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

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 disorders.

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.

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
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 places.

To examine dysfunction, the diagnosis of 296.33 Major
Depressive Disorder, Recurrent, without Psychotic Features
is chosen. 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 Remick, 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
dysfunction.

Distress will be explored using the diagnosis of 300.7
Hypochondriasis. 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 Deale 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 “D” 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 picture.

Danger will be examined using a seemingly benign disorder classified in the DSM IV-TR, 305.10 Nicotine Dependence. 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, Sibbald 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 Dunn 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 Duration. 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 Type. 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

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