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Coll. Antropol. **30** (2006) 3: 489–493
Original scientific paper

Do We Need the »Adolescent Crisis« Diagnosis?

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A B S T R A C T

The aim of the study was to examine patients in adolescent crisis at the beginning of treatment and after a period of 12 months in order to evaluate the relative diagnostic and therapeutic validity. The study included 153 Split University students in adolescent crisis; 90 of them were treated by counseling and 63 served as controls. For diagnosis, Hampstead index and Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) multiaxial evaluation were used, allowing a wider insight into personal functioning. The study sample was split in 7 significantly different diagnostic subgroups. The counseling-treated examinees had better personality functioning after 12 months, but did not differ significantly from the control group. Some of their single functions were more severely disturbed at the very beginning. Counseling is a valuable therapeutic and diagnostic tool for adolescent crisis. The assessment must evaluate the entire person, because looking at only one aspect, due to different development and its place, a wrong conclusion may be reached. The »adolescent's crisis« entity is clinically relevant.

Key words: *students, adolescent crisis, counseling*

Introduction

The term »adolescent crisis« does not exist in the International classification of diseases and related health problems (ICD-10)[1] nor in Diagnostic and statistical manual of mental disorders (DSM-IV)[2], but is widely used in clinical practice and in the literature[3–7]. Adolescent crisis is a developmental storm, which blows through adolescent's emotional and existential space[3]. Even with no deeper emotional disturbance, developmental crisis animates that something has to be balanced, held or treated in the adolescent[4–6]. In this developmental period every aspect of self- representation is questioned and an effort in achieving physical, instinctive, sexual, emotional and intellectual development is present[4,5,8]. The tasks of adolescence, such as the choice of a partner, of profession and of individual life style[9], in some adolescents trigger emotional storming and some of them experience real depressive breakdown[10–12]. The behavioural manifestations during such a crisis include neurotic elements, psychotic reactions, or antisocial outbursts: the differentiation between an adolescent crisis and real, deep, ominous psychopathology is very difficult, particularly at the beginning. How someone will solve the adolescent tasks depends on her/his prior development and ego abilities, family and social circumstances, and chance events[7,13]. The feelings of alienation, anxiety, and depression accompany that period and adolescent defends her/himself by intellectualism, rationalization, asceticism, and refusal of compromise, trying to find the balance between unacceptable instinct pressures and superego demands.

The personality development takes place in social environment by continued and discontinued advancements of maturity, experience, and their interactions. Indirect connections between maturity and experience lead to complex manifestations evoked by interactions of a person and her/his environment[14]. Understanding of abnormal adolescent functioning stems from knowledge of »normality« in the culture to which a particular adolescent belongs. Normal adolescents in various cultures differ in experience of self-representations; in many cultures girls show poorer self representation than boys[15].

The most demanding diagnostic problem in the work with such adolescents is to establish whether the present phenomenon is a transitional disorder in development,

Received for publication January 13, 2005

in solving the new relations toward parents and own sexuality, a permanent disorder, or stagnation in development with the possibility for nascent psychopathology. So, it is necessary to assess ego ability in solving inner demands.

The crisis in adolescence is a »break point« during which the adolescent comes to senses of him/herself as a complete person with own conscience and responsibility, and relations towards his/her partner and environment. Such course leads to »normal« adult, but various difficulties in development, mental or physical illnesses, social circumstances and chance events can disturb it and lead to pathologic formations or functions, or opposite, my also be positive in development of the adolescent, at this stage of life.

The aim of this study was to analyze undergraduate students in adolescent crisis at the beginning, after 1 month, and after 12 months of treatment, to evaluate the diagnosis and to assess the treatment results. Our hypothesis was that adequate diagnosis cannot be set at the very beginning, because the crisis phenomena cover and interact with the personality structure. We supposed that a presumptive, working diagnosis during the crisis is sufficient enough, and after its resolution a definitive diagnosis can be established.

Patients and Methods

In the period of late adolescence, 18–22 years, 153 Split University undergraduates in adolescent crisis, were diagnosed, included, and treated in the Student's Outpatient Clinic in Split, Croatia, between January 1992 and December 1997. Ninety out of them, 50 female and 40 male students were randomly allocated to a counseling program, while the remaining 63 (42 women and 21 men) were allocated to a control group, having only 1–2 initial consultations, later being just followed-up and revaluated after 12 months in order to control the effects of counseling, the self-healing phenomenon in transitory disturbances, and persisting maladjustments in untreated vs. treated subjects. The patients were 18 to 21 years old; the mean age in the intervention group was 20.1±0.94 years (20.1±1.02 women and 20.1±0.84 men), and 19.9±0.86 for female and 20.1±0.91 years for male examinees in the control group, whose mean age was 20.0±0.86.

The events during the 12 months of study were classified using Hampstead index[16] and Multiaxial assessment in DSM-IV[2]. The Hampstead index discloses the reason for help seeking, the adolescent's aspect, personal and family history, possibly important environmental impact, and the development of instincts (libido and aggression), ego (ego functions, defenses, identifications, partnership, affections) and superego, general outlines of regression and fixations, dynamic and structural aberrations: conflicts (inside /ego-superego/, outside /from surroundings/ and ambivalence), and some general characteristics, such as anticipation of the future, relation towards achievements, self introspection, verbalization, and diagnosis. In late adolescence, the adolescents with anxiety, the anxieties and worries often concern the quality of their performance or competence at university, partner relations, or sporting events, even when their performance is not being evaluated by others. They are typically overzealous in seeking approval and require excessive reassurance about their performance and their worries. The anxiety is often seen as somatoform disorder: gastrointestinal, pseudo neurological, sexual or cardiovascular. Depression in late adolescence, more common in women[17], leads to decrements in social and academic performance. Usual mood is dominated by dejection, gloominess and unhappiness. Self-concept centers on beliefs of inadequacy, worthlessness and low self-esteem. Adolescent crisis was working diagnose for students who were too anxiety and depress, with problems in academic achievements, partner or other social relations. The Multiaxial assessment detects the following: Axis I – clinical disorders; Axis II – personality disorders; Axis III – general medical conditions; Axis IV – psychosocial and environmental problems; Axis V – general assessment on a functional scale.

The counseling intervention was diagnostic and therapeutic at the same time, defined as an interacting process in understanding oneself and ones own environment. The changes in patient are expected in aim which decides alone. During the counseling process, the patient is familiarized with emotional verbalization, defining the essential problem, and after that, through reflection, confrontation, and sometimes interpretation, the person is allowed to look into what helps in problem solving[18,19]. The sessions were held once weekly, lasting 45 minutes, during which the patient achieved introspection, help and support in solving his/her trouble, and the final diagnosis was established with more confidence

Psychomotor and social functioning was estimated at the inception, after one month, and at the end of this study according to a global assessment (GAF) scale, where higher point score denotes better functioning: 100 superior functioning in a wide range of activities, 80 if symptoms are present, they are transient and expectable reactions to psychosocial stressors, 60 moderate symptoms, or moderate difficulty in social, occupational, or school functioning, 40 some impairment in reality testing or communication, 20 some danger of hurting self or others, 0 inadequate information[2].

Statistical significance of the observed differences was assessed using the chi-square test, Stuart-Mexwell test or Pearson χ^2 test, as appropriate, and $p<0.05$ was considered significant[20] using statistical package Statistica 6.0[21].

Results

All subjects either treated or controls, entered the study in a very anxious and depressed state, covering the students' personality. The initial diagnostic groups (after 1 month) among the treated and the control subjects were later (after 12 months) refined in seven subgroups, as

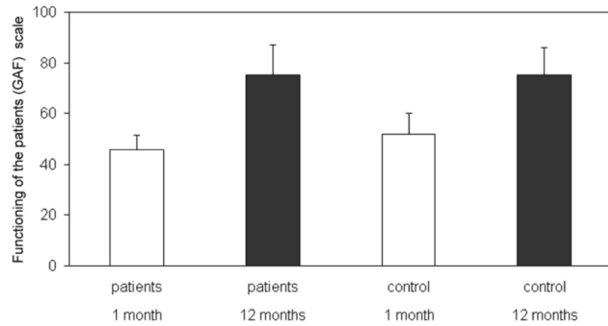

Fig 1. Treated patients and control according personality functioning after 1 and 12 months observation. p>0.5.

shown on Table 1. The differences between the intervention and the observation group were minor; while the observation group had 7 subsets, the intervention group had 6, lacking the 7th one (permanent psychosis, one patient).

In the intervention group, the initial diagnosis was unchanged after one year in 58 patients (64.7%); 23 (25.6%) patients passed from a more severe to a milder diagnostic subset, and 9 (10.0%) patients had the opposite switch. These changes, i.e. amelioration in 23 and worsening in 9 were marginally significant: Stuart-Mexwell test Q=6.26, df2, p=0.05.

As shown on Table 2, in the control group the diagnosis was unchanged in 53 (84.1%) examinees, in 9 (14.3%) it ameliorated, while it worsened in 1 (1.6%). These changes were statistically significant: Stuart-Mexwell test Q=8.00, df2, p=0.05

As can be seen from Figure 1, the examinees from either interventional or observational group, were functioning much better after 12 months. Among the treated patients the maximal achievement was 96 points, similar to the controls (89 points). At the end of the study 63 (70.0%) subjects from the intervention group, and 40 (63.5%) from the observation group were functioning well. Moderate functional problems had 24 (26.7%) patients from the treatment group, and 22 (34.9%) from the control group, while severe problems had 3 (3.3%) and 1 (1.6%) patient, respectively. According to personality functioning, treated patients did not differ significantly from those in the control group (χ^2=0.448, df1, p>0.5).

Neither at the beginning nor at the end of this study, the diagnostic spectrum differed significantly between the interventional and the observational group (χ^2=0.105, p=0.079).

Sorting our intervention patients according to diagnostic fluctuation over time, 6 subgroups may be formed, as shown on Table 1. Summing up subgroup 1 (n=33, 36.7%) and subgroup 4 (n=25, 27.7%), there were 58 (64.7%) patients that did not change the diagnostic class in the analyzed period (12 months). However, subgroups 2 (n= 6, 6.7%) and 5 (n= 3, 3.3%), totaling 9 (10.0%) patients, had milder diagnosis at the beginning than at the end of the study. Conversely, our subgroups 3 (n=17, 18.9%) and 6 (n=6, 6.7%), totaling 23 (25.6%) patients had more favorable diagnosis at the end.

The control group patients could be subdivided again in 6 subsets (group 2 was not represented, and group 7 was introduced). Among these individuals the diagnosis did not change in 53 or 84.1% (sum of group 1 with 38,

TABLE 1
INTERVENTION (TREATMENT) GROUP DIAGNOSIS AFTER 1 AND AFTER 12 MONTHS (TREATMENT)

Diagnosis after 1 month	Diagnosis at 12 months						Total	
	»Variation of normal«		Constant regression		Hindered psychosexual development			
»Variation of normal«	33	(36.7%)	6	(6.7%)			39	(43.3%)
Constant regression	17	(18.9%)	25	(27.7%)	3	(3.3%)	45	(50.0%)
Hindered psychosexual development			6	(6.7%)			6	(6.7%)
Total	50	(55.6%)	37	(41.1%)	3	(3.3%)	90	(100.0%)

TABLE 2
CONTROL (OBSERVATION) GROUP DIAGNOSES AFTER 1 AND AFTER 12 MONTHS

Diagnosis after 1 month	Diagnosis at 12 months						Total	
	»Variation of normal«		Constant regression		Hindered psychosexual development			
»Variation of normal«	38	(60.3%)	0	(0%)			38	(60.3%)
Constant regression	8	(12.7%)	14	(22.2%)	1	(1.6%)	23	(36.5%)
Hindered psychosexual development			1	(1.6%)	1	(1.6%)	2	(3.2%)
Total	46	(73.0%)	15	(23.8%)	2	(3.2%)	63	(100.0%)

group 4 with 14, and group 7 with one participant). After one year of follow-up 9 examinees (14.3%) passed to a less severe diagnostic level (8 from group 3, 1 from group 6), and 1 (1.6%) from group 5 passed to a worse level.

Adolescent crisis evolutionary subgroups after the 12 months' follow-up period were formed as follows:

– Subgroup 1 (G1, C1) – patients who after 1 and after 12 months had the same diagnosis of adolescent crisis
– Subgroup 2 (G2, C2) – patients with initial diagnosis of adolescent crisis, and after 12 months were reclassified as personality disorder
– Subgroup 3 (G3, C3) – patients who after 1 month were diagnosed as personality disorder, and after 12 months reclassified as adolescent crisis.
– Subgroup 4 (G4, C4) – patients who after 1 and after 12 months had the same diagnosis of personality disorder.
– Subgroup 5 (G5, C5) – patients who initially had the diagnosis of personality disorder, resulting in frank psychosis after 12 months.
– Subgroup 6 (G6, C6) – patients who after 1 month were classified as psychosis, and after 12 months a
– personality disorder was recognized
– Subgroup 7 (G7, C7) – patients classified as psychotic all the time

Discussion

The treated and the control patients differed significantly in terms of diagnostic subgroups, but the diagnoses at the beginning and at the end of the study period did not differ significantly between the arms. The variegated clinical presentations of adolescent crisis, changing with developmental alterations, resulting either from serious pathology or from developmental difficulties (which, because of ego weakness, induce regression mimicking deep pathology), makes the diagnosis of adolescent's crisis a practical clinical necessity.

Authors[7,22–24] have reported similar data; these authors consider such results important for psychodynamic theory of adolescence, illustrating a major diagnostic problem in these persons and highlighting all the difficulties in the field: initially it is often impossible to distinguish serious pathology from mild crisis[25–28]. Like studies[29–32] suggest that complex personal adaptation processes with developmental changes have to be carefully examined through the patient's main symptoms and environmental challenges in order to get appropriate insight into the pathogenic mechanisms. The time spent to get acquainted with the patient's personality and assiduous attending thereafter, during the crisis, is invaluable in the diagnostic-supportive-therapeutic process.

Our patients' functioning in adolescent crisis had a legion of starting problems but improved quite a lot over time, both in the intervention and in the control arm. The crisis phenomenology produced such difficulties in all the examinees, supporting the introduction of diagnostic subgroups. The adolescent's crisis is often a self-healing process. However, the counseled examinees showed a marginally better personality functioning. These results could not be compared, because no similar investigation was found. It would be good to plan such investigations on national, and probably on international adolescent population.

The development of programs bridging academic and scientific communication between mental health professionals and educators in making the best possible knowledge transmission about psychosocial and behavioral problems, and offering the mental health assistance to students who need it is highly recommended[33]. High school mental health consultants, as educational team members, offer the best assistance to students in such a need [33–35], and personal interaction/conversation is invaluable[7,22,36–38]. This study shows therapeutic and diagnostic difficulties in psychological procedures with adolescents, what is showed by assessments of diagnostic groups, and investigation, of all personality aspects of adolescents is original.

We conclude that counseling is an effective adjuvant therapeutic approach to adolescent's crisis. Because of the crisis phenomenology it is a diagnostic tool as well, helping in selection of patients who need it most and showing the path to further, complementary or different treatment. In adolescent's assessment it is necessary to view the whole person: looking at only one aspect, and due to different development and its velocity, a wrong conclusion may be reached. More than one diagnostic assessment is a must and the diagnosis of adolescent crisis is mandatory for good clinical practice.

Acknowledgements

This research was supported by the Ministry of Science, Education and Sports of the Republic of Croatia, project no. 0108308 to V.R.

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TREBA LI NAM DIJAGNOZA »ADOLESCENTNA KRIZA«?

S A Ž E T A K

Cilj rada bio je pratiti pacijente u adolescentnoj krizi na početku liječenja i nakon 12 mjeseci, kako bi se procijenila dijagnostička i terapijska postignuća. U studiju su uključena 153 studenta u adolescentnoj krizi, koji studiraju na Sveučilištu u Splitu. 90 od njih liječeno je savjetovanjem, a 63 studenta su bili kontrolna grupa. Pri dijagnostici poremećaja rabili smo Hampstead index i Multiaksijalnu procjenu po Dijagnostičkom i Statističkom Priručniku za Mentalne Poremećaje – četvrta revizija (DSM-IV), što je omogućilo širi uvid u unutarnje funkcioniranje osobe. Ispitivana grupa podijeljena je u 7 dijagnostičkih podgrupa, koje su se statistički značajno međusobno razlikovale. Ispitanici liječeni savjetovanjem, pokazivali su bolje funkcioniranje osobnosti nakon 12 mjeseci liječenja, premda razlika prema kontrolnoj grupi nije statistički značajna. U pojedinim funkcijama osobnosti, liječeni pacijenti na početku liječenja, imali su teže poremećaje. Savjetovanje je dobra terapijska i dijagnostička metoda u liječenju adolescentne krize. Pri procjeni, potrebno je obuhvatiti čitavu osobu, budući da promatranje pojedinih parametara, zbog različitog razvoja i brzine tijeka, može zavesti na pogrešno zaključivanje. Dijagnoza adolescentna kriza je klinički važna.