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# Love on the Edge: Navigating Disruptive Mood Dysregulation Disorder (DMDD) and Marital Distress – A Holistic Therapeutic Approach

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## Abstract

The present case report illustrated the challenging diagnostic case of Disruptive Mood Disorder (*DMDD*) with marital conflict. The study emphasizes the importance of various therapeutic strategies that manage relational conflicts, mood instability, and anger outbursts. A 27-year-old married man presented with constant irritability, frequent temper tantrums, and impulsive verbal violence that seriously disrupted his marriage. His clinical diagnosis was confirmed as *DMDD* and related features were assessed using the *MSE*, *BDI-II*, and *CAARS* along with behavioral monitoring via in-depth history. The patient's mood instability, behavior patterns, and relational difficulties were tracked down over several therapeutic sessions (including Cognitive-behavioral techniques, Breathing-based relaxation techniques. Islamically integrated anger management guidelines, and Behavior modification strategies). The patient showed improved insight, better-coping mechanisms, and decreased hostility towards his partner. Couple therapy austerely focuses on mutual tolerance, lessens the communication gap, and improves resolution options for saving their marriage, therefore raising marital satisfaction. Progress in emotional and interpersonal well-being was achieved by both psychiatric medication and the consistent use of learned strategies. This study emphasizes the need for a comprehensive therapy paradigm in treating individual psychopathology as well as relational discomfort in *DMD* patients.

***Keywords:*** Disruptive Mood Dysregulation Disorder, Marital Distress, Emotional Regulation, Couple Therapy, Holistic Therapeutic Approach, Cognitive-Behavioral Therapy (CBT)

## Introduction

Appearing in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM*-5) in 2013 by the American Psychiatric Association (*APA*), disruptive mood dysregulation disorder (*DMDD*) is a recent addition to psychiatric diagnosis. Previously routinely misdiagnosed with pediatric bipolar disorder despite lacking the episodic mood fluctuations of the condition, this diagnosis was developed to meet the clinical need for precisely identifying and treating individuals with chronic irritability and severe temper outbursts (Stringaris, 2011). Along with frequent, severe temper outbursts out of proportion to the surroundings and inconsistent with the child's developmental level, *DMDD* is marked by persistent annoyance or rage. Usually occurring three or more times a week, these outbursts have been prevalent for at least 12 months without any period free from symptoms spanning more than three months. Symptoms must show before age ten; the diagnosis covers youngsters six to eighteen (*APA*, 2013). The symptoms have to be severe in at least one of the at least two

locations—home, school, or among friends. Adoption of *DMDD* was meant to prevent the overdiagnosis of bipolar illness in younger persons and the consequent inappropriate treatment approaches, such as the prescription of antipsychotic drugs (Roy, et al., 2014). Scientific studies on the core causes of this disorder advocate that it could be a serious and severe range of irritability that requires individualized treatment plans (Vidal-Ribas, et al., 2016). It was seen in the literature that family dynamics can significantly be affected by the symptom presentation of *DMDD*; participants report higher rates of insecure attachment patterns than other mental issues along with increased stress levels (Deveney, et al., 2015; *NIMH*, 2023).

Cultural influence was also seen to be a salient ingredient for the course and progress of psychiatric problems. In Pakistan, *DMDD* symptoms could be seen contrarily depending on cultural values and societal norms. For example, enrage and temper bursts in children could be laid off as typical developmental patterns or credited to parenting style, leading to underdiagnosis or misdiagnosis. *DMDD*-focused literature requires a structured approach using this cultural lookout to guarantee that treatment plans and diagnostic criteria are relevant and appropriate for society.

Investigating the influence of a person's *DMDD* on family functioning, especially spouse interactions, is highly worth exploring. The frequent emotional outbursts and prolonged irritability could drain couples, increasing stress and reducing marriage satisfaction (Wiggins, et al., 2024). In Pakistan, where family systems are sometimes large and familial obligations are clearly defined, the stress of managing a behavioral disease may aggravate issues between couples. Such argumentations could be the reason for conflicts about daily chores, guilt or blame, and the division of family responsibilities to balance the needs. Furthermore, the stigma of Pakistani society on mental health could deter families from contacting professionals, therefore worsening spousal relationships. Anxiety about social rejection or criticism could cause isolation, and partners get deprived of the chances and paths to release stress. This isolation might worsen marital conflict since couples could feel they have to handle *DMDD's* obstacles without professional psychological guidance. Although *DMDD* is covered in the *DSM*-5, empirical studies on this disorder are still limited, and evidence-based treatment plans especially meant for this diagnosis are under development. Inspired by treatments for similar conditions such as *ADHD* and mood disorders, modern therapeutic approaches often merge cognitive-behavioral interventions with symptomatic drugs (Roy, et al., 2014).

In summary, Pakistan urgently needs culturally relevant studies even though worldwide research clarifies *DMDD* and its effects on family dynamics. Designing sensible, culturally relevant treatments depends on an awareness of how *DMDD* evolves in Pakistani society and how it affects spousal relationships. Such research would not only add to the worldwide conversation on mood dysregulation problems but would also pave the way for supportive strategies that improve familial bonds in the face of mental health challenges.

**Clinical Case Report**

The patient is a 27-year-old married male with an educational background up to matriculation. He is the second-born among eight siblings and has been employed in a factory at Wah Cantt. He has married his cousin (love marriage) for the past five years. The patient has no children and has been medically diagnosed as sterile. The patient was brought to the hospital by his brother and nephew due to an episode of severe agitation. At the time of presentation, he was visibly distressed and irritable. He had been exhibiting significant behavioral and emotional disturbances over the past few days, the following symptoms were observed: temper tantrums, irritable mood, increased appetite, disturbed sleep, increased verbal aggression, hopelessness, hypoglycemia, and anemia.

According to the informant, the patient was born without any apparent complications and achieved his developmental milestones at an appropriate age. He was described as having a strict and dominant nature from an early age. While he did not exhibit physical aggression, he was generally uncooperative with his siblings. Academically, he performed at an average level, but due to financial constraints and lack of interest, he discontinued his studies. Following the discontinuation of his education, the patient started working in the factory workshop. At his workplace, he displayed a dominant personality and was frequently involved in verbal confrontations. Despite his argumentative nature, he was recognized as a competent worker and faced no professional issues. He demonstrated strong work commitment, never took leave, and remained consistent in his employment without seeking a change in his workplace.

He described his wife as verbally aggressive, frequently using abusive language, particularly toward younger family members. According to the patient, she did not comply with his requests and often treated him as secondary in importance. This ongoing conflict led to frequent quarrels between them, characterized by intense verbal arguments, though he denied any physical violence. He reportedly has extreme distress due to his wife's attitude and poor understanding of his medical condition, chiefly his infertility. This distress has contributed to frequent anger outbursts directed toward his wife. The patient has been experiencing persistent psychological distress for the past 4.5 years. He has had multiple hospital admissions due to episodes of property destruction, verbal altercations, and hyperactivity. His mood remains irritable for prolonged periods, with pervasive restlessness and agitation observed both at home and in other settings. On average, he requires inpatient psychiatric care twice a year, during which he receives regular follow-ups, pharmacological management, and injectable medications as part of his treatment regimen.

Over the past month, his symptoms have intensified. He has exhibited frequent temper tantrums, verbal aggression toward his wife, and destructive behavior, including breaking household items such as glassware and utensils. During the current admission, an escalation of aggression was observed when he engaged in a physical dispute with his younger brother. The incident was triggered when he attempted to physically assault his wife over a minor disagreement regarding the placement of sugar in a different container. His aggressive tendencies appear to be easily provoked by minor stimuli, leading to excessive verbal and physical reactions. The patient has no documented family history of psychiatric illness. There is no reported history of substance abuse, significant forensic involvement, or extreme suicidal or homicidal attempts.

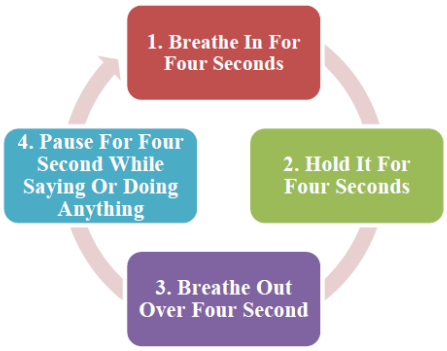
**Comprehensive Psychological Assessment**

On the ***Mental State Examination***, the patient was found to be oriented to person, place, and time. His mood was subjectively reported as low, while objectively, he appeared agitated. His speech was noted to be increased in rate, rhythm, and volume. Memory functions were intact, and his thinking was abstract. Judgment was assessed to be good; however, his concentration was significantly impaired. No perceptual abnormalities were observed. Insight into his condition was noted to be poor. This presentation aligns with the clinical features commonly observed in individuals with Disruptive Mood Dysregulation Disorder (*DMDD*), where persistent irritability and frequent episodes of verbal and behavioral dysregulation contribute to significant functional impairment (Axelson, et al., 2012).

The patient underwent a series of psychological assessments to evaluate the severity of his symptoms, particularly related to mood dysregulation and emotional instability. His ***Beck Depression Inventory (BDI-II) score was 22***, placing him in the moderate depression range consistent with the patient's subjective experience of hopelessness and frustration, particularly concerning his ongoing marital and interpersonal difficulties. During the assessment session,

the patient displayed limited engagement. His eye contact was inconsistent, shifting on and off throughout the session. He muttered about his restless attitude and showed indifference in the session even though he was well seated. He said again that he would rather go back to bed and that he was not ready to engage. One reported major obstacle to treatment adherence was his resistance to psychological assistance and therapy. He was advised to psychologically be ready for a follow-up session the next day, which would help to address his resistance. These therapeutic sessions would help him control his anger and emotional dysregulation, which are fundamental *DMDD* traits (Coldevin, et al., 2023).

The ***Conners' Adult ADHD Rating Scale (CAARS)*** score was 61, suggesting mild attention problems. Still, these shortcomings were somewhat less noticeable than the degree of emotional suffering. Previous studies have shown that rather than being symptomatic of a fundamental attention-deficit disorder, concentration problems in those with *DMDD* are generally secondary to chronic irritability and frequent temper outbursts (Brotman, et al., 2017). Rather than an independent neurodevelopmental disorder, the patient's continuous emotional instability seemed to aggravate his impulsiveness and difficulties sustaining focus.




Overall, the test results align with the clinical presentation of *DMDD*, emphasizing the need for targeted interventions addressing both emotional dysregulation and co-occurring depressive symptoms due to relationship issues (Stringaris, et al., 2018).

**Therapeutic Intervention Sessions**

During the therapeutic and psychoeducation sessions, the patient was able to maintain eye contact; the primary focus of the session was on establishing a therapeutic alliance and building rapport, which is essential for treatment adherence in individuals with *DMDD*. The patient was provided with ***psychoeducation*** regarding the course of therapy and the role of medications in managing his symptoms. He was informed that while pharmacological treatment would assist in mood stabilization, active emotional regulation strategies would be necessary for him to effectively control anger outbursts during his interaction with his wife and others (Vidal-Ribas & Stringaris, 2021). Given his history of temper tantrums followed by feelings of remorse, ***Anger Management Techniques*** were introduced to help him regulate his emotional responses.

As an initial intervention, ***Deep Breathing Exercises*** were introduced as a relaxation technique. Considering his short attention span and ongoing agitation, the patient was directed through a ten-minute deep breathing exercise. This approach facilitates lower physiological arousal and impulsive emotional reactivity (Decker, et al., 2019).

The "***1-to-20 Counting Strategy***" was implemented to ease the impulse response; in which he was directed to silently count from one to twenty in his preferred language prior to reacting to any provocation from others as per evidence-based *CB* approaches for anger management (Scott, et al., 2020). Considering the patient's restlessness, the provided tasks were purposefully kept short and handy. Psychologically designed controlled techniques are meant to maintain a healthy therapeutic alliance and to promote active treatment engagement. The method sought to guarantee therapeutic participation free from resistance, therefore enabling the patient to gradually acquire emotional control.

The main emphasis of the next session was to teach the patient relaxing techniques he might apply in the ward environment. One visual aid of the ***Square Breathing Exercise*** was made in Urdu and hung on his room's wall to help with this. Showing the chart was meant to serve as a continual reminder to him that impulse control is a skill, and he can achieve it. This approach sought to improve his autonomy in controlling his anger and underlined that these methods could be applied at home (Decker, et al., 2021).

In the ***Time-Out Technique***, the patient was told to leave the room for a few minutes before having conversations on delicate subjects that might set off wrath. Cognitive-behavioral treatments for *DMDD* have made great use of this approach since it lets people step back from emotionally charged events and recover self-control (Burke, et al., 2018). Information about the patient's behavioral improvement was obtained from fellow inpatients and the nursing staff before the follow-up. Although the staff said his conduct had improved somewhat, he still verbally abused other inpatients. The patient subjectively reported his mood as euthymic, yet his affect stayed low objectively. He indicated his need for discharge, therefore stressing the difficulty of keeping patients with chronic irritability involved in therapy. About the breathing exercises, the patient said he had tried the Square Breathing Exercise just twice and deliberately tried not to verbally attack the nursing staff. Still, his impulse control remained a problem that required more help.

The ***Mental Shield Identification Technique*** was so developed in response. Those who externalize blame and assign their emotional suffering to others may find this method very successful. Using a symbolic shield, the patient was guided in understanding that unwanted comments and provocations from others can be mentally deflected rather than absorbed (Graziano, et al., 2019). This technique aimed to assist the patient to separate himself from outside triggers thereby lowering emotional reactivity and angry outbursts. Thus, his interpersonal contact with his wife should improve. A reflection activity at the end of the session helped the patient examine his anger projection using the above-mentioned technique. He was asked to think about how he absorbs outside negativity and how using this approach would help him control his reactions. The therapeutic approach stayed slow to guarantee that the patient was not overwhelmed and to preserve the therapeutic partnership.

The patient was invited to give feedback on the last session. He claimed to have some awareness of his impulsive actions since, although he usually directs his wrath on others, he feels guilt and regret later. With his comment, "I might throw my anger onto others, but it is not under my control," he seemed to be acknowledging his struggle with emotions—a fundamental aspect of *DMDD* (Leibenluft, 2017). Further ***Behavioral Modification Techniques*** depend on this partial insight. The ***Filter Technique*** was introduced to improve impulse control and emotional management. The patient was shown a strainer or filter paper to understand this cognitive approach. Particularly for his wife, the patient was instructed to mentally "filter out" unfavorable parts of events between them, emphasizing the positive ones. This method sought to change attentional biases from upsetting cues to promote a more balanced emotional reaction (Dougherty, et al., 2018). The patient was urged to use this approach not only at home but also in his workplace and in the hospital ward, where he regularly encountered interpersonal problems.

Recently, the patient's behavior has also been evaluated. His interactions were observed to be more consistent, which was ascribed to regular therapeutic involvement and consistent drug adherence. His mood stayed euthymic; no claims of homicidal or suicidal thoughts surfaced. He showed enhanced emotional self-control and a better understanding of once-taught anger management techniques. Additionally presented as a culturally relevant remedy were ***Islamic Anger Management Strategies***. Prophetic advice on anger management was taught to the

patient on drinking water during rage outbursts, adjusting physical posture (e.g., sitting if standing, lying down if seated), and removing oneself from the anger-inducing environment (Abu-Raiya & Pargament, 2019). These distraction strategies fit contemporary behavioral therapies stressing physical mobility and cognitive shifting to lower emotional intensity (Fuchs & Riedl, 2020). The patient expressed willingness to implement these techniques at home, indicating treatment receptivity. His commitment indicated a mature sense of self-efficacy, which is a positive predictor of long-term emotional regulation success in individuals with *DMDD*.

Improving the patient's communication abilities with his wife centered on the main therapeutic objective of the last several sessions. It was underlined that constant use of previously learned anger management strategies would aid in lessening emotional outbursts and enhancing relationship dynamics since his anger was typically prompted by interpersonal problems. Examined the fundamental causes of his anger and depression symptoms connected to his marital tension; so, ***Couple Therapy*** sessions were scheduled to help enhance conflict resolution techniques and improve mutual understanding. The patient was notified ahead of time that his partner would be attending the next session, therefore enabling both partners to resolve their issues in a structured therapeutic setting (Christensen, et al., 2020). The patient's wife was invited to join in a session about the main causes of conflict in their marriage. The patient's impetuous anger and lack of cooperative behavior at home cause most conflicts and disagreements. His wife complained about his outbreaks of fury, saying he often took her for granted and was reluctant to help with household chores despite her efforts to compromise and manage domestic responsibilities. She also related stories of times he would criticize her, act verbally aggressively, and destroy houseware. ***Psychoeducation*** on emotional control and impulsive control was given to both partners to help them with these issues (Leibenluft & Stoddard, 2022). His wife was given a wholesome overview of his mental condition, and the patient's personality features and trouble with impulse control, which define his *DMDD* in a simplified manner. She was advised not to argue when the patient showed signs of increased anger; instead, she should concentrate on de-escalation techniques including first ignoring offensive comments to stop escalation. She was also recommended to help him in daily life activities and therapy, especially by stressing good behavioral improvements. The patient was then urged to keep using anger management strategies, particularly concerning balanced communication tactics and negotiating. The couple was counseled to focus on each other's likable traits and behaviors rather than their shortcomings, to encourage constructive dialogue between them (Benson, et al., 2019).

***Therapy termination*** was discussed in the last session. The patient was educated on the continual ongoing medication adherence as well as the use of acquired anger control techniques to enhance emotional stability. He was told that these acquired skills would always help him in better adaptation to the social, personal, and occupational domains. To guarantee long-term stability and mental well-being, especially with marital problems, he was also advised to seek more sessions when needed.

## Conclusion

The present study highlighted the dominating influence of chronic emotional dysregulation on personal relationships and their deterioration. The patient's marital bond and general psychosocial dealing suffered significantly from his persistent irritation, frequent anger outbursts, and poor impulse control. Significant improvement was seen utilizing a comprehensive therapeutic plan comprising cognitive-behavioral approaches, psychoeducation, and anger managing tactics including Islamic ways of anger regulation, relaxation practices, and couple therapy. Apart from aiding the patient to regain emotional control, the structured intervention assisted better communication and dispute resolution inside

his marriage. His wife's participation in therapy improved mutual understanding even more, therefore enabling both spouses to aim for a more intimate, respectful, and encouraging connection. The progress of the case directed our attention toward early *DMDD* diagnosis, and an evidence-based treatment plan can greatly improve private, societal, and marital functioning. Future studies ought to explore long-term therapeutic effects and culturally informed interventions to improve individuals experiencing emotional dysregulation within intimate relationships.

## Ethical Considerations/Disclosures

**Human Subjects:** Consent was obtained by the participants in this study.

**Conflicts of interest:** None

**Payment:** All authors have declared that no financial support was received from any organization for the submitted work.

**Other Relationships:**
All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

## References

Abu-Raiya, H., & Pargament, K. I. (2019). The psychology of Islam: Conceptual and empirical foundations. *The American Journal of Islamic Social Sciences, 36*(2), 1-20.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Axelson, D., Findling, R. L., Fristad, M. A., Kowatch, R. A., Youngstrom, E. A., Horwitz, S. M., ... & Birmaher, B. (2012). Examining the proposed disruptive mood dysregulation disorder diagnosis in children in the Longitudinal Assessment of Manic Symptoms study. *Journal of Clinical Psychiatry*, 73(10), 1342-1350.

Benson, L. A., Sevier, M., & Christensen, A. (2019). Couple therapy for anger and aggression: A review. *Journal of Marital and Family Therapy, 45*(2), 213-228. https://doi.org/10.1111/jmft.12312

Brotman, M. A., Kircanski, K., Stringaris, A., Pine, D. S., & Leibenluft, E. (2017). Irritability in youth: A translational model. *American Journal of Psychiatry, 174*(6), 520-532. https://doi.org/10.1176/appi.ajp.2016.16070839

Burke, J. D., Hipwell, A. E., & Loeber, R. (2018). Dimensions of oppositional defiant disorder as predictors of later psychosocial adjustment. *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(9), 673-680. https://doi.org/10.1016/j.jaac.2018.04.015

Christensen, A., Doss, B. D., & Jacobson, N. S. (2020). Integrative behavioral couple therapy: A therapist's guide to creating acceptance and change. *Guilford Press*.

Coldevin M, Brænden A, Zeiner P, Øyen A-S, Melinder A, Stubberud J. (2023). Disruptive mood dysregulation disorder in a Norwegian clinical child population. *Clin Child Psychol Psychiatry*. 29(2):393–406. doi: 10.1177/13591045231176928

Decker, S. H., Salavitz, J., & Mehta, R. (2019). The role of relaxation techniques in emotional regulation: Implications for mood disorders. *Journal of Clinical Psychology, 75*(4), 512-525.

Decker, S. H., Salavitz, J., & Mehta, R. (2021). Cognitive-behavioral interventions for mood dysregulation: Practical applications for anger management. *Journal of Clinical Psychology, 77*(3), 417-432.

Deveney, C. M., Hommer, R. E., Reeves, E., & Leibenluft, E. (2015). The neurodevelopmental basis of early childhood disruptive behavior: Irritability and the development of frontal-striatal-limbic circuits. *Frontiers in Psychiatry,* 6, 100.

Dougherty, L. R., Smith, V. C., Bufferd, S. J., & Carlson, G. A. (2018). Predicting irritability in children with mood dysregulation: A cognitive approach. *Journal of Child and Adolescent Psychiatry, 57*(5), 412-420. https://doi.org/10.1016/j.jaac.2018.01.021

Fuchs, L., & Riedl, D. (2020). Cognitive-behavioral distraction techniques in anger management therapy. *Behavior Research and Therapy, 134*, 103721.

Graziano, P. A., Ros, R., & Hart, K. C. (2019). Beyond behavior modification: Examining emotion dysregulation in youth with disruptive behavior disorders. *Journal of Abnormal Child Psychology, 47*(4), 589-600. https://doi.org/10.1007/s10802-019-00511-w

Leibenluft, E. (2017). Pediatric irritability: A systems neuroscience approach. *Trends in Cognitive Sciences, 21*(4), 277-290. https://doi.org/10.1016/j.tics.2017.01.005

Leibenluft, E., & Stoddard, J. (2022). The developmental neuroscience of irritability and its relation to psychiatric disorders. *American Journal of Psychiatry, 179*(7), 444-456. https://doi.org/10.1176/appi.ajp.2021.21030268

National Institute of Mental Health. (2023). *Disruptive Mood Dysregulation Disorder: The Basics*. Retrieved from https://www.nimh.nih.gov/health/publications/disruptive-mood-dysregulation-disorder

Roy, A. K., Lopes, V., & Klein, R. G. (2014). Disruptive mood dysregulation disorder: A new diagnostic approach to chronic irritability in youth. *American Journal of Psychiatry*, 171(9), 918-924.

Scott, J. C., Carl, J. R., & Leonard, N. (2020). Cognitive-behavioral approaches to impulse control: Practical applications for mood disorders. *Behavior Therapy, 51*(2), 243-258.

Stringaris, A. (2011). Disruptive mood dysregulation disorder. *Current Opinion in Psychiatry*, 24(3), 203-206.

Stringaris, A., Vidal-Ribas, P., Brotman, M. A., & Leibenluft, E. (2018). Practitioner review: Temperamental irritability and disruptive mood dysregulation disorder in youth. *Journal of Child Psychology and Psychiatry, 59*(7), 721-739. https://doi.org/10.1111/jcpp.12817

Vidal-Ribas, P., Brotman, M. A., Valdivieso, I., Leibenluft, E., & Stringaris, A. (2016). The status of irritability in psychiatry: A conceptual and quantitative review. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(7), 556-570.

Vidal-Ribas P, Stringaris A. (2021). How and why are depression and irritability linked? *J Child Adolesc Psychiatr Clin N Am*. 30(2):401–14. doi: 10.1016/j.chc.2020.10.009

Wiggins, J. L., Briggs-Gowan, M. J., Estabrook, R., & Carter, A. S. (2024). Disruptive mood dysregulation disorder, parental stress, and child behavior problems: A longitudinal investigation. *Frontiers in Child and Adolescent Psychiatry*, 1, 1430850. https://www.frontiersin.org/articles/10.3389/frcha.2024.1430850/full