

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



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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 et al. 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 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 1976; and also by O'Donnell and George 1977). The generic approach, a term proposed by Lindemann (1944), emphasized the similarities among all people that

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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 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 1976). Accordingly, several models of crisis intervention have been developed and proposed, including a three-phase model (Golan 1978), four stage model (Echterling et al. 1980), five stage model (Ruben and Ruben 1975; Lester and Brockopp 1976; Cohen et al. 1983; 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 et al. 1983; Ball et al. 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 et al. 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 et al. 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 et al. 1995). Sufficient research on adjustment disorder is lacking (Despland et al. 1995), and what has been conducted is of questionable validity. Many researchers think that the current definition of adjustment disorder is inadequate (Maercker et al. 2007). Additionally, some challenge the lack of clear differentiation between the various manifestations of adjustment disorder and normal adaptive reactions (Casey et al. 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 et al. 2007), marginal, or transitory (Fabrega et al. 1987), or as vague and useless (Ford et al. 1978). On the other hand, some think that the concept of adjustment disorder may seem as sufficiently justified (Maercker et al. 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 et al. 1999). In contrast, some reported that the diagnosis of adjustment disorder was valid and significantly differentiated from other diagnoses (Andreasen and Hoenk 1982; Snyder et al. 1990; Kovacs et al. 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 et al. 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 (Battegay 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.

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