

THE EFFECT OF ADHD DIAGNOSIS ON INDIVIDUAL IDENTITY FORMATION

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## **I. Introduction**

### *Abstract*

Identity formation and the narratives we construct about who we are, why we perceive the world around us the way we do, and the lens through which we interpret our environment are all life long processes that are formed as we encounter experiences that shape us into the person that we have been, are, and will be. Categorization processes, including the diagnostic process, have a dramatic effect on how we perceive ourselves, as they define and associate us within broader social groups that we use to relate to and identify ourselves. Diagnoses shape our identities through a variety of mechanisms, including stigma, illness narratives, illness stereotypes, social factors, and institutions, and how we perceive our diagnoses has a dramatic impact on how we view ourselves. Mental health diagnoses have a particular impact on individual identity formation, as we view the mind as central to our individual identity. While identity is a well studied phenomenon, Attention Deficit Hyperactivity Disorder, or ADHD, is a fairly new diagnostic label. Not much literature has been dedicated to studying how the ADHD diagnosis affects the individual's identity formation. Thus, my thesis enhances current research by describing the processes through which we form our identities, how we make sense of diagnoses, and the structures that form diagnoses in order to answer how ADHD diagnosis affects individual identity formation. After discussing the processes through which ADHD diagnosis is interpreted by the individual, my thesis discusses how to improve the diagnostic process and the ADHD label in hopes that refinement of these processes will benefit the individual. Study of how mental health and chronic diagnoses affect identity formation are essential for moral and social understanding of our diagnostic and social structures, as we should know how the diagnostic categories we create affect what it means to be us.

## II. Identity and Identity Formation

### *Introduction*

In answering the question of how ADHD diagnosis affects individual identity formation, we must first define identity and identity formation. Identity processes determine how the individual interprets their illness, experience their diagnosis, and are ultimately affected by their diagnostic label. In this chapter, I explain how identity is defined and formed, along with why identity breakdown is an important step in the process of creating a mature identity. This chapter will establish key information necessary in explaining how individual identity is impacted by ADHD diagnosis.

### *Definition of Identity*

The term ‘identity’ is complex and signifies a variety of meanings depending on the discipline studying it. Identity has been discussed for centuries, with competing theoretical frameworks used to understand identity and the identity formation process. While identity once was referred to as how one *perceives* themselves, current philosophy characterizes identity as how the individual *defines* himself and their character (Fearon). Therefore, identity can be described not only as an individual’s perception of who they are and how they interact with others, but also something that provides definition and distinguishment from a collective (Hogg and Abrams 1988, Jenkins, 1996). According to Wendt, identities are “relatively stable, role-specific understandings and expectations about self” (Wendt 1992). Because identity is used by the individual to define themselves, identity describes “aspect[s] of ourselves that [are], in some way, important to us” (Fearon). Identities are constructed so that we can make sense of ourselves and our lives. Identity sense-making is done through “ontological narratives”, which are “social and interpersonal stories about who we are”, created by drawing “on public narratives, narratives attached to institutions, and networks” (Barker). Identities can situate the individual within a collective framework like diagnosis.

Specifically, illness identities consist of “understanding[s] of self, and affiliation[s] with others, on the basis of shared experiences of symptoms and suffering” (Barker).

Considering that this thesis discusses identity within the context of a social category, or the diagnosis, and the individual, or the patient, it is important to discuss identity in the two different contexts. The term “identity” can be social or personal, with “social identity” referring to membership in a broader social category and “personal identity” concerning unique, unchangeable characteristics that the individual assigns significance to (Fearon). Identity can signify the social categories to which an individual belongs to and/or but also the origin of an individual’s self-worth and status (Fearon). Within the context of this thesis, I will be discussing the effect social categorization through diagnosis on personal identity. I argue that the social identity that the ADHD diagnosis provides the individual has a considerable effect on their personal identity. I argue that the ADHD diagnostic category is bound to an individual’s self-efficacy and dignity.

#### *Definition of Identity Formation*

Similarly, individual identity formation is a complex process informed by social structures and interpersonal interactions. Multiple frameworks have theorized how individual identity formation occurs. For the purpose of this thesis, I will use the identity theory and the social identity theory to explain how individual identity formation is theorized. Identity theory attempts to answer how individuals organize an identity, act in accordance with their constructed identity, and respond to “identity-relevant feedback” (Burke and Stets 2009). According to identity theory, identity refers to the internalized meanings that individuals subscribe to, either as an individual, in performing a role, or as a member of a group (Burke and Stets 2009). Thus, personal identity, role identity, and group identity make up the three “bases” of identity theory (Davis). According to the identity theory framework, an individual has multiple identities which are organized according to importance, with some identities

being more salient than others (Davis). Because some identities are considered more prominent than others, the individual is more likely to react to situations with the more salient identities and consider certain identities to better describe the individual's true self (Davis).

Conversely, social identity theory refers to how intergroup and intrapersonal dynamics affect the identity formation process (Abrams and Hogg 2004). Within a social identity, the individual takes into account "the perspective of others", thus acting as a "social object" who functions according to social expectations (Wendt 1994). Social identity is contained through social categories, which define and group individuals according to "rules of membership" and "sets of characteristics" (Fearon). When these rules are contested and social categories are scrutinized, a phenomenon known as 'identity politics' ensues.

Within these theoretical perspectives are micro and macro social identities that inform identity formation, like role identities and personal identity. Role identities are "labels applied to people who are expected or obligated to perform some set of actions, behaviors, routines, or functions" (Fearon). For example, an individual diagnosed with ADHD might be expected to act according to ADHD diagnostic criteria, such as hyperactive behavior or inattention. Conversely, personal identity consists of essential characteristics that, if changed, would mean that the person is no longer the same individual. For example, an individual suffering from advanced Alzheimer's would have lost essential qualities that defined the individual, both for the individual and for the community surrounding the individual.

Personal identity in particular has been referred to as an individual's dignity or honor, as the individual feels that they cannot change fundamental characteristics about themselves even if they wanted (Fearon).

### *Identity Breakdown*

Now that we have discussed identity and identity formation, let us explore identity breakdown, also known as 'identity crisis'. According to Erikson, identity crisis involves

uncertainty surrounding self-perception, “especially with regard to character, goals, and origins” and especially occurring “under disruptive, fast-changing conditions” such as adolescence (Fearon). For many, identity is synonymous with an individual’s dignity or honor, meaning a loss of identity entails a loss of self-respect (Fearon). This thesis discusses identity mostly within the context of identity crisis, as a diagnosis can be seen by many to be incredibly disruptive.

In the crisis, or exploration, phase of identity formation, the adolescent must “actively examine developmental opportunities and identity issues” (Hosek). Chronic mental health conditions such as ADHD often lead to feelings of inadequacy in adolescents which research shows “negative effects on developmental issues during adolescence”, specifically in regards to their lack of identity exploration (Hosek). Through identity breakdown, mature identity formation arises. According to Brown, “chronic illness forces people to come to new terms with the experience of time and change in their relation to past, present, and future”, with individuals with diverse worldviews framing their identity reconstruction in distinct ways (Brown). For example, those who experience a chronic mental illness diagnosis as “overwhelming, unpredictable, and uncontrollable” will encounter greater identity disruption (Brown).

### **III. Social Processes in Diagnosis**

#### *Introduction*

Particular attention is paid in this chapter to the role of social factors in the diagnostic process and how chronic mental illness specifically affects diagnosis. Below, I outline how mechanisms such as collective illness identity, medicalization, stigma, illness stereotypes, and perceived abilities affect a person’s illness experience. After I define each of the social processes described, I explain how social factors tangibly influence the diagnosis process. Definition of the social mechanisms in diagnosis is important in situating the individual in the



diagnostic sense making process and understanding how diagnosis affects individual identity formation.

*Definition of a Collective Illness Identity*

Arguably the most macrosocial effect of diagnosis is a collective illness identity, which is formed through other social consequences of diagnosis such as stigma and individual identity. Sometimes, individuals come together as a collective to form an illness identity in order to advocate for legitimacy and recognition. This phenomena is referred to as collective identity formation, in which “the social practices through which identities-- shared characteristics (boundaries) that mark *us* from *them*-- come to be constituted” (Barker). This collective illness identity is used by individuals to construct their individual identity, as “people construct a sense of themselves and of themselves in relation to others by situating themselves in public narratives to which they have access” (Barker). For example, Conrad and Potter (2000) cite the ADHD support community and self help books as a catalyst for adult ADHD acceptance within the general public (Barker).

The collective illness identity is first formed after receiving a medical diagnosis, then evolves as individuals “learn how to accommodate diagnoses into their identities” (Beard). Collective illness identity involves social constructionism, which states that individuals form understandings of concepts through social contexts (Brown). Social constructionism and collective illness identity are important sociological phenomena to include in the discussion of individual identity formation, otherwise discussion of the meaning-making that happens with diagnosis would be too narrowly focused. Social constructionism helps illuminate “how health and illness are rife with biased definitions and forms of social control” and lets us “learn about experience of illness and clinical interaction” as “social structures of society play key roles in health and illness” as dynamic and active agents (Brown). Social constructionism illuminates phenomena such as medicalization, and begs the question of

whether “social problems [are] objectively real” or rather the creation through “purposive action by social labelers and problem finders” (Brown). Medical sociology involves the labeling of behaviors and helps us to make sense of health at a microlevel, which involves “self-awareness, individual action, and interpersonal communication” (Brown).

### *The Role of Medicalization*

Social factors influencing diagnosis include medicalization, which is “when non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad). While some say medicalization helps to standardize the experience of individuals so they fit into society and can act as a functional member of society, others say that medicalization leads to a pathologization of everyday living.

Diagnosis can serve as “an important foundation for some forms of medicalisation” because diagnosis provides “a label to which medicine can anchor its authority, and around which it can express its concern and set its agendas” (Jutel). Thus, diagnoses are analytical tools that can be “deconstructed to reveal their social content” along with “the way classifications and labels are constructed, framed and enacted” (Jutel).

Furthermore, when problems are defined as medical, “the medical profession--with its prestige and connection to science--is then its sole proprietor: it effectively removes the problem from public debate and places it on a platform from which only medical experts can discuss it” (Rossi). Thus, the medical field is able to also define a problem’s treatment and prognosis, which “masks the true nature of the diagnosis by detaching it from judgments of moral defect” which allows for “social control masquerade[d] as a humanitarian effort” through “rehabilitation” (Rossi). Medicalization involves social control through language, “since giving the name [to a problem] has often been the starting point for social labelers” which diagnosis being the “language of medicine” (Brown). Medicalization is threatening because “diagnosis locates the parameters of normality and abnormality... and authorizes

medicine to label and deal with people on behalf of society at large” (Brown). Thus ensues the political turf war between those who wish not to be labeled as deviant and those who want their condition, and by themselves, to be legitimized by a diagnostic label.

### *The Role of Stigma*

Stigma, or negative beliefs against a group based on defining characteristics, also plays a role in diagnostic labeling (Corrigan). Stigma can result from outsiders or from the self, with some negative attitudes resulting in discrimination against those with a mental health diagnosis. Categories and labels also affect the stigma that individuals face when handling a diagnosis. For example, phrases such as “in remission” might make the individual feel forever bound to their diagnosis. This permanent linkage “may cause the individual to internalize pathology”, with “the language of the diagnosis” potentially affecting “self-perception in sensitive souls for a lifetime” (Gesicki et. al). This pathology can include the idea that the individual is a *patient* to be managed rather than an individual with a *disorder* to be treated.

Furthermore, these categories do more than just label the individual; they act as “representational systems of meaning that are recognized by wide segments of a society” (Tajfel and Turner 1979). Given that mental health disorders do not have observable characteristics or definitive markers, mental health stigma is much more common than stigma for physical impairments. Stigma is important to discuss in the context of identity formation, for how one interprets their diagnosis affects their health and their ability to thrive. However, though ADHD diagnoses can be stigmatizing because so many question the legitimacy of the condition, “it cannot be assumed... that [this] psychiatric diagnosis is stigmatising and/or unwanted, since both professionals and laypeople often embrace and seek it out” (Berger). While some people may find their diagnosis to be limiting, others find that diagnoses provide access to resources that can substantially improve their self perception, efficacy, and esteem.

When I set out to understand how diagnoses affect the individual, I thought that I would find criticisms of the diagnostic process and individual disdain of their diagnosis due to increased stigma towards mental health diagnoses. However, I was surprised to find that for many, diagnosis “may have profound consequences for their sense of self and their social identity” (Berger). While stigma has an effect on the way you handle your label, access to high quality services can improve your perception of your mental health condition.

### *Definition of Illness Stereotypes*

Illness stereotypes are social understandings of diseases. Illness stereotypes influence the patient’s reporting of symptoms and can interfere with the diagnostic process through biasing of symptom reporting. Diagnosis tends to follow an individual throughout their lifetime, with different diagnoses bearing different stereotypes. This in turn affects the individual’s diagnostic experience, as illness stereotypes cause “people [to] act on the basis of meanings... derive[d] from social interaction” rather than through experience (Blumer, 1969). Diagnoses affect the individual initially often through defensive processes because a diagnosis can be seen as a threat to an individual’s core identity (Croyle et al.). Individuals also tend to perceive their own diagnoses as differently than other people, as we tend to interpret our health issues more favorably than other health problems “because individuals are motivated to maintain a positive self image” (Jemmott et al.). Therefore, individuals might embrace or reject certain diagnoses based on how they view the diagnosis’ ability to enhance their own self image. “Beliefs about a group of individuals who have a certain disease” can be referred to as illness stereotypes, and they can influence individual behavior so they fit a certain mold or to avoid fitting an illness stereotype (Croyle et al.).

### *How Illness Stereotypes Influence ADHD Diagnosis*

The biases and beliefs that accompany illness stereotypes can lead the patient to change their behavior in order to produce a different diagnosis from the clinician. Thus,

illness stereotypes can lead individuals to perform in a way that they believe to be in conjunction with those who have been diagnosed with ADHD. This might cause clinicians to run unnecessary tests and suggest ineffective treatment plans for the individual. However, the fact that diagnoses can be seen as a threat to the patient points towards diagnoses are “an unrecognized socio-political phenomena” because discussion of the diagnostic process includes “more than just labeling and classification”, but also analysis of “professional authority, disease history, medicalization, diagnostic processes, [and] power” (Jutel). Illness stereotyping can be a huge problem manifested in misdiagnosis of the individual, potentially for their entire lifetime. Thus, mental health stigma and illness stereotyping is a threat to the diagnostic process, as it can lead to inaccurate “changes in perception that become part of a process of understanding oneself” (Nielsen, 906). In other words, illness stereotypes have the potential to change the diagnostic label assigned to an individual which deprives the individual of self actualization.

#### *Perceived Abilities and Limitations*

Just as mental health diagnosis affects individual identity formation, it also affects how competent individuals believe themselves to be. This phenomenon can be referred to as “the sick role”, in which an individual is allowed the privileges of a sick person, such as being liberated by the obligations of a healthy person, in the expectation that they take an active role in becoming healthy again. The diagnostic process both allows patients to perform the sick role, through accepting their diagnosis, while also postulating that the individual has a moral responsibility to experiment with their identity formation when playing out their sick role. Because diagnosis can provoke individuals to lose agency by performing the sick role, some believe that we should concentrate on managing behavior, finding “stimuli that provoke [disturbances]”, and recommending lifestyle changes that break the associations that cause the problems” instead of treating mental illness as a medical problem that needs to be

classified and cured (Strand). Some argue that the language used to describe individuals with a mental health diagnosis can greatly affect how the individual perceives themselves and their abilities. For example, referring to an individual as “schizophrenic” versus “having schizophrenia” reflect two different points of view as “in the first, the patient is coupled to a diseased identity-type; in the second, the disease is an object definable on its own, which the patient possesses” (Strand). In other words, one diagnostic label “is detachable from [the individual] and not implicated in all of [their] behavior, like a broken leg” (Strand). While diagnostic labeling operates by *explaining* behavior “rather than indicat[ing] culpability [for] not attaining some optimum level of functioning”, patient behavior is also identified as “pathological” through the diagnostic process (Strand).

#### *How Social Factors Influence Diagnosis*

While diagnosis is defined by an act of classification, it is better understood as “the end result of a longer series of events, as well as the beginning of an entirely new one”, as the diagnostic process does not take place “in a social vacuum, but within the matrix of social institutions and practices that surround the classification”, which “demands an understanding of diagnosis as the node in a broader network through which several actors--children, parents, doctors, schools, clinics, laws, the state, treatment therapies, etc.--intersect” (Rossi). Thus, it is important to understand how a diagnosis is conceptualized, how it is talked about, and what kind of object it is besides a focus on observable information.

While some individuals seek diagnosis, others find themselves in the doctor's office due to social concern, employment obligation, or a myriad of other circumstances. According to prototype theory, individuals more and more recognize prototypes of illness rather than recognizing symptoms consistent with a diagnosis (Rossi). In other words, prototype theory involves “categorization whereby an object is classified not by whether or not it meets certain criteria but whether it resembles the best example... of that classification” (Rossi). Therefore,

stereotypes of diagnoses become the metric by which outsiders determine whether an individual has an illness. A common example of this happens in the classroom, when teachers see disruptive behavior in a child and voice concerns to parents that the child might have ADHD when the child might actually be presenting symptomatology of anxiety.

Rossi, who conducted primary research at a diagnostic clinic for 1.5 years in studying diagnosis, explains that when he “pressed clinicians to help [him] understand how they arrived at a diagnosis for a particular patient, they would start to list observables... but often ended with an explanation resting on their own clinical intuition, more of the ‘pattern recognition’ or ‘gut instinct’ type of comments” (Rossi). He further notes that clinicians can change coding sections if the diagnosis result isn’t to their liking once it becomes obvious whether a score will change the resulting diagnosis. While he does not argue that clinicians ““fix” the scores intentionally”, he does suggest that “there is space for one’s “sense”” that clinicians can and “do indeed make use of” when diagnosing (Rossi). Clinical intuition and experience-driven decisions are possible through the use of prototypes, which affect individuals based on other social factors explained further down below.

Studies demonstrate that socio-demographic factors such as a patients’ race, employment status, or income often influence the doctor’s interpretation of symptoms and diagnosis. However, patients themselves often rely on “culturally prescribed models”, thus perceiv[ing] their illness, “interpret[ing symptoms] and respond to conditions based on their social and economic circumstances, personal biographies, health beliefs, [and] self-concepts” which in turn “define[s] and structure[s] the future of their illness experience” (Gill, Blumer). These cultural narratives create groups and culture spreads social values that affect how we act and how we think about ourselves and the way we act. For example, American emphasis on individualism might lead to under-diagnosis as people refrain from seeking help. Changing cultural narratives is possible, yet many times contested as narratives “need to be

defended and legitimized”, which “require[s] reason, talk, policy and role models” along with “conflict and confrontation” (Kuipers).

As the role of diagnosis within the practice of the modern mental health field has evolved, so too “has the play of social, political, technological, cultural and economic forces which impinge upon diagnostic categories and diagnostic processes” (Jutel). Diagnosis is a socio-political process, especially now that patients bring more information into the sense-making process. External, social factors which help shape the diagnostic structure along with the diagnostic process include culture, language, and education. While diagnosis and identity are two separate entities, they are “contingent upon and given shape by the cultural context” (Jutel). Furthermore, classification is a privileged structure that favors individuals who have access to resources that the system requires such as time, money, knowledge, and energy. “Diagnosis can provide a means for understanding forms of knowledge, social structures, relationships and actions”, making the examination of social factors crucial to understanding how diagnosis affects individual identity formation (Jutel).

#### **IV. Diagnosis and the DSM**

##### *Introduction*

So far, we have discussed identity formation and broader social processes involved in diagnosis. Now, we must discuss the definitional and structural components of diagnosis to understand how diagnoses are formed today and how the structure of mental health care impacts individual diagnosis. In this chapter, I define diagnosis along with the DSM, or Diagnostic and Statistical Manual of Mental Disorders, who creates mental health diagnosis. After discussing the history of the DSM, I will discuss how diagnoses are formed today and how the mental health structure impacts diagnostic processes. Though much of the theoretical, sociological, and psychological discussion of diagnosis and individual identity formation can be applied to diagnosis in general, this chapter focuses on discussing mental



health diagnosis in particular. This chapter will help the reader understand key concepts important in discussing how ADHD affects individual identity formation.

### *Definition of Diagnosis*

In order to answer how diagnosis affects individual identity, we must first establish what diagnosis is, how mental health categories are formed, and how mental health's history has shaped today's patient identity. As more questions and problems arise within the diagnostic process, it becomes easier for people to question how the structures that govern diagnosis within the mental health field came to be. Discussion of the socio-political role of mental health diagnosis in modern American society helps us to understand how we communicate and understand mental illness. This discussion thus enables clinicians to better treat mental illness, legislators to create efficacious policy, and social networks to provide better support for those with a mental health diagnosis. Research on the role of mental health diagnosis helps "bridge the theory-practice divide, providing clinicians and lay people with different perspectives from which to examine the challenges facing the sick, the healthy, and the clinician" (Jutel).

Diagnosis provides explanation and with it, clarity. With diagnosis, "things [do] not necessarily get better, but they become clearer" as "the unexplained becomes explained, and management is defined" (Nielsen). Diagnosis is a tool that allows patients to ground their subjective experiences in an objective standardised way. Diagnosis gives "a language with which to express and understand themselves" (Rossi). Diagnoses also help medical professionals "interpret [ patient symptoms] in order to arrive at an "organized illness" and determine the course of treatment for the individual (Brown). For patients who don't have an explanation for their symptomatology, diagnostic categorization can be a relief, providing closure and "offer[ing] a prediction about the future course of illness, or about the genetic or infectious risk to others" (Chiong).

Not only is diagnosis a process, but diagnoses themselves are malleable. While mental health diagnoses are standardised through the Diagnostic and Statistical Manual of Mental Disorders, diagnostic criteria and definitions evolve as experts understand more about the phenomena that they are diagnosing. Diagnosis is both a categorical event that provides definitions and a process which is implemented in the doctor-patient relationship which “categorises health realities in tangible ways, determining who has access to what resources, under whose jurisdiction the management of the condition will fall, and what the individual’s experience now means in terms of identity and prognosis” (Jutel).

Some question whether diagnoses should be viewed so objectively given their malleable nature. Nielsen, a leading researcher in diagnostic practices and medical anthropology, reports that her patients “use the ADHD diagnosis as a solidifying, structuring element in a chaotic world” because diagnosis helps name and frame their lived experience (Nielsen). The classification that accompanies diagnosis serves an important organizational role within society “as it provides access to services and therapies” for those who obtain the diagnostic label (Jutel).

Furthermore, diagnosis “shape[s] an experience of illness”, portraying the disease according to those with privilege and silencing others (Jutel). Diagnoses do not affect the individual just within the context of the doctor-patient relationship, but also affect the individual’s daily life. Many times, a mental health diagnosis follows the individual for their entire lifetime. Some classify diagnosis as a social practice in which abnormal behaviors are corrected and good behaviors are cultivated by the diagnostic framework. Nevertheless, diagnosis has a multifaceted effect on an individual’s life, with recorded diagnosis potentially affecting aspects such as “academic placement, potential employment opportunities, and standing in the community or legal system” (Washburn).

While illness experience has been widely studied by medical sociologists, psychologists, and researchers alike, diagnosis has not. This may be because diagnosis is widely intersectional and multidisciplinary, making the process hard to define “where medical professionals and other parties determine the existence and legitimacy of a condition” in this “politics of definitions”, whereby “illness designations are created from social conflict” (Brown). The impact that diagnosis makes in providing social legitimacy to a patient cannot be understated, as the experience of an illness is often perceived as much more subjective and at times less reliable than the diagnostic framework itself.

### *History of the Mental Health Profession*

In treating, talking about, and diagnosing patients, different mental health fields think about the same medical problem in very different ways, sometimes referring to the same phenomena using different terms. For example, the definition of what a diagnosis is, and how it functions, depends on each discipline’s perspective. The lack of coordination between the professions was a major problem in the 1960s, when the American Psychological Association (APA) was juggling the ideological differences between social, biological, and psychoanalytical psychologists, social workers. While some wanted to demedicalize the psychiatric field, others wanted psychiatry to become more scientific and there was “little communication occurred between or among the various groups”, which led to “massive public confusion about the differences” among the different mental health professions (Sabshin 1990, p. 1270). Thus, the formation of creating a diagnostic manual “seemed more appropriate to the encounter of political rivals than to the orderly pursuit of scientific knowledge” according to Robert Spitzer, head of the DSM-III Task Force on Nomenclature and Statistics (Strand). However, the manual steered clear of the etiology, or origin, of mental illness, as they were “reluctant to speculate on the origins of the symptoms they classified” (Strand). This was to eliminate confusion and standardize the practice of psychiatry as much

as possible. According to the Vice Chair of the DSM-5 Task Force, Darrel Regier, “what's most important is whether or not... the DSM will really help clinicians and researchers think more clearly about mental disorders and give us a common language that can help our field continue to develop and evolve” (Regier). However, “20th century classifications [have] become increasingly fuzzy” compared to 18th century diagnosis, whose classification “rested on symptom-based taxonomies, wherein there was a correspondence between the symptom and the disease” (Jutel).

### *Definition of the DSM*

The DSM, or Diagnostic and Statistical Manual of Mental Disorders, is important not only as a diagnostic tool, but also a standardization tool within the fields of psychiatry, psychology, and social work. This manual revolutionized mental health diagnosis and treatment because it allowed practitioners to classify conditions across disciplines. Before the DSM, the dominant treatment for mental illness was psychoanalysis. Psychoanalysis allowed for psychiatrists to be selective about their patients and have an autonomy domain that led them to be more isolated and seen as experts. However, with classification came “consensus on meaning, which in turn synchronizes action across several different domains” (Strand). Classification allowed practitioners to define and organize diagnoses in relation to other diagnoses, as well as marking certain conditions so that the public can recognize them. By marking certain conditions, classification places meaning on diagnoses in a systematic way, “furnishing the concepts that allow different people to have similar perceptions” (Strand).

The first version of the DSM was published in 1980 and entailed the first comprehensive classification of mental illness which “revolutionized both the practice of psychiatry and subsequent views of mental disorder” (Strand). While the primary reasons for the first DSM’s creation included “diagnostic specificity useful for insurance companies seeking less ambiguity in illness classification, ... more efficiency in coverage of mental

health treatment, [and] antibiotic specificity useful for pharmaceutical companies seeking to target drug therapies for specific mental illnesses”, there was a war within the field of mental health as to how treatment of these diseases was going to take place (Strand). This, along with social factors such as criticism of mental health treatment, the toppling of mental health treatment facilities, and community mental health policy implementation made it possible for the later DSM-3 to revolutionize mental health treatment. The DSM-III became so popular because it helped to define the roles of the mental healthcare professionals who would be using this diagnostic framework along with creating a new psychopharmaceutical culture in which mental illness is viewed today.

The categorization and definition of mental illness has a long history. In defining what abnormal behavior was, psychiatry moved to defining mental illness according to problems that could be medicalized (Strand). Mental health categories were classified according to the DSM-I, however mental health classification as seen today began with the novel DSM-III. While the DSM-I and DSM-II were “minimally concerned with diagnosis and had few clinical implications” and featured “disease descriptions [that] were minimal, and more definitional than diagnostic” (Strand). According to Strand, “the development of the DSM-III was initiated by a mundane bureaucratic requirement that came with US membership in the WHO”, requiring that “APA’s classification of mental illness [were] compatible with the taxonomy produced in the International Classification of Diseases” (Strand).

However, Robert Spitzer’s appointment to the “Task Force on Nomenclature and Statistics” ignored DSM precedence to “include hundreds of experts on over 14 committees for 6 years to produce the 500- page manual” that would change how mental health diagnosis was categorized (Strand). Spitzer and the rest of the task force conducted field trials in which “approximately 400 psychiatrists used drafts of the DSM-III... to diagnose the symptoms of more than 12,000 patients” in order to increase reliability between practitioners “using a

“kappa” statistic that was initially developed to construct research diagnostic criteria, and which produces reliability scores (from 0 to 1) by testing observed diagnoses of a specific disease by several clinicians against the frequency of the same diagnosis expected at random” (Blashfield 1984, p. 96; Kirk and Kutchins 288 *Theor Soc* (2011) 40:273–313 1992). The task force would then adjust the “operational criteria that defined the diagnoses included in manual in order to achieve higher kappa-scores, and thus greater uniformity and reliability in the clinical setting” (Strand). Thus, Spitzer operationalized classification within a field, at the time, in which practitioners did not prioritize a standardizing mental health diagnosis.

Thus, the DSM-III went from a manual that “was of little concern... to psychiatrists and practitioners in mental health” to “an empirically grounded and functional classification system” that was “scientifically sound”, “clinically useful”, and “would unify the profession” (Strand). The transformation of the DSM thus became “a tool by which psychiatry could assert its authority at time when many other professions were encroaching upon its domain” (Mayes & Horwitz).

#### *How Diagnoses are Formed Today*

Diagnosis today occurs through what Strand refers to as a “Chinese menu”, where an illness must have “at least three of six symptoms in Category A, at least two of four in Category B, four of seven in category C, and so on” in order to be identified (Strand). This information structure accompanies a “multi-axial system of evaluation “to ensure that certain information that may be of value in planning treatment and predicting outcomes” for the individual (APA, 1980). For example, a diagnosis of Attention Deficit Hyperactive Disorder would be coded within the context of a patient’s clinical syndrome (Axis I), whether it is a personality or developmental disorder (Axis II), any accompanying physical disorders and conditions (Axis III), the severity of psychosocial stressors (Axis IV), and the highest level of adaptive functioning (Axis V) (Strand). By using operationalized criteria and a multi-axial

system of evaluation, Spitzer hoped to create a diagnostic manual that would result in reliable diagnosis, prognosis, and treatment of the patient by clinicians.

While DSM-II was revised with research-oriented decision making, the creation of diagnostic categories was also influenced by politics within the Task Force, meaning that diagnoses were included by consensus of professional opinion (Robbins). Further bias is possible given that these task force members were uniquely chosen by Spitzer, demonstrating that the DSM reflects “the views and interests of the members appointed to the DSM task force”, “the interests of those that provide funding for and benefit from its creation and widespread use”, and is “first and foremost, a socially constructed document” (Robbins). An all or nothing approach is used within the DSM, in which you have to have 6 out of 10 symptoms to have a condition. However, the perspective is slowly shifting from such a black and white approach to a spectrum of diagnosis. Yet, even though revisions to the DSM aim to “improve reliability in diagnosis, evidence shows that this simply has not occurred” (Robbins). This calls into question the very framework that is used in order to diagnose individuals, even though its standardization of diagnostic terms and vocabulary is useful in the mental health field.

#### *How the Mental Health Structure Impacts Diagnosis*

With the creation of the DSM-III, it became possible to “define pathologies and order them in a classification” within a clinical context (Strand). Mental health categories formed primarily by using symptoms to classify mental illnesses. Spitzer introduced “the distress test” into the DSM-III, which states that “for a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause distress, or regularly be associated with some generalized impairment in social effectiveness or functioning” (APA). This definition allowed the patient to judge whether they are in need of a diagnosis as well as

changed the way in which patients identified with their diagnosis. In summation, the DSM has impacted patients more than any other document introduced to the mental health field.

The mental health structure itself is important to consider as a whole, as mechanisms outside of just the DSM are influencing the diagnoses that individuals receive. According to Jutel, “the way in which [diagnosis] is organised, structured and delivered results in consequences for those to whom the diagnosis applies” (Jutel). For example, insurance companies have annual contracts with patients which makes them prioritize cutting quarterly costs rather than considering the holistic, lifetime oriented health of an individual. This can lead to psychiatric decisions “that are neither economically smart for people nor good for them clinically” (Allen). Furthermore, as more diagnoses are given using the DSM, it’s influence and medical authority increases in legitimacy. Thus when an incorrect diagnosis is given, individuals do not question the diagnostic system but rather believe that under the right diagnosis, their symptomatology could be relieved.

While diseases are thought to be organized by labels that categorize patient experiences, “some diseases, such as tuberculosis or embolic stroke, identify a highly specific etiologic agent or process” while “others, like Alzheimer disease... indicate pathologic changes of unclear cause” while “syndromes and functional disorders simply describe collections of symptoms and signs that frequently occur together” (Chiong). Diagnosis provides an evaluative moral judgement on the individual with “healthy” individuals with no abnormality or symptomatology preferred to “diseased” individuals, once again demonstrating that these seemingly objective and scientific labels have wide reaching subjective implications. Thus, “the concept of disease involves a duality between a description (a physiological or functional difference between the patient and the “healthy” norm) and an evaluation (the judgment that this difference is abnormal or dysfunctional, and not just different)”, which is “obscured in everyday practice, in part due to the scientific



aspirations of medicine and scientific assumptions built into the medical model” (Chiong). Inherent to the western medical model is the belief that objective tests should be referenced about the layperson “subjective” experience because objectivity defines how things “really are” (Chiong). Western diagnosis causes us to explain “subjective symptoms... by reference to objective changes in the body” which makes us conceptualize diseases “distinct, objective entities that are common to afflicted patients” (Chiong). The most clear example of the tension between objectivity and subjectivity occurs with syndromes with no objective labels prescribed to them, such as chronic fatigue syndrome, leaving the patient with only the subjective experience of the illness which often feels illegitimate (Chiong).

This is a problem when it comes to diagnosis and individual identity formation, as both are much more subjective than western medical practice would have us believe. Along with the many other criticisms of the diagnostic process includes one suggesting that “rather than debating whether or not these syndromes and functional disorders are "real" or "legitimate" medical conditions, scrutiny should instead focus on conventional models of disease and the standard assumptions that patients and physicians bring to the medical encounter”, as “the presumption that disabilities and functional limitations are less real in the absence of an independently observable disease entity reflects an assumption that all real medical conditions must follow the same paradigm... [and] suggest that new modes of characterizing medical problems are needed” (Chiong).

## **V. Sense Making in Diagnosis**

### *Introduction*

Now that we have established how identity, social processes, and the diagnostic structure affect the illness experience, we can talk more specifically about how individuals make sense of diagnoses and incorporate illness narratives into their identity. The diagnostic sense making process outlines how the patient negotiates and accepts their diagnostic status.

This process must be explored for the reader to understand how diagnoses become incorporated into the individual's personal identity and illness narrative and how the individual participates in the diagnostic process. Through understanding the processes that allow individuals to interact with their diagnoses, we can later move to discuss how individuals specifically make sense of an ADHD diagnosis in the context of individual identity. I have outlined the five stages of the diagnostic sense making process to be: negotiation through the diagnostic discovery, narrative surrender, breakdown of the self, identity reconstruction, and new identity formation through diagnostic narrative construction.

#### *Negotiation through Diagnostic Discovery*

Diagnosis offers a *why*, an explanation to your season of struggling or why your life has been so challenging and gives you insight into your problems and how to act appropriately given the foil of the diagnostic classification. Therefore the first stage of the diagnostic sense making process includes negotiation through the diagnostic discovery process, in which the patient and doctor collaborate in order to arrive at an acceptable diagnosis. The diagnostic discovery process refers to the process of negotiation that the individual goes through when being diagnosed (Jutel). During this process, the individual collaborates with their doctor, “kind of volleying back and forth until [the] lay[person] [and] professional... agree upon the nature of the ailment” (Jutel). This process allows the individual to contest a diagnosis and reject a diagnostic hypothesis.

However, this process depends heavily on the doctor- the individual cannot crowdsource a diagnosis through consulting Google or a neighbor. Therefore, the diagnostic narrative is still established by the doctor. According to Jutel, the diagnostic discovery process can also entail individual narrative transformation as the diagnosis creates a “disruption in the personal biography and a re-writing of one's narrative” due to the “alteration in social capacity, potential and autonomy” that accompanies the diagnosis (Jutel).

Though the individual's condition has not changed, the introduction of a diagnosis can have an incredibly potent effect on how the individual conceptualizes themselves and their identity. Thus, it is incredibly important to receive accurate diagnosis.

Players within the diagnostic process sometimes convolute the doctor's ability to produce accurate diagnosis which can cause patient distress and inefficacious treatment plans. Diagnostic discovery involves dispute, which is important because "there is more room in psychiatry for a high degree of interpretation and direct bias" compared to medicine (Brown). For example, disease is considered to be much more biomedical and less subjective than illness, which is defined by psychological institutions like the DSM. According to Brown, illness involves a a struggling and emotional component as those who are diagnosed try and find explanations for the disorder and treatment, meaning that "people do not always experience a disease as illness" through "manag[ing] to avoid active symptoms, or attribute [symptoms] to other sources... [in order] to accommodate them" (Brown).

For those who are denied this collaboration, there is a loss of patient autonomy which can lead to resistance or an altogether rejection of their diagnosis. Just as individuals work to make sense of their diagnosis, they also work to make sense of their symptomatology prior to the diagnosis. Thus, if a doctor labels their health problems in a manner that is unsatisfying to the individual, patients can utilize a practice referred to by Gill et. al as "pre-emptive resistance" to "raise candidate explanations for their symptoms and then report circumstances that undermine these explanations", thus shaping the diagnosis given to them by the medical professional (Gill et. al). For example, "when patients provide information to doctors during clinic visits they may do much more than convey information about how they are feeling" by slanting information, "pressing the [clinician] to interpret the illness in a certain manner, casting certain interpretations as probable or improbable, and positioning themselves as reliable and authoritative sources of medical knowledge" (Gill). Patients may resist a

diagnosis by employing different strategies such as presenting conflating symptoms that do not align with the given diagnosis, alter reported symptoms, or simply outright disagree.

Another strategy employed during this negotiation is frontloading, in which patients “present their own interpretations of their problems in early phases of the visit” which allows them to “show how they have made sense of” their symptoms and hopefully causes “doctors to consider their [explanation’s] relevance during the visit” (Gill). Patients frontload in order to frame a problem, perhaps in hopes of receiving a particular treatment such as certain medication. In this way, patients influence the physician’s search for clues and generation of a hypothesis by posing their own straw-man hypotheses that will hopefully lead physicians to avoid certain diagnostic explanations.

Patient agreement with the diagnosis is potent because it is necessary for future treatment compliance. The problem needs to be interpreted in the same way in order for a remedy can be agreed upon. Once a diagnosis is determined, the layperson can engage in a “narrative surrender”, in which “a lay person’s story of embodied experience is re-appropriated, and recast by medicine” (Frank, 1995, Jutel). Once the narrative surrender has occurred, the individual can begin narrative reconstruction of their identity.

### *Narrative Surrender*

When an individual is given a diagnosis that they must incorporate into their identity, the individual asks themselves who they could be with the diagnostic label as a part of their identity. Illness narratives, or “stories of the self that construct meaning through the sequential ordering of important life events” help form illness identities, which are “understanding[s] of [the] self, and affiliation with others, on the basis of shared experiences of symptoms and suffering” (Barker). In this sense, illness narratives “demonstrate an enduring sense of identity, and the use of myriad strategies for achieving identity coherence”, namely through interpreting past behaviors through the lens of the

diagnosis “to allow for the inclusion of these experiences within an existing identity thereby preventing a dramatic rupture in biography” (Beard).

Individuals use diagnoses to create a lifetime narrative that defines how they perceive themselves, their abilities, and their limitations. Diagnosis, especially those involving chronic mental illness, “is associated with a search for symptom meaning and a recasting of the self” (Barker). Often, these individuals struggled to understand their symptoms without the context of a diagnostic label. This phenomena is especially prevalent within mental health diagnosis because physical chronic symptoms are seen as more objective than mental health symptoms. Furthermore, diagnosis of chronic illness can lead to a feeling of loss of control.

### *Breakdown of the Self*

The third stage in the diagnostic sense making process is the breakdown of the self, in which the individual questions what they consider to be “normal”, including themselves, their experiences, and their abilities. Specifically, chronic illnesses “disrupts the “taken-for-granted” world and... leads to a breakdown of the normal experience of self and of self in relation to others” (Barker). In being given a diagnostic label, individuals are able to name their suffering, but the diagnosis also “helps formulate and ask moral, existential questions such as who am I? What am I capable of? And what are my responsibilities?” (Nielsen, 906). Diagnosis forces the individual to question their perspective to consider other mechanisms that could be used in order to live a normal life, which in turn causes a breakdown of the individual’s identity. However, this examination of the self is essential in the formation of an individual identity that is more closely aligned to truth.

In the breakdown of the self, “everyday practices are scrutinized, evaluated and changed” (Nielsen, 892). Sometimes, mental health diagnosis arrives after individuals “struggle to meet expectations for leading an ordered life”, leading them to “examine what possibilities to strive for and search for ways of anchoring their experiences of suffering”

(Nielsen). The breakdown of the self constitutes how life will look like moving forward, and how to manage day to day reality given the new diagnostic framework.

### *Identity Reconstruction*

Compared to earlier stages, the identity reconstruction phase is much more experimental. Identity reconstruction can be understood as a time of internal questioning, when individuals construct narratives that explain who they are, what their experiences have been, and who they would like to be. Many factors affect the process of identity formation, such as education opportunities, social network, institutions, cultural attitudes, and behavioral expectations. If the adolescent would like to be accepted into society, they must form an identity that adheres to the factors outlined above. However, identity formation is a collaborative process, as “a central tenet of our understanding of identity and self-image... develop[s] through interactions with and relations to others” (Jones). Identity reconstruction consists of trying different treatments and seeking social support all in order to undergo a new individual identity formation.

Diagnosis and the frameworks that come with understanding your diagnosis can become a helpful way to change your thinking and actions. These frameworks include, but are not limited to, illness narratives and collective illness identities. The culmination of diagnostic “crafting and learning, searching and realising” leads to intimate self understanding, which is the ultimate goal of life (Nielsen, 900). Thus, those who construct a new identity are able to self actualize. Diagnosis has a transformative power, with “the diagnostic moment imposes an indelible division of “before” and “after” onto an individual's life story despite the absence of any material change in condition. The impact of the diagnostic pronouncement is as important as the disease itself, altering the sense of identity, and of future potential” (Jutel). Identity formation, and with it the relationship between illness identity, is a lifelong process. ADHD can be particularly disruptive to individual identity, as

ADHD is a chronic mental illness diagnosis that often has symptomology characteristic of the disorder.

### *New Identity Formation*

Diagnosis is seen by many as an objective reality. While sensemaking is a cognitive process, it also relies on social processes and support. According to Jutel, “empirical studies have yielded data demonstrating the impact and consequence of diagnosis on people’s lives, producing an important set of concepts to make sense of the diagnostic experience” (Jutel). How individuals then interpret their diagnosis “in relation to ourselves or amongst those close to us provides an insight into values, structures and contexts” because the diagnostic label might cause the individual to “develop an identity, or alternatively be identified in differing ways” (Jutel). Diagnosis can fundamentally alter the way in which a person defines themselves, thus potentially playing a huge role in individual identity construction.

Some struggle within this sense making process if they are dealing with a mental illness that is not recognized by mental health clinicians. In essence, if classification is a form of meaning-making, with conditions receiving a diagnosis if it is worth paying attention to, individuals experiencing symptoms without a diagnosis can be incredibly distressing. In this context, individuals with mental illness unrecognized by the psychological community do not have diagnostic language to explain their symptoms and form a self narrative. Knowing about a diagnosis makes new ways of interacting with the world possible, meaning that diagnosis “not only offers an explanation of past events and current problems, it also offers prospects for the future, new ways of thinking about responsibility and a structured self-narrative” (Nielsen, 898). Diagnosis has this power because individuals treat diagnosis as medical, objective truth. Diagnosis defines what is reality and by being given a diagnostic label, individuals have to re-examine how they perceive and interact with their inner and outer worlds.

## **VI. ADHD Diagnosis and Identity Formation**

### *Introduction*

Given discussion of how diagnosis and how the DSM defines mental health conditions, we can now move to defining ADHD, ADHD diagnostic criteria, and its effect on individual identity formation. Previous discussion of identity formation and social processes involved in the diagnostic discovery process will provide important context for discussion of how social processes and socioeconomic factors affect rates of ADHD diagnosis and individual identity formation. In this chapter, I discuss processes through which ADHD diagnosis is interpreted by the individual and what narratives are utilized by individuals to understand their diagnosis. This discussion is all in service of understanding how the individual perceives their ADHD diagnosis.

### *Definition of ADHD*

Attention deficit hyperactivity disorder, or ADHD, is characterized by inattention, hyperactivity, and impulsiveness (Aronson). ADHD is the “most common mental health diagnosis in children” and “the most frequent reason for their referral to services”(Eccleston). Most individuals with an ADHD diagnosis are diagnosed as adolescents, which happens to be a critical period for individual identity formation (Jones). As such, we will be discussing ADHD diagnosis in adolescence as those diagnosed as adults or in early childhood go through a less relevant process of identity formation discussed in this thesis. According to 2016 national survey data, 9.4% of US children receive an ADHD diagnosis and 8.4% of children currently have ADHD (Wolraich et al.). Case study of ADHD diagnosis on identity nicely complements the larger discussion of diagnostic processes and its impact on the individual. Like other diagnoses, an ADHD diagnosis can unlock tools for a person to help understand themselves and their past. As previously discussed, after the diagnosis a person typically goes through a sense making process through which self narratives and illness



narratives are constructed. Berger et. al found that individuals constructed self narratives in relation to their ADHD diagnosis, with research emphasizing the importance of early diagnosis of ADHD to increase treatment efficacy (Ketisch et al.).

The three domains for which ADHD is defined, inattention, hyperactivity, and impulsivity, contain 9 possible symptoms for which the individual must have at least 6 symptoms present (Gupta). It is possible to specify the ADHD diagnosis according to whether symptoms are present in one domain, but not in another. For example, “if the child has at least six symptoms on the inattention domain, s/he qualifies for the “ADHD- Predominantly Inattentive Type” diagnosis”, “if the child has at least six symptoms on the hyperactivity- impulsivity domain, s/he qualifies for the “ADHD- Predominantly Hyperactive-Impulsive Type” diagnosis”, and “if the child has at least six symptoms on both inattention and hyperactivity-impulsivity domains, s/he qualifies for the “ADHD-Combined Type” diagnosis (DSM-IV)” (Gupta).

Though ADHD criteria has evolved with each DSM manual, tools for diagnosis have essentially remained the same. As DSM guidelines for ADHD diagnosis are vague, ADHD is broadly a clinical diagnosis within a largely variable diagnostic process. There are ways in which ADHD can be managed and treated, but ADHD is a chronic disorder for which there is no cure. The most common treatment method for ADHD involves medication, particularly stimulants, which allows individuals with ADHD to function more appropriately in settings that require attention. ADHD medication use has increased by 800% between 1995 and 2015, with Commonly associated with ADHD are academic difficulties, which can require additional support such as extended time. Recently, rates of ADHD diagnosis have increased in the United States and worldwide, leading researchers to wonder why this phenomenon is occurring when “there is little evidence to suggest that... biological factors [are] increasing or causing increased rates of ADHD” (Braun et al., 2006, Nomura et al., 2010). However,

ADHD is a disorder that tends to present in families with one parent previously diagnosed with ADHD (Mattox & Harder, 2007; Minde et al., 2003).

ADHD has been criticised as a socially constructed or medicalized condition rather than a legitimate disorder. This creates a unique stigma that individuals with ADHD have to combat. Furthermore, ADHD is difficult to test for due to “ADHD's poor diagnostic reliability and changes in the DSM, which have broadened its diagnostic criteria” (Conrad and Potter, 2000, Cuffe, 2005). For example, differences in diagnostic criteria make it difficult to measure rates of ADHD prevalence in the United States and between countries, with estimates of ADHD prevalence in the United States ranging from 1.5% to 19.9% (Cuffe, 2005). Yet, poor diagnostic reliability alone cannot explain why ADHD diagnosis has become more prevalent. Even clinicians within the United States fail to rate the same individuals uniformly, with there being no behavioral standard to rate individuals against. However, ADHD diagnosis has significant implications for individuals' wellbeing and identity formation, making discussion of their experiences with the ADHD diagnosis a necessary discussion to promote healthy individual identity development.

#### *Diagnostic Criteria for ADHD*

One of the most utilized diagnostic tools for ADHD diagnosis is the The Conners Adults ADHD Rating Scale (CAARS), which is a self-report rating scale that includes subtests that measure symptoms of inattention and hyperactivity as defined in the DSM (Grogan). In terms of testing, sensitivity refers to a test's ability to distinguish true positive cases of ADHD, while specificity refers to a test's ability to find true negative cases of ADHD, or individuals who do not have ADHD. While CAARS has good sensitivity, it has low specificity which can lead to misdiagnosis for individuals with symptoms that are explained by other disorders, such as anxiety, learning disabilities, speech problems, and

oppositional defiant disorder (Leahy). While CAARS is useful for screening and diagnostic purposes, it has poor diagnostic reliability in part due to vague ADHD disorder itself.

Diagnostic criteria for ADHD directs clinicians to rely on intuition and clinical judgment. However, clinicians cannot assume comorbidity when using self-report screening measures, which is why experts call on a multifaceted approach for ADHD diagnosis. According to Gupta et. al, clinicians rely almost unilaterally on clinical judgement when making diagnostic decisions about ADHD (Gupta et. al). This is an issue due to the effect that misdiagnosis has on the individual. Due to the potential for co-morbidity, some clinicians argue that ADHD should not be a distinct diagnostic entity, but rather “a “symptom complex” characterized by multiple possible etiologies and a constellation of pathological behaviors” (Gupta).

While there is a set of criteria for diagnosing ADHD behavior, there is no measurable indicator for whether an individual has ADHD. Environmental factors, life circumstances, other mental health disorders, and cultural factors make it hard to attribute criteria such as inattention to one cause. More recently, standards advocate for “a multi-method approach to diagnosing ADHD where comorbid mental health disorders, family problems, school performativity, and social outcomes are factored into diagnosis” in addition to current diagnostic practices aimed at reducing confounding variables given the lack of a definitive diagnostic marker (Escobar, 2005, Hoza, 2007, Nijmeijer et al., 2010). Furthermore, because diagnostic criteria vary depending on country, systematic review of ADHD prevalence and experience is further complicated due to an inability to compare data due to the use of different diagnostic standards and evaluation methods (Edwards et. al).

#### *Social Processes Affecting Rates of Diagnosis*

Like many other diagnoses, diagnostic referrals are dependent on environmental factors such as access to care, social legitimacy of the diagnosis, stigma, and peer influence.

For example, Aronson et. al examined the potential for ADHD diagnosis to be confounded by peer influence and found that individuals report their rates of inattention and hyperactivity to resemble their friends (Aronson). Not only is inattention, a key identifier of ADHD behavior, susceptible to peer influence, but also current research is attempting to answer why rates of ADHD diagnosis are increasing due to environmental factors.

Peer influence can influence rates of ADHD diagnosis through several different modalities. Two social processes influencing ADHD prevalence in the population include spurious contagion and diagnosis-conversion (Aronson). In spurious contagion, “behaviors that are conducive to a diagnosis are socially influenced”. For instance, an individual close to those diagnosed with ADHD may perform learned behaviors “that are conducive to an ADHD diagnosis, such as a tendency to interrupt others” (Aronson). In the same instance, an individual in a friend group who does not use ADHD behaviors in their conversation style, such as fidgeting and interrupting, might be less likely to receive an ADHD diagnosis.

On the other hand, diagnosis-conversion occurs “when a person's increased awareness of a disease causes him to report having that disease” (Aronson). For example, exposure to people with an ADHD diagnosis increases awareness of the disorder through proximal exposure, which could lead them to seek treatment. Therefore, social processes could be confounding variables explaining the increase in ADHD prevalence in recent years. For example, Liu et al. (2010) found that diagnosis-conversion could have been a factor in increasing rates of autism diagnoses, as “living close to another child with autism increased a child's odds to become diagnosed with autism in the following year” (Aronson). However, while peer influence affects rates of ADHD diagnosis, evidence does not say “whether peer influence leads to more true positive diagnoses of ADHD or more false positive diagnoses of ADHD” as “it might be the case that peer influence contributes to improved diagnostic coverage of ADHD” (Aronson).

Social stigmatization can influence individuals “to mask their ADHD features during counseling” (Canu et al., 2007). Demographic factors also confound ADHD diagnosis, one example being that “doctors often consider it less problematic for a woman to act absent-minded”, which helps contribute “to lower rates of ADHD diagnosis in women” (Aronson). Another example can be found in students who have trouble with teachers. These students are less likely to report inattention, though their behavior is often reprimanded, which can lead to masking of inattentiveness rather than seeking a diagnosis for their behavior.

As discussed previously, another factor affecting rates of diagnosis is the diagnostic criteria of ADHD. Most epidemiological studies of ADHD estimate 3-7% prevalence of ADHD in the United States, with “ADHD's poor diagnostic reliability... le[ading] to public and medical uncertainty regarding whether ADHD is being over-diagnosed” or “if ADHD is even a valid mental health diagnosis” (Rafalovich, 2005, Moncrieff and Timimi, 2010, Timimi and Leo, 2009). According to these statistics, about one individual in every classroom has ADHD. However because the validity of ADHD is socially questioned, individuals with ADHD face a particular stigma in which they have to advocate for the legitimacy of their condition/diagnosis.

Potential for co-morbidity with an ADHD diagnosis is particularly high, with symptoms that overlap between ADHD and anxiety including “restlessness/psychomotor agitation, concentration difficulties, decreased attention, increased distractibility, mood swings, and anger outbursts” (Grogan). Furthermore, “higher endorsements of hyperactive/impulsive items positively correlated with endorsements of anxiety items on self-report symptom rating scales”, which could easily result in a misdiagnosis of ADHD (Grogan). With misdiagnosis comes not only increased rates of false positives for ADHD, but also leads to improper treatment.

According to Walker et al., exposure to adverse childhood experiences, or ACEs, is statistically significantly associated with parent-reported ADHD diagnosis (Walker et al.). Compared to children with no ACE's, "the odds of an ADHD diagnosis were 1.39, 1.92, and 2.72 times higher among children with one, two and three or more ACEs", with the strongest ACE association as "lived with someone with mental illness" followed by "parent/guardian incarceration" (Walker et al.). These results suggest that ACE exposure is positively correlated with increased ADHD prevalence.

#### *How Race and Socioeconomic Factors Affect Rates of ADHD Diagnosis*

According to Bax et. al, white children were more likely to have parent-reported diagnoses of ADHD compared to black, hispanic, and other race/ethnicity children (Bax et. al). Of those who were diagnosed with ADHD, "children who were White, male, and had health insurance had higher odds of taking medication" and "those with Medicaid, White, and 2-parent statuses had higher odds of parent-reported diagnoses" (Bax et. al). Furthermore, teachers and parents rate symptoms of ADHD "higher in black children and lower in Hispanic children when compared with white children" (Bax et. al). Yet, formal diagnostic rating scale assessment strategies indicated that there was no correlation between an individual's socioeconomic status and ADHD diagnosis. Therefore, it seems that higher socioeconomic status provides greater opportunity for diagnosis through greater economic means. For example, white children have a greater likelihood to receive a clinical ADHD diagnosis even though ADHD symptomology is reported at similar rates, even when adjusted for SES (Bax et. al).

These findings suggest that there are racial disparities in treatment and diagnosis of ADHD. Bax et. al found evidence that "parents were more likely to report that their child had received ADHD treatment with medication if they had Medicaid compared with those with others forms of health insurance" and that "black families were less likely to perceive their

children's hyperactivity as problematic or in need of treatment than were white families” (Bax et. al). While this difference in perception might be attributed to cultural factors, this alone does not explain differing rates of ADHD referral.

As discussed previously, failure to diagnose ADHD in adolescents substantially affects treatment efficacy and identity formation in the individual. For example, Wilkinson et al. discovered that symptoms of depression increase for individuals diagnosed with ADHD in adulthood while those diagnosed as adolescents experiencing fewer depressive symptoms in comparison (Wilkinson et al.). As ADHD statistically is more unrecognized in non-white adolescents, other findings such as substance abuse become the initial symptom that leads to ADHD consideration (Livingston). While literature does not suggest that substance abuse would not occur if these adults were properly diagnosed earlier in life, these individuals certainly would have had access to better resources to manage and understand their impulsive behaviors.

#### *The Role of Institutions and Teachers in Identity Formation*

Another interesting way in which diagnosis may affect identity involves the act of labeling itself as outlined in Tannenbaum's labeling theory, as the diagnosis itself may cause individuals to, “over time, change their behaviour in accordance with how they have been categorised” (Berger). For example, when individuals frame themselves as ‘a person with ADHD’, they gain access to certain privileges, such as extended time, and obligations, such as managing their diagnosis and its potential stigma. This framing is not done just by the individual, but also by institutions who categorize students with disabilities as ‘needing additional support’, which helps normalize learning problems and assists teachers in knowing how to best assist students (Hjörne). As explained by Hjörne, “once a category has been created, there is a tendency to find people who fit into it, and whose identity may be shaped accordingly” (Hjörne). Thus institutions play a large role not only in provision of services for

those diagnosed with ADHD, but also in shaping the identity and collective illness narrative of the disability.

According to Aronson, “over half of ADHD diagnoses are first suggested by children's teachers” (Aronson). However, because teachers “are often poorly educated about ADHD” and “targeted... by pharmaceutical” interests to refer children to doctors about ADHD, this can lead to under and overdiagnosis (Edwards and Sigel, 2015, Loe and Feldman, 2007, Phillips, 2006, Sax, 2003). Many high achieving students “with higher GPAs reported higher levels of inattention”, which is contrary to evidence that correlates ADHD with lower academic performance (Jiang et al., 2015, Loe and Feldman, 2007). This may be because students of higher socioeconomic status have access to resources to perform better academically as well as have access to resources to treat mental health conditions. Thus, those with additional time and monetary resources may be more likely to receive an ADHD diagnosis.

Furthermore, Conrad and Potter (2000) contest that individuals diagnosed with ADHD might be highly ‘diagnostic seeking’ and thus more likely to consult their doctor until their experience is legitimized through an ADHD diagnosis (Conrad et. al). This suggests that those with a motivation to receive a diagnosis are also more likely to obtain one. While teacher reports of ADHD symptomatology were not highly reliable, Biederman et. al found that “maternal reports of their children's psychopathology provided a reliable and accurate means of assessment” (Biederman). Not only were mothers unbiased when it came to symptom reporting, meaning they only reported symptoms that had actually occurred, but also “comparisons of parent and teacher reports of child psychopathology suggest that parent reports are valid indicators of ADHD symptomatology”, with “91% of the children with parent-reported ADD [having] a positive teacher report for the diagnosis” (Biederman).

*Narratives Used by Individuals to Understand Their ADHD Diagnosis*



The diagnostic process will look completely different for each individual depending on the individual's circumstances. Factors such as age, socioeconomic status, gender, culture, technology, and more all contribute in determining how the diagnostic process is interpreted by the individual. In Eccleston et. al's systematic review of adolescent experiences of living with a diagnosis of ADHD, five analytical themes emerged in how ADHD diagnosis was interpreted: differing perspectives of the problem, societal pressures, sense of self, feelings about medication, and maturational shift from passive to active (Eccleston et. al).

While some participants view ADHD as a physical condition or an academic disadvantage, other individuals interpret their ADHD diagnosis as part of their personality, an explanatory mechanism for their behavior and emotions, or even a part of 'being normal' (Eccleston et. al). Those who viewed ADHD as an illness or disability to blame for their difficulties had their perspective reinforced by the diagnostic process in which they were given a test in which they failed. Others saw the expectations of others to be the problem and felt that ADHD reflects their personality. While some saw how disadvantageous ADHD can be in an academic setting, "most participants considered ADHD to be a personal characteristic that comprised part of their identity", meaning "they often did not consider behaviors or 'symptoms' to be impairments" (Eccleston et. al).

Societal pressures faced by individuals with ADHD include stigma, rejection, managing others' expectations, conflict, and invalidation (Eccleston et. al). Girls particularly were found to internalize others' expectations while boys largely defended themselves against criticism with "bravado to protect their identity and self-esteem" (Eccleston). Furthermore, students with ADHD who were labeled as 'troublemakers' by teachers were found to have decreased self esteem and increased feelings of failure and inadequacy (Eccleston). In this case, the ADHD label may lead children to believe that they are defective which is harmful for their developing sense of self and identity.

Eccleston et. al found that the theme of sense of self emerged for individuals interpreting their ADHD diagnosis, with participants reporting feeling different, needing acceptance, affected self-esteem, and maintained/altered sense of identity (Eccleston et. al). Participants were often bullied which could have a “severe and lasting impact on their identity and self-esteem”, leading some to “hide their diagnosis... from others so they were not treated differently” (Eccleston). Some people did not feel shame about their diagnosis or even report experiences of stigma. In fact, some felt unique due to their ADHD diagnosis, with medicine helping them feel competent.

In interpreting their ADHD diagnosis, individuals also evaluated the efficacy and burden of treatment methods and their feelings about medication. Individuals often have little involvement in treatment decisions, with ADHD treatment almost exclusively composed of medication options. Many participants felt forced to take medication by authority figures such as parents or doctors. In particular, individuals did not feel that the severe side effects of taking medication were recognized even though “participants wished to be taken seriously and have their knowledge of their experiences acknowledged” (Eccleston). When their experiences were not acknowledged, “participants remained in conflict with others and became ‘non-compliant’” (Eccleston). Complaints about ADHD medication tended to center around how medicine made individuals feel different compared to their untreated self as well as deviant when compared to their peers. Around half of participant’s in Eccleston’s study reported a change in personality due to medication, with one reporting that “you feel like you are in your own world when you take Ritalin, as if you are in a bubble. People talk to you and you really. . .it is really different. . . It wasn’t me.” (Eccleston).

Even those who found medication to be beneficial experience adverse side effects. Side effects could be physical, including “loss of appetite, weight loss, dizziness, headaches, stomachaches, nausea, tiredness, and loss of energy” and/or emotional, including “feeling

numb, subdued, irritable, and losing motivation or desire to socialise or engage in activities they previously enjoyed” (Eccleston). While medication could be valuable to those looking to manage their behavior or improve their academic performance, side effects helped contribute to a sense of a loss of identity. Medication can lead individuals to believe that ADHD is something that has to be controlled which could lead to moral self-condemnation. According to Honkasilta et al.’s findings, children with this perspective “perceive the authentic self as fundamentally bad, problematic, or incapable, and welcome medication as an empowering, normalizing and enabling factor” (Honkasilta et al.).

Individuals also reported a shift from a passive to an active role in their diagnostic interpretation, with participants reaching out for support and thinking about the future. Some participants showed autonomy through deciding to stop taking medication. Individuals felt stress relating to whether they could meet social expectations, most often within an academic setting. Therefore, the sociocultural environment in which the individual is raised helps influence young people’s perceptions of their ADHD diagnosis.

#### *How ADHD Diagnosis Helps Form Identity*

Diagnoses can legitimize a person’s experience by allowing them “permission to be ill”, which “may enhance individuals’ social status and give them access to support and services” (Parsons, 1951). With a diagnosis, the individual will not be blamed for their ‘sickness’ and they might even be better understood by their community. In a 2013 study, Fleischmann and Miller found evidence that “once diagnosed with ADHD, adults were able to construct a more coherent view of their life, to remove self- blame and to take a more positive view of themselves” (Fleischmann and Miller, 2013). Because ADHD provides an explanation for unwanted behavior, the diagnosis can be a source of relief and bring a greater sense of social connection (Hanna’s, 2010). The process of understanding the self and individual identity involves the story that individuals tell themselves about who they are, how

others perceive them, and why they believe the things that they believe. Thus, diagnosis can serve as an important missing piece in a puzzle of self understanding.

An ADHD diagnosis can contribute largely to how an individual explains their behavior if the individual considers the diagnosis to be a significant life event. Identity is based upon self narratives that help the individual make sense of their behavior, meaning diagnosis probably will largely affect the individual's identity formation. The ADHD diagnosis can serve as redemption if it confirms the individual's "and others' life-long suspicions that something was wrong with them" and "why other people rarely understood them and their needs and difficulties" (Berger). By accepting their diagnosis, the individual gains access to a "culturally legitimate" explanatory framework that they can use when communicating who they are to others (Berger). Most research suggests that an ADHD diagnosis does impact identity substantially, with more than half of participants in Eccleston's systematic review of the literature "experiencing identity loss and [feeling] alien due to taking [ADHD] medication" (Eccleston). The specific effect of medication on identity formation will be later explored, however it is relevant for our discussion to understand the impact of diagnosis and treatment on the individual's self conception.

According to Fleischmann and Fleischmann (2012), adults diagnosed with ADHD "began to believe in their ability to lead more meaningful, manageable lives following an accurate diagnosis" (Grogan). However, other literature suggests that ADHD diagnosis could lead to stigmatizing reactions and increased stress, which could then negatively affect self perception and the individual's sense of mastery (Meeting). One of the most important determinants of how a young person interpreted their ADHD diagnosis was how they viewed their abilities when compared to peers (Jones). Therefore, the perception of ADHD diagnosis may vary from individual because of the narratives constructed by the individual rather than severity of ADHD symptoms. While psychiatric labeling may lead to negative effects for the

individual, it may also lead to an increased sense of control (Meeting). Psychiatric labeling can also impact outcomes such as employment, further impacting the individual's sense of mastery over their lives. Thus, the effect of labeling and categorization is a complicated process that must include the context of the individual's experiences and narratives.

### *Sense-making in ADHD Diagnosis*

As outlined in Jones et al., individuals diagnosed with ADHD typically go through the stages of relief/elation, confusion/emotional turmoil, anger, sadness and grief, and anxiety before accepting the diagnosis (Jones et al.). Each person must incorporate the ADHD diagnosis into their personal history and identity narratives along with their experiences with others. Furthermore, the individual receives an ADHD diagnosis as a layperson with the social biases and illness narratives that accompany ADHD, such as that this label belongs to disorderly and rowdy children.

Many individuals looking to incorporate an ADHD diagnosis into their personal narrative must negotiate relative normality and abnormality due to their classification. Commonly, children with ADHD can feel that they do not fit in and struggle to express themselves appropriately in social settings. While individuals who feel they lack social skills do not attribute these behaviors to their ADHD diagnosis, an ADHD diagnosis could be seen as explaining "their experiences of standing out,... social exclusion,... and failure in connecting to others" or "as a cementation of them not being normal" (Jones). In other words, the image that the individual has in relation to their peers impacts their perception of ADHD. For some, an ADHD diagnosis can dramatically affect feelings of self worth because it explains unidentified behavior. This can lead to the adolescent feeling "understood, seen, and treated" (Jones). This feeling can be especially potent for adolescents because ADHD is an invisible disorder in which you cannot detect deviancy from appearance; those with ADHD appear normally in society. However, "as a consequence of appearing normal to others",

individuals can feel that others do not understand them, which creates obstacles “as well as making them feel responsible for their shortcomings” (Jones).

The initial response to receiving an ADHD diagnosis for most adolescents was shock, as they might not identify themselves as the culturally understood rambunctious, troublemaking student that is well known for having ADHD. However, after reading further into the description and experiences of those with ADHD, most find commonality with the difficulties expressed and resonate with the disorder (Jones). Thus begins the process of incorporating the diagnostic label into the adolescent’s personal narrative.

Because ADHD is recognized in relation to the disabilities presented in an academic setting, this begs the question of how the individual functions academically after receiving an ADHD diagnosis. If they experienced stigma or feared being seen as a ‘problem child’, the individual could experience conflict. For those that eventually accept ADHD as a part of their identity, the diagnosis could have “a positive impact on the way they felt about themselves and their shortcomings” because they knew that “they were not alone with these difficulties and that these difficulties had been recognized” and medically legitimized (Jones).

Individuals also could learn to view their ADHD behavior, such as hyperactivity and impulsiveness, with pride and positivity. Particularly in western culture where academic excellence is coveted, an ADHD diagnosis can be a source of initial distress and subsequent relief once symptoms, such as inattention, are alleviated (Livingston).

One important caveat to note when discussing individuals diagnosed with ADHD is that there are three different subtypes of ADHD, with each version lending itself to different experiences for the individual. As aptly stated by Jones, “becoming oneself with ADHD is a complex and multifaceted process” (Jones).

Diagnosis can be a terrifying process for the individual depending on what kind of diagnosis is being examined, the circumstances, the level of social support, and stigma.

Diagnosis causes the individual to question their experiences and competencies, and due to mental health stigma many individuals examine themselves through a judgemental perspective rather than through an investigative, curious practice. This can lead folk to believe that without a diagnostic term, their experience is not legitimate. Conversely, with a diagnosis “the past becomes different as the present and future change shape” making the diagnostic process destabilizing for the individual (Nielsen, 898). Diagnosis brings with it challenges and new questions that individuals ask themselves, which is inherently destabilizing. Depending on the patient’s environment, “a diagnosis can be welcomed or eschewed” based on if it “vindicate[s] [or] blame[s]... legitimise[s] or stigmatise[s], facilitate[s] access to resources” or “restrict[s] opportunities” (Jutel).

## **VII. Conclusion**

### *Outline of Main Points*

In this thesis, I defined key concepts such as identity, identity formation, and social processes that affect the individual illness experience. Next, I outlined the social factors in diagnosis and individual identity formation. Afterwards, I defined diagnostic categories, how they are formed, and how they affect individual identity formation. After a macro-level discussion of the driving processes behind diagnosis and individual identity formation, I discussed the diagnostic sense-making process and layperson experience. By doing this, I was able to develop a multi-level answer to how mental health diagnosis, including ADHD, affects individual identity formation. I argue that ADHD diagnosis and the processes that accompany it provide an overall benefit to the individual. However, particular attention must be given to inequities in our mental health care system and the role of privilege in diagnosis. Furthermore, the improvements provided below could bring much needed change to the diagnostic system in order to provide better patient care and more constructive illness narratives for the individual.

*My Recommendations*

After detailed and nuanced discussion of relevant identity and diagnostic sense-making processes in the ADHD process, I will now provide my recommendations for improvements to the diagnostic system. These improvements will include robust criticism of the DSM and ADHD diagnosis along with my thoughts on how mental health practitioners can better combat mental health stigma, alternative solutions to the current diagnostic system, and helpful coping strategies for individuals managing an ADHD diagnosis. I argue that overall, ADHD diagnosis and the diagnostic system provides a positive benefit to society. However, the system needs improvement in order to ensure that diagnosis benefits the individual in a way that they can incorporate into their personal narrative and overall identity.

My first critique of the mental health diagnostic system involves the influence of insurance companies in diagnostic category creation. The DSM is used primarily within the mental health field because insurance companies need reasons to grant and/or restrict coverage rather than to “provide clear descriptions of diagnostic categories... to enable clinicians and investigators to diagnose, communicate about, study and treat various mental disorders” as stated in the introduction of the DSM-III (APA 1980). This criticism is strengthened by a study that found that 86% of clinical psychologists used the DSM-III because it was required by third-party payers, 43% used the DSM-III because it is “the only classification system presently available” and “they had no choice but to use it” (Miller et al. 1981). I believe the ADHD diagnostic criteria should include instructions for clinicians in differentiating between “mild” and “moderate” conditions within the DSM which can lead to guesswork in trying to determine the severity of a mental health diagnosis. If the DSM would take a more nuanced approach to diagnosis, we would move “away from the yes/no approach of categorized disorders and more toward a dimensional perspective that better depicts the way psychiatric illnesses actually appear in real life” (Regier). I propose a version of the



DSM that does not focus on clinician categorization of individuals based on discrete conditions but rather within a holistic context that takes into account other factors influencing individual behavior. While diagnostic assessment is moving towards a more encompassing perspective, which would include larger social and cultural factors, today's DSM remains an enterprise that locates an individual's problems within a western, psychopathological perspective.

Additionally, the revision process of the DSM should become a more transparent process with independent reviews conducted to ensure that changes are being made according to scientific research rather than on expert opinion and politics. Though "the DSM revision process has always been a closed, yet highly politicized process" with the "vast majority of published research studies relating to DSM-5... generated by current members of the DSM-V Task Force and Work Groups", the process could change if clinicians advocated for systematic improvement for their patients (Washburn). For example, raw data from research studies analysing the efficacy of DSM diagnostic criteria could be made available prior to the publication of revised DSMs, along with the replications needed to validate these studies (Washburn). Mental health experts want to update the DSM in order to increase validity and reliability of diagnostic labels, but they must do so in a more evidence based manner as to not disproportionately impact vulnerable populations who are most at risk when malpractice occurs (Washburn).

Future clinicians should be taught about the shortcomings of the DSM in order to increase "validity and reliability of the diagnostic criteria", because sole focus on pathology "may deter [clinicians] from the broader mission of client advocacy" (Robbins). Assessment is an incredibly important step in the diagnostic process, yet clinicians should not view diagnosis as a first step, as this leads to the medicalization of our society. Instead, clinicians should "remain open to assessing and engaging in systemic level change" through critical

observation of damaging practices, such as misdiagnosis, along with continuing education as the DSM evolves in order to ensure that individuals are not being harmed (Robbins). Otherwise, clinicians are in danger of providing pathology without providing resources and/or benefit to the individual. Also helpful in the training of clinicians would be the inclusion of a sociological approach of diagnosis and social science perspectives of the illness experience. For an activity so central to the medical profession, diagnosis is studied far less than it should be. Luckily, more clinicians already are beginning to focus more on the illness experience of the patient in order to understand more comprehensively how to best provide care to the individual. Yet, much more research needs to be done specifically regarding the impact of the diagnostic process on the individual and not just the individual's experience of an illness.

Furthermore, I propose that we combat illness stereotyping by listening to the experiences of individuals with a diagnostic label. Public perception of mental illness and laypeople's experiences increasingly affect the naming and framing of mental illness by clinicians. With accurate illness experience informing illness stereotypes, illness stereotypes might be beneficial to laypersons and clinicians alike to better understand the conditions of a mental illness. Mental health stigma can cause individuals to reject mental health diagnoses and result in an aversion to medicine along with a lack of trust in doctors. Thus, mental health stigma contributes to disempowering thoughts that can cause those with a diagnostic label to question their experiences and those without a diagnostic label to feel equally illegitimate. This illuminates the power gradient that exists between lay people and mental health professionals and which disproportionately affects vulnerable populations as different standards of care are present depending on SES.

In order to incorporate helpful coping strategies, early diagnosis is critical for individual success. Ketisch et al. suggests improvement of early ADHD detection through

universal screening in elementary schools, individual referrals for those with ADHD symptoms, and screening for comorbid disorders for those diagnosed with ADHD (Ketisch et al.). Strategies also call for a multifaceted approach for ADHD adolescents. For example, improved teaching strategies might not be enough for ADHD adolescents who face peer rejection. Instead, individuals with ADHD might benefit from resources that focus on their functional impairments so that individuals are satisfied with themselves and view themselves as capable in several domains (Ketisch et al.). Furthermore, coordinated communication between the adolescent, teachers, clinicians, and parents is crucial for treatment efficacy and to overcome treatment barriers, including mental health stigma and fundamental limitations of the U.S. mental healthcare system.

### *Final thoughts*

When starting my research, I first thought of diagnosis as a standardized label that practitioners used to refer to a patient's condition. And it is. The job of a diagnosis is to identify a problem along with concrete treatment and solution for the problem. However, diagnosis involves multiple parties and interest groups outside the patient who should fully understand the impact that mental health diagnosis has on society, not including the patient themselves. This process causes existential questions to arise and outside parties to question the everyday judgement and choices of a patient. We should care about the structures and categories we are creating because those are the same structures that we are using to understand ourselves. It is essential that we critique the structures that we reference in regards to our own individual identities so that we can improve how future patients self conceptualize. People should have access to information about who they are and be able to incorporate that information into their identity.

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