current life situation (31,32).
Furthermore, if patients report sleep and concentration issues and a limited ability to
recover, sleep, hygiene, as well as a balance between activity and relaxation, can
counteract these problems (32).

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Table 1

**Prevalence of stressors in the clinical sample**

<table>
<thead>
<tr>
<th>Stressful Life events</th>
<th>Yes, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family conflicts, yes, n (%)</td>
<td>176 (58.5%)</td>
</tr>
<tr>
<td>Financial problems, yes, n (%)</td>
<td>152 (50.5%)</td>
</tr>
<tr>
<td>Too much / too little work, yes, n (%)</td>
<td>144 (48.0%)</td>
</tr>
<tr>
<td>Termination of an important leisure activity, yes, n (%)</td>
<td>150 (45.4%)</td>
</tr>
<tr>
<td>Illness of a loved one, yes, n (%)</td>
<td>124 (41.2%)</td>
</tr>
<tr>
<td>Own serious illness, yes, n (%)</td>
<td>121 (40.2%)</td>
</tr>
<tr>
<td>Pressure to meet deadlines / time pressure, yes, n (%)</td>
<td>113 (37.5%)</td>
</tr>
<tr>
<td>Death of a loved one, yes, n (%)</td>
<td>109 (36.2%)</td>
</tr>
<tr>
<td>Unemployment, yes, n (%)</td>
<td>107 (35.5%)</td>
</tr>
<tr>
<td>Moving to a new home, yes, n (%)</td>
<td>105 (34.9%)</td>
</tr>
<tr>
<td>Divorce / separation, yes, n (%)</td>
<td>91 (30.2%)</td>
</tr>
<tr>
<td>Conflicts in work-life relations, yes, n (%)</td>
<td>88 (29.2%)</td>
</tr>
<tr>
<td>Assault, yes, n (%)</td>
<td>76 (25.2%)</td>
</tr>
<tr>
<td>Conflicts with neighbors, yes, n (%)</td>
<td>49 (16.3%)</td>
</tr>
<tr>
<td>Serious accident, yes, n (%)</td>
<td>32 (10.6%)</td>
</tr>
<tr>
<td>Adjustment due to retirement, yes, n (%)</td>
<td>9 (3.0%)</td>
</tr>
</tbody>
</table>
### Table 2.

**ADNM items**

<table>
<thead>
<tr>
<th>Preoccupation</th>
<th>Clinical Mean (SD)</th>
<th>Non-clinical Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1: I have to think about the stressful situation repeatedly</td>
<td>3.51 (.80)</td>
<td>3.31 (.79)</td>
</tr>
<tr>
<td>Item 2: I have to think about the stressful situation a lot and this is a great burden to me</td>
<td>3.23 (.98)</td>
<td>2.46 (.92)</td>
</tr>
<tr>
<td>Item 4: I constantly get memories of the stressful situation and can’t do anything to stop</td>
<td>3.28 (.96)</td>
<td>1.78 (.93)</td>
</tr>
<tr>
<td>Item 5: My thoughts often revolve around anything related to the stressful situation</td>
<td>3.32 (1.38)</td>
<td>2.14 (.89)</td>
</tr>
</tbody>
</table>

**Failure to adapt**

| Item 3: Since the stressful situation, I find it difficult to concentrate on certain things | 3.40 (.85)         | 1.79 (.91)             |
| Item 6: Since the stressful situation, I don’t like going to work or carrying out necessary tasks in everyday life | 2.95 (1.09)        | 1.85 (.97)             |
| Item 7: Since the stressful situation, I can no longer sleep properly          | 3.36 (.97)         | 1.58 (.87)             |
| Item 8: Overall, the stressful situation affected me strongly in my personal relationships, my leisure activities, or in other important areas of life | 3.44 (.86)         | 2.78 (1.05)            |
**Fig 1.** Networks of ADNM-8 adjustment disorder symptoms in clinical vs. non-clinical datasets using average spring layout. Nodes represent ADNM-8 items, and edges Regularized partial correlations with LASSO penalty. Distances among nodes and thickness of edges relate to the size of their partial correlations. Blue edges indicate positive relations and red edges indicate negative relationships. ADNM 1: Repeated thoughts; ADNM 2: Sense of burden; ADNM 3: Difficulties concentrating; ADNM 4: Constant memories; ADNM 5: Thoughts revolve; ADNM 6: Work/tasks difficulties; ADNM 7: Sleeping problems ADNM 8: Functional Impairment. The full items can be found in Table 1.
Fig 2. Standardised node strength centrality for the networks. ADNM 1: Repeated thoughts, ADNM 2: Sense of burden; ADNM 3: Difficulties concentrating; ADNM 4: Constant memories; ADNM 5: Thoughts revolve; ADNM 6: Work/tasks difficulties; ADNM 7: Sleeping problems ADNM 8: Functional Impairment. The full items can be found in Table 1.
References


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