American Counseling Association Practice Briefs

D M D a D

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Description of Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder (DMDD), a new diagnosis in *e 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 di culties with emotional regulation,

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 di erentiate between developmentally appropriate and atypical behaviors. e Early Development and Home Background (EDHB) clinical and parent rated forms are used to assist with the identi cation 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). e results of this 25-time questionnaire indicate additional symptoms and facto iona and(t)-3(-11ds)-8(e). Mc-7(ht(li)12(t)-(l)7(t)6(oq e)-5.9(a)9(r)4p6Ha)-5(l i)5.9(en)3(en)19(t m(t)5.9(en)19 thoehoehted L16(e)-5y help cohea46 Tw /Span≤ActualText₣EFF0009≥BDC 19(t2s)-8(EMC 1[(FTJT)-5(l a)9(n:(e)-6(a)Tw 9(t32
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e Clinician-Rated Severity of Oppositional De ant Disorder is used to identify the presence and severity of ODD. e questions are rated on a 4-point scale ranging from 'none' (0) to 'severe' (3) and higher scores suggest more severe symptoms. e 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 De ant 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). ere are no current instruments to assess intermittent explosive disorder in youth. Professional counselors should carefully consider the di erential 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). ese ndings 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 di erentiate between the two disorders. e 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 o en and almost constantly' (4). Scores can suggest a possible diagnosis of bipolar disorder as de ned 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

E ective intervention strategies and approaches for treating those who have DMDD are still under investigation. Treatment protocols are li11.9(n8,)-5.9(h)9(n)8(2(r)ue)6(o -5.9(h)4(e DS13(e)-6(81501 265.6031 Tm[(INTER)46.9(E2r)63(, 2E

the cardinal symptoms of disruptive mood dysregulation disorder *Journal of Canadian Academy of Child and Adolescent Psychiatry, 24*(1), 41-54.

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