

From Crisis to Adjustment Disorder: A Medicalization of a Concept?

ARTICLE IN PRESS

Tsvi Gil

SUMMARY

This review aimed to compare two concepts in the psychiatric literature: crisis and adjustment disorder. The two concepts stem from different theoretical perspectives, rely upon different (though relatively loose) bodies of data, and may serve different purposes. The concept of crisis originated from an approach that could be considered psychodynamic, humanistic, and community oriented. Treatment, according to this approach, is known as crisis intervention and is characterized as being principally psychological, social, humanistic, and systemic. The generic approach to crisis calls for immediate aid rather than for a diagnosis and regular appointments, as is customary in psychiatric practice. The concept of adjustment disorder, on the other hand, is a rather medical nosological approach, which strives to achieve a phenomenological and objective description of the patient, and which may lead to ordinary psychiatric treatment, such as pharmacotherapy.

Herein we present a review of literature on both approaches, with an emphasis on theoretical and empirical data. The findings appear to provide rather weak empirical support for both concepts. Some theoretical resolutions are proposed in an attempt to link the two concepts, such as a continuum of severity. We conclude that practitioners should decide for themselves, according to one's own theoretical framework and purpose of usage. Nonetheless, as formal psychiatric diagnosis demands more extensive scientific support and bears further implications (such as stigma), the current use of the diagnosis of adjustment disorder may seem less justified.

Keywords: Crisis, crisis intervention, adjustment disorder, diagnosis, medicalization

History of the Concept of Crisis

The concept of crisis in the psychiatric literature is thought to have evolved from the writings of such prominent psychiatrists as Erich Lindemann (1944) and Gerald Caplan (1994). Its roots are to be found among the post-Freudian theoreticians that emphasized ego psychology, such as Heinz Hartmann, Ernest Kriss, and Rudolph Loewenstein (Golan 1978), those that emphasized life-cycle development, such as Erik Erikson (1963), and humanistic psychotherapists (Maslow 1954, Rogers 1961). During the 1960s the concept of crisis was integrated into the community approach, wherein crisis was perceived as an inevitable part of normal development. Crises, albeit unpleasant, were recognized as necessary for development and growth – a part of the life cycle (Golan 1978) and part of normal life course (Cohen, Specter, and Claiborn 1983). Crises, as such, are not pathologies and

should be treated by means of psychological support, rather than with psychiatric aid, as proposed by Brockopp (in Lester and Brockopp (1976).

Treatment, according to the crisis approach, should occur within the community and in an every-day setting, rather than in psychiatric wards or clinics, which by their nature isolate the person in crisis rather than help him or her to rehabilitate while remaining in one's natural surroundings, (as is emphasized in Caplan's community and preventive approach (Caplan 1994). The best helper, according to this approach, is a para-professional that has received some training in offering empathy and in methods of intervention, rather than the professional psychotherapist trained in the theories of personality, psychopathology, and psychotherapy (emphasized by Brockopp in Lester and Brockopp 1976; and also by O'Donnell and George 1977). The generic approach, a term

Received: 10.09.2011 - **Accepted:** 10.02.2012

Psychol, Western Galilee Community Mental Health Clinics, Fligelman ('Mazra') Psychiatric Hospital, Acre; Latiff Community Mental Health Clinic for Children, Umm-Al-Fahem; Amit Institute, Hadera; Annafa Institute for Psychotherapy, Haifa, Israel.

E-mail: tsvigil@bezeqint.net

proposed by Lindemann (1944), emphasized the similarities among all people that undergo crisis, rather than personal differences. In other words, personality variables were perceived as less important than situational determinants. Accordingly, the helper's professional knowledge of psychiatry and psychotherapy was considered less relevant than an immediate and empathic response to the person in crisis (Litman's law, as referred to by McGees and Jennings in Lester and Brockopp 1976) and, therefore, availability and immediacy of help was of a greater importance than the routines of psychiatric work, such as intake, interviewing, diagnosis, and weekly sessions.

Crisis treatments emphasize client strengths and enhance hope, rather than deal with deprivation, conflict, and past trauma (Brockopp's discussion in Lester and Brockopp 1976). Accordingly, several models of crisis intervention have been developed and proposed, including a three-phase model (Golan 1978), four stage model (Echterling, Hartsough, and Zarle 1980), five stage model (Ruben and Ruben 1975; Lester and Brockopp 1976; Cohen, Claiborn, and Specter 1983; Resnick, and Slaikeu 1984), and nine stage model (Dixon 1979).

The literature includes criticism of the crisis approach – for the lack of satisfactory empirical support for its assumptions. For example, it remains debatable if crisis is really self-limited, as Caplan (1964) claimed, if people in crisis are really more amenable to intervention and change, and if crisis could truly be divided to sub-phases (Cohen, Specter, and Claiborn 1983; Ball, Links, Strike, and Boydell 2005). Nonetheless, as some of its prominent advocates noted, the first concern in the aftermath of a crisis is always to provide assistance (McFarlane 2000), not to conduct systematic research (Raphael, Wilson, Meldrum, and McFarlane 1996).

As the crisis literature proliferated, data have accumulated that offer some empirical support for its value in the prevention of long-term mental health problems (Caplan and Caplan 2000), and its theoretical assumptions have been updated (Slaikeu 1984; Caplan and Caplan 2000; Myer and Moore 2006). A recent development in the crisis approach involves extra-psychiatric context, namely, large-scale events that call for help, but which are not necessarily psychiatric by nature, such as the wars in Yugoslavia (around 1999) and the destruction of the New York World Trade Center on September 11 2001 (Roberts 2005). The social approach toward such events made clear, on one hand, that immediate aid is greatly needed and should be provided by available social agents – social workers, clergymen, officials, and doctors. On the other hand, such help was not perceived as psychiatry per se (i.e. interviewing, diagnosing, prescribing, consecutive sessions). This is not to imply, of course, that psychiatric aid was not provided to some victims of those terrible events, but that the nature of the problem and the required means of aid were not perceived nor were they addressed according to the

norms of psychiatry developed during the last decades. This can be regarded as an adaptation of the 1960's community approach, as described above.

History of the Concept of Adjustment Disorder

Adjustment disorder, as a defined diagnostic entity, appeared for the first time in the 3rd edition of the American Diagnostic and Statistical Manual (DSM-3) (American Psychiatric Association, 1980/1994) in 1980, as part of the group of anxiety disorders. In the first edition of the DSM the closest concept offered was, transient situational personality disorder. The second edition of the DSM offered the term, transient situational disturbance. The DSM defined adjustment disorders as a response to a variety of causal stressful events different than those associated with acute stress and post-traumatic stress disorders, which were perceived as responses to exceptionally threatening experiences. The current WHO classification system (ICD-10) (WHO 1992) added adjustment disorder as a substitute for the older and ill-defined terms reactive and endogenous depression, and clustered the accommodation-to-stress situations into four groups. Adjustment disorders are classified into two groups acute and not acute; the other two groups in this cluster are post-traumatic stress disorder and prolonged personality change following extreme stress, which may match the older concept of crisis. The psychodynamic diagnostic system (PDM Task Force 2006) introduced adjustment disorders quite similarly to the way it was introduced in the DSM, and as a part of the subjective experience section (S axis).

The appearance of the newer concept of adjustment disorder occurred despite of lack of a satisfactory theoretical ground. This diagnosis is unstable, is made in the absence of lucid criteria, and diagnosed patients have very little in common, except for lacking other (usually less severe) diagnoses (Greenberg, Rosenfeld and Ortega 1995). Nonetheless, since its appearance, the diagnosis of adjustment disorder proved to be useful, in terms of popularity of use, and especially in non-psychiatric settings, such as general hospitals (Pollock 1992). Its frequency in the population is estimated to vary between 5% and 21% among adults that present for outpatient mental health services (Jones et al. 1999) (different prevalence rates have been reported, presumably due to different operative definitions; see Ayuso-Mateos et al. [2001] in Europe, and Strain et al. [1993]) in America). Adjustment disorder appears to be perceived as a "light" diagnosis, characterized by transiency and lack of stigma, as reported by Greenberg, Rosenfeld and Ortega (1995). As such, one of its uses (probably not originally intended by its creators) was to enable treatment of patients not otherwise diagnosed that required financial support from healthcare insurance companies (Strain and Diefenbacher 2008).

A Criticism of the Concept of Adjustment Disorder

Currently, there are no biological markers, specific symptoms, or behavioral parameters that can be used to clearly differentiate adjustment disorder from other psychiatric disorders; adjustment disorder is strongly correlated with contextual factors (Despland, Monod, and Ferrero 1995). Sufficient research on adjustment disorder is lacking (Despland, Monod and Ferrero 1995), and what has been conducted is of questionable validity. Many researchers think that the current definition of adjustment disorder is inadequate (Maercker, Einsle, and Kollner 2007). Additionally, some challenge the lack of clear differentiation between the various manifestations of adjustment disorder and normal adaptive reactions (Casey, Dowrick and Wilkinson 2001).

When considering all reports it remains unclear if the diagnosis of adjustment disorder is a valid diagnostic entity, if it merely serves the pragmatic needs of diagnosticians (Pollock 1992), or it is a context-dependent label, as proposed by Horwitz (2002). Indeed, many clinicians relate to the diagnosis with reservation or suspicion, and view it as the “trash can” of psychiatric diagnoses (Andreasen and Wasek 1980). Some consider the diagnosis of adjustment disorder as residual (Maercker, Einsle and Kollner 2007), marginal, or transitory (Fabrega, Mezzich, and Mezzich 1987), or as vague and useless (Ford, Hudgens, and Welner 1978). On the other hand, some think that the concept of adjustment disorder may be seen as sufficiently justified (Maercker, Einsle and Kollner 2007), and that it is under-diagnosed and should be used more frequently than it presently is (Linden 2003).

Adjustment disorder was reported to be indistinguishable (or only insignificantly distinguishable) from other anxiety disorders (Schatzberg 1990) and depression (Bronisch and Hecht 1989). Some found its reliability to be particularly low (Newcorn and Strain 1992; Spalletta et al. 1996), and its construct validity to be unfounded (Jones, Yates, and Williams 1999). In contrast, some reported that the diagnosis of adjustment disorder was valid and significantly differentiated from other diagnoses (Andreasen and Hoenk 1982; Snyder, Strain, and Wolf 1990; Kovacs, Ho, and Pollock 1995), and some reported that the diagnosis could be useful following some modifications to its structure and diagnostic criteria (Strain et al. 1993).

From a Theoretical Concept to a Practical Method

Justification of a diagnosis, in terms of validity and usefulness, depend on its impact on treatment and prognosis (Spalletta et al. 1996). If adjustment disorder functions as an inheritor of the concept of crisis and its psychological rather than biological nature is to be emphasized, psychological intervention is to be recommended and its prognosis is expected to depend on the availability and immediacy of proper aid, particularly

that of a social nature, as reported by Bronisch (1991) in inpatients. On the other hand, interests of a political and economic nature may promote the view of adjustment disorder as a psychiatric disorder that requires pharmacological intervention, as reported by Horwitz (2002). As such, the emergence of the entity of adjustment disorder may be considered a representation of the transition of the discipline of psychiatry, as reflected in subsequent editions of the American DSM – from a psychodynamic and biopsychosocial approach to an approach characterized as more empirical and medical (Rogler 1997).

Some researchers consider adjustment disorder as a variant of anxiety disorder, as reported by Schatzberg (1990) and as described in the DSM-IV. Yet, as Linden (2003) notes, mental reactions to psychological turmoil do not necessarily involve fear or anxiety. Others consider adjustment disorder a type of depression, perhaps what was once referred to as reactive depression (Bronisch and Hecht 1989). The editors of the DSM-IV suggested the term minor depressive disorder (American Psychiatric Association 1994, pp. 719) as “provided for further study”, but the essential difference as compared to major depression is that minor depression involves fewer symptoms and less impairment. That definition does not seem to encompass the characteristic features of crisis, as described above. Consistent with these views, adjustment disorder should preferably be treated with anxiolytic or antidepressant medications; however, research raises doubts as to whether anti-depressant treatment is effective in the absence of major depression, especially when the depressive mood is related to a medical illness (Fava and Sonino 1996). Some researchers proposed that demoralization, as part of the response to a stressful event, should be differentiated from depression (De Figueiredo 1993; Slavney 1999). Spalletta et al. (1996), on the other hand, suggest that although patients diagnosed with adjustment disorder may exhibit both anxiety and depression, they are less anxious than anxiety disorder patients, and less depressed than depressive patients. Others, however, consider adjustment disorder on a continuum with post-traumatic diagnoses (Linden, 2003) or as stress related (Horwitz 1997; Maercker, Einsle and Kollner 2007). Another perspective on adjustment disorder suggests that it can be considered a variation of crisis, and can therefore be treated with psychological methods, such as crisis intervention, counseling, or even psychodynamic psychotherapy (Battagay 1995).

A Pragmatic Proposal for Resolution: Continuum of Setback or Diagnosis of the Subclinical

A possible link between the older concept of crisis and the newer concept of adjustment disorder can be found in M. Horowitz (1997). Horowitz conceptualized the stress response, which combined a recognizable stressful event, one's attempts to cope using familiar coping mechanisms, and pathological symptoms that are the result of failure to cope.

Adjustment disorder can be considered, though, as the pathological end of a normal crisis continuum. Put another way, people normally face crises and may experience some distress while coping; only those that fail to cope may exhibit the signs of a diagnosable adjustment disorder. Similarly, some researchers – mostly European – think that a useful diagnostic system should include sub-clinical levels of depression (Fava 1999; Schneider et al. 2000), a term that may correspond with the older concept of crisis. Crisis, though, may be perceived as the sub-clinical, sub-pathological end of the hypothesized adjustment disorder continuum. This Italian group, emphasizing the psychosocial aspects of a patient's response to medical illness, developed a related diagnostic system as a substitute or complement to the DSM to assist liaison psychiatrists (Fava et al. 1995). Maercker et al. (2007) support the view that adjustment disorder belongs to the stress continuum of diagnoses. A different conceptualization, although similar to Horowitz's in emphasizing the cognitive processing of emotional stimuli, was posited in Foa et al.'s model (Foa et al. 1989), which places adjustment disorder on the trauma continuum.

DISCUSSION

The issue of crisis versus adjustment disorder can be approached in two ways: theoretically and empirically. Theoretically speaking, the two approaches originate from and within different perspectives. Crisis theory originated from psychoanalysis, human psychology, and community psychology. Adjustment disorder is a concept born in nosological psychiatry, which strives to be descriptive, phenomenological, and atheoretical. The crisis approach engages a wide assembly of helpers, many of them para-professionals, while adjustment disorder is a psychiatric entity, constructed by and for the sake of psychiatrists. The concept of crisis is related to health, encompasses an optimistic view, and hence is less stigmatizing. On the other hand, adjustment disorder belongs to the realm of mental health professionals, and is part of the medical tradition; it emphasizes abnormality and pathology, and hence may be more stigmatizing.

Empirically, both concepts have gained weak support. The concept of adjustment disorder was advanced for practical reasons in the absence of empirical support. Its weaknesses – nebulous definition and boundaries, and lack of clear markers – are also its strengths, facilitating quick and handy usage of the diagnosis (the "trash can" approach) and is less stigmatizing than many other psychiatric diagnoses. Whereas it is difficult to find specific guidelines for treatment of adjustment disorder (Bisson and Sakhuja 2006), its diagnosis gives psychiatrists the freedom to use whatever treatment methods work. Researchers in the field of crisis, on the other hand, were busy with 'what to do', rather than systematically studying the

field. They attempted to be relevant to the community rather than to examine the basic premises of the approach they established. They felt that 'something has to be done', was more urgent than the study of the effects of their treatments.

A practitioner's choice of which concept to use may therefore be influenced by one's theoretical standpoint or by one's reading of the scientific literature; however, we think that the adjustment disorder concept is weaker than the concept of crisis, principally due to its directive to present a robust basis. A medical system of diagnosis should rely on a solid body of evidence, rather than on diagnostic convenience (First et al. 2004). Put another way, the practical usefulness of the diagnosis of adjustment disorder provided to the diagnosing psychiatrist may not be sufficient for justifying the inclusion of this new diagnostic entity in diagnosis manuals, and does not necessarily justify the labeling of distressed individuals as psychiatric patients, especially while psychiatry does not offer such individuals specific and effective treatment.

REFERENCES

- American Psychiatric Association (1980/1994) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Washington, DC.
- Andreasen N C, Wasek P (1980) Adjustment disorders in adolescents and adults. *Arc Gen Psychiat* 37: 1166-70.
- Andreasen N C, Hoenk P R (1982) The predictive value of adjustment disorder: a follow-up study. *Am J Psychiat* 139: 584-90.
- Ayuso-Mateos J L, Vazques-Barquero J L, Dowrick C et al (2001) The ODIN group: Depressive disorders in Europe: prevalence figures from the ODIN study. *Brit J Psychiat* 179: 308-16.
- Ball J S, Links P S, Strike C et al. (2005) "It's overwhelming... everything seems to be too much": a theory of crisis for individual with severe persistent mental illness. *Psychiat Rehab J* 29: 10 – 8.
- Battegay R (1995) Psychoanalytic aspects of crisis and crisis intervention (in German). *Zeitschrift fur Psychosomatic Medicine und Psychoanalysis* 41: 1-16.
- Bisson K, Sakhuja D (2006). Adjustment disorders. *Psychiatry* 5: 240-2.
- Bronisch T (1991) Adjustment reactions: a long term prospective and retrospective follow-up of former patients in a crisis intervention ward. *Act Psychiat Scand* 84: 86-93.
- Bronisch T, Hecht H (1989) Validity of adjustment disorder, comparison with major depression. *J Affect Dis* 17: 229-36.
- Caplan G (1964) *Principles of Preventive Psychiatry*. New-York, Basic Books.
- Caplan, G, Caplan R (2000) Principles of community psychiatry. *Commun Ment Health J* 36: 7-24.
- Casey P, Dowrick Ch, Wilkinson G (2001) Adjustment disorders: Fault line in the psychiatric glossary. *Brit J Psychiat* 179: 479-81.
- Cohen L, Specter J A, Claiborn W L (Eds) (1983) *Crisis Intervention*. New-York, human Sciences Press.
- De Figueiredo JM (1993) Depression and demoralization: Phenomenological differences and research perspectives. *Comp Psychiat* 34: 308-11.
- Despland J N, Monod L, Ferrero F (1995) Clinical relevance of adjustment disorder in DSM-III-R and DSM-IV. *Comp Psychiat* 36: 454-60.
- Dixon S L (1979) *Working with People in Crisis: Theory and Practice*. Mosby, St Louis, Missouri.
- Echterling L G., Hartsough D M, Zarle Th H (1980) Testing a model for the process of telephone crisis intervention. *Am J Comm Psychol* 8: 715-25.
- Erikson E H (1963). *Childhood and Society*. New-York, Norton.

- Fabrega H Jr, Mezzich J E, Mezzich A C (1987) Adjustment disorder as a marginal or transitional illness category in DSM-III. *Arch Gen Psychiat* 44: 567-72.
- Fava GA (1999) Subclinical symptoms in mood disorders. *Psychol Med* 29: 47-61.
- Fava GA, Freyberger HJ, Bech P et al (1995) Diagnostic criteria for use in psychosomatic research. *Psychother Psychosom* 63: 1-8.
- Fava G A, Sonino N (1996) Depression associated with medical illness. *CNS Drugs* 5.
- First M B, Pincus H A, Levine J B et al (2004) Clinical utility as a criterion for revising psychiatric diagnoses. *Am J Psychiat* 161: 946-54.
- Foa E B, Steketee G, Rothbaum BO (1989) Behavioral/cognitive conceptualization of post-traumatic stress disorder. *Behav Ther* 20: 155-76.
- Ford K, Hudgens R W, Welner A (1978) Undiagnosed psychiatric illness in adolescents: a prospective study and seven-year follow-up. *Arch Gen Psychiat* 35: 279-82.
- Golan N (1978) *Treatment in Crisis Situations*. New-York, Free Press.
- Greenberg W M, Rosenfeld D N, Ortega E A (1995) Adjustment disorder as an admission diagnosis. *Am J Psychiat* 152: 459-61.
- Horowitz M J (1997) *Stress Response Syndromes*. 3rd ed. Northvale, Aronson.
- Horwitz A V (2002). *Creating Mental Illness*, Chicago, University of Chicago Press.
- Jones R., Yates W R, Williams S, et al (1999) Outcome for adjustment disorder with depressed mood: comparison with other mood disorders. *J Affect Dis* 55: 55-61.
- Kovacs M, Ho V, Pollock M H (1995). Criterion and predictive validity of the diagnosis of adjustment disorder: a prospective study of youths with new-onset insulin dependent diabetes mellitus. *Am J Psychiat* 152: 523-8.
- Lester D, Brockopp G W (Eds.) (1976) *Crisis Intervention and Counseling by Telephone*. Springfield, Ill., Charles C. Thomas.
- Lindemann E (1944). *Symptomatology and management of acute grief*. *Am J Psychiat* 101.
- Linden M (2003) Posttraumatic embitterment disorder. *Psychother Psychosom* 72: 195-202.
- Maercker A, Einsle F, Kollner V (2007) Adjustment disorder as stress response syndromes: a new diagnostic concept and its exploration in a medical sample. *Psychopathology* 40: 135-46.
- Maslow A (1954). *Motivation and Personality*. New-York, Harper.
- McFarlane A C (2000). Can debriefing work? Critical appraisal of theories of intervention and outcome, with directions for future research. In B Raphael, J P. Wilson (Eds.), *Psychological Debriefing: Theory, evidence, and practice* Cambridge, United Kingdom: Cambridge University Press, pp. 337-50.
- Myer R A, Moore H B (2006) Crisis in Context Theory: An Ecological Model. *J Counsel Develop* 84: 139 – 48.
- Newcorn J H, Strain J (1992) Adjustment disorder in children and adolescents. *J Am Acad Child Adolescent Psychiat* 31: 318-27.
- O'Donnell J M, George K (1977) The use of volunteers in a community mental health center emergency and reception service: a comparison study of professional and lay telephone counseling. *Comm Ment Health J* 13: 3-12.
- PDM Task Force (2006) *Psychodynamic Diagnostic manual*. Silver Spring, MD., Alliance of psychoanalytic Organizations.
- Pollock D (1992) Structured ambiguity and the definition of psychiatric illness: adjustment disorder among medical inpatients. *Soc Sci Med* 35: 25-35.
- Raphael B, Wilson J, Meldrum L et al. (1996) Acute preventive interventions. In B A van der Kolk, A C McFarlane, L Weisaeth (Eds), *Traumatic Stress: The effects of overwhelming experience on the mind, body, and society*. New York: Guilford Press, pp. 47-76.
- Resnick H L P, Ruben H L, Ruben D D (Eds) (1975), *Emergency Psychiatric Care*. Charles, Bowie, MD.
- Roberts A R (Ed.) (2005). *Crisis Intervention Handbook: Assessment, Treatment, and Research*. Oxford University Press.
- Rogler L H (1997) Making sense of historical changes in the Diagnostic and Statistical Manual of Mental Disorders: five propositions. *J Health Soc Behav* 38: 9-12.
- Rogers C (1961) *On Becoming a Person*. Boston, Houghton Mifflin.
- Schatzberg A F (1990) Anxiety and adjustment disorder: a treatment approach. *J Clin Psychiat* 52: 140.
- Schneider G, Kruse A, Nehen HG et al (2000) The prevalence and differential diagnosis of subclinical depressive syndromes in inpatients 60 years and older. *Psychother Psychosom* 69: 251-60.
- Slaikeu K A (1984) *Crisis Intervention*. Boston, Allyn Bacon.
- Slavney PR (1999) Diagnosing demoralization in consultation psychiatry. *Psychosomatics* 40: 325-9.
- Snyder S, Strain JJ, Wolf D (1990). Differentiating major depression from adjustment disorder vs. depressed mood in the medical setting. *Gen Hosp Psychiat* 12: 159-65.
- Spalletta G, Trois A, Saracco M et al (1996) Symptom profile, axis II comorbidity, and suicidal behavior in young males with DSM-III-R depressive illness. *J Affect Dis* 39: 141-8.
- Strain JJ, Newcorn J, Wolf D et al (1993) Considering changes in adjustment disorder. *Hosp Comm Psychiat* 44: 5-13.
- Strain J J, Smith G C, Hammer J S et al (1998) Adjustment disorder: a multisite study of its utilization and intervention in the consultation-liaison psychiatry setting. *Gen Hosp Psychiat* 20: 139-49.
- Strain J, Diefenbacher A (2008) The adjustment disorders: the conundrums of the diagnosis. *Comp Psychiat* 49: 121-30.
- WHO (1992). *International Statistical Classification of Diseases and Related Health Problems*, 10 ed. (ICD-10), Geneva.