

Information about:

Oppositional Defiant Disorder (ODD)

Revised 2013



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 Agency 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.

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Children with Oppositional Defiant Disorder

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 other 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.

Children with Oppositional Defiant Disorder (continued)

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, and 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 a 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.

Children with Oppositional Defiant Disorder (continued)

See also: [Oppositional Defiant Disorder Resource Center](#)

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

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The American Academy of Child and Adolescent Psychiatry. (March 2011). Facts for Families: Children with Oppositional Defiant Disorder (No. 72). Retrieved from <http://aacap.org/page.wv?name=Children+with+Oppositional+Defiant+Disorder§ion=Facts+for+Families>

ODD: A Guide for Families

What Is Oppositional Defiant Disorder?

Oppositional defiant disorder (ODD) is one of a group of behavioral disorders called disruptive behavior disorders (DBD). These disorders are called this because children who have these disorders tend to disrupt those around them. ODD is one of the more common mental health disorders found in children and adolescents.

Physicians define ODD as a pattern of disobedient, hostile, and defiant behavior directed toward authority figures. Children and adolescents with ODD often rebel, are stubborn, argue with adults, and refuse to obey. They have angry outbursts and have a hard time controlling their temper.

Even the best-behaved children can be uncooperative and hostile at times, particularly adolescents, but those with ODD show a constant pattern of angry and verbally aggressive behaviors, usually aimed at parents and other authority figures. The most common behaviors that children and adolescents with ODD show are:

- Defiance
- Spitefulness
- Negativity
- Hostility and verbal aggression

A mental health professional is often called upon if these behaviors create a major disturbance at home, at school, or with peers.

Seeking treatment for children and adolescents suspected of having ODD is critical. This disorder is often accompanied by other serious mental health disorders, and, if left untreated, can develop into conduct disorder (CD), a more serious disruptive behavior disorder. Children with ODD who are not treated also are at an increased risk for substance abuse and delinquency.

Some parents have trouble seeing defiant behaviors as a symptom of a mental disorder. They may want to wait to start treatment until the child matures to see if he or she will “grow out of it.” Also, it is sometimes difficult to distinguish between ODD and normal, independence-seeking behavior that shows up during the “terrible twos” and early teen years.

However, there is evidence to suggest that early intervention and treatment will help a child overcome ODD. Treatment also may prevent its progression into a more serious mental health concern.

ODD: A Guide for Families (continued)

What Is Oppositional Defiant Disorder? (continued)

Treatment usually consists of a combination of therapies, including behavioral therapy, parent training, and family therapy. Some children may benefit from medication as well.

With treatment, children and adolescents can overcome the behavioral symptoms of ODD. They can learn techniques to manage their anger and develop new ways of coping with stressful situations. Treatment also can help parents learn better ways to discipline and techniques to reward good behavior.

With treatment, children and adolescents with ODD can overcome their difficult behaviors and lead happier, more fulfilling lives.

How Common Is ODD?

There is a range of estimates for how many children and adolescents have ODD. Evidence suggests that between 1 and 16 percent of children and adolescents have ODD. However, there is not very much information on the prevalence of ODD in preschool children, and estimates cannot be made.

ODD usually appears in late preschool or early school-aged children. In younger children, ODD is more common in boys than girls. However, in school-age children and adolescents the condition occurs about equally in boys and girls.

Although the disorder seems to occur more often in lower socioeconomic groups, ODD affects families of all backgrounds.

What Causes ODD?

There is no clear-cut cause of ODD. However, most experts believe that a combination of biological, psychological, and social risk factors play a role in the development of the disorder.

ODD: A Guide for Families (continued)

What Causes ODD? (continued)

Biological Factors

Children and adolescents are more susceptible to developing ODD if they have:

- A parent with a history of attention-deficit/ hyperactivity disorder (ADHD), ODD, or CD
- A parent with a mood disorder (such as depression or bipolar disorder)
- A parent who has a problem with drinking or substance abuse
- Impairment in the part of the brain responsible for reasoning, judgment, and impulse control
- A brain-chemical imbalance
- A mother who smoked during pregnancy
- Exposure to toxins
- Poor nutrition

Psychological Factors

- A poor relationship with one or more parent
- A neglectful or absent parent
- A difficulty or inability to form social relationships or process social cues

Social Factors

- Poverty
- Chaotic environment
- Abuse
- Neglect
- Lack of supervision
- Uninvolved parents
- Inconsistent discipline
- Family instability (such as divorce or frequent moves)

What Are the Symptoms of ODD?

Most children argue with parents and defy authority from time to time, especially when they are tired, hungry, or upset. Some of the behaviors associated with ODD also can arise in children who are undergoing a transition, who are under stress, or who are in the midst of a crisis. This makes the behavioral symptoms of ODD sometimes difficult for parents to distinguish from expectable stress-related behaviors.

ODD: A Guide for Families (continued)

What Are the Symptoms of ODD? (continued)

Children with ODD show an ongoing pattern of extreme negativity, hostility, and defiance that:

- Is constant
- Lasts at least 6 months
- Is excessive compared with what is usual for the child's age
- Is disruptive to the family and the school
- Is usually directed toward an authority figure (parents, teachers, principal, coach)

The following behavioral symptoms are associated with ODD:

- Frequent temper tantrums
- Excessive arguments with adults
- Actively refusing to comply with requests and rules
- Often questioning rules
- Deliberately annoying and upsetting others
- Often touchy or annoyed by others
- Blaming others for their mistakes
- Frequent outbursts of anger and resentment
- Spiteful attitude and revenge seeking

Typically, children with ODD do not engage in delinquent behavior. Also, children whose behavioral symptoms are specifically related to a mood disorder, such as depression or bipolar disorder, are usually not diagnosed with ODD.

Recently, it has been discovered that girls may show the symptoms of ODD differently than boys. Girls with ODD may show their aggressiveness through words rather than actions and in other indirect ways. For example, girls with ODD are more apt to lie and to be uncooperative while boys are more likely to lose their temper and argue with adults.

How Is ODD Diagnosed?

While there is no single test that can diagnose ODD, a mental health professional can determine whether a child or adolescent has the disorder by assessing the child's symptoms and behaviors and by using clinical experience to make a diagnosis.

Many parents first call upon the child's primary care physician for an evaluation. This evaluation typically begins by compiling a medical history and performing a physical examination.

ODD: A Guide for Families (continued)

Gathering Information

During the evaluation, the child's primary care clinician will look for physical or other mental health issues that may cause problems with behavior. If the doctor cannot find a physical cause for the symptoms, he or she may refer the child to a child and adolescent psychiatrist or a mental health professional who is trained to diagnose and treat mental illnesses in children and adolescents.

A child and adolescent psychiatrist or a qualified mental health professional usually diagnoses ODD.

A mental health professional will gather information from parents, teachers, and daycare providers as well as from the child.

Gathering information from as many people as possible will help the doctor determine how often the behaviors occur and where. It also will help the doctor determine how the behaviors affect the different areas of the child's life.

The mental health professional will determine whether:

- The behavior is severe
- The conflicts are with peers or authority figures
- The behavior is a result of stressful situations within the home
- The child reacts negatively to all authority figures, or only his or her parents or guardians

Answering these questions will help a mental health professional determine whether the child or adolescent has developed ODD or is responding to a short-lived, stressful situation.

Assessment tools, such as rating scales and questionnaires, may help the child's doctor measure the severity of the behaviors. These tools also may assist in establishing a diagnosis and tracking progress once treatment begins.

In addition to establishing a primary diagnosis, the doctor will look for signs of other conditions that often occur along with ODD, such as ADHD, anxiety, and mood disorders. The doctor also should look for signs that the child has been involved in bullying—as either the victim or perpetrator. Involvement in bullying often is a sign that the child is at risk for aggression and violence.

ODD: A Guide for Families (continued)

Establishing a Relationship

Like many mental health disorders, ODD is not always easy to accurately diagnose. Open communication among the mental health professional and the parents and child can help overcome the difficulties diagnosing this disorder. For example, some children see their behaviors as justified and are unmotivated to change. Also, some parents can become defensive when questioned about their parenting style. Having the parent and the child view the mental health professional as an ally can help.

Establishing a good relationship with a mental health professional is important to determining whether the child's behavior is a response to a short-lived situation or transition, ODD, or another serious behavioral condition, such as CD or a mood disorder.

Can ODD Occur with Other Conditions?

Many children who are diagnosed with ODD also have other treatable mental health and learning conditions. Having more than one condition is called having coexisting conditions. Some conditions that coexist with ODD are:

- ADHD
- Anxiety disorders
- Mood disorders (such as depression and bipolar disorder)
- Learning disorders
- Language disorders

Research indicates that some children develop the behavioral symptoms of ODD as a way to manage anxiety or uncertainty. Anxiety disorders and mood disorders are similar to ODD in that they are often a response to uncertainty and an unstable home and school environment. These similarities make it more likely that ODD and anxiety disorder and a mood disorder (such as depression) will occur together.

Among all conditions that coexist with ODD, ADHD is the most common. Both disorders share common symptoms of disruptive behaviors. However, children and adolescents who have both ODD and ADHD tend to be more aggressive, have more of the negative behavioral symptoms of ODD, and perform less well in school than those who have ODD alone. These children also tend to have more disruption in their families and with their relationships with authority figures than children who do not have ODD.

Doctors have found that ODD can be a precursor to CD. CD is a more serious behavioral disorder that can result in destructive antisocial behavior.

ODD: A Guide for Families (continued)

Can ODD Occur with Other Conditions? (continued)

While ODD behaviors may start in early preschool years, CD usually appears when children are older. A child or adolescent who has ADHD as a coexisting condition also seems to be at increased risk of developing CD. In addition, studies show that having CD puts children and adolescents at risk of developing a mood disorder or antisocial personality disorder later in life.

While having ODD and a coexisting condition puts a child at risk for developing other more serious mental health issues, treatments exist that can improve the symptoms of ADHD, anxiety disorders, mood disorders, and learning and language disorders. Also, treating other mental health and learning conditions that occur along with ODD has been shown to decrease the behavioral symptoms of ODD

Can ODD Be Prevented?

There is research that shows that early-intervention and school-based programs along with individual therapy can help prevent ODD.

Among preschoolers, the Head Start program has been shown to help children do well in school and prevent delinquency later in life. Head Start is a program of the United States Department of Health and Human Services (US-HHS) that provides education, health, and other services to low-income children and their families. Young children in this program learn social skills and how to resolve conflict and manage anger. A home visit to high-risk children also has been shown to help prevent ODD among preschoolers.

Among adolescents, psychotherapy (talk therapy), social-skills training, vocational training, and help with academics can help reduce disruptive behavior. In addition, school-based programs can be effective in stopping bullying, reducing antisocial behavior, and improving peer relationships.

Parent-management training programs have proven effective in preventing ODD among all age groups. These programs teach parents how to develop a nurturing and secure relationship with their child and how to set boundaries for unacceptable behavior.

ODD: A Guide for Families (continued)

How Is ODD Treated?

There is no one-size-fits-all treatment for children and adolescents with ODD. The most effective treatment plans are tailored to the needs and behavioral symptoms of each child. Treatment decisions are typically based on a number of different things, including the child's age, the severity of the behaviors, and whether the child has a coexisting mental health condition.

The goals and circumstances of the parents also are important when forming a treatment plan. In many cases, treatment may last several months or more and requires commitment and follow-through by parents as well as by others involved in the child's care.

Types of Treatment

Treatment usually consists of a combination of:

Parent-Management Training Programs and Family Therapy to teach parents and other family members how to manage the child's behavior. Parents, family members, and other caregivers are taught techniques in positive reinforcement and ways to discipline more effectively.

Cognitive Problem-Solving Skills Training to reduce inappropriate behaviors by teaching the child positive ways of responding to stressful situations. Children with ODD often only know of negative ways of interpreting and responding to real-life situations. Cognitive problem solving skills training teaches them how to see situations and respond appropriately.

Social-Skills Programs and School-Based Programs to teach children and adolescents how to relate more positively to peers and ways to improve their school work. These therapies are most successful when they are conducted in a natural environment, such as at the school or in a social group.

Medication may be necessary to help control some of the more distressing symptoms of ODD as well as the symptoms of coexisting conditions, such as ADHD, anxiety, and mood disorders. However, medication alone is not a treatment for ODD.

ODD: A Guide for Families (continued)

Treatments for Each Age Group

For preschool-age children, treatment often concentrates on parent-management training and education. School-age children perform best with a combination of school-based intervention, parent-management training, and individual therapy. For adolescents, individual therapy along with parent-management training has been shown to be the most effective form of treatment.

In all age groups, individual therapy focusing on problem-solving skills also has been shown to greatly improve the behavior of children and adolescents with ODD. Problem-solving skills training should be specific to the child's behavioral problems, geared to the child's age, and focused on helping the child acquire new problem-solving skills.

More About Parent-Management Training

Studies have shown that intervening with parents is one of the most effective ways to reduce the behavioral symptoms of ODD in all age groups. Parent management training teaches parents positive ways to manage their child's behavior, discipline techniques, and age-appropriate supervision. It is the treatment of choice to prevent disruptive childhood behavior for many mental health professionals.

This approach embraces the following principles:

- Increased positive parenting practices, such as providing supportive and consistent supervision and discipline
- Decreased negative parenting practices, such as the use of harsh punishment and focus on inappropriate behaviors
- Consistent punishment for disruptive behavior
- Predictable, immediate parental response
- Many of the following programs and publications have been noted as positive models by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Health and Human Services (US-HHS):

ODD: A Guide for Families (continued)

Programs and Books

Program Name	Age Range	Contact Information
Incredible Years	Up to 8 years	www.IncredibleYears.com
Triple P-Positive Parenting Program	Up to 13 years	http://www5.triplep.net
Parent-Child Interaction Therapy (PCIT)	Up to 8 years	www.pcit.org
Center for Collaborative Problem Solving	Up to 18 years	www.explosivechild.com
The Adolescent Transitions Program (ATP)	11 to 13 years	http://cfc.uoregon.edu/atp.htm
Book Name	Age Range	Publication Information
<i>The Defiant Child</i> by Douglas Riley, Ph.D.	Up to 13 years	The Guilford Press
<i>The Explosive Child</i> by R.W. Greene	Up to 13 years	Harper Paperbacks
<i>The Kazdin Method for Parenting the Defiant Child</i> by Allan E. Kazdin, Ph.D.	Up to 18 years	Houghton Mifflin
<i>Parent Management Training</i> by Allan Kazdin	Up to 18 years	Oxford University Press
<i>Multisystematic Treatment of Antisocial Behavior in Children and Adolescents</i> by Scott Henggeler, Sonja Schoenwald, Charles Borduin, and Melisa Rowland	Up to 18 years	The Guilford Press
<i>Helping the Noncompliant Child</i> by Robert McMahon and Rex Forehand	Up to 18 years	The Guilford Press

Medication

Medication alone has not been proven effective in treating ODD. However, medication may be a useful part of a comprehensive treatment plan to help control specific behaviors and to treat coexisting conditions, such as ADHD, anxiety, and mood disorders.

Successful treatment of coexisting conditions often makes ODD treatment more effective. For example, medication used to treat children with ADHD has been shown to lessen behavioral symptoms when ODD and ADHD coexist. When children and adolescents with ODD also have a mood disorder or anxiety, treatment with antidepressants and anti-anxiety medications has been shown to help lessen the behavioral symptoms of ODD.

ODD: A Guide for Families (continued)

Early Identification and Treatment

Behaviors that go along with ODD are difficult to change. Therefore, early identification and treatment of ODD give children and adolescents the best chance for success.

How Long Does Treatment Typically Last?

Most treatment plans for children and adolescents with ODD last several months or longer. For those with a more severe ODD, or ODD that does not respond to therapy, treatment can last many years and may include placement in a treatment center.

A residential treatment center only should be considered for families who are not able to provide therapy at home or at school. In-home services are preferable to residential placement and are often sponsored by state and local child welfare agencies.

Does ODD Improve over Time?

For many children, ODD **does** improve over time. Follow-up studies have found that approximately 67 percent of children diagnosed with ODD who received treatment will be symptom-free after three years. However, studies also show that approximately 30 percent of children who were diagnosed with ODD will go on to develop CD.

Other studies show that when the behavioral symptoms of ODD begin in early life (preschool or earlier), the child or adolescent will have less chance of being symptom-free later in life. Also, the risk of developing CD is three times greater for children who were initially diagnosed in preschool.

In addition, preschool children with ODD are more likely to have coexisting conditions, such as ADHD, anxiety disorders, or mood disorders (depression or bipolar disorder) later in life.

In all age groups, approximately 10 percent of children and adolescents diagnosed with ODD will eventually develop a more lasting personality disorder, such as antisocial personality disorder.

However, most children and adolescents will improve over time, especially if they receive treatment. Parents who suspect that their child has a behavioral problem should have their child evaluated. For children who receive treatment, the outlook is very good.

ODD: A Guide for Families (continued)

Which Therapies Have Been Shown Not to Work?

Experts agree that therapies given in a one-time or short-lived fashion, such as boot camps, tough-love camps, or scare tactics, are not effective for children and adolescents with ODD. In fact, these approaches may do more harm than good. Trying to scare or forcibly coerce children and adolescents into behaving may only reinforce aggressive behavior.

Children respond best to treatment that rewards positive behavior and teaches them skills to manage negative behavior.

What Does the Future Hold?

It was once thought that most children would outgrow ODD by adulthood. We now know this is not always true. While some of the symptoms of ODD can go away over time, and many children outgrow the disorder, some children with ODD will continue to experience the consequences of ODD during their later years.

For those who do not receive treatment, ODD can develop into CD, a more serious behavioral disorder. Of those with CD, almost 40 percent will develop antisocial personality disorder in adulthood.

Early diagnosis and treatment can help these individuals learn how to cope with stressful situations and manage their behavioral symptoms.

Psychotherapy, parent-management training, skills training, and family therapy work. Research shows that children and adolescents respond well to therapy for ODD. In fact, for those who receive treatment, many are symptom-free once therapy has concluded and will go on to lead rewarding and happy lives.

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The American Academy of Child and Adolescent Psychiatry. (March 2011). ODD: A Guide for Families. Retrieved from http://www.aacap.org/galleries/eAACAP.ResourceCenters/ODD_guide.pdf

Diagnosis of ODD: Don't Try This at Home

By Dr. James Sutton

I receive a ton of email from folks, mostly parents, who have read extensively on ODD. They have determined that their child has Oppositional Defiant Disorder, and, with the diagnosis part out of the way, they are anxious to jump straight into intervention. (And anyone who has spent as much as one day with a truly ODD youngster can understand the reason for the urgency.) But this line of reasoning could present significant consequences, as the observation, documentation and classification of a behavior makes up only a third of a competent and complete diagnosis. Cause must also be addressed, as well as interventions that are specific to behaviors and cause. A comprehensive diagnosis (as a component of a comprehensive assessment) is necessary because oppositional and defiant behavior, even when it is considered to be abnormal and excessive, rarely presents as a single condition or disorder. (I have held to this opinion for years, and was affirmed to hear Dr. Ross Greene make the same point in a lecture I attended.) More specifically, oppositional and defiant behavior (notice I didn't say Oppositional and Defiant Disorder) is commonly seen as a part of the following types of disorders, among others:

- Anxiety disorders
- Adjustment disorders
- Disorders of depression
- Disorders of attachment and bonding
- Disorders related to trauma
- Pervasive Developmental Disorders
- Disorders of mood stability

Making a correct diagnosis is roughly the psychological equivalent of making a correct diagnosis between heartburn and heart attack. It's critical.

So what is a proper diagnosis? Oppositional Defiant Disorder is correctly diagnosed only if the disorder meets three specific criteria: (These are based on the DSM IV-TR.)

At least four qualifying behaviors or characteristics are noted and have existed for six months or longer. This eliminates temporary reactions to conditions or circumstances that influence behavior.

There is significant clinical impairment of functioning. In other words, the child's behavior is digging a hole for them that only gets deeper. Their behaviors are detrimental to them, not just others. Oppositional behavior that leads to failure in school would be an example.

The behaviors are not attributed to another diagnosed condition or disorder.

Diagnosis of ODD: Don't Try This at Home (continued)

Is a complete evaluation always necessary?

Yes and no. Since ODD is based on fairly objective and observable findings, a full assessment might not be necessary. But an assessment does provide information critical to understanding the child and his or her “take” on things. This information plugs directly into plans for intervention. What would be included in an effective evaluation? Assessments will vary according to the professionals conducting them, but here's what I include in a full evaluation: (Due to my lecture schedule, I don't do these much anymore.)

An interview with the parents: This includes a comprehensive history, as well as a clear understanding of the concerns of the child's parents.

An interview with teachers: This provides information regarding social and academic functioning in a key environment outside the home.

Assessment of academic functioning: This addresses the issue of potential versus performance in essential academics. If this information is available through school records, there's no need to reassess the youngster in these skills.

Assessment of intellectual functioning: Again, this can sometimes be gleaned from school records. Even if this information is not available, it's not always necessary to conduct a full-scale intellectual assessment (which can add considerably to the cost of the evaluation). But enough information is needed to discern that the child is capable of understanding and complying with directives from authority figures.

Perceptual-motor assessment: I use the *Goodenough-Harris Drawing Test* and the *Bender Visual-Motor Gestalt Test*. Most oppositional and defiant youngsters are fine in perceptual-motor skills, but tend to drop a number of clues to their oppositionality and defiance on these tasks. Due to the unique format of the instruments, youngsters are often unaware of just how much information they are providing (thus they're not apt to “push” or over control the tasks).

Projective assessment: This is a very important part of the assessment of an oppositional youngster because the child cannot manipulate by telling you what he thinks you want to hear. The nature of projectives is that they have no right or wrong answers. For that reason, they often make an oppositional youngster uncomfortable. The structure and level of aggravation the child slips into this part of the assessment can be quite revealing and helpful in planning intervention. Two common examples of projectives are sentence completion tasks and standardized ink blot instruments.

Diagnosis of ODD: Don't Try This at Home (continued)

Diagnostic interview: A comprehensive interview with the child provides a wealth of strategic information. I happen to use a 155 question interview that I developed for

this purpose (although it's not always necessary to ask them all). The interview captures the youngster's take on peer relationships, school functioning, factors of home and community and, of course, self. It samples their concerns in their terms, providing insight to areas where they would be most receptive to intervention.

All this information is then compiled into a comprehensive report that outlines the findings, provides a diagnosis (if there is one), and offers recommendations for intervention. The cost of an assessment like this ranges from a few hundred dollars to well over \$1,000. Health insurance generally covers some, if not all, of the expense.

Who can do these evaluations?

Psychologists can, as well as anyone else trained and licensed or certified to do all components of the assessment. If your child's oppositional and defiant behavior is causing them to have serious trouble progressing through school, you might ask the school to do an assessment. They have folks on staff who do this sort of thing all the time.

They usually have at least one doctorate level psychologist on staff or as a consultant to help with the tougher challenges.

Large counties often have a county psychological board (check the phone book) that can refer specialists who work with children. Also, a department of psychology or counseling of a nearby university (universities offer graduate training) might provide assistance or direction. In some cases, they may provide actual counseling or therapy services through their lab programs. Although the services are being provided by students, they are supervised, and they are usually motivated to do a good job. You don't have much to lose, and the cost is minimal (like free, if they need kids). Keep in mind also that school counselors are required to maintain a resource list as part of their *Crisis Response Plan*. Ask them; they can probably help directly, or initiate a referral. Then, of course, there's always the phone book. I believe it is best to find someone who specializes in children and adolescents.

Diagnosis of ODD: Don't Try This at Home (continued)

Who should do the counseling or therapy?

For obvious reasons, it helps a lot if it is the same person who did the assessment. Rapport is already established, and there is no confusion regarding the interpretation of assessment results. Sometimes, however, this is not possible. I get a lot of calls and email asking about how to locate specialists in ODD in different states. Sorry, I'm not

aware of any registry like this, although county psychological boards might list specialties. That would be a good place to start.

Sutton, J. (n.d.). Diagnosis of ODD: Don't Try This at Home. Retrieved from http://www.friendlyoakpublications.com/Docspeak/?page_id=397

How to deal with Oppositional Behavior in Children and Teens

All children are oppositional at one time or another, often because they are stressed, hungry or tired. This is especially true when they are two to three and in their early teens. However, if oppositional and defiant behavior towards authority is interfering with daily functioning it may be a sign of a more serious problem.

Signs that a youth may have Oppositional Defiant Disorder (ODD):

- frequent temper tantrums
- active defiance towards rules or requests
- deliberate attempts to upset people
- being easily annoyed or “touchy”
- blaming others for behavior or mistakes.

If a parent or caregiver believes a child may have ODD it is important that they seek a mental health assessment for the child and professional help.

What happens when a child has Oppositional Defiant Disorder?

- ODD children see interactions with authority as win/lose situations and desperately feel they need to win.
- ODD children are trying to grow up too fast and take on adult like emotional responsibilities. In other words, they are trying to take the adult role in the family hierarchy.
- ODD children are trying to control the timing, content and mood of interaction and it is not as much about the outcome of the interaction as it is about creating the conflict. When an ODD child pushes buttons and an adult loses control of their emotions, the child may feel that they have taken the parents authority.
- ODD children have a difficult time soothing themselves and don't like to be soothed by adults, as this puts them back in the role of the child.

Looking carefully at a family's structure can be a part of figuring out what is going on. ***Are the rules inconsistent, lenient or too strict?***

Tips for Parents: How to Deal with Oppositional Behavior

1. Take back the control of the timing and content of interaction by knowing when you are going to get emotional or when your buttons are being pushed. In other words, don't have the discussion until you know you can remain calm. Conventional wisdom about parenting says that it is important to give consequences right after the behavior but for oppositional kids it is better to delay this discussion until both parties are cooled down.

How to deal with Oppositional Behavior in Children and Teens (continued)

Tips for Parents: How to Deal with Oppositional Behavior (continued)

2. Have a plan to take a time out and always allow your child to take a time out to cool down. Remember this is how teenagers sometimes “save face” in an argument.
3. Check the number of positive vs. negative interactions you are having with your child and try to increase the positive. Often if the relationship is stressed there will be a lot of daily negative interaction. Do something fun together and make a connection. The goal is to have many more positive interactions than negative.
4. Remind your oppositional child you love them in many different ways. Though your child may know you love them they may feel less loved if there is ongoing conflict. Remember soothing your child is part of a strategy that will take them from an adult role and put them back into the role of a protected child.
5. Last but certainly not least - take care of yourself so you can take care of your child. Seek the support you need. Try to maintain your own life and interests. Breathe.

Robl, A. (2011, January 27). Salt Lake County Youth Services. Retrieved from <http://youthserviceslc.wordpress.com/2011/01/27/how-to-deal-with-oppositional-behavior-in-children-and-teens/>

Home and Family Strategies: Oppositional Defiant Disorder

This Quick Fact Sheet contains strategies designed to address potential symptoms of Oppositional Defiant Disorder and should be used in consultation and collaboration with mental health personnel or as part of a larger intervention approach. These pages contain only a portion of many possible strategies available to address symptoms of Oppositional Defiant Disorder. Strategies should always be individualized and implemented with careful consideration of the differences of each child and the context of their individual circumstances. Additionally, this information should never be used to formulate a diagnosis. Mental health diagnoses should be made only by a trained mental health professional after a thorough evaluation.

If you notice a significant change in mood in your child that lasts for more than a week, share your observations with your child's pediatrician and/or school's mental health support team.

Belonging, Competence/Mastery, Safety, Self-Determination

Home and family environment, rules, and activities should strive to provide these children with a sense of belonging, competence, and safety every day. Successful intervention is dependent on structuring a household and family routines that promote more socially acceptable means for the children to acquire not only what WE think they need, but also what THEY think they need.

Sustained Commitment

Much of the initial work with a child with Oppositional Defiant Disorder may involve managing the child's attempts to thwart your efforts to help and support him or her. Parents and caregivers must remain committed through such difficult periods. It may take a long time to see change and things may worsen before they improve.

Compassionate Understanding

Parents and guardians must develop compassionate understanding regarding the dynamics underlying their child's behavior. Understanding the child's present environment, as well as the environment where his or her difficulties began, the child's perception of his or her experience, and the motivation and purposes behind his or her behavior will help provide a guide for the development of effective interventions.

Home and Family Strategies: Oppositional Defiant Disorder (continued)

High Levels of Stimulation

Activities that are highly stimulating (perceived risk taking, physical activity, and activities of high interest) are best incorporated as an integral part of the child's lifestyle, not exclusively something used as a reward for good behavior. Without extensive opportunities for engaging in stimulating, socially acceptable activities, the child will readily move to socially unacceptable and problematic avenues for stimulation.

Prevention

To be most effective, parents and guardians need to focus largely on the environment and antecedents to unacceptable behavior. Rather than spending a lot of time and energy "chasing" behaviors, caregivers should modify the child's environment in ways that will help meet and respond to the emotional needs of the child.

Structured Household

Your child will respond best to a structured household in which all family members follow family rules. This structure will allow parents/guardians to defer to the power of the rules, refocusing power struggles away from their relationship. Rules must be applied consistently to allow the child to focus on his/her behavior rather than on another family member's behavior. At the same time, unduly harsh limit setting (i.e. yelling, backing the child into a corner) often activates a 'fight or flight' response that negatively impacts both the child and the parent. Limit setting that is calm, clear, firm, and supportive will have the greatest positive impact.

Skills for Emotional Management/Affective Regulation

Your child will likely benefit from skills training in emotional management/affective regulation. One of the best strategies for teaching and reinforcing these skills is participation in structured and supported activities with some degree of aggressive competition. These activities must be carefully supervised as your child will most often fail within this realm before developing the necessary skills to navigate such a task.

Home and Family Strategies: Oppositional Defiant Disorder (continued)

Time-Out

A child with Oppositional Defiant Disorder will benefit from the opportunity for self imposed time outs to give them time to cool down and/or regain perspective. This time-out should not be used as a punishment or threat, but rather as an opportunity to be offered if caregivers see early signs of agitation or escalation. Parents/guardians should discuss logistical details (i.e. where it will be, how to access it appropriately, how long s/he can stay there, what s/he can do there, etc.) with their children in order for the time-out option to be most effective. Allowing the child to participate in stimulating activities while in the time out space will yield better results.

Behavioral Reinforcement

Children with oppositional defiant disorder respond best to a behavioral model that reinforces desired behavior through awarding of concrete reinforcement or sanctioned power. Level/token systems will likely work well if the reinforcers are something of value to them. Take the time to get to know about your child's interests, understand what types of reinforcers they are most driven by, and then integrate these into the child's behavioral reinforcement plan.

Logical Consequences

The child should be held accountable for his or her actions with consequences that are logical (or natural) for his or her behaviors. Keep in mind that consequences are designed to teach and not to punish. Wherever possible, allow the child to choose between two logical consequence alternatives. Holding children accountable while helping them to develop empathy for those who have been negatively affected by their actions (e.g. Restorative Justice Programs) will likely be beneficial.

Opportunities to Practice Generosity

Provide ample opportunity to practice generosity. Without opportunities to give to others, young people do not develop as caring individuals. Strategies to support and help children with this disorder must combine both behavioral intervention and efforts to enhance moral development.

Home and Family Strategies: Oppositional Defiant Disorder (continued)

Family Support

Success is dependent upon adults' abilities to deal with the child's overwhelming emotions without themselves becoming overwhelmed. Parents and guardians need understanding support systems and opportunities to constructively process their feelings about parenting these challenging children. A support system that offers respite opportunities for caregivers and/or their children is ideal. Parents too may need the option for a time-out.

Suicidal Risk/Crisis

There are some signs that may indicate overt suicidal crisis and should be acted upon immediately by engaging your community's mental health crisis team. Call First Call at 488-7777* or dial 9-1-1 if you notice any of these signs:

- Threats or attempts to hurt or kill oneself
- Looking for the means (e.g. gun, pills, rope) to kill oneself
- Making final arrangements such as writing a will or a farewell letter or giving away cherished belongings
- Pre-occupation with suicide or dying (often expressed through writing, art, music, online forums like facebook) in conjunction with depressed symptoms or high risk behavior
- Showing sudden improvement after a period of extreme sadness and/or withdrawal

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Students FIRST Project. (n.d.). Home and Family Strategies: Oppositional Defiant Disorder. HowardCenter. Retrieved from <http://studentsfirstproject.org/wp-content/uploads/Home-and-Family-ODD-Strategies.pdf>

School and Classroom Strategies: Oppositional Defiant Disorder

This Quick Fact Sheet contains strategies designed to address potential symptoms of Oppositional Defiant Disorder and should be used in consultation and collaboration with your school's mental health personnel or as part of a larger intervention approach. These pages contain only a portion of many possible strategies available to address symptoms of Oppositional Defiant Disorder in the classroom. Strategies should always be individualized and implemented with careful consideration of the differences of each student and the context of their individual circumstances. Additionally, this information should never be used to formulate a diagnosis. Mental health diagnoses should be made only by a trained mental health professional after a thorough evaluation.

If you notice a significant change in mood in any child that lasts for more than a week, share your observations with the child's parent and/or guardian and with your school's mental health support team.

Belonging, Competence/Mastery, Safety, Self-Determination

School and classroom environment, policies, and procedures as well as academic programming should strive to provide these students with a sense of belonging, competence, and safety throughout the school day, every day. Successful intervention is dependent on structuring a classroom that promotes more socially acceptable means for the student to acquire not only what WE think they need, but also what THEY think they need.

Sustained Commitment

Much of the initial work with students with Oppositional Defiant Disorder may involve managing the student's attempts to thwart your own efforts to help and support him or her. School personnel must remain committed to these students through such difficult periods. It may take a long time to see change and things may worsen before they improve.

Compassionate Understanding

Schools must develop a compassionate understanding of these students and of the dynamics underlying their behavior. Understanding the student's present environment, as well as the environment where his or her difficulties began, the student's perception of his or her experience, and the motivation and purposes behind his or her behavior will help provide a guide for the development of effective interventions.

School and Classroom Strategies: Oppositional Defiant Disorder (continued)

High Levels of Stimulation

Activities that are highly stimulating (perceived risk taking, physical activity, activities of high interest) are best incorporated as an integral part of the student's school day, not exclusively something used as a reward for good behavior. Without extensive opportunities for engaging in stimulating, socially acceptable activities, the student will readily move to socially unacceptable and problematic avenues for stimulation.

Prevention

To be most effective with these students, schools need to focus largely on the environment and antecedents to unacceptable behavior. School personnel often spend an enormous amount of energy "chasing" behaviors, many of which could have been diverted with appropriate environmental modifications that respond to the emotional needs of the student.

Rule-Centered Classroom with "Padded" Boundaries

These students most often respond best to a rule-centered (vs. authority-centered) classroom. This allows the educator and the student to defer to the power of the rules, refocusing power struggles away from their relationship. Rules must be applied consistently to allow the student to focus on his/her behavior rather than on the educator's behavior. At the same time, unduly harsh limit setting (i.e. yelling, backing student into a corner) will activate a 'fight or flight' response in many of these students. Limit setting that is calm, clear, firm, and supportive will have the greatest positive impact.

Skills for Emotional Management/Affective Regulation

These students will usually benefit from skills training in emotional management/affective regulation. One of the best strategies for teaching and reinforcing these skills is participation in structured and supported activities with some degree of aggressive competition. These activities must be carefully supervised as the student will most often fail within this realm before developing the necessary skills to navigate such a task.

School and Classroom Strategies: Oppositional Defiant Disorder (continued)

Time-Out

A student with Oppositional Defiant Disorder will benefit from the opportunity for self-imposed time-outs to give them time to cool down and/or regain perspective. This time-out should not be used as a punishment or threat, but rather as an opportunity to be offered if school staff see early signs of agitation or escalation. If incorporating a time-out option, staff should meet with the student proactively to discuss logistical details (where it will be, how to access it appropriately, how long he/she can stay there, what he/she can do there, etc.) Allowing the student to participate in stimulating activities while in the time out space will yield better results.

Behavioral Reinforcement

These students will respond best to a model that reinforces desired behavior through awarding of concrete reinforcement or sanctioned power. Level/token systems tend to work well with these students if the reinforcers are something of value to them. Take the time to get to know the student and understand what types of reinforcers they are most driven by and integrate these into the student's behavioral planning.

Logical Consequences

The student should be held accountable for his or her actions with consequences that are logical (or natural) to his or her actions. Keep in mind that consequences are designed to teach and not to punish. Wherever possible, allow the student to choose between two logical consequence alternatives. Programs designed to hold these students accountable while helping them to develop empathy for those who have been negatively affected by their actions (i.e. Restorative Justice Programs) are beneficial to these students.

Opportunities to Practice Generosity

Provide these students with ample opportunity to practice generosity. Without opportunities to give to others, young people do not develop as caring individuals. Strategies to support and help students with this disorder must combine both behavioral intervention and efforts to enhance moral development.

School and Classroom Strategies: Oppositional Defiant Disorder (continued)

Support for Staff

Success with these students is dependent upon the adult's ability to deal with the student's overwhelming emotions without themselves becoming overwhelmed. School staff need opportunities to constructively process their own feelings about working with these challenging students. A clinical supervision model (like in the mental health field) is a good model for school staff hoping for additional support.

Suicidal Risk/Crisis

There are some signs that may indicate overt suicidal crisis and should be acted upon immediately by engaging your school's mental health crisis team and calling First Call at 488-7777 or dialing 9-1-1. These include:

- Threats or attempts to hurt or kill oneself
- Looking for the means (e.g. gun, pills, rope) to kill oneself
- Making final arrangements such as writing a will or a farewell letter or giving away cherished belongings
- Pre-occupation with suicide or dying (often expressed through writing, art, music, online chat spaces) in conjunction with depression symptoms or high risk behavior
- Showing sudden improvement after a period of extreme sadness and/or withdrawal

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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.

Individual advocacy for your own child:

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?

Advocating for Your Child: 25 Tips for Parents (continued)

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 in-service 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?

Advocating for Your Child: 25 Tips for Parents (continued)

- 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.

Statewide advocacy for all children, including your own:

- 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.

Advocating for Your Child: 25 Tips for Parents (continued)

- 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 effect 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!

Advocating for Your Child: 25 Tips for Parents (continued)

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

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

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

National Alliance on Mental Illness
3803 N. Fairfax Dr. Suite 100
Arlington, VA 22203
(703) 524-7600
www.nami.org

Advocating for Your Child: 25 Tips for Parents (continued)

Resources (continued)

National Disability Rights Network (NDRN)
900 Second St. NE, Suite 211
Washington, DC 20002
(202) 408-9514
www.ndrn.org

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

The Balanced Mind Foundation
1187 Wilmette Avenue
P.M.B. #331
Wilmette, IL 60091
(847) 256-8525

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

Advocating for Your Child: 25 Tips for Parents (continued)

Resources (continued)

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

Depression and Related Affective Disorders Association (DRADA)
Meyer 3-181, 600 North Wolfe Street
Baltimore, MD 21287-7381
(410) 955-4647
www.drada.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).

Fassler, D. (2003). Advocating for Your Child: 25 Tips for Parents. Retrieved from http://www.nami.org/Content/ContentGroups/CAAC/How_To_Advocate_For_Your_Child.htm