

Supporting Co-Occurring Intermittent Explosive Disorder (IED) in Individuals with Autism

NM START PROGRAM

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START Model

The START (Systemic-Therapeutic-Assessment-Resources-Treatment) 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 unique presentation and prevalence of Intermittent Explosive Disorder (IED) in individuals with Autism.
- 2) Describe challenges of traditional management strategies for IED in individuals with Autism as specified in the literature.
- 3) Identify 3-5 evidence-based practical management strategies for parents, teachers and providers in handling challenging behaviors and crisis events for individuals with IED and ASD.

Aggression is the number
one reason for referral to
NM START

Diagnostic Criteria for IED

DSM-5 Diagnostic Criteria for IED (312.34)

- **Criterion A:** Recurrent behavioral outbursts representing a failure to control aggressive impulses, manifested by either:
 - **A1 (High-Frequency/Low-Intensity):** Verbal aggression (e.g., tantrums, tirades) or physical aggression towards property, animals, or people, occurring on average **twice weekly for 3 months**. This aggression does not result in physical injury or destruction of property
 - **A2 (Low-Frequency/High-Intensity):** **Three outbursts** involving physical assault or damage/destruction of property within a **12-month period**.
- **Criterion B:** The magnitude of aggression is grossly out of proportion to the provocation or stressor.

Diagnostic Criteria for IED, cont.

- **Criterion C:** Outbursts are **not premeditated** and are not aimed at achieving a tangible objective (e.g., power, money).
- **Criterion D:** Outbursts **cause marked distress, impairment in occupational or interpersonal functioning, or are associated with financial/legal consequences.**
- **Criterion E:** The individual is at least **6 years old** (or equivalent developmental age).
- **Criterion F:** Outbursts are not better explained by another mental disorder (e.g., Bipolar Disorder, ADHD, Conduct Disorder) or medical/substance use condition



Clinical Prevalence of IED

- **Lifetime Risk:** Studies show 6.3% to 7.3% of adults may experience IED. Mean age of diagnosis is around 14-15 years old.
- **Annual Prevalence:** Nearly 3% to 4% of the population meets the criteria for IED in any given year.
- **Demographics:** It is more common in younger adults (under 40) and those with a high school education or less. Found across all racial and ethnic groups, with research indicating higher prevalence rates among Black (9-12%), Hispanic (5.8%), and other non-white populations, often linked to socioeconomic factors rather than race alone. Is often associated with lower education, lower income, and younger age.
- **Comorbidity:** About 82% of individuals with IED also suffer from other conditions, such as depression, anxiety, or substance abuse.

Prevalence of IED in ASD

- Epidemiological studies on ASD with IED are limited
- Prevalence of aggressive behaviors in ASD is around 20% (1 in 5).
- Presence of co-occurring diagnoses with IED is 80%
- Most aggression is directed to caregivers versus non-caregivers

Difficulties with Diagnostic Overshadowing

- Response to sensory overload
- Emotional stress
- Fatigue
- Illness
- Involuntary reaction not premeditated
- Can involve rocking, injury, destruction, aggression, pacing, crying or running away



Autistic Meltdown

Explosive Tantrum

- Extreme, sudden outburst of rage
- Disproportionate reaction to a stressor
- Not premeditated
- Verbal or physical aggression
- Individual often states they feel out of control

Adverse Outcomes

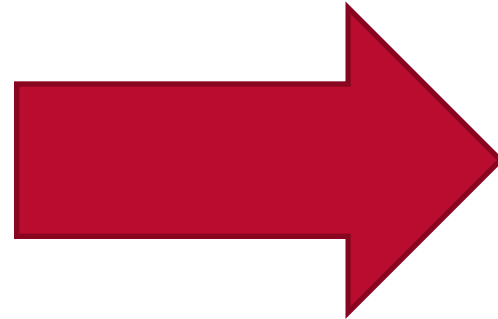
- Reduced participation in inclusive communities
- Removal from school or group home settings
- Hospitalization
- Law enforcement interaction
- Inability to work
- Caregiver burden/ injury



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Below the Surface: Cognitive Roots

- Alexithymia- difficulties understanding one's own emotions
- Anger Rumination- Continuous thinking about instances that cause anger.
- Empathy: Relating to the emotions of others.



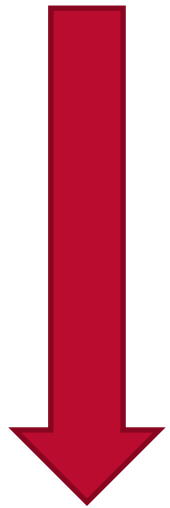
- Related to increased levels of aggression
- Related to increased levels of aggression
- No relationship. In fact, clinical groups tend to have higher sensitivity to emotions of others.

Why?

- Alexithymia
 - Individuals may not be aware of anger until it is beyond their control.
 - “0 to 100”
 - “Comes out of nowhere”
 - “Out of control”
- Anger rumination
 - Cyclical thinking
 - Primed for anger/aggression
 - Sadness rumination does not have SAME relationship
- Empathy
 - Hypersensitivity to negative emotions
 - Hostile attribution bias (“they’re mad at me”)

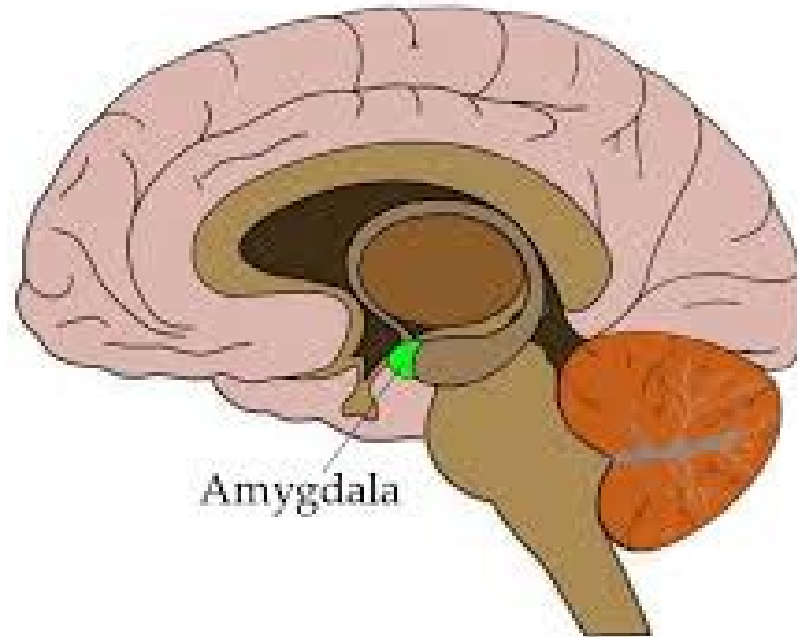


Below the Surface: Brain Function



Orbital Medial Prefrontal Cortex:

- Value-based decision making
- Emotional regulation
- Social cognition



Amygdala:

- Threat perception and response
- Emotional processing



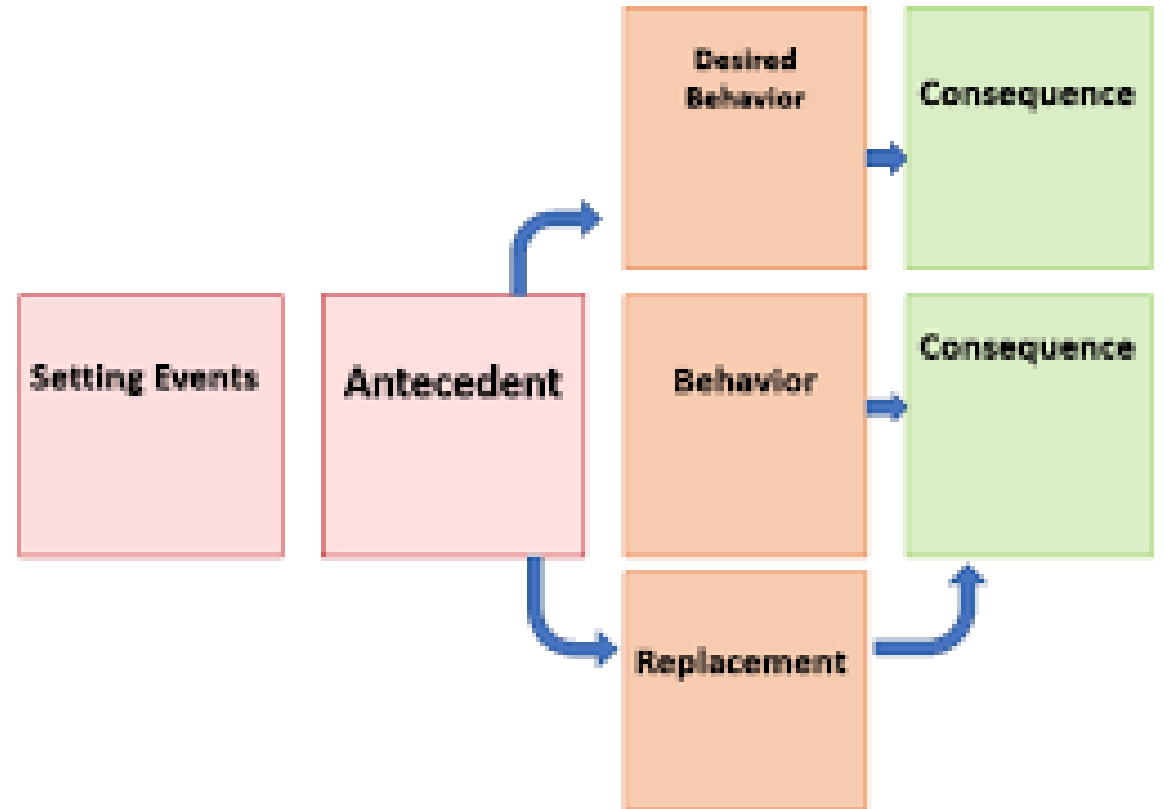
Treatment Recommendations for Aggression in Individual with ASD

Behavioral

Pharmacological

Behavioral

- Functional Behavior Assessment
- Differential Reinforcement
 - Non-contingent Reinforcement
- Functional Communication Training



Pharmacological

- Second Generation Antipsychotics
 - Risperidone
 - Aripiprazole
 - Clozapine
 - Olanzapine
 - Quetiapine
 - Ziprasidone
 - Paliperidone
 - Lurasidone
- First Generation Antipsychotics
 - Haloperidol
- Non-antipsychotic Medication
 - Antiepileptic medications
 - Lithium
 - N-acetylcysteine
 - Naltrexone

Therapeutic

- Cognitive Behavior Therapy
 - Address thought patterns
 - Support emotional awareness and regulation
- Combine with pharmacological (SSRI) treatment



Management of Refractory Aggression

- In a study of 135 individuals with ASD treated at a clinic, 39.5% met criteria for drug refractory behaviors (non-responsive to initial treatment)
- To date, there are no guidelines for treatment of refractory ASD-associated aggression (2016).
- Often include concomitant antipsychotic use
 - Relatively well tolerated
 - Safety concerns for children



Other Challenges

- Medication Adherence
 - Parent Decision
 - Person Resistance
- Adherence to Behavioral Protocol
 - Attrition
 - Family stressors/ recent changes
- Others?

(Liu & Yin, 2024)

References

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