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Parents' Decision-Making Process About Treatment For Their Child's Oppositional Defiant Disorder

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EdS, University of Nevada, Las Vegas, 2005

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Oppositional defiant disorder (ODD) occurs in up to 16% of U.S. children and is characterized by defiant, disobedient, disruptive, and antisocial behavior toward adults or authority figures that persists for more than 6 months, which can be burdensome for parents. The purpose of this phenomenological study was to explore how parents of a child newly diagnosed with ODD select the treatment for their child. Social cognitive theory and decision theory provided the theoretical framework. A demographic questionnaire and semistructured interviews were used to collect data from 6 parents about their decision-making process. Data were analyzed using the 7-step procedure outlined by Moustakas. Results indicated parents' decisions about treatment were predicated by seeking information about different treatment options, seeking advice from professionals and other parents of children with a diagnosis of ODD, insurance coverage, and rapidity of response to treatment. Parents indicated that support from other parents of children diagnosed with ODD was an essential component of any decision they made about treatment. Findings may encourage parents of children with ODD to educate themselves and consult with others about treatment options. Practitioners may also use the findings to guide parents in making informed choices for their children. Knowledge, treatment, and education can properly advise parents of children diagnosed with ODD regarding appropriate treatment options.

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Chapter 1: Introduction to the Study

Oppositional defiant disorder (ODD) is a serious mental health disorder that adversely affects more than one million U.S. families, and occurs in 1% to 16% of all children (Hamilton & Armando, 2008). ODD is closely related to conduct disorder (CD) and manifested by repetitive and persistent patterns of opposition: namely, defiant, disobedient, disruptive, and antisocial behavior toward adults or authority figures that persists for more than 6 months (Fraser & Wray, 2008). Children with childhood-onset conduct problems often show comorbidity with attention deficit hyperactivity disorder (ADHD; Frick, 2009).

The diagnostic criteria for ODD are characterized by the frequent occurrence of at least four behaviors, including loss of temper, engagement in arguments, active defiance or refusal to comply with the requests or rules of adults, deliberate performance of behaviors that annoy other people, blaming others for his or her own mistakes or misbehavior, expression of being touchy or easily annoyed by others, anger and resentment, or an appearance of being spiteful and resentful (Hamilton & Armando, 2008). Although researchers (Breitenstein, Hill, & Gross, 2009; Fraser & Wray, 2008; Hamilton & Armando, 2008; Robin, 2008; Wehmeier et al., 2011) have examined ODD and its causes and effects, researchers have not studied the decision-making process of parents with children with ODD. Most researchers have used quantitative research methods, but qualitative research is needed to identify how parents choose various treatment options. In this study, I used a qualitative design to identify how parents chose treatment options for their children diagnosed with ODD, barriers to their obtaining information about treatment options, and the individuals who parents are most likely to trust for useful information. In the future, the study results may promote social change by helping parents select appropriate treatment that will enhance the quality of life for their children.

In this chapter, I provide the background of the study. I also include the statement of the problem, purpose of the study, research questions, theoretical framework, nature of the study, operational definitions of terms, assumptions, limitations, scope, delimitations, and significance of the study.

Background

ODD is prevalent in 4% to 16% of children of preschool age, and 65% of preschoolers diagnosed with ODD remain in treatment for 4 years or more (Shenk et al., 2012). Several of the antisocial behavior patterns used to detect this disorder may be present in preschoolers and adolescents who exhibit some degree of antisocial behavior; however, children with ODD exhibit a persistent pattern of antisocial behavior that is difficult to control, coupled with serious impairment in everyday life at home and in school (Hamilton & Armando, 2008). Breitenstein et al. (2009) reported the symptom criteria for disruptive behavior disorders (DBD). In the case of ODD, children lose their tempers and argue with adults. They may actively defy or refuse to comply with adults' requests or rules, act in ways that are angry, resentful, or spiteful, blame others for mistakes or misbehavior, become easily annoyed, or act to annoy others deliberately. After 3 years, 67% of cases are resolved and 30% of cases progress to CD (Lavigne, Gouze, Hopkins, Bryant, & LeBailly, 2012).

Internalizing disorders in children with ODD have a different pattern of comorbidity between boys and girls. Researchers associate ODD with major depression and anxiety in boys, but only with anxiety disorders in girls (Lavigne et al., 2012). In terms of prevalence of ODD in children under 18, rates for boys are higher than the rates for girls before puberty; however, ODD rates become equal after puberty (Lavigne et al., 2012).

Researchers have shown that behavior disorders, such as ODD can result from low academic performance and learning problems that begin in the early years of learning and persist through high school (Da Fonseca et al., 2010; Tynan, 2008). Behaviors associated with ODD in young children include poor literacy skills and the inability to master reading and language. These difficulties place children in a vicious cycle. Learning problems may cause children to disengage socially and academically, and they may become increasingly frustrated, which may aggravate their behavior problems. Behavior problems affect children’s achievement (Tynan, 2008). Often, teachers must intervene, or children with behavior problems are socially excluded or mistrusted by their peers, triggering even more reactive, inappropriate behaviors (Kazdin, 2010). At times, rejection from peers results in these children associating with more deviant peers, further aggravating their behavior problems (Tynan, 2008).

An ODD diagnosis can be stressful for the family and has a significant effect on the child’s social and educational performance (Fraser & Wray, 2008; Hamilton & Armando, 2008; Robin, 2008; Wehmeier et al., 2011). ODD usually presents in preschool-age children (Breitenstein et al., 2009). When ODD is not detected and controlled in its early stages, the behaviors become difficult to manage and may result in criminal tendencies during adolescence (Hamilton & Armando, 2008). Early diagnosis of

ODD, although stressful for parents, helps defray later negative consequences for the child if the parents can obtain worthwhile treatment for him or her.

Research is needed to identify how parents choose treatment options, barriers to obtaining information about treatment options, and individuals who parents are most likely to trust to provide useful information. A wide variety of treatments are available for ODD, which makes it challenging for parents to make a decision regarding the best treatment for their child. Some of the most common forms of treatment for children include individual and group therapy; behavioral therapy; residential treatment; pharmacotherapy; family training (e.g., parent effectiveness training [PET]); and unconventional treatments, such as innovative community-based treatments (Kazdin, 2008). Eyberg, Nelson, and Boggs (2008) noted training children diagnosed with ODD in social behaviors, problem solving, and anger management has been a treatment approach; however, Kazdin (2010) asserted such approaches have not been as effective as parent or teacher interventions.

Parents must consider when to begin treatment. Researchers (Falissard, Coghill, Rothenberger, & Lorenzo, 2010; Kazdin, 2010; Scott, 2008) suggested early intervention in the treatment of ODD is more likely to be successful when intervention includes both parents and children. Fulkerson and Webb (2005) advocated parent training that emphasizes positive attending, ignoring, effectively using rewards and punishments, and imposing time-out as effective for treating ODD. Understanding adults’ beliefs and knowledge about the acceptability or usefulness of each treatment may help determine which factors influence these decisions. However, this does not account for the influence of pretreatment opinions. For example, parents may avoid the use of medications to treat

ODD unless they already tried alternatives, either alone or in combination with drug therapy. Johnston, Seipp, Hommersen, Hoza, and Fine (2005) studied the influence of educational factors and treatment methods for ADHD in boys. The researchers concluded the influence of educational factors on the choice of treatment methods made by parents for ADHD could be extended to treatment choices for ODD.

A significant body of published works exists regarding the efficacy of different treatments for ODD, with a few studies focusing on comparing the treatment forms. Researchers conducted studies to respond to an extensive debate on the effectiveness of ODD treatment methods, such as Turgay’s (2009) study on drug therapy and Waxmonsky et al.’s (2008) study on behavioral therapy. Researchers have not contucted systematic qualitative investigations to address important underlying factors that influence treatment choices.

The recommended treatment in most cases of ODD is multimodal and extensive, and treatment typically involves psychotherapeutic approaches, medication, and sociotherapy. Behavioral therapy may be administered by parents or may involve group-based or individual sessions with one or two therapists (Dretzke et al., 2005). Although various treatments for children with ODD exist, medication is the predominant treatment (Findling, 2008; Haas, Karcher, & Pandina, 2008; Turgay, 2009). Children with ODD can also be treated with a combination of behavioral therapy and drug therapy (Johnston et al., 2005; Waxmonsky et al., 2008) and alternative therapies, such as behavioral parent training (BPT), psychopharmacological treatment, PET, and individual and group therapy (Costin & Chambers, 2007; Lavigne et al., 2012; Verduin, Abikoff, & Kurtz, 2008).

Dretzke et al. (2005) found parent training and education programs are efficient and cost-effective therapy for children diagnosed with ODD.

Further research is needed to understand how parents make treatment choices and whom they trust to provide information regarding ODD treatment. One issue for parents is that the specific actions of some ODD medications are unknown. Coyle (2000) found no substantial clinical research on the pharmacologic treatment of children diagnosed with behavioral disturbances and suggested that children with behavioral disturbances “are now increasingly subjected to quick and inexpensive fixes” (p. 1060) instead of multimodal therapies. Clinicians advising parents about the range of treatment choices are often not certain which treatment or combination of treatments will be the most effective. Johnston, Hommersen, and Seipp (2007) suggested parents choose treatment options based on proven efficacy or on their pretreatment ideas about treatment methods.

The severity of the child’s inappropriate behavior is an influencing factor in adults’ perceptions of the acceptability of one treatment mode compared to others. Parents who live with children with severely inappropriate behavior may be in despair at the time they must make thoughtful decisions about treatments. The clinicians advising parents at this critical time need increased understanding of the factors influencing parents’ treatment choices, barriers to seeking information, and individuals who parents trust for assistance in making decisions regarding the treatment for their child with ODD.

Statement of the Problem

When children are psychotherapy clients, parents play a pivotal role in evaluating and selecting the course of treatment. Parents of a child newly diagnosed with ODD rarely have the information necessary to make an informed decision regarding the appropriate treatment for their child. Most treatment for ODD is extensive and may involve medication (Findling, 2008; Gadow, Nolan, Sverd, Sprafkin, & Schneider, 2008; Turgay, 2009); behavior management (Waxmonsky et al., 2008); a combination of both (Ercan, Varan, & Deniz, 2005); or alternative treatments, such as PET and individual and group therapy (Costin & Chambers, 2007; J. Gordon, 2010; T. Gordon, 1970; Searight, Rottnek, & Abby, 2001). Understanding parents’ process of decision-making regarding treatment modes will help identify factors influencing these decisions and how mental health practitioners and other clinicians can assist parents in the process (Kazdin, 2008).

Although significant research exists on ODD and treatments for ODD, few researchers have focused on the decision-making process of parents with children with ODD. Further, researchers (Callahan & Eyberg, 2010; Johnston et al., 2005; Lavigne et al., 2008) who have examined the decision-making process of parents with children with ODD have primarily used quantitative methodology. In this study, I used qualitative methodology to examine the decision-making process of parents regarding ODD treatment options for their children. The research questions addressed the information that would be useful to parents, barriers to obtaining information, the persons parents trust to give them the best information, and the treatment plan parents select as a result of their decision-making process.

Purpose Statement

The purpose of this qualitative study was to explore the lived experiences of how parents of a child newly diagnosed with ODD chose the treatment for their child. I investigated barriers to obtaining information and sources of information to determine impediments to gathering necessary knowledge regarding whom parents are most likely to trust in the decision-making process.

Research Questions

I developed one overarching research question for this phenomenological study: What factors explain how parents of a child newly diagnosed with ODD decide the treatment for the child based on their lived experience? The subquestions were:

1. What type(s) of information would be useful for parents of a child newly diagnosed with ODD to have to determine the most appropriate treatment for their child?
2. Whom do parents trust to provide information about treatment for their child?
3. What are the barriers parents perceive to acquiring information about treatment options?
4. Based on their knowledge of treatment options, which treatment(s) did parents choose and why?

Theoretical Framework

The primary theoretical foundation of this study was social cognitive theory. Social cognitive theory explains how behaviors are learned and how individuals maintain behavioral patterns. Social cognitive theory posits that cognitive factors influence behavior, including outcome expectations or the perceived value associated with the consequence of a behavior (Bandura, 2001). Key concepts of this theory include environmental factors and behaviors of others, which form the basis for intervention strategies that elicit changes in behavioral response patterns.

According to social cognitive theory, individuals have beliefs regarding which events are connected, expectations about consequences of their actions or outcome expectations, and expectations about their competence to perform the behavior needed to influence outcomes. People are more likely to adopt a new behavior if they believe the behavior will result in a positive outcome (Bandura, 2001). In the context of this study, an application of social cognitive theory would hold that parents of children diagnosed with ODD who receive detailed treatment information about drug therapies and alternative therapies pretreatment, which are cognitive factors, may choose treatments for their children based on these factors. If parents believe the outcome of drug therapy will be more favorable, they may choose that mode of treatment. Likewise, if parents believe that alternative therapies, such as psychopharmacological treatment, PET, and individual and group therapy, will have more favorable outcomes, they may choose one or more of the available alternative therapies.

A second theoretical framework for this study was decision theory. Decision theory states people act rationally. They choose from a variety of alternatives, and during the decision-making process, they consider uncertainty and risk factors (Sen, 1971). Decision-making begins when those who must make the decision note their needs; in this study, decision makers were parents of a child diagnosed with ODD. Although parents approach the decision-making process with a set of values and beliefs intact, they must also gather information, which is a cognitive process. Both social cognitive theory and decision theory provided a more comprehensive theoretical framework applied to causes of ODD, which I discuss in more detail in Chapter 2.

Nature of the Study

In this qualitative study, parents with children recently diagnosed with ODD were asked about their experiences in obtaining information to make a decision regarding the appropriate treatment for their child. The study design was phenomenological because the purpose of the study was to understand the experience of the participants (see Creswell, 2012b). Intensive interviews with parents enabled understanding of this unique population and how parents go about acquiring information to decide about treatment for their children considering the low incidence of ODD. I explored the process parents used for decision-making, the barriers that prevented them from obtaining useful information, and the people who were most helpful and trusted in the decision-making process.

The interviews stopped when data saturation was reached, which occurred when no new information came from the parents. Interviews were transcribed, and Moustakas's (1994) steps for analyzing qualitative data were followed: (a) listing and preliminary grouping, (b) reducing and eliminating, (c) clustering and thematizing invariant constituents, (d) identifying final invariant constituents and themes, (e) using relevant invariant constituents and themes, (f) constructing an individual structural description, and (g) incorporating the invariant constituents and themes into the meanings and essences of the experience. I synthesized the emergent patterns and themes for similarities and differences. In Chapter 4, I report these results.

Definitions of Terms

Attention deficit/hyperactivity disorder (ADHD): A behavioral disorder that affects a child's ability to control attention, to concentrate, and to control impulses. Children with ADHD are easily distracted and often do not think before they respond.

Children with ADHD often have above-average intelligence, but they experience learning difficulties and have problems socializing because they are unable to focus (Gau et al., 2010).

Conduct disorder (CD): A group of behavioral problems, including aggression and defiance, evidenced by a child to a much higher degree than expected for the child's age. Behaviors include fighting, physical cruelty, destructiveness, lying, and stealing (Rowe, Costello, Angold, Copeland, & Maughan, 2010).

Disruptive behavior disorders (DBD): Behaviors that range from minimally disruptive, such as quarrels, to those resulting in maximum disruptions, such as intentional cruelty (American Psychiatric Association [APA], 2013). In the DSM-5-TR (APA, 2013), CD and ODD are categorized as DBD.

Evidence-based psychosocial treatments (EBTs): Treatments for children with disruptive behaviors that are empirically based and include a specific procedure or a set of procedures with therapeutic intent (Eyberg et al., 2008).

Oppositional defiant disorder (ODD): A behavioral disorder characterized by disruptive and contrary behaviors, including lack of response to instructions; refusal to take direction; or refusing requests directed toward authority figures, such as parents or teachers, and persist for longer than 6 months (Fraser & Wray, 2008).

Oppositional defiant disorder rating system (ODDRS): A rating scale that is completed by parents based on the criteria for ODD in the DSM-IV-TR (O'Laughlin, Hackenberg, & Riccardi, 2010). No updates to the ODDRS based on the DSM-5 have been made.

Parent effectiveness training (PET): An educational program developed by T. Gordon (1970) based on a theory of healthy relationships and aimed at solving problems in the parent-child relationship (Wood & Davidson, 2007).

Parent management training: An evidence-based intervention that "focuses on parent-child interactions, relationships and child behavior at home, in school, and in the community" (Kazdin, 2010, p. 212). Parent management training emphasizes changing the child's negative or oppositional responses to parents, teachers, siblings, and peers to more positive responses (Kazdin, 2010).

Systematic training for effective parenting (STEP): A parenting skills program for parents that promotes a more participatory family structure by encouraging responsibility in children and better communication between children and parents, and by helping children understand the results and consequences of their choices. STEP is available in four versions: (a) early childhood (children up to age 6), (b) children ages 6 through 12, (c) STEP/Teen, and (d) Spanish STEP for Spanish-speaking children ages 6 through 12 (Dinkmeyer, 2010).

Assumptions, Scope, Delimitations, and Limitations

Assumptions

The first assumption was that parents of children newly diagnosed with ODD would be available to participate. Second, I assumed participants would be willing and able to participate in the study, and that they would stay in the study throughout its completion. I also assumed parents would be able to make a responsible decision related to treatment options for their child diagnosed with ODD. These assumptions were based on the low prevalence of ODD and the attitudes and beliefs of parents of these children.

Parents had to be open to the interview process and understand the nature of their child's disability.

Scope of the Study

Although I have access to records of children who are eligible for special education services and their parents through my employer, a large school district in the southwestern United States, using such records would be considered a breach of confidentiality. The scope of the research was limited to parents of children diagnosed with ODD who were able to report the decision-making process they followed when selecting an ODD treatment mode. A recent diagnosis—less than 1 year—was preferred, but not essential, as the parents' recollections would be fresh in their minds. Therefore, I asked psychological and medical professionals who might diagnose children with ODD to offer the parents of newly diagnosed children the opportunity to participate in this study by providing them my contact information through the recruitment flyer I gave to those professionals (see Appendix A). I made no attempt to transfer the results to other populations, as is consistent with qualitative research (Moustakas, 1994).

Two theoretical frameworks underlay this study: social cognitive theory and decision theory. Both involved the process parents undergo when they receive a diagnosis for their child that requires them to make a decision that will affect the child and the family. The purpose of this study was to understand this process and learn whether these theoretical frameworks would frame the conclusions.

Transferability, the ability to transfer the findings to another population or setting, contrasts with generalizability, the ability to generalize findings to a larger population. Transferability is determined by the reader; generalizability is determined by a researcher

(Creswell, 2012). I considered transferability when conducting this study. Parents with children who received a diagnosis requiring special education could have had difficulty thinking clearly and articulating their decision-making process regarding appropriate help for their child. The outcome of this investigation may provide transferable knowledge about decision-making for parents of children with other conditions so that professionals in education and other fields can support parents following diagnosis.

Delimitations

This study was delimited to parents' decision-making process regarding ODD treatment options for their children and included two additional factors that could affect the way they process information about the treatment the children received. These factors were barriers to acquiring knowledge regarding ODD treatments along with the selection of the person or persons they would trust to aid in their decision-making. The study only included parents of children with ODD in Las Vegas, Nevada.

Limitations

Because data were collected primarily from interviews, it was possible that some participants could have failed to complete the interview process or could have dropped out of the study for various reasons. I expected to need a minimum of 10 parents of children diagnosed with ODD, and it was possible that as many as 20 could have been necessary before achieving saturation. If the child had two parents, it would have been useful if both participated; however, if that was not possible, only one parent participated and reported the experience of both parents. This was as a possible limitation of the study. Because this was a qualitative study, I made no attempt to generalize the results.

An additional limitation was that some parents may not have had all of the ODD treatment options accessible to them, even if they received the information. For example, a treatment option may not have been covered by insurance or was not affordable for parents. Further, professionals may not have practiced a particular therapy or offered treatment in the necessary geographical area. In such cases, parents could not have chosen an option even if it would be the best choice for them. Parents could have had additional reasons, such as transportation or work hours, that limited their access to treatment.

Researcher bias is one threat to the validity or trustworthiness of qualitative research. In the present study, I conducted member checking and peer review to reduce bias and ensure that I had faithfully recorded the information from the participants. In addition, the faculty review committee and Institutional Review Board (IRB) from Walden University ensured the study would be of high quality by screening for researcher bias in the research design, questions, and results.

Significance of the Study

Little literature exists regarding the decision-making process of parents of a child newly diagnosed with ODD in their choice of treatment options. This study addressed the suggestion by Kazdin (2008) to learn more about the factors associated with ODD that are directly related to parents’ choice of treatment for their child. This study provided insight regarding how parents make important decisions when faced with a diagnosis of a psychiatric disorder in their child. The results of this study may improve clinical practitioners’ ability to understand the barriers to obtaining the information needed to make critical decisions and increase the knowledge researchers have about who is most useful and trusted in assisting the parents. In addition, the results of this study may expand clinical practitioners' knowledge so that they can properly advise parents of children diagnosed with ODD how to choose the appropriate treatment.

The diagnosis of ODD is becoming more prevalent (Shenk et al., 2012), and it often leads to more intense and complex behavioral disorders. Lavigne et al. (2012) discovered that approximately 30% of children with ODD eventually develop CD. For children diagnosed with ODD at preschool age, the risk for developing CD is 3 times higher (Hamilton & Armando, 2008). Approximately 10% of children diagnosed with ODD will eventually develop a more lasting personality disorder, such as antisocial personality disorder (Shenk et al., 2012). For families with children diagnosed with ODD, the results of this study may contribute to positive social change by providing insight into the decision-making process involved in determining appropriate treatment for the child with ODD. I identified the barriers to obtaining information and persons who could assist in the decision-making process.

Summary

Children diagnosed with ODD show persistent patterns of defiant, disobedient, disruptive, or antisocial behaviors that are difficult to control and affect their everyday life at home and in school (Hamilton & Armando, 2008). Children with ODD may have learning difficulties with reading, literacy, and language, resulting in low academic performance (Da Fonseca et al., 2010; Tynan, 2008). A diagnosis of ODD is stressful for the entire family (Hamilton & Armando, 2008). A wide variety of treatments for ODD are available; most options are multimodal and extensive and involve psychotherapeutic approaches, medication, and sociotherapy. In this qualitative study, I explored how parents made a decision regarding appropriate treatment for their child with ODD, the barriers that prevented them from obtaining or accessing information, and the individuals they found most helpful and trustworthy in making such an important decision.

In this chapter, I presented the background of the study, statement of the problem, nature of the study, research questions, purpose, and theoretical framework. I also provided operational definitions of key terms. I presented assumptions, limitations, scope, delimitations, and significance of the study. In Chapter 2, I will review literature relevant to the study by addressing major ODD treatment options and information about children with ODD and their parents.

Chapter 2: Literature Review

The purpose of the study was to explore how parents of a child newly diagnosed with ODD decide treatment for their child. I investigated barriers to obtaining information and sources of information to determine factors that may impede parents from gathering necessary knowledge. I also studied who parents are most likely to trust in the decision-making process. In this chapter, I will review treatment options, including medication therapy, behavioral therapy, special education, parent management training, and PET. I examined the effectiveness of medical treatments, along with the use of such medications with other treatment options. The decision-making process about the treatment options and parents' knowledge of the treatments were important in answering the research questions. Because of the close relationship between ODD and CD, I will discuss the difference between the two.

In this chapter, I will review older and recent literature about ODD and options for treatment of ODD. Researchers have shown that a wide variety of treatments for ODD are available; however, little research exists regarding the relationship between educating parents about treatment options, parental choice of treatment, and the process of coming to a decision. The present study was designed to address the gap in literature regarding the decision-making process of parents for the appropriate treatment for their child diagnosed with ODD.

I used the databases Academic Search Premier, ProQuest, PsycArticles, and PsycInfo to search for relevant literature. I performed aadditional Internet searches with Google Scholar. Other resources included books available online and from the local library. Key search terms included the following: *oppositional defiant disorder*, *conduct* *disorder*, *social cognitive theory*, *decision theory, oppositional defiant disorder treatment, oppositional defiant disorder rating system (ODDRS), oppositional defiant disorder drug therapy, oppositional defiant disorder behavioral therapy, oppositional defiant disorder treatment options*, and *oppositional defiant disorder parents' treatment beliefs*.

Theoretical Foundation of ODD

The cause of ODD has not been determined, but researchers rely on two theories to explain the disorder: developmental theory and learning theory. Developmental theory suggests ODD is a result of incomplete development, and children with ODD do not complete the developmental aspects that typical children master during their toddler years (Posey et al., 2007). Frick (2009, 2012) identified developmental issues in children related to psychopathy and suggested children who show callous-unemotional traits that include a severe, aggressive, and stable pattern of antisocial behavior are a clinically important subgroup of children with childhood-onset conduct problems. According to Kahn, Frick, Youngstrom, Findling, and Youngstrom (2012), children with callous-unemotional traits show numerous emotional, cognitive, and personality features distinct from other antisocial youth and are similar to features found in adults diagnosed as psychopathic. Learning theory suggests ODD results from negative interactions with parents and authority figures that cause the ODD behavior (Kane, 2008).

Hommersen, Murray, Ohan, and Johnston (2006) designed the Oppositional Defiant Disorder Rating Scale (ODDRS) and created the psychometric properties of a parent-completed rating scale based on the criteria for ODD in the DSM-IV-TR (APA, 2000). Parents of children with ADHD completed the ODDRS. The ODDRS has high internal consistency, high interrater reliability, and moderate 1-year test-retest reliability. The scale correlated as expected with related subscales from the Child Behavior Checklist and with overreactive parenting. The strong psychometric properties of the ODDRS make it a suitable measure for assessing ODD that complies with the DSM-IV-TR standards (Hommersen et al., 2006).

In terms of developmental prognosis, Kane (2008) suggested four possible paths. First, many children diagnosed with ODD will grow out of ODD. Half of the preschoolers diagnosed with ODD display typical age-appropriate behavior by age 8. In older children diagnosed with ODD, however, 75% will meet the diagnostic criteria for the disorder later in life. Second, ODD may turn into a different medical condition. Between 5% and 10% of preschoolers with ODD have their diagnosis changed from ODD to ADHD (Kane, 2008). In some children, the defiant behavior gets worse, and these children are eventually diagnosed with CD. Third, children diagnosed with ODD do not develop any other related problems; this is atypical because only 5% of 8-year-old children diagnosed with ODD have no other disorder. Fourth, the child develops other disorders in addition to ODD, which is the most common pattern researchers observe (Kane, 2008).

Recent research has demonstrated the early and efficient treatment of ODD improves the capacity for positive familial interaction and the development of a skill set that can prevent future comorbidity with more severe disorders and mental health problems (Hamilton & Armando, 2008). Fewer than 20% of young children meeting the DSM-IV-TR criteria for ODD (APA, 2000) are referred for mental health services (Costin & Chambers, 2007; Dretzke et al., 2005). To reach more children who exhibit symptoms of ODD, identification and treatment must occur outside of the mental health services system (Kazdin, 2008). Researchers have developed several school-based interventions; however, when ODD symptoms occur at home, such interventions may not be effective (Scott, 2008). According to Falissard et al. (2010), after teachers, family physicians have the most contact with the families of children diagnosed with ODD, and parents tend to trust family physicians’ recommendations when seeking help for their children’s problem behaviors. Johnston et al. (2005) examined the relationship between parents’ perceptions and attitudes and their experiences with different treatments for their children diagnosed with ODD and found that parents’ beliefs were related to their choice of treatment. Some parents chose behavior management and medications as treatment modes, while others explored different treatment options, such as vitamin therapies.

Theoretical Foundation of the Study

In the current study, the theoretical framework was based on social cognitive theory and decision theory. Social cognitive theory “emphasizes the importance of self-efficacy and outcome expectations as important determinants of behavior” (Janicke & Finney, 2003, p. 548). In the present study, as in the study conducted by Janicke and Finney (2003), parents who seek treatment for their child with ODD should demonstrate self-efficacy and expect outcomes from their behavior, such as selecting a treatment for their child. Janicke and Finney explored parent primary care use for their children using social cogntive theory as their theoretical foundation. The researchers found that social and cognitive factors predicted use of primary care services.

As applied to this study, social cognitive theory posits that parents of children diagnosed with ODD who receive detailed treatment information about drug therapies and alternative therapies before treatment, which are cognitive factors, may choose treatments for their children based on these factors. If parents believe the outcome of drug therapy will be more favorable, they may choose that mode of treatment. Likewise, if parents believe that alternative therapies, such as psychopharmacological treatment, TT, PET, and individual and group therapy, will have more favorable outcomes, they may choose one or more of the available alternative therapies.

Decision theory is based on the assumptions that during the decision-making process, individuals must consider uncertainty and risky factors, and people act rationally, consider uncertainty and risk, and make their choices from a variety of alternatives (Sen, 1971). Parents of a child diagnosed with ODD approach the decision-making process with a set of values and beliefs and must also gather information, which is a cognitive process. The social-cognitive processes required for parental decision-making force the parents to solve problems in new ways that were unanticipated when they became parents. Coletti et al. (2012) studied the decision-making process regarding medication as a treatment for children with ADHD. Coletti et al. conducted focus groups and “identified social, cognitive, and affective influences on decision making” (p. 227), supporting the use of social cognitive theory and decision-making theory as a theoretical basis for the present study.

Therapies for Treatment of ODD

Drug Therapies

Medication is one of the main treatments for children with ODD. Parental perceptions of the efficacy of such treatments influence their choice of treatment options. Turgay (2009) discussed some of the medications used in the treatment of ADHD that also may be effective in the treatment of ODD patients. Turgay (2009) also described the proven efficacy of atomoxetine in the treatment of ODD, which overlaps ADHD symptoms. In addition, patients with ODD and subsequent CD presenting with symptoms similar to severe aggression showed improvement and response to treatment regimens using risperidone combined with or without psychostimulants. Some findings suggested that alpha (2)-agonists and antidepressants are good second-line treatments in the overall treatment and management of ODD and its comorbidities (Turgay, 2009).

Findling (2008) published a review of atypical antipsychotic treatment of DBD in children and adolescents, which included indications that atypical antipsychotic treatment is somewhat effective in patients with DBD, such as CD and ODD, especially those who present with symptoms of severe aggression. Risperidone is effective for treating aggressive behavior in this patient population (Haas et al., 2008). Haas et al. (2008) conducted a study on the treatment of children's and adolescents' disruptive behavior disorders using risperidone. Haas et al. focused on exploring the long-term safety of risperidone as maintenance therapy in children and adolescents with DBD. Researchers valued safety and efficacy in the intent-to-treat population, and the findings showed risperidone was safe and well-tolerated (Haas et al., 2008). Studies performed on the effectiveness of olanzapine, quetiapine, and aripiprazole caused researchers to suggest more research is necessary for these potential agents for therapy to draw more definitive conclusions and to measure the associated side effects, such as weight gain, headache, and somnolence, with therapeutic use of these drugs in children and adolescents (Findling, 2008).

Methylphenidate was shown to be effective for children with ODD who comorbidly experienced chronic multiple tic disorders and ADHD (Gadow et al., 2008). Hazell et al. (2011) compared responses to atomoxetine treatment and methylphenidate treatment of children and adolescents with core ADHD symptoms during a 6-week period. Hazell et al. used the ADHD Rating Scale-IV-Parent Version: Investigator Administered and Scored (ADHDRS) scores to assess treatment response. Response rates were defined as ≥ 40% reduction in ADHDRS total score. Hazell et al. found, at the end of 6 weeks of treatment, atomoxetine and methylphenidate were comparable for reducing core ADHD symptoms in children and adolescents.

Matsudaira (2007) published findings on the recent use of the first nonstimulant medication therapy, atomoxetine hydrochloride, which was successful in treating ODD. The use of alternative treatments, such as omega-3s, has yet to show benefits for ODD patients. In the Durham trial, Richardson (as cited in Matsudaira, 2007) tested omega-3s with omega-6s on schoolchildren with developmental coordination disorder (many had ADHD symptoms). Matsudaira reported improved scores in coordination and short-term memory.

Bangs et al. (2008) tested the efficiency of atomoxetine for the treatment of ODD comorbid with ADHD in children between the ages of 6–12. The patients met the DSM-IV-TR (APA, 2000) diagnostic criteria for ODD. Results indicated the children with ADHD and comorbid ODD showed marked improvement in ADHD symptoms and functioning when given atomoxetine. It was unclear whether atomoxetine affected any specific and enduring improvements in ODD patients outside the comorbidity group (Bangs et al., 2008).

Ghuman et al. (2007) explored whether demographic or pretreatment clinical and social characteristics influenced the response of methylphenidate in preschool-age children with ADHD. The results indicated that among preschoolers diagnosed with ADHD, the presence of one comorbid disorder, which most often was ODD, indicated a treatment response at levels equal to those seen in school-age children. Two comorbid disorders showed moderate treatment response. In children with three or more comorbid disorders, no treatment responses to methylphenidate were evident.

Dunn and Kronenberger (2007) researched the effect of adding quetiapine in methylphenidate treatment based upon the efficacy in adolescents with comorbid ADHD, CD, or ODD with aggression. Dunn and Kronenberger explored the safety and efficacy of adding the atypical antipsychotic, quetiapine, to ongoing osmotic-controlled release oral delivery system methylphenidate treatment for patients with comorbid ADHD and severe aggressive symptoms, which were partially responsive to the methylphenidate therapy. The Clinical Global Impressions Scale and Rating of Aggression Against People and/or Property criteria for significant improvement were used to measure symptom severity. Results of the study showed adding quetiapine to methylphenidate was effective in improving aggression in patients who had not shown a positive response to osmotic-controlled release oral delivery system methylphenidate alone at a 54-mg/day dose (Dunn & Kronenberger, 2007).

Researchers showed methylphenidate therapy is effective in reducing hyperactivity and inattention symptoms in children with ODD. Posey et al. (2007) reported methylphenidate yielded significant improvement when administered at the .25- and .5-mg/kg doses. Symptoms, such as hyperactivity and impulsive actions, improved after methylphenidate therapy more than symptoms, such as inattention. In ODD or stereotyped and repetitive behavior cases, no significant gains appeared.

Barzman, DelBello, Adler, Stanford, and Strakowski (2006) studied the efficiency and tolerability of quetiapine versus divalproex for the treatment of impulsivity and reactive aggression in adolescents comorbidly diagnosed with bipolar disorder and DBD. The findings indicated quetiapine and divalproex had similar efficacy when used in the treatment of impulsivity and reactive aggression related to comorbid bipolar and DBD in adolescents. Quetiapine and divalproex were effective in monotherapy for the treatment of impulsivity and reactive aggression in adolescents with bipolar and DBD.

Pandina, Aman, and Findling (2006) published a review of the results of recent studies that measured the efficacy and safety of risperidone therapy in the treatment of pediatric patients with DBD, such as ODD and ADHD. Pandina et al. analyzed movement disorders, prolactin concentrations, body weight, and cognitive function data from short- and long-term studies in this patient population. The finding was that risperidone is an efficient and well-tolerated treatment therapy available for children and adolescents diagnosed with DBD.

Spencer et al. (2006) researched the efficacy and safety of mixed amphetamine salts extended release (Adderall XR) in the management of ODD with or without comorbid ADHD in school-aged children and adolescents. A significant improvement from baseline in ODD symptoms was recorded for the mixed amphetamine salts Adderall XR. During the study, patients with ODD demonstrated tolerance of mixed amphetamine salts extended release Adderall XR with few occurrences of adverse effects. Higher doses of mixed amphetamine salts extended release Adderall XR (30 mg and 40 mg) were effective and well-tolerated in the management of ODD in these school-aged children and adolescents in the presence or absence of ADHD (Spencer et al., 2006).

Ercan et al. (2005) evaluated the effects of a combined treatment of ongoing methylphenidate management and a parent-training program that continued for 5 months and focused on children diagnosed with ADHD. The findings indicated this combined treatment therapy reduced the ADHD, ODD, and CD symptoms in the patient group. A further analysis of results indicated that medication, rather than parent training, was responsible for improvements in the reduction of symptoms and in the mother-child relationship (Ercan et al., 2005). The results of this study emphasized the role that stimulant drug therapy plays in the treatment of ODD.

Two groups of researchers studied the effect of Strattera on children with both ADHD and ODD. Kane (2009) concluded that Strattera helped with ODD, while Hautmann et al. (2011) obtained results that indicated Strattera did not improve ODD conditions. A large Canadian study showed that Risperdal helped with aggressive behavior in children with below normal intelligence. Regardless of the presence or absence of ADHD, this study indicated that 80% of children with explosive behavior improved when given the mood stabilizer divalproex (Kane, 2009).

Behavioral Therapy

Parents consider many treatment options for their children diagnosed with ODD, leading to the question of whether behavioral therapy works for these children either by itself or in conjunction with drug therapy. Waxmonsky et al. (2008) studied the efficacy and tolerability of methylphenidate combined with behavior modification in 33 children age 5–12 with ADHD who also exhibited symptoms of severe mood dysregulation, which included children who showed symptoms of ODD and CD. The severe mood dysregulation group also had elevated scores on the Young Mania Rating Scale. These children were compared to a group of 68 children who did not exhibit symptoms of severe mood dysregulation. The patients exhibited significant improvement in externalizing; however, there was no evidence of differential treatment efficacy or tolerability. The severe mood dysregulation group exhibited elevated Young Mania Rating Scale scores and more symptoms of ODD and CD, and they were more likely to continue to be impaired at home than children in the non-severe mood dysregulation group. Waxmonsky et al. found methylphenidate and behavior modification are tolerable and effective treatments for children with ADHD and severe mood dysregulation, but additional treatments may be needed to optimize their functioning.

The complication of comorbidity in behavioral therapy. Ollendick, Jarrett, Grills-Taquechel, Hovey, and Wolff (2008) examined the effects of comorbidity on treatment outcomes for anxiety, ADHD, ODD, and CD and found comorbidity may be a predictor and moderator of treatment outcome in youths with these disorders. This study was significant because no researchers have studied whether comorbidity predicts or moderates treatment outcomes. However, a few researchers (Dunn & Kronenberger, 2007; Ghuman et al., 2007) touched on this subject and the results indicated comorbidity did not affect treatment outcomes (Ollendick et al., 2008).

Adding to behavioral therapy. Hamilton and Armando (2008) researched the effectiveness of parent training, collaborative problem solving, and psychological intervention in ODD treatment. The researchers found a psychological intervention that involves both the parents and the child can improve short- and long-term outcomes of drug therapy and prevent the development of comorbidity. Collaborative problem solving is a psychological intervention that develops a child’s skills in tolerating frustration, demonstrating flexibility, and avoiding emotional overreaction. Hamilton and Armando (2008) found when ODD coexists with ADHD, stimulant therapy, like psychological interventions, parent training, and collaborative problem solving, can reduce the symptoms of both disorders.

Including parents in behavioral therapy. Another behavioral therapy that was effective in treatment and management of ODD in children was family interventions. Children suffering from ADHD present with aggressive symptoms that include arguments with their parents about a variety of issues, especially if they also suffer from ODD or CD (Robin, 2008). Robin (2008) found family interventions were effective in reducing the occurrence of such conflicts in two independent investigations.

Eyberg et al. (2008) reviewed the available literature from 1996–2007 on EBTs for children and adolescents with disruptive behavior. This review updated Brestan and Eyberg’s (1998) report on EBTs for child and adolescent disruptive behaviors, such as ODD and CD. Research was assessed using the criteria for EBTs developed by the Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1996, 1998, as cited in Eyberg et al., 2008). Eyberg et al. described EBTs and their evidence-based research on moderators and mediators of treatment outcome, and the extent to which the studies represented the wider patient base or could be generalized. The review provided best practice recommendations from the available EBTs; however, Eyberg et al. stated more research was needed to understand the efficiency of EBTs for children and adolescents with disruptive behavior disorders.

Hautmann, Hanish, Mayer, Plück, and Döpfner (2008) studied the effectiveness of a Prevention Program for Externalizing Problem Behavior (PEP) in children with symptoms of ADHD and ODD. In their study, the researchers tested the effects of PEP under conditions of high external validity. This method of intervention was assessed using a within-subject control group design with three assessment points: two before (pre1 and pre2) and one immediately after (post) the PEP training. Data collection methods included questionnaires on the symptoms of the patient and the mother as well as parenting procedures. The results indicated parenting and child behavior problems were reduced posttreatment and were more significant than the changes observed during the waiting period. A limitation of this study was that no long-term follow-up was conducted to see if treatment gains were maintained. These findings indicated PEP can be used as a treatment option in routine care settings without losing other positive treatment effects (Hautmann et al., 2008).

MacKenzie (2007) discussed the BPT model, a family-based, validated intervention strategy for children aged 3–8 years. This model is based on social learning theory and principles of operant conditioning. The purpose of BPT is to improve child behavior and functioning by changing parenting behaviors (MacKenzie, 2007). Specifically, parents are taught to reinforce desired child behaviors with positive reinforcers, such as social praise, verbal attention, affection, and tangible rewards. Parents are also taught to respond to serious misbehavior with noncoercive punishment techniques, such as time-outs. Parents learn monitoring skills that help them distinguish between positive and negative behaviors, respond appropriately to these behaviors, and accurately assess changes in child behavior functioning over time with techniques, such as daily behavioral data collection and graphing (MacKenzie, 2007). MacKenzie noted that the efficacy of BPT increased when adding treatment modules to the basic BPT model.

Webster-Stratton and Hammond (1997) added individual child-focused problem-solving modules to the BPT module for children aged 4–8 with severe conduct problems to enhance treatment outcomes. In their study, they compared intervention trainings and found that at 6 months, children in the treatment group significantly improved compared to children in the control group; children who participated in the child-focused module showed the most significant improvements. Some researchers (Breitenstein et al., 2009; Shenk et al., 2012; Tse, 2006) suggested preschool-aged children respond better to treatment than older children. MacKenzie (2007) advocated early intervention in the preschool and elementary school years.

Parent effectiveness training. Parent effectiveness training is an intervention based on T. Gordon's (1970) theory of healthy relationships. The theory of healthy human relationships consists of nine principles for one person in a relationship. The nine principles are as follows, (a) feeling accepting of the other, (b) demonstrating acceptance of the other, (c) trying to become accepting of more of the other's behavior, (d) becoming aware of accepting feelings, (e) learning to express unaccepting feelings honestly, (f) communicating unaccepting feelings nonvaluatively, (g) refusing to use power in conflict resolution, (h) refusing to give in to the other's use of power, and (i) resolving conflicts by a "no-lose" method (T. Gordon, 1970, p. 410).

Although PET principles apply to any interpersonal relationship, the person in power has the primary responsibility for initiating change. In PET, the person in power is the parent; however, in PET, no use of parental power appears. This training emphasizes the needs of both the parents and the child and focuses on resolving conflicts to meet the needs of both. The principles communicate goals for parents to work toward to relate to the three major skills taught in PET: (a) acceptance, (b) nonacceptance, and (c) fair conflict resolution (J. Gordon, 2010).

Baumrind (1978) identified three styles of parenting: authoritarian, authoritative (democratic), and permissive. Parent effectiveness training is based on teaching democratic parenting. Other concepts and skills parents develop during PET include acceptance of the child as he or she is, demonstration of this acceptance with active listening, expression of authentic feelings without shame, avoidance of labels and judgments, understanding of anger and its underlying causes, modification of the physical environment to prevent problems and conflicts, and participation in rule setting as a family. Parents learn how to talk to their children so they will listen, how to listen to their children so that children feel their parents genuinely understand them, how to resolve conflicts in the family that result in a win-win for everyone, and how to solve family problems. These skills are not often evident in parenting in Western cultures where the tendency is for parents to convey nonacceptance of inappropriate behaviors. In PET, however, nonacceptance of inappropriate behaviors requires developing a particular style of parental assertiveness that includes emotional awareness, self-regulation, and honesty about the parent’s feelings regarding the child’s behavior rather than disapproval (J. Gordon, 2010).

J. Gordon (2010) based PET skill building on the empirical work of Jourard’s (1971) transparency of relationships; Dewey’s (1938) idea of holistic learning between student and teacher, applied to the interaction of parent and child; and Maslow's (1954, 1970) theory of the hierarchy of human needs. J. Gordon's experience in the U.S. Air Force taught him the success or failure of any program depends on creating a nonthreatening environment, allowing and accepting resistance, coaching specific skills, and role modeling by facilitators. These elements became part of PET (Wood & Davidson, 2007). When PET was introduced, the program's underlying philosophy was controversial because it deviated from traditional notions of parenting. In the PET program, the focus is on family functions in terms of the parent-child relationship and is not based on external social expectations. Gordon (1970, 2010) believed that parental expectations should be based less on rules and more on developing empathetic relationships between parent and child to foster self-responsibility and self-actualization (Wood & Davidson, 2007).

Parent management training. Treatment of ODD focuses on behavioral management, especially by parents. Although special education is highly recommended, empirical research has indicated parent management training is more effective in lessening the antisocial behavioral patterns of children suffering from ODD. Parent management training is recommended for parents of children with ODD to help them change the pattern of negative interactions between parents and children that occur in these families. The purpose of parent management training is to train parents to recognize their child's positive behaviors and reinforce them, and to use brief negative consequences for poor behavior (Lavigne et al., 2012).

In a study by Costin and Chambers (2007) designed to test the effectiveness of parent management training, the children studied had severe ODD and were referred to a mental health clinic. Procedures used for assessing symptomatic changes were the Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999), the Parent Stress Index Child Domain (Abidin, 1983), and the Child Behavior Checklist (Achenbach, 1991). Data were collected posttreatment and 5 months after, as a follow-up. The results indicated a decrease in child symptomatology. No conclusive evidence of any effect of comorbidity appeared on the outcome measures. This study showed parent management training is a robust intervention suitable for routine clinical practice. The parent management training intervention reduced the child's antisocial behavior symptoms and children with one or more comorbid disorders and ODD had an equally positive response (Costin & Chambers, 2007).

Tse (2006) reviewed the literature on psychosocial treatments for preschoolers with DBD to identify ways to use interventions developed in research settings in clinical preschool day treatment programs, often associated with parent management training and other parental interventions. Tse noted that little to no research was available on the effectiveness of day treatment programs, although the day treatment program model was prevalent as a treatment for disruptive preschoolers. Tse concluded preschool day treatment programs could improve access to care, emphasize social problem-solving skills, and use strategies to engage families in treatment. More research on day treatment programs is needed to clarify the role of these programs in child psychiatry clinics and to shed light on optimal methods of service delivery (Tse, 2006).

Dretzke et al. (2005) studied the effectiveness of parent management training programs in the alleviation of CD in children compared to special education programs. The results indicated parent training and special education programs are efficient and cost-effective therapies for children with CD and ODD. The relative effectiveness and cost-effectiveness of different models such as therapy intensity and setting require more research and investigation. In Dretzke et al.'s research, a total of 30 studies included comparison of parent training and special education programs. This research showed consistent evidence of improvement in child behavior with parent training and special education programs. No programs showed a significant worsening in behavior outcome.

Prevention program for externalizing problem behavior. Hautmann et al. (2011) investigated the differential effectiveness of PEP (Plück, Wieczorrek, Wolff-Metternich, & Döpfner, 2006), a parent management training program for children with externalizing problem behavior. The researchers tested the training with 270 families with children aged 3–10 years. Attention problems, disruptive behavior problems, parenting skills, and parental depression, anxiety, and stress were assessed with four different standardized instruments. Researchers made assessments 3 months before treatment, immediately before treatment, immediately after treatment, and 12 months after as a follow-up. Data analysis involved growth mixture modeling, a statistical probabilistic model for subpopulations within an overall population (Mengersen, Robert, & Titterington, 2011). Attention problems yielded two groups: (a) severely impaired and (b) less impaired. The more impaired group showed stronger treatment effects because of the parent training. Disruptive behavior problems yielded three subgroups, with two subgroups exhibiting high initial levels of disruptive behavior problems and the third subgroup exhibiting low initial levels. One of the more impaired groups showed a strong decrease in problem behavior during treatment. The other two groups showed only moderate decreases in problem behavior. Hautmann et al. (2011) found that some children with significant impairments exhibited the most effective results from the parent training.

Other Treatment Modes for ODD

In a case study, Verduin et al. (2008) explored special education and several other evidence-based treatments for ADHD in a preschool-age child. The researchers focused on the treatment of an 11-year-old boy diagnosed with simultaneous ADHD and ODD. Several evidence-based treatments, such as BPT, school consultation, behavioral training of educators, school-based contingency management, and a behavioral daily report card, were used with the child. The researchers analyzed the problems common to the clinical application of empirically-supported interventions. Researchers have explored many problems regarding the limited evidence available on the efficacy of interventions for preschool-age children with ADHD and ODD, factors that affect treatment planning and sequencing, importance of cooperation between schools and parents, and evidence-based assessment of treatment gains (Verduin et al., 2008).

In a paper published in 2001, Searight et al. also described the diagnostic features, etiology, and importance of family psychotherapy in the treatment of children with ODD. The authors stated that CD and ODD are common childhood psychiatric problems that have an increased incidence in adolescence. The main diagnostic features Searight et al. described for CD were aggression, theft, vandalism, violations of rules, and telling of lies. For a confirmative diagnosis, these behavioral patterns must have taken place for at least a 6-month period. Searight et al. also showed that CD has a multifactorial etiology that includes biologic, psychosocial, and familial factors. The differential diagnosis of CD and ODD includes ODD, ADHD, mood disorder, and intermittent explosive disorder.

In the studies cited in the present literature review, researchers combined medication with parent training programs designed to fulfill the needs of children with ADHD and ODD. Further research is required to determine which of the therapies mentioned are most effective in treatment and control of ODD at an early age to prevent the increase in manifestation of symptomatic changes during adolescence that culminate in violent, destructive, and criminal behavior, which may result in referral to mental health facilities.

Selection of an Effective Treatment

Parents of children with ODD have a range of treatments available that include medication, therapy, parent training, emotional skills training, and combinations of treatments; thus, decision-making can be a complex task. Johnston et al. (2007) studied a sample group of 109 mothers of boys with ADHD who were 5–12 years old. The mothers were given detailed descriptions to read of boys with ADHD and of boys with both ADHD and ODD. The subjects were then divided into two groups. One group was given descriptions of BPT to read, and the second group was given descriptions of stimulant medication as treatments for the children in the case descriptions (Johnston et al., 2007). Afterward, participants were asked to rate the acceptability and effectiveness of the treatments and to provide information on their experiences with both types of treatment. Mothers rated BPT as more acceptable than medication. No difference was seen in ratings of the effectiveness of both treatments in the study, although mothers rated medication as more effective than behavioral strategies in the case of their own children. This finding supported the premise that belief of parents in any particular treatment protocol is based on their own experience (Johnston et al., 2007).

Kane (2009) described how the combination of behavior therapy and appropriate medicines can be used to treat children effectively. Kane noted findings from several studies that involved the examination of the effects of certain medications on ODD suggested certain treatments. Kane assessed the use of Ritalin to treat children with both ADHD and ODD. Kane found 90% of the children treated with Ritalin no longer had the symptoms of ODD by the end of the study. Kane reported a number of children dropped from the study for failure to comply with the treatment regimen. Even with these children being included as treatment failures, however, the study still showed a 75% success rate.

Assessing Parents' Beliefs and Attitudes That Lead to Their Decision-Making

The majority of studies regarding parents' beliefs and attitudes toward ODD focused on the child-therapist relationship with parents included as part of the treatment for improvement of ODD symptoms. Lavigne et al. (2008) examined the effectiveness of a moderately intensive, 12-session parent training program, the Webster-Stratton Incredible Years program, for 117 parents of children with ODD aged 3–12 years. The program is based on two models for delivering mental health interventions within a primary health care setting: (a) an office staff model in which services were provided by nurses and (b) a mental health intervention model in which treatment was provided by a psychologist. Lavigne et al. compared these models to a third model, a minimal intervention treatment, using bibliotherapy. The final sample consisted of 49 children with ODD and their families in the nurse treatment group, 37 in the psychologist treatment group, and 31 in the minimal intervention treatment. Seven registered nurses provided treatment for the nurse-led group, and five doctoral-level clinical child psychologists provided treatment in the psychologist-led group. Parents in the minimal intervention treatment group participated in the Incredible Years program, but did not participate in any treatment sessions.

Children in Lavigne et al.’s (2008) study were administered the Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999) and the Child Behavior Checklist (Achenbach, 1991) pre and posttreatment. The results of the study showed improvement in children’s behaviors and on parent-reported measures of ODD symptoms across posttreatment and 12-month follow-up for all groups, but no overall treatment group effects were evident. A dose effect (i.e., number of treatments attended) showed a reliable, clinically significant gain after seven sessions on the intensity scale of the Eyberg Child Behavior Inventory and nine sessions on the externalizing scale of the Child Behavior Checklist. Lavigne et al. concluded the Webster-Stratton Incredible Years program can be implemented in primary care using either the nurse-led or psychologist-led models. In addition, the researchers found no real advantage to therapist-led treatment compared to bibliotherapy, unless parents attend a significant number of sessions. Lavigne et al. noted their results differed from previous studies in which therapist-led training was more effective for treating ODD symptoms; however, their study was a more rigorous test than prior studies because they focused only on children who met DSM-IV criteria for ODD and because their study was designed as an effectiveness trial. For the children with confirmed ODD diagnoses who participated in this study, the results showed minimal therapist-led intervention can be more effective than intensive or moderately intensive therapist-led treatment (Lavigne et al., 2008).

Kazdin and Whitley (2006) examined the parent-therapist relationship in parent management training for children diagnosed with ODD because parental involvement in treatment is extensive in parent management training. Parent management training can also decrease negative parental attitudes and beliefs about treatment and improve cooperation, enhancing the possibilities that children will remain in treatment. Participants included 53 girls and 165 boys aged 2–14 years who were referred clinically for oppositional, aggressive, and antisocial behavior. Therapists obtained information pertaining to background, diagnosis, and parental interpersonal relations during a pretreatment interview. Four standardized instruments were also used. Kazdin and Whitley used the Working Alliance Inventory (Horvath & Greenberg, 1989) to measure the parent-therapist alliance in terms of the tasks and their relevance in therapy, mutually decided goals for treatment, and the extent to which the parent-therapist relationship is positive and accepting. Parent pretreatment social relations and social support were assessed pretreatment with the Family Relationships subscale of the Family Environment Scale (Moos & Moos, 1981) and the Sense of Support Scale (Aneshensel & Stone, 1982). Changes in parenting practices were assessed posttreatment with the Treatment Improvement Scale (Kazdin, 2005) to determine the extent to which parents react more positively in relation to problems with their child. The scale items reflect specific parenting skills addressed in parent management training.

The results of the study conducted by Kazdin and Whitley (2006) showed that posttreatment, higher quality parent-therapist alliances were related to better parenting. Further, higher quality parent pretreatment relations and support related to higher quality parent-therapist alliances and more improvements made by parents in social relationships and support. An important conclusion reached by Kazdin and Whitley relevant to the present study is that interpersonal relationships and attitudes toward therapeutic treatment for ODD are critical and that placing the parent-child relationship in the context of the therapeutic relationship may help the child’s therapeutic progress and identify developmental issues about relationships for both parents and children.

Callahan and Eyberg (2010) also studied parenting behaviors and attitudes toward ODD. The researchers examined the relationship of parenting behaviors and socioeconomic status (SES). The sample consisted of 89 mothers of children aged 3 to 6 years who were referred for treatment for ODD. Parent-child interactions were measured using the Dyadic Parent-Child Interaction Coding System (Eyberg, Nelson, Duke, & Boggs, 2004) categories of prosocial talk (PRO) and negative talk (NTA). Graduate students, supervised by licensed clinical psychologists, conducted the assessments. The results of the Dyadic Parent-Child Interaction Coding System were correlated with Hollingshead’s (1975) Four-Factor Index of Social Status (HI), a measure of SES based on the education and occupation of each employed parent living at home.

Callahan and Eyberg (2010) hypothesized that a positive relationship would appear between SES and PRO and a negative relationship between SES and NTA. The results suggested PRO increased for mother-child dyads as HI increased; however, three times more variance than HI appeared in differences in PRO for the three individual indices of SES—income, education, and occupation. Education was especially related to PRO; mothers who held graduate degrees had significantly higher proportions of PRO than mothers whose education level included some college or technical school. The second hypothesis that SES would be negatively correlated with NTA was not supported; no relationship between SES and NTA was evident regardless of SES measurement method (Callahan & Eyberg, 2010).

In Johnston et al.’s (2005) groundbreaking study, the researchers assessed relations between parents’ beliefs and attitudes and their experiences with different treatments for their child’s disorder. Findings indicated parents prefer to use behavior management and stimulant medications in treating ADHD or ODD. Some made use of vitamin therapies. Parents’ beliefs were related to their use of different treatments. Parents who used less empirically-supported treatments were more likely to see ADHD behaviors as internal to the child, enduring, and pervasive. Johnston et al.’s findings showed the importance of assessing parents’ use of alternate treatments and how parents’ beliefs and attributions influence their choice of shaping treatment options. These, in turn, influence the decision-making process and the eventual treatment decision, which was the focus of the present study.

Intervention Principles

Scott (2008) proposed seven intervention principles to determine the best treatment options for children diagnosed with ODD. The first principle is to engage the family. Families seeking mental health services may fear being judged as bad. Further, families with children diagnosed with ODD are more likely to be disadvantaged and disorganized, and may have had unpleasant encounters with agency officials or school and welfare officers. Moreover, treatment dropout rates are high. Offering to help with travel, providing child care, and holding sessions at times more convenient for the family are actions that are likely to build better relationships with the family and facilitate retention (Scott, 2008).

The second principle identified by Scott (2008) is to select the appropriate treatment and the appropriate person to deliver the treatment. Because successful treatment in one area may not always apply to to other areas, interventions should specifically address the family and school context. The third principle is to develop strengths of both the child and the family to promote engagement and enhance more positive treatment outcomes. Emphasizing the child's strengths encourages more constructive rather than destructive behaviors, which, in turn, may lead to increased achievement in school, increased self-esteem, and an overall productive future (Scott, 2008). The fourth principle is to treat comorbid conditions, such as ADHD or posttraumatic stress disorder. The fifth principle is to promote social and scholastic learning. While the aim of interventions and treatments is to reduce antisocial behavior, children must also learn to make friends, to negotiate, and to engage other positive social behaviors. Intellectual disabilities, such as the inability to read, which is common in children diagnosed with ODD, and difficulties with studying or homework need to be addressed as well.

The sixth principle proposed by Scott (2008) is to use guidelines. Steiner (1997) developed practice parameters for the assessment and treatment of CD, such as ODD. The seventh and final principle is to treat children in their natural environments. Many interventions are intended for outpatient or community settings; however, interventions like enhanced BPT that include individual child-focused problem-solving modules (Webster-Stratton & Hammond, 1997) or other programs with problem-solving components, such as Problem Solving Skills Training (Kazdin, Bass, Siegel, & Thomas, 1989) and the Coping Power Program (Lochman & Wells, 2002), have been shown to be more efficacious.

Comparing and Assessing Treatment Options

The review of the literature revealed medication, behavioral therapy, or a combination incorporates the main types of treatment used for children with ODD. Medication includes drugs, such as atomoxetine, risperidone, quetiapine, aripiprazole, Methylphenidate, divalproex, Adderall XR, and Strattera. Behavioral therapy methods include collaborative problem solving, PEP, BPT, parent effectiveness training (PET), and parent management training. In this section, I present studies to compare treatment methods.

Turgay (2009) described the proven efficacy of atomoxetine in the treatment of ODD, which overlaps with ADHD symptoms. Patients with ODD and subsequent CD presenting with symptoms similar to severe aggression also showed improvement and response to treatment regimens using risperidone either combined with or without psychostimulants. Pandina et al.'s (2006) review of previous studies that involved measuring the efficacy and safety of risperidone therapy in the treatment of pediatric patients with DBD, such as ODD and ADHD, demonstrated risperidone is an efficient and well-tolerated treatment therapy available for children and adolescents suffering from DBD. Haas et al. (2008) also found risperidone to be safe and well-tolerated for treating aggressive behavior patients with ODD. A large Canadian study (Kane, 2009) showed that risperidone helped with aggressive behavior in children with below normal intelligence. This results indicated 80% of children with explosive behavior improved when also given divalproex, whether or not ADHD was present (Kane, 2009).

Methylphenidate was shown to be effective for children with ODD who comorbidly experienced chronic multiple tic disorders and ADHD (Gadow et al., 2008).

Hazell et al. (2011) compared responses to atomoxetine and methylphenidate treatment of children and adolescents with core ADHD symptoms during a 6-week time period and found that at the end of the 6 weeks, atomoxetine and methylphenidate were equally effective for reducing core ADHD symptoms in children and adolescents.

Bangs et al. (2008) tested the efficacy of atomoxetine for the treatment of ODD comorbid with ADHD in children between the ages of 6 and 12 and found children with ADHD and comorbid ODD showed marked improvement in ADHD symptoms and functioning. Dunn and Kronenberger (2007) studied the effect of adding quetiapine in methylphenidate treatment based on the efficacy in adolescents with comorbid ADHD, CD, or ODD with aggression. Their results showed adding quetiapine to methylphenidate was efficacious for improving aggression in patients who had not shown a good response to osmotic-controlled release oral delivery system methylphenidate alone at a 54-mg/day dose (Dunn & Kronenberger, 2007). Posey et al. (2007) reported methylphenidate yielded significant improvement when administered at the .25 and .5-mg/kg doses. Symptoms, such as hyperactivity and impulsive actions, improved more than inattention; however, in ODD or stereotyped and repetitive behavior cases, no significant gains appeared. Barzman et al. (2006) found quetiapine and divalproex had similar efficacy when used in the treatment of impulsivity and reactive aggression related to comorbid bipolar and DBD in adolescents.

Spencer et al. (2006) researched the efficacy and safety of Adderall XR in the management of ODD with or without comorbid ADHD in school-aged children and adolescents and found that patients with ODD showed a good tolerance with few occurrences of adverse events. Higher doses were effective and well-tolerated in the management of ODD in these school-aged children and adolescents whether or not they had ADHD (Spencer et al., 2006). Ercan et al. (2005) evaluated the effects of a combined treatment of ongoing methylphenidate management and a parent-training program that continued for 5 months with children diagnosed with ADHD and found this combined treatment form of therapy reduced the ADHD, ODD, and CD symptoms in the patient group. Hautmann et al. (2011) and Kane (2009) researched the effect of Strattera on children with both ADHD and ODD. Kane concluded Strattera helped with ODD; however, Hautmann et al. found Strattera did not help.

The use of behavioral and pharmacological treatments for children with ODD and their acceptance by parents materially affects the lives of such children. Hamilton and Armando (2008) researched the effectiveness of parent training and collaborative problem solving, a psychological intervention for treating ODD that aims to develop a child’s skills in tolerating frustration, demonstrating flexibility, and avoiding emotional overreaction. Hamilton and Armando found a psychological intervention that involves both the parents and child can vastly improve short- and long-term outcomes of drug therapy and also prevent the development of comorbidity.

Hautmann et al. (2008) studied the effectiveness of PEP in children with symptoms of ADHD and ODD. Attention problems, disruptive behavior problems, parenting skills, and parental depression, anxiety, and stress were assessed with four different standardized instruments. Assessments were made 3 months before treatment, immediately before treatment, immediately after treatment, and at a 12-month follow-up. Attention problems yielded two groups: (a) severely impaired and (b) less impaired.

Hautmann et al. found some of the most impaired children exhibited the most effective results

Webster-Stratton and Hammond (1997) focused on the BPT model, a family-based, validated intervention strategy for children aged 3–8 years. Webster-Stratton and Hammond added individual child-focused problem-solving modules to the BPT module for children aged 4–8 with severe conduct problems to enhance treatment outcomes. The researchers found at 6 months, children in the treatment group significantly improved compared to children in the control group; children who participated in the child-focused module showed the most significant improvement.

Parent effectiveness training (PET), an intervention based on T. Gordon’s (1970) theory of healthy relationships, is based on nine principles that include creating a nonthreatening environment, allowing and accepting resistance, coaching specific skills, and role modeling by the facilitators. The chief focus in the PET program is on how the family functions in terms of the parent-child relationship and is not based on external social expectations.

Empirical research has shown that parent management training is more effective in lessening the antisocial behavioral patterns of children suffering from ODD. The purpose of parent management training is to train parents to recognize their child’s positive behaviors and reinforce them and to use brief negative consequences for poor behavior (Lavigne et al., 2012). Parent management training is recommended for parents of children with ODD to change the pattern of negative interactions between parents and child that typically occur in these families.

In Costin and Chambers's (2007) study, the children studied had severe ODD and were referred to a mental health clinic. The study results showed the parent management training intervention reduced the child's antisocial behavior symptoms, and children with one or more comorbid disorders in addition to ODD had an equally positive response (Costin & Chambers, 2007). Dretzke et al. (2005) examined the effectiveness of parent management training programs compared to special education in the alleviation of CD in children and found parent training and special education programs are efficient and cost-effective therapies for children with CD and ODD.

Waxmonsky et al. (2008) studied the efficacy and tolerability of methylphenidate and behavior modification in 33 children aged 5–12 with ADHD and exhibiting symptoms of severe mood dysregulation, which included children who showed symptoms of ODD and CD. The researchers found methylphenidate and behavior modification are tolerable and effective treatments for children with ADHD and severe mood dysregulation, but additional treatments may be needed to optimize their functioning. In Johnston et al.'s (2007) study of mothers of boys aged 5 to 12 years with ADHD, one group received descriptions of BPT to read, and the second group received descriptions of stimulant medication as treatments for the children in the case descriptions. Afterward, participants were asked to rate the acceptability and effectiveness of the treatments and to provide information regarding their experiences with both types of treatment. Mothers rated BPT as more acceptable than medication (Johnston et al., 2007).

Kane (2009) noted several studies that involved examination of the effects of certain medications on ODD-suggested treatments, such as Ritalin. Kane's report assessed the use of Ritalin to treat children with both ADHD and ODD. The researcher found 90% of the children treated with Ritalin no longer showed symptoms of ODD by the end of the study.

Summary

In this literature review, I discussed the relationship between ODD and CD and the various treatment options available to parents of children diagnosed with ODD. These options included drug therapies, behavioral therapy, special education, parent management training, and various combinations of these therapies. This review was the foundation of the research on parents' decision-making process regarding the selection of available treatment options for their child with ODD. In terms of parent beliefs and attitudes, parents appear to prefer behavior management and stimulant medication in treating ODD (Johnston et al., 2005; Kazdin & Whitley, 2006; Lavigne et al., 2008).

Much research exists pertaining to the efficacy of different treatments for ODD, with a few studies focusing on the comparisons of the various treatment forms. Turgay (2009) advocated drug therapy, and previous researchers (Dretzke et al., 2005; Waxmonsky et al., 2008) advocated behavioral therapy. Children with ODD can also be treated with a combination of behavioral therapy and drug therapy (Johnston et al., 2005; Waxmonsky et al., 2008) and alternative therapies, such as BPT, psychopharmacological treatment, PET, and individual and group therapy (Costin & Chambers, 2007; Lavigne et al., 2012; Verduin et al., 2008).

The results of the current study fill the research gap regarding how parents make treatment choices and whom they trust to provide information regarding ODD treatment.

In Chapter 3, I describe the methodology of the study, including an explanation of the settings and participants, instrumentation, method of data collection, and data analysis.

Chapter 3: Research Method

The purpose of this qualitative study was to explore how parents of a child newly diagnosed with ODD decided the treatment for their child. In addition, I investigated barriers to obtaining information and sources of information to determine what might impede parents from gathering necessary knowledge as well as to identify who parents are most likely to trust in the decision-making process. In this chapter, I present the research design, procedures, data collection, and data analysis methodology. I also describe the two research tools and their relationship to the research questions, and summarize measures taken for the protection of participants.

I conducted a phenomenological study, which was appropriate for learning about the lived experiences of a group of people. Data were collected with a demographic questionnaire and interviews with parents of a child newly diagnosed with ODD. The purpose was to investigate parents' decision-making process regarding treatment selection for their child, the barriers related to their acquisition of information or their coming to a decision, and the individuals they felt were most helpful in their decision-making. I discuss the research design, setting and sample, data collection and analysis, and protection of participants' rights .

Research Design

Research design is determined by the problem under investigation, the purpose of the study, and the research questions to be answered (Anderson, in press). I am employed in the special education division of a large school district and find that parents are often overwhelmed with the behaviors of their children with ODD and are also overwhelmed by the unusual ODD diagnosis. Many teachers, physicians, psychologists, and other medical and educational clinicians were at a loss when parents asked for advice about how to treat their child with ODD. In spite of an apparent lack of information, parents were making decisions about treating their child with ODD. I realized parents sought information and a decision-making process occurred; however, I wanted to know how parents made their decisions. A thorough review of the existing literature indicated a lack of knowledge regarding how parents make decisions about treatment for their children. This realization led to the problem, the purpose, and the research questions for the study.

I considered several research designs before selecting a qualitative phenomenological design to explore parental decision-making regarding treatment options for children newly diagnosed with ODD. I initially considered using the ODDRS so that parents could rate their child's behavior; however, the ODDRS is most commonly employed for diagnostic purposes either with or without structured interviews (O'Laughlin et al., 2010). Teachers also completed the ODDRS for diagnostic purposes. For the present study, the problem was treatment selection, not diagnosis or behavior analysis of the child because both diagnosis and behavior analysis had already been accomplished.

Decision-making by parents for treatment of ODD had not been studied. Janicke and Finney (2003) used social cognitive theory to examine parents' decisions to take their child with an illness for primary care services. Forry, Tout, Rothenberg, Sandstrom, and Vesely (2013) conducted a literature review and found the decision-making process parents used to select child care comprised several aspects: (a) parents considered a number of options, (b) parents relied primarily on informal sources for information, and (c) parents noted the duration of the search for child care. The literature reviewed by

Forry et al. included both quantitative and qualitative studies that contained closed and open-ended questions. Forry et al. did not offer a value judgment or a preference regarding research design.

In the family guide of the National Alliance on Mental Illness, Gruttadaro, Burns, Duckworth, and Crudo (2007) did not offer advice on how parents should select a treatment for their child with a mental illness. Instead, Gruttadaro et al. discussed a range of evidence-based practices in the belief that an informed parent is the best source of an appropriate treatment decision. Gruttadaro et al. provided information pertaining to understanding evidence-based practices, discussing evidence-based practices with providers, knowing what practices are available, and becoming actively involved in disseminating evidence-based practices. Gruttadaro et al. did not provide any findings regarding how parents make treatment decisions.

Given the lack of research on parental decision-making for children with ODD, variables could not be identified for investigation, and generalizability to a larger population was not feasible based on the problem under investigation. Consequently, a quantitative study would not have been useful. I considered providing a checklist of reasons for making a decision, but I decided that surveys did not offer the parents the opportunity to talk in depth about their decision-making process. As a result of the literature review and consideration of research designs, I determined a qualitative approach was the best choice to address the problem, purpose, and research questions for the present study.

Kuna (2006) proposed asking a series of questions to determine whether a qualitative research design is the best choice for a study:

1. Is the study exploratory?
2. Is the study descriptive?
3. Is the study looking for new perspectives on old problems or in-depth information?

I considered several qualitative designs for this study, including case study, narrative inquiry, and ethnography. Researchers who use case study designs typically seek answers to how and why questions (Yin, 2014). The hallmarks of a case study are the use of a bounded sample, little researcher control of behaviors, use of multiple sources of data, and use of theory to guide data collection and analysis (Yin, 2014). Because the aim of this study was to understand the experiences and perceptions of parents through the use of a single semistructured interview, this method was unsuitable.

Narrative inquiry addresses participants' stories about their lives (Clandinin & Connelly, 2000). Because the goal of this study was to understand how parents decided treatment for their child, rather than a history of how the child was diagnosed and treated, this design was inappropriate for this study. Ethnographers focus on studying groups and the culture associated with those groups (Tracy, 2013). Ethnographers often embed themselves in the researched groups for extensive periods of time (Tracy, 2013). Because the focus of this study was not the culture of parents of children with ODD, I did not select this design.

In the present study, I explored and described a phenomenon—the decision-making process of parents of a child with ODD as they considered the treatments available for their child. Because I investigated a phenomenon, the research design was classified as phenomenological and was chosen as the best design for this study.

Researchers who employ a phenomenological design are interested in understanding the experiences and perceptions of the participants though their worldview. Because the focus of this study was understanding the participants' decision-making process and experiences and perceptions associated with this process, I chose a phenomenological design.

The overarching research question for this phenomenological study was, What factors explain how parents of a child newly diagnosed with ODD decide the treatment for the child? The subquestions were as follows:

1. What type(s) of information would be useful for parents of a child newly diagnosed with ODD to have to determine the most appropriate treatment for their child?
2. Whom do parents trust to provide information about treatment for their child?
3. What are the barriers parents perceive to acquiring information about treatment options?
4. Based on their knowledge of treatment options, which treatment(s) did parents choose and why?

This study of parental choice of treatment options for ODD was qualitative, enabling the discovery of patterns and themes based on the central phenomenon of the decision-making process of parents of children newly diagnosed with ODD (see Creswell, 2012a). The problem addressed in the present study was that parents of a child newly diagnosed with ODD often become overwhelmed in understanding the condition, may not know what treatments are available, may not know whom to trust for information, and may have difficulty coming to a decision. In this study, the aim was to understand how parents decided the most appropriate treatment for their child with ODD, the barriers to obtaining information about treatments for ODD, and who parents are most likely to trust to provide information.

Because ODD has a relatively low incidence and the research problem would be best addressed by speaking directly with the parents, a qualitative approach was appropriate for this study. A qualitative methodology is appropriate when the researcher's objective is to probe more deeply and more fully to understand the multiple views of study participants (Kuna, 2006). The qualitative method allows researchers to obtain a more realistic sense of the problem under study than numerical data and statistical analysis associated with the quantitative method could provide (Merriam, 2016). In this study, the treatment selected by the parents was not important; their method of decision-making was.

Role of the Researcher

Qualitative research is interpretive in nature, and the researcher is intensely involved throughout the study (Kuna, 2006). Therefore, a researcher must develop a relationship of trust with interviewees (Marshall & Rossman, 2010). Researchers cannot allow personal biases to influence the research process (Creswell, 2012b; Kuna, 2006). I held no previous notions about the research topic or study participants and approached the study from the perspective of critical subjectivity.

The principle of not forming judgments ahead of time in qualitative research is known as *epoché,* a Greek word for perceiving the world in new ways without judgment (Patton, 2002), even if a researcher has experience with the phenomenon under investigation. *Epoché* occurs typically during the process of interviews. In contrast, bracketing involves the recognition by a researcher of important words or ideas that may or may not emerge from the interview data; a researcher literally brackets the ideas that are written on the transcribed page (Bednall, 2006). In the present study, I collected data with no preconceived notions pertaining to potential findings.

According to Bednall (2006), critical subjectivity means that researchers have heightened self-awareness while conducting their research and understand their psychological and emotional states before, during, and after the study. To enhance privacy and minimize disruptions, I conducted interviews at private locations where interviewees would feel comfortable and which facilitated candid responses. This approach helped ensure confidentiality, an ethical concern.

Sample Size, Sampling Procedure, and Participants

In qualitative research, determining sample size is challenging and is most often based on the concept of saturation (Creswell, 2012a; Mason, 2010). According to Creswell (2012a), “saturation in [qualitative] research is a state in which the researcher makes the subjective determination that new data will not provide any new information or insights for the developing categories” (p. 433). To identify a starting point for the number of participants to be interviewed, I considered the findings of Mason (2010), who explored sample size in 560 qualitative studies conducted for doctoral dissertations. From these studies, Mason found the mean number of interviewees to be 31, with a standard deviation of 18.7, suggesting a starting point of about 12–13 participants. Similarly, Baker and Edwards (2012) gathered written responses regarding the appropriate number of interviews for qualitative studies from 14 experts and early career researchers. The overall response was “it depends” (Baker & Edwards, 2012, p. 42). Creswell (2012a) suggested 20–30 participants for dissertation research.

Based on the findings of Mason (2010) and Baker and Edwards (2012), the correct sample size for this study began with the number of parents available to be interviewed. I added interviews until saturation was reached. Because of the low incidence of ODD and the qualitative research design, the initial sample size could have been as few as five parents or as many as 16, a compromise of the sample sizes noted by Creswell (2012a) and Mason (2010). I employed a purposeful sampling procedure (see Creswell, 2012a) using information and personnel available to me through my employment with a large school district in the southwestern United States. Through that source, I learned which psychological and medical professionals were most likely to diagnose children with ODD, and I contacted them and asked them to distribute my recruitment flyer (see Appendix A). Educational, medical, and psychological professionals were asked to refer parents of children diagnosed with ODD to me for participation, thereby protecting their confidentiality. I made no initial contacts to protect the confidentiality of potential participants.

The participants in this study were the parent or parents of a child newly diagnosed with ODD. According to Creswell (2012a), snowball sampling may be used during qualitative research to engage additional participants, if needed. Snowball sampling involves one participant referring another, who refers another, and so on. To protect confidentiality, parents could ask other parents to contact me; I did not make initial contact.

When I saw that more data gathering and analysis through additional interviews did not yield new information, I considered the point of saturation for this study reached, and I did not conduct additional interviews, as suggested by Creswell (2012a) and Moustakas (1994). In the present study, the initial sample was six parents, and saturation was reached.

Recruitment of Participants

Of the various sources of information, including clinical providers, schools, and other counselors, parents are often the best informed regarding the behavior of, and to some extent efficacy of, treatment for their children with ODD. Consequently, data for this study were best collected from the parents. The names of prospective participants were obtained from a population in a large geographical area (see Johnston et al., 2005). To find them, it was necessary to cooperate with clinicians who could identify prospective participants.

Research began by identifying clinicians or a diagnostic center that served clients with ODD. Clinicians were asked to provide a flyer (see Appendix A) about the study to parents who met the criteria for participation. The flyer directed interested parents to contact me to learn more about the study in detail. If a suitable population of willing respondents could not be found through this method, then I would have contacted other clinical practitioners contacted about distributing flyers pertaining to the study, or I could have electronically distributed flyers to listservs or social media groups likely to be frequented by parents of children with ODD.

The participation of the patients’ parents depended on willingness and consent, and on the child’s diagnosis of ODD. To be included in the study, the parents must have had a child diagnosed with ODD within a 1-year time frame; parents of children diagnosed with conditions other than ODD were excluded. Gender and age of the child were irrelevant, although as Lavigne et al. (2012) noted, rates of prevalence of ODD in children under 18 are higher in boys than in girls. In Kazdin and Whitley's (2006) study, the ratio of boys to girls was nearly 3:1; thus, it was probably that in this study, parents were more likely to have a boy than a girl with ODD. The preference was for parents of a child who was newly diagnosed with ODD. The length of time since diagnosis was less than 1 year so that the memory of the decision-making process for appropriate treatment for the child was fresh in the minds of the participants.

Data Collection Methods

Because of confidentiality requirements, clinicians or other practitioners who worked with the target population for the study could only inform them that a study was taking place and how to contact me. Interested parents contacted me by telephone, and I explained the study in detail, answered any questions they had, and requested their participation. For those who agreed to participate, an interview meeting was scheduled at an agreed upon time and place. I conducted interviews in a private place where conversations could not be overheard, such as in a borrowed office. My address and telephone number were provided to the parents in case the parents decided not to participate or needed to reschedule.

At the meeting, I provided the informed consent form (Appendix B) and began the interview by asking questions using a Demographic Questionnaire (see Appendix C) to gain descriptive information regarding the characteristics of the sample (i.e., child's age, gender, ethnicity, when child was diagnosed with ODD; parents' level of education, occupation). To ensure fidelity of the interviews, I followed a prescribed interview protocol (see Appendix D). To ensure that useful and accurate data were obtained, I audiotaped interviews. Participants were informed through the consent form and reminded at our meeting that the interviews were audiotaped and that they had to be willing to be audiotaped to participate. I transcribed the interviews, and checked the written transcriptions against the original recordings for accuracy to ensure that I did not miss or alter anything during transcription.

Appendix C includes an annotated protocol of the interview to explain the reason for asking each question, and noted the research question(s) addressed through each interview question. Each question in the interview protocol related to one or more of the research questions that guided this research. I obtained demographic information through a questionnaire. The first interview question served to establish rapport with the participants.

Following the interview, I immediately debriefed participants. According to Sieber (2004), “debriefing refers to a conversation between investigator and subject that occurs after the research session” (para. 1). Viewed as “the post-session counterpart of informed consent” (Sieber, 2004, para. 1), debriefing served several purposes. First, it provided both the participant and myself the opportunity to ask and answer any questions that may have arisen as a result of the interview questions. Second, debriefing has some therapeutic or educational value because the interviewer can offer information to the participant that may compromised the research if given during the interview. Finally, through debriefing, I thanked the participant for participating in the research process and learned how the interview affected him or her (Sieber, 2004).

Data Analysis Plan

I analyzed data from the interview transcripts following the 7-step procedures outlined by Moustakas (1994). The first step, listing and preliminary grouping, required the listing of every expression relevant to the experience, a process called *horizonalization.* In this process, the researcher approximates the farthest horizon, or distance, of the research. In the second step, the researcher determines the invariant constituents, those that reflect the fundamental meaning of the information. According to Moustakas, determining the presence of the invariant constituents requires understanding if the words or phrases are necessary and enough to understand the experience and decide if it is possible to label and abstract the words. The process of identifying invariant constituents is called *reduction and elimination*: The words are reduced to their essential meanings, and unnecessary ones are eliminated.

The third step proposed by Moustakas (1994) was clustering the invariant constituents and identifying the core themes that emerged. The fourth step required me to make a final identification of invariant constituents and themes by checking them against what the participants said. If inaccurate, they were dropped from the analysis. In the fifth step, I started to describe the experience under study, using words from the transcripts, based on the invariant constituents and themes that emerged from the data. This process produced a textural description. In the sixth step, I wrote a structural description of the experience under investigation, describing the structure of the experience—in this case, the process of decision-making undertaken by parents of a child with ODD regarding deciding treatment options. Finally, I wrote the description of the phenomenon under study, attempting to combine the individual experiences into one overall experience of all participants (Moustakas, 1994, pp. 120-121).

Discrepant Cases

According to Creswell (2012b), discrepant cases involve data that provide a variant perspective from themes that emerge. The credibility of a study can be increased by reporting discrepant cases. Such cases, if they are present, lead to modifying or expanding the emerging theme or themes (Creswell, 2012b). In this study, I presented discrepant cases as they occurred. I looked for cases in which the emerging theme did not fit and developed explanations of any discrepancies.

Issues of Trustworthiness

In qualitative research, the term *trustworthiness* is applied to determine the validity and reliability of a study (Babbie, 2012; Marshall & Rossman, 2010; Maxwell, 2012). Trustworthiness is the extent to which confidence or trust exists in a study and its findings (Robson, 2011). I used the methods of peer debriefing and member checking to address trustworthiness in this study.

Peer debriefing involved enlisting the help of colleagues to review and ask questions about the study to “test out insights, ideas, and analysis with colleagues outside the context [of the study]” (Petty, Thomson, & Stew, 2012, p. 382). I reviewed the purpose and objectives of this study with a select group of knowledgeable colleagues with whom I have worked and obtained feedback regarding the suitability, credibility, and potential contributions of the study. Specifically, because I work in special education in a large public school district, I had special education teachers—specialists who work with children with CD and ODD—and administrators who specialized in special education issues, including diagnosis and placement, review the study. Because of the size of the district, individuals assigned to work closely with parents as a part of their job description were also available. After IRB approval of the proposal, I invited a minimum of five colleagues to collaborate with me by providing feedback about the study.

Another way of ensuring trustworthiness was through checking the audiotapes against the transcripts. Additionally, member checking allowed participants to review the transcripts or the final description of the phenomenon. “Member checking is primarily used in qualitative inquiry methodology and is defined as a quality control process by which a researcher seeks to improve the accuracy, credibility and validity of what has been recorded during a research interview” (Harper & Cole, 2012, p. 510). In member checking, a researcher systematically seeks feedback pertaining to data from the participants (Creswell, 2012b). Participants were allowed to review their interview transcripts for accuracy if they wished, and opportunities for member checking also arose during the course of normal conversation with the participants (Creswell, 2012b). Member checking, whether done formally or informally, establishes credibility of the data (Maxwell, 2012). Based on feedback from the participants, I edited the transcripts or the final description of the decision-making process as necessary to be sure the information provided by the participants was accurately reported.

Transferability

Although qualitative studies are not generally considered generalizable, the concept of transferability suggests that the results of qualitative research can be applied—transferred—to other contexts and settings (Trochim, 2006). I was responsible for providing the reader with a thorough, thick description of the phenomenon under investigation; the reader decides if the researcher provided enough information or context to transfer the findings or method to another setting or context (Trochim, 2006).

Dependability

In quantitative research, dependability is called *reliability* and concerns the ability of another researcher to repeat or replicate a study (Trochim, 2006). To check for dependability in a qualitative study, Lincoln and Guba (1985) suggested an external audit, having another researcher review the results, interpretation, and conclusion. The audit process improves accuracy in the research process and outcome and serves as a means of validating the research. According to Lincoln and Guba (1985), some problems are evident in an audit of this nature; in particular, if an auditor disagrees with my interpretation of the findings, then the question of whose interpretation is valid becomes important. My Dissertation Committee acted in this role.

Confirmability

Qualitative research, according to Trochim (2006), entails that a researcher will conduct the study from his or her own perspective. Lincoln and Guba (1985) suggested four ways of confirming qualitative research: (a) external audit, (b) audit trail, (c) triangulation, and (d) reflexivity. The external audit process was discussed in the previous section on dependability. An audit trail is a careful record of the processes and data elements used in the qualitative study, including raw data and any notes. I maintained all records of processes and data elements as the study progressed so that an audit trail was established.

Triangulation is the use of multiple data sources to verify the patterns and themes that emerge from the primary data collection. Lincoln and Guba (1985) argued triangulation is of dubious necessity; however, Patton (2002) identified four types of triangulation that could be used for confirmability of findings: (a) methods, using alternate methods to arrive at the same conclusion; (b) sources, gathering data from different sources or in different settings; (c) analyst, getting at least one additional researcher to review the data and the findings; and (d) theory, analyzing the data through another theoretical lens. In the present study, I used analyst triangulation as a means of confirming the findings and interpretation of the results. My Dissertation Committee acted in this role.

Protection of Participants' Rights

Consideration of the rights, interests, and safety of participants is fundamental to research studies. I followed all Walden University IRB guidelines for informed consent and confidentiality. Potential participants received an explanation of the purpose of the research, procedures, and outcomes of the study. I emphasized that their participation was voluntary and that they will not be forced to participate. I performed consent and safety monitoring to safeguard volunteer participants and facilitate responsible research. Parent participants signed a consent form regarding their participation (see Appendix A).

I made every effort to ensure the confidentiality of the participants. Each form containing personally identifiable information regarding a participant was serialized, and the sheet connecting the individual's form serial number to his or her name remained with the clinical practitioner who referred the participant to me. Records that link the participants' codes to personal identifiers were maintained in a secure file that was locked and available only to me. This information will be destroyed after it is no longer needed, and the study is concluded. I will keep audiotapes and transcripts in a locked cabinet for at least 5 years and then destroyed this data in a shredder at the end of the 5 years. Audiotapes will be destroyed in an environmentally appropriate manner so that no trace is evident. No monetary payment was offered to persons for their participation. I shared the results of the research with participants upon completion of the study.

Summary

The purpose of the study was to explore how parents of a child newly diagnosed with ODD decide the treatment for their child. I explored barriers to obtaining information and sources of information to determine what factors may impede parents from gathering necessary knowledge regarding treatment options. I also sought to determine who parents are most likely to trust in the decision-making process. This chapter includes the research design, rationale, role of the researcher, methodology, issues of trustworthiness, and protection of participants’ rights. A qualitative approach was identified as the best option to fulfill the purpose of the study and answer the study research questions. I used a demographic questionnaire and interview protocol to gather information about the parents and their decision-making process. Data were sorted into categories that emerged naturally from the interview transcripts. I sorted and analyzed data until I reached saturation. Chapter 4 presents the results of the data analysis.

Chapter 4: Results

The purpose of this qualitative study was to explore how parents of a child newly diagnosed with ODD decided the treatment for their child. In addition, I investigated barriers to obtaining information and sources of information to determine what factors may impede parents from gathering knowledge needed to make decisions. Parents also discussed whom they were most likely to trust during the decision-making process. The overarching research question for this phenomenological study was, What factors explain how parents of a child newly diagnosed with ODD decide the treatment for the child based on their lived experience? The following list presents the subquestions.

1. What type(s) of information would be useful for parents of a child newly diagnosed with ODD to have to determine the most appropriate treatment for their child?
2. Whom do parents trust to provide information about treatment for their child?
3. What are the barriers parents perceive to acquiring information about treatment options?
4. Based on their knowledge of treatment options, which treatment(s) did parents choose and why?

I employed these questions to guide the research study and to shape the interview questions.

Setting

This study took place at a therapy center in Las Vegas, Nevada. The center serves clients with ODD. Clinicians who worked at the center handed out flyers regarding the study to parents who met the criteria for participation. Clinicians did not answer questions about the study; they simply handed out the flyer and directed parents who were interested in participation to contact me for more details. After parents made contact with me, I conducted an initial screening to ensure they met selection criteria. After this was confirmed, parents had an opportunity to ask questions about the study. At the end of the initial contact, a meeting to conduct the interview was set and consent forms were signed. Interviews took place either in a room at the center or at the local library.

Demographics

The participants in this study were six parents, five mothers, and one father, of a child diagnosed with ODD. The participants were recruited from a therapy center that diagnosed and offered treatment for children with ODD. To be included in the study, the parents must have had a child diagnosed with ODD within a 1-year time frame. The parents' children were between the ages of 5 and 7 years. The length of time since the child received the ODD diagnosis was less than 1 year to ensure that the memory of the decision-making process for appropriate treatment for the child was fresh in the participants' minds.

I collected demographic data with the use of a demographic questionnaire at the beginning of the interview. I read the questionnaire to participants and recorded their answers. Table 1 presents the results of an analysis of the demographic information.

The participants were primarily the mother of the child (n = 5, 83%), though the children these participants discussed consisted of equal numbers of male (n = 3, 50%) and female (n = 3, 50%) children. All six children discussed were citizens of the United States, and no demographic information about participants' race was collected. Participants reported the children were diagnosed predominantly by clinic psychologists (*n* = 5, 83%) between June and December of 2015. Three of the participating mothers had a high school education. One father had a high school education; the remaining participants had at least some college education.

Table 1

Demographic Features of the Participants

Demographic	*n*	%
Parent responding		
Mother	5	83
Father	1	17
Child's grade level		
Kindergarten	1	17
First grade	2	33
Second grade	2	33
No response	1	17
Child's gender		
Male	3	50
Female	3	50
Child's age		
5	1	17
6	3	50
7	2	33
Child's nationality		
American	6	100
Parent's ethnicity		
White	4	67
Black	1	17
Hispanic	1	17
Area family lives		
Urban	6	100
Parent's education		
High school	4	33
College	1	50
Graduate school	1	
Other	0	
Parent's occupation		
Administrative assistant	1	17
Airline representative	1	17
Elementary teacher	1	17
Homemaker	1	17
Post office worker	1	17
Retail sales	1	17
When child diagnosed		
June 2015	1	17
September 2015	1	17
October 2015	1	17
November 2015	2	33
December 2015	1	17
Who diagnosed child		
Clinic psychologist	5	83
School psychologist	1	17

Note. Due to rounding error, not all percentages may sum to 100.

Data Collection

I selected six participants for the study. To ensure fidelity of the interviews, I followed a prescribed interview protocol (see Appendix D). The interview protocol is annotated to explain the reason for asking each question, and the research question(s) addressed through each interview question are noted. Each question in the interview protocol related to one or more of the research questions that guided this study. The first interview question was used to establish rapport with the participants.

To ensure that I obtained useful and accurate data, I audiotaped interviews with the permission of the participants. Participants were informed through the consent form and reminded at the meeting that the interviews were audiotaped. Demographic information was obtained through the demographic questionnaire. Interviews lasted approximately 30 minutes, and I immediately debriefed participants. During this time, participants had an opportunity to ask any questions. They were again given information about the purpose of the study and were told that they would receive information pertaining to the results after dissertation approval.

Data Analysis

I analyzed the data through exploration of the participants’ interview responses. Data analysis involved coding, thematization, and clear presentation of the data (see Creswell, 1998). I also examined any discrepancies in the participants’ responses.

Data analysis involved examining the interview transcripts following the 7-step procedure outlined by Moustakas (1994). To begin the analysis, the transcripts were read and reread so a clear understanding of each interview was developed. After reading the interviews, I began the coding process. The coding process entailed analyzing each transcript separately.

Data Management

I transcribed the interviews and checked the written transcriptions against the original recordings for accuracy to ensure that nothing was missed or altered during transcription. The interviews were transcribed by playing back the interview and typing the text into a Word document. After interview transcription, I uploaded the data into NVivo 11 to aid with the organization and analysis of the data. Demographic information was collected and organized in an Excel spreadsheet to aid in analysis.

Descriptive Process

After uploading the transcribed interviews into NVivo 11, I reexamined the data for themes. During this process, I noted the emergence of patterns, frequently used words, and common ideas. Next, the coding process began. The first step, listing and preliminary grouping, required the listing of every expression relevant to the experience, a process called *horizonalization*. In the second step, the invariant constituents, I determined those data that reflect the fundamental meaning of the information. According to Moustakas (1994), determining the presence of the invariant constituents required understanding whether the words or phrases were necessary and sufficient to understand the experience and deciding whether it was possible to label and extract the words (creating units of meaning). As recommended by Moustakas, the transcripts were broken down into individual units of meaning. A unit of meaning could be a word, phrase, or paragraph. These units of meaning were highlighted in NVivo 11 and assigned a code. Each unit of meaning was assigned a code that described the contents. Codes were assigned based on the meaning of the selected excerpt. A code could describe an action, emotion, or thought. At the end of the process, the words were reduced to their essential meanings, and unnecessary ones were eliminated. I discarded codes that did not relate directly to the research questions. The code *background information* was discarded because it did not apply to the research questions.

During this process, I created a total of 37 codes. Following Moustakas's (1994) recommendations, the codes were created by exploring the data and finding a description that expressed the meaning of the code. The codes were based on the experiences of the participants and the literature used to form a basis for this study. The codes were created in such a way that they expressed the essence of the data and could express the meaning of the data in a manner that precluded the need to view the raw information. I sorted 109 units of meaning into the 37 codes. Table 2 presents all 37 codes.

Table 2

List of Codes

Codes	Codes
Barrier – lack of information	Quick diagnosis
Barrier – language	School psychologist
Barrier – attitudes	Sought support from friends
Child always angry	Special education teacher
Consult doctor	Support group
Clinic	Teacher
Other health care practitioner	School nurse
Don't trust schools	Getting education
Financial barrier	Does it work for Hispanic families
No barriers	Research evidence
Trust is an issue	Length of time to see improvement
Knew something was wrong	Ease of implementation
Asked the school	Thought things would change in a year
Other parent support important	Treatment progression has been good
Other school professional	Denial
Others who speak Spanish	Consult medical friends
Looked for experienced provider	Quick referral
	Consulted school for information

After this stage, I gathered the codes into themes. The third step proposed by Moustakas (1994) is clustering the invariant constituents and identifying the core themes that emerged. The fourth step requires making a final identification of invariant constituents and themes by checking them against what the participants said. If themes were inaccurate, I dropped them from the analysis. I examined the codes for commonalities and grouped those together. These commonalities were then compared to the research questions. Codes that provided an answer to a research question were organized according to the applicable question. These codes were then grouped into similar categories. Once further reduction was not possible, I examined the groups and determined a theme name that described the group codes.

After analyzing the data, four themes emerged. The themes were compared to the transcripts to ensure they reflected the essence of the experience of the participants with the phenomenon under study. I used the themes to answer the research questions for this study. I wrote a structural description of the experience under investigation—in this case, the process of decision-making undertaken by parents of a child with ODD in deciding treatment options. This description combined the individual experiences of the participants into one overarching experience of all participants (see Moustakas, 1994).

Data Representation

I gathered and reported the data in tables and figures. Demographics and the codes and discarded data were reported in tabular format. I reported the themes identified during data analysis using figures and narrative text.

Discrepant Cases

I found one discrepant case when analyzing the data. Participant 2 was the only participant who did not indicate that the issue began when becoming aware of his child's behavior. Participant 2 stated he did not notice, or was not aware of, the behavior in the home. For Participant 2, the process of diagnosis and treatment began when the school contacted him with concerns about his child. After being contacted, he began to receive information, diagnosis, and support.

Issues of Trustworthiness

In qualitative research, the term *trustworthiness* is applied to determine the validity and reliability of a study (Babbie, 2012; Marshall & Rossman, 2010; Maxwell, 2012). Trustworthiness is the extent to which confidence or trust exists in a study and its findings (Robson, 2011).

Credibility and Confirmability

I used the methods of peer debriefing and member checking to address credibility and confirmability in this study. Peer debriefing involves enlisting the help of colleagues to review and ask questions about the study to "test out insights, ideas, and analysis with colleagues outside the context [of the study]" (Petty et al., 2012, p. 382). I reviewed the purpose and objectives of this study with a select group of knowledgeable colleagues who I have worked with and obtained feedback from regarding the suitability, credibility, and potential contributions of the study. To protect the confidentiality of the participants, I did not share any identifying information about the participants with these colleagues Specifically, because I work in special education in a large public school district, I had access to special education teachers, specialists who work with children with CD and

ODD, and administrators who specialize in special education issues, including diagnosis and placement. Because of the size of the district, individuals assigned to work closely with parents as a part of their job description were also available. I invited five colleagues to collaborate with me and provide feedback about the study. I asked the peer reviewers to read the results of the data analysis and asked them to provide any feedback they thought relevant.

I compared all audio recordings and transcripts to ensure accuracy of the transcription. Participants were emailed copies of their transcripts and asked to review for accuracy after I completed transcription. Based on feedback from the participants, no transcripts required editing.

Transferability

In qualitative research transferability is determined by the reader. To enhance transferability, I gathered demographic information, ensured that the responses were thick and rich in retail and content, and listed my processes during data analysis. This information could help future researchers to have a clear picture of this study and enhance their ability to determine if these results are applicable to their situation.

Dependability and Confirmability

To check for confirmability and dependability in this qualitative study, I conducted an external audit. The audit process improves accuracy in the research process and outcome and serves as a means of validating the research. For this study, the committee members served as auditors to ensure the dependability of results.

Results

The results are organized by research question. I identified four themes during the data analysis process. Figure 1 presents the themes. The themes were (a) *getting educated*, (b) *barriers to treatment*, (c) *consulting with others*, and (d) *treatment options and reasons for selecting treatment. Making the decision*, found at the center of the figure, is a representation of the research question.

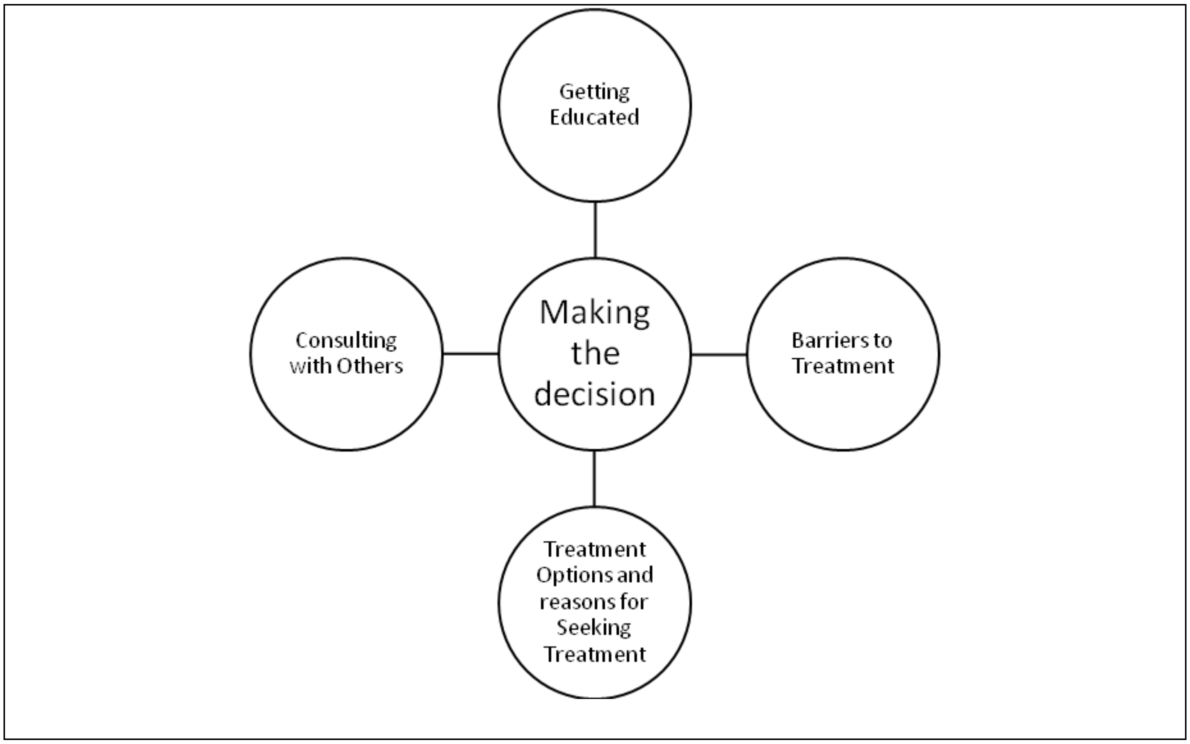

Figure 1. Uncovered themes.

Theme 1: Getting Educated

The first subresearch question asked, What type(s) of information would be useful for parents of a child newly diagnosed with ODD to have to determine the most appropriate treatment for their child? The theme that emerged from participants' responses was *getting educated.*

All parents spoke about the importance of getting education about ODD. They all felt it was highly important to gather as much knowledge as possible. The participants indicated they needed to understand the disorder and the treatment options. Participant 2 said after receiving the diagnosis, “I begin reading about the disorder.” Participant 1 believed that having information was important to make an educated decision. Participant 3 also did research and said, “I read that the treatment plans varied for different ages and how long the disorder has been progressing.” Participant 3 indicated he had never heard of ODD before the diagnosis and felt the need to learn as much as possible. He indicated, “We used our computer to gather any information on ODD.” Other participants used similar words. Participant 6 stated, “We read about the disorder.” The parents in the study had the need to find information on their own in addition to anything they learned from professionals. They took advantage of resources available to learn everything they could about the disorder and possible treatment options. One of their overriding concerns was to ensure that they had the most recent and up-to-date information possible.

Five of the parents indicated they turned to the Internet to locate current information. They used search engines, such as Google, and social media sites, such as Facebook. Participant 5 spoke about using the Internet: “I feel that educational reading materials, such as social media and Facebook helped a lot.” Participant 6 also used the Internet and said, “We went on the website (Google). We read about the disorder from various websites.” In addition, Participant 6 was interested in locating specific information regarding the efficacy of different treatment options. She said she wished to learn if, “the recommended treatment works for families like ours? Especially, Hispanics families.” Participant 4 stated she wished to find updated information but had difficulty because of the available reading materials. She spoke about the materials she located and reported, “I couldn’t find much reading materials that was easy reading.”

Theme 2: Consulting With Others

The second subresearch question asked, Whom do parents trust to provide information about treatment for their child? The theme that emerged from participants’ responses was *consulting with others*.

All of the parents in the study relied on others to gather information. The individuals accessed included medical professionals, educational professionals, and parents of children with ODD.

All six of the parents spoke about the different educational professionals they consulted. Half of the participants spoke about working with a school psychologist. Participant 5 stated, “The school psychologist was most helpful on this disorder.” Two of the parents indicated the person who provided the diagnosis for their child was a school psychologist. Participant 4 spoke about the school psychologist she worked with and indicated, “The school psychologist gave him various assessments. My child does have a high IQ.” The results of the assessment conducted by the school psychologist partially supported her beliefs about her child. Participant 4 said, “I thought my child was just plain bored! That was the reasons, I felt, why he is always angry.” Thus, the finding that her child was intelligent confirmed her belief about his abilities; however, the school psychologist was able to separate the child’s level of intelligence from his behavior and provide the diagnosis in a manner that the parent could understand and accept. All of the parents who interacted with school psychologists seemed to have positive interactions and found these professionals to be helpful throughout the process.

Five of the parents identified other school professionals as being helpful, but most did not indicate what function these professionals served. Specifically, educational professional included general education teachers, special education teachers, principals, and other educational professionals. Participant 5 identified the educational specialists who provided support and information and stated, “I talked to the school’s nurse and primary teacher.” Participant 3 spoke about working with the special education teacher and said, “The special education talked about the IEP plan in the school district. I felt that the special education teacher would have updated training, which would be useful.” Two of the participants indicated their child’s general education teachers were helpful. Participant 4 stated she spoke with her child’s principal after receiving the diagnosis: “Talked to Principal, to see if has seemed other children with this type of behavior. We asked the school for more information on ODD and also Conduct Disorder.” She was able to get support and information from the school, which helped her understand the diagnosis.

Medical professionals identified included doctors and the school nurse. Participant 1 said, “We talked to our doctor, who is very knowledgeable about ODD.” She went on to say, “Our doctor knew right away what the disorder was.” Her relationship with her family doctor helped her to understand what the diagnosis meant and how to deal with it. Participant 3 spoke about selecting a clinic and said,

> I decided to take my child to a clinic that was recommended. I did suggest for an evaluation to be performed, before making a decision. I also wanted a psychologist who has worked with over 5 other cases on ODD. That was important to me.

Participant 3 wanted to make sure his child received care the he believed to be high in quality. Two parents indicated they had used other health care professionals but they did not identify what role those professionals played in the diagnosis and treatment plan.

One of the main forms of support that the participants identified in this study was aid from other parents who had children with ODD. All of the participants indicated this form of support was important. Participant 1 said,

> We felt that people who deal with this disorder would have a lot of current education. We talked to one parent who child who is the same age as our child. This parent shared a great of information about ODD.

Participant 1 was able to share concerns, learn about the disorder, and gain support from other parents who faced similar issues. Participant 4 agreed and said, “Other parent[s] of a child with ODD. I feel the best people to talk to are other parents.”

Participant 4 spoke about parent support groups and said, “Parent support groups are highly recommended for families raising a child with ODD. Sharing encouragement, frustrations, and successful/unsuccessful strategies with others can be therapeutic and helpful.” She found support groups were helpful for her. Support groups offer support and encouragement for the parents and helped them learn to cope with the challenges connected with raising a child with an ODD diagnosis. Participant 6 described this dynamic and stated, “I believe talking to other parents is the best choice. The reason is parents are with the children 24hrs. They see all of the behaviors involved within the hours of the day & night.” It was important for her to receive help from a person who faced similar challenges on a day-to-day basis. Participant 6 stated, “Nobody understands what it’s like to parent an oppositional, defiant child unless you have one.” Thus, reaching out to other parents helped her feel less isolated and alone. In addition, it was important for Participant 6 to find parents, “who are Hispanic” and shared cultural norms.

Theme 3: Barriers to Treatment

The third subresearch question asked, What are the barriers parents perceive to acquiring information about treatment options? The theme that emerged was *barriers to treatment*.

The parents spoke about barriers to treatment. Generally, they did not believe that major barriers to treatment existed. Two of the participants could not identify any barriers. Participant 5 said, “There were [not] any barriers for me. I felt that I had enough information on the disorder, which was assessable for me” Other parents involved in the study listed a variety of barriers. The participants did not reach a solid consensus regarding any one barrier to treatment from the group. Two of the parents spoke about financial issues connected to the use of insurance and the cost of treatment. Participant 3 said, “There are financial barriers to counseling and other resources.” He found this to be difficult because he did not know, “which insurance company will pay. How many sessions are allowed?” Participant 6 agreed with Participant 1 and stated, “after reading about the research supporting the recommended treatment, the cost was most important. Some insurance don’t pay the entire cost.” This was a stressor for him and caused anxiety.

Two participants indicated they had issues with trust. Participant 3 said, “Certain ethic groups of people, do not share information gaining trust is a number issue.” He believed that he needed to form relationships with others and know that they were trustworthy before he would be able to rely on what they said. Participant 4 had challenges with trust as well. She said, “I feel that schools will not give you all of the information that is needed, to trust.” She felt as if the school was not being straightforward and giving her the best information, which hindered a smooth working relationship. In addition, Participant 4 reported that initially, she had an issue with denial. She did not want to believe that her child had ODD.

Other barriers discussed by the parents in this study included a lack of information, language, and attitudes. Participant 1 worried about attitude. She said, “We have one barrier. Pejorative attitudes induce us to fear.” She worried about biases and the lack of understanding that others had for people with some type of mental health diagnosis. Participant 3 also spoke about a language barrier and said, “My English is not good . . . Speaking in a native language is important, when gathering information, from others.”

Theme 4: Treatment Options and Reasons for Selecting Treatment

The fourth subresearch question asked, Based on their knowledge of treatment options, which treatment(s) did parents choose and why? The theme that emerged from participants’ responses was *treatment options and reasons for selecting treatment*.

Participants 5 and 6 did not indicate which treatment options they considered and selected. Participant 4 selected a combination of approaches. This participant used family therapy, parent coaching, and social skills training. Participant 4 reported, “We are pleased in treatment for showing consistent, unconditional love and acceptance of our child, even during difficult and disruptive situations.” Participant 3 also selected family therapy and parent coaching. Participant 2 considered a variety of treatment options, including parent-management training, family therapy, social skills programs, and school based programs. After doing research she said, “I went with the school-age children perform best with a combination of school-based intervention, parent-management training, and individual therapy.” Participant 1 chose cognitive problem-solving skill training. She described it and said, “This treatment teaches us that children with ODD often only know of negative ways of interpreting and responding to real-life situations.”

Five of the parents indicated the main determining factor in choosing a treatment option was length of time for response. Participant 5 said length of time to see improvement and ease of implementation were deciding factors in choosing a treatment option. He stated, “I wanted to see how my child’s behavior, has changed. Treatment progressed has been favorable, at this time. At first, I didn’t see any improvements. After time has gone by, I did see improvement. I would say, within 4 weeks.”

Only Participant 6 differed from the group. For this parent, two factors were regarded as important: (a) cost and (b) if the treatment selected was shown to be effective for Hispanic families. Participant 3 also found length of time to see improvement as important. He said, “When a treatment doesn’t work, whether it’s therapeutic or pharmaceutical, one of the things a good clinician will do is reexamine the diagnosis.” He wanted to know that clinicians would adjust treatment as necessary. Participant 2 also selected length of time to see improvement as the most important factor in selecting a treatment plan. She said, “Treatment progressed has been favorable, at this time. I was informed that most treatment plans for children and adolescents with ODD last several months or longer.” Participant 1 considered length of time to see improvement, but in addition she said, “the goals and circumstances of the parents also are important when forming a treatment plan.” When speaking about her choice, she said, “Treatment progressed has been favorable, at this time. We studied all options and we felt that our treatment plan is the best. We can see the change."

Composite Description

A composite description of how parents made the decision about finding and selecting treatment was used to provide an overview of the process and to answer the overarching research question. The question was, What factors explain how parents of a child newly diagnosed with ODD decide upon the treatment for the child?

All of the participants in this study shared a similar decision process. For five of the participants in the study, the decision process began when they noticed that their child was having behavioral and anger issues. Participant 1 stated, "We notice[d] that our daughter was acting very angry all of the time. We knew something was wrong." The participant felt the behavior being exhibited was extreme. This led Participant 1 to seek help. Participant 4 had a similar experience and stated, "After displaying various behaviors in school and at home, we decided to have him evaluated." Participants 5 echoed the other participants and said, "After observing my child's behavior. I decided to take my child to the clinic." For the remainder of the parents, a choice to seek treatment occurred when they noticed behaviors outside the norm.

After the process began, the parents selected a clinic based on recommendations from a school or medical professional. Participant 2 said, "One teacher at school suggested that we should that her to a professional. We decided to take her to the clinic." Participant 5 said he consulted people at child's school. He noted, "I talked to the school's nurse and primary teacher." Participant 1 said when she was trying to find treatment, "We talked to our doctor, who is very knowledgeable about ODD." Four of the children in the study received a diagnosis from a clinic and two were diagnosed by a school psychologist.

After the diagnosis had been confirmed, parents sought information and then chose a treatment plan. Many parents did research, used the Internet to learn more information, sought support from professionals, or spoke with parents of children who also had ODD. Participant 2 said, “I actually went on the Internet, for current information.” Participant 3 also used the Internet and said, “[I] read that the treatment plans varied for different ages and how long the disorder has been progressing.” Several other parents spoke about seeking support from professionals. Participant 3 mentioned choosing to consult the special education teacher and said, “I felt that the special education teacher would have updated training, which would be useful.” One of the most popular methods of support for this group was to rely on other parents for support, knowledge, and encouragement. Participant 3 noted, “We also attended a support group, to gather information. This was very helpful to me.” Participant 1 had a similar experience and stated,

> [We received support from] other parents of a child with ODD. We felt that people who deal with this disorder would have a lot of current education. We talked to one parent who child who is the same age as our child. This parent shared a great of information about ODD.

These families sought help and support from a variety of sources.

All of the parents in the study reported being pleased with the plans they chose and the support they received. They indicated the treatment was effective and they could see changes in their children’s behavior. Participant 5 spoke about her child’s behavior and said, “It took about 4 weeks [to see a change].” Participant 1 also spoke about the treatment and said, “Treatment progress has been favorable, at this time. We studied all options and we felt that our treatment plan is the best. We can see the change.” Participant 3 spoke at length and indicated:

> Family therapy and parent coaching have been found to be highly effective forms of treatment. ODD often develops in a child predisposed to the illness and who lives in a home with either too much, or not enough structure. Family therapy and parent coaching are helpful in teaching parents how to adapt their parenting styles to help their child be successful.

All of the parents in the study reported being pleased with the treatment plans they chose for their children. All parents also reported that they were seeing improvements in their children’s behaviors. Parents reported barriers, or lack thereof, when it came to accessing treatment. Some barriers, such as cost, were listed as obstacles to managing their children’s diagnoses. Four of the participants indicated they experienced some type of barrier, with two reporting that they did not face barriers.

For two of the participants, cost was an issue when it came to treatment. Participant 3 stated, “There are financial barriers to counseling and other resources… Some problems are: which insurance company will pay. How many sessions are allowed?” Participant 6 spoke about how cost figured into the selection of treatment and indicated, “After reading about the research supporting the recommended treatment, the cost was most important. Some insurance don’t pay the entire cost.” Other obstacles included (a) language, with Participant 3 stating, “My English is not that good”; (b) lack of trust, with Participant 3 indicating, “Certain ethic groups of people, do not share information gaining trust is a number issue"; and (c) not enough information, with Participant 6 saying, "Not too much information or education on about ODD." Participants 2 and 5 indicated they did not encounter any barriers. Participant 5 reported, "There were any barriers for me. I felt that I had enough information on the disorder, which was assessable for me." Participant 2 said, "there were no barriers for me."

Summary

The research question for this study asked, What factors explain how parents of a child newly diagnosed with ODD decide upon the treatment for the child? The parents in this study had similar experiences with the process of receiving a diagnosis for their children and coming up with a treatment plan.

For the parents in this study, the most important factor that led to treatment was the realization that a problem existed with their child's behavior. Four parents understood on their own that an issue was present and sought support. The majority of parents identified their child was having an issue and arranged for an assessment. Thus, in order to receive treatment, it was necessary to identify the problem.

The subquestions included the following.

1. What type(s) of information would be useful for parents of a child newly diagnosed with ODD to have to determine the most appropriate treatment for their child?

Parents indicated they wanted information regarding the disorder and various treatment options. They were willing to seek the information themselves, with many turning to the Internet for answers.

2. Whom do parents trust to provide information about treatment for their child?

Parents reported they sought support from the schools, friends, family, and medical professions. The most popular place to find support was from other parents with children who had ODD. Parents found fellow parents to be supportive and full of information.

3. What are the barriers parents perceive to acquiring information about treatment options?

Parents did not identify one singular barrier to treatment for those who identified barriers. Barriers mentioned by participants included cost, language, lack of trust, lack of information, and fear of others. Some parents did not identify any barriers to needed information.

4. Based on their knowledge of treatment options, which treatment(s) did parents choose and why?

Parents reported the most helpful ways they managed to help their children were through self-education and support from other parents. Overall, the parents chose programs based on length of time to see improvements, and all parents indicated they were pleased with their children’s progress and could see differences in their behaviors.

In Chapter 4, I reviewed the participant demographics, data collection and analysis process, and reported the results of the study. The chapter also included issues of trustworthiness. Chapter 5 will present a discussion of the results in relation to the existing research literature, to explore discrepant cases, and to discuss limitations of the study, recommendations for action, and directions for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

ODD is a serious mental health disorder that adversely affects more than 1 million U.S. families and occurs in 1% to 16% of children (Hamilton & Armando, 2008). ODD is a form of CD manifested by repetitive and persistent patterns of opposition: namely, defiant, disobedient, disruptive, and antisocial behavior toward adults or authority figures that persists for more than 6 months (Fraser & Wray, 2008). The purpose of this qualitative study was to explore how parents of a child newly diagnosed with ODD chose treatment plans for their children. I investigated barriers to obtaining information and sources of information to determine the factors that may impede parents from gathering necessary knowledge about treatment. I also investigated which individuals parents were most likely to trust in the decision-making process.

One research question guided the study: What factors explain how parents of a child newly diagnosed with ODD decide the treatment for the child based on their lived experience? In addition to the overarching research question, I also posed the following subquestions to explore barriers to obtaining information, which sources of information determine what may impede parents from gathering necessary knowledge, and who parents were most likely to trust in the decision-making process:

1. What type(s) of information would be useful for parents of a child newly diagnosed with ODD to have to determine the most appropriate treatment for their child?
2. Whom do parents trust to provide information about treatment for their child?
3. What are the barriers parents perceive to acquiring information about treatment options?

4. Based on their knowledge of treatment options, which treatment(s) did parents choose and why?

Interpretation of the Findings

Findings Related to the Literature

To answer Research Question 1, I analyzed data from the interview transcripts following the 7-step procedure outlined by Moustakas (1994). After analyzing the data, I identified four themes: (a) getting educated, (b) consulting with others, (c) barriers to treatment, and (d) treatment options and reasons for selecting treatment.

Getting educated. The first theme was getting educated, wherein participants spoke about the importance of educating themselves on ODD, feeling that it was important to obtain as much information as possible on the disorder so they could understand available treatment options. The parents in the study had to find information on their own in addition to what they learned from professionals. They took advantage of available resources to learn everything they could about the disorder and the treatment options. One of their overriding concerns was to ensure that they had the most recent and up-to-date information.

The findings of this study were similar to the findings of previous studies, including work by Dretzke et al. (2005), Costin and Chambers (2007), and J. Gordon (2010), who asserted parents getting educated about ODD was an important first step in establishing a treatment regimen for their children. Hamilton and Armando (2008) determined the earlier parents educate themselves on various concepts associated with ODD, the more beneficial it is for them and the child because it leads to developing skill sets that can prevent future comorbidity with more severe disorders and mental health problems. Children with childhood-onset conduct problems often show comorbidity with ADHD (Frick, 2009) and depression in boys and anxiety disorders in girls (Lavigne et al., 2012). The earlier parents learn their child has ODD, the earlier they can educate themselves on the disorder and the available treatment options. When they do this, they significantly reduce the possibility of comorbidities developing in their child.

Consulting with others. The second theme was consulting with others when participants spoke about relying on others to gather information, including medical professionals, educational professionals, and other parents of children with ODD. Parents who interacted with school psychologists seemed to have positive interactions and found them helpful throughout the process. Parents indicated education professionals, including general education teachers, special education teachers, and principals, were helpful. Additionally, parents indicated medical professionals and parent support groups were beneficial.

The findings of this study were similar to the findings of a study by Kazdin and Whitley (2006), who determined consulting with others assists parents in developing more positive reactions to problems with their child. Kazdin and Whitley asserted that benefits for children with ODD are partially based on parents consulting with others. The researchers found higher quality parent-therapist alliances related to improvements made by parents in social relationships and support. Kazdin and Whitley’s findings are relevant to the present study because interpersonal relationships and attitudes toward therapeutic treatment for ODD are critical, and placing the parent-child relationship in the context of the therapeutic relationship may help the child’s therapeutic progress.

Barriers to treatment. The third theme, barriers to treatment, consisted of participants reporting they did not believe major barriers to treatment existed. However, this was not consistent for all participants. Some parents in the study listed a variety of barriers, but there was no consensus regarding any one barrier to treatment from the group. Some barriers included financial issues connected to insurance and treatment costs, lack of trust, lack of information, language, and attitudes.

Although the literature did not address barriers regarding finance and language, a significant deal of information exists regarding attitudes and trust as barriers to care. These barriers occurred for the child, with children's peers often mistrusting and excluding the child with ODD (Kazdin, 2010). Exclusion from classmates occurs within the classroom, where the child is forced to receive protection from the teacher after the behavior is noticed. Much like the previous themes, where comorbidities were found to be prevalent with the lack of immediate treatment, exclusion and mistrust are often catalysts for other behaviors to manifest in children with ODD (Tynan, 2008). This mistrust often triggers reactive behaviors that are inappropriate, which can lead to children with ODD associating with more deviant peers and further aggravating their problems (Kazdin, 2010; Tynan, 2008). If these behaviors are unchecked, criminal tendencies may arise during adolescence, which may result in negative consequences for both the child and the child's family (Hamilton & Armando, 2008).

Treatment options and reasons for selecting treatment. The final theme was treatment options and reasons for selecting treatment, in which participants spoke at length about the combination of approaches to assist their children with ODD and why they chose those treatments. The approaches that participants took included family therapy, parent coaching, social skills training, and cognitive problem-solving skill training. The reasons for choosing these treatments were usually related to length of time for response. For at least one participant, cost was a reason to select a certain treatment.

Previous researchers reported numerous approaches for treating ODD (Eyberg et al., 2008; Kazdin, 2008), making it difficult for parents to reach a decision regarding the best treatment for their child. Some of the most common treatments for children included individual therapy, group therapy, behavioral therapy, residential treatment, pharmacotherapy, family training (e.g., parent effectiveness training), and unconventional treatments, such as innovative community-based treatments (Kazdin, 2008). Although Eyberg et al. (2008) reported problem solving and anger management are potential treatments for training children diagnosed with ODD in social behaviors, Kazdin (2010) asserted such approaches have not been as effective as parent or teacher interventions. The recommended treatment in most cases of ODD is multimodal and extensive, and treatment typically involves psychotherapeutic approaches, medication, and sociotherapy (Dretzke et al., 2005). Parents may administer behavioral therapy, or therapy may involve group-based or individual sessions with one or two therapists (Dretzke et al., 2005). Although various treatments for children with ODD exist, medication is the predominant form of treatment (Findling, 2008; Haas et al., 2008; Turgay, 2009).

Findings Related to the Theoretical Framework

In relation to the theoretical framework of the current study, Bandura’s (2001) social cognitive theory, I found social cognitive theory related to each of the findings. Regarding the theme of getting educated, social cognitive theory is rooted in the notion that the observation of others facilitates learning. The main assumption of social cognitive theory is that people learn by observing others, and learners acquire new behaviors and knowledge by simply observing a model. While learning by direct experience and modeling, the individual acquires knowledge from observation. Regarding the current study, parents acquired knowledge about getting educated by observing other parents. The advancements of technology and online communication also increased parents’ social learning. In relation to barriers for treatment, I found that one of the biggest barriers was self-efficacy, which refers to one’s confidence in his or her abilities to succeed and persist at a given task. Other barriers included stigma and the cost associated with treatment for ODD. Researchers previously reported nearly two-thirds of individuals with diagnosable mental disorders do not receive treatment, which may relate to social cognitive theory. Although some barriers function in isolation, other barriers will interact with and reinforce other barriers. Either way, barriers influence parents’ and children’s evaluation of the acceptability of treatment options.

Similar to the theme of getting educated, consulting with others aligned with the tenets of social cognitive theory, which include observation and modeling. Parents in the current study had the ability to observe other parents in a similar situation and make comparisons. When parents get educated by examining the empirical basis for solutions for their children, they increase their knowledge of developmental norms, age-appropriate expectations, and dysfunctional attributions, which increases their capacity to regulate their emotions. When parents consult with others, they establish rapport, listen, and engage, which determines the illness framework for the family and allows for understanding between parents and children. Regarding the theme of treatment options and reasons for selecting treatments, social cognitive theory was applicable in several ways. Focusing on treatment options, social cognitive theory relates by creating a positive and healthy cognitive mind-set by addressing related conditions, such as anxiety and depression. Additionally, in terms of seeking treatment, social cognitive theory allows for cognitive problem-solving skills training. Some reasons for selecting treatments are that children with ODD are at increased risk of developing conduct disorder and antisocial personality disorder during adulthood.

Limitations

Regarding the limitations of the current study, I experienced some initial concerns, as outlined in Chapter 1. The first concern was interviewees failing to complete the interview process; however, this did not occur because all participants completed the interview process. The second limitation was parents not completing the study together. Again, this did not occur because the married participants provided the information necessary for data collection. The primary concern was a lack of ODD treatments available to the participants. I expected that not all participants would have access to the same ODD treatments because of a lack of financial resources or a lack of services within a certain geographical region. Despite these concerns, I found all participants had access to similar services regardless of financial or geographical circumstances. Additionally, there was no researcher bias.

Recommendations for Future Research

Multiple recommendations for future research stem from the findings of this study. The first is that more research is needed regarding the duration of ODD. Although researchers have proven children often outgrow ODD, future researchers should focus on whether therapy helps to shorten the duration of the diagnosis. Adolescents with ODD respond well to therapy, skills training, parent management, and family therapy; therefore, researchers should examine these strategies as a means of shortening the length of time a child has ODD.

The second recommendation for future researchers is that more research is needed regarding the development of comorbid behaviors among children who do not receive ODD treatment in a timely manner. Although researchers know these children have the potential to develop CD and antisocial personality disorder, researchers have not discovered the point at which the diagnosis becomes irreversible. Additionally, researchers should conduct research on how to reverse these effects. Researchers could work backward to determine the causes of antisocial personality disorder and establish safeguards to prevent children from developing these issues later in life. This research may influence improvements in parent education training and awareness about the early warning signs of ODD.

Implications

Multiple implications of the findings exist. The first is that if parents seek treatment early, preferably immediately after they learn that their child has ODD, they can expect better outcomes in the lifespan of the child in comparison with children whose parents do not seek treatment early. When children are diagnosed and receive treatment sooner, there is less likelihood of comorbidities developing, such as ADHD, depression, and anxiety disorders (Frick, 2009; Lavigne et al., 2012). Another implication from the study is that increased understanding needs to occur regarding the implications of ODD, as a limited body of evidence exists regarding the efficacy of ODD studies pertaining to attitudes and potential barriers. Although participants in this study were not in agreement regarding attitudes concerning their children’s status as ODD, previous literature indicated that this is a barrier parents face, as other parents of children with ODD are often not knowledgeable about the condition, which can exacerbate the child’s behavior (Kazdin, 2010). The beliefs parents have about ODD and the attitudes concerning their children’s treatment are important to allow for increased understanding of the disorder and intervention strategies. Knowledge gleaned from parent experiences can inform perceptions regarding the effect on patterns of treatment within the clinical practice of dealing with ODD. This knowledge also caters to teacher and child behavioral training as well as the needs of classroom-based training.

Findings from the study may have implications for positive social change. Focusing on the themes specifically, this study has the potential to contribute to positive social change through individuals receiving education, consulting with others, reporting their barriers to treatment, exploring their treatment options, and selecting a certain treatment. Given that participants spoke about the importance of learning about ODD, this study can assist in ensuring medical professionals do what they can to help the parents of children with ODD by providing them the most information possible. This will make parents more well-informed and not left wondering why their children behave in certain ways. Informed parents can ensure their children receive care faster. This relates to another theme: consulting with others. The positive social change that results from consulting with others stems from information gathering, when individuals can benefit from relying on others who have gone through treating ODD in their own children. For parents, selecting treatment for their children with ODD can be challenging because of the wide variety of treatments available. Parents educating themselves and consulting with others about treatment options are important steps parents can take to make deliberate decisions regarding treatment for their children, leading to informed choices about effective treatment. As for barriers to treatment, this study could inform individuals of the various barriers to treatment for ODD. Although most participants in the study stated they did not encounter barriers, some reported barriers regarding costs, trust, information, language, and attitudes. Using the findings of this study, medical professionals can become more inclusive in their practices, especially regarding language, attitudes, and information. Finally, understanding the reasons parents select treatment approaches may help health care professionals and educators suggest appropriate and cost-contingent treatment options, thereby helping parents select treatments that will enhance the quality of life for their children.

Conclusion

The purpose of this qualitative study was to explore how parents of a child newly diagnosed with ODD chose treatment for their child. Additionally, I investigated barriers to obtaining information and sources of information to determine what factors may impede parents from gathering necessary knowledge to make a decision and the individuals who parents were most likely to trust in the decision-making. Four themes emerged from data collection, including getting educated, consulting with others, barriers to treatment, and treatment options and reasons for selecting treatment. Participants spoke about experiences related to having a child with ODD, focusing on importance of educating themselves on ODD, and stating it was important to get as much information as possible regarding the disorder so they could understand available treatment options. Parents also mentioned how they relied on others to gather information, including medical professionals, educational professionals, and other parents of children with ODD. They addressed barriers, such as financial issues connected to insurance and treatment costs, trust, a lack of information, language, and attitudes. Parents stated their reasons for selecting treatment and the combination of approaches taken to assist their children with ODD and why they chose treatment.

Considering the findings of this study, I recommended more research regarding the length of ODD and the development of comorbid behaviors among children who do not receive ODD treatment in time. Future research can improve parent education training and awareness regarding the early warning signs of potential ODD.

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Appendix A: Participant Recruitment Flyer

Research Participants Needed

Parents!

Has your child recently been diagnosed with

Oppositional Defiant Disorder (ODD)?

Have you decided upon a treatment for your child?

If the answer to both questions is YES,

please contact

Ponchita Lopez
Walden University Doctoral Candidate
702-743-7417

Your participation in her research study
might help other parents in their decision-making process
about treatment for their child with ODD.

Thank you!

Appendix B: Informed Consent

You are the parent(s) of a child who has been diagnosed with oppositional defiant disorder (ODD). I would like you to participate in a research study about how you decided about the treatment for your child. This form is part of a process called “informed consent” so that you understand what the study is about before deciding whether to take part.

I am a doctoral student at Walden University. This study is for my doctoral research requirement.

Background Information:

The purpose of this study is to study the decision-making process of parents about treatment options for their child diagnosed with ODD.

Procedures:

If you agree to be in this study, I will interview you. The interview is expected to take about 30-40 minutes. I may ask you if I can interview you more than one time. The interviews will be recorded and transcribed.

What I find out from this study may help professionals in a variety of fields to understand how parents make decisions about treatment options for their child with ODD. If you want a copy of what I find out, I will give you a copy of the abstract of the doctoral dissertation, which is a summary of the study.

Voluntary Nature of the Study:

Your participation in this study is voluntary, and it is your decision whether you want to be in the study. If you decide to join the study now, you can still change your mind during the study and stop participating at any time. There is no penalty or problem if you decide not to participate or to stop participating after you begin. If you feel stressed during the study, you may stop at any time. You may skip any questions that you feel are too personal either on the demographic questionnaire or in the interview.

Risks and Benefits of Being in the Study:

Participating in the study has no known risks.Parents should indicate if there are any concerns about talking about their child’s condition.The benefits are learning about the process you experienced in deciding a course of treatment for your child with ODD.

There is no monetary compensation for participating in the study.

Confidentiality:

Any information you provide will be kept confidential.I will not use your information for any purposes outside this research project. I will code all information, and nothing will have your name on it or identify you in any way. I will also keep the information in a locked file cabinet in a location that only I can access. I will present the research at a professional conference.

Contacts and Questions:

You may ask any questions you have at this time. If you have questions later, you may contact me by phone (702-616-4071) or by email (Ponchitasl@hotmail.com). Walden University's approval number for this study is (IRB will enter approval number here), and it expires on (IRB will enter expiration date). If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210.

Statement of Consent:

I have read the above information and asked all the questions necessary so that I understand the research.I feel I understand the study well enough to make a decision about my involvement. By signing below, I am agreeing to participate in the study as described above.

Printed name of participant ______________________________

Date of consent ______________________________

Participant's written name ______________________________

Researcher's written name ______________________________

.

Appendix C: Demographic Questionnaire

Code: ________________________________

Phone number:

Email address:

Date:

1. Parent (mother or father): ____
2. Grade level in which your child studies: ________________________________
3. Child's gender: ____
4. Child's age: ____
5. Child's nationality:____
6. What is your ethnicity?____
7. In what kind of area do you live? Choose one.

   Rural – in the country out of a city or town

   Suburban – neither rural nor urban

   Urban – in a city or a town

8. What is the education level completed by the child's parents?

   Father:

   high school_____

   technical school_____

   college_____

   graduate school_____

   other_____

Mother:

high school_____

technical school_____

college_____

graduate school_____

other_____

9. What are the occupations of the child's parents?

Mother: ____

Father: ____

10. When was your child diagnosed with ODD?

____

Who diagnosed your child with

ODD?____

Appendix D: Annotated Interview Protocol

Thank you for completing the questionnaire, Mr. and/or Ms. (may not be married)______________. I am Mrs. Lopez, and I am the researcher conducting this study about parents of children with ODD. If I can make you more comfortable, please do not hesitate to ask. If you need a break, please let me know.

1. Please tell me a little about yourselves. (Here the researcher would gather and probe for basic intake demographic information: race, age, health and social history, etc., based on the demographic questionnaire. The researcher will ask them the information so that they do not have to read or write.)

2. You said that _______________________ was the person who gave you your child's ODD diagnosis. How did you decide to have your child evaluated? How did you decide who should evaluate your child? (Addressing research question #2, here the researcher wants to know if the parents sought out information about their child's behavior or if some other person suggested an evaluation—i.e., teacher, school psychologist, physician, social worker, etc.)

3. Before you decided on a course of treatment for your child, what did you think could be done to help your child? (Addressing research question #1, this acts as the pretest where the researcher is trying to find out what they already may have known before they made a decision, but it is done as part of an interview.)

4. Did you try to locate any information about ODD on your own after you were told of your child's diagnosis? What resources did you use? (Addressing research questions #1 and #3, this gives an indication of the parents' self-sufficiency in obtaining information and if any barriers to obtaining information were evident.)

5. What type(s) of person(s) didyou think would be able to help your child? (This question addresses research questions #2 and #4 about gathering information from an individual and deciding about treatment options. ***If necessary, the following probes might be used, and the use of a probe would be indicated in the results***:(a) physician, (b) psychiatrist, (c) other health care practitioner, (d) teacher, (e) special education teacher, (f) counselor, (g) other school professional, (h) other parent of a child with ODD, and/or (i) other?)

6. Whose opinion or information would you trust the most to help you decide how best to treatyour child? (This question addresses research questions #2 and #3, regarding gathering information from an individual and identifying barriers to obtaining information. ***If necessary, the following probes might be used, and the use of a probe would be indicated in the results***:(a) physician, (b) psychiatrist, (c) other health care practitioner, (d) teacher, (e) special education teacher, (f)

counselor, (g) other school professional, (h) other parent of a child with ODD, and/or (i) other?)

7. Were there any barriers to finding out about treatment options for your child? If so, what were they? Were you able to get around the barriers? If yes, how? If no, why or why not? What might have been helpful to you in removing the barriers? (Addressing research question #3, this question directly concerns barriers to making treatment decisions.)

8. What treatment options did you consider for your child? How did you learn about those treatment options? What were the most important considerations for you in deciding which treatment option to choose? What aspects of the treatment options that you considered were most appealing to you and why? What were the aspects of the least appealing options you considered and why were they unappealing? (This question addresses research question #4. ***If necessary, the following probes might be usedregarding considerations in determining the treatment option, and the use of a probe would be indicated in the results***: (a) length of time to see improvement, (b) cost, (c) ease of implementation, (d) research evidence, etc.)

9. Who was most helpful to you in making a decision about your child's treatment? Whose opinion did you think was most valid and why? (Research question #2. The previous questions ask who might be helpful or who was asked; this question asks for the specific individual who was most helpful in coming to a treatment decision.)

10. What was the decision process you used to make your final decision about the treatment for your child? (Overarching research question)

11. If the treatment has progressed, how pleased or displeased are you with the outcomes.(If the outcome has not been favorable, the researcher will ask about what the parents are considering doing at this time and what is going into their current decision-making process. In other words, having gone through the decision-making process with unanticipated poor results, what will they do now?)