

## Deconstructing the DSM-5

By Jason H. King

### Assessment and diagnosis of disruptive mood dysregulation disorder

During the past two decades, the prevalence of pediatric bipolar disorder has dramatically increased. Many clinicians, acting with good intent to help children and adolescents, have incorrectly diagnosed them with bipolar disorder and recommended use of antipsychotic medication for treatment of chronic and distressing irritable mood.

However, Ellen Leibenluft, M.D. (senior investigator and chief of the Section on Bipolar Spectrum Disorders and of the Emotion and Development Branch at the National Institute of Mental Health Intramural Research Program) tracked a large group of young adolescents diagnosed with bipolar disorder into their 30s. She found no evidence that chronic irritability was a predictor of bipolar disorder in adults.

### The new landscape

To address concerns expressed by parents and mental health professionals about the overdiagnosis and treatment of bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder (DMDD), was added to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The diagnosis applies to children and refers to the presentation of persistent irritability and frequent episodes of extreme behavioral dyscontrol.

The following symptoms characterize DMDD:

- Severe and recurrent temper outbursts resulting from insignificant provocation or situation
- Verbal or behavioral manifestations, such as in the form of verbal rages, or physical aggression toward people or property
- Mood and behavior that is grossly out of proportion in intensity or duration to the situation or provocation and inconsistent with the child's developmental level
- Temper outbursts in at least two settings: at home, at school or with peers, with one of these settings being "severe"
- Temper outbursts present for at least 12 months, three times per week, with symptoms not absent for less than three months at a time
- Observable by others (parents, peers, teachers) in children 6 years of age or older, with onset before age 10

I must emphasize that the hallmark DMDD symptom is very severe, nonepisodic irritability that is persistent, frequent and extreme, and is differentiated from a pattern of irritability when frustrated. Assessment of irritable mood and temper outburst severity, frequency and chronicity are essential with this disorder. Moreover, developmentally appropriate mood elevation, such as what occurs in the context of a highly positive event or its anticipation, should not be considered a symptom of mania or hypomania.

If the child's irritable mood is episodic or fluctuates over time and in multiple environments, and the irritable mood is comorbid with increased grandiose energy and activity characteristic of hypomanic or manic episodes, then a diagnosis of bipolar disorder may be indicated.

If the child is older than 6 and has impulsive anger-based outbursts with no comorbid mood fluctuations and no persistent irritability, then a diagnosis of intermittent explosive disorder may be warranted if the outbursts (temper tantrums, tirades, verbal arguments or fights) occur two times per week for three months.

Keep in mind that DMDD is mutually exclusive with bipolar disorder, intermittent explosive disorder, posttraumatic stress disorder and oppositional defiant disorder. Yet, DMDD can coexist with attention-deficit/hyperactivity disorder, conduct disorder, substance use disorders and major depressive disorder if clear-cut changes between these disorders and DMDD are reported and observable.

Because children and adolescents may develop an irritable or cranky mood rather than a sad or dejected mood during depressive episodes, DMDD is listed in the DSM-5 depressive disorder chapter instead of the disruptive, impulse control and conduct disorders chapter. However, making a clear distinction between DMDD and the more common non-mood-based, disruptive behavioral disorders can be challenging.

### Latest research

This year, William Copeland and colleagues determined that DMDD prevalence rates will range from 0.8 percent to 3.3 percent with children displaying elevated rates of social impairments, school suspension, service use and poverty. They also found that DMDD frequently co-occurs with other psychiatric disorders yet meets common standards for psychiatric "caseness" by identifying children with severe levels of both emotional and behavioral dysregulation.

In contrast, in 2012, David Axelson and colleagues found that 26 percent of study participants formally diagnosed with bipolar disorder met the operational DMDD criteria. DMDD participants had higher rates and more severe symptoms of oppositional defiant disorder (58 percent) and conduct disorder (61 percent) but did not differ in the rates and severity of mood, anxiety or attention-deficit/hyperactivity disorders.

DMDD was not associated with new onset of mood or anxiety disorders or with parental psychiatric history. Overall, they found that DMDD could not be delimited from oppositional defiant disorder and conduct disorder and had limited diagnostic stability.

In a study in 2012, David Margulies and colleagues found that 30.5 percent of psychiatric hospital inpatient children met criteria for DMDD by parent report and 15.9 percent by inpatient unit observation. Fifty-six percent of the children had parent-reported manic symptoms. Of those, 45.7 percent met criteria for DMDD by parent report, though only 17.4 percent met the criteria when observed on the inpatient unit.

Although the addition of DMDD does decrease the diagnosis rate of bipolar disorder in children, much of that reduction depends on whether the counselor uses client history or observation during the assessment process. To elucidate the clinical presentation and “flavor” of DMDD, I present a case that my colleague, Matt Buckley, recently shared.

### Case study: Aaron

Aaron is a 9-year-old Caucasian boy brought into treatment by his mother and father, Shari and Wayne, who were at their “wit’s end” regarding what to do with him. Aaron presents with angry and destructive outbursts that appear uncontrollable and result in emotional and physical upheaval in the home.

A week prior to Shari and Wayne, calling for the initial consult, Aaron threw his sister’s backpack through a plate glass window because she would not change the TV channel to a program he wanted to watch. This happened despite clear family rules about use of the TV and it being his sister’s turn to watch her favorite show.

When Shari tried to intervene, Aaron grabbed her hair, pulled it violently and punched her in the arm. In the initial intake, Shari says, “I have learned to get good at protecting myself and have even taken some self-defense courses at the local gym. I just never dreamed I would be defending myself against my 9-year-old son.”

Aaron is grumpy and irritable most of the time. He has outbursts in the morning when he is forced to wake up and right before he goes to bed. His parents have developed a strategy of winding down two hours before bedtime to let Aaron know he needs to prepare himself for bed. Despite this strategy, they say that 80 percent of the time, a disruptive event takes place that prevents everyone from going to bed peacefully.

When asked how long this has been happening, they indicate Aaron has been acting this way for the past 13 months. When asked why they waited that long before getting help, they both respond that they thought Aaron was going through a stage they had hoped he would outgrow.

They also describe several incidents in which Aaron has acted in a violent and explosive manner. A month previous, Aaron was with Shari and his younger sister at Walmart. He went into the store’s video games section while his mother and sister shopped for needed supplies.

Shari engaged in her preventative speech, which included describing how Aaron has not respected time limits in the past, how her shopping will take only about 5 minutes and how she does not have time to wait for him to look at video games. During this speech, Aaron became agitated and said, “Whatever!” and then left for the video games department. Shari went after him and said, “I will be leaving in five minutes, and you better be at the car by the time I leave!”

Shari noted in the intake that she will not grab Aaron or physically try to restrain him because, "That is when he 'loses it' and gets really violent." Shari and her daughter finished shopping, went to the car and waited 15 minutes for Aaron to meet them so they could leave. Aaron walked slowly out of the store and to the car.

Shari met Aaron outside of the car and said, "I told you five minutes and we have been waiting her for 15 minutes. You will have no TV time tonight after dinner." Upon hearing this, Aaron yelled, "You are a f----- bitch! I hate you and this whole damned family!" He then kicked Shari in the shin and jumped in the back of the car where his sister was sitting. He kicked the seat violently most of the way home.

When they arrived home, Shari told Aaron to go to his room. He went through the den where his older sister was watching TV. When Aaron looked at her, she rolled her eyes. He immediately became furious, overturning a bookshelf and hitting and kicking the walls on the way to his bedroom. He slammed the door and could be heard yelling and tearing the posters off his bedroom walls.

This event is representative of the outbursts Aaron has engaged in for more than a year. When questioned why she didn't leave Aaron at home while she went to the store, Shari says she doesn't dare because Aaron may get violent with his older sister Corey. Shari explains that Aaron and Corey have the most contentious relationship. Corey is at the stage where she is embarrassed about her brother's behavior and will ridicule him in front of her friends. Shari describes Aaron's relationship with Marie, his younger sister, as the most loving. She notes that Aaron acts very protective of Marie and has never threatened her.

When asked how Aaron behaves in other environments and social situations, particularly school, Shari acknowledges there have been outbursts at school and that Aaron's teachers report he is a "problem student." When other disruptive students act out, Aaron joins in with them. Teachers note that Aaron's level of concentration appears to be strong and consistent, but he is especially sensitive to criticism.

Aaron's parents say they can't identify any severe mood swings that appear to be abnormal. Rather, Aaron is just cranky and irritable all the time. He can be compliant and even helpful around the house, they say, but those times are rare and can dissipate without warning. When asked about the nature of his violent outbursts, both Shari and Wayne note their belief that he acts out of frustration, as though he doesn't know what to do with his emotions. They both deny mania, increased energy, grandiose ideation, increase in risky behaviors, delusions or a decreased need for sleep even though Aaron frequently wants to stay up past his bedtime.

When asked about depressive symptoms, both parents report that though Aaron seems to enjoy activities with friends, there are times when he isolates himself at home and has a reduced interest in interacting with others. During these times, he would rather play video games in his room or watch TV. Aaron does not appear to have any attention problems. He is able to concentrate at school and get his schoolwork done, even though he complains about doing homework.

## Assessment

In completing the DSM-5 Early Development and Home Background form and Level 1 Cross-Cutting Symptom Measures for children 6-17 (available at [psychiatry.org/practice/dsm/dsm5/online-assessment-measures](http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures)), Aaron produced elevated scores.

This indicated the need for Level 2 Cross-Cutting Symptom Measures:

- Score on Depression—Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress—Depression—Parent Item Bank): 66.6 (moderate)
- Score on Irritability—Parent/Guardian of Child Age 6–17 (Affective Reactivity Index): 12 (severe)
- Score on Anger—Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent): 85.2 (severe)
- Score on Mania—Parent/Guardian of Child Age 6–17 (Adapted from the Altman Self-Rating Mania Scale): 5 (mild)

The combination of biopsychosocial information, the mental status examination, the teacher report, the clinical interview and cross-cutting symptom measures (parent, child and clinician rated) justifies a DSM-5 diagnosis of 296.99 Disruptive Mood Dysregulation Disorder with V61.20 Parent-Child Relational Problem and V61.8 Sibling Relational Problem for Aaron.

In conclusion, even though some of the emerging research indicates that DMDD may be justified as a distinct nosology, I am not convinced that we need this disorder. Dysthymia (now titled “persistent depressive disorder” in the DSM-5) is a viable option to designate chronic irritable mood lasting a minimum of 12 months in children, and that is mutually exclusive with a history of hypomania or mania (as required in the DSM-IV and retained in the DSM-5).

In my professional opinion, the American Psychiatric Association should have added a “disruptive mood dysregulation” descriptive specifier (requiring the same severity, frequency and chronicity of irritable mood and temper outbursts) to dysthymia. Until next month, be well.

## Bio

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