There Are No Bad Kids: An Antiracist Approach to Oppositional Defiant Disorder

Rupinder K. Legha, MD

OPPOSITIONAL DEFIANT DISORDER: THE NEED FOR AN ANTIRACIST APPROACH

Oppositional defiant disorder (ODD) is a childhood disruptive, impulse control, and conduct disorder characterized by anger or irritability, argumentativeness or defiance, and vindictiveness (Table 1).[1] Black, Hispanic, and American Indian/Alaska Native children—hereafter referred to as racially minoritized children—are more likely to be diagnosed with ODD than white children.[2–4] One recent large-scale analysis found that the diagnosis of ODD is 35% more prevalent in Black people than in white people.[5] These disparities worsen in juvenile detention and child welfare settings, where racially minoritized youth are overrepresented.[6,7]

ODD describes the presence of unwanted behaviors and suggests they are features of the child, rather than manifestations of underlying neurodevelopmental difference (eg, autism), prior history (eg, trauma), or co-occurring mental health challenges (eg, depression).[1] The diagnosis becomes racist when applied indiscriminately to racially minoritized children as a "bad kid" label, placing blame on them for these unwanted behaviors. Doing so is especially problematic when these behaviors serve as reactions or adaptations to racism. This misattribution can incite adverse outcomes, including missed treatment opportunities from misdiagnosis, failure to protect against racism, and harsher school disciplinary practices.[2,3,8–10]

However, there are no specific guidelines that take an antiracist approach to protect children against this harm.[11,12] This antiracist approach addresses this void, urging clinicians to recognize the historical legacy of racism shaping ODD overdiagnosis; the racism influencing diagnosis and treatment; and key documentation, psychoeducation, and clinical activism strategies.[13,14] Two real-life cases illustrate how it confronts the racism shaping ODD in practical contexts (Tables 2 and 3).

STEP 1: CONNECT ODD OVERDIAGNOSIS TO MENTAL HEALTH CARE'S LEGACY OF RACISM

Aggression and defiance can be powerful transgenerational adaptations to histories and systems of oppression. Yet organized mental health has historically pathologized racially minoritized people's resistance to racial violence at the expense of denouncing racial violence itself.[15] For drapetomania, or "runaway slave syndrome," coined by Dr Samuel Cartwright in 1851, the recommended treatment was whipping.[16] During the Civil Rights Movement, psychiatrists labeled Black men championing their human rights with a "protest psychosis" diagnosis.[17] In both cases, more humane alternatives, like abolishing slavery, instead of whipping enslaved people, were disregarded. Notably, in the 1960s, other

Antiracism in Mental Health Fellowship, Los Angeles, California

Address correspondence to: Rupinder K. Legha, MD, 4859 W Slauson Ave, #693, Los Angeles, CA 90056. antiracistmd@gmail.com, 323-250-2151

Dr Legha conceptualized and designed the study, drafted the initial manuscript, and critically reviewed and revised the manuscript. As the sole author, Dr Legha approved the final manuscript as submitted and agrees to be accountable for all aspects of the work.

CONFLICT OF INTEREST DISCLOSURES: Dr Legha has no conflicts of interest to disclose.

FUNDING: No funding was secured for this study.

Accepted for Publication Date: November 14, 2024

https://doi.org/10.1542/peds.2024-068415

To cite: Legha RK. There Are No Bad Kids: An Antiracist Approach to Oppositional Defiant Disorder. *Pediatrics*. 2025;155(2):e2024068415

TABLE 1. Abridged Diagnostic Criteria for Oppositional Defiant Disorder (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* [*DSM-5-TR*])
A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months, as evidenced by at least 4 symptoms from any of the following categories, as exhibited during interaction with at least 1 individual who is not a sibling.
Angry/irritable mood 1. Often loses temper 2. Is often touchy or easily annoyed 3. Is often angry and resentful
Argumentative/defiant behavior 4. Often argues with authority figures or, for children and adolescents, with adults 5. Often actively defies or refuses to comply with requests from authority figures or with rules 6. Often deliberately annoys others 7. Often blames others for his or her mistakes and misbehavior
Vindictiveness 8. Has been spiteful or vindictive at least twice within the past 6 mo
Mild: Symptoms confined to only 1 setting (home, work, school, peers)
Moderate: Symptoms present in at least 2 settings
Severe: Symptoms present in 3 or more settings

mental health professionals were championing racism's eradication, rather than diagnosing protest psychosis, as the definitive pathology underlying minoritized discontent.[18,19] Both diagnoses reneged on a duty to advocate against social injustice.

Mental health care's legacy of racism, while distinctly anti-Black due to its intertwinement with slavery, has not spared other racialized groups. Intelligence testing created by psychologists justified 20th-century eugenics mass sterilization campaigns targeting Black, Hispanic, and American Indian girls and women.[20,21] This testing has contributed to racially minoritized children's overrepresentation in special education placement.[22] ODD's overdiagnosis today perpetuates this legacy's normalization of racial oppression, pathologizing of resistance, and behavioral control as intervention, rather than advocacy against racial violence.[13] Because diagnostic labels remain an enduring weapon of choice for white normativity, clinicians should think twice about applying ODD to racially minoritized children. Repairing this history involves challenging it, not perpetuating it.[13,14]

STEP 2: DIAGNOSE THE RACISM INVOLVED

An antiracist approach to racially minoritized children with ODD mandates analyzing how racism shapes misdiagnosis—not automatically implementing the adult supervision, discipline, and parent training recommended by practice parameters.[11,12] Recognizing pertinent inequities helps pediatric clinicians avoid the following:

- Perpetuating anger and adultification biases: Adults are more likely to perceive Black children as stronger, more

TABLE 2. Applying an Antiracist Approach to ODD to Protect a Child Against Racist Harm: Case 1	
Brief case formulation: A child aged 17 y previously diagnosed with ODD has spent much of his adolescence in juvenile detention settings or suspended from school. After being caught smoking cannabis while on probation, he is sent to a residential facility far from home. He runs away but is quickly detained again, eventually being released to his guardian's home. He presents for his annual physical with his new pediatrician.	
Step 1: Connect ODD to the legacy of racism in mental health care	The pediatrician, noting he is a racially minoritized child with an ODD diagnosis, invokes an antiracist approach. They question whether the behaviors reflect a response to his traumatic experiences with the police, rather than an innate predisposition. They consult with the mental health clinician integrated into their primary care clinic.
Step 2: Diagnose the racism	Both clinicians discern that the child has been exposed to many adults (teachers, principals, doctors, public defenders, police, probation officers) who perceive him as being angrier and less innocent than he is. His middle school principal reported the argumentative and defiant behavior resulting in the ODD diagnosis made by a school psychologist. They worry the child has been subjected to harsh disciplinary measures, leading to severe distress driving cannabis use and resulting in probation violations. They recognize the inequities shaping this child's experience, specifically that Black children are more likely to be arrested, compared with white youth, and less likely to be diverted. The mental health clinician conducts a probing diagnostic assessment that reveals childhood trauma stemming from an uncle who was shot and killed by the police. The child experienced this loss at the beginning of middle school before he was diagnosed with ODD. However, school records make no mention of this trauma. The child's guardian shares that the principal "treated my son like a criminal" and called him "oppositional" and "defiant." When the mental health clinician probes about other relationships in other settings, the guardian emphasizes that other teachers found him respectful and polite, and family members often ask him to babysit his younger cousins. Both clinicians are concerned that the ODD misdiagnosis has hastened this child's traumatic journey along the school-to-prison trajectory while neglecting his suspected posttraumatic stress disorder.
Step 3: Engage in antiracist psychoeducation, documentation, and clinical activism	The pediatrician notes that racism is not mentioned once in the chart and that the child is labeled "African American," even though he identifies as being "Afro-Latino." They document how the child has been inappropriately labeled with ODD, his mistreatment, overlooked, and his "misbehavior" is an adaptive cry for help. The child's posttraumatic stress disorder has been overlooked and gone untreated. They share these concerns with the child's guardian, who agrees, and draft a letter of support to the child's public defender expressing their concerns.
Outcome: The attorney shares the letter with the judge who agrees that the child has been unfairly labeled and that his distress is being punished, rather than treated. The judge reroutes the child to a diversion program. Feeling more seen by the adults in his life, the child begins attending therapy and stops smoking cannabis.	
Abbreviation: ODD, oppositional defiant disorder.	

TABLE 3. Applying an Antiracist Approach to ODD to Protect a Child Against Racist Harm: Case 2

Brief case formulation: A child aged 15 y is brought in by police to an ED after running away from their group home. They are on a legal hold. They arrive physically restrained, crying and pleading. The EMT introduces them as a "15-year-old Hispanic female, a frequent flier, brought in again for danger to others. Being loud and aggressive, angry and irritable with everyone for weeks." The danger to others pertains to the child resisting restraint from the EMTs after the group home called 911 to report they ran away. The EMT adds, "This is the final straw—the group home wants to kick them out. They've got an attitude and are really sassy." The hospital is a busy public facility, there is no child psychiatrist in the region, and the adult psychiatrist only rotates during the day. This unavailability leaves the ED physician to manage this child. The ED physician reviews their chart and notes they have been brought in from their group home in restraints multiple times, received multiple chemical restraints, and have a historical diagnosis of ODD.	
Step 1: Connect ODD overdiagnosis to the legacy of racism in mental health care	The ED physician immediately questions whether the perception of this child being violent obscures the violence the child has endured. They ask the EMT to avoid calling them a "frequent flier," accusing them of having an attitude and being sassy, and making harsh statements in front of the child so they are not adultified or degraded. They focus on removing the restraints so they are not further violated and establishing themselves as an advocate, not an authority figure, stating, "I am so sorry this happened. I am here to help."
Step 2: Diagnose the racism	The physician probes for additional sources of violence and discrimination. They learn the child was sent to foster care when they were aged 12 y and have since bounced from one foster home or group home to another. When asked whether they have ever been abused, they freeze and say nothing. The child is clearly precocious, but they missed a lot of school during their early childhood, and this resulted in punishments that alienated them. When asked about differential treatment at school, they note they have been sent to the principal's office for disobedience, adding, "I always get in trouble for stuff everyone else does, but they get away with it. The teachers seem to hate me." It is clear the child is running away from the group home because they are distressed and do not trust adult authority figures to help them. The ED physician wonders whether their irritability is related to being depressed but has been misconstrued as anger. The child cries during most of the assessment. The physician responds, "I am concerned you have been mislabeled and mistreated. You have been through so much and deserve to get help. I am sorry we have failed you." They peruse the chart to assess how the ODD diagnosis was made and see that it was entered into the chart during the very first ED visit 2 years earlier, but there is no clear explanation of how the child met the diagnostic criteria. Instead, ODD has been copied and pasted into every subsequent ED visit without diagnostic justification.
Step 3: Engage in antiracist psychoeducation, documentation, and clinical activism	The physician notes no mention of the child's behavior in relation to racism or mistreatment in the chart. Worried the child is traumatized, depressed, and being actively abused, they break with the usual pattern of restraining, injecting, and discharging the child back to the group home. They, instead, ask for a psychiatry consultation while documenting their concerns for the child's life trajectory as they are being hurled down the school-to-prison trajectory pipeline, noting the child's unrecognized intelligence, capacity to connect, and resilience.
Outcome: The psychiatry service reviews the chart, noting the ED physician's concerns that the child has been misdiagnosed with ODD and that their symptoms have not been contextualized amid the racism and trauma they have experienced. Their mental health evaluation comes from a place of compassion, not judgment, and the child responds by opening up about feeling suicidal. The psychiatry service rejects the ODD diagnosis, diagnoses the child with untreated severe depression, and recommends inpatient psychiatric hospitalization for stabilization.	

Abbreviations: ED, emergency department; EMT, emergency medical technician; ODD, oppositional defiant disorder.

adultlike, less innocent, and less deserving of attention than white children.[23–25] These biases, derived from anti-Black ideologies legitimizing enslaved children's abuse, persist through racially minoritized children's overpunishment, criminalization, and neglect of their pain, emotional and physical.[26–28] When children are labeled oppositional, contextualization should follow. It includes scrutinizing the adult authority figures (clinicians, teachers, school administrators, and police officers) assessing them; conducting impartial assessments of their emotions and behaviors; and making ample attempts to identify dehumanization and discrimination.

- Ignoring intersecting systems of oppression: Adultification biases impact racially minoritized girls in unique ways.[25] Negative stereotypes of Black women being angry, aggressive, and hypersexual lead adults to treat Black girls inappropriately, punishing them for subjective infractions, like disruption or disobedience, that their peers evade.[23–25] They are suspended at 5 times the rate of white girls, while American Indian girls experience suspension at over twice the rate.[29,30] Racially minoritized lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students often endure multiple forms of bullying and harassment and punishment for their clothing, gender presentation, and public displays of affection, leading to increased rates of disciplinary actions within school environments.[31] LGBTQ girls in particular are disproportionately punished due to normative societal expectations for sexual behavior and gender identity.[32,33] These inequities warrant exploring differential treatment at school (case 2) while noting ODD's gender differences. Girls experience more internalizing symptomatology than boys. ODD is more common in boys during childhood, but this gender gap narrows in adolescence.[34]
- Misdiagnosing: Mitigating racial discrimination's harm involves considering alternative diagnoses, like attention-deficit/hyperactivity disorder (ADHD) or autism spectrum disorder, which can present similarly to ODD.[2,35] Although a defining feature of ODD, irritability is not diagnostic. A nonspecific indicator, irritability in youth warrants checking for mood and anxiety disorders and posttraumatic stress disorder.[36] Clinicians requiring a diagnosis for billing but lacking time to probe for trauma, attentional challenges, and mood symptoms

might consider less stigmatizing alternatives, including the various adjustment disorders or unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. The widespread practice of copying and pasting a historical diagnosis without proper assessment, which can perpetuate bias, is discouraged.[37]

- Advancing the school-to-prison trajectory: An ODD label can heighten racially minoritized children's already elevated risks of suspension, expulsion, and justice involvement.[27] Black and American Indian/Alaska Native youth face higher arrest rates than white youth. Black and Hispanic youth experience the highest incarceration rates, followed by American Indian and then white youth.[38,39] Racism profoundly impacts children, resulting in higher rates of anxiety, depression, and behavior problems.[40–42] Racially minoritized youth who are also disabled, transgender, undocumented, or otherwise marginalized face additional toxic stress from intersectional discrimination and can be punished for their victimization.[43,44] Explaining behavior through an ODD diagnosis can come at the expense of validating discrimination and trauma, thereby facilitating racially minoritized children's pushout into carceral settings for the same behaviors garnering mental health care referrals and diversion for white youth.[39,45]
- Justifying punishment and coercion: Diagnosing a racially minoritized child with ODD can be tantamount to calling them a "bad kid," amplifying established patterns of punishment and coercion, like excessive suspension and expulsions, seclusion and restraint, and police stops and juvenile justice involvement.[28,46,47] An antiracist approach supplants individualized constructions of problematic behavior with structural analyses of the racial violence assailing children, recognizing the latter as the core problem driving the former. Moreover, it calls for protection against it.[13,14] Assessing behaviors across multiple settings and relationships helps. Putting less onus on racially minoritized children for behaviors caused by racism is therapeutic and could improve service engagement.

STEP 3: ENGAGE IN ANTIRACIST PSYCHOEDUCATION, DOCUMENTATION, AND CLINICAL ACTIVISM

Pediatric clinicians who have connected a racially minoritized child's ODD diagnosis to historical context and assessed its racist harm are primed to protect them through the following clinical strategies.

Antiracist psychoeducation[14]: This strategy involves explaining to children and families how ODD's overdiagnosis can perpetuate a historical arc of racism (step 1) and thwart healthy developmental outcomes (step 2). A full informed consent process illuminates an ODD diagnosis' risks, underscoring that mental health diagnoses are not objective markers of disease but rather highly subjective constructions of human behavior shaped by historical and sociopolitical context.[15]

- Antiracist documentation[14]: This process involves scanning charts for pejorative language portraying children as aggressive (eg, defiant, difficult, uncooperative[48]) and examining whether their behaviors have been explored as a form of distress stemming from the stress and trauma of racism. Clinicians can then document the role racism plays in shaping behavior, adult authority figures' perceptions of it, and how an ODD diagnosis can cause harm by obscuring vulnerability, trauma, sadness, and attentional challenges (step 2).[2] Highlighting strengths and concern for mistreatment humanizes children, rewrites their pejorative narratives, and reconfigures them as "good kids" deserving of care. Documenting when a child no longer meets the criteria for ODD, due to symptoms being better explained by a different diagnosis or precipitating circumstance, further mitigates bias.
- Clinical activism[14]: Pediatric clinicians extend advocacy beyond health care by redirecting psychoeducational measures toward school administrators, police officers, and court representatives and shifting antiracist documentation strategies from medical charts toward school letters and court reports. This clinical activism highlights the school-to-prison trajectory's detriment and reconfigures oppositional behavior as adaptive, rather than problematic, in the face of racism.

AN ANTIRACIST APPROACH TO ODD: NEXT STEPS

A color-blind[49] approach to ODD uses a race-neutral orientation to minimize racism's formative role in shaping children's behavior and adult authority figures' responses to it.[14,15] This antiracist approach, by contrast, centers racism to protect racially minoritized children from its harm. Illuminating history and systems of oppression, rehumanizing children against bias and degradation, and pathologizing structural violence, not individuals' adaptive responses to it, are its cornerstones.[16,17]

ODD is an example of diagnostic condemnation whereby clinicians can indict racially minoritized children instead of standing up against injustice in their defense. Other forms include the overdiagnosis of psychotic and disruptive disorders.[2,50] They function as a unique form of race-based medicine[51] whereby race is an unnamed diagnostic variable. More research is needed about ODD's impact when the diagnosis does not contextualize symptoms amid racism or becomes punitive when lacking diagnostic reliability, as depicted in the 2 cases (Tables 2 and 3). Exploring this issue might illuminate whether this diagnosis should exist at all. In the meantime, this antiracist approach insists there are no "bad kids" and upholds our oath to protect them all.

ABBREVIATIONS

ED: emergency department
EMT: emergency medical technician
ODD: oppositional defiant disorder

ACKNOWLEDGMENTS

Dr Legha acknowledges Ms Akima Aiken Brown, who read, revised, and provided feedback for the initial and first revision of this paper. Without her support, this paper would not have been possible. Dr Legha acknowledges Dr Nathalie Martinek, who expertly reviewed and provided feedback for the first revision of this paper.

REFERENCES

1. American Psychiatric Association. Oppositional defiant disorder. In *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)*. American Psychiatric Association; 2022:522–523.
2. Fadus MC, Ginsburg KR, Sobowale K, et al. Unconscious bias and the diagnosis of disruptive behavior disorders and ADHD in African American and Hispanic youth. *Acad Psychiatry.* 2020;44(1):95–102. PubMed doi: 10.1007/s40596-019-01127-6
3. Ballentine KL. Understanding racial differences in diagnosing ODD versus ADHD using critical race theory. *Fam Soc.* 2019;100(3):282–292. doi: 10.1177/1044389419842765
4. Beals J, Piasecki J, Nelson S, et al. Psychiatric disorder among American Indian adolescents: prevalence in Northern Plains youth. *J Am Acad Child Adolesc Psychiatry.* 1997;36(9):1252–1259. PubMed doi: 10.1097/00004583-199709000-00018
5. Shalaby N, Sengupta S, Williams JB. Large-scale analysis reveals racial disparities in the prevalence of ADHD and conduct disorders. *Sci Rep.* 2024;14(1):25123. PubMed doi: 10.1038/s41598-024-75954-5
6. Keil V, Price J. Externalizing behavior disorders in child welfare settings: definition, prevalence, and implications for assessment and treatment. *Child Youth Serv Rev.* 2006;28(7):761–779. doi: 10.1016/j.childyouth.2005.08.006
7. Burke JD, Mulvey EP, Schubert CA. Prevalence of mental health problems and service use among first-time juvenile offenders. *J Child Fam Stud.* 2015;24(12):3774–3781. PubMed doi: 10.1007/s10826-015-0185-8
8. Clarke J, Van Ameron G. Parents whose children have oppositional defiant disorder talk to one another on the internet. *Child Adolesc Social Work J.* 2015;32(4):341–350. doi: 10.1007/s10560-015-0377-5
9. Szentiványi D, Balázs J. Quality of life in children and adolescents with symptoms or diagnosis of conduct disorder or oppositional defiant disorder. *Ment Health Prev.* 2018;10:1–8. doi: 10.1016/j.mhp.2018.02.001
10. Okonofua JA, Walton GM, Eberhardt JL. A vicious cycle. *Perspect Psychol Sci.* 2016;11(3):381–398. PubMed doi: 10.1177/1745691616635592
11. Steiner H, Remsing L; Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. *J Am Acad Child Adolesc Psychiatry.* 2007;46(1):126–141. PubMed doi: 10.1097/01.chi.0000246060.62706.af
12. Riley M, Ahmed S, Locke A. Common questions about oppositional defiant disorder. *Am Fam Physician.* 2016;93(7):586–591. PubMed
13. Legha RK, Martinek NN. No more building resiliency: confronting American psychology's white supremacist past to reimagine its antiracist future. *Rev Gen Psychol.* 2023;27(4):410–425. doi: 10.1177/10892680231155132
14. Legha RK, Gordon-Achebe K. The color of child protection in America: antiracism and abolition in child mental health. *Child Adolesc Psychiatr Clin N Am.* 2022;31(4):693–718. PubMed doi: 10.1016/j.chc.2022.05.004
15. Legha RK, Clayton A, Yuen L, Gordon-Achebe K. Nurturing children's mental health body and soul: confronting American child psychiatry's racist past to reimagine its antiracist future. *Child Adolesc Psychiatr Clin N Am.* 2022;31(2):277–294. PubMed doi: 10.1016/j.chc.2021.11.006
16. Willoughby CD. Running away from drapetomania: Samuel A. Cartwright, medicine, and race in the Antebellum South. *J South Hist.* 2018;84(3):579–614. doi: 10.1353/soh.2018.0164
17. Bromberg W, Simon F. The "protest" psychosis. A special type of reactive psychosis. *Arch Gen Psychiatry.* 1968;19(2):155–160. PubMed doi: 10.1001/archpsyc.1968.01740080027005
18. Grier WH, Cobbs PM, Harris FR. *Black Rage*. Basic Books; 1968.
19. Aiello M, Bismar D, Casanova S, et al Protecting and defending our people: nakni tushka anowa (the warrior's path) final report. APA Division 45 Warrior's Path Presidential Task Force (2020). *J Indig Res.* 2021;9(2021):Article 8. doi: 10.26077/2en0-6610
20. Novak NL, Lira N, O'Connor KE, Harlow SD, Kardia SLR, Stern AM. Disproportionate sterilization of Latinos under California's eugenic sterilization program, 1920–1945. *Am J Public Health.* 2018;108(5):611–613. PubMed doi: 10.2105/AJPH.2018.304369
21. Roberts D. *Killing the Black Body.* Vintage Books; 2000.
22. Black E. *War Against the Weak: Eugenics and America's Campaign to Create a Master Race*. Thunder's Mouth Press; 2004.
23. Halberstadt AG, Castro VL, Chu Q, Lozada FT, Sims CM. Preservice teachers' racialized emotion recognition, anger bias, and hostility attributions. *Contemp Educ Psychol.* 2018;54:125–138. doi: 10.1016/j.cedpsych.2018.06.004
24. Cooke AN, Halberstadt AG. Adultification, anger bias, and adults' different perceptions of Black and white children. *Cogn Emot.* 2021;35(7):1416–1422. PubMed doi: 10.1080/02699931.2021.1950127
25. Epstein R, Blake J, González T. Girlhood interrupted: the erasure of Black girls' childhood. *SSRN.* 2017. doi: 10.2139/ssrn.3000695
26. Goyal MK, Kuppermann N, Cleary SD, Teach SJ, Chamberlain JM. Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatr.* 2015;169(11):996–1002. PubMed doi: 10.1001/jamapediatrics.2015.1915

27. Skiba RJ, Arredondo MI, Williams NT. More than a metaphor: the contribution of exclusionary discipline to a school-to-prison pipeline. *Equity Excell Educ.* 2014;47(4):546–564. doi: 10.1080/10665684.2014.958965

28. McCombs J, Scott C, Losen DJ. *Pushed out: trends and disparities in out-of-school suspension*. Learning Policy Institute. Published September 30, 2022. Accessed November 5, 2024. https://learningpolicyinstitute.org/product/crdc-school-suspension-report

29. United States Government Accountability Office. Nationally Black girls receive more frequent and more severe discipline in school than other girls. Published September 2024. Accessed November 5, 2024. https://pressley.house.gov/wp-content/uploads/2024/09/GAO-Final-Report.pdf

30. Crenshaw KW, Ocen P, Nanda J. *Black girls matter: pushed out, overpoliced and underprotected*. Columbia Law School; 2015. Accessed November 5, 2024. https://scholarship.law.columbia.edu/faculty_scholarship/3227

31. Skiba RJ, Mediratta K, Rausch MK, eds. *Inequality in School Discipline: Research and Practice to Reduce Disparities*. Springer; 2016.

32. Snapp SD, Hoenig JM, Fields A, Russell ST. Messy, butch, and queer: LGBTQ youth and the school-to-prison pipeline. *J Adolesc Res.* 2015;30(1):57–82. doi: 10.1177/0743558414557625

33. Pasko L.Straight and narrow: girls, sexualities, and the youth justice system. In: Cox A, Abrams LS, eds. *The Palgrave International Handbook of Youth Imprisonment*. Palgrave Studies in Prisons and Penology. Palgrave Macmillan; 2021. doi: 10.1007/978-3-030-68759-5_13

34. Demmer DH, Hooley M, Sheen J, McGillivray JA, Lum JA. Sex differences in the prevalence of oppositional defiant disorder during middle childhood: a meta-analysis. *J Abnorm Child Psychol*. 2017;45(2):313–325. PubMed doi: 10.1007/s10802-016-0170-8

35. Gadow KD, Devincent CJ, Drabick DA. Oppositional defiant disorder as a clinical phenotype in children with autism spectrum disorder. *J Autism Dev Disord*. 2008;38(7):1302–1310. PubMed doi: 10.1007/s10803-007-0516-8

36. Leibenluft E, Allen LE, Althoff RR, et al. Irritability in youths: a critical integrative review. *Am J Psychiatry*. 2024;181(4):275–290. PubMed doi: 10.1176/appi.ajp.20230256

37. O'Donnell HC, Kaushal R, Barrón Y, Callahan MA, Adelman RD, Siegler EL. Physicians' attitudes towards copy and pasting in electronic note writing. *J Gen Intern Med*. 2009;24(1):63–68. PubMed doi: 10.1007/s11606-008-0843-2

38. Jackson DB, Fahmy C, Vaughn MG, Testa A. Police stops among at-risk youth: repercussions for mental health. *J Adol Health*. 2019;65(5):627–632.

39. Puzzanchera CM, Hockenberry S, Sickmund M. *Youth and the Juvenile Justice System: 2022 National Report*. National Center for Juvenile Justice; 2022.

40. Trent M, Dooley DG, Dougé J, et al; Section on Adolescent Health; Council on Community Pediatrics; Committee on Adolescence. The impact of racism on child and adolescent health. *Pediatrics*. 2019;144(2):e20191765. PubMed doi: 10.1542/peds.2019-1765

41. Mpofu JJ, Cooper AC, Ashley C, et al. Perceived racism and demographic, mental health, and behavioral characteristics among high school students during the COVID-19 pandemic—adolescent behaviors and experiences survey, United States, January-June 2021. *MMWR Suppl*. 2022;71(3):22–27. PubMed doi: 10.15585/mmwr.su7103a4

42. Pachter LM, Coll CG. Racism and child health: a review of the literature and future directions. *J Dev Behav Pediatr*. 2009;30(3):255–263. PubMed doi: 10.1097/DBP.0b013e3181a7ed5a

43. Mereish EH, Parra LA, Watson RJ, Fish JN. Subtle and intersectional minority stress and depressive symptoms among sexual and gender minority adolescents of color: mediating role of self-esteem and sense of mastery. *Prev Sci*. 2022;23(1):142–153. PubMed doi: 10.1007/s11121-021-01294-9

44. Green AE, Price MN, Dorison SH. Cumulative minority stress and suicide risk among LGBTQ youth. *Am J Community Psychol*. 2022;69(1–2):157–168. PubMed doi: 10.1002/ajcp.12553

45. Ramey DM. The social structure of criminalized and medicalized school discipline. *Sociol Educ*. 2015;88(3):181–201. doi: 10.1177/0038040715587114

46. Nash KA, Tolliver DG, Taylor RA, et al. Racial and ethnic disparities in physical restraint use for pediatric patients in the emergency department. *JAMA Pediatr*. 2021;175(12):1283–1285. PubMed doi: 10.1001/jamapediatrics.2021.3348

47. Piquero AR. Disproportionate minority contact. *Future Child*. 2008;18(2):59–79. PubMed doi: 10.1353/foc.0.0013

48. Sun M, Oliwa T, Peek ME, Tung EL. Negative patient descriptors: documenting racial bias in the electronic health record. *Health Aff (Millwood)*. 2022;41(2):203–211. PubMed doi: 10.1377/hlthaff.2021.01423

49. Bonilla-Silva E. *Racism Without Racists: Color-Blind Racism and the Persistence of Racial Inequality in America*. Rowman & Littlefield Publishers; 2003.

50. Muroff J, Edelsohn GA, Joe S, Ford BC. The role of race in diagnostic and disposition decision making in a pediatric psychiatric emergency service. *Gen Hosp Psychiatry*. 2008;30(3):269–276. PubMed doi: 10.1016/j.genhosppsych.2008.01.003

51. Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. *Lancet*. 2020;396(10257):1125–1128. PubMed doi: 10.1016/S0140-6736(20)32076-6