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CASE REPORT
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Unraveling the Diagnostic Challenge: A Case Report on Disruptive Mood Dysregulation Disorder

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Introduction

The DSM-5 diagnostic criteria for disruptive mood dysregulation disorder (DMDD) require outbursts that are grossly out of proportion to the situation. These temper outbursts present with verbal rages or physical aggression towards people or property and are inappropriate for the child's developmental level. Temper outbursts occur, on average, three or more times per week, with variations in mood between outbursts. Symptoms must be exhibited before age 10 years, be present for at least 12 months, and be present within at least two settings.[1] A newer addition to DSM-5, DMDD is often underdiagnosed, especially in the case of other childhood comorbidities. Here is an interesting case report on DMDD with an attempt to emphasize the importance of meticulously observing every symptom, including irritability, to discern its underlying cause and phenomenology for precise diagnosis.

Informed Consent

The following case is presented after informed consent from the patient and his legal guardian-mother, as the child is below 18 years of age.

Case Summary

A 16 years old male patient was brought to OPD by his mother and admitted to the Psychiatry Department with the following complaints since last 6 to 7 years that had worsened in the last 3 to 4 years: Episodes of irritability without provocation, marked by clenching of teeth, physical aggression, hitting oneself and relatives, and punching walls. There were 3 to 4 such episodes per day, including at home, the workplace, and school, each lasting for ½ to 1 hour. He was expelled from the school for the same reason, leading to significant socio-functional impairment. His mother reported that he remained unexplainably irritable and angry most of the day. The inter-episodic mood always remained irritable. There were no somatic symptoms or alteration in sleep or appetite. There had never been a distinct period or other complaints lasting for more than a day for manic, hypomanic, or other symptoms to be met. His home atmosphere was

cordial, with no prior records of substance abuse or a victim of bullying, violence or abuse. He has been reportedly short-tempered, irritable and introverted since childhood. The mother had previously consulted OPD five times for irritability, physical aggression and poor scholastic performance. He didn't have any family history of mood disorders, but his mother was diagnosed with schizophreniform disorder and was on treatment for it. After history and observation, he was advised an intelligence quotient (IQ) assessment, which turned out to be borderline (78) on the Binet Kamat intelligence test. Differential diagnoses like behavioral disturbance due to poor understanding, hypomania and oppositional defiant disorder were considered, but later two were discarded due to failure to meet diagnostic criteria. He was subjected to eight cognitive behavior therapy (CBT) sessions, considering his complaints were behavioral disturbances secondary to low IQ. However, minimal improvement warranted admission and longer in-patient observation. After five serial interviews, the patient himself reported that he had unprovoked episodes of excessive irritability and that he couldn't control it even if he tried hard. He had to punch walls, beat himself or his relatives, or verbally abuse others to relieve his anger. Lab evaluations, including EEG and MRI were within the normal range. He was considered to meet the criteria for DMDD as per DSM 5 and T. Lithium carbonate (600 mg/day) was started as an anti-impulsive agent along with CBT sessions. He was observed as an in-patient for 9 days and discharged with a 60% improvement on the same treatment. After serial follow-ups and five CBT sessions over two months, 80 to 85% improvement is observed and reported; he is allowed to join school next semester and has improved relationships with peers at work. The patient reports subjective improvement in mood and quality of life.

Discussion

DMDD itself is a rare diagnosis, with its lifetime prevalence being 3% in children aged 9 to 19 years.[2,3] DMDD is often missed or misdiagnosed on the lines of bipolar mood disorder, oppositional defiant disorder or attention deficit hyperkinetic disorder.[4] The case report emphasizes meticulously observing every symptom, including irritability, highlighting the importance of thorough assessment in diagnosing mental health disorders. Irritability, although common, can manifest differently depending on the underlying cause and context. For instance, in DMDD, irritability is pervasive and severe, impacting various aspects of a child's life, including their relationships and academic performance.

DMDD exhibits markedly decreased activation of the paralimbic system (cingulate gyrus, striatal, thalamic, parietal, and parahippocampal regions) after negative feedback.[5] In DMDD, the prefrontal lobe tends to show less activity in comparison to bipolar mood disorder, which shows overactivity.[5] By paying close attention to the nuances of irritability and other associated symptoms, clinicians can differentiate DMDD from other comorbidities. This precision in diagnosis is crucial for developing tailored treatment plans and improving outcomes for patients. Longitudinal studies thus far have shown that patients with DMDD in childhood have a high risk of progression to major depressive disorder, dysthymic disorder and anxiety disorders over time.[2] Understanding the phenomenology of DMDD involves considering its developmental trajectory, comorbidities, and response to interventions. This comprehensive approach ensures that individuals receive appropriate support and interventions to manage their symptoms effectively.

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