

Disruptive Mood Dysregulation Disorder (DMDD)

A plain-English guide for you and your family

WHAT IS HAPPENING

DMDD is diagnosed in children who have severe temper outbursts — screaming, hitting, breaking things — at least three times a week, way out of proportion to what set them off. Between outbursts the child is not calm: they stay irritable or angry most of the day, nearly every day, and other people can see it. This pattern must last at least 12 months, show up in at least two places (home, school, with friends), and start before age 10. The diagnosis is only made between ages 6 and 18. It is treated with therapy first, and it is NOT the same as childhood bipolar disorder.

What you might feel

- Severe temper outbursts 3 or more times a week — yelling, screaming, hitting people, or breaking things
- Angry or grouchy mood almost all day, nearly every day, between outbursts — not just during tantrums
- Problems happen in at least 2 out of 3 places — home, school, or with friends
- Symptoms have lasted at least 12 months, with no break longer than 3 months in a row
- Symptoms started before age 10
- Shame, guilt, and low self-worth after an outburst
- Social isolation — fewer friends, exclusion from playdates or birthday parties
- School problems — detentions, suspensions, or falling grades despite normal intelligence
- Family stress — parents report feeling exhausted, helpless, or constantly walking on eggshells

Call the doctor right away if...

- Any distinct period lasting more than 1 day with elevated mood, decreased need for sleep, and high energy — this pattern excludes DMDD and points to bipolar disorder instead

- Suicidal statements or self-harm in a chronically irritable child or teen — long-lasting irritability is a high-risk state for depression and suicide
- Physical aggression that causes injury to people or serious property damage — safety planning and crisis intervention come before anything else
- Symptoms that started suddenly right after a medication (steroids, stimulants) or a head injury — that is not DMDD; the cause is the medication or injury
- First appearance of symptoms at age 16–18 with no history in childhood — DMDD must have started before age 10, so look for a different explanation such as depression or substance use

What the care team will do

- Safety first during outbursts: protect the child, siblings, and staff without punitive restraint
- Screen for depression and suicidal ideation at every contact, especially in adolescents
- Coach caregivers on consistent, non-escalating responses and trigger mapping
- Verify the diagnosis window before reinforcing the label: onset before 10, diagnosis between 6 and 18
- If any elevated-mood episode is reported, escalate for bipolar re-evaluation before antidepressants are started

Medicines you may be given — and why

Stimulants (methylphenidate, amphetamine salts) — when ADHD is also present

Lifts the levels of dopamine (a brain messenger that helps you focus and control impulses) and norepinephrine (a messenger that helps you stay alert and think ahead) in the prefrontal cortex (the front part of the brain that acts like brakes on big feelings and snap reactions). When a child with DMDD also has ADHD, this extra signal helps the brain put the brakes on angry outbursts and frustration before they boil over.

SSRIs (fluoxetine, citalopram, sertraline) — used off-label, often added to a stimulant and therapy

Raises the level of serotonin (a brain messenger that steadies mood, sleep, and how you react to frustration) by stopping brain cells from pulling it back in too quickly. Over several weeks, the extra serotonin softens the child's chronic grumpy, angry baseline and the sad feelings many children with DMDD carry underneath. The brain becomes less quick to flare into rage, and everyday frustrations feel more manageable.

Atypical antipsychotics (risperidone, aripiprazole) — reserved for severe, dangerous aggression when other treatments have not worked

Blocks dopamine D2 receptors (docking spots for dopamine, a brain messenger tied to arousal and aggression) and serotonin 5-HT_{2A} receptors in the mesolimbic pathway (a deep brain circuit that drives intense emotional reactions). By turning down the volume on these signals, the drug dials down severe, explosive aggression and physical violence when behavioral therapy, stimulants, and SSRIs have not been enough. These drugs are used only for short periods while the team builds safer skills and surroundings, with a clear plan to taper off as soon as possible.

Where this information comes from

- American Psychiatric Association DSM-5-TR (2022) — Disruptive Mood Dysregulation Disorder diagnostic criteria
- NIMH — Disruptive Mood Dysregulation Disorder overview and treatment research
- AACAP practice recommendations on chronic irritability in youth
- Cochrane systematic reviews on interventions for childhood irritability and aggression

Last reviewed: 2026-06-01