
Conceptualizing Psychiatric Disorders Using “Four D’s” of Diagnoses

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Abstract

Assessing when a patient problem or symptom elevates to the severity required to diagnose a psychiatric condition can be a difficult task, particularly for inexperienced practitioners. The “Four D’s” consisting of deviance, dysfunction, distress, and danger can be a valuable tool to all practitioners when assessing reported traits, symptoms, or conditions in order to illuminate the point of at which these factors might represent a DSM IV-TR disorder. This article summarizes the “Four D’s” (including a potential fifth “D” of duration) and provides the practitioner with an example of each “D” utilizing a DSM IV-TR diagnosis.

One of the inherent difficulties in diagnosing a mental disorder is determining at whatever level a particular trait or problem becomes a clinical diagnosis. An old joke serves well to illustrate this point. Question: “What is the difference between someone who is crazy and someone who is eccentric?” Answer: “About ten million dollars”. This joke is humorous because it reflects the grey lines that define when symptoms rise to the point of classification as a disorder. As such, it also speaks to the difficulty of mental health diagnosis. An individual with many resources may not experience a similar set of emotions, cognitions or behaviors as a problem since it is likely that the person will be afforded latitude that someone with limited resources will not. Every human being experiences a range of problematic emotions, cognitions and behaviors across the life span. When does a problem become a disorder? To answer the question in part, mental health professionals can utilize the “four Ds”, danger, deviance, dysfunction and distress to conceptualize mental disorders².

This article will explore in some detail the four “Ds” and how they contribute to psychiatric disorders. Each “D” will be explored through one of the Axis I disorders of the Diagnostic and Statistical Manual fourth text revised edition [DSM IV-TR]¹.

The first “D” to be discussed is that of deviance. Deviance can primarily be understood through formal classification schemes such as those provided in the DSM IV-TR diagnostic criteria. Apart from these, other tests which provide norms for the general population can be helpful to

determine degree of deviation from the norm. Further, clinical interviews can collect information helpful in both these examples. However, many disorders share common patterns of deviance and need to be examined in a differential diagnostic model⁸.

This “D” can be illustrated using 302.2 Pedophilia, a DSM IV-TR diagnosis in which deviance is the hallmark of the disorder¹. Pedophilia is a specific paraphilia, a class of disorders characterized by recurrent intense, sexually arousing fantasies, behaviors or urges. Pedophilia is characterized by recurrent urges, fantasies or behaviors existing over at least 6 months and directed at children 13 years of age or younger. These symptoms must present significant distress or impairment. The individual must be over the age of 16 and 5 years older than the subject of the desire. Seto⁶ surveyed a number of studies and found that anywhere from three to nine percent of males report some interest in underage children and a number of these studies demonstrated that this interest could be turned into action if the circumstances were right. Thus, those who have the thoughts are either in the minority or in a small minority of males. In addition he points out that the actual number of males who meet the other criteria of time and intensity is very likely much less than the three to nine percent figure. Given the legal and social attitudes concerning pedophilia the number of individuals who can be diagnosed with the disorder is difficult to ascertain. The fact that up to nine percent of males may have sexual interest in children may set an upper limit to the prevalence. This however may still

be questionable given a potential bias against reporting (e.g., potential respondents would find it taboo to admit to certain tendencies/feelings/thoughts). Females with these propensities are even rarer in the literature as Seto demonstrates. These factors taken together illustrate both the statistical and societal nature of deviance in pedophilia.

A second “D”, dysfunction, is also important to determine the presence of a problem large enough to be considered a diagnosis. Whatever the dysfunction, it must be significant enough to interfere in the individual’s life in some major way. In addition, it is important to look for dysfunction across life domains as they may exist in obvious places as well as less likely places⁸.

To examine dysfunction, the diagnosis of 296.33 Major Depressive Disorder, Recurrent, without Psychotic Features is chosen¹. This disorder is characterized by two or more episodes of a major depressive episode. When the classification of severe is used, it indicates that this episode has elevated to the point where many it markedly interferes with the individual’s occupational or social life. In order to warrant a diagnosis, this interference must be defined by the presence of a minimum number of the symptom classifications outlined in the criteria. These symptoms will evidence themselves through a negative impact (dysfunction) in multiple areas of the individual’s life. For example, the person will experience a depressed mood for most of the day which will interfere with relationships with others, as easily perceived by outside observers. He/she has a great decrease in pleasure in almost all of the activities of life which will likely make the person avoid many of these, resulting in increasing dysfunction. The individual may experience insomnia or hypersomnia to the point of interfering with daily tasks. He/she will experience marked energy loss and may not have the motivation or energy to do common tasks such as personal hygiene or household maintenance. The person may have a diminished ability to concentrate which interferes with the ability to complete tasks at home and work. When a person has been diagnosed with major depression, it is likely that the individual has experienced some dysfunction in almost every area of life and severe dysfunction in many areas. In fact, in an inquiry by Remick⁴, many areas of dysfunction were identified in the research. He found that depressive disorders and poor work productivity are related as demonstrated by a threefold increase in the number of sick days in the months preceding the illness for workers with depression compared with coworkers who did not show increases in sick days

preceding illness that was not depression. There is evidence that children of women with depression have higher rates of dysfunction in school, are less socially competent, and display lower self-esteem than their classmates mothers whose mothers who are not depressed. Finally depression’s ability to cause life dysfunction becomes evident by the fact that the leading cause of disability among people aged 18 to 44 years is depression.

A third “D”, distress, is related to dysfunction in that it becomes an important way to grade perceptual dysfunction in an individual’s life. This relationship is not always linear. A person can experience a great deal of dysfunction and very little distress or vice versa. The essential component of distress is the extent to which the issue distresses the individual, not the objective measure of the severity of the dysfunction⁸.

Distress will be explored using the diagnosis of 300.7 Hypochondriasis¹. The features of Hypochondriasis consist of a preoccupation with the fear of having, or the idea that one has, a serious disease. This fear is based on the misinterpretation of an individual’s bodily symptoms. Currently this diagnosis is classified as a somatoform disorder. However, it also features elements of an anxiety disorder. The distress of the preoccupation of the disorder persists in spite of medical evaluations and reassurance. Salkovskis, Warwick and Deale⁵ found that these individuals tend to use considerably more medical resources and tend to be rather intractable in terms of their prognoses. Further, although reassurance that is offered may decrease short term distress, it increases distress in the long run. Therefore, it seems the more medical reassurance that is sought, the more distress increases. This feature makes the problem of distress a fundamental feature of the disorder. In fact, the researchers found that effective treatments all centered on decreasing the amount of distress experienced by the individual with the disorder. This decrease is accomplished through thought restructuring, to refocus the individual’s attention away from somatic symptoms toward non distressing thoughts and activities, thus getting the individual to decrease the amount of behavior consumed by the distress. Ultimately, if one can lower the anxiety and distress level, a positive outcome may be more likely.

A fourth “Ds” is danger. To outline this concept more specifically, the danger component consists of two broad themes, danger to self and danger to others. Diagnostically speaking, there is a wide continuum of danger. There is some element of danger in every diagnosis and within each

diagnosis there is a continuum of severity. Once these have been explained in broad strokes one can explore how these are played out in a specific diagnostic picture⁸.

Danger will be examined using a seemingly benign disorder classified in the DSM IV-TR, 305.10 Nicotine Dependence¹. The major features of dangerousness in Nicotine Dependence are the self inflicted hazards placed on those meeting diagnostic criteria. That being the case, Nicotine Dependence may also be a danger to others through the harmful effects of second hand smoke. In some substance abuse disorders, danger to self may also be evidenced by vulnerability (danger that may be inflicted by others), as a result of the usage of the substance. Nicotine Dependence is characterized as a substance abuse disorder and features elements of tolerance and withdrawal. The diagnosis has dangerous physical effects through the health conditions related to it and dangerous mental health effects evidenced by the emotions and behaviors that people exhibit when nicotine is unavailable or when they are trying to quit. Individuals may also avoid activities or situations which negatively impact their lives due to the inability to use the substance. Approximately 80 percent of smokers express the interest in quitting. Thirty five percent of smokers actually try to quit in any given year, while only five percent are successful. This again illustrates the cognitive dissonance endured by a large number of smokers. With regard to physical dangerousness, an article summarizing a center for disease report, Sibbald⁷ documented that over eight and a half million Americans are diagnosed with over 12.5 million smoking related diseases. Moreover 10 percent of all current and former smokers have a smoking related chronic disease. These diseases include heart disease, emphysema, stroke and cancer. Further, 440,000 Americans die prematurely every year due to a smoking related illness. Clearly nicotine dependence is a diagnosis wrought with danger.

Though the danger of Nicotine Dependence may obvious given the statistics, it is also clear that other mental illnesses carry substantial elements of danger. This is true even for those diagnoses not involving dependence on chemical substances that negatively impact one’s health. Hiroeh, Mortensen and Dunn³ followed over 257,000 individuals in the Danish psychiatric register and documented their causes of death. They found that individuals with mental illnesses had a 25 percent higher chance of dying from any unnatural cause, including homicide, suicide, and accidents. Further, they found that almost all psychiatric diagnoses show elevated mortality as compared to the general population. Of

all types of unnatural deaths, suicide was the most prevalent. This evidence clearly shows the necessity of assessing danger when conceptualizing a mental diagnosis.

As the “four D’s” have been developed in the literature, some have suggested including a fifth “D”, that of Duration². Duration becomes important since it can illuminate whether an emotion, cognition or behavior is a fleeting symptom without consequence or is persistent enough for classification. Further, this “D” can sometimes help the clinician differentiate between Axis I disorders. To illustrate this, one can examine the diagnoses of 298.8 Brief Psychotic Disorder, 295.40 Schizophreniform Disorder, and 295.90 Schizophrenia, Undifferentiated Type¹. If an individual presents to the clinician with the necessary symptoms to meet the criteria for 295.90 Schizophrenia, Undifferentiated Type, without evidence of duration, it will be difficult to accurately diagnose the individual. For instance, if the individual has these symptoms but the symptoms have only lasted one hour, that individual cannot be diagnosed with any of the above disorders. To meet the criteria for Brief Psychotic Disorder, the symptoms must be present for at least one day but not longer than one month. Schizophreniform Disorder becomes a possibility after one month and until six months have passed. After six months of time with this individual exhibiting the necessary symptoms, Schizophrenia, Undifferentiated Type becomes the only diagnosis available (of the aforementioned) with which the individual can be accurately classified.

Without the clarifying aids of danger, deviance, dysfunction, distress and duration, separating everyday problems from those that elevate to levels of disorders would be difficult. The four “D’s” are a valuable construct for the clinician to identify the points on a continuum at which human cognition, emotion and behavior change from normal into abnormal and thus can be classified as a psychiatric disorder. They provide assistance to increase diagnostic accuracy and reliability by imparting another framework with which to think about the individual’s experience. The clinician can then use this framework to guide the process of devising an individualized care plan to decrease deviance, dysfunction, distress, danger and duration of the presenting problems. The four “D’s” cannot provide nor should it be offered as an alternative to the more traditional DSM IV-TR multi-axial diagnostic structure. It can however provide a complementing construct to aid the clinician to holistically assess human emotions, cognitions and behaviors that may constitute mental disorders.

References

1. Diagnostic and statistical manual of mental disorders. 4th text revision ed. Washington D.C.: American Psychiatric Association; 2000
2. Comer, R.J. Abnormal Psychology. New York, NY: Worth Publishing; 2010.
3. Hiroeh U, Mortensen P, Dunn G. Death by homicide, suicide, and other unnatural causes in people with mental illness: a population based study. *The Lancet*. 2001; 358(9299): 2110-2112.
4. Remick R. Diagnosis and management of depression in primary care: a clinical update and review. *Journal of the Canadian Medical Association*. 2002; 167(11): 1253-1260.
5. Salkovskis P, Warwick H, Deale A. Cognitive-behavioral treatment for severe and persistent health anxiety hypochondriasis. *Brief Treatment and Crisis Intervention* 2003; 3(3): 353-368.
6. Seto M. Pedophilia and sexual offenses against children. *Annual Review of Sex Research* 2004; 15, 321-361.
7. Sibbald B. Smoking's morbidity toll estimated in the US. *Journal of the Canadian Medical Association* 2003; 169(10): 1067.
8. Wilmhurst L. *Essentials of Child Psychopathology*. Hoboken: NJ: John Wiley & Sons; 2005.

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