

IED, ODD, Bipolar Disorder, Oh My!

When individuals with IDD struggle with mood regulation

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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 Alphabet Soup Chart

Aggression is the number
one reason for referral to
NM START

Severe and Challenging Behavior in Individuals with ASD

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)

A Point of Clarity

Profound ASD (Lord et al., ...)

Chronologically age 8 and older

Intellectual and Adaptive scores < SS 50

Nonverbal or minimally verbal

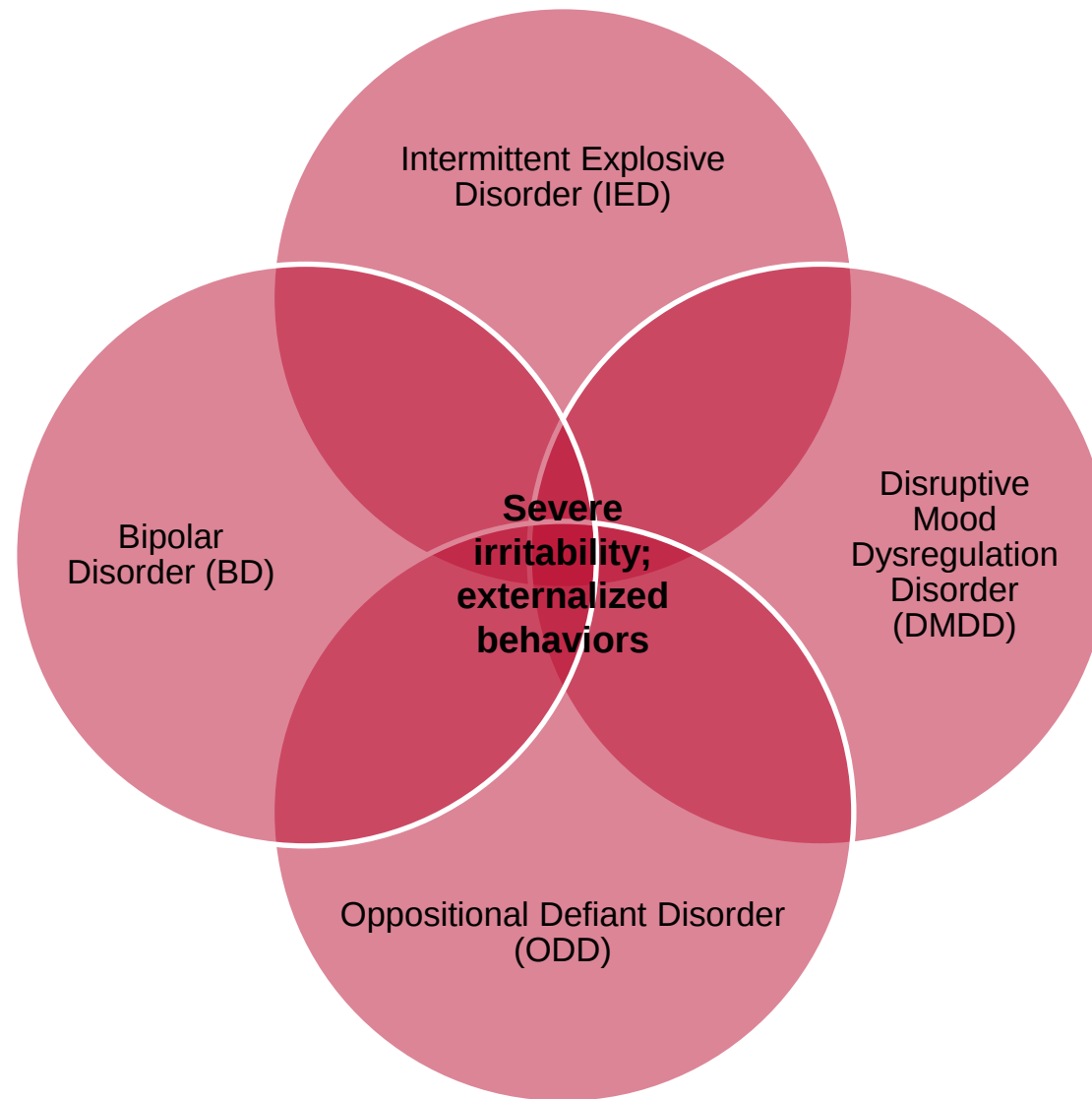
Requires 24/7 care and supervision



This is not who we are talking about today...

Today we are discussing

- Individuals over age 6
- Mild, moderate, borderline or typical intellectual abilities
- Verbal



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
				

(American Psychiatric Association, 2022)

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
- Bipolar Disorder can be diagnosed at any age, but tends to emerge in the teen years to early adulthood

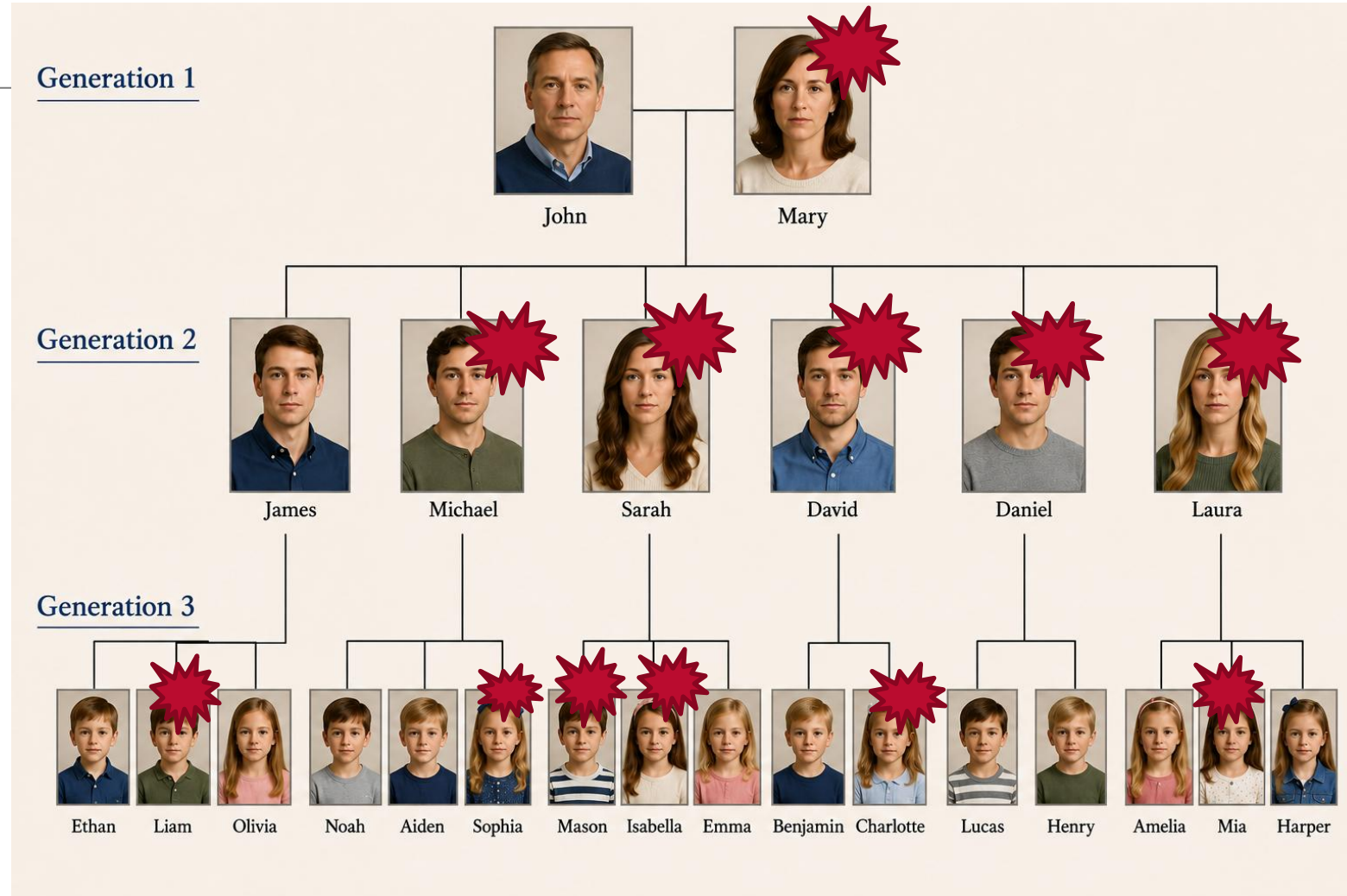
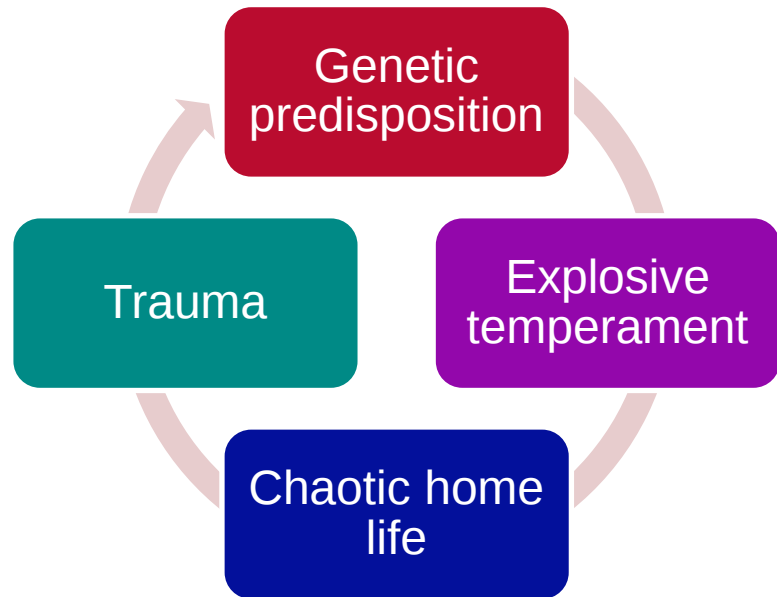
Clinical Prevalence of IED

- 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.



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

Genetic Predispositions/ Family Dynamics



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

Clinical Prevalence of Other Conditions

- Bipolar Disorder
 - Overlap in symptoms complicates diagnosis, prevalence estimates of co-occurrence and treatment (Vasconcelos-Moreno, et al., 2025)
- DMDD
 - Controversial new diagnosis
 - ASD is highest co-occurring condition in DMDD
 - Estimates suggest around 10% of kids with ASD have DMDD (Mayes et al., 2015)
- ODD
 - The elevated rate of ODD in autistic individuals is largely driven by co-occurring ADHD (Mayes et al., 2025)
 - 53% of kids with ADHD-Combined met criteria for ODD.
 - 62% of children with both autism and the combined type of ADHD display symptoms of ODD
 - 24% for autism without ADHD

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

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.



Adverse Outcomes

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

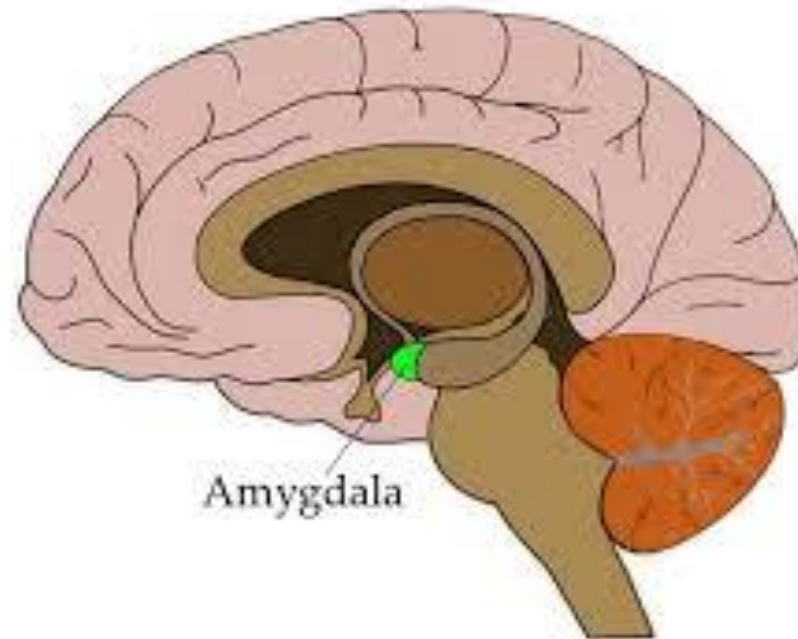


Below the Surface: Brain Function



Orbital Medial Prefrontal Cortex:

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

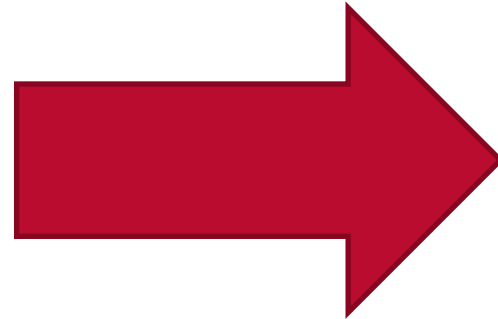


Amygdala:

- Threat perception and response
 - Emotional processing
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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”)



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?

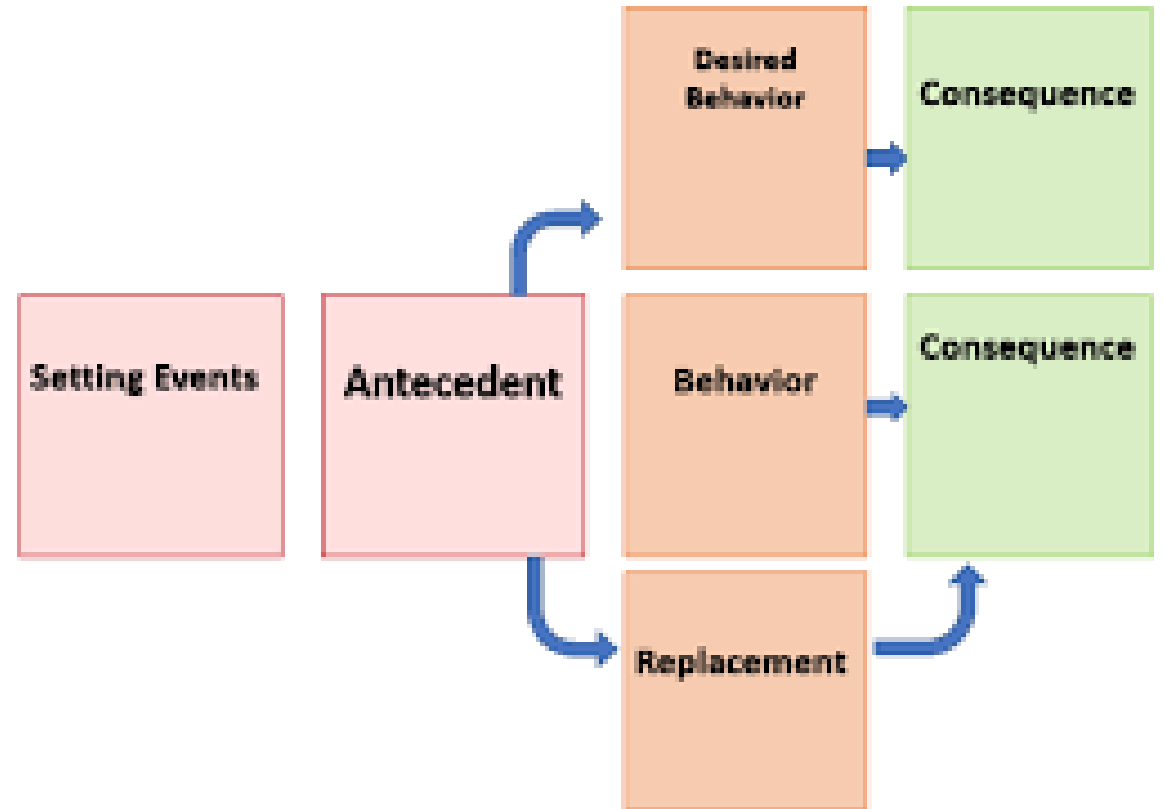
Is ABA indicated?

- Targets/ skills?
- Environmental support
- Social validity?



Behavioral

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



Environmental Support

- High predictability
- Low stress/ stimulation
- Ample time and space to regulate
- Co-regulation

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

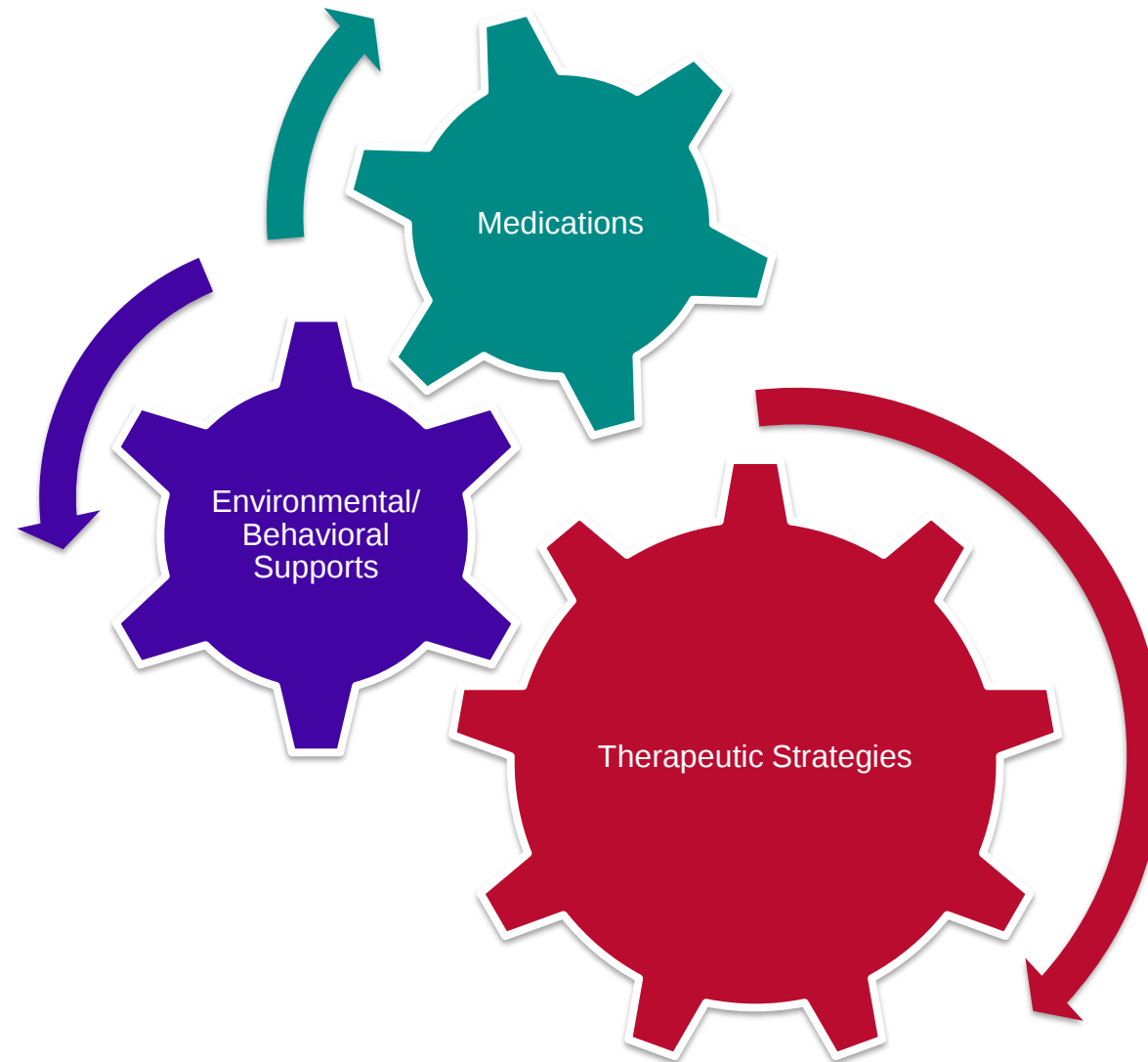
- In a study of 135 individuals with ASD treated at a clinic, 39.5% met criteria for drug refractory behaviors (non-responsive to initial treatment)
- To date, there are no guidelines for treatment of refractory ASD-associated aggression (2016).
- Often include concomitant antipsychotic use
 - Relatively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



Other Challenges

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





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)

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- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.; DSM-5-TR). American Psychiatric Association Publishing. <https://doi.org/10.1176/appi.books.9780890425787>
 - Lokman, S., Bal, R., Didden, R., & Embregts, P. J. C. M. (2025). Working to promote feelings of safety among individuals with mild intellectual disabilities or borderline intellectual functioning who display severe challenging behavior: A qualitative study within residential care. *Journal of Mental Health Research in Intellectual Disabilities*. <https://doi.org/10.1080/19315864.2025.2542140>
 - Mayes, S. D., Waxmonsky, J. G., Calhoun, S. L., Bixler, E. O., Kokotovich, C., Mathiowetz, C., & Boweja, B. (2015). Disruptive mood dysregulation disorder symptoms in children with autism, ADHD, and neurotypical development and impact of co-occurring ODD, depression, and anxiety. *Research in Autism Spectrum Disorders*, 18, 64–72. <https://doi.org/10.1016/j.rasd.2015.07.008>
 - Mayes, S. D., & Waschbusch, D. A. (2023). Oppositional defiant disorder in autism and ADHD. *Journal of Autism and Developmental Disorders*. <https://doi.org/10.1007/s10803-024-06473-8>
 - Vasconcelos-Moreno, M. P., Prates-Baldez, D., Santos-Terra, J., Deckmann, I., Di Gesu, N. M., Lemann, R. S., Riesgo, R., Goffinett, C., & Kapczinski, F. (2025). Clinical interplay between autism spectrum disorder and bipolar disorder: A narrative review. *Trends in Psychiatry and Psychotherapy*, 47, e20240393. <https://doi.org/10.47626/2237-6089-2024-0039>
 - Yalin, N., & Young, A. H. (2020). Pharmacological treatment of bipolar depression: What are the current and emerging options? *Neuropsychiatric Disease and Treatment*, 16, 1459–1472. <https://doi.org/10.2147/NDT.S245166>