WWW.IJRPR.COM

International Journal of Research Publication and Reviews

Journal homepage: www.ijrpr.com ISSN 2582-7421

Disruptive Mood Dysregulation Disorder in India: A Growing Pediatric Mental Health Challenge

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ABSTRACT :

Disruptive Mood Dysregulation Disorder (DMDD), introduced in DSM-5, is an emerging pediatric mental health concern in India. Characterized by chronic irritability and severe temper outbursts, its prevalence among urban Indian children is rising, yet remains underrecognized. Contributing factors include family dysfunction, academic pressures, and childhood trauma. Diagnosis is challenged by stigma, limited awareness, and resource constraints. Conventional treatments involve cognitive-behavioral therapy, parent training, and medications, while homeopathy offers complementary approaches. Urgent action is needed to enhance early detection, public education, culturally sensitive tools, and integrated care systems to address this growing burden and protect children's mental well-being.

Introduction

Disruptive Mood Dysregulation Disorder (DMDD) is a relatively recent addition to the psychiatric classification systems, first introduced in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013. It was established to address the overdiagnosis of pediatric bipolar disorder and to characterize children with severe irritability and temper outbursts who do not fit the criteria for bipolarity[1]. In India, though awareness is still developing, increasing numbers of cases have been reported, particularly in urban clinical settings. This article aims to explore the epidemiology, clinical presentation, risk factors, stigma, management strategies, and the need for integrated care approaches for DMDD in India.

Epidemiology and Prevalence

DMDD is characterized by chronic irritability, anger, and frequent, severe temper outbursts that are grossly out of proportion to the situation[2]. Globally, the prevalence of DMDD ranges from 2-5% among children and adolescents[3]. Indian data on DMDD is limited, as the disorder is still under-recognized in many parts of the country. However, studies in urban psychiatric clinics in metropolitan cities like Mumbai, Delhi, and Bangalore indicate an increasing trend of mood dysregulation disorders among children aged 6–16 years[4].

A multicentric study conducted by the National Institute of Mental Health and Neurosciences (NIMHANS) found that symptoms consistent with DMDD were present in approximately 3.8% of urban schoolchildren surveyed, with higher rates in boys than girls[5]. Additionally, community-based studies in Kerala and Maharashtra have highlighted similar trends, suggesting that while awareness remains low, the clinical burden is significant[6].

Clinical Features and Diagnosis

The key diagnostic features of DMDD include:

Severe, recurrent temper outbursts (verbal or behavioral) occurring on average three or more times per week.
Persistently irritable or angry mood present most of the day, nearly every day, between outbursts.
Symptoms persisting for at least 12 months.
Onset before age 10, but diagnosis not made before 6 or after 18 years[2].

In India, clinical differentiation of DMDD from attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and bipolar disorder is challenging due to overlapping symptoms and limited mental health resources in schools and primary care[7]. Lack of culturally appropriate screening tools further complicates diagnosis, with many cases being either ignored or misclassified[8].

Risk Factors and Contributing Elements
Several socio-cultural and psychological factors contribute to the development of DMDD in Indian children:
Family Dysfunction: Parental conflicts, harsh parenting, and inconsistent discipline styles have been associated with increased irritability and mood dysregulation in children[9].
Urbanization and Academic Pressure: The stressors of competitive academic systems, social comparison, and reduced recreational spaces in urban India significantly impact children's emotional regulation[10].
Childhood Trauma: Exposure to abuse, neglect, or witnessing domestic violence has been linked to mood instability and disruptive behaviors[11].
Neurodevelopmental Comorbidities: DMDD frequently coexists with ADHD, learning disabilities, and anxiety disorders, further complicating its clinical picture[12].

Stigma and Social Perception

In India, mental health stigma remains pervasive, particularly concerning children's behavioral and emotional disorders. Mood dysregulation in children is often attributed to 'bad upbringing' or lack of discipline rather than being seen as a legitimate mental health concern[13]. A study conducted by the Indian Psychiatric Society reported that over 65% of parents felt shame or guilt when seeking psychiatric care for their child, fearing social judgment and ostracism[14].

Moreover, teachers and school authorities may label children with DMDD-like behaviors as 'problematic' or 'disobedient', overlooking underlying emotional distress. This leads to delayed diagnosis, poor academic outcomes, and social isolation[15].

Management and Treatment Approaches

Conventional Management
The management of DMDD involves a combination of pharmacological and non-pharmacological interventions:
Cognitive-Behavioral Therapy (CBT): Structured CBT techniques help children manage anger and improve emotion regulation skills[16].
Parent Management Training (PMT): Educating parents about consistent discipline, positive reinforcement, and anger management strategies plays a crucial role in treatment .
Medication: In severe cases, medications such as mood stabilizers (e.g., lithium) and atypical antipsychotics (e.g., risperidone) are prescribed cautiously, considering side effects in children[18].

Homoeopathic Perspectives

Homoeopathy, with its individualized, holistic approach, offers complementary care for children with DMDD in India. Remedies are selected based on the totality of symptoms, constitutional makeup, and emotional triggers. Common remedies include:
Chamomilla: For excessively irritable, capricious children who are inconsolable unless carried and who exhibit anger with crying spells[19].
Nux vomica: For impatient, irritable children intolerant to contradiction and easily provoked[20].

Cina: For children prone to temper tantrums, especially when hungry or tired, accompanied by grinding of teeth or abdominal complaints[21].

Staphysagria: For suppressed anger, where outbursts follow long periods of emotional suppression[22].

Tuberculinum: Violent temper tantrums, destructive behaviour, restless, dissatisfied, constantly changing wants, often has a strong desire for travel or change[23].

Ignatia: Emotional hypersensitivity, silent brooding anger, sudden emotional outbursts after grief or disappointment; sighing, sobbing. Suppressed anger with hysteria-like symptoms[24].

Belladonna: Sudden intense anger attacks, flushed face, dilated pupils, often violent behaviors; everything happens suddenly and intensely[25].

Stramonium: Violent behavior with intense fear; night terrors; aggression out of fear; child clings to parents but can become extremely violent or destructive[26].

Veratrum Album: Destructive rage, shrieking, desire to tear things; religious mania sometimes; extreme obstinacy and defiance in children[27].

While controlled trials in India are limited, case reports and clinical experiences suggest positive outcomes, especially when combined with counseling and family therapy[28].

Public Health Challenges

India faces multiple obstacles in effectively addressing DMDD:

Limited Child Mental Health Services: Less than 0.1 psychiatrists per 100,000 population are trained in child and adolescent mental health in India[29].
Lack of Awareness: Both parents and teachers often lack awareness of mood disorders in children, mistaking symptoms for behavioral issues.
Resource Constraints: Inadequate school counseling systems, especially in rural areas, limit early intervention opportunities[30].
Policy Gaps: While national programs like the National Mental Health Programme (NMHP) exist, child-specific provisions for disorders like DMDD remain poorly defined[31].

Conclusion

Disruptive Mood Dysregulation Disorder is an underrecognized yet increasingly relevant mental health issue affecting Indian children. The socio-cultural dynamics of Indian families, coupled with academic pressures, urban stressors, and limited mental health infrastructure, contribute to the growing burden of DMDD. Addressing this challenge **requires a multipronged approach:** raising public awareness, training healthcare providers and educators, integrating mental health services in schools, and promoting culturally sensitive diagnostic tools.

The integration of conventional psychiatry with complementary therapies like Homoeopathy, family counseling, and school-based interventions offers promise in improving emotional regulation and quality of life for affected children. Strengthening public mental health policies, reducing stigma, and ensuring accessible services are critical to safeguarding the mental well-being of India's future generations.

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