

March 15, 2015

Disruptive Mood Dysregulation Disorder

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Description of Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder (DMDD), a new diagnosis in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), is characterized by chronic, severe persistent irritability in children and adolescents. DMDD was added to the *DSM-5*, in part, to address concerns about potential over-diagnosis and overtreatment of bipolar disorder in children (APA, 2013). DMDD characterizes behavior that is considered outside of the normal range of childhood behavior; the major features of this disorder include severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation (APA, 2013).

Children with DMDD demonstrate low frustration tolerance and exhibit difficulties with emotional regulation, distress tolerance, and behavioral self-control. In order to meet the diagnostic criteria for DMDD, children must demonstrate outbursts at least three times per week for a period of at least one year across at least two of the following settings: home, school, and with peers (APA 2013). Children who meet the criteria for DMDD will often present as irritable and angry throughout the day. Professional counselors should refrain from assigning this diagnosis to those either under the age of six or over the age 18 (APA, 2013). There must be clear evidence of an onset of symptoms prior to age 10.

DMDD is a newly described mental health disorder and thus, prevalence estimates are unclear. Based on prevalence rates of chronic irritability, a diagnostic criterion of DMDD, one might postulate that the prevalence of disruptive mood dysregulation disorder among children and adolescents is estimated to fall into the 2%–5% range (APA, 2013). Information related to prognosis is limited; however, research suggests that children diagnosed with DMDD are more likely to develop depression or anxiety disorders in adulthood and not bipolar disorder (Barnhill, 2014).

IDENTIFICATION/ASSESSMENT STRATEGIES

There are several differential diagnoses to consider when evaluating whether a client meets the criteria for DMDD. First, it is important to rule out the presence of a major depressive disorder (MDD). For clients who do meet criteria for MDD, a diagnosis of DMDD would only be assigned if it was clear that the irritability and behavioral outbursts do not occur exclusively during a MDD episode. Also, by definition, DMDD cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar (APA, 2013).

Because DMDD is a new diagnosis, there are no available assessment tools to assist in diagnosing and assessing the disorder per se. Professional counselors are currently dependent upon a process of ruling out other medical disorders (e.g., major depressive disorder, oppositional defiant disorder, intermittent explosive disorder and bipolar disorder). What follows is a brief discussion of several instruments that may help in assessing symptoms which relate to DMDD.

Early Childhood Development

Counselors are encouraged to conduct a comprehensive psychosocial assessment due to the over-lapping symptoms of DMDD with other depressive and anxiety disorders. Particular attention needs to be given the nature of the irritability as it is non-episodic, chronic, elevated, persistent, and frequent. It should not be confused with irritability that presents only during stressful circumstances or developmentally appropriate emotional responses (King, 2013). Early childhood development assessments may help counselors differentiate between developmentally appropriate and atypical behaviors. The Early Development and Home Background (EDHB) clinical and parent rated forms are used to assist with the identification of early developmental and home experiences that might attribute to current mental health symptoms (APA, 2013).

Counselors can use the *DSM-5* Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17 to identify symptoms that may be present across multiple *DSM-5* diagnoses (e.g., depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use). The results of this 25-item questionnaire indicate additional symptoms and factors that may impact diagnosis and treatment (APA, 2013).

Resource:

American Psychiatric Association (2013). Early Development and Home Background (EDHB)

Form: <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Early>

American Psychiatric Association (2013). *DSM-5* Parent/Guardian-Rated Level 1 Cross Cutting Symptom Measure—Child Age 6–17: <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Early>

Major Depressive Disorder (MDD)

Although major depressive disorder (MDD) and DMDD can coexist, the behaviors displayed by children with DMDD should not occur exclusively during an episode of MDD (APA, 2013). Professional counselors can use MDD screening tools to aid in the diagnosis of MDD and DMDD. The Beck Depression Inventory for Youth (BDI-Y) is a self-report assessment that screens for symptoms of depression in children and adolescents from ages 7-18 years. The BDI-Y contains 20 questions that can be answered using a Likert scale ranging from 'never' (zero) to 'always' (three). Scores range from 'average' to 'extremely elevated depression.'

The Severity Measure for Depression—Child Age 11–17 (adapted from the PHQ-9 modified for Adolescents) is a 9-item questionnaire that assesses the severity of depressive symptoms and episodes in children and adolescents ages 11-17. Scores range from 'not at all' (0) to 'nearly every day' (3) with higher scores indicating more severe symptoms and episodes. Counselors are encouraged to use the assessment results as an addendum to their clinical interview (APA, 2013).

Resource:

American Psychiatric Association (2013). Severity Measure for Depression—Child Age 11–17: <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Early>

Counseling Youth with Depression: <http://counselingyouthwithdepression.weebly.com/beck-youth-inventories-byi.html>

Pearson: <http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byiii.html?Pid=015-8014-197>

Oppositional Defiant Disorder (ODD)

As operationalized in the *DSM-5*, oppositional defiant disorder (ODD) and DMDD cannot be concurrently diagnosed. If diagnostic criteria are met for both disorders, the professional counselor should only assign the DMDD diagnosis and not the ODD diagnosis (APA, 2013).

The Child Behavior Checklist (CBCL; Achenbach, 1991) is part of the Achenbach System of Empirically Based Assessment (ASEBA). There are two components of the ASEBA: the Teacher's Report Form (TRF; completed by teachers), and the Youth Self-Report (YSR; completed by the client).

The Clinician-Rated Severity of Oppositional Defiant Disorder is used to identify the presence and severity of ODD. The questions are rated on a 4-point scale ranging from 'none' (0) to 'severe' (3) and higher scores suggest more severe symptoms. The tool is completed by the clinician during the clinical interview (APA, 2013).

Resource:

Achenbach System of Empirically-Based Assessment: <http://www.aseba.org/>

American Psychiatric Association (2013). Clinician-Rated Severity of Oppositional Defiant Disorder: <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Early>

Intermittent Explosive Disorder

Intermittent explosive disorder (IED) and DMDD can also not be diagnosed concurrently. If diagnostic criteria are met for both disorders, the professional counselor should only assign the DMDD diagnosis and not the IED diagnosis (APA, 2013). There are no current instruments to assess intermittent explosive disorder in youth. Professional counselors should carefully consider the differential diagnostic criteria associated with each disorder when symptoms of DMDD and IED coexist.

Bipolar Disorder

As previously stated, the DMDD diagnosis was added, in part, to address concerns among mental health professionals about the potential over-diagnosis and overtreatment of bipolar disorder in children. DMDD cannot be diagnosed along with bipolar disorder and it should not be diagnosed if a child has ever experienced a manic or hypomanic episode (APA, 2013). Children diagnosed with DMDD are at greater risk of being diagnosed with a depressive or anxiety disorder, than they are bipolar disorder (Barnhill, 2014). These findings suggest that DMDD and bipolar disorder are independent diagnoses (Shirazi, Shabani, & Shahrivar, 2014), but again, they cannot be diagnosed together. Using an existing tool to assess for bipolar disorder in children can help the professional counselor differentiate between the two disorders. The Child Bipolar Questionnaire (CBQ) is a self-report instrument containing 65 items rated on a four point Likert-scale ranging from 'never' (1) to 'very often and almost constantly' (4). Scores can suggest a possible diagnosis of bipolar disorder as defined in the DSM-IV.

Resource:

Juvenile Bipolar Research Foundation: <http://www.jbrf.org/the-child-bipolar-questionnaire-for-families-use/>

Shirazi, E., Shabani, A., & Shahrivar, Z. (2014). Disruptive mood dysregulation disorder and bipolar disorder: Convergence or divergence? *Iranian Journal of Psychiatry & Clinical Psychology*, 20(2), 95-110.

INTERVENTION/TREATMENT STRATEGIES

Effective intervention strategies and approaches for treating those who have DMDD are still under investigation. Treatment protocols are limited due to the recent addition of the diagnosis to the *DSM-5*, as well as the findings that most children diagnosed with DMDD have a comorbid diagnosis such as ODD or ADHD (Johnson & McGuinness, 2014; Tourian et al., 2015). Treatments used to address bipolar disorder, oppositional defiant disorder, conduct disorder and ADHD are often applied in treating those who have DMDD (Manis, Norris, Paylo, & Kress, 2015). While there are no best practices specific to DMDD, common treatment includes pharmacological intervention paired with Cognitive Behavioral Therapy. Professional counselors are reminded that therapeutic interventions should be modified and personalized to fit the individual client's needs and DMDD diagnosis (APA, 2013; Waxmonsky et al., 2013; Waxmonsky & Periseau, 2009).

Pharmacological Interventions

Pharmacological interventions, including antipsychotics, mood stabilizers and stimulants have been used to treat severe mood dysregulation, a symptom of DMDD (Waxmonsky & Periseau, 2009). There has been variability in the effectiveness of treatment. Two primary factors contributing to the variability include: (a) limited data pertaining to course of the DMDD diagnosis, and (b) the selection of medications commonly used to treat other mental and emotional disorders with overlapping symptoms are used to treat DMDD. Stimulants

may be ineffective in treating severe mood dysregulation due to their tendency to induce mania. Severe mood dysregulation has been effectively treated by mood stabilizers, especially lithium, but their side effects limit endorsement as first line treatment. Antipsychotics, such as Risperdone may be more effective than traditional non-antipsychotic mood stabilizers (Waxmonsky & Pariseau, 2009).

Resource:

Waxmonsky, J. G., & Pariseau, M. E. (2009). Treatment of children with severe mood dysregulation. *Child and Adolescent Psychopharmacology News*, 14(6), 7-11.

Cognitive Behavioral Therapy (CBT)

There is some evidence that Cognitive Behavioral Therapy (CBT) may be effective in treating severe mood dysregulation, a symptom of DMDD. Techniques include stabilizing the child's daily routines, increasing family supports, and monitoring affect/emotions. Treatment outcomes have yielded a reduction of physical aggression, improved self-esteem, enhanced ability to self-recognize negative emotions (e.g., anger), and an increased ability to identify the connection between one's mood and exhibited behavior (Waxmonsky et al., 2013).

Resource:

Waxmonsky, J. G., Wymbs, F. A., Pariseau, M. E., Belin, P. J., Waschbusch, D. A., & Babocsai, L. (2013). A novel group therapy for children with ADHD and severe mood dysregulation. *Journal of Attention Disorders*, 17(6), 527-541.

Adlerian Play Therapy

Adlerian Play Therapy (AdPT) may reduce disruptive behaviors, a symptom of DMDD (e.g., rule breaking, aggression, attention seeking) in a classroom setting. AdPT integrates directive and non-directive play techniques that encourage children to rehearse changing perceptions, attitudes, and behaviors through language and/or metaphors. The techniques are grounded in the basic principles of Adlerian Therapy (e.g., early recollections, birth order, social interests; Meany-Walen, Bratton, & Kottman, 2014).

Resource:

Meany-Walen, K. K., Bratton, S. C., & Kottman, T. (2014). Effects of Adlerian Play Therapy on reducing students' disruptive behaviors. *Journal of Counseling and Development*, 92, 47-56.
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Waxmonsky, J. G., Wymbs, F. A., Pariseau, M. E., Belin, P. J., Waschbusch, D. A., & Babocsai, L. (2013). A novel group therapy for children with ADHD and severe mood dysregulation. *Journal of Attention Disorders*, 17(6), 527-541.

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