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Need of collaborative approach for decision making in terms of identification and management of disruptive mood dysregulation disorder and the indispensable role of parents, peers. Teachers and community healthcare workers

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Abstract
Introduction: Disruptive mood dysregulation disorder (DMDD) is a mental disorder of children and adolescents. The main feature of this disorder is the presence of persistently irritable or angry moods and frequent temper outbursts. The symptoms may disrupt many areas of a child's life such as Family, School, and social settings in the form of Family conflict, difficulty in an interpersonal relationship with peers and other members of society, and difficulty in academic performance and peer relation at school, School suspensions, and an environment of stress. According to DSM-V diagnostic criteria for diagnosis, the symptoms must be 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. The symptoms are observable by parents, family members, peers, and school teachers. Pharmacological and Psychological treatments are two major types of treatment currently used to treat disruptive mood dysregulation disorder symptoms. Psychological treatments include Cognitive-behavioral therapy exposure-based Cognitive Behavioral Therapy**,** Interpersonal psychotherapy, Integrative Group, Dialectical Behaviour, Emotion Regulation Training, Parent Training, and Computer-based training.
Conclusion: According to DSM-V diagnostic criteria for diagnosis, the symptoms must be present in at least two of three settings and are severe in at least one of these and the symptoms must be observable by parents, family members, peers, and school teachers. The most of the treatment approach is based on teaching or behavior modification, and applicable for children as well as parents teachers, and caregivers, many studies focused on teaching one factor such as either parents or teachers, so teaching one group is not efficient for diagnosis, because identification and treatment need multidimensions approach, it is necessary to train together to all stakeholders responsible for children mental health, it is necessary to educate parents, teachers, and community healthcare workers for better identification because the collaborative decision is beneficial for children with disruptive mood dysregulation disorder.

Keywords: DMDD, collaborative approach, disruptive disorder, mental disorder, mood dysregulation

Introduction

Disruptive mood dysregulation disorder (DMDD) is a mental disorder of children and adolescents. The main feature of this disorder is the presence of persistently irritable or angry moods and frequent temper outbursts [1]. The symptoms may disrupt many areas of a child's life [2], such as Family, School, and social settings in the form of Family conflict, Difficulty in social relationships with peers and other members of society, and difficulty in academic performance and peer relation at school, School suspensions, and an environment of stress [3]. Multiple psychosocial factors such as broken family, lower parental support and parental marital satisfaction, family conflict, family history of psychiatric illness, childhood abuse [4], and co-morbid disorders are common contributory factors [5]. The maternal mood symptoms during pregnancy, maternal depression during the first years after childbirth, and low maternal level of education are early risk factors for developing DMDD by 11 years of age [6]. According to DSM-V diagnostic criteria presence of Severe recurrent temper outbursts that are grossly out of proportion in intensity/duration to the situation/provocation, inconsistent with developmental level, three or more times per week with the presence of persistently irritable or angry between temper outbursts are common symptoms of DMDD. The symptoms must be 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 [3] and the symptoms are observable by parents, family members, peers, and school teachers are necessary for the diagnosis of DMDD. A study reported that Irritability, temper tantrums, verbal rages, and physical aggression toward family members were the most common presenting complaints [7]. Pharmacological and Psychological treatments are two major types of treatment approach currently used to treat disruptive mood dysregulation disorder symptoms. Psychological treatments include Psychotherapy, Parent training, and Computer-based training. Pharmacological treatment is done in either hospital or community settings by registered medical personnel. While Psychological treatments need a multidimensional approach. Cognitive-behavioral therapy is commonly used to teach children and teens how to deal with thoughts and feelings that contribute

to their feeling depressed or anxious [3]. Exposure-Based Cognitive Behavioural Therapy is used to teach Parents about how to tolerate their emotional responses to their youth's irritability and increase their adaptive contingencies for their youth's behaviour [8]. Interpersonal psychotherapy (IPT) with modifications improves mood symptoms by improving relationships, through building adaptive interpersonal skills [9]. Integrative Group Therapy significantly improves parent-rated irritability [10]. Dialectical Behaviour focuses to teach children adaptive coping skills and teaching their parents how to reinforce effective behaviors at home, Emotion Regulation Training decreases depression, stress, and anxiety, and Irritability [11, 12]. Parent management training focuses on improving the parent-child relationship. Computer-based training is effective for irritable youth with disruptive mood dysregulation disorder who may prone to misperceiving ambiguous facial expressions as angry.

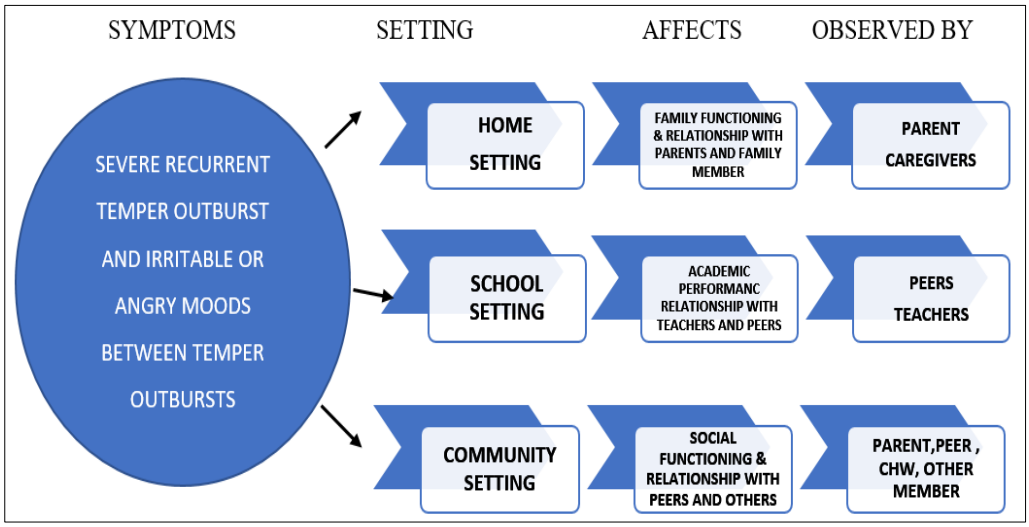

Fig 1: Symptoms expression and observation

Conclusion

The symptoms of Disruptive mood dysregulation disorder disrupt family, School, and society. Multiple psychosocial factors such as family, parental factors, history of psychiatric illness, childhood abuse, and co-morbid disorders are common contributory factors. According to DSM-V diagnostic criteria for diagnosis, the symptoms must be present in at least two of three settings such as home, school, or with peers and are severe in at least one of these and must be observable by parents, family members, peers, and school teachers. The most of the treatment approach is based on teaching or behavior modification for children as well as parents, and most of the treatment is for parents teachers and caregivers, it is also can not be ignored that the lack of trained psychiatric healthcare personnel in Indian villages affects early identification and referral services. The health service in the rural area is provided by ANM, MPW, and ASHA workers, the most focused area of these workers is RCH service and there is a lack of attention is given to the mental health of children and adolescents. The mental health survey of India 2016 also stated that there is low mental health literacy and minimal contribution for other stakeholders in terms of mental health. In most educational intervention studies they focused on one factor in this such as either parents or teachers, so teaching one group is not efficient for diagnosis, because identification and treatment need a multidimensions approach, it is necessary to give teaching intervention together to all stakeholders responsible for children mental health. School teachers, community health workers such as ASHA, ANM, MPW, and RMO are key stakeholders in the rural area responsible for physical health as well as mental health so it is necessary to educate parents, teachers, and community healthcare workers for better identification because the collaborative decision is beneficial for children with disruptive mood dysregulation disorder.

Recommendation

A study for evaluation of Collaborative teaching intervention in terms of knowledge attitude and belief regarding Identification and management of Disruptive mood dysregulation Disorder among parents, Peers. Teachers and Community healthcare workers may be conducted.

Abbreviations

ANM: Auxiliary nurse-midwifery
MPW: multipurpose healthcare workers
RMO: rural medical officer
DMDD: disruptive mood dysregulation disorder
ASHA: Accredited social health activist.

Conflict of interest: None

References

1. Child disruptive mood and behavior. Child disruptive mood and behavior. [Online]. Available from: https://abalancecounseling.com/services/child-disruptive-mood-behavior/#1582742824975-da94aa40-45d9a62e-c32c.
2. Cherry K, Verywell mind. [Online], 2021. [cited 2021 March 29. Available from: https://www.verywellmind.com/disruptive-mood-dysregulation-disorder-

4774447#:~:text=While%20temper%20tantrums%20tend%20to,areas%20of%20a%20child's%20life.
3. Association AP. DSM 5- Diagnostic and Statistical Manual of Mental Disorders Washington: American Psychiatric Association,2013.
4. Samiksha Sahu DSSCPMSMVSK. Demographic and psychosocial profile of disruptive mood dysregulation disorder in Indian settings. Indian Psychiatry Journal,2020:29(2):228-236.
5. Rachel H.B. Mitchell VTJCASAIaBIG. Prevalence and Correlates of Disruptive Mood Dysregulation Disorder Among Adolescents with Bipolar Disorder. Journal of Child and Adolescent Psychopharmacology, 2016, 23-26.
6. Matijasevichad TNMSSAJDBLAFCBA. Perinatal and postnatal risk factors for disruptive mood dysregulation disorder at age 11: 2004 Pelotas Birth Cohort Study. Journal of Affective Disorders,2017:215:263-268.
7. Evren Tufan ZTNDSTUSMkCaBS. Sociodemographic and Clinical Features of Disruptive Mood Dysregulation Disorder: A Chart Review. Journal of Child and Adolescent Psychopharmacology,2016:23:26(2).
8. Perhamus JLKKJBG. Exposure-Based Cognitive-Behavioral Therapy for Disruptive Mood Dysregulation Disorder: An Evidence Based Case Study. Behavior Therapy,2020:51(2):320-333.
9. Leslie Miller SAHML&R. Interpersonal Psychotherapy for Adolescents With Mood and Behavior Dysregulation: Evidence-Based Case Study. Evidence-Based Practice in Child and Adolescent Mental Health,2016:14:1(41):159-175.
10. James G Waxmonsky DAWPBWPNFWEP. A Randomized Clinical Trial of an Integrative Group Therapy for Children With Severe Mood Dysregulation. Journal of the American Academy of Child & Adolescent Psychiatry, 2016:01:55(3):196-207.
11. Francheska Perepletchikova DNSRABFEMJW. Randomized Clinical Trial of Dialectical Behavior Therapy for Preadolescent Children With Disruptive Mood Dysregulation Disorder: Feasibility and Outcomes. Journal of the American Academy of Child & Adolescent Psychiatry,2017:01:56(10):832-840.
12. Hosein Sheybani NM,MN. The Efficacy of Emotion Regulation Training on Stress, Anxiety, Depression and Irritability of the Students With Disruptive Mood Dysregulation Disorder. Iranian Journal of Psychiatric Nursing,2018:5(6):37-44.
13. Garrett M Sparks DAAHYKMDSBB. Disruptive Mood Dysregulation Disorder and Chronic Irritability in Youth at Familial Risk for Bipolar Disorder. Journal of the American Academy of Child & Adolescent Psychiatry,2014:01:53(4):408-416.
14. Susan D. Mayes JDWcaSLCaEOB. Disruptive Mood Dysregulation Disorder Symptoms and Association with Oppositional Defiant and Other Disorders in a General Population Child Sample. Journal of Child and Adolescent Psychopharmacology,2016:01:26(2):101-106.
15. Pei-Yin Pan ATFaCBY. Aripiprazole/Methylphenidate Combination in Children and Adolescents with Disruptive Mood Dysregulation Disorder and Attention-Deficit/Hyperactivity Disorder: An Open-Label Study. Journal of Child and Adolescent Psychopharmacology,2018:10:28.
16. Drew E. Winters SFELaLAH. Improvements in Irritability with Open-Label Methylphenidate Treatment in Youth with Comorbid Attention Deficit/Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. Journal of Child and Adolescent Psychopharmacology, 2018:28(5):298-305.
17. Megan E. Tudor KIEB. Cognitive-Behavioral Therapy for a 9-Year-Old Girl With Disruptive Mood Dysregulation Disorder, 2016.
18. Browne D. Healthline. [Online], 2017. Available from: https://www.healthline.com/health/disruptive-mood-dysregulation-disorder.
19. Zaky EA. Disruptive Mood Dysregulation Disorder (DMDD). Clinical Depression, 2015, 1(1).
20. Leyla Ezgi Tüğena MGABA. Disruptive Mood Dysregulation Disorder in A Primary School Sample. Asian Journal of Psychiatry, 2020, 48.
21. Megan E. Tudor KIEBJPDGSP. Cognitive-Behavioral Therapy for a 9-Year-Old Girl With Disruptive Mood Dysregulation Disorder. Clinical case studies, 2016, 22.