TPM Vol. 32, No. S1, 2025
ISSN: 1972-6325
https://www.tpmap.org/

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A CASE REPORT ON DISRUPTIVE MOOD DYSREGULATION DISORDER

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Abstract:

Disruptive Mood Dysregulation Disorder (DMDD) is a challenging pediatric condition characterized by chronic irritability and severe temper outbursts, often leading to significant functional impairment. This case report highlights the management of a teenage girl with DMDD, presenting with mood lability, anger outbursts, and sleep disturbances. A multimodal treatment approach, including psychoeducation, cognitive-behavioral therapy, and pharmacotherapy with Olanzapine, Escitalopram, and Clonazepam, was implemented. The intervention led to marked improvements in mood stability, reduced anger episodes, and better social and academic functioning. The case emphasizes the importance of early diagnosis, consistent treatment adherence, and comprehensive care in achieving favorable outcomes in DMDD.

INTRODUCTION:

Disruptive Mood Dysregulation Disorder (DMDD) is a relatively recent addition to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). It is characterized by severe irritability, frequent temper outbursts, and chronic mood dysregulation in children and adolescents. Epidemiological studies suggest a prevalence of 0.8% to 3.3% in community samples, with higher rates observed in clinical populations. DMDD is often associated with significant functional impairment, increased familial distress, and a heightened risk of developing depressive or anxiety disorders later in life. Recent trends underscore the importance of early diagnosis and intervention to mitigate the disorder's long-term impact on emotional, social, and academic development. This case underscores the complexities of managing DMDD in paediatric patients, particularly those with irregular treatment adherence, highlighting the importance of comprehensive and consistent care for effective outcomes.

CASE REPORT:

Miss C, a girl in her early teens, was brought to the child and adolescent psychiatry clinic due to a range of concerning symptoms. Her parents reported frequent episodes of inconsolable crying during the night, with Miss C unable to recall these episodes the following morning. These episodes required parental reassurance for resolution. Over the

past year, she exhibited increasing irritability, unprovoked anger outburst, physical and verbal aggression, particularly directed towards her parents. Additional concerns included demanding behavior, school refusal and sleep disturbances in the form of initiating and maintaining. Her symptoms caused significant impairment in her daily functioning, including academic and social domains.

Miss C was born by normal vaginal delivery and achieved normal developmental milestones. She had a slow to warm up temperament. She attained menarche at the age of 11 years, with no mood or behavioral changes during peri-menstrual periods. Her medical history revealed irregular medication usage and sporadic follow-up visits since her initial psychiatric diagnosis in 2022.

A thorough clinical workup was conducted. Baseline investigations, including complete blood count, were within normal limits. CT brain was done to rule out organic causes and was unremarkable. Pediatric opinion was obtained to exclude genetic disorders. An IQ assessment indicated average intellectual functioning. Rating scales, including the Hamilton Depression Rating Scale (HAM-D) and Child Behavior Rating Scales, were administered to quantify symptom severity. Given the severity of her anger outbursts and the inability to manage her at home, Miss C was admitted for comprehensive evaluation and management. Clinical assessment revealed mood lability, impaired emotional regulation, and heightened irritability. These symptoms, along with her history, supported a diagnosis of Disruptive Mood Dysregulation Disorder (DMDD). A comprehensive treatment plan was initiated, including parent psychoeducation, cognitive-behavioral therapy (CBT), and pharmacotherapy.

Pharmacotherapy began with tablet Olanzapine at an initial dose of 2.5 mg at night, gradually titrated up to 7.5 mg per day in divided doses to stabilize mood and manage emotional dysregulation. Tablet Escitalopram 5 mg was introduced in the morning to address persistent mood symptoms. Tablet Clonazepam 0.25 mg at bedtime was prescribed primarily to improve sleep. With significant improvement in symptoms, the medication regimen was optimized: Olanzapine was tapered to 5 mg at bedtime, Escitalopram was maintained at 5 mg in the morning, and Clonazepam was continued at 0.25 mg at bedtime for sleep support.

The treatment plan aimed to equip Miss C and her family with a thorough understanding of the illness, emphasize the importance of regular follow-ups and medication adherence, and provide them with effective coping strategies and management techniques.

Over time, significant improvements were observed in Miss C's mood stability, reduction in anger outbursts, and better interpersonal interactions. School attendance improved, and her overall well-being indicated a positive response to the tailored intervention.

DISCUSSION:

Disruptive Mood Dysregulation Disorder (DMDD) presents unique challenges in pediatric mental health care due to its chronic irritability and temper outbursts, which can disrupt familial and social functioning. This case exemplifies the significant impact of inconsistent treatment adherence on symptom severity and functional impairment. Early intervention and sustained follow-up are essential to improving outcomes.

The multimodal approach employed psychoeducation, CBT, and pharmacotherapy which proved effective for Miss C. Psychoeducation empowered her family to better understand and manage her condition, while CBT addressed her emotional dysregulation. Pharmacotherapy augmented these efforts by stabilizing her mood. The integration of these modalities emphasizes the importance of a holistic treatment strategy in managing DMDD.

This case also highlights the necessity of addressing systemic barriers such as irregular follow-up, which can hinder recovery. Enhanced therapeutic engagement and family involvement are key to overcoming these challenges, enabling sustained symptom relief and functional improvement.

Conclusion:

This case underscores the critical importance of early diagnosis, consistent treatment, and comprehensive care strategies in managing Disruptive Mood Dysregulation Disorder. The integration of psychoeducation, psychotherapy, and pharmacological treatment, combined with regular follow-up, significantly improved outcomes for Miss C. These findings support the role of tailored, multimodal interventions in addressing the complexities of DMDD.

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