Week 7: Ground Rounds Case Presentation Patient A.K.

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Introduction

Disruptive mood dysregulation disorder (DMDD) was first introduced to the domain of depressive disorders in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders and was done so because there were concerns that children with temper outbursts, anger, and irritability were being inappropriately diagnosed with bipolar disorder (Mürner-Lavanchy et al., 2023). The purpose of this case presentation is to develop 3 objectives related to this case presentation based on Blum's taxonomy, develop and complete the provided SOAP note template based on this patient experience with patient A.K. that includes subject and objective data, a full mental status examination, three differential diagnoses in order from most to least relevant with supporting evidence, develop and discuss a treatment plan to include psychotherapy, pharmacologic interventions, nonpharmacological treatment and alternative therapies, one health promotion activity and one patient education strategy, and a reflection to include what may have been done differently and three questions or prompts to my colleagues viewing my Kaltura video and reading this case presentation.

Objectives

1. Analyze the client's presenting symptoms in this case study to formulate a clear and concise diagnosis.
2. Recognize, compare, and contrast the symptomology that differentiates Disruptive Mood Dysregulation Disorder from Oppositional Defiant Disorder and Intermittent Explosive Disorder.
3. Based on the client's presenting symptoms and primary differential diagnosis, devise a treatment plan that will support the client and his parents and include measurable treatment follow-ups and outcomes.

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CC (chief complaint): Patient A.K. states, "My issue is I go from happy to mad in seconds and I am not sure why."

HPI: Patient A.K. is a 10-year-old Caucasian male who presents to Park Place Behavioral Health on an involuntary hold, or a Baker Act, for aggression and threatening self-harm. Patient A.J. reports he experienced a "blind rage" after being told he had to wait 15 minutes at a doctor's appointment. He reports that he has episodes of "blackouts and anger" that sometimes come out of nowhere. Prior to this admission, he was taking Abilify 2mg PO QHS for mood and behavioral issues as well as Guanfacine extended-release 1mg PO QAM for behavioral disturbances. Patient A.K. reports that since his last admission here 10 months ago, everything has been going better. He reports attending weekly therapy sessions and states this has been very helpful, he takes medications daily and overall is doing well in school and at home.

Patient A.K. has had 3 admissions to this crisis unit in the past two years starting at 8 years of age for increased aggression, impulsion, temper outbursts, physical harm toward others and himself, and suicidal ideations. His first admission to the crisis center was in 2022 when he was 8 years old due to increased aggression, kicking and punching a wall, stating that he wanted to kill himself with a knife, and trying to run away from the police. At that time, he admitted to having daily rages disproportionate to situations, banging his head, and punching himself when he is upset. His family reports patient A.J. having daily rages disproportionate to situations and states that he bangs his head and punches himself when he is upset. Per his family, his symptoms are severe at home but are also present and less severe when he is at school. Patient A.K.'s parents have monthly meetings with his teachers to discuss his progress and behavior at school. Two years ago when he was initially diagnosed with DMDD, patient A.K. was having anger outbursts and verbal rages at school if he didn't get his way. Occasionally, per his

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teachers, he would hit a wall or hit himself on the head when he was angry during these outbursts. His teachers described his mood as anxious and irritable most of the time.

In mid-2023, patient A.J. presented to the crisis center again after trying to choke himself after his mother found out he was using her money to play a video game. He states that he did this to punish himself. At that time, the patient reported his main trigger for outbursts was "not getting my way or feeling like I did something wrong". During this time patient A.K. was still having behavioral issues at school if he didn' get his way. He was noted to be yelling or hitting himself or the wall if he didn't get his way and was placed in time out in the principles office until he calmed down.

Substance Current Use:

- **Caregivers:** Patient A.K. lives with his adoptive mother and father.

- **Hospitalizations:** Patient A.K. has had two previous admissions to a crisis unit with the first being in 2022 when he was 8 years old and the second being in 2023 when he was 9 years old. The first admission was due to increased aggression, kicking and punching a wall, and stating that he wanted to kill himself with a knife, and trying to run away from the police. The second admission was due to increased agitation and self-harm by trying to choke himself after he stated he was punishing himself after his mother found out he was using her money on a video game.

- **Medication Trials:** Patient A.K. has taken Abilify and Guanfacine in the past.

- **Psychotherapy or Previous Psychiatric Diagnosis:** Patient A.K. reports this admission that since his last admission, he has been going to weekly therapy sessions which he finds very helpful. He has been previously diagnosed with attention-deficit hyperactivity disorder, oppositional defiant disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder.

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Substance Current Use: Patient A.K. denies any current or past use of caffeine, alcohol, tobacco, or illicit drug use.

Family Psychiatric/Substance Use History: Patient A.K.'s biological mother had bipolar disorder. No further information is known about his biological parents and/or family and their psychiatric or substance use history.

Psychosocial History: Patient A.K. was adopted when he was 4 years old and now lives with his adoptive mother, father, and pet dog. He has three biological sisters and 1 biological brother that he visits but he does not live with them. He is currently in 4th grade, denies any bullying, and states that he has no friends. In his free time he likes to play video games. He denies any past or current legal issues or arrests. He reports his religious beliefs are Christian and he sometimes goes to church with his parents.

Surgical History: Patient A.K. denies any past surgical history.

Medical History:

- **Current Medications**: Patient A.K. currently takes Abilify 2mg PO QHS for mood and behavioral issues as well as Guanfacine extended-release 1mg PO QAM for behavioral disturbances.
- **Allergies**: Onion.
- **Reproductive Hx**: Patient A.K. states that he is not currently in a relationship. He does not respond when asked if he prefers boys or girls in a relationship. Patient A.K.'s mother states that he is unsure of his sexual orientation at this time.

ROS:

- GENERAL: No fatigue, weakness, weight loss, fever, or chills.

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- HEENT: No double vision, blurred vision, or vision loss. No yellow sclerae. No congestion, runny nose, sneezing, sore throat, or hearing loss.
- SKIN: No itching, bruising, or rash.
- CARDIOVASCULAR: No chest pressure, chest discomfort, or chest pain. No palpitations or extremity edema.
- RESPIRATORY: No cough, sputum, or shortness of breath.
- GASTROINTESTINAL: No diarrhea, nausea, vomiting, or anorexia. No bleeding or abdominal pain.
- GENITOURINARY: No urinary urgency, hesitancy, odor, burning on urination, or odd color.
- NEUROLOGICAL: No paralysis, dizziness, syncope, ataxia, headache, numbness or tingling. No changes in bladder or bowel control.
- MUSCULOSKELETAL: No back pain, muscle pain joint pain, or stiffness.
- HEMATOLOGIC: No bruising, bleeding, or anemia.
- LYMPHATICS: No history of splenectomy or enlarged lymph nodes.
- ENDOCRINOLOGIC: No, reports of cold or heat intolerance, sweating, polydipsia, or polyuria.

Objective:

Diagnostic results: The following vital signs were obtained on patient A.K.: Blood Pressure 111/49, pulse 84 beats per minute, respiratory rate 20 breaths per minute, temperature 96.5 degrees Fahrenheit. There were no assessment tools or diagnostic results attached to or discussed in this case study.

Since DMDD is a relatively new diagnosis, there is no gold standard in assessment tools as they are still being developed. To further assess patient A.K. for DMDD and to rule out other variables and medical causes of illness, I would order a complete laboratory workup to include a complete blood

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count, comprehensive metabolic panel, thyroid screening, free T4, vitamin D level, and urine drug screen, (Bains and Abdijadid, n.d.; Sekhon and Gupta, n.d.).

One screening tool that is used often is Kiddie Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version (K-SADS-PL). The K-SADS-PL is the most used screening instrument in combination with the DMDD module to diagnose DMDD (Mürner-Lavanchy et al., 2023). The K-SADS-PL takes about 35-75 minutes to complete when comparing healthy subjects to those with mental illness and is a semi-structured interview used to help diagnose mental disorders in children aged 6–18 (Mürner-Lavanchy et al., 2023). The K-SADS-PL has good to excellent test-retest reliability and high inter-rater reliability and is available for free online (Mürner-Lavanchy et al., 2023). The DMDD module is a 4-item checklist assessing the DSM-5 criteria of DMDD and has high inter-rater reliability (Mürner-Lavanchy et al., 2023).

The Affective Reactivity Index (ARI) is a 6-item scale used in primary care to assess irritability and can be helpful in the diagnosis of DMDD (Tapia and John, 2018). Another screening tool is the Children's Interview for Psychiatric Syndromes which is a useful screening tool for DMDD (Tapia and John, 2018).

Mental Status Examination: Patient A.K. is clean, neat, hair is brushed, he is casually dressed, normal BMI, and anxious. No tattoos, piercings, or scars are noted. He has decreased eye contact, displays no unusual or repetitive movements in the jaw, face, or tongue, and is evasive in his conversation. His speech is of normal rate and volume, he is articulate, fluent, and displays no accent, stutter, or lisp. His mood is irritable, his affect is irritable and angry, and his range is restricted. His affect is congruent to his mood. His thought process is linear and goal-directed and he denies any suicidal or homicidal ideations

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or hallucinations. He is alert, oriented to person, place, and time, his short- and long-term memory appear intact, and his attention is distracted. His judgment and insight are poor.

Diagnostic Impression:

1. Disruptive Mood Dysregulation Disorder
2. Oppositional Defiant Disorder
3. Intermittent Explosive Disorder

Disruptive Mood Dysregulation Disorder

The first differential diagnosis I assigned to patient A.K. was disruptive mood dysregulation disorder (DMDD). Per the DSM-5-TR, diagnostic criteria A of DMDD reads, "Severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation" (American Psychiatric Association, 2022-a; Sekhon and Gupta, n.d.). Criteria B of DMDD states, "The temper outbursts are inconsistent with developmental level," and criteria C reads, "The temper outbursts occur, on average, three or more times per week" (American Psychiatric Association, 2022-a; Mürner-Lavanchy et al., 2023). Criteria D reads, "The mood between temper outbursts is persistently irritable or angry most of the day, almost every day, and is seen by others" (American Psychiatric Association, 2022-a). Criteria E states, "Criteria A-D have been present for 12 months or more and during that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in criteria A-D" (American Psychiatric Association, 2022-a). Next, criteria F reads, "Criteria A and D are present in at least 2 of 3 settings and are severe in at least one of these" (American Psychiatric Association, 2022-a; Sekhon and Gupta, n.d.). Criteria G states, "The diagnosis should not be made for the first time before the age of 6 years or after the age of 18 years" (American Psychiatric Association, 2022-a). Criteria H goes on to state, "By history or observation, the age at onset of Criteria A-E is before 10 years" (American Psychiatric Association, 2022-

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a). Criteria I states, "There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met" (American Psychiatric Association, 2022-a). Next, Criteria J reads, "The behaviors do not occur exclusively during an episode of a major depressive disorder and are not better explained by another mental disorder" (American Psychiatric Association, 2022-a). Lastly, Criteria K reads, "The symptoms are not better explained by the physiological effects of a substance or another medical or neurological condition" (American Psychiatric Association, 2022-a).

Patient A.K. was noted to have both verbal and behavioral anger outbursts that were out of proportion to the situation and that were inconsistent with his developmental level and this would fulfill criteria A and B of DMDD. Patient A.K. was initially having daily rages/temper outbursts and was noted to be irritable and/or angry most of the time, most of the week and these symptoms would fulfill criteria C and D of DMDD. Patient A.K. started to have these symptoms when he was first diagnosed at 8 years of age and has had these symptoms for the past two years, and these symptoms have occurred both at school and in his home. This would fulfill criteria E, F, G, and H of DMDD. Patient A.K. has never met the full criteria for a manic or hypomanic episode, and these symptoms did not occur in the settings of a major depressive episode or are better explained by another mental disorder, and this would fulfill criteria I and J of DMDD. Lastly, patient A.K.'s symptoms are not known to be caused by the physiological effects of a substance or another medical or neurological condition, and this would fulfill criteria K of DMDD. Per the DSM-5-TR, DMDD cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, and therefore I believe that the symptoms that patient A.K. presented with were best described by DMDD (American Psychiatric Association, 2022-a).

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Oppositional Defiant Disorder

The second differential diagnosis I assigned to patient A.K. was oppositional defiant disorder (ODD). Per the DSM-5-TR, criteria A of ODD states, "A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting for at least 6 months as evidence by at least 4 symptoms from any of the following categories, and are present during an interaction with at least one individual who is not a sibling: Angry/Irritable Mood: (1) often loses temper; (2) is often touchy or is easily annoyed; (3) if often angry and resentful" (American Psychiatric Association, 2022-b; Burke et al., 2024). Criteria A goes on to describe argumentative/defiant behavior as, "(4) Often argues with authority figures or, for children and adolescents, with adults; (5) Often actively defies or refuses to comply with requests from authority figures or with rules; (6) Often deliberately annoys others; and (7) Often blames others for his or her mistakes or misbehavior" (American Psychiatric Association, 2022-b; Burke et al., 2024). Criteria A continues with vindictiveness, " (7) has been spiteful or vindictive at least twice within the past 6 moths" (American Psychiatric Association, 2022-b). Criteria B goes on to state, "The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context or it impacts negatively on social, educational, occupational, or other important areas of functioning" (American Psychiatric Association, 2022-b; Burke et al., 2024). Criteria C goes on to state, "The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder, and they are not met for disruptive mood dysregulation disorder" (American Psychiatric Association, 2022-b; Burke et al., 2024). Patient A.K. has met the full diagnostic criteria for DMDD and therefore, would not also meet the criteria for ODD.

Intermittent Explosive Disorder

The last diagnostic criteria I assigned to patient A.K. was intermittent explosive disorder (IED). Diagnostic criteria A for IED states, "Recurrent behavioral outbursts representing a failure to control

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aggressive impulses as manifested by either of the following: (1) Verbal or physical aggression toward property, animals or other individuals, occurring twice weekly, on average, for 3 months where the physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals; or (2) Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period" (American Psychiatric Association, 2022-b; Patoilo et al., 2021). Criteria B of IED reads, "The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors" (American Psychiatric Association, 2022-b; Patoilo et al., 2021). Criteria C states, "The recurrent aggressive outbursts are not premeditated as in impulsive or anger-based and are not committed to achieving some tangible objective like money, power, or intimidation" (American Psychiatric Association, 2022-b; Patoilo et al., 2021). Criteria D of IED states, "The recurrent aggressive outbursts cause either marked distress in the individual or the impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences" (American Psychiatric Association, 2022-b; Patoilo et al., 2021). Next, criteria E states, " Chronological age is at least 6 years" (American Psychiatric Association, 2022-b). Lastly, criteria F states, " The recurrent aggressive outburstst are not better explained by another mental disorder, are not attributable to a medical condition, or to the physiological effects of a substance" (American Psychiatric Association, 2022-b). The DSM-5-TR goes on to state that for children aged 6-18 years that aggressive behavior that occurs in the setting of adjustment disorder should not be considered for this diagnosis (American Psychiatric Association, 2022-b). Again, patient A.K. better met the full diagnostic criteria for DMDD, so he would not also be diagnosed with IED at this time.

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Case Formulation and Treatment Plan

Psychotherapy and Nonpharmacologic Treatment

My first recommendation for patient A.K. would be to start exposure-based cognitive behavioral therapy with a local psychotherapist. Cognitive behavioral therapy (CBT) is an evidence-based practice that has been proven to help patients with disruptive mood dysregulation disorder (DMDD) develop effective coping strategies, regulate their moods, and manage their irritability (Naim et al., 2021). Exposure-based CBT targets increased reactivity to a frustrative nonreward, and irregular approach responses to threats (Linke et al., 2020). At minimum, I would recommend patient A.K. to attend 12 individual sessions lasting 60 minutes in length.

At the same time, I would recommend that his parents to attend parent management training (PMT). Studies have shown PMT to decrease (externalizing behaviors, oppositionality, impulsivity, and aggression that are characteristic of DMDD (Naim et al., 2021). The main goal of PMT is to facilitate the use of consistent positive reinforcement for adaptive child behaviors, and consistent nonreinforcement or mild negative consequences for maladaptive child behaviors (Linke et al., 2020). I would refer patient A.K.'s parents to a local psychotherapist who specializes in PMT for a minimum of 12 sessions that are 60 minutes each.

Pharmacologic Treatment

All prescription use in the setting of DMDD is considered off-label due to the lack of clinical trials in this newly-coined diagnosis (Tapia and John, 2018). Due to this newer diagnosis of DMDD, children with DMDD may be viewed and treated similarly to children with attention-deficit hyperactivity disorder (ADHD) and irritability or aggression (Hendrickson et al., 2020). Studies have shown improvement in

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symptoms with the use of stimulants, mood stabilizers, second-generation antipsychotics, and antidepressants (Hendrickson et al., 2020).

Patient A.K. has trialed Abilify 2mg by mouth daily at night for his mood/behavioral disturbances along with Guanfacine extended-release 1mg by mouth every morning for his behavioral disturbances. He has tolerated these medications but remains back in the children's crisis unit.

The first medication I would suggest for patient A.K. is Carbamazepine 100mg by mouth, twice daily. Carbamazepine, or Tegretol, has an FDA indication for seizures, trigeminal neuralgia, and bipolar disorder and is considered a mood stabilizer (Feder et al., 2018). It has an off-label indication for impulse control disorders, violence and aggression, bipolar maintenance therapy, and migraine prophylaxis (Feder et al., 2018). Carbamazepine is a sodium channel blocker and is metabolized primarily through the CYP3A4 pathway (Feder et al., 2018). The most common side effects are dizziness, somnolence, nausea, and headache (Feder et al., 2018). Serious, but rare complications include agranulocytosis, aplastic anemia, neutropenia, an increase in hepatic enzymes, hepatitis, hyponatremia, SIADH, and rash (Feder et al., 2018). I would educate both patient A.K. and his parents on these potential side effects and report them immediately if noted.

Prior to the initiation of carbamazepine, I would obtain baseline laboratory studies to include a complete blood count, a comprehensive metabolic panel, liver function tests, thyroid function tests, a carbamazepine serum level, and an ECG (Feder et al., 2018; Stahl et al., 2021). To follow up, I would have patient A.K. repeat a CBC every 2 weeks for 2 months to monitor for blood disorders and then every 3 months for the duration of treatment (Stahl et al., 2021). I would monitor his carbamazepine level with every dose change and also every 2 weeks (Stahl et al., 2021). I would also repeat liver function testing, kidney function testing, thyroid function testing, and sodium level monitoring every 6 months for the duration of treatment (Stahl et al., 2021).

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I would have patient A.K. follow up in the office after one week to assess his symptoms. The goal is a reduction of the symptoms of violence, aggression, and better pulse control. Carbamazepine can be titrated up to 100mg/day, weekly, but caution should be taken as a slower dose titration can delay the onset of the therapeutic action but can enhance the tolerability of the drug's sedating side effects, and slowly increasing the dose can also minimize the impact of carbamazepine on the bone marrow (Stahl et al., 2021). If no change in symptoms was noted after one week, I would increase his dose of Carbamazepine to 150mg by mouth twice per day and have him follow up again in one week.

In addition to the carbamazepine, I would also start patient A.K. on clonidine hydrochloride 0.1mg Tablet by mouth at nighttime as clonidine has FDA-approval for ADHD in children aged 6-17, and an off-label use for anxiety and ODD (Feder et al., 2018; Stahl et al., 2021). Clinical studies have shown clonidine to decrease residual hyperactivity, impulsivity, and aggression in children with ADHD, as well as help with sleep (Feder et al., 2018). Patient A.K. has a history of ADHD and clonidine is approved as a non-stimulant medication for ADHD that works by centrally acting on the postsynaptic alpha 2 receptors in the prefrontal cortex (Feder et al., 2018). It is metabolized primarily through the liver and is labeled as a centrally acting alpha 2 agonist (Feder et al., 2018).

Prior to the initiation of clonidine, I would obtain patient A.K.'s vital signs as clonidine will also lower blood pressure (Stahl et al., 2021). I would instruct patient A.K.'s parents to check his blood pressure nightly before his dose of clonidine and to hold the dose for a systolic blood pressure of less than 90mmHg. I would educate both A.K. and his parents that the most common side effects of clonidine are somnolence, fatigue, constipation, dizziness, and headache (Feder et al., 2018; Stahl et al., 2021). I would also educate them on the more severe side effects to monitor for including syncope, low blood pressure, and orthostatis (Feder et al., 2018). I would also educate both patient A.K. and his parents that the extended-release tablets need to be taken whole and cannot be chewed, crushed, or

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broken (Stahl et al., 2021). I would have patient A.K. return to the office in one week to reassess his symptoms. The goal is a reduction in his impulsivity and aggression, and a benefit is improved sleep. Clonidine ER can be increased by 0.1mg/day per week with a max dose of 0.4mg/day (Feder et al., 2018). Overall, studies have shown that the combination of CBT, PMT, and stimulation medication reduces irritability (Linke et al., 2020).

Health Promotion and Patient Education Strategy

One health promotion activity I would suggest to patient A.K. is for him to engage in a skill-building program or child and youth development program, as they can increase protective factors and healthy behaviors that can reduce risk factors that can lead to the development of mental disorders (Youth.gov, n.d.). Skill-building programs can be instructed by teachers or counselors and teach youth the skills to manage social interactions and how to control executive responses to anger and impulsivity (Youth.gov, n.d.).

One patient education strategy I would use in the case of patient A.K. is to fully educate both patient A.K. and his parents about disruptive mood dysregulation disorder. Patient A.K.'s parents can best learn how to support him and his DMDD diagnosis by learning about DMDD (Greenstein, 2018). I would educate all of them in the office and utilize the verbal teach-back method on patient A.K. and his parents to verify what information has been learned (U.S. Department of Health and Human Services, 2018).

Social Determinates of Health

Social determinants of health are conditions in which people are born, grow, live, work, and age that can affect health outcomes (Xiao et al., 2023). Factors associated with DMDD include disrupted family life, psychological abuse or neglect, early trauma, a parent having a psychiatric disorder, a single-

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parent household, limited parent education the death of a parent, parental grief, divorce, and malnutrition (American Psychiatric Association, 2022-a). Other factors associated with DMDD include a family history of depression, growing up in a postconflict war zone, or a community affected by racism and/or discrimination (American Psychiatric Association, 2022-a).

Patient A.K.'s biological mother had a history of bipolar disorder and since he was not adopted until he was 4 years of age, there is no information on if he had early childhood trauma. His biological father was not around, and therefore, he had a disrupted family life and was the product of a single-parent household.

Outpatient psychotherapy referrals for both patient A.K. and his parents were made. Patient A.K. was referred to exposure-based cognitive behavioral therapy and his parents were referred to Parent Management Training. Both patient A.K. and his parents were referred to the 'Managing Entities' website which is a state department that contracts for mental health services to find help in their area.

The following emergency numbers were provided to patient A.K. and his parents: 911 for any emergency, or call or text 988 in Florida to reach the Suicide and Crisis Lifeline (Florida Department of Health, n.d.). The Teen Line can be reached at 800-852-8336 Nationwide from 6 PM - 10 PM PST or TEXT 'TEEN' to 839863 and is an anonymous, nonjudgmental space for youth where teens can access personal peer-to-peer support from highly trained teens supervised by adult mental health professionals (Florida Department of Health, n.d.).

Patient A.K. was instructed to go to the nearest ER or call 911 if they become actively suicidal and/or homicidal. Time was provided for questions and answers. Provided supportive listening throughout the entire visit. Both the client and his parents verbalized understanding of the above-

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discussed information. Both the client and his parents are amenable to this plan and agree to follow the treatment regimen as discussed.

Reflections

Overall, I feel that the patient's health history and mental examination were adequately completed by my instructor and I agree with the diagnosis of disruptive mood dysregulation disorder. If I had the chance to go back and change anything, I would take the time to administer the Kiddie Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version (K-SADS-PL) assessment tool along with the DMDD module to assess for DMDD symptoms. I would also check baseline labs to include a complete blood count, comprehensive metabolic panel, thyroid screening, free T4, vitamin D level, and a urine drug screen to rule out other medical causes of illness.

This case study has really taught me how to differentiate disruptive mood regulation disorder from oppositional defiant disorder, intermittent explosive disorder, and bipolar disorder to name a few. When diagnosing DMDD, it is vital to collect a specific and thorough health history and physical examination to accurately rule out other causes of illness and other psychiatric diagnoses.

Questions

1. What other treatment options, either nonpharmacologic or pharmacologic, would be appropriate in the setting of this case study with patient A.K.?
2. Do you agree with the treatment plan? Why or why not? Provide supporting evidence.
3. What other differential diagnoses may be considered for patient A.K.? Provide supporting evidence.

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Conclusion

Disruptive mood dysregulation disorder, oppositional defiant disorder, and intermittent explosive disorder are all very similar diagnoses and it is important to complete a thorough health history and investigation into the patient's current symptoms to differentiate the correct diagnosis for your patient. When interviewing, assessing, and diagnosing children and adolescents, it is always imperative to obtain collateral information from parents and teachers to decipher the individual's behavior outside of the clinical setting.

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PRECEPTOR VERFICIATION:

I confirm the patient used for this assignment is a patient that was seen and managed by the student at their Meditrek approved clinical site during this quarter course of learning.

Preceptor signature: Marcela Alvarez-Payo, DNP, APRN-BC

Date: 4/3/2024

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