Tutorial Assignment 2

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Introduction

Disruptive Mood Dysregulation Disorder (DMDD) is a mood disorder that is characterised by severe temper outbursts and persistent irritability, most of the time, across multiple contexts (American Psychiatric Association [APA], 2013; Baweja et al., 2016; Frances, 2013; Lochman et al., 2015). When it was initially included in the DSM-5, there was a growing recognition of a pandemic of over-diagnosis of Bipolar Disorder among children who displayed tempers (Baweja et al., 2016; Lochman et al., 2015). This tended to weigh these children down with the implications of a Bipolar diagnosis, and unnecessary and distressing treatments (Frances, 2013; Lochman et al., 2015). DMDD was meant to fix this, but threatens to introduce a host of new problems instead. Criticism of the inclusion ranges from a lack of valid studies to support the disorder to worries that the diagnostic criteria of DMDD create a real risk that it will be overdiagnosed (Baweja et al., 2016; Frances, 2013; Lochman et al., 2015)

As above, this essay began with the background and context of DMDD, and a description of the disorder. Following, this essay will present and discuss why DMDD should remain in the DSM and why it should not. Then, this essay will summarise the literature, and I will explain why I think that DMDD fails to adequately solve the problem it was created to deal with, and outline some potential alternatives.

Advantages and Disadvanteges

As mentioned above, prior to the DSM-5 there was a broadening of the definition for Bipolar Disorder (BD) in children in order to explain to some degree impairment caused by irritabilit, anger, and temper outbursts (Baweja et al., 2016; Mahli and Bell, 2019). The rising rate of diagnoses for BD in children coincided with increased innapropriate and unsafe use of adult antipsychotics on children (Baweja et al., 2016; Frances, 2013; Lochman et al., 2015; Mahli and Bell, 2019). At the same time, however, the impairment and harm that this over-diagnosis was trying to address is real, the chronic irritability and anger, the outbursts do cause these children harm and they should be given treatment of some kind (Baweja et al., 2016). Clearly this is an issue that needs to be resolved, there are children that experience impairment that harms

them, but they are also harmed by the diagnosis of BD. The creation of DMDD theoretically fixes this error by creating a new construct that describes this impairment without attaching itself to BD and adult antipsychotics (Baweja et al., 2016; Frances, 2013; Mahli and Bell, 2019).

However, DMDD introduced a number of new problems. Firstly, the disorder was included based on very little research of any validity, and what research did exist was originally for a testing construct called Severe Mood Dysregulation, which shared only some of the same criteria as DMDD (Baweja et al., 2016; Frances, 2013; Lochman et al., 2015; Mahli and Bell, 2019). Furthermore, there is an issue with the construct itself. The only aspect of DMDD that cannot be accounted for in Oppositional Defiant Disorder (ODD) is irritability, to the point that if one ignores the comorbidity restriction on DMDD, almost all children with DMDD would simply have an ODD diagnosis (Baweja et al., 2016; Lochman et al., 2015; Mahli and Bell, 2019; Mayes et al., 2016; Mayes et al., 2019). Irritability is the only symptom of DMDD that does not exist in ODD (APA, 2013). However, irritability is a feature of many other mood and behavioural disorders, and is often a reaction to the symptoms of another disorder (Mahli and Bell, 2019; Mayes et al., 2016; Mayes et al., 2019). Additionally, the criteria themselves are vague. There is no clear definition of 'temper outbursts' and how to distinguish them from normal expressions of a child's emotions at their development level (Baweja et al., 2016; Frances, 2013; Mahli and Bell, 2019). The duration and age restrictions require that clinicians diagnose children based on the children's guardians' impressions and their own impressions (Mahli and Bell, 2019). DMDD also does not have clear treatment guidelines, and oftentimes clinicians are left to figure out how to treat children on their own, more often than not with antipsychotics and antidepressants (Mahli and Bell, 2019). As a result, in practice there is incredibly little agreement between clinicians on individual cases, and therefore a real threat of DMDD itself becoming massively overdiagnosed (Frances, 2013; Lochman et al., 2015; Mahli and Bell, 2019). Essentially, DMDD has created the same problem that it was originally designed to fix.

Conclusion

While DMDD was included for a noble cause, reducing the danger an innapropriate BD diagnosis would have on a child, its inclusion seems ill-informed. There is an alternative route that can be taken, recommended by the task-force for the World Health Organisation's ICD-11. Instead of an unnecessary new construct, the ICD-11 simply added an addendum to ODD that specified whether or not the child had irritability, the only symptom that ODD does not share with DMDD (Lochman et al., 2015; Mahli and Bell, 2019; Mayes et al., 2016; Mayes et al., 2019). This was supported by robust empirical data, and achieved its goal without adding an entirely new vector for misdiagnosis (Mayes et al., 2016; Mayes et al., 2019). Finally, ODD already has a number of clear treatments that are useful for children with DMDD, so there is significantly less risk of misdiagnosis leading to severely negative outcomes (Lochman et al., 2015; Mayes et al., 2016; Mayes et al., 2019).

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