

# Disruptive Mood Dysregulation Disorder

Code: 296.99 (F34.8)

## Disruptive Mood Dysregulation Disorder

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### Diagnostic Criteria 296.99 (F34.8)

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.

B. The temper outbursts are inconsistent with developmental level.

C. The temper outbursts occur, on average, three or more times per week.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.

F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By history or observation, the age at onset of Criteria A–E is before 10 years.

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. Note: Developmentally appropriate mood disorder, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

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, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

### Diagnostic Features

The core feature of disruptive mood dysregulation disorder is chronic, severe persistent irritability. This severe irritability has two prominent clinical manifestations, the first of which is temper outbursts. These outbursts typically occur in response to frustration and can be verbal or behavioral (the latter in the form of aggression against property, self, or others). They occur frequently (i.e., on average, three or more times per week) (Criterion C) over at least 1 year in at least two settings (Criteria E and F), such as in the home and at school, and they must be developmentally inappropriate (Criterion B). The second manifestation of severe irritability consists of chronic, persistently irritable or angry mood that is observable by others in the severe temper outbursts. This irritable or angry mood must be characteristic of the child, being present most of the day, nearly every day, and observable by others in the child's environment (Criterion D).

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The diagnosis of disruptive mood dysregulation disorder must be carefully distinguished from presentations of other, related conditions, particularly pediatric bipolar disorder. In fact, disruptive mood dysregulation disorder was added to DSM-5 to address the considerable concern about the appropriate classification and treatment of children with chronic, persistent irritability relative to children who present with classic (i.e., episodic) bipolar disorder.

Some research on episodic irritability as characteristic of bipolar disorder in children, although both DSM-IV and DSM-5 require that both children and adults have distinct episodes of irritability, has led to a diagnosis of oppositional defiant disorder. During the latter decades of the 20th century, this contention by researchers that severe, chronic irritability is a manifestation of pediatric mania coincided with an increase in the rates at which clinicians assigned the diagnosis of bipolar disorder to their pediatric patients. This sharp increase in rates appears to be attributable to clinicians combining at least two clinical presentations into a single category. That is, both classic, episodic presentations of mania and non-episodic presentations of severe irritability have been labeled as bipolar disorder in children. In DSM-5, the term bipolar disorder is explicitly reserved for episodic presentations of bipolar symptoms. DSM-IV did not include a diagnosis designed to capture youths whose hallmark symptoms consisted of very severe, non-episodic irritability, whereas DSM-5, with the inclusion of disruptive mood dysregulation disorder, provides a distinct category for such presentations.

### Prevalence

Disruptive mood dysregulation disorder is common among children presenting to pediatric mental health clinics. Prevalence estimates of the disorder in the community are unclear. Based on rates of chronic and severe persistent irritability, which is the core feature of the disorder, the overall 6-month to 1-year period prevalence of disruptive mood dysregulation disorder among children and adolescents probably falls in the 2%–5% range. However, rates are expected to be higher in males and school-age children than in females and adolescents.

### Development and Course

The onset of disruptive mood dysregulation disorder must be before age 10 years, and the diagnosis should not be applied to children with a developmental age of less than 6 years. It is unknown whether the disorder presents only in this age-defined manner. The symptoms of disruptive mood dysregulation disorder are likely to change as children grow, and use of the diagnosis should be restricted to age groups within which its validity has been established (7–18 years). Approximately half of children with severe, chronic irritability will have a presentation that continues to meet criteria for the condition 1 year later. Rates of conversion from severe, nonepisodic irritability to bipolar disorder are very low. Children with chronic irritability are at risk for developing depressive and/or anxiety disorders in adulthood.

Age-related variation also differentiates classic bipolar disorder and disruptive mood dysregulation disorder. Rates of bipolar disorder generally are very low for adolescents (<1%), with a steady increase into early adulthood (1%–2% prevalence). Disruptive mood dysregulation disorder is more common than bipolar disorder prior to adolescence, and symptoms of the condition generally become less common as children transition into adulthood.

### Risk and Prognostic Factors

Temperamental. Children with chronic irritability typically exhibit complicated psychiatric histories. In such children, a relatively extensive history of chronic irritability is 158 Depressive Disorders

common, typically manifesting before full criteria for the syndrome are met. Such prodromic presentations may have qualified for a diagnosis of oppositional defiant disorder. Many children with disruptive mood dysregulation disorder have symptoms that also meet criteria for attention-deficit/hyperactivity disorder (ADHD) and for an anxiety disorder, with such diagnoses often being present from a relatively early age. For some children, the criteria for major depressive disorder may also be met.

Genetic and physiological. In terms of familial aggregation and genetics, it has been suggested that children presenting with chronic, non-episodic irritability can be differentiated from children with bipolar disorder in their family-based risk. However, these two groups do not differ in familial rates of anxiety disorders, unipolar depressive disorders, or substance abuse. Compared with children with pediatric bipolar disorder or other mental illnesses, those with disruptive mood dysregulation disorder exhibit both commonalities and differences in information-processing deficits. For example, time-emotion labeling deficits, as well as perturbed decision making and cognitive control, are present in children with bipolar disorder and chronically irritable children, as well as in children with some other psychiatric conditions. There is also evidence for disorder-specific dysfunction, such as during tasks assessing attention deployment in response to emotional stimuli, which has demonstrated unique risks of dysfunction in children with chronic irritability.

### Gender-Related Diagnostic Issues

Children presenting to clinics with features of disruptive mood dysregulation disorder are predominantly male. Among community samples, a male preponderance appears to be supported. This difference in prevalence between males and females differentiates disruptive mood dysregulation disorder from bipolar disorder, in which there is an equal gender prevalence.

### Suicide Risk

In general, evidence documenting suicidal behavior and aggression, as well as other severe functional consequences, in disruptive mood dysregulation disorder should be noted when evaluating children with chronic irritability.

### Functional Consequences

Disruptive Mood Dysregulation Disorder Chronic, severe irritability, such as is seen in disruptive mood dysregulation disorder, is associated with marked disruption in a child's family and peer relationships, as well as in school performance. Because of their extremely low frustration tolerance, such children generally have difficulty succeeding in school; they are often unable to participate in the activities typically enjoyed by healthy children; their family life is severely disrupted by their outbursts and irritability; and they have trouble finding or sustaining friendships. Levels of dysfunction in children with bipolar disorder and disruptive mood dysregulation disorder are generally comparable. Both conditions cause severe disruption in the lives of the affected individual and their families. In both disruptive mood dysregulation disorder and pediatric bipolar disorder, dangerous behavior, suicidal ideation or suicide attempts, severe aggression, and psychiatric hospitalization are common.

### Differential Diagnosis

Because chronically irritable children and adolescents typically present with complex histories, the diagnosis of disruptive mood dysregulation disorder must be made while considering the presence or absence of multiple other conditions. Despite the need to consider many other syndromes, differentiation of disruptive mood dysregulation disorder from bipolar disorder and oppositional defiant disorder requires particularly careful assessment.

Bipolar disorder. The central feature differentiating disruptive mood dysregulation disorder from bipolar disorder in children involves the longitudinal course of the core symptoms. In children, as in adults, bipolar disorder and bipolar I disorder manifest as an episodic illness with discrete episodes of mood perturbation that can be differentiated from the child's typical presentation. The mood perturbation that occurs during a manic episode is distinctly different from the child's usual mood. In addition, during a manic episode, the change in mood must be accompanied by the onset, or worsening, of associated cognitive, behavioral, and physical symptoms (e.g., distractibility, increased goal-directed activity), which are also present to a degree that is distinctly different from the child's usual baseline. Thus, in the case of a manic episode, parents (and, depending on developmental level, children) should be able to identify a distinct time period during which the child's mood and behavior were markedly different from usual. In contrast, the irritability of disruptive mood dysregulation disorder is persistent and is present over many months, while it may wax and wane to a certain degree, severe irritability is characteristic of the child with disruptive mood dysregulation disorder. Thus, while bipolar disorders are episodic conditions, disruptive mood dysregulation disorder is not. In fact, the diagnosis of disruptive mood dysregulation disorder cannot be assigned to a child who has ever experienced a full-duration (hypomanic or manic episode [irritable or euphoric]) in which he or she has ever had a manic or hypomanic episode lasting more than 1 day. Another central differentiating feature between bipolar disorders and disruptive mood dysregulation disorder is the presence of elevated or expansive mood and grandiosity. These symptoms are common features of mania but are not characteristic of disruptive mood dysregulation disorder.

Oppositional defiant disorder. While symptoms of oppositional defiant disorder typically do occur in children with disruptive mood dysregulation disorder, most symptoms of disruptive mood dysregulation disorder are relatively new in children with oppositional defiant disorder. The key features that warrant the diagnosis of disruptive mood dysregulation disorder in children whose symptoms also meet criteria for oppositional defiant disorder are the presence of severe and frequently recurrent outbursts and a persistent disruption in mood between outbursts. In addition, the diagnosis of disruptive mood dysregulation disorder requires severe impairment in at least one setting (i.e., home, school, or among peers) and mild to moderate impairment in a second setting. For this reason, while most children whose symptoms meet criteria for disruptive mood dysregulation disorder will also have a presentation that meets criteria for oppositional defiant disorder, the reverse is not the case. That is, in only approximately 15% of individuals with oppositional defiant disorder would criteria for disruptive mood dysregulation disorder be met. Moreover, even for children in whom criteria for both disorders are met, only the diagnosis of disruptive mood dysregulation disorder should be made. Finally, both the prominent mood symptoms in disruptive mood dysregulation disorder and the high risk for depression and anxiety disorders in follow-up studies justify placement of disruptive mood dysregulation disorder among the depressive disorders in DSM-5. (Oppositional defiant disorder is included in the chapter "Disruptive, Impulse Control, and Conduct Disorders.") This reflects the more prominent mood component among individuals with disruptive mood dysregulation disorder, as compared with individuals with oppositional defiant disorder. Nevertheless, it also should be noted that disruptive mood dysregulation disorder appears to carry a high risk for behavioral problems as well as mood problems.

Attention-deficit/hyperactivity disorder, major depressive disorder, anxiety disorders, and autism spectrum disorder. Unlike children diagnosed with bipolar disorder or oppositional defiant disorder, a child whose symptoms meet criteria for disruptive mood dysregulation disorder also can receive a comorbid diagnosis of ADHD, major depressive disorder, and/or anxiety disorder. However, children whose irritability is present only in the context of a major depressive episode or persistent depressive disorder (dysthymia) 160 Depressive Disorders

should receive one of those diagnoses rather than disruptive mood dysregulation disorder. Children with disruptive mood dysregulation disorder may have symptoms that also meet criteria for an anxiety disorder and can receive both diagnoses, but children whose irritability is manifest only in the context of exacerbation of an anxiety disorder should receive the relevant anxiety disorder diagnosis rather than disruptive mood dysregulation disorder. In addition, children with autism spectrum disorders frequently present with temper outbursts when, for example, their routines are disturbed. In that instance, the temper outbursts would be considered secondary to the autism spectrum disorder, and the child should not receive the diagnosis of disruptive mood dysregulation disorder. Intermittent explosive disorder. Children with symptoms suggestive of intermittent explosive disorder present with instances of severe temper outbursts, much like children with disruptive mood dysregulation disorder. However, unlike disruptive mood dysregulation disorder, intermittent explosive disorder does not require persistent disruption in mood between outbursts. In addition, intermittent explosive disorder requires only 3 months of active symptoms, in contrast to the 12-month requirement for disruptive mood dysregulation disorder. Thus, these two diagnoses should not be made in the same child. For children with outbursts and intermittent, persistent irritability, only the diagnosis of disruptive mood dysregulation disorder should be made.

### Comorbidity

Rates of comorbidity in disruptive mood dysregulation disorder are extremely high. It is rare to find individuals whose symptoms meet criteria for disruptive mood dysregulation disorder alone. Comorbidity between disruptive mood dysregulation disorder and other DSM-defined syndromes appears higher than for many other pediatric mental illnesses. The strongest overlap is with oppositional defiant disorder. Not only is the overall rate of comorbidity high in disruptive mood dysregulation disorder, but also the range of comorbid illnesses appears particularly diverse. These children typically present to the clinic with a wide range of disruptive behavior, mood, anxiety, and even autism spectrum symptoms and diagnoses. However, children with disruptive mood dysregulation disorder should not have symptoms that meet criteria for bipolar disorder, as in that context, only the bipolar disorder diagnosis should be made. If children have symptoms that meet criteria for oppositional defiant disorder or intermittent explosive disorder and disruptive mood dysregulation disorder, only the diagnosis of disruptive mood dysregulation disorder should be assigned. Also, as noted earlier, the diagnosis of disruptive mood dysregulation disorder should not be assigned if the symptoms occur only in an anxiety-provoking context, when the routines of a child with autism spectrum disorder or obsessive-compulsive disorder are disturbed, or in the context of a major depressive episode.

### Major Depressive Disorder

### Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week