Walking on Eggshells:
Understanding Disruptive Mood Dysregulation Disorder

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Disruptive Mood Dysregulation Disorder (DMDD) was first included in the Diagnostic and Statistical Manual of Mental Disorders in the 5th edition (2013). Thus, it is a relatively new diagnosis. The diagnosis of DMDD was established to address a concern about the over-diagnosis of bipolar disorder in children. However, the constellation of symptoms in children and adolescents is now new. The primary symptoms of DMDD are "persistent irritability and frequent episodes of extreme behavioral dyscontrol." Parents of children with DMDD report that their children do not have tantrums; they have rages. The family reports that they "walk on eggshells" around the child. The child may not show these rage behaviors at school until they "perceive" that the work is too difficult for them or that there is too much work.

The DSM-V criteria for DMDD are as follows:

- severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation
- temper outbursts are inconsistent with developmental level
- temper outbursts occur, on average, three or more times per week
- mood between temper outbursts is persistently irritable or angry most of the day
- the above criteria have been present for 12 or more months, without a period lasting three or more months in which all criteria are present
- the above criteria are present in at least two of three settings and are severe in at least one setting
- the diagnosis should not be made for the first time before age 6 or after age 18
- the age of onset is prior to age 10
- there has never been a distinct period lasting more than one day during which the full symptom criteria for a manic or hypomanic episode have been met, with the exception of duration
- the behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder
- the symptoms are not attributable to the psychological effects of a substance or another medical or neurological condition

As this is a relatively new diagnosis, the prevalence rate is not yet clear. However, it is estimated that it occurs in between 2% and 5% of children. There

appear to be more males diagnosed than females. As noted above, the age of onset of the disorder is prior to age 10. While children may demonstrate the irritability and temper outbursts prior to age 6, the diagnosis is not made prior to age 6 to allow for developmental maturation.

True bipolar disorder prior to adolescence is relatively rare, estimated at less than 1%. The distinguishing symptom that distinguishes DMDD from Bipolar Disorder are manic or hypomanic episodes. Children with DMDD do not have episodes of hypomania or mania.

DMDD almost always co-exists with other disorders. Common co-morbidities include anxiety, depression and ADHD. In many children with DMDD we find co-existing neurodevelopmental disorders such as learning disorders and Autism Spectrum Disorders. These co-morbidities make intervention especially complicated. Within school settings, many of the students with DMDD are identified for special education services as a student with an Emotional Disability.

As with other conditions of childhood, treatment starts with appropriate diagnosis of DMDD as well as any co-morbid conditions. This requires a complete review of all available developmental, medical and educational information. Comprehensive evaluation is strongly recommended to rule out co-existing learning and developmental disorders. The second part of treatment is parent education about DMDD and counseling regarding how to manage the child. If the disruptive outbursts are present at school or in day care settings, education of staff and the implementation of appropriate behavioral interventions are necessary. Consideration of medication to treat the presenting symptoms is usually critical. Close communication between the family, treating therapist, school and medical specialist will greatly improve the efficacy of all treatment modalities. Ongoing family therapy and direct therapy with the child are important. While the primary symptom of DMDD is mood dysregulation, the child's behavior and emotions usually cause family dysregulation.

A long-term study conducted by Copeland et al. (2014) revealed that those with DMDD do not fare well as adults. The vast majority of children with DMDD experience anxiety and depression as adults, as opposed to bipolar disorder. When compared to individuals with no psychiatric diagnosis or other psychiatric conditions, they have more health problems, financial strain and social isolation. These children do not suffer in silence and their suffering does not end as they enter adolescence and adulthood.

For further information regarding DMDD, visit the following videos and references.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

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Webinar: Severe Irritability and DMDD in Youth https://www.nimh.nih.gov/news/media/2016/webinar-severe-irritability-and-dmdd-in-youth-dr-kenneth-towbin.shtml