IED, ODD, Bipolar Disorder, Oh My!

When individuals with IDD struggle with mood regulation

NM START PROGRAM

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START Model

The START (**S**ystemic-**T**herapeutic-**A**ssessment-**R**esources-**T**reatment) model is an evidence-informed model of integrated community crisis prevention & intervention services for individuals ages 6 and older with intellectual and developmental disabilities and mental health needs.

START was first developed in 1988 by Dr. Joan B. Beasley and was cited as a best practice in the 2002 US Surgeon General's report and by the National Academy of Sciences in 2016.

The **National Center for START Services** at the UNH Institute on Disability oversees the development, measurement and quality of START programs across the country.

Objectives

1) Describe the differences between common diagnoses given to those with severe and challenging externalizing behaviors and mood regulation differences
2) Describe known medical and behavioral etiologies of these differences.
3) Identify novel intervention approaches, informed by positive and behavioral psychology, and trauma-informed care.

The **#1** reason children and adults are referred to NM START is because of **aggression**.

Severe and Challenging Behavior

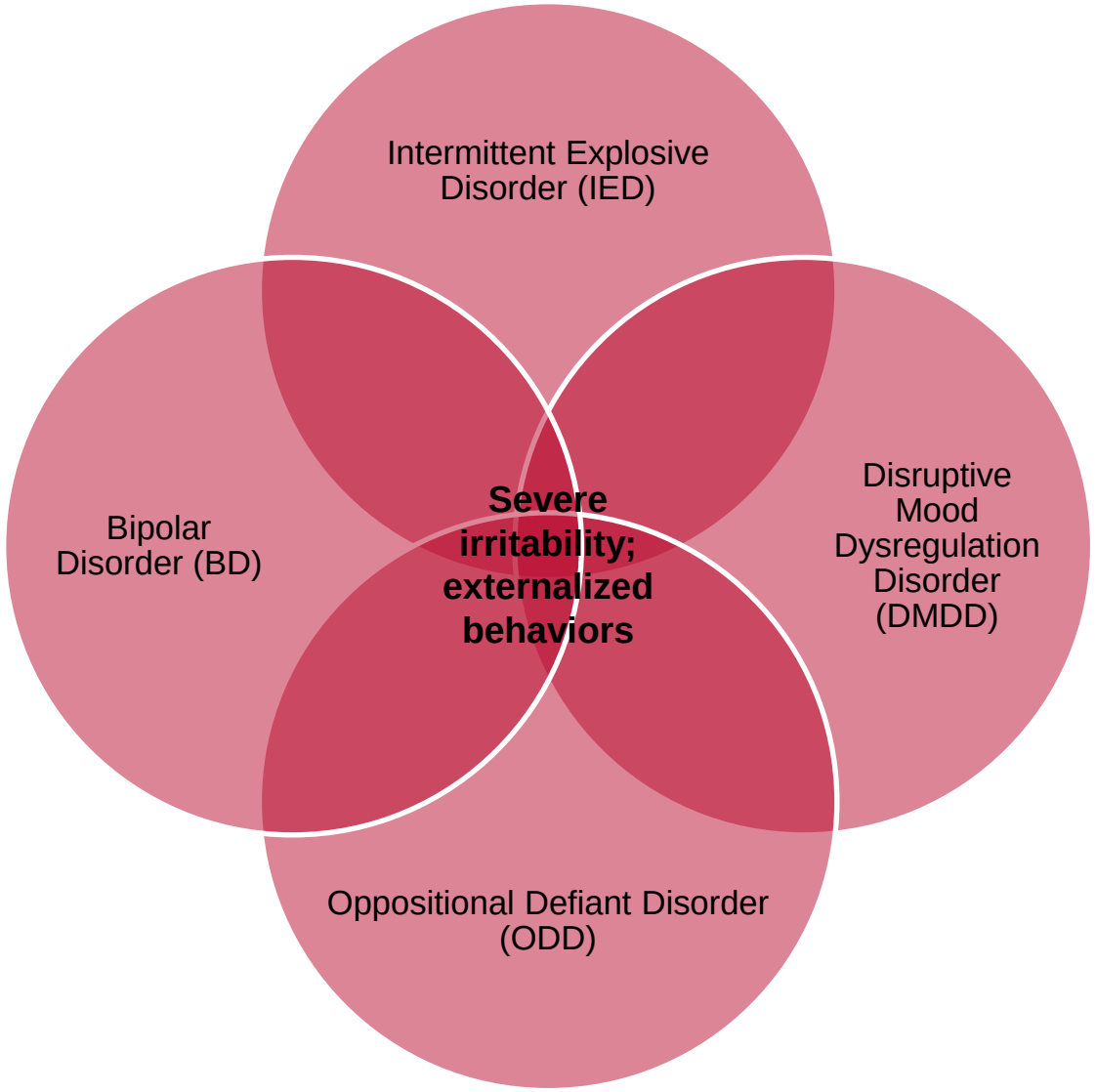
Aggression

- Prevalence estimates between 9-68% (varies by definition)
- Associated with age, language ability, IQ and adaptive functioning

Self-Injurious Behavior (including Non-Suicidal Self-Injury)

- Prevalence around 42%- 50%
- Occurs across lifespan
- Associated with adaptive functioning, communication, IQ, sleep, sensory processing, impulsivity and overactivity.

(Fitzpatrick, et al., 2016;Vandewalle & Melia 2021)


Intermittent Explosive Disorder (IED)
Bipolar Disorder (BD)
Disruptive Mood Dysregulation Disorder (DMDD)
Oppositional Defiant Disorder (ODD)
Severe irritability; externalized behaviors

Key Differences

Condition	Episode Duration	Between Episodes	Primary Pattern	Key Difference
Intermittent Explosive Disorder (IED)	About 30 minutes	Normal, calm behavior	Sudden anger explosions	Brief rage followed by exhaustion and regret
Bipolar Disorder	Days to weeks	Mood episodes continue	Cycles between depression and mania explosions	Long-term mood swings, not just anger
Disruptive Mood Dysregulation Disorder (DMDD)	All day, every day	Always irritable	Constant bad mood	No breaks from irritability, only diagnosed in children
Oppositional Defiant Disorder (ODD)	Ongoing for months	Consistently defiant	Argues with authority figures *Goal Oriented	Blames others, shows no remorse

Thriveworks

Other considerations

- IED and ODD require a developmental age of at least 6 years
- DMDD diagnosed between ages 6-18 with symptoms present before age 10
- Cannot diagnose ODD OR IED with DMDD
- BD can be diagnosed at any age, but tends to emerge in the teen years to early adulthood

Genetic predispositions, high family stress/ family dynamics, trauma (exposure to violence, emotional),

Trauma and ASD/ IDD

Individuals with ASD/IDD are more likely to endorse experiencing traumatic events

- More often
- Greater Intensity

Differences in

- Communication
- Cognitive functioning
- Actual experiences
  - Ostracism
  - Bullying
  - Medical procedures
- Sensory experiences
- Perceptions of social experiences

The Impact of Trauma

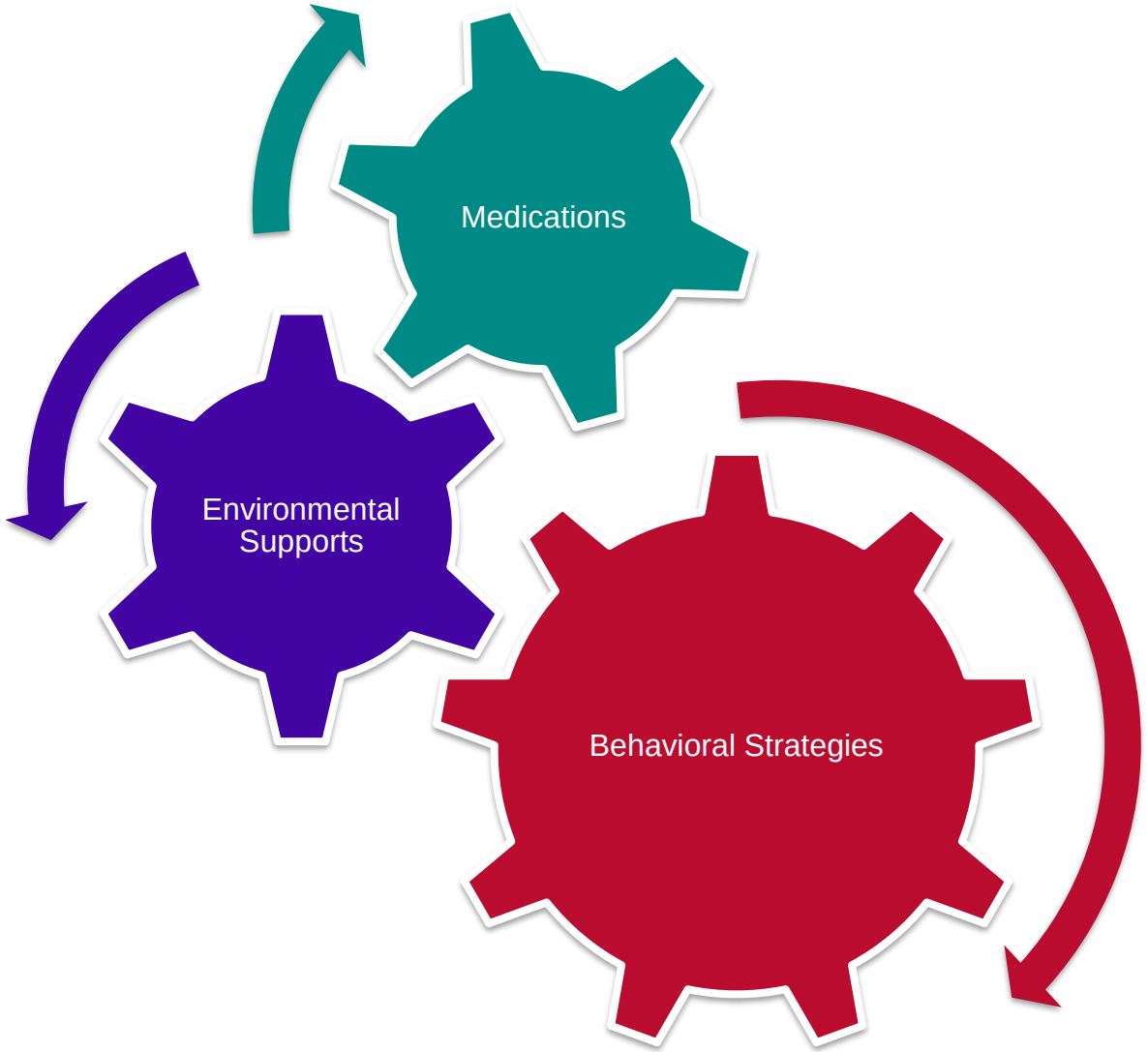
- A history of abuse or neglect is highly prevalent among bipolar disorder (estimated 40% to 80%)
- IED and ODD also shows a strong link.
- DMDD data is still emerging.

Common Treatments by Disorder

Disorder	Psychotherapy Approaches	Common Medications Used
IED	Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), anger management therapy, relaxation training, problem-solving skills	Selective serotonin reuptake inhibitors (SSRIs) like fluoxetine, mood stabilizers, anticonvulsants, and antipsychotics
ODD & DMDD	Parent training (Parent Management Training), family therapy, CBT, and DBT-C (for children)	Stimulants (often first-line if ADHD is comorbid), antidepressants (SSRIs), atypical antipsychotics, and mood stabilizers
Bipolar Disorder	CBT, family therapy, psychoeducation, and interpersonal and social rhythm therapy	Mood stabilizers (e.g., lithium, valproic acid, lamotrigine) and atypical antipsychotics are standard

Is there a treatment you often see students with disabilities receive that's not up here?

Yalin & Young, 2020; Yale Medicine, 2025; Mayo Clinic, 2024)


Medications
Environmental Supports
Behavioral Strategies

PRO: A model for fostering safety in group home settings

- 1) Life is as “ordinary as possible.”
- 2) Focus is not entirely on prevention of Challenging Behavior (CB).
- 3) Adapts to needs of service users
- 4) Encourages development of self-confidence
- 5) Offers unconditionality in support of relationship
- 6) Offers unconditionality in terms of housing
- 7) Staff well-being and competence prioritized
- 8) All professionals take responsibility for PRO care

(Lokman, et al., 2025)

References

- Lokman, S., Bal, R., Didden, R., & Embregts, P.J.C.M. (2025). Working to promote feelings of safety among individual with mild intellectual disabilities or borderline intellectual functionin who display severe challenging behaivor: A qualitative study within residential care. Journal of Mental Health Research in Intellectual Disabilities. DOI: https://doi.org/10.1080/19315864.2025.2542140.
- Yalin N, Young AH. Pharmacological Treatment of Bipolar Depression: What are the Current and Emerging Options? Neuropsychiatr Dis Treat. 2020 Jun 9;16:1459-1472. doi: 10.2147/NDT.S245166. PMID: 32606699; PMCID: PMC7294105.