Welcome back to Nimble Youth, the podcast where we navigate the complex world of pediatric mental health with expert guidance and practical insight. I'm your host, Matt Butterman. Today, we're tackling a condition that can be as confusing as it is distressing for both kids and parents. It's called disruptive mood dysregulation disorder or DMDD. While it may not be as widely recognized as ADHD or anxiety, DMDD has a profound impact on the emotional and behavioral health of many children.

DMDD is characterized by severe and frequent temper outburst that are grossly out of proportion to the situation and is paired with a persistently irritable or angry mood. It's not just acting out. It's a very serious condition that affects a child's ability to function at home, in school, and in relationships. Here are a couple key facts to know. Up to three percent of children and adolescents are affected by DMDD, making it more common than many parents and even some professionals realize.

And among children who receive mental health services for chronic irritability or explosive anger, as many as forty percent may meet criteria for DMDD. To help us unpack what DMDD looks like, how it's diagnosed, and what parents can do to support their child, I'm joined once again by our trusted guest, pediatrician doctor Gretchen Hoyle, who brings over twenty five years of experience from the clinical front lines. Before we get into it, we remind you that the content of this podcast is intended for informational purposes only and should not be construed as medical advice. While we aim to provide valuable insights on pediatric mental health, it's very important to consult with a qualified health care professional for any concerns or questions regarding your child's mental well-being. Always seek the advice of your doctor, therapist, or other qualified health provider with any medical or mental health concerns.

Doctor Hoyle, welcome back to Nimble Youth. So let's start with the basics. What exactly is DMDD? Sure. Thanks for having me.

So DMDD, like you said in the introduction, stands for disruptive mood dysregulation disorder. So lots of “dys” is in there. It's a childhood mood disorder, So it's in the family of mood disorders, but it's also defined by frequent severe temper outbursts that can be verbal or physical that are typically way out of proportion to the situation that triggered them. So something typically fairly minor between siblings or a parent correction or something can become a really out of proportion response. Right.

Yeah. And not something we'd call typical, misbehavior or or Correct. Or SAS talk back sort of thing. Right? Right.

But then the other, like, hallmark of this condition is that between these episodes of outbursty, tantrum-y behavior, the child has a baseline of sort of irritability and anger that's there most of the day, almost every day. And so that's sort of their mood is, you know, not normal to start with, and then they will have these episodes of outbursts that punctuate their day to day lives. What are the ages of diagnosis typically for DMDD? Yeah. So, typically, the diagnosis is made. It needs to be made, you know, based on the criteria between the ages of six and 18.

Some Symptoms have to start before age 10, but it really can be any any time during that, window. Mhmm. Yeah. And and talking about the sort of outburst or tantrums, is there a sort of a measure of how dysfunctional it has to be before you make that diagnosis? Right.

Yeah. So I'd like to use a metaphor to sort of describe what this looks like in a clinical situation. And so, if you think of it this way where, let's say, that you have a dock that's on the sound that is connected to the ocean. So the reason that's important is because there's high tide and low tide in this situation. Right?

And the dock is fixed in relation to the bottom of the sound. So it's not a floating dock, just for people who may wanna wanna have more information about the, what we're describing here. So if you have a a boat that's tied to that dock, in order for that relationship to be functional, the boat needs to be positioned lower than the dock. Okay? And so then there are four potential situations that you can have with regard to kids and sort of and these outbursty behavior y things.

Okay. So let's say that you have what everyone kinda wants to have, which is, let's say, this is a low tide kid. And by that, the analogy there is that they basically have a fairly low amount of irritability and anger and, you know, anxiety, and they're pretty chill. And they may, you know, so their boat is at low tide. And they may have the occasional storm tantrum y kind of thing, which is normal.

But because their boat, you know, starts at low tide, then when the storm comes in, the water may rise a little bit, but it's not a huge deal, and the boat still is in the right position. And then another potential, you know, relationship there would be that you have a low tide kid, but that that kid has the occasional, you know, storms. And those storms can be, you know, can actually be kind of frequent. And in that situation, you know, you're starting at low tide and you're getting these storms. So there is some water that's sort of sloshing up onto the dock, but it's not so much that it becomes dysfunctional.

Right? Okay. And so then let's say that you can also be in a situation where you have a high tide kid. So in this, like, analogy, we're saying that high tide would mean that their baseline level of, like, irritability and anxiety and anger is fairly high. And so that, I think a lot of times people sort of think of that as sometimes that's the way that teenagers act.

Right? Where they're just sort of grouchy and grumpy kinda all the time or it feels like it's, you know, and they'll go through, you know, different phases of that. And a lot of times people are like, oh, it's, you know, they're teenagers. That's sort of getting chalked up to, you know, adolescence. And a lot of times that is, you know, just sort of what it is.

And they're at high tide and there's sort of baseline irritability, but they don't tend to engage in like tantrum y behavior. Right? So, if they get up if they get irritated by somebody, they're just gonna go to their room and, you know, be grouchy and, you know, that's just that's just them.

And it's and that also is still, for the most part, fairly functional. I mean, you know, they're still doing their usual things throughout the day to function.

And so then you can imagine the last, you know, possible relationship here, which is that you have a high tide kid. Right? So their baseline level of irritability and anxiety is already high. And then they also, on top of that, have these storms that are really frequent. So at least three times a week, they're very intense.

So you have all of this, you know, stuff that's happening during the sort of tantrum y behavior. Aggression could be physical, could be verbal, could be breaking things, could just generally look like a fairly, you know, person who is pretty out of control. Right? And they can have a fairly long duration. So when you have that combination, so what you're having then you have storms that are coming in frequently and they're coming in at high tide.

So those two things together means that there's a lot of water that is coming up and washing over that dock, and it may even push the boat up on top of it. And now everything's, you know, not in the right position, and it's dysfunctional. And that's kind of what, you know, it is like for families where their child has this condition. So DMDD where their baseline they have baseline irritability, and then they have additional episodes of tantrum y outbursty behavior. Right.

It's a tempest. It's like a tsunami that has, you know, broad effects on the family. Right? It really does. It is the kind of thing where, you know, parents will describe that they feel like they're walking on eggshells and that, you know, other, like, other kids in the family or siblings are, you know, sort of constantly trying to not get into it with the kid who, you know, has this condition, it is, it it can be extremely disruptive.

Yeah. Right. For sure. Yeah. Right.

And so, in the introduction, I think I gave a statistic of about four percent of youth diagnosed with this. So is it I guess, in the range somewhere between two and five percent, they're saying. But, you see it more in boys than in girls. Is that right? Yeah.

And I think, you know, a lot of these sort of outbursty, like, what we call in previous podcasts these externalizing symptoms where you're having some aggression and, and the kinds of things that would get you in trouble at school or in a different setting. And so a lot of times, those tend to be more common in boys, but it can definitely happen in girls as well. Right. And so DMDD doesn't always show up on its own. Right?

Or probably, you know, fairly infrequently, it would be on its own. Right? Yes. I mean, I think a lot of times and and I will say that, for a lot of patients who end up with a diagnosis of DMDD, they are often being cared for by psychiatrists. Right?

So this is, this is, you know, fairly complex stuff. What will sometimes happen is that in the general pediatrics clinic that we will be seeing a patient who has what looks to be like it's kind of

an overlap of ADHD and anxiety. And most kids who ultimately get a diagnosis of DMDD will have had those diagnoses as well. Right? And so if you think about it, like, their anxiety almost represents, you know, whether they're low or high tide.

Like, that's the sort of their baseline, like, mood. Right? And if that if they're super anxious, then they can seem pretty irritable and angry, and so that's sort of their baseline mood. And then ADHD can often be representative of these impulsive episodes of aggression and outburst behavior. And so a lot of times what's happened is that we in the general pediatrics clinic have said, oh, you know, we need to manage your ADHD and anxiety.

And so we'll, you know, we'll do that. But if we're not, like, successful at getting things better, in that setting, then a lot of times we'll ask for help from the psychiatrist. General pedes. Yeah. Right.

Right. So, when a child comes in perhaps with their parents, you know, and, you track some of these symptoms Yeah. That are there. How do you make that final diagnosis? What are some of the tools that you use?

Right. So we would, you know, rely again on our anxiety and ADHD screeners that we have talked about in previous podcasts. There's also another screening tool called the MOAS. That's the modified overt aggression scale. And it asks questions about, like, sort of aggressive behavior.

And it breaks it down into, you know, is this aggression, like, verbal against, you know, another person, like, shouting at somebody or cursing or, you know, like that kind of aggression or physical aggression? Or is there aggression against property, like they're breaking things? Or even self, you know, aggression. Right? So head banging or that kind of thing.

And so, that is another tool that we can use. And the MOAS asks some specific questions about the frequency, like how often this is happening because that's a big component of the DMDD diagnosis. And so, you know, a psychiatrist will often kinda go down those questions and see if we can check the, you know, requirements for making that diagnosis. Right. Yep.

Do we know what causes DMDD? Yeah. That's a great question. So, like most mood disorders, you know, there is certainly a genetic component. And so, you know, for sometimes we'll have folks who have, like, mood disorders that run-in the family, and then that will maybe shed some light for us on, you know, what's happening with the child.

But there's a genetic component to it. But there's often also, you know, some exposure to trauma or family stress, And sometimes that those those conditions can appear more frequently in kids who, you know, sometimes it's kids who are in foster care or have been adopted or some other, like, early issue that may have kinda pushed them in that direction, if that makes sense. Yeah. That's not always the case, but that can be associated with it. And it's also just generally, like, neurologically, it's just similar to just having difficulty with emotional regulation.

So, you know, we talked about ADHD as being, you know, a disorder of executive function and self regulation. Well, this has has all that in spades, but, like, especially the emotional regulation part of the neurologic, function of your brain being able to help you regulate those emotions and keep that panicky fight or flight system in check. If that's not working very well, then, you know, that can often lead to these kinda outbursty behaviors. So I guess early on, there was some buzz about DMDD being sort of a childhood version of bipolar disorders or a nascent version of, that. And I certainly have known some folks with bipolar disorders, cyclothymia, and it seems somewhat similar.

But Right. Where do we stand on that now? Yeah. So that's a great question. So the current evidence really suggests that DMDD and bipolar disorder are different.

And, so if you think of bipolar disorder is typically episodic with, like, clear periods of mania and depression, so that's about two poles, whereas DMDD is chronic, and the irritability is just at baseline. It's kinda always there. And then they've also looked, you know, long term. And, you know, the question was, well, do the kiddos who, you know, have a DMDD diagnosis in childhood, do they meet criteria for diagnosis of bipolar disorder in adulthood? And it just doesn't seem to have panned out.

Gotcha. So it just looks like it's a category correctly different thing, although there are a lot of overlaps, like, with any of these conditions. Yeah. Right. Yeah.

So how do we treat DMDD? Mhmm. Yeah. So, you know, first, we really do wanna get some therapy involved. A lot of times, the most effective way to do that, especially with kids who are old enough to, you know, kind of work on techniques to help with their emotions is to start with cognitive behavioral therapy.

And that just helps kids, you know, cognitively, you're trying to get your brain involved with managing your behavior and your emotions. And so that's really our kinda go to, remedy. There's also really good work being done in parent management training, which just teaches, like, consistency structure. And, and that can be really helpful because a lot of times what will set these kids off with these episodes is something that was unexpected that happens, which, you know, that's just life a lot of the time. But to the degree that we can keep things fairly structured, that can be helpful for them, and they're just a little bit better able to manage.

And then there are medication options as well. So a lot of times, by the time we get to a diagnosis of DMDD, kiddos have been on medicine to treat their anxiety and or their ADHD. But there is an additional class of medicines called atypical antipsychotics that are sometimes used, and they can be very helpful, especially if the aggression is severe. For the most part, those medications are managed by psychiatrists. Right.

Yep. And you mentioned that trauma can be a a trigger for DMDD. And, so is there a role for trauma informed care? Absolutely. Yeah.

So so many of these kids have experienced trauma. The therapy that they get needs to reflect that with a focus on building, like, safety, emotional regulation, healthy relationships. Gotcha. Mhmm. So what's the outlook for these kids?

How does the treatment of DMDD pan out? Mhmm. Yeah. So the good news is and, like, there's a theme here in that the earlier we start intervening, the better. With everything.

Yeah. Yep. And so with early intervention and support, you know, most of these kids get quite a bit better. It's pretty remarkable how much improvement. And when we improve their symptoms, that has a lot of sort of downstream effects on sort of everyone around them.

And so it's a really, sort of rewarding condition to manage in order and and if you're, you know, making headway. So that's really good. And so, you know, it does change over time. So a lot of times, you're not getting these outbursty behaviors that you got in childhood. That by the time they're an adolescent, it's more sort of the classic depression or anxiety.

And so then we have to address that, you know, as well with our modalities that we talked about in previous podcasts. But the sooner we get to it, then typically, the better outcome we get. Right. And so for parents, if they think their child, you know, might have Mhmm. DMDD, what are some things to look for?

Right. So it's helpful to sorta like, like, I will often encounter parents in clinic where they're like, they just have, you know, tantrums, like, all the time, and it's exhausting. And then their parents are often fairly traumatized. And so it can take a bit to try to really get to an understanding as to what the frequency, intensity, and duration of these episodes are and then what their baseline, you know, like, irritability is. But the more information that folks can come in with, okay, over the last two weeks, this has happened.

Like, here, it's they've had an outburst that lasted more than three or four minutes, you know, five times, six times. And and maybe a couple of little anecdotal things about what triggered them. And that like, having that information from the parent is super helpful. And we're just gonna do our you know, we're probably gonna do lots of questionnaires to try to get to an understanding as to what we're looking at. But the more, like, aware the parent is of what the patterns are with the child's behavior, the, you know, the quicker we can come to a diagnosis.

Right. Yeah. Right. And as with ADHD, DMDD, can affect the child's performance in school Sure. Pretty pretty severely.

And so, for some of them, I guess, a five zero four Yep. Plan is an option. Yeah. That can be really helpful. And so a lot of times, what that involves is just, you know, basically, being able to take a time out, get some time to, to kinda get themselves together.

And so, you know, it's a lot of sorta meeting the school halfway with, okay. We're gonna do this on our end with therapy and potentially medication. And then the school's like, okay. Well, we're gonna you know, if we are having these episodes, then we're gonna this is the plan for when we're in one. And those two things together can be really helpful.

And then, hopefully, you know, the hope is that they're gonna become less frequent, you know, like shorter duration and less intense over time. Right. Yep. And so, for for, treating DMDD, the collaborative care model we've talked about some of these times is a particularly effective way of treating this right. Can you talk a little bit about how it's done in your practice and Mhmm.

And some others as well? Absolutely. So yeah. So the psychiatric collaborative care model is a is a model that we're using in our practice where we have sort of a multidisciplinary approach, and we use a behavioral health care manager who, will interact with the family and get a really, like, extensive history, which is super helpful from my perspective because, you know, sometimes don't have as much time. And so I want to get, you know, as much information as I can.

My behavior health care manager will collect that information and then she can do things like, help, you know, find the right therapist, talk to the school, and get the accommodations plan. Potentially, we'll do a referral to psychiatry. And then while we're, you know, oftentimes, there's a lag time in getting in with psychiatry. And during that time, we'll manage the child in conjunction with our psychiatric consultant. And so if we needed, we, you know, to do medication, then, we have somebody right there who can help us make good decisions on what direction to go in.

Right. Yeah. And with DMDD being a a sort of a multifaceted issue, it requires a multifaceted solution. Right? I agree.

Absolutely. Yeah. There's a neurologic component, so that often needs to be addressed with medicine. There is a behavioral component, so, like, different therapeutic interventions along those lines are helpful. And then it tends to incur in you know, in order to meet the criteria, it has to be happening in more than one, like, in more than one context.

So you have to involve the school at some level. I mean, like, if they're having an outburst at school, then we need to be able to have connection with the school to be able to, you know, put in place the accommodations they need. Right. Yep. And for the parents who are dealing with this, which is a a a major problem for the whole family Mhmm.

I think it's important to remember that, it's not a reflection of your No. Your parenting. It's just one of those things. And and, you know, the earlier you stop blaming yourself and Right. Get in to see Come on in.

Absolutely. Yeah. And I mean, I have tons of families where they have this condition in one child, but they have other children who don't have it. So it's not, you know, it's not a parenting

thing. It's the there are things that we can do that can make parenting more effective for people who have this condition.

But, the earlier we get a chance to make a, you know, an assessment, then the better. Absolutely. Well, thanks again, doctor Hoyle, for your insight on this condition that we have not covered, until now. So, it was very insightful and informative to learn about it. And, thank you to our listeners for joining us on the Nimble Youth Podcast.

Please do visit our website at www.nimbleyouthpodcast.com for recordings of past episodes and the show notes for each episode. Until next time, please take care of yourselves and each other.