DISRUPTIVE MOOD DYSREGULATION DISORDER

TREATMENT PLAN

FOR PARENTS AND CHILD

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CHILD ASSESSMENT

1. Do you feel sad almost everyday?
A. always
B. sometimes
C. never

2. Do you feel angry almost everyday for no reason?
A. always
B. sometimes
C. never

3. When you feel angry, do you feel out of control?
A. always
B. sometimes
C. never

4. When you are angry do you scream and shout at your friends and family?
A. always
B. sometimes
C. never

5. When you are angry, do you hit or strike at friends, family, or objects?
A. always
B. sometimes
C. never

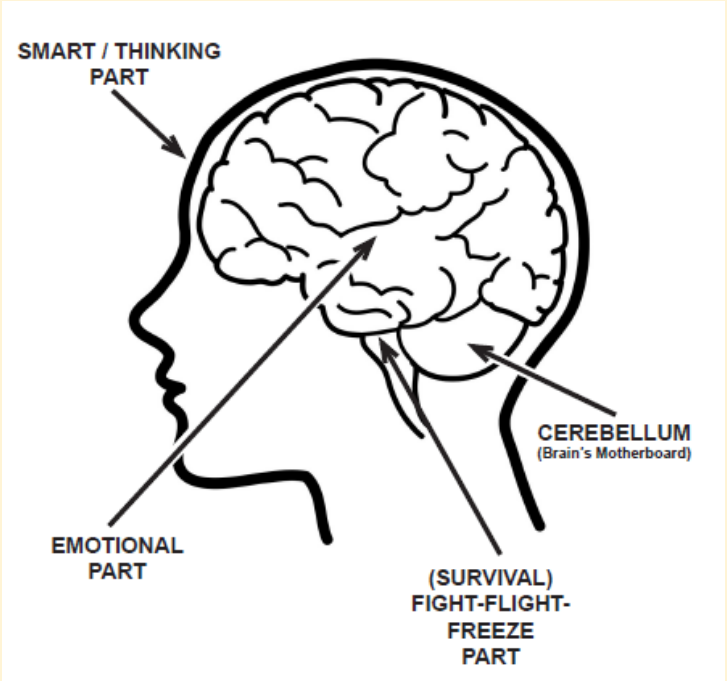
6. Do you have these anger outbursts 3 times a week?
A. always
B. sometimes
C. never

7. Where do these anger outbursts always happen?
A. home
B. school
C. other
D. everywhere

WHAT IS DMDD?

Overview

DMDD, or Disruptive Mood Dysregulation Disorder, is a new disorder that was added to the DSM-5 in 2013. It was put in place to more accurately describe and diagnose children who had been previously diagnosed with Pediatric Bipolar Disorder but did not experience the usual hypomanic symptoms and manic episodes that are characteristic of Bipolar Disorder.



Description

DMDD is a condition in which the child experiences chronic irritability, sadness, and severe temper outbursts that are out of proportion to the situation. Children suffering from DMDD are not able to regulate their emotions properly and respond to situations in a way that is inappropriate to their developmental level. This is partly due to the over stimulation of the amygdala in the brain which causes a decrease in frontal lobe activity, the thinking part of the brain. In other words, children with DMDD "think" with their emotions and lack the basic developmental ability to reason, analyze, and respond properly to situations.

BACKGROUND

History

The history behind the differential diagnosis for DMDD is crucial for all involved to understand. The study named the Global Burden of Disease by Leibenluft showed that the diagnosis for Bipolar Disorder in children and teenagers has increased by 500% in America in the past 20 years. This caused intense debate on how to differentiate chronic irritability symptoms versus a combined series of mood swings with hypomanic episodes and major depressive episodes. A clinical trial was done with children ranging from ages 7 and 17 to test these symptoms overtime to evaluate whether a differential diagnosis for Bipolar Disorder was possible. The results of this showed that the development of chronic paroxysmal (frequent but short) irritability was linked with an appearance of manic episodes. While just chronic irritability and symptoms were linked to anxiety and depressive disorders. Based on the study, the chance of children with chronic paroxysmal irritability and elation had a 50 percent increase in developing Bipolar Disorder than the rest. This is when the DSM-5 added DMDD under the category of depression disorders instead of Bipolar Disorders. So what is the take away? One of the most important ways to differentiate DMDD versus Bipolar Disorder is the through the presence of elated, hypomanic episodes- while they exist in those with Bipolar Disorder, they do not in those with DMDD.

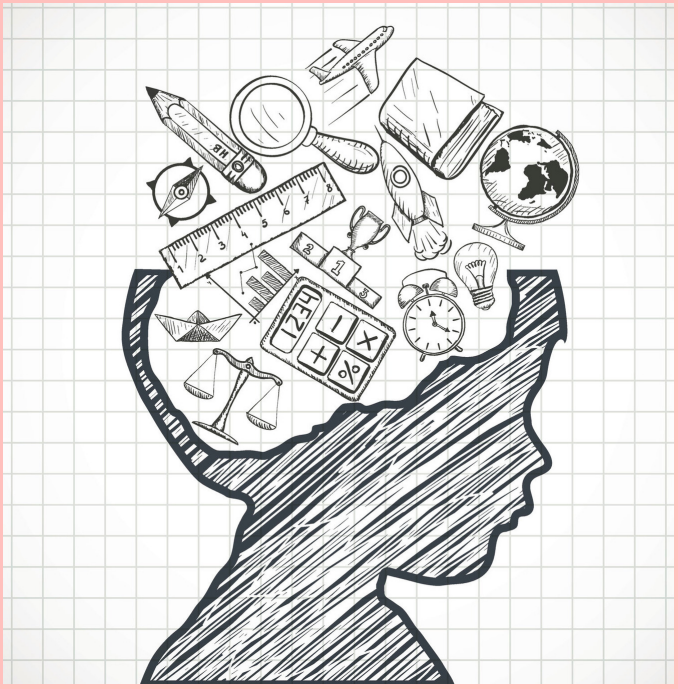
Bipolar disorder	DMDD
Discrete mood episodes of mania and depression	Severe, non-episodic irritability
Lifelong episodic illness	Does not develop into Bipolar Disorder
Decreased focus on irritability in DSMV	Associated with severe outbursts/tantrums
Can be diagnosed at any age but rare in childhood; peak onset in 20s-30s	Cannot be first diagnosed before 6 or after 18
Psychosis may be present	Not associated with psychosis

Risk

You may wonder why is it is crucial to differentiate the diagnosis and treatment of children with DMDD versus Bipolar Disorder. This is due to the fact that there is a lot of risk associated with giving children the wrong medical treatment. The antipsychotics given to patients diagnosed with Bipolar Disorder come with very harsh side effects that are harmful in children that don't need them. Giving a child atypical antipsychotics can have severe side effects such as rapid weight gain, an increased risk in developing type 2 diabetes, a shortened life span, and stunt in growth and development.

CAUSES

As of 2018, scientists have not found any direct causes to why DMDD occurs in children. However, there are certain children who are more at risk of developing DMDD than others.



Risk Factors

- Early Psychological Trauma and Abuse
- Family structure (recent family death or divorce)
- Poor diet
- Neurological disability
- Early diagnosis of ADHD and/or anxiety

SIGNS AND SYMPTOMS

There are very specific criteria a child must meet before being diagnosed with DMDD. However, if your child has struggled previously with temper outbursts, uncontrollable emotions or reactions, attention deficit, and anxiety, they may be more at risk for developing or having DMDD. Therefore, it is necessary to know the signs and symptoms to assess whether your child is at risk and needs to be diagnosed. DMDD symptoms typically emerge before the age of 10, however, the diagnosis is not given to children under the age of 6 or over the age of 18 in order to be diagnosed, the child must present symptoms consistently over the course of 12 months. These symptoms include irritability and angry mood for most of the day, causing trouble functioning due to irritability among peers, in school, and at home. Temper outbursts (verbal and behavioral) 3 or more times a week (temper outbursts consisting of verbal or physical aggression that are out of proportion to the triggering situation or event and inappropriate to the child's developmental level). The child also displays irritable, angry, grumpy, or sad moods in between the angry outbursts.

DSM-5 Criteria for DMDD

- Criterion A: 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
- Criterion B: The temper outbursts are inconsistent with developmental level
- Criterion C: The temper outbursts occur on average three or more times per week
- Criterion D: The mood between temper outbursts in persistently irritable or angry most of the day nearly every day, and is observable by others (e.g., parents, teachers, peers)
- Criterion E: Criteria A through D have been present for twelve or more months. Throughout that time, the individual has not had a period lasting three or more consecutive months without all of the symptoms in Criteria A through D
- Criterion F: Criteria A and D are present in at least two of the three settings (at home, at school, with peers) and are severe in at least one of these
- Criterion G: The diagnosis should not be made for the first time before age six or after age eighteen
- Criterion H: By history or observation, the age of onset of Criteria A through E is before age ten
- Criterion I: There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met
- Criterion J: The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, post-traumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia])
- Criterion K: The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition

DIAGNOSIS

Thus far, there are no laboratory, genetic, imaging tests, or official methods to diagnose DMDD other than basing the child's symptoms on the criteria found in the DSM-5. However, it is required that the diagnosis be made through the clinical judgement of a psychiatrist or other professional. The diagnosis should also not be made before the age of 6 or after the age of 18. The symptoms must also have had an onset before the age of 10 and have been recurrent for one year for the most accurate results. The current most reliable source of diagnosing used by professionals is ruling out the occurence of other mental disorders such as major depressive disorder, oppositional defiant disorder, intermittent explosive disorder, and bipolar disorder that cannot coexist with the diagnosis of DMDD.

Exclusionary symptoms/criteria that do not indicate DMDD:

- Manic or hypomanic episodes, better explained by BD
- Observations of qualifying behaviors that exclusively occur during episodes of depression; that are attributable to effects of substance use or better explained by other neurologic, medical, or psychiatric conditions
- Coexistence of oppositional defiant disorder or intermittent explosive disorder

TREATMENT

Therapuetic

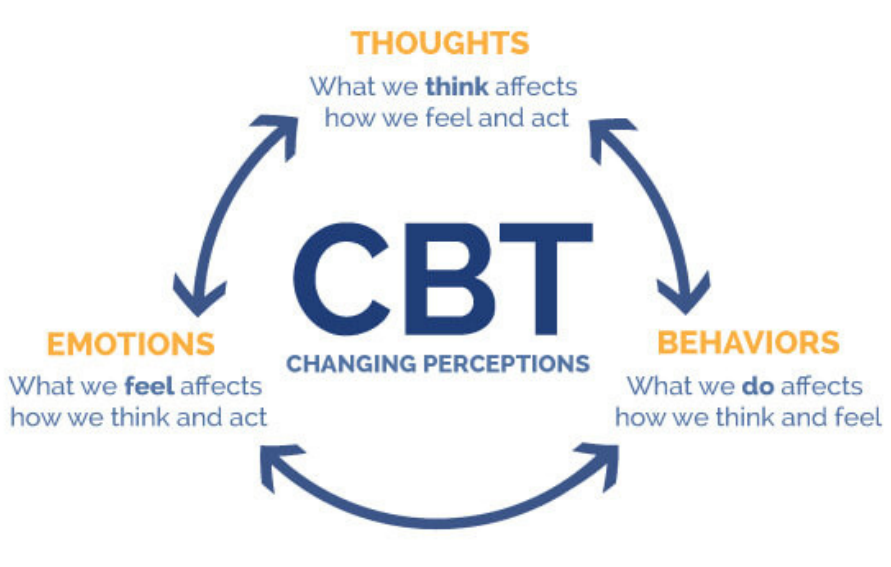
The most recommended form of treatment from children suffering from DMDD is behavioral therapy. There are many different kinds of therapeutic approaches, however, the most effective ones in this case are the ones that address coping mechanisms to control behavior in children. These types of therapies will give children the tools to deal with the emotions and irritability that lead to temper outbursts.

Pharmacological

The medical approach for treatment is less recommended by psychiatrists, however, it is effective and possible if necessary. Doctors recommend using medicine only sparingly as it could affect the child's growth and development. The medicines used should treat symptoms of impulsivity, aggressiveness, and irritability/sadness.

COGNITIVE BEHAVIORAL THERAPY

Cognitive Behavioral Therapy or (CBT) is a common form of psychotherapy or talk therapy that helps alleviate symptoms of mental disorders. It is performed by licensed professional therapists or psychologists and the sessions are often alone with the patient. The purpose of CBT is to help the patient become aware of inaccurate or negative self talk/thinking they do so they can respond in a more effective way. In the case of DMDD, CBT would treat the depression/irritability symptoms by helping the child become self aware of their thoughts during temper tantrums and analyze different ways they can deal with their emotions rather than with verbal and physical aggression.



Outcome?

The treatment outcome for using CBT on a child is reduced physical aggression, improved self esteem, the ability to self-recognize negative emotions, and identify the connection between one's mood and exhibited behavior. Therefore if your child struggles primarily with these symptoms, this is the best option for them.

DIALECTICAL BEHAVIORAL THERAPY

Pre-Treatment Stage
Set goals for therapy.

Stage 1
Move to gain control of behavior.

Stage 2
Work on fully experiencing emotions.

Stage 3
Focus on building a healthy lifestyle and developing self-reliance.

Stage 4
Seek deeper meaning through spiritual fulfillment and work on moving from a sense of incompleteness to connection with a greater whole.

Dialectical Behavioral Therapy, or DBT, is also another form of cognitive therapy. It is given through the form of talking one on one with a licensed therapist. DBT is mainly focused on balancing out emotions in a patient. There are three main goals of DBT. The first is to increase mindfulness to improve the patients acceptance of whatever is occurring at the present moment. The second is distress tolerance, which is increasing the child's tolerance to negative emotions. The third is emotional regulation, to cover strategies that manage the child's intense emotions negatively their life. The last goal is interpersonal effectiveness, it helps the child communicate with others in an assertive, respectful way.

ANTI-DEPRESSANTS

It is often not recommended by psychiatrists to give children medical treatments for DMDD. However, if the child's symptoms become too severe, or if therapeutic techniques are not effective, it is a plausible solution. Antidepressants can be used to treat the irritability and depressed mood symptoms displayed by a child with DMDD. The most recommended antidepressants are SSRI's (Selective Serotonin Reuptake Inhibitors) in low doses; these types of antidepressants come with the least and most mild side effects, as well as being approved for children. SSRI's work by blocking the reabsorption of serotonin, the neurotransmitter that makes you happy, into the brain. This in turn makes serotonin more available in the body, causing increased sensations of happiness and easing depression.

SSRI'S:

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Paroxetine (Paxil, Pexeva)
- Sertraline (Zoloft)
- Vilazodone (Viibryd)

STIMULANTS

Central nervous system stimulants used to treat ADHD (attention deficit hyperactive disorder) can also be used to relieve certain symptoms in children with DMDD. These stimulants are mainly targeted to treat the symptoms of irritability, aggressiveness, and impulsivity in children with DMDD. Stimulants work by enhancing the release of the neurotransmitter dopamine, while stimulating the receptors as well so they pick up the signal faster. This in turn reduces impulsivity and hyperactivity in children.

Stimulants for DMDD:

- Methylphenidate (Ritalin)
- Amphetamine (Dexedrine, ProCentra, Zenzedi, Adderall)

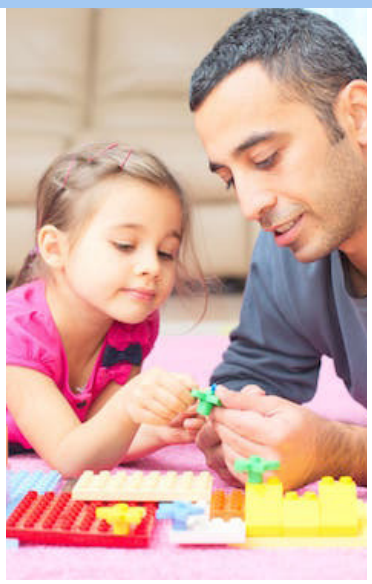
PARENT INTERVENTION

Dealing with a child that requires extensive care is not always a simple task. One of the most important aspects of treatment for childhood mental disorders is the child-parent relationship. Therapy and medicine treatments are not effective alone; the environment in which the child lives in has major impacts on their mental health.

Therefore, it is essential that parents who are dealing with a child with DMDD have the training and ability to reinforce treatment at home. There are various different parent trainings that parents can take to help prevent aggression and irritable behavior at home. These trainings are aimed at helping the parents interact with their Child in a way that reduces their symptoms and helps them overcome them. Parent training also gives parents tools on how to respond to the child's behaviors effectively as well as anticipate events that may lead the child to display aggressive or uncontrollable behavior.

PARENT-CHILD INTERACTION THERAPY

Parent Child Interaction Therapy (PCIT) is a combination of play therapy and behavioral therapy for children ages 2-7 and their parents. The adults can benefit from this by learning new skills and techniques to relate to their children with DMDD. Overall PCIT helps improve the family dynamics at home by working to reduce negative behavior and interactions within the family and learn new, effective ways to communicate that are more encouraging and positive. During a session, Parents are taught these skills and they practice them with their child in a playroom while being coached by a therapist who gives them direct feedback after. This helps alleviate the symptoms of defiance and aggressiveness in the child with DMDD while improving their social and cooperative skills as well.



Parent Skills

- Give labeled praise for child's positive behavior
- Reflect or paraphrase the child's appropriate talk
- To use behavioral descriptions to describe the child's positive behavior
- To avoid using commands, questions, or criticism because these verbalizations are intrusive and often give attention to negative behavior

PARENT MANAGEMENT TRAINING

In Parent Management Training (PMT), parents participate in sessions led by the therapist without children. This treatment is usually effective for children ages 3-13. In PMT sessions, skills to deal more effectively with challenging behaviors are taught and modeled by the therapist and then role played by the parents. They are usually taught over the span of 10 sessions and parents are expected to practice the different skills learned throughout the session, at home with their children before the next session.

For example, one of the techniques parents learn in these sessions is using a token economy. This is where parents establish a point system that are rewards the child based on good behavior. The child will be able to make the connection between good behavior and rewards to use for their own benefits and this in turn reinforces positive actions and behaviors. This can make children aware of their DMDD symptoms when throwing temper tantrums or being verbally/physically aggressive and cause influences them to avoid those behaviors to receive a reward.