Oppositional Defiant Disorder in Adolescents:

What School Counselors Need to Know

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ABSTRACT

Adolescence is a difficult time in life due to the social, emotional, and biological changes that teens experience. For an adolescent who has Oppositional Defiant Disorder (O.D.D.) this stage of development may be even more complicated, as these children may have more trouble than other adolescents with social interactions, academics and controlling their emotions. School counselors can play an integral role in helping students who have been diagnosed with this disorder. In order to do this, an understanding of Oppositional Defiant Disorder, its treatment, and interventions are important so that the needs of these students and their families can be met.

Much information can be found in literature for parents with children who have Oppositional Defiant Disorder. Students who seek attention with inappropriate behavior, have trouble making and maintaining friendships, and who challenge authority figures are often in the

early stages of Oppositional Defiant Disorder. Parents and other caring adults may wish to consider partnering with the school to develop strategies that minimize the barriers to student success. It is important for School counselors to know about O.D.D. and what actions and strategies can be put into place to help students express healthy emotions, find positive interactions in their relationships, and have opportunity for success in school.

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Chapter I: Introduction

Adolescence is a stage of life that results in many changes. Some of these changes are biological such as a time of rapid growth in height, weight, and sexual maturation. These biological changes can influence social and emotional changes as well. In some cases, teens become more self-conscious and concerned with their peer groups which replace their families as being central in their lives. Risk-taking behaviors can increase, and interests can change. Because of these changes and other factors in their lives, middle school can be a challenging time for students.

When people ask about the career of this researcher and are told she is a middle school teacher and attends graduate school to become a school counselor, the typical reactions include: "Oh, you must be an angel!", or "I could never do that!", and "Kids that age are so disrespectful!"

While occasionally in agreement with the thought expressed by others, working with middle school-age adolescents is very rewarding. Yes, there are some difficult students and difficult situations, but the "tough" or "disrespectful" children in this age group are not the only kids in the middle schools, and helping them is just as rewarding as helping the other students who are not quite as outwardly "tough."

Some of the children who appear to have more challenges and who are tougher and more disrespectful to authority are sometimes diagnosed with a disorder known as Oppositional Defiant Disorder (O.D.D.). O.D.D. can affect many areas of a child's life. A child with O.D.D. often has trouble following rules and meeting expectations of authority figures such as parents and teachers, so both home and school can become battle grounds. They can also have trouble socially making and keeping friends because of their argumentative and irritable nature

(Bernstein, 1996). When a child has a good support system and his/her disorder has been properly assessed and diagnosed by trained professionals, he/she can improve the opportunities for managing the condition.

Statement of the Problem

Students who have Oppositional Defiant Disorder often have a difficult time in middle school. They need caring adults to help them and their families deal with their struggles so they can have opportunities for success in their academic, social, and emotional situations in middle school. Therefore, the problem becomes, how can school counselors be informed about the characteristics of Oppositional Defiant Disorder, its limitations, and how they can help these adolescents and their families. The more caring and informed adults these children have in their lives, the more likely they will be able to deal with the disorder.

Statement of Purpose

The purpose of this literature review is to describe the characteristics of oppositional defiant disorder in adolescents, its treatments, and what school counselors need to know to help the students, families, and their classroom teachers. Literature was reviewed in the spring of 2009.

Research Questions

The questions that will guide the literature review are:

What are the characteristics of Oppositional Defiant Disorder?

What are strategies that work with adolescents with O.D.D?

What do school counselors need to know in order to help students with oppositional defiant disorder, their families, and their teachers?

Definition of Terms

There are certain terms that should be defined for clarity of understanding the literature review.

Cognitive-Behavioral Therapy (C.B.T.): Cognitive-behavioral therapy (CBT) is based on cognitive theory and behavioral principles. Cognitive-behavioral therapists focus on the current cognition related to the persistence of a problem, rather than the problem's origin. A change in this cognition can lead to behavioral changes according to this type of theory (Goisman, 1997).

Comorbid: Comorbid describes a condition that occurs at the same time as another condition.

Oppositional Defiant Disorder: Oppositional defiant disorder (O.D.D.) is a condition that is distinguished by negative, openly provocative, uncooperative, and hostile behavior that is more frequent and severe than the behavior of the child's peers of the same age and developmental level. It is severe enough that it interferes with adaptive patterns in the major areas in the child's life (PDM Task Force, 2006, p. 258).

Strong-Willed Child: A strong-willed child has a basic nature of independence and determination. A strong-willed child might display an obstinate temperament that may be mistaken for defiance. (Tobias, 1999, p.9-10)

Triggers: Circumstances that may lead to anger or defiant behaviors.

Assumptions and Limitations

It is assumed that Oppositional Defiant Disorder is occurring more frequently in school settings; and that it may go unnoticed because of misinformation and misunderstanding by parents and school staff. It is also assumed that not all school counselors are informed about Oppositional Defiant Disorder and may not know strategies to assist these children and their

families. While there are several types of conduct disorders, this study will be limited to the specific oppositional defiant behavior.

One limitation is that school counselors generally do not make the initial assessment and medical diagnosis or recommendations for therapy or medication for the child with O.D.D., and that the counselor contribution is limited to assisting with family support and accommodations for school. The school counselor's role is to work in partnership with the parent, diagnosing expert, and the student and thus their contribution may be somewhat limited due to resources available in many school settings. Another limitation is that there may be a great quantity of research in this area but the researcher has limited time to access and read all that is available. Some literature may have been overlooked. Literature was reviewed in the spring of 2009.

Chapter II: Literature Review

Introduction

This chapter will include a discussion of the characteristics of Oppositional Defiant Disorder, followed by ideas for accommodation plans and interventions. The chapter will conclude with guidelines for helping students with Oppositional Defiant Disorder, their parents, and their teachers.

Defining Oppositional Behavior

Oppositional defiant disorder (O.D.D.) is a condition that is distinguished by chronic argumentativeness, negativity, hostility, and defiance in adolescents and a refusal to comply with requests by authority (Kelsberg, 2006). In the 2006 Psychodynamic Diagnostic Manual, the PDM Task Force stated:

> While all children can be negative in the service of self-definition, openly provocative, uncooperative, and hostile behavior becomes a serious concern when it is a continuing pattern markedly more frequent and consistent than the behavior of other children of the same age and developmental level, and when it interferes with adaptive patterns in the major areas in the child's life. Symptoms such as temper tantrums, excessive arguing with adults, active defiance of requests and rules, deliberate attempts to annoy or upset people, blaming others, being touchy and easily annoyed by others, and expressing anger and resentment are frequent features of this problem (PDM Task Force, 2006, p. 257).

Psychologist James Windell (1996) described a child he worked with in a group setting who refused to do what he asked, challenging his authority. He stated that the child was extremely stubborn and said "no" to anyone in authority and even groups of people such as

therapists working with him. Saying "no" to society and authority were a way of life for him (Windell, 1996, p. 12).

According to Riley (1997), it is important to keep in mind that while most children have oppositional or defiant behaviors, those with O.D.D. display behaviors that "occur at a rate and intensity far beyond that seen in the subject's peers and should be of such magnitude that they create noticeable difficulties in social, academic, and occupational functioning" (p. 3). Adolescents with O.D.D. are typically seen by adults as noncompliant and stubborn. These children believe that other people are too controlling and critical of them, causing them to feel they are victims of injustice, which is the root of what is seen in their behaviors (PDM Task Force, 2006, p. 258). An example from Bernstein (1996) follows:

> Stephen was a 15-year old boy residing at home and attending the local junior high school. His parents reported that everything with him was a hassle. Minor requests to clean up his room, do his homework, or help with chores were consistently met with protest. He could not tolerate having anyone tell him what to do. Often, when his demands were not met, he would storm off to his room, slamming the door and occasionally punching holes in the wall. He displayed some remorse afterwards, but remained stubborn and convinced about the legitimacy of his demands. This pattern of negative and noncompliant behavior had existed since he was 8 years old, but worsened in the seventh grade.
>
> As is sometimes the case, the school reports were a bit more charitable. Stephen was viewed as a spunky young man with a good sense of humor. Teacher comments reflected that he usually did his work and was a B or C student. His behavior was occasionally disruptive, but he responded well when limits were set. Stephen appeared to do better in

> the structured school setting. He was liked by his peers and regarded as a good athlete who would get carried away at times. Family friends and neighbors felt that he was manageable as long as no one "crossed him" (Bernstein, 1996, p. 7-8).
>
> Stephen's view was interesting. He believed that his parents were too demanding and critical. "I'm just not going to let them boss me around all the time," he declared. "I'm almost 16 now and can take care of myself." When challenged on his behavior at home, he acknowledged that he lost his temper too easily, but quickly added that it wouldn't happen if his parents "stayed off my case." With prodding, Stephen confessed that he was easily annoyed, moody, and suspicious of others. He added that he might be better off if he did not get angry so often (Bernstein, 1996, p. 7-8).

The difference in perception between adults and adolescent is evident in this case example. In another case example of a boy Bernstein called David; the school environment was more of a problem.

> His teachers complained that he was often the "class clown," and never turned in his homework assignments. They noted that he would sometimes put his head down and go to sleep in the back of the classroom. David was well-liked by his peers but maintained rather superficial relationships. The school counselor commented that no one really knew him. (Bernstein, 1996, p. 23)

Clarifying Defiant Behavior

Ralph Loeber, Ph.D., a psychological researcher with the Western Psychiatric Institute and Clinic of the School of Medicine at the University of Pittsburgh, Pennsylvania identified pathways from stubborn to more serious behavior and felt that adolescents who had previously shown themselves to be stubbornly defiant, and who avoided authority often became more

difficult to handle and often were diagnosed as having Oppositional Defiant Disorder. This can lead to problems at home, with school authorities, police, and juvenile court authorities (cited in Windell, 1996).

O.D.D. most commonly occurs co-morbidly with other disorders or conditions such as anxiety, depression, Attention Deficit/Hyperactivity Disorder, and may be seen occurring with other conduct disorder as well (Kelsberg, 2006). As many as 80% of children with O.D.D. also have Attention Deficit Hyperactivity Disorder and are likely to have problems with learning, anxiety, or depression, or may go on to develop additional conduct disorders according to Cook (2005), and The PDM Task Force (2006). Children with O.D.D. often have low self-esteem and often feel that they are not getting the attention that they deserve (Mental health: Oppositional defiant disorder, 2007). "Behind the overt disruptiveness of oppositional children, are feelings of demoralization, resentment, self-doubt, and self-hatred" (PDM Task Force, 2006, p. 258).

Kelsberg (2006) stated that it is very important for medical professionals to diagnose and treat co-morbid conditions or illnesses. The self-demoralizing feelings, along with alcohol or drug use, can increase symptoms such as irritability, personality changes, and defiance. Recognizing that it is not uncommon for an adolescent to experience co-morbid conditions can be the first step of treatment. It can make the life of the teen and his or her family better.

Strategies for Adolescents with Oppositional Defiant Disorder

Windell (1996) stated that giving only one-on-one treatment by a licensed professional has not proved very successful with adolescents with oppositional defiant or conduct disorders. Medication and psychopharmacology have not shown to be successful either. In nearly all successful cases, research by Windell (1996) found parental involvement, school support and the family therapy all made a difference. Parents were taught to be the teachers of their children. The

most successful training programs are group parent training classes and family therapy with a trained professional (Windell, 1996). According to Cook (2005), children with O.D.D. benefit from some specific skills training as well. This will be discussed further in the next section.

Tobias (1999) emphasized that the relationship with the child needs to be considered before any interventions can be successful. The more secure the relationship, the less often the adolescent will try to test its boundaries. According to Tobias (1999) cultivating the basic parenting relationship in a caring way may solicit a more positive response in a teen with O.D.D. and is the foundation that is needed before spending additional time on the newest trends and techniques of working with adolescents with this order (p.26-27).

Tobias (1999) believed that being strong-willed is not necessarily negative, and with creative discipline, a strong-willed child has potential to do great things. Rather than thinking of these adolescents who are obstinate and hyper, Tobias suggests thinking of them as strong-willed with:

> "...firm convictions, a high spirit, and a sense of adventure. Think about some of the great leaders and innovators in our past – Thomas Jefferson, Marie Curie, Albert Einstein, Joan of Arc, Thomas Edison, and others. Each of these people held up under adversity, stood up for his or her convictions, and persisted against all odds; they refused to believe their dreams were impossible" (Tobias, 1999, p. 11).

Similarly, Riley (1997) stated that children with O.D.D. are not used to being admired or praised, so supporting them for being strong in their conviction may be an effective way to get their attention. "The strong-willed child usually possesses more creative potential and strength of character than his compliant siblings, provided his parents can help him channel his impulses and gain control of his rampaging will" (Dobson, 1978, p. 10). Tobias (1999) suggested using

creative discipline to direct the adolescent's energy into the right channels and using his or her determination to achieve positive results (p.17).

Bernstein (1996) stated that therapists who work with adolescents need to be aware of their sensitive nature. Confrontations will most likely be seen as threatening to these children, and are often seen as a "challenge to their integrity" (p. 72). These adolescents generally react better to conversation that is nonjudgmental, where the adult shows concern and curiosity, rather than being intimidating or strongly stated. This type of conversation will be more likely to create relationships and communication rather than have the adolescent poised for a confrontation or power struggle.

Tobias (1999) suggested motivating and inspiring these adolescents instead of engaging in power struggles with them (p.18). Riley (1997) stated in the introduction of his book, adolescents who display oppositional behaviors can change their behavior under the right conditions and circumstances.

The needs of adolescents with O.D.D. are structure, guidance, and flexibility of interventions, according to Riley (1997). For example, interventions should be personalized based on each teen's unique situation. If depression is a co-morbid condition, treatment by a medical doctor would be an appropriate strategy for the family to consider. If peer groups are detrimental to the teen's success or if the teen behaves inappropriately around adults, the discipline structure should become firm to counteract that. If behaviors improve, more leniencies may be granted. This shows flexibility based on the adolescent's needs and actions.

Therapists can analyze the child's thought processes to challenge negative views of life or events. This can help the child realize that there are choices available to control actions and then events in his or her life, according to Bernstein, (1996).

Helping the Defiant Teen

Riley (1997) offers parents suggestions of how to talk to an oppositional child or teenager about his or her behavior. It is important to talk to the child first and not jump directly to punishment. Set the stage for the conversation by letting the child know in advance that good listening is important and "if he or she fails to listen and make good decisions, then immediate consequences will follow" (p. 65). The conversation is not to convince the child to agree with the parent, and should not be stated this way. Instead, a brief, straightforward statement of intent is best. Follow-through is essential.

Good discipline, according to Riley (1997), includes one-on-one conversations that begin with a tone and posture that are friendly but firm to establish the roles of adult and child. Adolescents need to understand that their actions impact others and if the behavior is negative, adults need to explain why behavior needs to change. Consequences and replacement behaviors need to be clearly stated and understood. Replacement thoughts are also helpful to deter inappropriate future behavior.

All behaviors have positive and negative consequences. Riley (1997) stated that oppositional defiant adolescents do not always foresee the potential negative consequences of their actions. As a result, the negative consequence needs to be stronger than what the adolescent sees as positive reinforcement of the behavior.

"Oppositional defiant and conduct-disordered adolescents have tremendous difficulty accepting limits. They routinely stretch rules and react negatively to any imposition of authority. Their lack of self-control fuels much of their deviant behavior (Bernstein, 1996, p. 85.) Setting

limits and following-through with enforcement can help by protecting the adolescents and others from their impulsive nature.

Parents, teachers, and counselors need to monitor and anticipate the need for such limits and be firm with them. Signs of O.D.D. may include escalating emotions, hyperreactivity, and defensive posturing where responding to and diffusing the situation externally would be necessary, according to Bernstein (1996). Limits can be discussed with the adolescents by reasoning that the more control they have on their own actions and the more responsibility they take for their behavior, the lesser the need for external control or limits imposed by others. Pointing out the choices in the situation and listening for cues that the adolescents sometimes give to invite adults to set limits for them is often helpful (Bernstein, 1996).

There are indications that children who are temperamentally difficult from birth who receive positive parenting avoid becoming more oppositional. However, children who are treated in a negative way with harsh discipline or inconsistency, often become more disruptive and harder to handle as they get older (Windell, 1996).

What School Counselors Need to Know

Education is the key and being informed is the first step that school counselors need to take in order to help students with Oppositional Defiant Disorder, their parents, and other school personnel. Since school counselors are an integral part of children's support system, Cook (2005) stated that counselors are often some of the first to intervene with children with O.D.D. when they are disruptive or have inappropriate behavior in schools.

One of the first steps counselors should take to help a child with O.D.D. is talking with the parents, teachers, and child to find out what triggers the child's feelings that may lead to defiant behavior. Next, the counselor would make observations in the classroom and other areas

of the school such as lunchroom and playground to note the interaction the student has with others. It is crucial to understand as much as possible about the child and determine what triggers the feelings, and what motivates his or her behavior.

Leah Davies (2006) has worked with children for many years as a teacher, a counselor, a prevention specialist, and has directed educational and prevention services for a mental health agency. From her experience, she explained how school counselors can help students by providing anger management and social relationship skills to small groups of students or with individual students. Problem-solving and communication skills are two more themes that can be beneficial to work on with a child with O.D.D. (Davies, 2006). Helping students with O.D.D. with social skills was also described by Cook (2005), specifically anger management skills training, relaxation techniques, assertiveness training, and problem-solving techniques.

Children with O.D.D. often misinterpret social cues and have trouble expressing their negative feelings in an appropriate manner, so learning about what triggers the defiant feelings, identifying them themselves, and then reacting appropriately are the first steps. "If children become more tuned into their body signals, they can take care of themselves and deal with the anger and the precipitant for their anger before they blow" (Cook, 2005 p.4).

Relaxation training may lower the child's tension level so that he can think more clearly and have less reactive behavior. This may help children communicate their feelings and needs in an assertive manner without anger getting in the way of their messages. They are taught to solve problems in a different way than they have done in the past, which can be more effective with a relaxed, clearheaded approach (Cook, 2005).

Guidelines for Helping

School counselors can also be resources for overwhelmed teachers who work with children with O.D.D. For example, counselors can be helpful when unsafe conditions are created in the school or classroom or when the teacher needs help coping with the stress of teaching defiant and uncooperative children in the classroom (Davies, 2006).

Riley (1997) mentioned a very important point about working with adolescents who have O.D.D.: "the dominant thoughts of the oppositional child revolve around defeating anyone's attempt to exercise authority over him" (p. 3).

Keeping this in mind, Riley (1997) also listed rules or guidelines to help people such as parents, teachers and school counselors who work with and care for children with O.D.D. For example, children who are oppositional seem to live in a fantasy land where they are able to defeat all authority figures. In this way they are optimistic, yet may fail to learn from experience. Oppositional children believe, "You must be fair to me, regardless of how I treat you," and then often seek revenge when things do not to their way. They have a need to feel tough, and if they ignore authority long enough, eventually the person will give up and go away as they feel equal with adults in power. Oppositional children from middle-class homes often emulate the behavior of their least-successful peers. Oppositional children and teenagers attempt to answer most questions with "I don't know" and deny responsibility (Riley, 1997).

Replacement thoughts can help by taking the place of the perceptions that seem to dominate the thinking of adolescents with O.D.D. For example, rather than thinking that they can defeat all adults, keeping in mind that adults own everything and can take it away if they choose, may change a teen's thinking. Also, revenge is not always the best option. For teens who think it is, a visit to people in prison to ask them how well their revenge strategies worked may prove

them wrong (Riley, 1997, p.76-77). Follow through is essential, so if consequences are stated, it is important to ensure that they happen.

Bernstein (1996) recommended that caring adults choose their battles when dealing with, teaching, or counseling children who are controlling and defiant. Attention-getting clothing, style of appearance, use of jargon or profanity, or other actions that initiate annoyances may be used to test limits and reactions. Unless extreme, adults would do well simply to ignore such behaviors as conveying clear expectation kids learn they can control their own actions without much adult intervention. It is important to demonstrate that adults are neither intimidated nor compelled to discipline them for minor infractions. When this strategy is practiced, most find that the provocative behavior dissipates rapidly, that is, the teen will put down the rubber band or simply pick up the trash that has missed the wastebasket (Bernstein, 1996, p.78-79).

Bernstein (1996) also noted that oppositional defiant youth are instinctively defensive as "They have great difficulty accepting any confrontation that could perforate their defensive structure" (p. 79). He went on to say that their appearances are very important to note, and that while the adolescents may not tell the whole truth, their appearance often will. Gently pointing out discrepancies between their words and appearances or body language can be helpful and help them to open up. Over time, as relationships are established and the child learns to trust, his or her self-awareness increases (Bernstein, 1996).

In order to work effectively with adolescents with Oppositional Defiant Disorder, the definition of oppositional behavior must be clearly understood by all who are working with the adolescents so everyone is on the same page. Forming a partnership with the child, the parents and the school can create the needed structure the child needs. This partnership and

understanding can lead to interventions and strategies to help the student find opportunities to become successful in the home and school.

Chapter III: Summary, Discussion, and Recommendations

Introduction

This chapter will include a summary of the literature presented in Chapter II including the characteristics of oppositional defiant disorder, ideas for accommodation plans and interventions, and guidelines for helping students with Oppositional Defiant Disorder, their parents, and their teachers. In addition, recommendations to school counselors will be given. The chapter will conclude with implications for further research.

Summary

The literature on Oppositional Defiant Disorder (O.D.D.) provided information on the topics of characteristics of the disorder, suggestions for working with adolescents with O.D.D., and possible ideas for a school counselor. Nearly all of the resources cited defined the characteristics of oppositional defiant behavior similarly. Both the PDM Task Force (2006) and Kelsberg (2006) described the chronic nature of O.D.D. as patterns of negative, uncooperative, and hostile behaviors. Windell (1996) wrote that adolescents with oppositional behaviors are stubborn and defiant of authority, whether it is in interactions with one person or with a group such as society. Bernstein (1996) also mentioned that when adults are too controlling and critical of adolescents with O.D.D. it may lead the teen to act out further.

Loeber (cited in Windell, 1996) said that children with behavior that escalated from being stubborn to being openly defiant, and then who were disrespectful of authority while becoming more difficult to handle, were often diagnosed with O.D.D. He said that this may lead to escalating problems at home, with school authorities, police, and juvenile court authorities. According to Riley (1997) and the PDM Task Force (2006), these behaviors are much more

severe than those of the child's peers and create a noticeable difference in the child's functioning in different areas of his or her life.

These resources also agreed that O.D.D. is often found together with other related disorders and conditions. Kelsberg (2006) and Cook (2005) found that O.D.D. is often found with disorders such as anxiety, depression, and Attention Deficit Hyperactivity Disorder. In fact, Cook stated that up to 80% of children have O.D.D. comorbid with Attention Deficit Hyperactivity Disorder, and that they are likely to have problems with learning.

Kelsberg (2006) and the American Psychiatric Association agreed that children with O.D.D. can also go on to develop conduct disorders. Kelsberg (2006) stated that it is important to diagnose and treat these co-morbid conditions as well as alcohol or drug use that may occur, because these can increase irritability, personality changes, and defiance. Mental Health (2007) also mentioned that it is not uncommon for children with O.D.D. to have low self-esteem or feel like they are not getting the attention they deserve.

Bernstein (1996) stated that nonjudgmental conversations are more effective discipline strategies than confrontation with these adolescents. Because of their sensitive nature, these teens often perceive confrontations as challenges to their integrity. He also said that teens need help to change their thinking and see that they have choices and can take appropriate control in their lives.

Setting firm limits and enforcing them, as well as keeping in mind to listen for cues from the adolescents, is an important part of this. This was echoed by Riley (1997) with the expectations for firm and clear structure that is very important. The structure can be adjusted when they are doing well, and involved interventions depending on other factors or as related issues such as depression or social situations that may influence negative behavior.

Discussion

The literature review offered many suggestions related to successful interventions for children with O.D.D. Windell (1996) proposed group parent training classes and family therapy as a beginning treatment outside of school settings, and Bernstein (1996) agreed that parents needed to be involved when making changes. Cook (2005) suggested that school counselors can work with children with O.D.D. on social skills training such as anger management, relaxation techniques, assertiveness training, and problem solving techniques. Counselors may wish to consider offering groups with these themes for students who struggle to respect adult authority figures. The school counselor also may partner with community agencies to initiate support groups or parenting groups for families.

Dobson, (1978) Riley, (1997) and Tobias (1999) were like-minded in their view of children with oppositional defiant behaviors as strong-willed children. The researchers suggested that the adults reframe how teens are perceived, and redirect their energy to help them see their strength as an asset and use their determination to achieve positive results. Counselors and teachers who work with O.D.D students in the classroom would benefit from focusing on the positive strengths and contributions of the children. Providing opportunity to debate, develop classroom leadership skills and channeling the energy of the child into positive applications could benefit all involved.

Riley (1997) felt that showing the teen praise and admiration for their strength can get their attention so that behavior can be changed. Researchers Riley and Tobias (1999) stressed avoiding power struggles and making sure to improve the quality of the relationship with the adolescent so that the discipline and motivational strategies used will be more successful. The adolescents are at the center of these suggestions, and all are infused with the belief that a child

with Oppositional Defiant Disorder can change his or her behavior with the assistance of caring adults. Counselors and parents can develop a plan of action to ensure that the teens are receiving positive reinforcement, appropriate consequences, and opportunities for choice in a consistent manner.

The research beginning with Cook (2005) indicated that school counselors are often some of the first to intervene with children with O.D.D. and can be a very important part of their support systems. Learning as much as possible by talking to the adolescent, parents, teachers, and doing observations in different settings around the school to see what triggers negative behaviors and motivates their positive behaviors is a starting point for the school counselor.

Cook and Davies (2006) both agreed that counselors should work independently and with small groups on social relationship skills such as anger management, problem solving, and communication skills, relaxation techniques and assertiveness training. Bernstein (1996) encourages a common goal for school and home to support self-monitoring for students with O.D.D.

Davies (2006) said that school counselors should act as resource people for teachers who become overwhelmed or stressed by the behaviors of children with O.D.D. Counselors are also helpful when unsafe conditions are created by or with students with O.D.D. Having a plan in place that includes a "cool down" area for the teen is important.

Riley (1997) said that those who work with these adolescents should keep in mind that their dominant thoughts revolve around defeating others' attempts to control them. Students with O.D.D. think and experience perceptions differently, so school counselors may be able to help with replacement thoughts for their distorted views. Bernstein (1996) also added to gently point out incongruencies, by helping teens see that it is to their benefit to cooperate.

Finally, some behaviors need simply to be ignored. Bernstein (1996) recommended choosing what battles to fight and disregarding those behaviors that are intended to get attention, annoy, or test limits. As each child is different and goes through different developmental and growth stages, annual contact with parents and teachers may help the counselor monitor what is working and what could be fine-tuned for opportunities for success at home and at school. The literature clearly indicated that it is a partnership that works together to support children who struggle with O.D. D.

Recommendations

The skills training lessons and group therapy that Cook (2005) recommended would be easily implemented and may be beneficial to this population of students. Social skills training such as anger management training, relaxation techniques, assertiveness training, and problem solving techniques, in particular, was determined to be the most helpful. Further research may be beneficial to determine what works on gender, age and ethnicity groupings of children. Are all accommodations "one-size-fits-all" or are there specific trends that may be more beneficial to specific groups of the population?

Counselors could collect data to begin studies and make recommendations for strategies that are most effective for a variety of students by creating a curriculum or group-lesson plans to teach and practice coping skills for children with O.D.D. Along with training sessions for parents and teachers, researchers may wish to explore how to work effectively with students to gather data from them regarding what is most helpful with the frustration of oppositional defiant disorder. A school counselor could also suggest community resources, support groups, and make available reference books to assist the parents. Further research in this area of what is working

or most helpful can remove barriers to success and help children and teens with O.D.D. have more success at home and at school.

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