

CLINICAL BRIEF 01

NAVIGATING THE MEDICATION CONVERSATION

With Black and Brown Families

WHY THIS CONVERSATION REQUIRES A DIFFERENT APPROACH

Medication hesitancy in Black and brown communities is a rational response to documented history: over-medication of Black children in educational settings, medical exploitation, psychiatric misdiagnosis, and ongoing racial disparities in how psychotropic medications are prescribed and monitored. (Morgan et al., *Journal of Child Psychology and Psychiatry*, 2020)

A 2020 literature review in the *Journal of Attention Disorders* found that Black caregivers of children with ADHD expressed concerns around medication side effects, fears of dependency, distrust of medical authority, and concerns about social stigma and labeling. These are not obstacles to overcome. They are starting points for a genuine clinical conversation. (Glasofer et al., *Journal of Attention Disorders*, 2020)

WHAT THE RESEARCH TELLS US ABOUT MEDICATION DISPARITIES

15% lower probability of medication access for Black children with ADHD compared to white children. (Yang et al., *Psychiatric Services*, 2022)

12% lower medication access for Hispanic children with ADHD compared to white children. (Yang et al., *Psychiatric Services*, 2022)

"Black families in particular want to start with therapy first and see how it works before considering medication if therapy is not working." (Child Mind Institute, citing Dr. Stephanie Shepherd, 2025)

OPENING THE CONVERSATION: LANGUAGE THAT WORKS

- **Start with permission:** "Before I share my clinical thinking, I'd like to hear what you already know or have heard about medication for ADHD, and whether you have any concerns. You have every right to ask questions about anything I recommend."
- **Acknowledge history explicitly:** "I know that Black families have had real reasons, historically and today, to be cautious about medication. I want you to know that I take that seriously and I'm not going to push you toward anything you're not ready for."
- **Present the full picture:** Offer behavioral therapy and skills-based options first and with equal clinical weight. Framing medication as optional rather than inevitable increases trust and engagement. (Child Mind Institute, 2025; Pfiffner and DuPaul, 2015)
- **Address side effect concerns factually and specifically:** Ask what specific concerns the family has, then address each one directly with accurate information. Generalized reassurance is less effective than specific, honest answers about what the research actually shows about appetite, sleep, and cardiovascular effects.
- **Name the stigma concern before the family does:** "I know some families worry about what a medication prescription means for how others see their child, or what it might mean on school or medical records. Let's talk about that."

IF THE FAMILY DECLINES MEDICATION

Accept this as a valid clinical decision and begin with behavioral interventions. Behavioral parent training, CBT for ADHD, executive function coaching, school-based accommodations, and family psychoeducation are all evidence-based and effective. A family that starts with behavioral treatment and sees results may revisit medication willingness as the therapeutic relationship deepens. (Pfiffner and DuPaul, 2015; Barkley, 2015)

Clinical principle: A family that trusts you enough to come back is more valuable than a family that fills a prescription once and disappears. Meet them where they are.

FAITH AND MEDICATION: WHEN THEY INTERSECT

Some families hold sincere faith-based reservations about medication. Acknowledge the faith framework respectfully, then provide accurate neurological information without positioning science and faith as competitors: "I completely respect that faith is central to how your family approaches wellbeing. What we know about ADHD is that it's a neurological condition, similar to how someone might need glasses for their vision. Many families find that faith support and clinical care work well together."



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CLINICAL BRIEF 02

ENGAGING FAMILIES IN ADHD TREATMENT

A Clinician Guide for Black and Brown Communities

THE EVIDENCE ON FAMILY ENGAGEMENT AND OUTCOMES

Family engagement is not supplementary to ADHD treatment for children and adolescents. It is a primary treatment variable. Parental involvement in ADHD care is among the strongest predictors of treatment initiation, adherence, and outcomes, and this relationship is even more pronounced in Black and Hispanic families, where family decision-making is often collective and community-embedded. (Nissley-Tsiopinis et al., *Child and Family Behavior Therapy*, 2023)

A 2023 PMC study on barriers and facilitators of ADHD treatment in Black and Latino children found that working alliance between clinician and caregiver, caregiver empowerment, and trust in the provider were the strongest facilitators of treatment engagement and completion. (PMC, *ADHD Treatment Barriers and Facilitators*, 2023)

UNDERSTANDING HOW "FAMILY" IS DEFINED

In many Black and Hispanic/Latino families, the caregiving network extends beyond the nuclear household. Grandparents, aunts, uncles, older siblings, godparents, and faith community members may all play active roles in a child's care and in family decision-making. A treatment plan that accounts only for the presenting caregiver misses the full decision-making ecology. (Perez Jolles et al., *Patient Education and Counseling*, 2019)

- **Ask at intake:** "Who else is involved in your child's care and in family decisions? Are there other people who should be part of our conversations or who will need to understand what we're doing together?"
- **Offer to include extended family in key appointments:** A grandparent who understands ADHD neurology is an asset. One who does not may undo clinical work at home. Invest time in the broader network.
- **Respect collectivist decision-making:** Some families will not make treatment decisions until key family members have been consulted. Build time for this into your clinical process rather than interpreting delay as resistance.

PSYCHOEDUCATION AS THE FOUNDATION

Psychoeducation about ADHD that is culturally grounded, jargon-free, and responsive to the family's specific concerns is the most important early investment a clinician can make. Families that understand what ADHD is neurologically, what it is not, and what the evidence says about treatment are significantly more likely to engage in and complete care. (Barkley, 2015; Fabiano et al., 2015)

- **Lead with reframing:** Begin every psychoeducation conversation by explicitly separating ADHD from character, parenting quality, and moral failure. This reframe is the gateway to everything else.
- **Use concrete examples relevant to the family's daily life:** Abstract clinical language about executive function is less effective than specific illustrations the family recognizes from their own experience with their child.
- **Provide written materials at an accessible reading level:** The Society for ADHD and Co-Occurring Conditions provides free, culturally conscious ADHD psychoeducation materials specifically developed for Black and brown families at www.societyforadhd.org/resource-library.

BEHAVIORAL PARENT TRAINING: CULTURAL ADAPTATION MATTERS

Behavioral parent training (BPT) is the gold-standard evidence-based intervention for children with ADHD under 12, and is recommended alongside medication in major clinical guidelines. However, standard BPT protocols were developed primarily with white, middle-class families and contain elements that may be culturally misaligned for Black families. (Pfiffner and DuPaul, 2015; Fabiano et al., 2015)

A 2024 Georgetown University study found that Black clinicians identified multiple points of cultural misalignment in standard parent-child interaction therapy for Black families, including disciplinary norms, assumptions about family structure, and protocol inflexibility. Clinicians serving Black families should be aware of these misalignments and adapt accordingly. (Coates et al., *International Journal of Environmental Research and Public Health*, 2024)

- **Discuss disciplinary norms openly and respectfully:** Many Black families hold culturally grounded views about discipline that differ from BPT assumptions. Approach these differences with curiosity, not correction. (Coates et al., 2024)
- **Attend to generational patterns:** Black clinicians in the Georgetown study identified generational patterns of discipline as a significant cultural variable. Exploring what caregivers experienced in their own childhoods is both relationally valuable and clinically relevant. (Coates et al., *International Journal of Environmental Research and Public Health*, 2024)

- **Build flexibility into the protocol:** Rigid adherence to manualized BPT in families where the protocol does not fit produces dropout. Adapt session pacing, content sequencing, and homework expectations to the family's actual circumstances.

MOTIVATIONAL INTERVIEWING AS A RELATIONAL TOOL

Motivational interviewing (MI), an evidence-based approach that uses empathic listening, reflective questioning, and collaborative exploration of ambivalence, is particularly well-suited to building engagement with Black and brown families who may be ambivalent about treatment. MI does not persuade. It creates a space for the family to articulate their own reasons for change. *(Miller and Rollnick, Motivational Interviewing, 3rd ed., 2013)*

Clinicians in the BC-ADHD program, a family preparation intervention for ADHD care with diverse families, reported using MI strategies throughout engagement to promote change talk, with an 86% session attendance rate in an initial trial including 27% Black families. *(Nissley-Tsiopinis et al., Child and Family Behavior Therapy, 2023)*



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CLINICAL BRIEF 03

RECOGNIZING ADHD IN BLACK GIRLS AND WOMEN

A Clinical Brief for All Clinicians Treating ADHD

THE DOUBLE INVISIBILITY

Black girls and women with ADHD face two compounding diagnostic barriers simultaneously: the gender bias that causes female ADHD presentations to be missed or misattributed, and the racial bias that causes Black patients to be underdiagnosed with ADHD and overdiagnosed with conduct and mood disorders. The intersection of these two patterns produces some of the most dramatically underserved presentations in ADHD clinical practice.

Least likely Black females were the cohort least likely to receive an ADHD diagnosis in a 2024 analysis of 849,281 ADHD patients. (Shalaby, Sengupta and Williams, Scientific Reports, 2024)

4 years longer average wait for diagnosis in women compared to men. (Frontiers in Psychiatry, 2023; PMC, 2024)

5 years average later diagnosis for girls compared to boys across the general population. (Almekhlafi and Jain, Journal of Women's Mental Health, 2024)

HOW ADHD PRESENTS DIFFERENTLY IN GIRLS AND WOMEN

ADHD diagnostic criteria were developed primarily from research on white male children exhibiting hyperactive-impulsive presentations. Girls and women are significantly more likely to present with the inattentive type and with internalized rather than externalized symptoms. The clinician who is looking for hyperactivity and impulsivity will miss the majority of female ADHD presentations. (Hinshaw et al., Journal of Child Psychology and Psychiatry, 2022; Almekhlafi and Jain, 2024)

- **Inattentive presentation dominates:** Daydreaming, difficulty sustaining attention during conversation or reading, losing belongings, forgetting appointments, and difficulty following through on tasks without external structure are more common presentations in girls and women than hyperactivity. (Hinshaw et al., Journal of Child Psychology and Psychiatry, 2022)
- **Masking and compensation:** Girls are socialized toward compliance, people-pleasing, and emotional suppression. By the time many reach adolescence, they have developed elaborate compensatory strategies that conceal their neurological difficulties from clinicians and teachers. The compensation is exhausting and eventually fails. (Livingston et al., Autism, 2019; Young et al., 2020)
- **Emotional dysregulation over behavioral dysregulation:** In girls and women, ADHD more commonly presents as emotional volatility, intense sensitivity to criticism and rejection, low frustration tolerance, and mood fluctuations that are frequently misdiagnosed as anxiety, depression, or borderline personality disorder. (Stickley et al., Journal of Attention Disorders, 2022)
- **Perfectionism and high achievement as masking:** High-achieving girls with ADHD may maintain academic performance through unsustainable levels of effort. Grades do not rule out ADHD. Functional impairment in organization, time management, sleep, relationships, and self-regulation can coexist with strong academic output. (Quinn and Madhoo, Primary Care Companion for CNS Disorders, 2014)
- **Anxiety and depression as presenting complaints:** By the time many women with ADHD reach a clinician, their primary presenting complaints are anxiety and depression. Treating only the anxiety or depression without identifying the underlying ADHD produces incomplete and unsustained results. (Stickley et al., Journal of Attention Disorders, 2022; Hinshaw et al., 2022)

THE BLACK FEMALE EXPERIENCE: ADDITIONAL CLINICAL CONSIDERATIONS

For Black girls and women, the female ADHD presentation is further complicated by the expectations of the Strong Black Woman cultural schema, which valorizes emotional suppression, self-reliance, and managing others' needs above one's own. This schema, while a source of resilience and community cohesion, actively suppresses help-seeking and makes the already-difficult task of ADHD self-identification nearly impossible. (Watson and Hunter, Counseling Psychology Quarterly, 2016; Lewis et al., 2013)

- **Hypervigilance as a confound:** Black girls growing up in environments of chronic stress, discrimination, or neighborhood insecurity may exhibit hypervigilance and attentional patterns that overlap with ADHD symptomatology but reflect adaptive responses to environment. Differential assessment requires careful developmental and contextual history-taking. (Carter et al., 2019; DeGruy, Post Traumatic Slave Syndrome, 2017)
- **Behavioral expectations in school:** Black girls who exhibit ADHD-related behaviors in school are more likely to receive disciplinary responses than referrals for evaluation. A history of behavioral incidents in a Black female

patient should trigger ADHD inquiry, not reinforce a behavioral explanation. (Morris and Perry, *Sociology of Education*, 2017; GAO, 2024)

- **The diagnostic relief of late diagnosis:** Many Black women who receive a late ADHD diagnosis describe it as profoundly validating after decades of believing they were fundamentally flawed. Clinicians are in a position to provide that recognition. The relational and clinical value of accurate diagnosis at any age is substantial.

CLINICAL ACTIONS

- **Screen routinely for ADHD in Black female patients presenting with anxiety, depression, or burnout:** These are the presenting complaints most likely to sit on top of undiagnosed ADHD in this population. (Stickley et al., *Journal of Attention Disorders*, 2022)
- **Take a thorough developmental and functional history:** Ask about childhood academic experience, organizational patterns, time management, the effort required to maintain performance, and the experience of being described as spacey, disorganized, or emotionally sensitive.
- **Use multi-informant data and do not rely on office presentation alone:** A Black woman who has spent her life masking will present competently in a clinical appointment. This is not evidence of absence of ADHD. It is evidence of a highly practiced compensatory system. (Livingston et al., *Autism*, 2019)
- **Ask about exhaustion:** "Do you feel like you work significantly harder than others to achieve the same results? Does maintaining your daily functioning feel exhausting in a way others don't seem to understand?" These questions open the door to the masked ADHD presentation.

Clinical note: Women diagnosed with ADHD in adulthood commonly report having received multiple prior diagnoses of anxiety disorder, depressive disorder, or personality disorder. (Stickley et al., *Journal of Attention Disorders*, 2022; Quinn and Madhoo, *Primary Care Companion for CNS Disorders*, 2014). ADHD should be part of the differential assessment for any Black female patient with a complex or treatment-resistant mental health history.



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CLINICAL BRIEF 04

ADHD AND CO-OCCURRING CONDITIONS*A Clinician Quick Reference for Black and Brown Communities***WHY CO-OCCURRING CONDITIONS MATTER IN BIPOC ADHD CARE**

ADHD rarely occurs in isolation. Research consistently documents that the majority of individuals with ADHD have at least one co-occurring condition, and that in clinical populations, the rate approaches 80%. (Creyos, *ADHD Comorbidity*, 2026)

In Black and brown communities, co-occurring conditions carry additional clinical significance for two reasons: they are frequently the presenting complaint when the underlying ADHD has not been identified, and they are the conditions most likely to be treated in isolation without addressing the ADHD substrate driving them.

ANXIETY DISORDERS

- **Prevalence with ADHD:** ADHD is associated with a 2.2 to 9.1-fold increased risk of anxiety disorders compared to individuals without ADHD. (ScienceDirect, 2023)
- **In Black and brown communities:** Anxiety in BIPOC patients is frequently presented as physical symptoms (headaches, stomach pain, fatigue) rather than psychological worry, reflecting cultural norms around how distress is expressed and what symptoms are considered "medical." Clinicians who ask only about worry and fear will miss anxiety presentations in many Black and brown patients.
- **Key clinical implication:** When anxiety and ADHD co-occur, anxiety often worsens executive function deficits and reduces the effectiveness of ADHD interventions. Non-stimulant ADHD medications (atomoxetine, guanfacine, viloxazine) may be preferable when anxiety is significant. (Pliszka, *Journal of the American Academy of Child and Adolescent Psychiatry*, 2007)

DEPRESSION AND MOOD DISORDERS

- **Prevalence with ADHD:** Depression is nearly three times as common in adults with ADHD, and an estimated 44% of individuals with ADHD will experience a depressive episode before age 30. ADHD is associated with a 1.6 to 9.0-fold increased risk of major depressive disorder. (Creyos, 2026; ScienceDirect, 2023)
- **In Black and brown communities:** Depression in Black patients is frequently more severe at presentation due to delayed help-seeking driven by stigma and medical mistrust. Clinicians should screen for ADHD in Black patients presenting with depression, particularly when the depression has a chronic, treatment-resistant, or functionally disabling character. (Alang, *Health Services Research*, 2019)
- **Key clinical implication:** Depression in the context of undiagnosed ADHD is often a downstream consequence of years of functional failure, chronic criticism, and identity disruption. When ADHD is identified and treated, co-occurring depression frequently improves as well. (Barkley, 2015)

OPPOSITIONAL DEFIANT DISORDER (ODD) AND CONDUCT DISORDER (CD)

- **Prevalence with ADHD:** ODD co-occurs with ADHD in approximately 50% of children with ADHD. Conduct disorder develops in a subset of children with ADHD and ODD, particularly when ADHD is unidentified and untreated. (Pliszka, 2015; Barkley, 2015)
- **In Black and brown communities:** Black and brown youth with ADHD-related behaviors are significantly more likely to receive ODD or CD diagnoses in place of, or without, ADHD. Black individuals were 61% more likely to receive a conduct disorder diagnosis than white individuals in an 849,281-patient ADHD cohort. (Shalaby, Sengupta and Williams, *Scientific Reports*, 2024)
- **Key clinical implication:** Before concluding ODD or CD as primary diagnoses, conduct a thorough ADHD evaluation. Identify ADHD when present, treat it, and reassess ODD and CD diagnoses in the context of appropriate ADHD management.

TRAUMA AND PTSD

- **Prevalence with ADHD:** ADHD and trauma histories co-occur at elevated rates, and their symptom profiles overlap substantially, making differential diagnosis complex. Inattention, hypervigilance, emotional dysregulation, and impulsivity are features of both ADHD and trauma responses. (Szymanski et al., *Journal of Attention Disorders*, 2011)

Black and brown patients carry elevated rates of adverse childhood experiences including community violence, housing instability, discrimination-related stress, and family disruption. Trauma-informed assessment and care is not optional

when treating ADHD in Black and brown communities. It is standard practice. (Wolff and Baglivio, 2017; Merrick et al., CDC, 2018)

- **Key clinical implication:** Use validated trauma screening tools alongside ADHD assessment. When trauma and ADHD co-occur, sequence treatment thoughtfully: stabilize safety, address trauma responses, and ensure ADHD treatment accounts for the hyperarousal patterns that trauma produces.

SUBSTANCE USE DISORDERS

- **Prevalence with ADHD:** ADHD is associated with a 2.3 to 9.7-fold increased risk of substance use disorders. Among youth with ADHD as a primary diagnosis in community mental health settings, approximately 5% have a co-occurring high-risk substance use or SUD. (ScienceDirect, 2023; Ware et al., Frontiers in Psychiatry, 2024)
- **Key clinical implication:** Screen for ADHD in every patient presenting with substance use disorder, particularly when the substance use history begins in adolescence. Treating ADHD appropriately, including with medication when clinically indicated, reduces substance use risk.

LEARNING DISABILITIES

- **Prevalence with ADHD:** Learning disabilities, including dyslexia, dyscalculia, and dyspraxia, co-occur with ADHD at significantly elevated rates compared to the general population. (Mayes and Calhoun, Psychology in the Schools, 2006)
- **Key clinical implication:** When ADHD is identified in a Black or brown child who is struggling academically, screen for co-occurring learning disabilities. A comprehensive neuropsychological evaluation that includes both ADHD and learning disability assessment produces a complete picture and informs school accommodation requests.

SLEEP DISORDERS

- **Prevalence with ADHD:** Up to 80% of adults and 82% of children with ADHD experience significant sleep problems. ADHD is associated with an 8-fold increased rate of diagnosed sleep disorders compared to the general population. (Bondopandhyay et al., Frontiers in Psychiatry, 2024; PMC, 2025)
- **Key clinical implication:** Sleep screening should be routine in every ADHD assessment. Untreated sleep disorders worsen every ADHD symptom. Distinguish between sleep problems as a feature of ADHD neurology and sleep problems as side effects of stimulant medication.

Quick reference: when to suspect undiagnosed ADHD underlying a co-occurring condition Consider ADHD evaluation when: a patient has treatment-resistant anxiety or depression; a Black or brown patient has received an ODD or CD diagnosis; a patient with substance use disorder reports a history of school difficulties or chronic dysregulation; a Black girl or woman has a complex multi-diagnosis history; or any patient describes lifelong patterns of disorganization, time management difficulty, and difficulty sustaining attention that predate the presenting complaint.



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