The Process and Implications of Diagnosing Oppositional Defiant Disorder in African American Males

The Professional Counselor
Volume 6, Issue 2, Pages 147–160
http://tpcjournal.nbcc.org

doi:10.15241/mg.6.2.147

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Research studies indicate that the number of African Americans diagnosed with oppositional defiant disorder (ODD) is disproportionately higher than other demographic groups. A consensual qualitative research (CQR) design was used to understand the contextual factors, diagnostic processes and implications associated with ODD in African American males. Six mental health professionals were interviewed and four domains identified: insurance influence, ODD diagnostic criteria, ODD stigmatization, and assessment, diagnosis, and treatment. Findings indicated that factors beyond the health needs of the client, including counselor bias, might play a critical role in diagnostic assessment. Implications are provided for counselors and counselor educators. Recommendations for further research are suggested on the diagnosis–billing model and the long-term implications of ODD diagnoses for African American males.

Keywords: **oppositional defiant disorder (ODD), diagnosis, African American males, consensual qualitative research (CQR), insurance**

Research studies indicate that the number of African Americans diagnosed with oppositional defiant disorder (ODD) is disproportionately higher than other demographic groups (Feisthamel & Schwartz, 2009; Schwartz & Feisthamel, 2009). One contributing factor for this disproportionality is that White American clients presenting with the same disruptive behavioral symptoms as African American clients tend to be diagnosed with adjustment disorder. Feisthamel and Schwartz (2009) concluded, "counselors perceive attention deficit, oppositional, and conduct-related problems as significantly more common among clients of color" (p. 51), and racial diagnostic bias may influence the assessment process. Racial biases in clinical decision making are explained in a conceptual pathway developed by Feisthamel and Schwartz (2007).

In the pathway, counselors who hold stereotypical beliefs about clients selectively attend to client information. The counselor's judgment is influenced by personal bias, resulting in misdiagnosing the client. African American masculinity stereotypes of criminal mindedness, violent behavior, aggression and hostility (Spencer, 2013) held by counselors with low multicultural social justice counseling competence (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015; Sue, Arredondo, & McDavis, 1992) potentially foster misdiagnosis and overdiagnosis of African American males with ODD.

Studies on how African American males are diagnosed with ODD and specific implications for African American males are relatively nonexistent. McNeil, Capage, and Bennett (2002) indicated the majority of information on children diagnosed with ODD has been obtained from primarily White children and families. They recommended that counselors working with African American families consider the African American family's unique stressors, worldviews and burdens; possible inclusion

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of the extended family; possible therapist biases that conflict with client's worldview; and positive factors that lead to competency, self-reliance and health in African American culture (Lindsey & Cuellar, 2000). Thus, an appropriate ODD diagnosis in African American males requires assessment and treatment plan considerations that include other related factors.

Diagnosing Oppositional Defiant Disorder in African American Males

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; American Psychiatric Association [APA], 2013), ODD is characterized by a pattern of behavior that includes angry and irritable mood, argumentative and defiant behavior, and/or vindictiveness. Symptoms must cause significant problems at home, school or work; must occur with at least one individual who is not a sibling; and must persist for 6 months or more (APA, 2013). The diagnostic assessment also determines that (a) these behaviors are displayed more often than is typical for peers, and (b) symptoms are not associated with other mental health disorders such as anxiety, depression, antisocial behavior and substance abuse disorders.

High rates of ODD diagnosis among African American males may occur because of low cultural competency in diagnosis and counselor bias (Guindon & Sobhany, 2001; Hays, Prosek, & McLeod, 2010; Snowden, 2003). Spencer and Oatts (1999) and Clark (2007), for example, found that health professionals misinterpreted symptoms of disruptive behavior disorders like ODD at greater rates for African American children. Misdiagnosis was common among children assessed as having symptoms of (a) obsessive compulsive disorder and response to rigid classroom rules, (b) bipolar disorder or attention-deficit/hyperactivity disorder and engagement in destructive behavior, and (c) anxiety disorder (e.g., social anxiety) and dislike for school, and defiance toward teachers. These symptoms also may result from unfair treatment and discrimination (Smith & Harper, 2015). Misdiagnosis of ODD can reasonably be expected to have potentially adverse implications for healthy psychological, emotional and social development in family and education systems.

Family Systems

Primary caregivers of children diagnosed with ODD report mild to moderate levels of depression and anxiety and severe levels of stress (Oruche et al., 2015). Caregivers report having overwhelming difficulty managing the aggressive and defiant nature of their children's behaviors and constantly watching over their children to prevent them from hurting themselves or others (Oruche et al., 2015). The well-being of family members who are not primary caregivers (i.e., in some cases fathers, siblings, grandparents) is rarely considered in disruptive behavior research, although these family members experience many of the same stressors outlined by primary caregivers (Kilmer, Cook, Taylor, Kane, & Clark, 2008). Siblings of diagnosed adolescents have demonstrated high rates of anxiety, poor school performance and adjustment problems (Kilmer et al., 2008; Oruche et al., 2015). Children with disruptive behavior disorders whose family members participated in their treatment showed improved grade point averages and attendance and reduced drop-out rates relative to students whose family members considered themselves uninvolved (Reinke, Herman, Petras, & Ialongo, 2008). While family interventions appear helpful, an accurate diagnosis remains the first step in creating an effective treatment plan and not causing further harm to clients (e.g., school suspension, expulsion, incarceration; Smith & Harper, 2015).

Educational Systems

Students with aggressive disruptive behaviors also have higher rates of mental health risk factors, including school maladjustment, antisocial activity, substance use and early sexual activity (Schofield,

Bierman, Heinrichs, & Nix, 2008). Children diagnosed with ODD experience a range of academic problems, including in-school suspensions (Reinke et al., 2008), high school drop-out (Vitaro, Brendgen, Larose, & Trembaly, 2005), and lower academic grades and achievement scores (Bub, McCartney, & Willett, 2007). ODD was not cited as a contributing factor; however, a recent report by Smith and Harper (2015) revealed that in Southern states African American males comprised 47% of student suspensions and 44% of expulsions from K–12 public schools in the United States, which was highest among all racial and ethnic groups. School administrators also were more likely to rate African American children higher on symptoms related to behavioral disorders than White American children (Epstein et al., 2005).

Finally, 50–70% of juveniles detained in the United States have a diagnosable behavioral health disorder (e.g., ODD; Schubert & Mulvey, 2014). While African American youth make up only 16% of the total youth population in the United States, they account for 37% of the detained population (National Council on Crime and Delinquency, 2007). Given the potential negative trajectory of an ODD diagnosis for some African American males, the diagnostic process warrants further consideration.

Method

Design

The purpose of this qualitative research study was to (a) help understand and explain the contextual factors, diagnostic processes and counseling outcomes associated with the diagnosis of ODD in African American males, and (b) identify, describe, and make meaning of patterns and trends in mental health care systems that may be associated with the apparent overdiagnosis of African American boys with ODD. A consensual qualitative research (CQR) design was employed in this study to identify, describe and make meaning of the diagnostic processes and outcomes related to ODD. The following components of CQR identified by Hill et al. (2005) were used in this study: (a) open-ended questions in semistructured interviews "to allow for the collection of consistent data across individuals, as well as more in-depth examination of individual experiences," (b) research team collaboration (i.e., two judges and one auditor) throughout the data analysis process for multiple perspectives, (c) "consensus to arrive at the meaning of the data," (d) an auditor to check the work of the two judges; and (e) "domains, core ideas, and cross-analyses in the data analysis" (p. 196).

Research Team

The research team included a counselor educator and licensed psychologist (African American male, age 42), counselor educator and licensed professional counselor (White American female, age 36), three clinical mental health graduate students (African American female, age 23; White American female, age 28; White American male, age 29) and one public administration graduate student (African American female, 34). All research team members had clinical experience (i.e., as mental health counselors, research and counseling interns, or parents of clients receiving counseling) with African American males who have been diagnosed with ODD. Training to conduct the study involved reading and discussing [Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; Hill, Thompson, & Williams, 1997]; attending in-person research team meetings to discuss, design, plan and implement the research study; and electronic communication throughout the process. Feelings and reactions (i.e., biases) related to the study were openly discussed among the research team throughout the process to minimize influences on data analysis. Research team biases included: (a) awareness of apparent disproportionality of ODD diagnosis in African American males compared to other populations, based on clinical experience, (b) potential low multicultural competence of counselors making diagnoses, and (c) difficulties for African American males with an ODD diagnosis.

Participants

Six mental health professionals met the following criteria for participation in this study: (a) the ability to verbally describe and explain the diagnostic criteria for ODD (during the interview for data collection), (b) a minimum of 2 years' clinical experience working with clients who have ODD as demonstrated by professional resume or curriculum vitae and explanation at the interview, and (c) a professional mental health license.

The sample consisted of diverse practitioners in identity, years of experience, professional position and places of employment. Racial/ethnic and gender identities of participants were: African American female, African American male, multiracial Arab American female, White American female (n = 2), and White American male. Participant ages ranged from: (a) 30–35 years (n = 2), (b) 35–40 years (n = 2) and (c) over 40 years (n = 2). Reported mental health licenses included: licensed professional counselor associate (n = 1), licensed professional counselor (n = 2), licensed professional counselor supervisor (n = 1), licensed clinical social worker (n = 1) and licensed psychological associate (n = 1). Years holding licensure ranged from less than one to greater than 15. The majority of participants described their professional position as a clinical supervisor and mental health counselor (n = 3), with others identifying as mental health counselors (n = 2) and multisystemic therapy program supervisor (n = 1). All participants reported working within a private organization, with two participants employed by a for-profit community mental health agency, three participants by a non-profit community mental health agency and one participant in private practice.

Procedure

The Institutional Review Board for the Use of Human Subjects in Research evaluated and approved the study. Participant recruitment involved purposeful sampling of mental health providers from local Critical Access Behavioral Health Agencies likely to meet participant criteria. Research team members contacted 10 potential participants by e-mail and follow-up phone calls to explain the study and ask for their participation. Once eligibility had been determined based on selection criteria, six mental health professionals were selected to create an intentionally diverse sample. Participants scheduled an in-person appointment to complete the informed consent process with a team member, signed the form indicating understanding and agreement to participate in the study, and engaged in an in-depth interview lasting 1 to 1.5 hours, at the office of the participants or the first author. Codes and pseudonyms protected confidential participant information and data was audio-recorded and transcribed for each interview.

Measures

Semi-structured interviews. Interview questions for the study were based on a literature review, an evaluation of the *DSM-5* (APA, 2013) criteria for ODD, and pilot field interviews with mental health professionals, clients, and clinical directors experienced in providing or receiving services related to ODD. Participants were asked 12 initial questions about the process of making an ODD diagnosis for African American male clients that focused on: life circumstances that contributed to an ODD diagnosis; structural and cultural factors related to diagnosis (e.g., What are the social systems involved in the diagnosis?); post-diagnosis outcomes and implications (e.g., What happens after a client receives the diagnosis?); and treatment plan considerations (e.g., What are the benefits and/or problems of the treatment plan?).

Data Analysis

Data were analyzed using CQR beginning with a start domain list created from the initial interview questions and transcript of the first interview, where all research team members coded first interview data into domains, "topics used to group or cluster data" (Hill et al., 2005, p. 200). Next, core

ideas, "summaries of the data that capture the essence of what was said in fewer words with greater clarity," from each domain were recorded using direct quotes from participants (Hill et al., 2005, p. 200). Cross-analysis was then completed to characterize the frequency of the data: "general applies to all or all but one case; typical applies to more than half up to cutoff for general; and variant applies to two cases up to the cutoff for typical" (Hill et al., 2005, p. 203). Finally, one team member acted as the auditor and provided feedback throughout the analysis process, and most importantly, ensured "that all important material has been faithfully represented in the core ideas, that the wording of the core ideas succinctly captures the essence of the raw data, and that the cross-analysis elegantly and faithfully represents the data" (Hill et al., p. 201).

The consensus process commenced in the collaborative team design and implementation of the study and proceeded with the independent analysis of the data by the coders and auditor. Domains, core ideas and cross-analyses were then presented, discussed, debated and confirmed during in-person research team meetings, by e-mail and video conferencing. A multilayered consensus process over time contributed to the stability of the data for trustworthiness, along with: (a) consistency and documentation of data collection procedures, (b) research team description and positionality statement, (c) providing quotes that capture core ideas, and (d) using a research team of coders and an auditor to analyze data. No cases were withheld from the initial cross-analysis for the stability check of the data, as Hill et al. (2005) found it is not necessary. Rather, Hill et al. (2005) suggested presenting "evidence of trustworthiness in conducting data analysis," as described (p. 202).

Findings

Four domains were identified related to diagnosing ODD. Categories further define each domain, supported by core ideas using direct quotes from the participants. Table 1 shows the frequency of categories within each of the domains. Hill et al. (1997) outlined the following categories: *general* if it applies to all (6), *typical* if it applies to half or more (3–5), and *variant* if it applies to less than half of the participants (2 up to typical; all categories applied to at least half of the participants; therefore, none were variant).

Insurance Influence

Most insurance companies require counselors to diagnose clients with a mental disorder in order to obtain payment for mental health services (Kautz, Mauch, & Smith, 2008). Many insurance companies require that a diagnosis be made during the first few counseling sessions, sometimes within the very first counseling session. All participants described the role and influence of insurance companies and managed care in the diagnostic process. One participant expressed, "the diagnosis is necessary to get paid, so you have to find something. You are not looking objectively. You are just giving them a diagnosis." The participant continued:

> We see this proportion of diagnoses [with African American males] because the insurance in managed care world drives agencies like this one and drives providers to say that an [African American] child is diagnosed a particular way . . . There is this incentive to diagnose and to diagnose in a short period of time.

Table 1

Summary of Domains From the Cross-Analysis of the Participants (N = 6)

Domain and Category	*Frequency*
Insurance influence	
Diagnosis required for payment of services	General
Reimbursement likelihood drives the type of diagnosis given	General
Insufficient assessment time allotted for proper diagnosis	General
Oppositional defiant disorder diagnostic criteria	
Criteria are too general	General
Criteria provide a convenient catch-all for providers	General
Oppositional defiant disorder is stigmatized	
African American males	Typical
Long-term negative implications	Typical
Assessment, diagnosis and treatment	
Family, community and other contextual considerations	General
Mental health counselor bias	Typical
Cultural and contextual integration	Typical

Findings suggested that the assessment time allotted by insurance companies to diagnose a mental disorder undermines the diagnostic process and invalidates the diagnosis. One participant emphasized, "the client is not going to open up to you within that time frame; this is the first time the child is ever seeing you. Those types of things progress over time." Further structural and systemic assessment problems also were identified by another participant:

> You're allowed to do one assessment per year for the client . . . The assessor would take the previous assessment, use a majority of that information, and then just ask what has changed between then and now . . . there [are] a lot of questions that the previous assessment didn't answer or didn't really look into. So that piece gets missed.

Oppositional Defiant Disorder Diagnostic Criteria

The *DSM-5* criteria for ODD are too general, providing a convenient catch-all for providers. Symptoms of ODD align with typical child and adolescent behavior as well as other childhood disorders (e.g., ADHD), adjustment disorder, depression and anxiety, depending on developmental context (APA, 2013). Every participant expressed the relative malleability of the ODD criteria. "It's an easy diagnosis for most people to fit into that category, if they're having trouble with the legal system and there's nothing else going on," noted one participant. Another added that ODD "serves as a holding cell for behaviors that are not understood." Finally, one mental health counselor stated:

> There are no differentials for ODD. It's all under this blurry category of disruptive behaviors. On one hand it looks easy to diagnose, but on the other hand it's very complicated when you are not ethically doing the right thing.

Oppositional Defiant Disorder Is Stigmatized

An ODD diagnosis carries negative social weight and judgment within and beyond the mental health fields. African American males are particularly vulnerable to diagnostic stigmatization due to multiple marginalizations that can occur when intersecting with other forms of oppression, such as racism (Arrendondo, 1999; Ratts et al., 2015). Most participants referenced long-term negative implications for these clients, including, "I think it leaves a permanent scar, with elementary kids all the way up." One participant expressed further that:

> I have had kids that have been diagnosed with [ODD] and they drop out. I have had young African American boys in my office and they say 'You know this has been going on with me since I was a kid?' And you know that they are telling the truth. They ask themselves, 'Why am I still in school?' So they drop out.

Another mental health counselor added:

> I see it when we go to court even [with] an African American judge. African American boys would typically get a harsher sentence. It's a systemic issue. We just start viewing through a lens and we automatically have an assumption to what the problem is. We have a negative interpretation of one kid's actions versus another.

Assessment, Diagnosis and Treatment

Assessment, diagnosis and treatment do not account for family, community and other contextual problems affecting the client's mood and behavior. One mental health counselor explained, "if the parent has been incarcerated, they are going to act out. If they are dealing with a domestic violence situation in their home, this is a way of relieving stress for them." Another participant added:

> We leave the whole family out of this process . . . That may be where the problems exist. It is person centered to a fault. To the neglect of it being family centered versus person centered or being both, because you would dare not want to intervene with a child and not involve family. Despite [that] the parents will come and say, 95% of the time, 'I am okay—you need to fix my son or daughter.' When treatment plans get tailored based on that premise, then everybody is in trouble.

Trauma also was identified as a contextual issue that warrants consideration in the diagnostic process.

> Past trauma, living in very difficult situations, near or below poverty are not taken into account. What might be very adaptive behaviors for a kid, or might be situational dependent, are then just translated into the diagnosis.

Participants acknowledged mental health counselor bias plays a role in diagnosis as well. A mental health counselor may have a tendency to diagnose certain clients with ODD because it is a familiar and commonly used diagnosis. One mental health counselor stated, "a lot of times, particularly with new clinicians, [ODD] is a buzz word . . . like ADD was a buzz word years ago." A different participant shared the diagnostic rationale, "it helps them, too, because it's a relatively non-offensive diagnosis. It's not as personal a diagnosis, so they don't feel as bad being diagnosed oppositional defiant disorder as they would something else."

The relative cultural competency of practitioners also was referenced by participants as potentially compromising the diagnostic process, with one indicating that:

> When I think about oversight and training, it's limited in terms of how much exposure they've had to diversity training or multiculturalism. What might present as disrespect or non-compliance might be very culturally appropriate . . . The assumption is made that these things are all dysfunctional for the individual as opposed to other contextual factors that are going on.

Discussion

The purpose of this study was to understand the diagnostic processes and implications associated with ODD. Findings suggest that a diagnosis of ODD can result from more factors than client symptoms fitting the diagnostic criteria. While none of the research or interview questions asked specifically about the role of insurance or managed care, every participant indicated that third party billing influenced the diagnostic process.

Specifically, the mental health counselors interviewed were keenly aware of the necessity of making a diagnosis for insurance reimbursement. It appeared that ODD is considered a reliable diagnosis for billing purposes; however, diagnostic necessity may also create an ethical dilemma for mental health counselors who want to provide quality care and need to earn a living. The possibility of racial diagnostic bias remains, even with insurance requirements, when African Americans are more likely to receive a diagnosis of ODD, while White Americans presenting with similar symptoms receive a diagnosis of adjustment disorder (Feisthamel & Schwartz, 2009; Schwartz & Feisthamel, 2009).

Professional ethical standards and best practices warrant full consideration of a diagnosis, including the purpose served and implications, as related to the health and well-being of clients (American Counseling Association [ACA], 2014). Even when a diagnosis is not warranted or conflicts with theoretical, philosophical or therapeutic approaches, mental health providers serving clients who do not pay cash for services are forced to accommodate diagnostic requirements. The use of a diagnosis as a therapeutic tool, designed to act in concert with others, has also come to serve as the gateway to mental health care services.

In the case of African American male clients, an ODD diagnosis can be particularly stigmatizing with immediate and long-term implications for marginalization and tracking (Cossu et al., 2015). Educational, judicial and incarceration data clearly demonstrate that African American males are disproportionately suspended and expelled from school compared to their peers (U.S. Department of Education Office for Civil Rights, 2014); receive harsher sentences in judicial systems for the same offenses as other defendants (Ghandnoosh, 2014; Rehavi & Starr, 2012); and are more likely to be stopped, searched, assaulted and killed by police officers than other community members (Gabrielson, Jones, & Sagara, 2014; Weatherspoon, 2004). Since ODD is categorized as a disruptive behavior disorder, it may be considered, intentionally or unintentionally, a justification, rationale or explanation for these disparate outcomes. When the diagnosis of a mental disorder is used for purposes other than helping the client, it opens the door to unintended and problematic consequences.

The assessment process is critical to making an accurate diagnosis and should not be limited to the most readily available, convenient or confirmatory information. With ODD, alternative, viable explanations for client symptoms have to be considered that may include family history and dynamics, personal trauma and social–cultural context. Guindon and Sobhany (2001) noted, "often there are discrepancies between the counselor's perception of their clients' mental health problems and those of the clients themselves" (p. 277). Again, there may be a tendency to diagnose African American males with perceived behavioral problems with ODD without full consideration of historical and contextual variables that may better explain mood and behavior and warrant a different diagnosis altogether

(Hays et al., 2010).

Mental health counselors also have certain biases, within and beyond personal awareness, that create diagnostic tendencies, which may undermine the diagnostic process and invalidate the results of the assessment. Assessment practices and structures appear to accommodate intrinsic and individual information, more so than extrinsic and systemic variables (Hays et al., 2010). For these reasons, the gathering of client information for diagnostic purposes must be as comprehensive and inclusive as possible, notwithstanding measures to limit mental health counselor bias, such as supervision and consultation.

The ACA *Code of Ethics* outlines the need for even the most experienced counselors to seek supervision and consultation when necessary (ACA, 2014). One potential blind spot for many counselors experiencing bias toward African American male clients is not realizing the need for supervision and consultation when it arises. Understanding that ODD diagnoses within the African American male community have been shown to be inflated is a first step toward decreasing counselor bias. Second, recognizing the subjective nature of making an ODD diagnosis, especially since many of the behaviors and emotions listed as diagnostic criteria also "occur commonly in normally developing children and adolescents" (APA, 2013, p. 15) is another critical aspect of ensuring accurate diagnoses are made.

Counselors are trained from a multimodal approach to diagnosis based on Western medicine; therefore, diagnosing clients is a culturally-based practice (Sue & Sue, 2015). Furthermore, most research in the area of mental and behavioral health has, in large part, not included people of color (U.S. Department of Health and Human Services, 2001). Cultural discrepancies also are evident in the demographic characteristics represented within the counseling profession. Approximately 71% of counselors in the United States are women, and only 18.4% of counselors identify as *Black or African American* (U.S. Department of Labor, 2015); therefore, most African American male clients will likely have different cultural backgrounds from their counselors. These factors create a need for consultation and supervision to ensure that the personal and professional worldviews of counselors are not inhibiting accurate diagnosis and treatment planning for African American male clients.

In addition to supervision, another measure to limit counselor bias would be to practice reflective cultural auditing, a 13-step process for walking counselors through how culture may impact their work with clients from initial meeting through termination and follow-up. This process allows counselors to reflect on what may seem like client *resistance,* but may instead be a "disruption in the working alliance" (Collins, Arthur, & Wong-Wylie, 2010, p. 345) based on cultural differences. In addition to utilizing reflective audits of individual cases, it also can be helpful for counselors to review case files regularly, taking into account race and ethnic background, along with symptoms and reported diagnosis. Finding diagnostic patterns within one's own practice can help counselors reflect on their clinical work and identify areas of bias that may exist.

Implications for Professional Counselors

Thinking through the diagnostic process and beyond the diagnosis requires the mental health counselor to consider and balance the needs of the client, provision of ethical and effective mental health services, expectations and requirements of employers, and earning a living. The following recommendations are offered to help mental health professionals balance these diagnostic considerations in light of current findings, particularly in the assessment and diagnosis of ODD.

In order to make an accurate diagnosis, billing considerations should not be a determining factor in the assessment process. We acknowledge that payment for services is a necessary component for earning a living as a mental health counselor; at the same time, there is an inherent conflict of interest between ethical diagnostic practices and billing when they are not considered as separate processes. Counselors can reference the ACA *Code of Ethics* (2014) regarding cultural sensitivity (Section E.5.b) as well as historical and social prejudices in the diagnosis of pathology (Section E.5.c). Additionally, counselors may reference the guidelines for informed consent in the counseling relationship (Section A.2.b), ensuring that clients are aware of how information in their client records will be used and how it may impact clients in the future. When appropriate, counselors may choose a less stigmatizing diagnosis initially (e.g., adjustment disorder), while continuing to learn more about a client's context and cultural background before making a final diagnosis.

Consider extrinsic and external factors that may contribute to emotional and behavioral symptoms presented. It is important to keep in mind that a pattern of ODD behavior includes anger and irritability, argumentative and defiant behavior, and/or vindictiveness, which causes significant problems at work, school or home, and lasts at least 6 months. In order to qualify as ODD symptoms, these behaviors must occur with at least one person who is not a sibling, and must occur on their own (i.e., not as part of another mental health problem, such as depression, anxiety, antisocial behavior and substance abuse disorders). If family history and dynamics, personal trauma and community/contextual factors contribute to any of the above systems, a diagnosis of ODD may not be the most accurate, thereby leading to ineffective, if not harmful treatment plans and outcomes. A diagnosis of adjustment disorder may be more beneficial to ensure that the client receives adequate treatment, which would hopefully increase the client's chances of having a positive counseling outcome.

African American males are diagnosed with ODD at a disproportionately higher rate than other social demographic groups (Feisthamel & Schwartz, 2009). Ethical and best practice standards require mental health professionals to understand personal biases that might inform their work as well as to develop strategies to reduce or eliminate negative impact (ACA, 2014; Ratts et al., 2015; Sue et al., 1992). In addition, mental health counselors need to use continuing education to remain aware of current trends in the field relevant to the populations they serve (ACA, 2014; Ratts et al., 2015). Health professionals should adhere to diagnostic criteria and integrate multicultural counseling competencies in order to avoid making decisions based on pre-defined misconceptions.

Implications for Counselor Educators and Supervisors

Included in the Council for Accreditation of Counseling and Related Educational Programs (CACREP) accreditation standards is the responsibility of counselor education programs to train students on "the effects of power and privilege for counselors and clients" (CACREP, 2016, p. 9). It is imperative that counselor educators provide specific training on racial bias among counselors, which often is automatic and hidden from conscious awareness (Abreu, 2001).

Creating a safe, comfortable, respectful classroom environment in which students are able to honestly self-reflect and ask questions is necessary to integrate and infuse multicultural and social justice counseling competence training within counselor education programs (Ratts et al., 2015). Counselors-in-training need the opportunity to think critically and experience cognitive dissonance in the classroom regarding ways African American males are portrayed and the erroneous assumptions often made by authority figures and institutions of power. In turn, counselors need to be aware of how these portrayals and assumptions potentially impact the mental health services African American males receive.

In addition to didactic teaching, experiential exercises also are critical for meaningful learning to take place (Sue & Sue, 2015). Assignments that illustrate personal and systemic prejudice can help students reflect on their own potential biases as well as build awareness of systemic influences that may impact clients of color in ways counselors-in-training previously had not considered. Reading assignments that illustrate common biases among counselors can normalize the phenomenon in ways that facilitate student openness to learning and self-reflection. In addition, using diverse theories when discussing diagnosis and treatment planning can ensure multiple perspectives are acknowledged, including the perspective that diagnoses can be both helpful and harmful to clients. Counselor educators have a responsibility to ensure students graduate with an awareness of the need to constantly monitor their own biases and prejudices toward African American males, as well as knowing when to seek supervision and consultation.

Finally, counselor educators can implement a multicultural competence approach to teaching clinical assessment and diagnosis. Guindon and Sobhany (2001) offered a conceptual framework that can be utilized in the classroom in order to achieve this goal: (a) obtain a specific and complete understanding of the client's chief complaint, (b) be aware of discrepancies in counselor and client perceptions of clinical reality, (c) elicit clients' clinical realities and explain counselor clinical models, (d) engage in active negotiation with the client as a therapeutic ally, (e) recognize the importance of renegotiation (of perception of presenting problem), and (f) use assessment instruments advisedly and with caution. The authors intended for this framework to be used by "counselors from any cultural background [to] assist those who are not like themselves" (Guindon & Sobhany, 2001, p. 279).

Limitations of the Study

The CQR model allowed the research team to independently and collaboratively analyze the data through a deliberate, thorough and comprehensive process over time to understand the meanings. Multiple perspectives and the relational dynamic within our team helped to check our own biases and to clearly grasp the view of our participants. The findings of this study represent an in-depth analysis of the perspectives of six licensed mental health professionals with experience diagnosing and working with clients who are diagnosed with ODD that may apply to some degree to working with similar populations and contexts. Life and professional experiences of the researchers and participants, however, naturally interact and influence our understandings of the meanings of the data. As such, different combinations of research team members, participants, or contexts could reveal similar, additional or different findings in a similar study. Finally, two graduate student members of the initial research team graduated before data analysis commenced; therefore, we had fewer coders than originally planned. Additional coders would have provided other perspectives on the data and may have further enhanced the meaning-making process.

Conclusion and Future Research

A mental health diagnosis such as ODD has destructive potential when not used properly. Professional counselors, then, have social power in their capacity to diagnose a client with a mental disorder (APA, 2013; Prilleltensky, 2008). Such power requires that counselors cultivate awareness of personal and professional biases that may influence the diagnostic process. Factors driving the diagnostic process extend beyond the mental health needs of the client and can play a critical role in assessment. Contextual explanations, including historic and systemic contexts, must be considered before a diagnosis is given. Attending to the role of counselor bias to prevent overdiagnosis is an ethical responsibility for which counselor educators and practicing counselors must hold themselves accountable.

Additional research is needed to consider whether the diagnosis–billing model is the most optimal and ethical for mental health care, particularly for preventive mental health and for African American male clients and other marginalized populations. Further study also is warranted to capture the long-term implications of an ODD diagnosis, including identifying ways in which a client's family can advocate for school and community resources (e.g., outpatient counseling, mentoring programs, support groups). Finally, possible relationships between an ODD diagnosis, school discipline practices and crime adjudication with marginalized groups (e.g., African American males) should be explored, given the drop-out-of-school-to-prison pipeline that is now widely recognized as a reality for many African American males (Barbarin, 2010).

Conflict of Interest and Funding Disclosure
The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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