

***Prevalence of Adjustment Disorder Among Employees of Middle-Level Management
in the Apparel Sector in Sri Lanka***

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Abstract

Adjustment Disorder (AjD) is a transient psychological disorder that develops as a result of facing stressful life events. At present, the Diagnostic and Statistical Manual of Mental Disorders- 5th Edition (DSM-5) and the International Classification of Diseases - 11th Revision (ICD-11) are the two widely recognized diagnostic criteria. The Adjustment Disorder New Module 20 (ADNM-20), a self-reported questionnaire, is universally accepted as an effective screening tool for AjD and is widely being used. The objective of the study was to identify the prevalence rate of AjD among middle-level employees of the apparel sector in Sri Lanka. The current study followed a quantitative research design. Three hundred employees were screened for AjD symptoms using the DSM-5 criteria and ADNM-20 questionnaire. The results revealed a high prevalence rate of 56.33%. In addition, among the six subscales of ADNM-20, the avoidance subscale emerged with the highest mean score. Furthermore, it demonstrated that divorced female employees, employees within the 36-45-year age category, and employees working in the Human Resources (HR) and Industrial Engineering (IE) departments presented severe symptoms of AjD. The overall findings highlighted the urgent need for extensive future research on AjD, not only within the apparel sector but across all industries and work settings.

Keywords: Adjustment Disorder, ADNM-20, Apparel Sector

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I. Introduction

Adjustment Disorder (AjD) involves a maladaptive emotional and/or behavioural response to a specific psychosocial stressor at a level that is disproportionate to the severity of the stressor. (O'Donnell et al., 2019). As seen in other stress-related disorders, DSM-5 diagnostic criteria for AjD particularly recognise guidelines to decide what type of events or circumstances could be considered as stressors, or in relation to identifying the severity or nature of the stressor. Likewise, past research stipulates those stressors can include traumatic events or decisive life changes following a traumatic event such as an unexpected death of a loved one, and other stressful critical events such as an acute illness or unemployment (Einsle et al., 2010).

Prevalence rates of AjD vary markedly due to various factors, including sampling process, population, and the diversity of measures used for assessment and diagnosis. Population-based studies have found prevalence rates of less than 1% among five European countries, and this low proportion may be due to limitations of the diagnostic tools used (Gradus, 2017). However, a recent study conducted using a diagnostic concept found the prevalence rate of AjD at 2% and 76% of those with AjD were female, suggesting women are at a higher risk of developing AjD (Glaesmer et al., 2015).

Notably, the highest prevalence rate for DSM-III-defined psychological stress was 42%, which was documented among Japanese breast cancer patients (Okamura et al., 2000). Likewise, AjD was the most prevalent disorder among individuals presenting with self-harm during routine psychiatric assessment in emergency department settings (Taggart et al., 2006). In addition, a prevalence rate of 15-19% was observed in oncology-related palliative and non-palliative care settings (Mitchell et al., 2011). Furthermore, it was found that AjD accounted for 18.5% of consultation-liaison referrals in Irish general hospitals, whereas a psychosocial stressor was found in 93% of referrals, and this included medical illness in 59% of patients (O'Donnell et al., 2019). Other consultant psychiatry liaison samples have reported AjD at a prevalence rate of 30%. Additionally, AjD was diagnosed at a rate of 12% in psychiatric consultations in psychiatry services in the United States, Canada, and Australia (Strain et al., 1998).

However, apart from consultation liaison settings, research on the prevalence of AjD in other public or private sectors of society is minimal. No research has been done to assess the prevalence of AjD in the apparel sector in Sri Lanka or across the world. One key factor for the lack of research could be the absence of clearly defined and specific symptom criteria through which AjD can be differentiated from other stress-related disorders such as major depression (Bachem & Casey, 2018). AjD is seen to be too broad to be clinically relevant, as it overlaps with other distress disorders. This would restrict the validity and growth of research in the area of AjD.

At the present moment, the process of conceptualising AjD as a separate and distinct disorder is in a state of transition, and with the recent revisions of the two main diagnostic manuals (DSM-5 and ICD-11), AjD-related research has seen a growing interest not only in consultation settings but also in other areas and among specified groups of individuals.

A. The Diagnosis of AjD

AjD is currently diagnosed using two frameworks: the Diagnostic and Statistical Manual of Mental Disorders, text revision of the Fifth edition of DSM-5 (DSM-5-TR) published by the American Psychiatric Association in 2022, and the eleventh edition of the International Classification of Diseases (ICD-11) (World Health Organisation, 2018).

The DSM criteria for the diagnosis of AjD have expanded over the years. Initially, in DSM-I and DSM-II, AjD was described merely as a “transient situational personality disorder” (DSM-I) and “transient situational disturbances” (DSM-II) respectively. The introduction of the term “Adjustment Disorder” was documented under DSM-III while DSM-IV catered to the development of symptoms related to AjD. The present classification, DSM-5 consists of a five-point criterion for the diagnosis of AjD. It demonstrates that an individual who develops emotional and behavioural symptoms which are disproportionate to the severity of an identifiable stressor(s) and/or presents with significant impairment in social, occupational, or other areas of functioning within three (03) months of exposure to the stressor, can be diagnosed as suffering from AjD.

In addition, the criterion stipulates that the symptoms should not fulfill the diagnostic criterion of another disorder under the DSM classification nor be an aggravated pre-existing psychological disorder whereas it further emphasizes that the symptoms should not exist for more than six (06) additional months after the stressor has diminished. Along with the diagnostic criteria, DSM-5 also includes several subtypes of AjD: subtype-1) AjD with depressive symptoms, subtype-2) AjD with anxious symptoms, subtype-3) AjD with a mix of both depressive and anxious symptoms, subtype-4) AjD with disturbances of conduct and subtype-5) AjD with disturbances of conduct and emotions.

On the other hand, the ICD-11 introduced changes that marked a significant paradigm shift. In line with the DSM, the ICD recognises AjD as a stress-related disorder; however, with a different classification. Accordingly, an individual is required to experience at least one or more identifiable stressors to be diagnosed with AjD under ICD-11 provided that he or she does not meet the criterion of another clinical diagnosis. The symptoms are classified into two categories: category-1) preoccupation, which involves excessive worry, distressing thoughts, and rumination related to the current stressor, and category-2) failure to adapt, which includes significant impairment in social, family, and occupational aspects of life (Zelviene, Kazlauskas, & Maercker, 2020). Additionally, higher loneliness and lower self-efficacy were related to higher AjD symptom severity. In addition, ICD-11 recognises that symptoms tend to diminish within six (06) months unless the stressor prevails for a longer period. Despite AjD being addressed under two widely recognised diagnostic classifications; DSM-5 and ICD-11, one could argue that many terms related to symptoms such as ‘excessive’ and ‘disproportionate’ lack a specific definition thus, leading to problems in administering the AjD diagnosis. Despite the frequent use of AjD in clinical practice, it has been studied in research fairly recently. Furthermore, it can be suggested that the absence of a clear and distinctive diagnostic criterion according to the ICD-11 and DSM-5 might have hindered the development of adequate assessment tools to screen AjD.

Recently, specific instruments to measure AjD have begun to emerge, and the ADN-20 is the most widely recognised tool and is available as a structured clinical interview (Maercker, Einsle & Köllner, 2007) or self-report questionnaire (Einsle et al., 2010) which includes two (02) sections. Under the first section, the participants are required to select acute and chronic

life stressors presented over the past month and identify the most distressing one among the selected options. The second section consists of twenty (20) items which are categorised to form six (06) subscales: preoccupation, failure to adapt, avoidance, depressive mood, anxiety, and impulse disturbance. Each item is rated on a 4-point Likert scale on the severity of the experience during the past two (02) weeks whereas the total sum of all item responses elicits the overall severity of AjD symptoms. Several successful attempts have been made in the past to validate this questionnaire with studies demonstrating significant levels of specificity and sensitivity, creating specific diagnostic criteria for AjD (Bachem et al., 2017) (Lorenz, Bachem & Maercker, 2016). In addition, despite fewer items, the more condensed forms of ADNM-20, such as the ADNM-8 and ADNM-4 have also shown high levels of convergent and construct validity which proves that these instruments too can be utilised effectively to screen for AjD or other stress-related symptoms (Ben-Ezra et al., 2018). However, several validation studies were conducted showing stronger psychometric properties for the longer versions of the ADNM questionnaires.

B. The Prevalence of AjD in the Apparel Sector in Sri Lanka

The context of the present study is the apparel industry in Sri Lanka which has generated a high unemployment rate at 4% in 2016 and is home to the highest departures toward foreign employment (Welmilla, 2020). However, according to MAS Fabric Park (2018), around 15% of Sri Lanka's workforce is employed within the apparel industry (Lakshani & Weerasinghe, 2020), including a workforce of over 300,000 individuals, with a majority of female workers (Daily FT, 2019).

When considering the export income, Sri Lanka's garment sector accounted for 40% of total exports in 2017, generating 5.3 billion US\$ from export trade in 2019, increasing at 5.1% annually, according to reports by the Joint Apparel Association Forum (The Financial Express, 2020). For the year 2019, the sector's export income was calculated to be US\$ 4.2 billion, representing a 39.6% increase over the previous year and the year-over-year increase in exports in 2019 was 24% (Central Bank Annual Report, 2019). Notably, apparel exports in June 2022 had reached an all-time high, at a figure of US\$ 537 million monthly (Daily FT, 2022) despite numerous challenges resulting from the Covid pandemic and ongoing economic crisis.

However, the apparel sector, despite being a high-calibre business, in terms of its foreign income generation platform, has its drawbacks of which the most notable would be the additional responsibilities that the employees have undertaken to keep up with the demands of the industry. Particularly, one could state that the employees in middle-level roles who are responsible for the production and quality assurance of the industry, are subject to the most stressful conditions. As a result of the inability to cope with work-related stress, creates a degree of employee vulnerability toward developing an array of stress-related disorders, out of which depression and anxiety are the two most widely known and studied in the Sri Lankan context. Hence, AjD in the Sri Lankan context is relatively unknown, and it seems to go unnoticed, hindering individuals from seeking the help they need to overcome this disorder. Therefore, the aim of this paper is to identify the prevalence rate of AjD among middle-level employees in the apparel sector in Sri Lanka. This research would be a precursor to other studies, both locally and globally, to focus on the prevalence of this disorder among the apparel sector employees of middle-level management.

II. Methodology

Study Design

The present research is a descriptive cross-sectional study and is one component of a bigger study with several other components.

Study Setting

The study was conducted in eight (08) selected apparel sector organisations situated in six (06) different industrial zones; Katunayake, Kaduwela, Buttala, Baddegama, Pinnaduwa, and Koggala and managed by one administrative body. This is one of the leading private-sector apparel manufacturers in Sri Lanka.

Sample/Participants

The sample included employees from the middle-level management from eight (08) different factories of the organisation comprising approximately three hundred (300) employees; Baddegama - 38, Kaduwela - 38, Katunayaka-STAR - 38, Koggala-01 - 38, Katunayaka LLI - 37, Pinnaduwa - 37, Koggala-02 - 37, and Buttala - 37.

The employees of the middle-level management represented different departments, including team leaders, operation executives, and managers.

The rationale behind the selection of middle-level management is that the middle layer is the most accountable for implementing plans and achieving targets. As a result, these employees are subjected to multi-dimensional and multi-faceted work challenges while balancing the pressures from both the higher and lower tiers of the organisation. In addition, middle-level employees are generally not compensated in proportion to the responsibilities they undertake nor have the liberty to resign whenever they wish which further contributes to emotional distress. Due to the above reasons, middle-level employees were regarded as the most suitable group of individuals for the study.

Inclusion Criteria

All middle-level apparel sector employees were enrolled in the study irrespective of their age, gender, race, or socio-economic status, alongside other factors.

Exclusion Criteria

Employees with other mental health disorders, physical disabilities, and those who were on medication for various diseases were excluded from this study. Employees with alcohol, tobacco, or drug addiction were also not included.

Sampling Method

The random sampling method was used to recruit participants for the present study which allows researchers to statistically measure the true disorder prevalence in the population (Brynildsrud, 2020) with the support of the HR department.

Sample Size

The sample size is three hundred (300) middle-level employees in the apparel sector industry setting.

Materials/ Measures

For the data collection, the participants were screened for AjD using the DSM-5 and ADN-20 Questionnaire.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

According to DSM-5, the emergence of behavioural or emotional symptoms in reaction to one or more identifiable stressors should occur not less than three (03) months after the stressors' onset (American Psychiatric Association, 2013). In addition, these stress-related symptoms should not be another indicator of a mental illness, and they should not last longer than six (06) months after the stressor has terminated.

Past studies have demonstrated that DSM-5 depicts a higher internal consistency with a Cronbach Alpha value of more than 0.90 (Patra & Sarkar, 2013). This criterion is universally recognised as the core diagnostic manual for psychological disorders and thus, was incorporated to screen participants for AjD in the present study.

Adjustment Disorder - New Module 20 Questionnaire (ADNM - 20)

The ADNM is a measure of AjD that is composed of two sections: the item list and the stressor list. The most distressing events that a person may have had in the last two years are included in the stressor list, and the final section of the questionnaire asks about how frequently a person experienced AjD symptoms during the previous two weeks using a Likert scale. This Likert scale has four rating points, where one represents "Never" and four represents "Often." The ADNM-20 is composed of subscales that include avoidance, sad mood, anxiety, impulse disturbance, obsession, and failure to adapt (Lorenz et al., 2016). Preoccupation and failure to adjust are the items under the subscales that are thought to be the main symptoms of AjD; the total score of the items determines how severe the symptoms are (Lorenz et al., 2016).

Similar to DSM-5, past studies reveal a high internal consistency with a Cronbach Alpha value of 0.94 (Lorenz et al., 2016), whereas the Chinese version of the questionnaire reported a higher internal consistency with a Cronbach Alpha value of 0.93 (Tang et al., 2020). To utilise the questionnaire, it was validated in the Sri Lankan context as a part of the study.

Adaptation of ADNM-20 to the Sri Lankan Context

1. The translation, validation, and adaptation process were done following the recommended translation and adaptation procedure for health instruments, compiled by the World Health Organisation (World Health Organisation, 2010).
2. Considering this guideline, all documents followed the procedure of forward translation, expert-panel back translation, pre-testing, and cognitive interviewing and then the final version was documented.

3. Thereafter, the translated document was sent to three experts in the field of mental health for expert panel review.
4. Written permission was also obtained from the authors of the ADN-20 questionnaire.
5. Once all the experts attested to the translations as accepted, a pilot study was conducted with thirty (30) participants.
6. Subsequently, the ADN-20 questionnaire, according to the Sri Lankan context, was finalised based on the feedback obtained from the pilot study, and the finalised questionnaire was utilised for the present study.

Data Collection Procedure

A batch of volunteer, trained counsellors who presented themselves for the administration of a tool in a PhD study, administered the screening procedure for AjD using the DSM-5 guidelines and the ADN-20 self-report questionnaire.

Ethical Considerations

The General Sir John Kotelawala Defence University (KDU) Ethics Review Committee in Sri Lanka granted ethical approval for the study. Written informed consents were taken from all employees before participation. Their participation in the study was completely voluntary, and their right to choose whether to participate or depart was adequately recognised.

They had the liberty to withdraw from the study at any time, without assigning a reason, and doing so had no negative effects on their career or tenure. The data was kept in a password-protected computer. All data was stored anonymously whereas the confidentiality of the participants and their information was guaranteed. A special identification code was added to the completed questionnaires to completely anonymise them. However, they were provided adequate information and guidance about the study. Furthermore, they were provided an opportunity to approach counsellors and other specialists for support if any incidents occurred. It was assured that there was no physical or psychological harm done to the participants during this study, and if anyone did experience any emotional or psychological distress, they were given the information they needed to be referred to professionals who could offer them psychological support.

III. Results

Out of the three hundred (300) employees who were screened for AjD, one hundred and sixty-nine (169) individuals were diagnosed with symptoms of AjD. Based on the data, the prevalence rate was calculated as 56.33%.

Among the participants with AjD, 73 (43.2%) were males and 96 (56.8%) were females. The majority of the patients were in the 26-35 year age group (36.1%), while the least number of participants belonged to the age group of 46-55 years (10.7%). The majority of the participants were married (52.1%), while 43.8% were single and the rest were divorced (4.1%). Descriptive statistics for all sociodemographic variables are presented in Table 1.

Table 1: Sociodemographic characteristics of the sample

Variables	Males		Females		Total	
Age group (In years)	n	%	n	%	n	%
18-25 years	19	26.0	33	34.4	52	30.8
26-35 years	26	35.6	35	36.5	61	36.1
36-45 years	18	24.7	20	20.8	38	22.5
46-55 years	10	13.7	8	8.3	18	10.7
Marital status	n	%	n	%	n	%
Divorced	4	5.5	3	3.1	7	4.1
Married	44	60.3	44	45.8	88	52.1
Single	25	34.2	49	51.0	74	43.8
Designation	n	%	n	%	n	%
HR (Human Resources)	5	6.8	9	9.4	14	8.3
IE (Industrial Engineering)	6	8.2	5	5.2	11	6.5
OT (Other)	15	20.5	17	17.7	32	18.9
PR (Production)	29	39.7	44	45.8	73	43.2
QA (Quality Assurance)	9	12.3	17	17.7	26	15.4
ST (Stores)	9	12.3	4	4.2	13	7.7
Educational level	n	%	n	%	n	%
GCE Ordinary Level	19	26.0	18	18.8	37	21.9
GCE Advanced Level/Diploma	44	60.3	65	67.7	109	64.5
Degree/Masters	10	13.7	13	13.6	23	13.6

Both males and females had nearly similar mean total scores for ADN-20, 60.93 and 61.21 respectively. The ADN-20 sub-scale analysis revealed the highest mean scores for the 'avoidance' category (13.41, SD 2.15), followed by 'preoccupations' (12.50, SD 1.92) and 'failure to adapt' (11.51, SD 2.67). Both males and females had the lowest mean scores for the 'anxiety' sub-scale, with scores of 5.25 (SD 1.56) and 5.74 (SD 1.29).

Table 2: Distribution of mean values in the subscales of ADN-20

ADNM-20 sub-scale	Mean	Theoretical maximum
Depressed mood	9.01	12
Preoccupations	12.50	16
Avoidance	13.41	16
Anxiety	5.53	8
Impulse disturbances	9.14	12
Failure to adapt	11.51	16

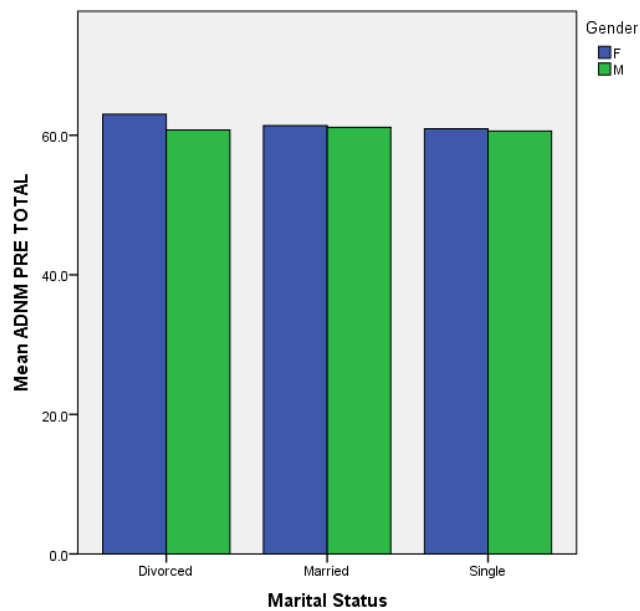


Figure 1: Mean ADN-20 score with marital status

According to Figure 1, divorced females seem to have a slightly higher ADN-20 mean score across categories of marital status. Both male and female participants who were single were reported to have a comparatively lower mean score for ADN-20.

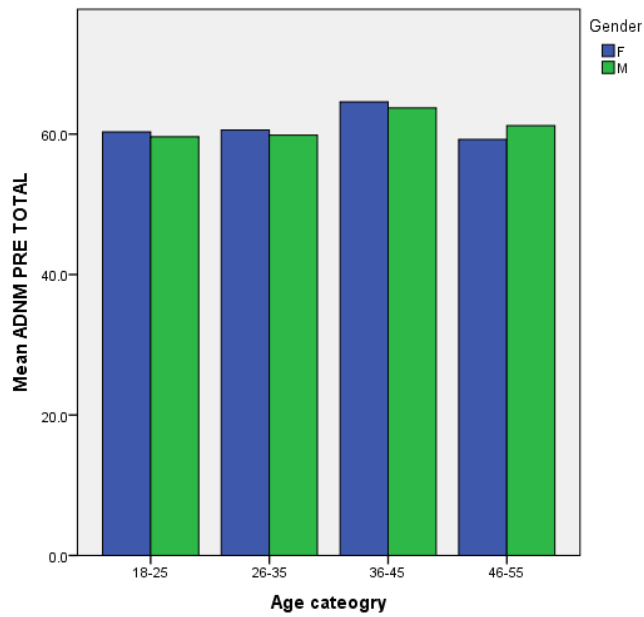


Figure 2: Mean ADN-20 score with age

According to Figure 2, both male and female participants in the age category of 36-45 years were reported to have the highest ADN-20 mean scores. The lowest ADN-20 score was reported by females in the age category of 46-55 years.

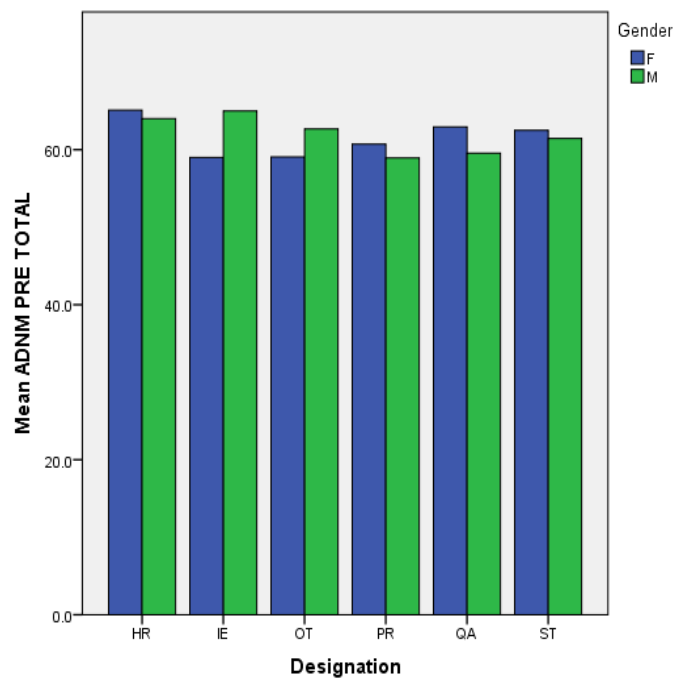


Figure 3: Mean ADN-20 score with designation

Figure 3 shows the mean ADN-20 scores of the participants against their designation. Accordingly, females who worked in HR and males who worked in IE were reported to have the highest mean ADN-20 score.

IV. Discussion

The current study aims to assess the prevalence rate of AjD among middle-level employees in the Sri Lankan apparel sector using a validated psychometric scale, ADN-20. The results revealed that 56.33% of the considered population was diagnosed with AjD where it can be noted that the figure was considerably high. The significance of this result in the context of the apparel sector management employees is this industry continues to be a vital contributor to the economy of the nation. Employees in middle-level management in this industry face a wide range of stressors, making them more prone to suffering from signs of AjD compared to the general population.

This result can be aligned with the study by Vancappelen et al. (2021) which was carried out among the French general population during the COVID-19 pandemic and recorded a rate of 61.3%. Both these results highlight that the prevalence of AjD could be shown at higher rates even in different study samples and contexts. Similarly, the study by Makki et al. (2024) also supports these results which found a 50% prevalence rate of AjD among medical undergraduates in Saudi Arabia. However, the generalizability of the current study findings is doubtful as these results are specific to the apparel sector middle-level management employees and may not generalise to other work settings or general populations.

Contradicting the above results, according to the study conducted by Glasemer and his colleagues in 2015, the German general population carries 2% of individuals diagnosed with AjD. It could be acknowledged that AjD may manifest differently, leading to discrepancies in the prevalence rates.

In that scenario, the demographic characteristics of the considered sample play a significant role in the research outcomes. The differences in age, gender, cultural background, and socioeconomic status could have influenced the prevalence rates.

The results demonstrated that the 'avoidance' category of the ADN-20 scale had the highest mean score (13.41) which consisted of the items: avoiding talking about a stressful situation, avoiding things that reminded them of a situation, or trying to suppress feelings that are a burden. Therefore, it is evident that 'avoidance' is a significant component of AjD among the apparel sector employees in this study, which would also explain the reason why many individuals refrain from voicing their feelings and seeking treatment for AjD.

Furthermore, the results revealed that symptoms were more prevalent among divorced females, employees who are working within the HR and IE departments, and individuals who are within the age group of 36 – 45 years. Females who worked in quality assurance and stores, tended to have higher ADN-20 scores, compared to males in the industry. These findings reflect the general societal pressures of the national context, where female workers tend to face more stress than men. When comparing divorced females in the Sri Lankan context, they are over-scrutinized in the workplace leading to additional mental trauma (Adikaram, 2019), resulting in high ADN-20 scores. They also tend to lack support from a partner in their emotional well-being, and therefore, have high stress levels. Whereas in the 36-45 age category, the high scores are explained as it is the period in an individual's life which usually consists of many challenges, from career progression to work-life balance maintenance.

On another note, the HR and IE departments cater to the key components of the industry, where the HR department oversees all matters related to the large workforce from salary matters to personal issues whereas the IE department attempts to integrate manpower with the efficient use of machinery to maximise productivity. The individuals employed in these two departments are subjected to many challenges and obstacles, increasing the risk of developing symptoms of AjD. Therefore, from the analysis of results, it is evident that divorced female employees, employees within the 36-45 age category, and those within the HR and IE departments exhibit AjD symptoms with high intensity compared to their counterparts. This data suggests that workplace distress symptoms are higher due to the stress related to divorce, belonging to a middle-aged bracket, or being within certain industries where work demands are higher such as HR and IE departments. As work demands are higher in HR and IE, then psychological distress would constantly be higher. Further, the symptoms present widely in all departments may address that the individual trait can be a causative factor.

Specifically, in this research which was carried out in the Asian context, the perceived status of work stress and AjD may differ when compared to research in the West. This could be due to the changes in thought patterns of the individuals with the cultural influence. A higher prevalence rate can be observed due to several factors. As the apparel sector is often characterised by its demanding and target-oriented nature including repetitive tasks, long hours of working, and potential exposure to occupational hazards, which may lead to adjustment difficulties and increased stress.

However, the current research has attempted to enhance the generalizability of the findings to broader populations in the same field, by recruiting participants from eight (08) different factories, representing a sample from a diverse range of sociodemographic backgrounds. Despite a staggering prevalence rate, Sri Lanka lacks extensive and comprehensive research on AjD, and as a result, the public is unaware of the disorder. Thus, hinders individuals who have developed AjD or those who are vulnerable to developing AjD symptoms as a result of their workplace, age level, or relationship history. Therefore, future research could investigate the potential coping mechanisms, and identify interventions that can be utilised for individuals who have already developed the symptoms of the disorder and the contributing factors to the high prevalence rate of AjD among the apparel sector employees such as job demand and work setting. On the other hand, a longitudinal study could explain how AjD affects the mental health of an individual and the long-term consequences on the lifestyle. In addition, the studies can be further focused on how the existing interventions could be tailored to the unique needs of the apparel sector workers in terms of implementation and evaluation to promote better mental health outcomes.

The employment of a robust psychometric scale, ADN-20 with established validity and reliability in assessing AjD has strengthened the current study. Such a methodological strategy would enhance the credibility of the findings. The reliability of the study findings was further ensured as these findings could be replicable and are transparent in terms of data analysis procedure. The current study does not encounter the effect of potential confounding variables such as family history, personal experiences of trauma exposure, and other life stressors that may influence the occurrence of AjD. The validity of the findings would have been affected in a situation where such factors were not taken into consideration. Another limitation of the study is the lack of qualitative data to capture the perspectives of middle-level management apparel sector employees regarding their difficulties in managing AjD.

As the study is solely based on quantitative data, incorporating a qualitative phase could provide more valuable insights into the contextual factors and lived experiences contributing to this higher prevalence rate.

V. Conclusion

In consideration of all factors, the study attempted to investigate the prevalence rate of AjD among middle-level, apparel sector employees in Sri Lanka. The results demonstrated a high prevalence rate of 56.33% among the target population with the ADN-20 avoidance category emerging as the highest-rated subscale. In addition to this, it was evident that divorced females, employees within the 36-45 age category, and those employed in the HR and IE departments obtained higher ADN-20 scores, revealing that they presented severe symptoms. The development of AjD is due to a wide range of factors ascertained in the workplace, age, and other related factors. Therefore, based on the findings, it can be concluded that AjD is highly prevalent among middle-level employees in the apparel sector of the country. Further research must be conducted to broaden knowledge of stress in the workplace and to provide interventions that can help manage the symptoms of AjD.

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Abbreviations and Specific Symbols

AjD - Adjustment Disorder

ADN 20 -Adjustment Disorder New Module 20 Questionnaire

DSM - TR - Diagnostic and Statistical Manual of Mental Disorders Text Revision

ICD - International Classification of Diseases

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