

Information about:

Oppositional Defiant Disorder

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Vermont
Family
Network

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Introduction

Information About Oppositional Defiant Disorder (ODD) is part of a series of information packets developed by the Vermont Family Network (VFN). Designed to provide basic information, the packet includes fact sheets, articles, advocacy tips, and resources for families of children with special needs and for the professionals working with them.

After reading the packet, we hope that you'll have a greater understanding of oppositional defiant disorder (ODD) and the ways in which parents and professionals can support children at home, in school, and in the community. We've selected information from a variety of sources, and many articles are on the Internet.

Thank you to BEST (Building Effective Strategies for Teaching), Vermont Department of Education, for making this publication possible. Thanks also go to the organizations and authors who gave us permission to use their articles and fact sheets. Use of any specific articles in this packet is meant for information purposes only and doesn't indicate any endorsement on the part of VFN of the views and opinions of the authors.

Because your comments are important to us, we've included a reader's response form at the end of the packet. Please take a few minutes to fill it out and return it to our office. Thank you.

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Children With Oppositional Defiant Disorder

No. 72; Updated June 2009

All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family and academic life.

In children with Oppositional Defiant Disorder (ODD), there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Symptoms of ODD may include:

- Frequent temper tantrums
- Excessive arguing with adults
- Often questioning rules
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Mean and hateful talking when upset
- Spiteful attitude and revenge seeking

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school. One to sixteen percent of all school-age children and adolescents have ODD. The causes of ODD are unknown, but many parents report that their child with ODD was more rigid and demanding than the child's siblings from an early age. Biological, psychological and social factors may have a role.

A child presenting with ODD symptoms should have a comprehensive evaluation. It is important to look for other disorders which may be present; such as, attention-deficit hyperactivity disorder (ADHD), learning disabilities, mood disorders (depression, bipolar disorder) and anxiety disorders. It may be difficult to improve the symptoms of ODD without treating the coexisting disorder. Some children with ODD may go on to develop conduct disorder.

Treatment of ODD may include: Parent Management Training Programs to help parents and others manage the child's behavior. Individual Psychotherapy to develop more effective anger management. Family Psychotherapy to improve communication and mutual understanding. Cognitive Problem-Solving Skills Training and Therapies to assist with problem solving and decrease negativity. Social Skills Training to increase flexibility and improve social skills and frustration tolerance with peers.

Medication may be helpful in controlling some of the more distressing symptoms of ODD as well

as the symptoms related to coexistent conditions such as ADHD, anxiety and mood disorders.

A child with ODD can be very difficult for parents. These parents need support and understanding. Parents can help their child with ODD in the following ways:

- Always build on the positives, give the child praise and positive reinforcement when he shows flexibility or cooperation.
- Take a time-out or break if you are about to make the conflict with your child worse, not better. This is good modeling for your child. Support your child if he decides to take a time-out to prevent overreacting.
- Pick your battles. Since the child with ODD has trouble avoiding power struggles, prioritize the things you want your child to do. If you give your child a time-out in his room for misbehavior, don't add time for arguing. Say "your time will start when you go to your room."
- Set up reasonable, age appropriate limits with consequences that can be enforced consistently.
- Maintain interests other than your child with ODD, so that managing your child doesn't take all your time and energy. Try to work with and obtain support from the other adults (teachers, coaches, and spouse) dealing with your child.
- Manage your own stress with healthy life choices such as exercise and relaxation. Use respite care and other breaks as needed

Many children with ODD will respond to the positive parenting techniques. Parents may ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist or qualified mental health professional who can diagnose and treat ODD and any coexisting psychiatric condition.

See also:

[eAACAP Oppositional Defiant Disorder Resource Center](#)

This resource center offers a definition of the disorder, answers to frequently asked questions, and information on getting help.

For additional information see other *Facts for Families*:

www.aacap.org/cs/root/facts_for_families/facts_for_families_numerical_list

[#6 Children Who Can't Pay Attention/ADHD](#)

[#16 Learning Disabilities](#)

[#4 The Depressed Child](#)

[#38 Manic-Depressive Illness in Teens](#)

[#52 Comprehensive Psychiatric Evaluation](#)

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[#00 Definition of a Child and Adolescent Psychiatrist](#)

Excerpts from *Your Child* on Oppositional Defiant Disorders

All children are oppositional from time to time. There are also times in normal development when oppositional behavior is expected. This is especially true when the thrust towards separation is most intense, around the ages of two and three, and again in early adolescence.

However, openly uncooperative and hostile behavior becomes a serious concern when it is so incessant and fierce that it stands out when compared with other children's behavior and when it affects the child's social, family, and academic life.

Excerpts from *Your Adolescent* on Oppositional Defiant Disorders

At times, all teenagers are oppositional, argumentative, and inattentive. Absorbed in their own thoughts and concerns and more interested in their peer group, teenagers frequently turn a deaf ear to the adult world. Even when the demands are reasonable, a teenager may respond with belligerence or passivity. Because the thrust toward separation is especially intense, adolescence is a time when oppositional behavior is sometimes expected.

Disrespectful, defiant, and hostile behavior, however, must be carefully examined in a teenager when it begins to affect the youngster's social, family, and academic life or seems extreme compared to the teen's peers.

See also: *Your Child* (1998 Harper Collins) / *Your Adolescent* (1999 Harper Collins)

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You may also mail in your contribution. Please make checks payable to the AACAP and send to Campaign for America's Kids, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 7,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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The information on this website is provided for general reference purposes. It does not constitute medical or other professional advice and should not be used as a substitute for the medical care and advice of your child and adolescent psychiatrist or other physician. Only a qualified, licensed physician can determine the individual treatment that is appropriate for your particular circumstances. All decisions about clinical care should be made in consultation with a physician.

Oppositional Defiant Disorder

What is ODD?

ODD is a persistent pattern (lasting for at least six months) of negativistic, hostile, disobedient, and defiant behavior in a child or teen without serious violation of the basic rights of others.

What are the symptoms of ODD?

Symptoms of ODD may include the following behaviors when they occur more often than normal for your age group:

losing your temper

arguing with adults; defying adults or refusing adult requests or rules

deliberately annoying others

blaming others for your own mistakes or misbehavior

being touchy or easily annoyed

being angry and resentful

being spiteful or vindictive

swearing or using obscene language

having a low opinion of yourself

The person with ODD is moody and easily frustrated, has a low opinion of him or herself, and may abuse drugs.

What causes ODD?

The cause of Oppositional Defiant Disorder is unknown at this time. The following are some of the theories being investigated:

It may be related to the child's temperament and the family's response to that temperament.

A predisposition to ODD is inherited in some families.

There may be problems in the brain that cause ODD.

It may be caused by a chemical imbalance in the brain.

What happens to people who have ODD?

The course of Oppositional Defiant Disorder is different in different people. It is a disorder of childhood and adolescence that usually begins by age 8, if not earlier. In some children it changes into a conduct disorder or a mood disorder. Later in life, it can develop into Passive Aggressive Personality Disorder or Antisocial Personality Disorder. With treatment, reasonable social and occupational adjustment can be made in adulthood.

What is the treatment of Oppositional Defiant Disorder?

Treatment of ODD usually consists of group, individual and/or family therapy and education, keeping a consistent daily schedule, support, limit-setting, discipline, consistent rules, having a healthy role model to look up to, training in how to get along with others, behavior modification, and sometimes residential treatment, day treatment and/or medication.

What can I do to deal with my ODD?

Attend therapy sessions.

Use self time-outs.

Identify what increases anxiety.

Talk about feelings instead of acting on them.

Find and use ways to calm yourself.

Remind yourself often of your goals.

Get involved in tasks and physical activities that provide a healthy outlet for your energy.

Learn how to talk with others.

Develop a predictable, consistent, daily schedule of activity.

Figure out ways to have fun and feel good.

Learn how to get along with other people.

Find ways to avoid getting too riled up.

Learn to admit mistakes in a matter-of-fact way.

What can I do to keep the symptoms from coming back once they're under control?

During a period of good adjustment, the patient and his family and the therapist should plan what steps to take if signs of relapse appear. The plan should include what specific symptoms are important warnings of relapse. Make an agreement to call the therapist right away when those specific symptoms occur, and at the same time to notify friends and other people who can help. Plan ahead for specific ways to limit stress and stimulation and to make the daily schedule more predictable and consistent if warning signs of relapse appear.

Where can I get more information about ODD?

There are some good books about ODD and its treatment

Russell Barkley Defiant Children, second edition. Guilford Press, 1997.

Rex Forehand and Nicholas Long Parenting the Strong-Willed Child. NTC Publishing Group, 1996.

Ross W. Greene The Explosive Child. Harper Collins, 1998.

Robert L. Hendren (editor) Disruptive Behavior Disorders in Children and Adolescents. In Review of Psychiatry, vol. 18, American Psychiatric Press, 1999.

Harold Koplewicz. Its Nobodys Fault: New Hope and Help for Difficult Children and Their Parents. Random House, 1997.

Carol W Peschel et. al., (editors) Neurobiological Disorders in Children and Adolescents. Jossey-Bass, 1992.

The following organizations can provide help, information and support:

American Academy of Child and Adolescent Psychiatry

A professional organization that provides many publications for the layperson. Call 202-966-7300 or reach them online at www.aacap.org

Family Self-Help Group for Parents of Children and Adolescents

Sponsored by the National Alliance for the Mentally Ill (NAMI). Offers support, information and advice for parents of children with psychiatric disorders. To see if there is a group in your area, call NAMI at 1-800-950-NAMI or reach them online at www.nami.org

Family Ties

A self-help group for parents of children with psychiatric or behavior problems.

Call your local self-help clearinghouse for information about meetings near you, or call the National Self-Help Clearinghouse at 1-212-817-1822. Not available in all areas.

Toughlove

Provides mutual support for parents whose children are having trouble. A self-help group. You can find their number in your local telephone book, or reach them online at www.toughlove.com

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ODD: Why an Assessment is Necessary

Hardly a week goes by that I don't receive several dozen emails from parents, grandparents and teachers. They note that their child, grandchild or student is definitely ODD (Oppositional Defiant Disorder). When I ask how the youngster was diagnosed, I'm often told that they, the parent, grandparent or teacher, made the diagnosis themselves based on the observable symptoms and behaviors.

If only it were this easy. I've always held to the notion that effective intervention must follow accurate assessment. Otherwise, a condition could be treated as one thing when it is actually something else. In such a case not only will interventions not be effective, appropriate diagnosis and treatment are overlooked. This could cause the real problem to fester and worsen.

There are a number of childhood conditions that present much the same symptoms and behaviors as ODD. These include depression, anxiety disorders, ADHD, stress disorders, bipolar conditions, emerging personality disorders, medical conditions and other concerns. An evaluation and diagnosis of ODD must consider all of these and determine that they are not the child's primary condition or disorder, or that two or more conditions coexist (comorbidity). An accurate evaluation of ODD must also determine the severity and impact of the child's symptoms and behaviors over time, exactly how the behaviors affect others, and the overall clinical significance of the disorder as it could affect the growth and development of the youngster. In short, an effective evaluation is a complete mapping of an uncharted region ... the inner workings of a child.

Components of a Comprehensive Assessment

I'm clear on the fact that there is no one way to do an evaluation. (I'm referring to the terms *assessment* and *evaluation* and being the same thing.) What is listed here is a model for a process I used for years. It represents what I consider to be the basics. (Because of my writing and speaking schedule, I rarely do evaluations anymore.) I normally do not repeat parts of an assessment that have been done recently, such as testing at school. If the reports and records contain the information I need, I use them. This can save time and it's easier on the child, not to mention the benefit to the parents' pocketbook.

Review of available records and reports: Unless we take a look, information valuable to treatment can remain buried. I once evaluated a fourth grade girl whose medical background indicated that she had reduced hearing in one ear and no hearing in the other. The teacher did not know this. The child was

seated in the back of the room with her best ear to a wall. Behaviorally she looked indifferent, uncooperative and noncompliant. She did an abrupt turnaround with a little preferential seating.

Interviews with parents and teachers: This can be done in writing, in person, or both. I generally ask parents and teachers to write down their concerns in order of priority ... on *one* sheet of paper (this keeps it quick, focused and concise). I ask them to also briefly list the youngster's three best strengths or qualities. If a child has several teachers, I prefer that they all do a page on the child. It's amazing how this little activity can quickly differentiate between problem and non-problem areas at home and school. If we don't have to "fix" everything, the job is easier.

Perceptual-motor assessment: Some examiners would leave this one out of the assessment. I consider it to be essential with an ODD youngster because the child either doesn't want to answer your questions initially, or they are apt to tell you what they think you want to hear (especially if they think they're in trouble). By giving a couple of drawing tasks that require no speaking at all, I positively disrupt what the child is expecting. Also, distinct patterns of oppositional and defiant behavior can be uncovered on these instruments, often without the child even knowing it.

Assessment of academic functioning: Why is this child not completing school work? Is the work too difficult (always a possibility), or is the *child* too difficult? This part of the assessment doesn't have to be all that deep, but it does need to settle the issue of potential versus performance.

Assessment of intellectual functioning: IQ testing can signal areas of interest, strengths and needs, learning modalities and potential for insight, all of which are helpful in developing intervention. Extremes in intellectual functioning can present difficulty. Mentally retarded oppositional and defiant youngsters are resistant to change; they have trouble developing insight into their behavior (they have to experience consequences instead of considering "What if ..." as motivation to change behavior). Of course, if a child is seriously deficient in intellectual skills, you probably already know it. Really bright youngsters, on the other hand, already know they're smarter than the adults; they stay a jump ahead of everyone.

Projective assessment: Projective assessment consists of questions and challenges that have no right or wrong answers. This assessment serves to evaluate how youngsters structure their responses to the tasks. Assessment instruments include the famous "ink blot" cards, sentence completion questions and open-ended thematic (story) cards. The examiner looks for content and patterns of responses that can lend insight into the child's emotional and psychological state. Since youngsters typically have little experience with projective assessment, this part of the evaluation is difficult

for the child to “fake” or manipulate. For the same reason, it’s a part of the assessment that can make them uncomfortable. But even this discomfort is diagnostically valuable; it shows how youngsters handle situations they cannot control.

Diagnostic Interview: I put the diagnostic (clinical) interview at the end of the assessment because it can affect rapport. However, in the hands of a skilled and compassionate interviewer, it can deepen rapport. It just depends. I use an interview I wrote; it consists of 155 questions that sample a child’s perception of how they operate in the essential “Life Fields” of school, home and community, peers and self. The interview is extremely comprehensive, covering everything from relationships to drug/alcohol use to depression to suicidal thoughts or gestures. (Obviously, I don’t use the whole interview with young children.) The interview not only collects valuable information in the child’s own words, it lets the child consider their needs and priorities for intervention. What better place to start counseling or therapy than with an issue the child *already* sees as pertinent?

What it Means, Where to Go, What to Pay

Any psychologist will tell you that the most difficult part of an assessment is the challenge of making sense of all the information collected. This involves pulling together all the pieces and parts into a narrative interpretation of the assessment, providing a diagnosis (if appropriate), and offering plenty of practical recommendations for treatment and intervention at home and school.

A comprehensive assessment is usually done by a psychologist, but it can be done by anyone having the training and certification or licensure to do so. I recommend that parents find someone who specializes in children and adolescents. A referral from a pediatrician would be a good place to start, as would the psychology or special education departments of a local university. Large counties, especially those with large cities, often have a psychological association; members can be accessed through a referral line. Also, child psychiatrists sometimes have a psychologist on staff or available to do assessments.

Fees vary, but generally run between \$500 and \$1500, depending on customary fees in the area and, quite frankly, the reputation and track record of the assessment professional. These expenses are usually covered, at least in part, under health insurance.

James D. Sutton, EdD, Consulting Psychologist, www.DocSpeak.com

Tips for Parents: Could something REALLY be wrong with my difficult child?

Yes, No, Maybe.....

- **Trust your intuition.**
If you have a gut feeling that something is not right, trust that feeling. Intuition is real. Find time to be very quiet and listen. Ask for guidance and don't be "attached" to one answer or outcome. Be open to all avenues and suggestions that come in the stillness. This requires courage and faith.
- **No one knows your child better than you do.**
Other people see your child in different settings under various conditions. You are the only one who sees everything. Watch other children and compare behavior.
- **If you feel that something is not right, take action.**
Read, investigate, find the answers. It would be nice if someone else would do this for you, but don't count on it. You will be your child's advocate for life. Worrying is useless, a waste of time and energy. Channel that energy into finding answers.
- **Don't blame anyone else.**
It's too easy to blame the teachers, your ex-spouse, siblings... but it won't do any good. This won't help your child. Another waste of time and energy.
- **Give up on excuses.**
Every child deals with something. Coping is a skill that normally developing kids can learn. If a child isn't learning to cope, there may be a real problem preventing that process. Being a "fall birthday," "a boy", an "only child", "adopted", ... such labels hide real problems. If the other parent or grandparents assure you that nothing is wrong, TRUST YOUR INTUITION. Their denial won't help your child.
- **Don't blame yourself.**
No matter what your spouse or your mother or your mother-in-law or your neighbor says, don't blame yourself unless you KNOW that you are a terrible, neglectful, abusive person. If you are, get help. If you are doing the best that you can do and it still isn't enough, your child has a

problem. You may need help in learning to cope with the problem, but the only thing you can blame is GENETICS, maybe.

- **Find a support group.**
This can be a hard road and the support of other parents who have dealt with similar issues can save your sanity. You are not the first and you will not be the last one to face such things. Trying to do this alone or trying to be everything for a problem child can drain all the energy in the family.
- **Be relentless.**
If your child's problem has a physical cause, find the right diagnosis, the right medication, the right dosage.

Don't rule out a physical cause unless someone solves the problem completely. When working with professionals, don't accept a less-than-adequate explanation. Some conditions have many different facets and each area requires treatment.

- **Ask questions.**
This is your child's life. Ask questions. Question answers. Don't stop until you are satisfied. When your child is enjoying life and you are enjoying your child, you've found the right path.
- **Become an expert.**
Read, investigate, search. Always question the source. Learn to differentiate between sound knowledge and quackery. Don't waste time listening to someone who knows someone whose cousin's neighbor had a child just like yours. Do expect connections and answers to come from "out of nowhere." Pursue these. This is a quest.

Elaine Gibson, www.conductdisorders.com.

Adapted for use by Vermont Parent Information Center, June, 2003

7 Tips for Getting Along Better with Your Kids

Tip #1: Affirm Unconditionally. Whether we like it or not, we live in a conditional society. We have to perform to stay employed. Sometimes our children sense that they must perform to be loved. They have difficulty separating who they are from what they do, and unfortunately we too often add to the confusion by praising our kids when they make the team, if they make first chair trombone, and because they won the contest. Although there is nothing wrong with recognizing a child's accomplishments, such affirmation must balance with recognizing the youngster's unconditional value.

One way to do this is to simply say to the youngster, "You know Suzie, I was just thinking about something. I know that we have our differences from time to time, but, through it all, you're one of the best things that ever came into my life. You don't have to say anything; I just wanted you to know." The secret to making this affirmation "stick" is to immediately ask a non-related question (such as, "Say, can you tell me where the scissors are?"), leave the room, or in some way make it comfortable for the youngster not to respond to what you have said.

Casual notes left on the bathroom mirror are another way to affirm a youngster without him or her feeling like you are making a "big deal" out of it. Keep affirming in small, almost "casual," ways. It will begin to pay off.

Tip #2: Empower the Youngster with Choices. Whenever possible, allow the youngster to exercise skills of decision-making by offering choices. This is especially helpful with the youngster who has difficulty completing tasks, as the child is more apt to initiate and complete that which he or she has selected. For instance, give the youngster five cards, each of which has an assigned task written on it. Tell the child that, if he or she begins the tasks within ten minutes (point to the clock) and completes them, only three of the tasks need be done; two cards can be returned. This approach not only eliminates a number of hassles, it is usually perceived by the child as being a fair and reasonable gesture.

Tip #3: Occasionally Let the Youngster Lead. If you have a youngster who is sometimes critical of the way you do things, let them plan the next family outing or activity. Provide a few guidelines and a budget, then let the kid have a go at it. This won't necessarily ensure that everyone will have a great time on the activity, but it will eliminate much of the complaining. Be certain to recognize the youngster for his or her efforts.

I encourage families to have a message center, the "Important Things to Remember" Board (on or near the refrigerator, of course). Things that are important, such as appointments and activities, are on the Board, and everyone is expected to read it and be responsible daily for what is on it. "I didn't know" is not an excuse. Let the youngster take responsibility for posting messages on the Board for a week, as you pass this responsibility around to family members who can handle it. This strategy also ensures that the youngster in charge of the Board will not "forget" what is on it. Again, recognize efforts.

Tip #4: Make Tasks Fun. There's no rule that says that chores and tasks have to be miserable and never-ending. It's a fact, however, that more conflicts occur within families over issues of tasks (including homework) than anything else.

If your children have a set time to complete chores at home, try implementing the "Caught You!" Award. Set a timer to go off sometime during chores, telling the youngsters that, whenever the timer goes off, they will win an award (such as a prize, extra allowance, or a later bedtime) if they are "caught" doing the chore. Not only does this approach make it more likely that chores will get done, it is fun to do.

Another fun way to approach tasks is called "Slip and Draw." Every time your children complete a homework assignment, or some other task or chore, give them a slip of paper to sign ("certify" the slips by initialing them on one side with a colored pen). The slip is then placed in a coffee can with a slit cut in the lid. At the end of several days or a week, have a drawing for a nice prize (it helps if the prize is displayed in a very conspicuous place). Youngsters quickly figure out that the more slips they have in the can, the better chance they have of winning. The more slips, the more completed task---and the fewer problems.

Tip #5: Lighten Up. If we're not careful, we'll become so overcome by parenthood we'll neglect the opportunities to enjoy it. Hang on to your sense of humor; you'll need it. Spontaneity is a great source of fun, and when done in good faith, it almost always improves relationships. Food fights and water-gun duels are messy, but loads of fun. No harm is intended or taken, and everyone joins in on the cleanup.

Let your kids know that parents aren't perfect. Encourage them to let you know (appropriately) if you do or say something that bothers them or hurts their feelings. If you were wrong, apologize. Everyone makes mistakes, but those with real class stand responsible, and try to set things straight as best they can.

Want to really make an impression on your children? Let them self-evaluate. When given an opportunity to evaluate themselves, kids are usually tougher than the adults. I got this idea from a teacher who essentially eliminated all complaining and grumbling in her classroom. She would give her students an

assignment, along with a simple checklist which had a sticker paper-clipped to it. Any youngster who completed the checklist (stayed in seat, worked silently, and completed the assignment) could turn it in with the assignment and keep the sticker. She said it worked very well. It would not be difficult to modify this approach to the home environment. For example, prepay a child for doing an extra task, and let them determine if they should keep the money or not. If this approach doesn't work, don't repeat it, but it's worth a try.

Tip #6: Spit in the Soup. Sometimes stronger action is called for. Think about it. If, during lunch with a friend, you lean over and spit in their soup, there are a number of things you could say. You couldn't, however, say that it was a mistake. It was a deliberate act. If you have a child who too often drags his or her feet, a simple provocative statement can be just the ticket to create some sort of action. An example might be, "Johnny, I was kind of wondering if you were going to forget to put the trash out on the street like last week and the week before? I'm going to watch and see if you put the trash out this morning. If it doesn't get put out, maybe we need to talk about it tonight. What would be a good time for you to meet with me?" Now if this kid wants to avoid the talk, all he has to do is put out the trash.

Tip #7: Recognize Improvement. Kids sometimes feel that, if they ever did anything well, no one would ever notice anyway. So notice. Recognize the child's effort, express your appreciation about it, and interpret what you think the improvement means. For example, "Mark, I haven't had to say a word about homework all week. That really impresses me, and it tells me that you're doing an excellent job of being more responsible."

The Book:

In his book, "If My Kid's So Nice ... Why's He Driving ME Crazy?" nationally recognized educator, psychologist, and author Dr. James Sutton addresses what he calls the "Good Kid" Disorder. He shows parents and teachers the behaviors to watch for, and how to better understand and respond to the youngster displaying them. Dr. Sutton cautions against the "No-lutions," seven typical reactions to the oppositional and defiant child that not only don't work, they add to the distress. Practical and proven strategies and interventions for improving task completion at home and at school, while encouraging more harmony in relationships, round out this excellent and timely resource. This book is published by Friendly Oaks Publications in hardbound edition with a full color dust jacket. Call 1-800-659-6628 to order.

"<http://www.docspeak.com/Books/>"

Classroom Management of Oppositional Defiant Disordered (ODD) Students

The bases of ODD classroom management are:

1. Escape for the child (in a confrontation, no one wins)
2. Affecting attitudes of everyone

Escape means "get away" or "get out of" ... and when you are in a classroom full of children this may seem pretty tricky. What it means in terms of an ODD student is to "get away" from triggers that bring on the ODD behavior.

Ways towards ODD confrontation: (things NOT to do!!)

- Responding quickly
- Trying to "convince"
- Threatening
- Raising the stakes
- Creating an audience
- Keeping it going for a long time
- Using sarcasm, anger etc.
- Using bribes
- "Cutting" the ODD child with words

Ways to move away from ODD confrontations: (things TO do!)

- Giving simple, direct choices, that are real - not "do you want to follow directions or get kicked out?" The ODD child will always pick "kicked out" to have a confrontation.
- Following the predetermined behavior plan.
- Listening
- Giving brief and direct responses
- Private at all costs
- Walking away

Now evaluate yourself and track your progress... do a mental report card for yourself.

Did you buy into the struggle or just "window shop"? When you are done with your evaluation share it with someone else. Another teacher perhaps, or a supportive administrator who is struggling with these same issues. Or, you could be really pro-active and give the parents a call and tell them of your successes and shortcomings in a situation and you may find that not only have

they tried that same technique but when they did it "it turned out like this". This is called "sharing" a unique concept that somehow teachers and parents have lost the ability to do as we all bog down in the legalize of special education law.

Affecting Attitudes:

This is where it gets real tricky. Most ODD students are pretty savvy when it comes to obvious attempts at positive reinforcement. You must understand that they need to "save face" with their quality of ODD'ness and will reject positive strokes because they think they are being "played". So this will make them "on guard" even more. Especially, if they think you are trying to "control" them by "strokes". Thus, they get even more determined to "outsmart" you and sabotage your game before the first quarter starts. So, without the fanfare that works very well for other students, you must give them the positive stuff also. But, the trick is to "sneak" it past them without arousing their feelings of being overly controlled.

- Whisper it as you pass them "hey nice work there" or "love the dreadlocks". Be brief and sincere. Plan your strategy early and be determined to go with it at the first opportunity.
- Notes, these can do a lot. A simple note left somewhere for the ODD student to discover is not public. The fun for you is in finding inventive hiding spots for them. For example, imagine an ODD student finding a note from you inside his nine page outline for his science project. Most people have done secret pals. The fun is in leaving the surprise without being discovered, same concept.
- Flash cards, this is a new variation on an old theme.
- Emotion flash cards, kept in a pocket or on a clip board. Keeping them small and discreet is the key. Make a level of emotion flash cards. 1-5 works great for many kids. Not too many but enough to have more than "mad, sad, and glad which may be the only emotions ODD students can identify at first.

Start with:

1. Thrilled, and use it very, very sparingly. The ODD student should not see this except when something very positive has happened.
2. Happy, this should express your contentment with the ODD student simply doing what is expected of everyone with some effort.
3. Encouragement, this should be common. "You can do this, I know you can!" Use this often.
4. Concern, this should be flashed when the ODD student is beginning to show signs of an angry confrontation and to "open the door" for the student to talk to you if needed.

5. Disappointment, use this when the ODD student makes an inappropriate comment during class discussion. A “cue card” that you are unhappy with something the student is doing that doesn’t call audience attention to the situation.

Now, the way to use the cards. The cards should be small, palm sized if necessary, and should be very casually flashed to the student when appropriate. Color coding works very well. If the ODD student is placed properly in your class (near where you begin instruction) and away from distractions, only the student will see them. Plan in advance to explain these flash cards to the ODD student. This will also be a part of your written plan to avoid confrontations. This works very well for students who have ADD or ADHD and have processing deficits or reading difficulty. Flash cards don’t have to be used. You can develop your own secret system with the ODD student and parents in advance if you like. For example, small plastic figurines on your desk work, color mood charts with slide to indicate color (very discreet), hand signals, audible signals like Morse code, and anything that is just between you and the student.

Two Rules for Success:

1. When the ODD student is neutral or positive you should be positive and engaging. This is the time to offer encouraging feedback and instruction.
2. When the ODD student is negative, you should be neutral (emotionless) and businesslike. You should follow through on pre-determined plans and consequences.

It takes a great deal of tolerance and emotional self-control to not “buy into” confrontations. Remember, the cost of buying in can bankrupt any lesson plan or class.

Recognize the Stages of Anger:

- Irritation
- Agitation
- Loss of control
- Resolution

The dos and don’ts with Angry ODD students:

Do:

- Use the students name
- Remove the audience
- Use humor to de-escalate (but never sarcasm)

- Double your physical distance
- Attempt to distract
- Minimize discussion (not a time to “process” just allow cool down)

Don't:

- Touch the ODD student
- Raise your voice
- Threaten consequences
- Point your finger
- Crowd the student
- Feed the rage fuel

- **Watch your own body language!**
 1. Are you giving personal space?
 2. How is your posture? Firm and rigid or relaxed?
 3. How is your eye contact? Are you avoiding or engaging and asking to help?

- **Take inventory of your thoughts.**
 1. Are you concentrating or annoyed?
 2. Are you reacting to your plans for the day and left over resentment about previous failed plans?
 3. Concentrate on the ODD student's emotional state and how you are able to help at this crucial time.

- **Watch your speech!**
 1. Use a calm voice
 2. You should use a slow cadence repeating calmly directions and support
 3. Communicate your confidence in the ODD student to regain control

TIME OUT

This is where so many rigid school rules really fail for ODD students. In order to work, time out must get **creative** and must involve being reasonable, respectful, and fair. Sending the ODD student to the principal's office to “fully report” his failure does nothing short of lighting a fuse and adding more fuel. Sending the ODD student to the school detention center (or the land of lepers from the child's point of view) only exacerbates the already low self-esteem and regard that the ODD student has for him/her self. By knowing this in advance, a plan must be developed with all involved to accommodate the ODD student's predictable losses of all behavioral control. They must be anticipated and plans made to fully address them. This is where you must get creative.

For example, in one individual's behavior plan he walks off his meltdowns. He is 11, and he gets a walking pass. He is respected enough to bring himself

under control, and return when he is “composed” . Eventually, he will bring himself under control in his seat without the walks. But for now, any control is better than total meltdown” . The teacher notices an impending “meltdown” (through her assessment of him that should begin every class period) and gives him an errand to run for her. Such “errands” prevent escalation and the teacher doesn’t “out” him in front of the class.

He is handed his plan and reads it on his own in hall walking and follows it.

Example:

I _____

1. Will walk fast, not run, down halls a,b,c.
2. Will not stop to look in classrooms or talk to students or staff in halls.
3. Will walk until “icky” feeling is gone.
4. Will think about breathing and remember to do breathing exercises.
5. Will return to class when calm, return pass to teacher and take seat as quietly as possible.
6. Will talk to teacher as soon as possible about “icky” feeling and where it came from.

This works for this particular child and modifications of this nature can work for any child.

Conclusion:

This information is intended to give you a place to start with direct confrontation management. There are also lots of classroom modifications that you are probably more familiar with because they are used all of the time with ADHD students. LD or ADHD management strategies can be used to enhance the learning of students who have both ODD and ADHD or LD.

Adapted From: ConductDisorders.com: A place for US - Support group, Article by “Martie”, moderator of Jerri’s Parent Advocate Forum

Dr. Fassler is a Board Certified Child and Adolescent Psychiatrist practicing in Burlington, Vermont.

Advocating for Your Child: 25 Tips for Parents

by David Fassler, M.D.

According to the Surgeon General, 1 child in 5 will experience significant problems due to a psychiatric disorder. The good news is that we can help many, if not most, of these youngsters. The real tragedy is that so few, less than 1 in 3, are receiving the comprehensive treatment they really need.

Children and adolescents with emotional and behavioral problems deserve access to the best possible mental health care. Unfortunately, such services are often difficult to obtain. Parents can help by being informed, involved and persistent advocates on behalf of their children.

The following outline offers specific tips and suggestions which parents may find useful in such advocacy efforts:

1. Get a comprehensive evaluation. Child psychiatric disorders are complex and confusing. A full assessment will often involve several visits. Effective treatment depends on a careful and accurate diagnosis.
2. Insist on the best. Talk to physicians, therapists, guidance counselors and other parents. Find out who in your community has the most experience and expertise in evaluating and treating your child's particular condition. Check the clinician's credentials carefully. Are they appropriately licensed or certified in your state? If he or she is a physician, are they "Board Certified"? Push schools, insurance companies and state agencies to provide the most appropriate and best possible services, not merely services which are deemed sufficient or adequate.
3. Ask lots of questions about any diagnosis or proposed treatment. Encourage your child to ask any questions he or she may have, as well. Remember that no one has all the answers, and that there are few simple solutions for complex child psychiatric disorders. In addition, all treatments have both risks and benefits. Make sure you and your child understand the full range of treatment options available so you can make a truly informed decision.
4. Insist on care which is "family centered" and which builds on your child's strengths. Ask about specific goals and objectives. How will you know if treatment is helping? If your child's problems persist or worsen, what options and alternatives are available?
5. Ask about comprehensive "wrap around" or individualized services, geared specifically to the needs of your child and family. Are such services available in your state or community? If not, why not?

6. Be prepared. One of the most important things you can do to help your child is to keep all information, including past consultation and treatment reports, in an organized place. Insist on receiving your own copies of all evaluations. Records can easily be misplaced, delayed or even destroyed. Maintaining your own file with all relevant information can help avoid unnecessary duplication of previous treatment efforts.
7. Feel free to seek a second opinion. Any responsible mental health professional will be glad to help with referrals or by sharing information. If you have any questions at all about your child's diagnosis or the proposed course of treatment, by all means, arrange an independent consultation with another clinician.
8. Help your child learn about their condition. Use books, pamphlets and the Internet. Make sure the information is age-appropriate. Answer questions with honest, accurate and consistent information, but don't overload children with more detail than they need or want.
9. Learn the details of your insurance policy, and learn about the laws governing insurance in your state. For example, in some states, insurance companies must provide access to a specialist, such as a child and adolescent psychiatrist, within a certain distance from your home. If no such specialist is available as part of the company's "network", you may be able to receive treatment from a provider of your choice, with the insurance company responsible for full payment.
10. Work with the schools. Insist on access to appropriate mental health consultation services. Suggest inservice training programs to enhance awareness about child psychiatric disorders. Request copies of your child's educational records, including the results of any formal testing or other evaluations. Ask to be included in any and all school meetings held to discuss your child.
11. Learn about the reimbursement and funding systems in your state. The more you know, the better you can advocate on behalf of your child. How does Medicaid work? Which services are covered and which are excluded? Is there a "waiver program" which allows increased flexibility based on the specific needs of children and families? Is your child eligible? If not, why not? What other sources of funding are potentially available?
12. Get to know the state insurance commissioner and healthcare "ombudsperson" or consumer representative. Ask them to attend regular meetings with parent groups. Let them know about your experiences.
13. Use a lawyer, if necessary. Learn about the local legal resources. Find out which lawyers in your community are familiar with educational and mental health issues. Talk to your local Protection and Advocacy agency or American Civil Liberties Union for suggestions. Call the State Bar Association. Talk to other parents who are lawyers or who have used lawyers. Consider a legal consultation to make sure you are pursuing all appropriate avenues and options regarding services for your child.

14. Become politically active. Meet with state senators and representatives. Question candidates about their positions on access to necessary and appropriate mental health services for children and families. Testify at hearings on state legislation and budgets. Legislators are more likely to be influenced and persuaded by personal stories than by data, statistics or the opinions of professionals.
15. Build coalitions and work with local advocacy and parent organizations such as NAMI, NMHA and the Federation of Families. Develop and publicize a common "Agenda for Children's Mental Health".
16. Teach children about advocacy. Invite them to become involved in advocacy activities, where appropriate, but don't force them to participate.
17. Develop a legislative strategy. If your state does not yet have parity legislation, put this at the top of the agenda. Other "family protection" initiatives include:
 - access to an independent panel to review and potentially reverse insurance company denials
 - consumer representation on community mental health center boards
 - adequate network provisions, which mandate timely and appropriate access to specialists
 - adequate funding for school and community based mental health services.
18. Seek bipartisan support. Mental illness affects families of all political persuasions. Building a broad base of support has been a key to successful legislative initiatives, both at the State and Federal levels.
19. Fight stigma. Develop an ongoing local education campaign that reiterates the key messages:
 - child psychiatric disorders are very real illnesses
 - they affect lots of kids and adolescents
 - fortunately, they are also quite treatable, especially if treatment begins early and is individualized to the needs of each child and family.
20. Become involved with medical education. Meet with local medical students and residents. Sensitize them to the issues and challenges families face when caring for a child with emotional and behavioral problems.
21. Use the media. Write letters to the editor and/or op-ed pieces on child mental health issues. Meet with local reporters covering health care topics. Suggest story ideas to local TV stations.
22. Work with local professional organizations. Psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors are natural allies with a common advocacy agenda. Coordinate efforts on issues such as parity, funding for mental health services, managed care oversight, etc. Professional organizations may also have access to resources, including funds for lobbying and/or public education initiatives, from their national associations.

23. Talk to other parents. Seek out and join local parent support groups. If none exist, consider starting one. Develop an email "listserv" to facilitate communication. Circulate articles, information and suggestions about local resources.
24. Attend regional and national conferences of parent and advocacy organizations. Such meetings provide information, ideas, camaraderie and support. Sharing experiences with other parents is both helpful and empowering.
25. Don't give up. Aim for and celebrate incremental victories and accomplishments. Remember, advocacy is an ongoing process!

There's no right or wrong way to be an advocate for your child. Advocacy efforts and initiatives should be individualized to your state, community and the particular issues, circumstances and needs within your family. Advocacy is also hard work. Even when people want to help, and are willing to listen, it takes lots of time and energy to change the system. But when it works, and it often does, the outcome is clearly worthwhile. You really can make a difference, both for your own child, and ultimately for all children who need and deserve access to appropriate and effective mental health treatment services.

Resources

The following organizations are excellent resources regarding advocacy on behalf of children's mental health:

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016
(202) 966-7300
www.aacap.org

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(703) 524-7600
www.nami.org

American Psychiatric Association
Division of Public Affairs
1400 K Street, NW
Washington, DC 20005
(202) 682-6140
www.psych.org

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
1-800-969-6642
www.nmha.org

Federation of Families for Children's Mental Health
1101 King Street, Suite 420
Alexandria, VA 22314
(703) 684-7710
www.ffcmh.org

The Children's Defense Fund
25 E Street NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
Washington, DC 20005-5002
(202) 467-5730
www.bazelon.org

Continued on next page

Resources *(continued)*

Childhood and Adolescent Bipolar
Foundation
1187 Wilmette Avenue
P.M.B. #331
Wilmette, IL 60091
(847) 256-8525
www.bpkids.org

Children and Adults with
Attention-Deficit/Hyperactivity
Disorder (CHADD)
8181 Professional Place, Suite 201,
Landover, MD 20785 CHADD
1-800-233-4050, (301) 306-7070
www.chadd.org

Juvenile Bipolar Research Foundation
49 S. Quaker Road
Pawling, NY 12564
(203) 226-2216
www.bpchildresearch.org

Depression and Bipolar Support Alliance
(DBSA)
730 N. Franklin Street, Suite 501
Chicago, IL 60610
1-800-826-3632
(312) 642-0049
www.ndmda.org

Dr. Fassler is a Board Certified Child and Adolescent Psychiatrist practicing in Burlington, Vermont. He is a Clinical Associate Professor in the Department of Psychiatry at the University of Vermont College of Medicine. Dr. Fassler is also a Trustee of the American Psychiatric Association (www.psych.org), a Fellow of the American Academy of Child and Adolescent Psychiatry (www.aacap.org), and a member of the Board of the Federation of Families for Children's Mental Health (www.ffcmh.org).

Resources

Books

- Sutton, J. (2003). What Parents Need to Know About ODD. Friendly Oaks Publications.
- Bodenhamer. G. (1992). Back in Control. Simon & Shuster.
- Turecki, S. (1985). The Difficult Child. Bantam Books.
- Greene, R. (1998). The Explosive Child. Harper Collins.
- Riley, D. (1997). The Defiant Child. Taylor Publishing Company.
- Sutton, J. (2003). If My Kid's So Nice...Why's He Driving ME Crazy? Friendly Oaks Publications
- Wenning, K. (1999). Winning Cooperation from Your Child! (revised) Jason Aronson.
- Riley, D. (2000). The Depressed Child. Taylor Publishing.
- Long, N. and Long, J. (2001)The Angry Smile. PRO-ED.
- Barkley, R. and Benton, C. (1998) Your Defiant Child: Eight Steps to Better Behavior. Guilford Press.
- Taylor, J.F. (2001). From Defiance to Cooperation: Real Solutions for Transforming the Angry, Defiant, Discouraged Child. Prima Publishing.

Web sites

www.familyvillage.wisc.edu

"We are a global community that integrates information, resources, and communication opportunities on the Internet for persons with cognitive and other disabilities, for their families, and for those that provide them services and support.

Our community includes informational resources on specific diagnoses, communication connections, adaptive products and technology adaptive

recreational activities, education, worship, health issues, disability-related media and literature, and much, much more.”

www.conductdisorders.com

“We are a group of parents who are raising challenging children. Our kids have many different diagnoses, but all of them are oppositional and resistant to parenting.”

www.nami.org

NAMI (National Alliance for the Mentally Ill) is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these diseases.

www.DocSpeak.com

Web site for Dr. James Sutton. Included in this site is complete information about Dr. Sutton and his current programs, information about related products, materials and services and, of course, a number of free articles. The new ODD Page provides good insight and a lot of ideas.

Dear Reader,

Vermont Family Network (VFN) strives to make each of its publications clear, correct, and complete. Please help us by answering a few questions.

1. *Which publication* are you evaluating? Oppositional Defiant Disorder

2. Please rate this publication:	EXCELLENT	GOOD	FAIR	POOR
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b. for <i>clarity</i> (ease of use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. for <i>accuracy</i> of information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. <i>overall</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. If you *found any incorrect information* in this publication, please specify the page(s) and correction(s) to be made. _____

4. If you felt *information was left out* of this publication, please specify the page(s) and addition(s) to be made. _____

5. If you found *anything hard to understand* in this publication, please specify the page(s) and confusing passage(s). _____

6. If any part *of* this publication was *especially good* at helping you understand the topic, please specify the page(s) and passage(s). _____

7. How do you *plan to use* the information you've obtained from this publication? _____

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