

ADHD IDENTITY: A CONCEPTUAL DEVELOPMENTAL MODEL

by

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## **Abstract**

There is an extremely limited amount of research that looks at the identity development for adults with disabilities, particularly those who identify with a hidden diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD). More and more students with disabilities, such as ADHD, are entering college in the United States. It is increasingly important to understand the processes by which adults with ADHD develop psychosocially and develop a healthy identity around their diagnosis. Faculty and administrators in education can better understand how to assist this exceptional population in order to assist them in their development of a positive identity.

This study was focused on investigating the process of forging an ADHD identity. Other factors considered in the study were gender, race/ethnicity/culture, and sexual identity.

The participants in this study were adults with ADHD recruited from a four-year private institution of higher education in the Western United States. Each participant completed an extensive interview with the researcher. Themes from the interviews were analyzed through a framework that included the theories of Erikson (1959, 1982), Chickering and Reisser (1993), and Gibson (2005).

Results were discussed and the limitations to the study were considered. More research in the area of ADHD identity development was indicated from the results of this study. Suggestions for further research that focuses on this psychosocial dynamic process of identity development in adulthood was reviewed.

## **Chapter 1: Introduction**

### **Background of the Problem**

The identification process for those diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) is complex. However, identifying as a person with ADHD has important implications for an individual's interpersonal interactions and well-being. By claiming an identity that includes ADHD as an aspect, one can advocate for special needs in one's social and physical environments. One can also receive special benefits, such as accommodations through a university's academic support center or in the workplace. Less is known about ADHD in adulthood compared to the research on childhood (Weyandt & DuPaul, 2006). ADHD affects approximately 2% to 4% of the college student population. College students with ADHD are at greater risk of experiencing academic and psychological difficulties. Having an ADHD diagnosis is a highly stigmatized status, and claiming an ADHD identity may lead to negative stereotypes regarding aspects of being a disabled person (Shames & Alden, 2005).

Not all the individuals who meet the criteria for an ADHD diagnosis claim it as an identity (Weyandt & DuPaul, 2006). Findings suggest that approximately 25% of the students receiving disability services have ADHD, but this number may be inaccurate due to the hidden nature of the diagnosis. Future research in adult populations with ADHD is needed. Weyandt and DuPaul encourage that additional studies on effects of medications, psychological, academic, and neurological functioning are needed for adults with ADHD. Little is understood regarding any aspect of adults with the disorder.

The goal of this dissertation was to assess how individuals with ADHD develop a conceptualization of self as having ADHD. The study attempts to shed light as to how these individuals develop a sense of identity and how their sense of identity evolves over time (if it at all does). This study is also concerned with how demographic factors such as sexual identity, gender, or race/ethnicity/culture influence this developmental process.

The remainder of Chapter 1 will provide an overview of the demographics of individuals with ADHD and identity development, which will continue into Chapter 2. Chapter 1 will include a statement of the problem, purpose of the study, and the importance of the study. In order to understand how and why some adults with ADHD claim and identity and others do not, it will be important to define ADHD. Chapter 2 provides an overview of the disorder, as well as overviews of a variety of developmental models, which attempt to explain various aspects of identity development. Finally, this chapter will include the limitations and delimitations, a definition of terms used in the study, and an outline of the organization of the remaining chapters.

### **Statement of the Problem**

As the number of adults with ADHD continues to rise there is a greater need for proficiency in working with this population. Practitioners, teachers, researchers, and those living with the diagnosis must understand how ADHD affects an individual's identity development. Programs and learning environments must be created and constructed around this understanding as to how identity development is impacted by having ADHD.

### **Purpose of the Study**

The purpose of the study is to describe the experiences that influence the identity development of adults with ADHD. Complex theoretical resources such as Erikson (1982), Chickering and Reisser (1993), or Gibson (2005) fail to adequately describe the development of identity for specific communities, such adults with ADHD. Cass (1979) does an adequate job of providing a developmental framework for one aspect of the individual's identity. She describes the identity formation for only a sexual identity development. Gill (1997) on the other hand, sets forth a model that attempts to describe the facet of developing a disabled identity. Finally, Abes et al. (2007) attempt to explain how individual's with multiple identities forms a cohesive sense of self by addressing the development as a multidimensional process. Kohlberg (1966) and Spence (1993) have addressed issues of developing an identity based on gender. Root (1990), Phinney (1989), and Poston (1990) provide models that consider the identity development for race and ethnicity.

Thompson, Bryson, and Castell (2001) argue that disability, sexual minority, gender, racial/ethnic, or multiple identity development theories have adequately described the developmental process for these individuals. They suggest that a more complex theoretical lens is needed to capture the unique experiences of adults with ADHD. The authors encourage the need for better theories and practices in order to better support and understand minorities with disabilities, such as ADHD. Their argument gives rise to the importance of the intended study. It is the lack of knowledge in the literature that

highlights the importance of this study's need in shedding light upon the complexities of identity development for individuals with ADHD (Weyandt & DuPaul, 2006).

The purpose of this phenomenological study is to understand the development of an ADHD identity for adults. Several psychosocial theories will provide the framework for interpreting the identity development of adults with ADHD. The three theories that will guide the inquiry will come from authors Erikson (1959), Chickering and Reisser (1993), and Gibson (2005).

Chickering and Reisser (1993) present a psychosocial theory on student identity development that views development as a series of tasks or stages dealing with thinking, feeling, believing, and relating to others. The seven vector model explains the development of students while in college. The seven vectors are (a) developing competence, (b) managing emotions, (c) moving through autonomy toward interdependence, (d) establishing identity, (e) developing mature relationships, (f) developing purpose, and (g) developing integrity (Chickering & Reisser, 1993). By examining the identity development of adults with ADHD from a psychosocial theoretical perspective, this study was conducted to gain a better understanding of how identity development is formed.

The following research questions guided this study: (a) how do adults with ADHD come to understand their identity development; (b) how does other dimensions of identity, such as gender, race/ethnicity/culture, or sexual identity intersect with ADHD

identity development; and (c) how does this process inform the embracement or rejection of a ADHD identity?

### **Importance of the Study**

The significance of this study is that it allows practitioners to those with ADHD in a more effective manner. A model of identity development can be useful in a variety of clinical situations, including within a classroom, medical, or social environment. While there has been a start to understanding disability identity development and identity development in general, there is limited information in the understanding as to how adults with ADHD develop a healthy sense of identity. There is a gap in the research in this area (Weyandt & DuPaul, 2006, Shames & Alden, 2005).

This study may also be useful in other areas of identity development. Scholars who study racial/ethnic/culture, gender, sexual identity, or multiple factors in identity development might find this study helpful. This study highlights the development of a marginalized group that may have parallel qualities to these other areas. This study might be helpful in understanding the development of multiple identities, as ADHD may be only one component to consider. It may be helpful in understanding the ways in which multiple identities are navigated (Reynolds & Pope, 1991).

Recommendations for professionals who are interested in how identity development with ADHD intersects with other systems and environments could benefit from examining this study. Relational issues and mental health questions for adults with

ADHD might find benefit from this study for those scholars that are studying these effects. There is still a significant need for further research (Weyandt & DuPaul, 2006).

The primary purpose of this study is to provide significant knowledge to the literature on identity development of those living with ADHD. There are no published dissertations that address this complex issue. This study will hopefully provide faculty and professions who work with individuals with ADHD, as well as those diagnosed with ADHD, with information and education that will promote positive identities, programming, and treatment for those with ADHD.

### **Limitations and Delimitations**

There are several limitations to this study that must be addressed. First, the study is limited in that it only examines the experiences of adults with ADHD, primarily college students. The sample was limited due to recruitment from an urban university due to methodological reasons, our understanding of the process of identity development for those outside the sample is limited. The construction of an ADHD identity is very much paired with where one is at in their lifespan development. The identity development for someone who was diagnosed with ADHD at 8 years old may be different than someone who was diagnosed at 19 or 53 years old for example.

Additionally, this study only explores an ADHD diagnosis. This is a very specific type of disorder that affects academic and psychological functioning. For example, other learning disorders or disabilities may not influence identity development in the same way as having an ADHD diagnosis. Generalizing the results of this study to populations of

individuals with ADHD outside of this sample may be a limitation. Future research should expand this model to include other specific types of disabilities, such as learning disorders or autism and other groups.

The data is not longitudinal in this study presenting another limitation. Without longitudinal data how one completes an ADHD identity in later adulthood cannot be determined. The author of this study is not diagnosed with ADHD, which is a potential bias in the data. While affected by ADHD, similarities and differences between the interviewer and respondents can affect the validity of the data (Tourangeau, Rips, & Raninski, 2000).

The sample was a sample of convenience due to the constraints of the study. There were restrictions involved in finding participants that meet the qualifications for this study. The population of individuals with ADHD at an urban research university was relatively small compared to the overall larger context. This study was also based on self-reporting, particularly on the respondents disclosing their ADHD diagnosis. Self-reporting may be subject to response bias.

Another limitation to this study is the manner in which participants were selected. Participants were recruited from the academic support center and flyers. The majority of participants have received some type of support services. Respondents were given cash compensation which affects motivation for participation.

Finally, the validity of the categories created from the interviews could be questioned. The author's rating and analysis of the data into categories may be different from what the participant intended to convey in the interview or survey.

Despite the limitations, this was an interesting study with informative results that might be the catalyst for more in-depth investigation into how an ADHD diagnosis affects the identity development for those with the disorder.

### **Definition of Terms**

The following terms and acronyms are used in this study. They describe various aspects of the factors considered in this study.

*ADHD* refers to Attention-Deficit/Hyperactivity Disorder. ADHD is a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (2000). The primary feature of ADHD is a more severe pattern of inattention and/or hyperactivity-impulsivity compared to equal levels of development. Generally, the symptoms must be present before the age of seven years. The impairment must occur within two environments, such as school, work, or home.

*LD* refers to Learning Disability. Learning disability is a classification including several disorders in which a person has difficulty learning in a typical manner. LD is typically caused by unknown factors.

*Sexual identity* refers to an enduring pattern of attraction, behavior, emotion, identity, and social contacts which can include attraction to the opposite sex, same-sex, neither sex, or both sexes. *Gay* refers to men who have romantic feelings for those of the same

gender. It may also refer to anyone who has sexual relationships with the same gender.

*Lesbian* refers specifically to females attracted to other females.

*Gender* refers to a cultural role. It is not a biological sex.

*Race/ethnicity/culture* refers to socially constructed labels. Ethnicity is a population of human beings whose members identify with each other, on the basis of a real or a presumed common genealogy or ancestry. The term race refers to the concept of dividing people into populations or groups on the basis of various sets of physical characteristics. Culture is the beliefs and behaviors characteristic of a particular social, ethnic, or age group.

*Identity development* refers to a process of learning that one is competent and that one is independent in their thoughts and values. A feeling of positive self-esteem is an indicator for identity development and it is a process of maturation (Chickering & Reisser, 1993).

### **Organization of the Study**

The first 2 chapters will set the stage for the remainder of this study. Chapter 1 introduces the problem and the significance of this study. Chapter 2 highlights the current and existing research on the topic of ADHD and identity development. It is also significant in its discussion of the variety of theoretical models that work to explain various aspects of identity. Chapter 3 provides an overview of the methodology for the study. Chapter 4 includes the results for the study. Finally, in Chapter 5, a discussion and conclusion of the study's findings occurs. In Chapter 5 the discussion of the study

will occur. Chapter 5 will include: the summary of findings with the purpose of the study, methodology, sample population, data collection, and key findings. Also included in Chapter 5 will be the implications for practice, limitations of the study, recommendations of future research, and a conclusion.

## **Chapter 2: Literature Review**

Traditional models of identity development have unfortunately been unable to capture the dynamic experience of individuals who identify as having Attention-Deficit/Hyperactivity Disorder (ADHD). A review of the literature focusing on the identity development of adults with ADHD remains dismal. Minorities with disabilities, when reviewing the literature, have been given limited attention and remain invisible (Underhile & Cowels, 1998). Attention has been given more to adolescent minority students in this population (Henning-Stout, James, & Macintosh, 2000). College campuses and workplace environments have been growing with diversity and students with ADHD are an additional contributing factor to a diverse environment. There are more and more students entering college with disabilities, but ADHD in particular is often “hidden.” It is also more and more important with this increase in ADHD to provide accurate information to the public. Understanding the identity development for individuals with ADHD is potentially very useful to practitioners who will be assisting this population.

The purpose of this study was to examine the identity development of individuals with the hidden disability of ADHD. This particular identity development was analyzed specifically within the framework of three existing models: Erikson (1982), Chickering and Reisser (1993), and Gibson (2005). This study will also consider other models and theories on identity development. Additionally, this literature review will consider

models of sexual identity development, race/ethnic/culture identity development, gender identity development, disability identity development, and multiple identity development.

This chapter focuses on the overview of ADHD. An overview of the general theories related to identity development across the lifespan and college student identity development, as well as minority models of identity development, will be presented. The literature on students with disabilities and ADHD will be examined. The current research and literature about issues of identity development for those with ADHD will be addressed. The development of an ADHD identity will also be considered in how it relates to the overall identity development, considering the influence of additional diversity factors, such as gender, sexual identity, and race/ethnicity/culture.

### **Background of ADHD**

Developmentally inappropriate levels of inattention and/or hyperactivity-impulsivity that are exhibited across the life span are how Barkley (2006) characterizes ADHD. College students with ADHD complete fewer degree programs compared with their peers without ADHD. While the actual number of college students with ADHD is unknown, it is approximated that 18% of college students who receive disability services are identified with having ADHD (NCES, 2001; Wolf, 2001).

Many studies have looked at the prevalence of ADHD among children and adolescents under 18 years old. It is estimated that there is an approximate 1 to 10% prevalence of ADHD within the school-aged population. Polanczyk et al. (2007) estimated a world-wide prevalence of ADHD of 5.29%. In college, students with ADHD

are not required to disclose their disability, leaving the prevalence numbers for this population unavailable. About two in five college students with disabilities have ADHD or a learning disability (DuPaul, Weyandt, O'Dell, & Varejao, 2009). Studies suggest that approximately 2% to 8% of college students' self-report symptoms associated with ADHD. These numbers do not reflect the numbers of students with documented ADHD. More studies are needed to document the number of college students with diagnosed and documented ADHD across colleges and universities (DuPaul et al., 2009).

#### **Academic functioning of adults with ADHD.**

Poor academic achievement, school failure, and being less likely to complete a college education than their non-ADHD peers, are all risk factors for college students with ADHD (DuPaul et al., 2009). A study by Heiligenstein, Guenther, Levy, Savino, and Fulwiler (1999) found that there were lower GPAs, self-reported academic problems, and a higher probability of being on academic probation for the ADHD college students than their control group. They suggested external factors affected the symptoms of ADHD, such as the specific university, loss of support due to living away from home and family, and the lack of individualized education. Study habits and skills, and academic adjustment were all negatively correlated to ADHD symptoms in a recent study by Norwalk, Norvilitis, & MacLean, 2008). Despite the challenges college students with ADHD face, some studies suggest that there can be academic success for this population. One study found that the GPA for both college students with ADHD and without was similar (Sparks, Javorsky, & Philips, 2004).

**Social functioning of adults with ADHD.**

Like the review of academic functioning for adults with ADHD, the review of studies on the social functioning revealed similar findings. Meaux, Green, and Broussard (2009) found seven factors that help college students with ADHD cope with college adjustment. The factors they identified were: accountability, learning from consequences, alarms and reminder, CNS stimulants, self-talk, removing distractions, and staying busy/proper scheduling. It has been found that college students with ADHD are more likely to engage in smoking both nicotine and marijuana, and other drug use, other than alcohol. Students with active symptoms of ADHD engaged more in substance abuse behaviors compared to students without active symptoms (Upadhyaya et al., 2005). It has also been found that students with ADHD experience a lower quality of life compared to their non-ADHD peers (Grenwald-Mayes, 2002). However Rabiner, Anastopoulos, Costello, Hoyle, and Swartzwelder (2008) found positive findings regarding the social functioning of college students with ADHD. They found there was no difference between students with ADHD and non-ADHD in the self-reporting of satisfaction with social relationships.

**Psychological and neuropsychological functioning of adults with ADHD.**

Of the relative few studies on the psychological or neurological functioning of adult students with ADHD, the findings have been mixed (DuPaul et al., 2009). Findings have been unclear. Psychological distress and aggression have been the overwhelming findings, but other studies have not supported these differences. On neuropsychological

testing, ADHD students and non-ADHD students perform at equal levels (DuPaul et al., 2009).

### **Background of Identity Development**

Identity development is considered a critical task to master during young adulthood and throughout the lifespan. Experiences during this time of development are influenced by past experiences, as well as current experience is very powerful in shaping how one thinks, behaves, and perceives themselves. Theories are useful tools in helping those interested in understanding diverse populations. Theories, however, consider broad frameworks and may miss unique individual experience that shape student identity development. Erikson (1950, 1968, 1982) and Chickering and Reisser (1969, 1993) are developmental theorists who have addressed developmental issues of adulthood.

#### **Erikson.**

Erikson proposes that each stage of human development is presented by a crisis in which the individual must resolve in order to develop in a healthy manner. It is ideal for the individual to resolve the crisis, but this may not happen in real life circumstances. He believed that the interactions of biologically based maturations and the demands of society is what allow personalities to evolve. The crisis at each of Erikson's ten developmental stages asks the individual to adjust to stressors and conflicts. Erikson was one of the first developmental theorists to consider non-Western cultures (Zastrow & Kirst-Ashman, 2010).

Erikson may aid in the understanding of the developmental experiences of adults with ADHD. He developed one of the most popular theories of understanding human development (Erikson, 1959). As this study explores the identity development of those with ADHD, this theory is crucial. Erikson describes how people develop their individual self-representations.

The early adolescent stage (stage five), later adolescent stage (stage six), as well as stage the subsequent stages into adulthood describes the developmental stages most significant for identity development. In stage five, the crisis to be resolved during early adolescents is group identity versus alienation. Between the ages of twelve to eighteen years of life the developmental crisis includes: physical maturation, formal operations, emotional development, membership in peer groups, and platonic and romantic relationships. In stage six, the crisis to be resolved during later adolescents is individual identity versus identity confusion. Between the ages of eighteen and twenty-two years of life the developmental tasks include: autonomy from parents, sex role identification, internalized mortality, and career choice (Erikson, 1982).

### **Chickering and Reisser.**

According to Chickering & Reisser (1993), student developmental theory must be relevant and useful. Their seven vector model is an example of this. The model explains the development of students as they progress in college. Stimulation of a students' thought and decision-making process is what propels a student forward along the vectors. They may also move backwards if there is a lack of stimulation. The seven vectors are

(a) developing competence, (b) managing emotions, (c) moving through autonomy toward interdependence, (d) establishing identity, (e) developing mature relationships, (f) developing purpose, and (g) developing integrity (Chickering & Reisser, 1993).

Chickering's (1969) Theory of Identity Development is a psychosocial theory that views development as a series of tasks or stages dealing with thinking, feeling, believing, and relating to others. Chickering proposed seven vectors of development that contribute to the formation of identity. Students move through these vectors at different rates, vectors can interact with each other and students often find themselves re-examining issues associated with vectors they had previously worked through. Although not rigidly sequential, vectors do build on each other, leading to greater complexity, stability and intellectual aspects of development.

***Developing competence.***

“Developing Competence” is characterized by three different types of competence that are developed in this vector. Intellectual competence, physical and manual competence, and interpersonal competence are the three types (Chickering & Reisser, 1993).

Intellectual competence is the skill of using one's mind. Mastering content, gaining intellectual sophistication, and building skills that help in comprehension and analyzing is what is involved in intellectual competence.

Athletic, artistic, and other tangible activities are how physical and manual competence is developed and generated. Strength, fitness, and self-discipline can all be observed in growth. Students' skills in group work and settings characterize

interpersonal competence. Ability to listen, cooperate, and communicate, as well as “work smoothly with a group, facilitate other’s communication, add to the overall direction of the conversation rather than go off on tangents, and be sensitive and empathetic with others” demonstrate college students’ development in this first vector (Chickering & Reisser, 1993, pp. 46, 72).

***Managing emotions.***

Students become more aware of their emotions in the second vector. When students learn to identify and accept feelings as normal reactions to life experience awareness of emotions increases. Students can understand and amend outdated assumptions that amplify negative feelings (Chickering & Reisser, 1993). It is suggested by this theory that students enter college “loaded with emotional baggage” and only enter this vector when they learn these “appropriate channels for releasing irritations before they explode, dealing with fears before they immobilize, and healing emotional wounds before they infect other friendships” (pp. 46, 83). Students’ ability to respond appropriately to the emotions that may face them is the most important aspect of this vector. Fear, anxiety, anger leading toward aggression, depression, guilt, shame, care, optimism, and inspiration are all emotions that can be common in college students’ experiences and development (Chickering & Reisser, 1993; Evans, Forney, Guido, Patton, & Renn, 2010).

***Moving through autonomy toward interdependence.***

Movement through autonomy toward interdependence for college students, according to Chickering and Reisser (1993), consists of emotional and instrumental independence

as well as the recognition and acceptance of interdependence. A movement away from reassurance, affection, and approval from parents, peers, and other social groups is the characterization of emotional independence. Students may risk loss of friends or status during this vector in order to pursue strong interests or stand on convictions. An increased ability to be self-sufficient and to leave one place and be successful in another is how instrumental independence is defined. During this vector, students become improved critical thinkers. They become better at putting these thoughts into action. When students master lessons about reciprocity, compromise, and sacrifice recognition and acceptance occurs. In this third vector, self sufficiency becomes the most important aspect and feature.

***Developing mature interpersonal relationships.***

Students are prone to develop more mature relationships during the “Developing Mature Interpersonal Relationships” vector. According to Chickering and Reisser (1993), mature relationships are characterized by “tolerance and appreciation of differences and capacity for intimacy” (p. 48). Students are required to accept individuals for who they are, appreciate differences, bridge gaps, and be objective in this vector. A heightened sense of appreciation for community and cultural diversity can also be observed in this vector (p. 146). Students are able to make lasting commitments grounded in honesty and responsiveness due to an increase sense of intimacy in relationships. In both friendly and romantic relationships, there is a movement away from excessive dependence or

dominance. Interdependence between equals occurs in vector four. During this vector, deeper connections develop between individuals.

***Establishing identity.***

This vector is dependent on the experience in the vectors that come before it. Identity development is “like assembling a jigsaw puzzle or remodeling a house” (Chickering & Reisser, 1993, p. 48). There are several characteristics of “Establishing Identity.” These characteristics include: comfort with body and appearance, comfort with gender and sexual orientation, sense of self in social, historical, and cultural contexts, clarification of self-concept through roles and life-style, sense of self in response to feedback from valued others, self-acceptance and self-esteem, and personal stability and integration. Increased awareness of familial and religious connections, as well as a sense of how one is evaluated by others, and establishing roles at home and at work are other factors of development in this vector. Clarity and stability are the result of student maturation and development in this vector.

***Developing purpose.***

Students then attempt to determine “who they want to be” in the sixth vector. Developing purpose really “entails an increasing ability to be intentional, to assess interests and options, to clarify goals, to persist despite obstacles, and to make plans” (Chickering & Reisser, 1993, p. 209). Some of these plans include generating vocational plans and aspirations, personal interests, and interpersonal and family commitment. Students discover what they love to do and attempt to follow through on those jobs and

interests in this vector. Life-style and family considerations also become a factor in decisions and goal setting as students develop in vector six (Evans, Forney, Guido, Patton, & Renn, 2010).

***Developing integrity.***

“Developing Integrity” is the final vector in this theory. Students, while in college, tend to experience a change in their value system and develop their own set of values and interests. They move away from the dogmatic beliefs from their past. Humanizing values, personalizing values, and developing congruence are the three different stages in this last vector (Chickering & Reisser, 1993). Balancing self-interests with the interests of other humans is the definition of humanizing values. Confirming core values and beliefs through one’s experience while respecting other opinions and points of view involves personalizing values. Developing congruence occurs during this vector. congruence is when students’ behavior becomes consistent with the values and beliefs they hold. Students’ values and beliefs have implications in their actions is recognized in this vector (Evans, Forney, Guido, Patton, & Renn, 2010).

Chickering and Reisser (1993) state that there is a lack of literature that sheds light as to how a minority identity is constructed. The authors argue research is needed to address the impact of issues such as race/ethnicity/culture, gender, and sexual identity. This could also be assumed for individuals with disabilities, such as ADHD. The research that does focus on identity development is specifically focused on those with learning disabilities (Bentley-Townlin, 2002).

### **Background of Identity Development and ADHD and Disability**

Anctil, Ishikawa, and Scott (2008) provided a model for academic identity development particular for students with learning disabilities. They explored the cognitive and behavioral manifestations of self-determination particularly with successful students with LD in college. The study provides evidence into the area of development surrounding self-determination in college that has been lacking in the review of the literature.

This study provides a model of academic identity development for college students with learning disabilities with four integrative themes. The themes identified by Anctil et al. (2008) include: persistence, competence, career decision making, and self-realization. While the study offers a model of identity development, there is no ethnic diversity represented in the sample. The current study seeks to highlight the effects of race/ethnicity on the development of an ADHD identity in college. Anctil et al. (2008) did not conduct any triangulation of the data gathered from their participants. Like the purposed current study, this study offered financial incentives that may have biased the sample and results. This study highlights the need for further research providing more evidence and examples of successful adults with learning disabilities who have navigated a positive identity. This supports the current study's investigation into a developmental model for adults with ADHD.

Shames and Alden (2005) explore the identity changes that college students with learning disabilities and ADHD report after they participate in a study abroad program.

They propose a model of identity development based on the effect of a specific program. They recommend how to better include this population of students within specialized programs. Their study provides further evidence for the support of the currently proposed study, highlighting the need for more generalizing to the overall context of developing an ADHD identity in adulthood.

Adults with learning disabilities, such as ADHD, experience social and educational marginalization over their development (Shames & Alden, 2005). There has been a gap in the literature that explains this development, particularly for those who possess an ADHD diagnosis. Being able to complete the long-term goals of a task or focusing for a sustained period of time, forgetfulness, motivation issues, poor self-esteem, difficulty in relationships, and difficulty navigating social environments are all symptoms associated with ADHD that have an effect upon marginalization (Novotni & Whiteman, 2003). For adults with ADHD, the diagnosis is a persistent issue, continuing throughout adulthood. They often cannot tolerate boredom and lack an ability to organize in both short- and long-term timeframes (Barkley, 1997).

According to the DSM-IV-TR (American Psychiatric Association, 2000), the features of ADHD have severe implications for the social and emotional functioning of a adults with this diagnosis. The number of these students has increased over the years on college campuses. But it is difficult to get an accurate assessment considering many students do not disclose their diagnosis or have never been formally diagnosed (Shames & Alden, 2005). It is often the case for individuals that ADHD exists with another DSM-IV-TR

diagnosis, such as depression, anxiety, or another type of learning disability. This could be up to 40% of those with ADHD (Shames & Alden).

Similar to the theoretical framework followed in this study, Shames and Alden (2005) utilize the constructs of developing an identity in college from Chickering and Reisser (1993). The authors confirm in their study that the understanding of an identity development can be confusing based on the multiple approaches outlined in the review of the literature. They confirm the lack in any one model to full capture all aspects of identity development. The article reinforces that many factors, including gender, sexual identity, and race/ethnicity/culture, all impact an individual's development of an identity. Until this article, no attempts have been made to understand the development of an ADHD identity in the literature. A significant limitation to this study is that the model only focuses on a LD or ADHD identity development, specific to the effect of a study abroad program influence this identity development. It is arguable that identity development takes place across multiple domains simultaneously and over time. Identity development is a highly unique experience, as signified by Shames and Alden. The difficulty in attempting to capture all aspects of development of adults with ADHD may be challenging.

It is important to highlight that individuals with ADHD have high intelligence levels and can perform complex educational and academic tasks, but maybe in alternative ways (Shames & Alden, 2005). They can be successful and what this study hopes to demonstrate is that they can forge a healthy and positive identity as a person with ADHD.

Much of the literature on adults with ADHD has been focused on the challenges they face and not on how they develop a sense of identity (Shmulsky, 2003). College students with ADHD can be resilient and successful. The need for this study is key to address this gap in the knowledge for how the development of these factors may occur. With all this considered, the majority of the literature continues to remain focused on understanding ADHD for primary school children (Shames & Alden, 2005). While research suggests students with ADHD may be slow to learn, this article highlights positive identity development can occur with the correct interventions. The following article explores the identity development of school aged children after receiving an ADHD diagnosis.

In a study by Brady (2004), the focus was on how children with ADHD develop a sense of identity based on their knowledge about their diagnosis and treatment. This article represents the majority of the literature on ADHD with a focus on childhood and adolescents, regardless of the aspect of ADHD under investigation. In the small sample, the researchers found that there were both practical and social consequences with having a diagnosis of ADHD. This diagnosis, it was found, gave a framework for understanding behavior. The results were able to contradict prior findings that having a medical diagnosis of ADHD did not always negatively affect students. The authors argue that referrals influence outcomes for students, which then in-turn influence identity development. These results are significant to the current study in that it provides evidence of identity development models taking into account prior attachment experiences. The researchers suggest that the experiences of primary school students

should be considered in understanding their experiences in developing a cohesive identity (Brady). This finding supports the notions being undertaken in the current study.

### **Overview of Disability Identity Development Models**

#### **Medical model of disability.**

Justification of disability is the primary concern of the medical model of disability. Disability is simply the problem of the individual. There is no distinction between the impairment faced and the disability itself in this model. Any deprivation encountered by disabled people was located within their focal system (Swain, French, & Cameron, 2003).

Hahn (1994) proposes from a medical model disability is regarded as a limitation or deficit. In response to this belief, he offers a minority-group model. This model regards disability intersection of people and their environment. Hahn states that the problems of disability are outside instead of internal. Equality and liberty are what is required to provide remedy for people with disabilities. The investigation into disability identity has not received the status compared to racial/ethnic or gender development studies. Strength in Hahn's model of identity is that it incorporates many alternative theoretical perspectives in the study of disability identity development.

In the medical model, the disabled person is seen as defective and is in need of a cure. They are defined as dependents that require caretakers to assist them on a daily basis. The medical model does not take a strengths based approach; rather the model focuses solely on the individual's deficits. Results from this deficit approach lead to segregation for the disabled person. Disabled individuals lack respect in the medical model. There is an

ignorance of cultural, social and institutional barriers that disabled people face within the model. Abnormality is thought of as being undesirable in most mainstream cultures and in the medical model this requires disabled individuals to take means to become normal.

The International Classification of Impairments, Disabilities and Handicaps developed by the World Health Organization in 1980. It summarizes the medical model and makes several distinctions. One distinction is impairment. Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function. The second distinction is disability. Disability is defined as any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (Barnes, Mercer, & Shakespeare, 1999).

The Union of Physically Impaired Against Segregation (UPIAS), in 1976, produced a document calling for the formation of a group. This group would allow the views of disabled people themselves to be heard and would lead to the creation of the Social Model Of Disability (Barnes, Mercer, & Shakespeare, 1999).

### **Social model of disability.**

For much of the 1980s and 1990s the social model of disability has been the foundation for collective organization amongst people with disabilities (Oliver, 1996). The model has been successful in promoting disability as a civil rights issue and has been pivotal in giving disabled people autonomy and control over their individual lives. These successes have not been without scrutiny as well.

Oliver (1996) states that since the 1960s there has been various attempts to develop a method to conceptualize the understanding of disability. This has led to the adoption of two alternative schemas in understanding disability. The World Health Organization (WHO) International Classification of Impairment, Disability, and Handicap (ICIDH) include three criteria: impairment, disability, and handicap. Impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function. Disability is any restriction or lack of ability to perform an activity in the manner or within the age range to be considered normal. Handicap is a disadvantage for a given individual, resulting from an impairment or disability that limits or prevents fulfillment of a role that is normal for that individual (Wood, 1980). The Disabled People's International (DPI) puts the second schema forth. DPI defines disability with two categories: impairment and disability. Impairment is the functional limitation within the individual. This limitation is caused by physical, mental or sensory impairment. Disability is the loss of limitation of opportunities to take part in the normal life of a community (DPI, 1982). Terminology in both schemas is confusing and there are real similarities between both.

Finding causality has been a major effort of both the scientific and social science communities (Oliver, 1996). Both camps from DPI and WHO accuse the other of being inaccurate in explaining the causality for disability. Within the DPI schema, disability is understood as entirely social, it has nothing to do with the body. Under this schema,

impairment is nothing less than a physical body description. Within the WHO schema, chronic illness is causally related to the disadvantages disabled people experience.

The concept of normality underlies both schemas. There is the assumption that all disabled people are trying to achieve normality. The current trend in the disability movement is insisting on an approach that celebrates the differences and does not focus on the restoration of normalcy for people with disabilities. Oliver (1996) argues to not assume that model in general can account for all explanations. The social model of disability cannot explain all facets of disability. He argues that the social model is not social theory. He also stress that one should not ignore the criticisms of the model nor abandon the usefulness of it. It is Oliver's belief that to understand the identity of people with disabilities a dialogue must occur between people who are disabled and the medical community.

### **Gill.**

Gill (1997) builds on Erikson's (1968) psychological development model, which argues that identity development is an essential life task that most human beings undertake. In Gill's model, she creates a model of identity development that examines how people with disabilities come to terms with who they are. She argues that identity development for people with disabilities is a journey. In this journey, individuals will become comfortable with membership in a collective group identity as individuals who are disabled. Gill's theory of disability development has become the dominant model of identity development applied to individuals with disabilities since its inception in 1997.

While Gill does not focus specifically on college students, like the focus of the current study, she does look at how a disability identity is integrated. This integration is complex, and like the models of identity for the LGBT community, disabled people exist within families and communities that do not share their experiences.

Gill's (1997) model describes how the process of identity development occurring for with people with disabilities. She presents a four-stage model. It is the following four stages that Gill believes individuals with disabilities progress through in their identity development. The stages of identity development according to Gill are: (a) coming to feel we belong (integrating into society), (b) coming home (integrating into the disability community), (c) coming together (internally integrating our sameness and differences), and (d) coming out (integrating how we feel with how we present ourselves).

People with disabilities work hard to gain access to mainstream society in the first stage of Gill's model. This first stage is called "coming to see we belong (integrating into society)." People with disabilities want to be treated at equal counterparts along with other non-disabled citizens. They want to be seen as everyday members of society. During this stage, presenting oneself as able-bodied is of paramount importance. The key task is to try to "pass" so that one does not appear to be disabled.

In stage two, "coming home (integrating into the disability community)," an individual with a disability comes into contact with a community of "others." Individuals are often resistant to the idea of identifying with a community of people with disabilities,

according to Gill. After engaging with others who have disabilities, this resistance is typically overcome. Those that have prior experience as a disabled person “coming home” can help others by finding joy in their company. “Coming home” allows people with disabilities to connect, regardless of where they identify in Gill’s stage model. This connection helps fulfill companionship and decreases identity isolation. Relationships are formed based on facing similar obstacles. These relationships expose an individual to others who view their disability as a positive cultural identity. Individuals come to understand that living with a disability makes them part of a unique culture. Gill concludes this is achieved by the exposure to others that identify themselves as part of disability culture.

Once stage two is experienced, according to Gill (1997) individuals begin to enter stage three. Stage three is “coming together (internally integrating our sameness and differences). Coming to accept the notion that one will live in two cultures is the developmental identity task crucial to stage three. The two cultures include: the world of disability and the world of able-bodied. In order to achieve this task, Gill concludes one must separate from the mainstream culture in which they were raised. “In order to affirm our disability experience as a positive and important feature of our identities, people with disabilities have had to separate and individuate from a parent culture that fears and devalues disability” (Gill, 1997, p.44). Ties to the mainstream culture are so deep Gill argues that the process of separation is very difficult. “Coming together” is about the process of learning how to exist in two cultures as a person with disabilities. It allows

individuals with disabilities to heal themselves as well as bridge the gap between the two worlds. Gill states that the important aspect of this stage is the individuals learned ability to move in and out of both worlds. This movement is key in the formation of a positive self-image for people with disabilities.

Finally, after negotiating the previous three stages, the individual with disabilities is ready to move into the last stage of identity development. Gill calls this last stage “coming out (integrating how we feel with how we present ourselves).” In this stage, one no longer feels the need to hide their identity as a disabled individual. Individual liberation from the social barriers that stigmatize disability is the main task of this stage and this occurs by one embracing the cultural ties to the world of disability. The authentic self is exploring in a more comprehensive manner now that freedom is achieved. “Coming out” is not necessarily a personal choice, but a personal choice, which has profound implications. Gill believes by publicly embracing one’s disability can lead to increased levels of political activism. The process of identity development according to Gill is a linear progression. She describes the various stages as a set of steps. Her model is a set of very specific task that one must move through sequentially.

**Olkin.**

Olkin (1999) provides a conceptual framework based on the social model of disability that helps to understand the individual with a disability in the context of their specific experiences. She emphasizes the importance of considering the logistical, social, legal,

and attitudinal constraints for people with disabilities. Her model asks to define disability as a minority experience rather than a medical deficit.

Olkin (1999) suggests the minority model of understanding disability identity is the new paradigm to view disability. People with disabilities must be considered a minority or underrepresented population. In this model, disability is socially constructed and the problem lies in the environment and not with the person who is disabled.

In Olkin's (1999) model, the individual moves from the vulnerable effects of stigma, prejudice, and discrimination toward having the disability become part of one's self-identity. As one develops a sense of being a person with a disability, one moves from *Functional Limitations Group*, to *Disability Identity Group*, and then to *Civil Rights Group*. While in the *Functional Limitations Group*, the disabled individual sees himself or herself as being non-disabled. They may move then to see themselves as disabled but still does not identify as a person with a disability. In the *Disabled Identity Group*, the individual identifies as a person with a disability. Finally, in the *Civil Rights Group*, the disabled individual feels a part of a disabled community and becomes a disability rights activist. This model is without criticism; the model may not take into all accounts of a person with a disabilities identity and further marginalize the individual by claiming a minority status (Shakespeare et al., 1996). The oversight of neglecting a disability identity has been found to be the result of viewing disability historically from a medical model (Gibson, 2006).

**Gibson.**

Gibson (2006) emphasizes the shift from the medical model of disability toward a minority model. Her model of disability identity development encourages the environment to take responsibility and create the accommodations the disabled person requires. Gibson (2005) introduced the Disability Identity Development Model which helps clinicians understand people with disabilities and helps them better serve this population with effective treatments. It is similar to other multicultural identity models discussed later in this review. The model gives insights as to the crises a disabled person may struggle with. The model contains three stages and identity development according to Gibson can be fluid. While this model can assist in the understanding as to how one with a disability comes to view themselves; it is only a tool. It does not solely explain the developmental process for a disabled person. Gibson highlights that humans are very complex and that the entire person must be considered when evaluating identity development. This information gives support for the need of the current study to further explain a hidden disability such as ADHD, but Gibson warns, all factors must be considered in this understanding as well.

In a study by Daughtry, Gibson, and Abels (2009), the lack of role models needed to successfully move forward from Stage 1 in the Gibson model is emphasized. Their study highlights the importance that mentoring can have on developing a positive identity for a disabled person. There is a lack of mentors the study suggests, which in turn has a negative impact upon individuals with disabilities. It can be inferred from the

implications that having access to an effective mentor can increase a disabled person's ability to progress through the Disability Identity Developmental Model more efficiently.

***Stage 1: Passive awareness.***

This stage can begin at birth and continue into adulthood according to Gibson (2005). Characteristics of this stage include: (a) no role models of disability, (b) medical needs are satisfied, (c) learning to deny certain social aspects of one's disability, (d) the disability remains in denial within the family, (e) co-dependency occurs, (f) one shies away from attention, and (g) one does not associate with others who have a disability.

***Stage 2: Realization.***

Stage two often occurs in adolescence or early adulthood. Characteristics of stage two include: (a) beginning to self as having disability, (b) self-hate occurs, (c) anger is displayed, (d) a concern with how others perceive self, (e) concern with appearance occurs, and (f) "Superman/woman" complex takes place (Gibson, 2006, p. 7).

***Stage 3: Acceptance.***

Adulthood is the general time when the disabled person experiences stage three. The hallmarks of this stage include the following: (a) a shift to embracing self away from a negative focus on "being different," (b) one begins to view self as relevant and equal to others, (c) one begins to incorporate others with disabilities into one's life, (d) one becomes involved in disability advocacy and activism, and (e) self is integrated into the able-bodied world (Gibson, 2006, p. 7).

## **Overview of Race and Ethnicity Identity Development Models**

Henderson (2001) cites that twenty percent of undergraduate students with disabilities are racial/ethnic minorities. The majority of the focus on race and disability has been on African-Americans. Disability and race research show that the two influence each other (Vernon, 1999). African-Americans it is argued by Stuart (1992) who are disabled have a limited ability to form a healthy identity. However, studies often focus on just one aspect of an individual's identity, such a gender or race (Ostrander, 2008). Ostrander suggests that gender may have more of an impact upon disability experiences than race. Bender (2006), in a study of 20 white and black men, found gender identity to be a more salient issue than race in forming a disability identity. Bussing, Gary, Mills, and Garvan (2003) found that there were cultural variations in the models of parental explanation of ADHD that influenced how either Caucasians and African-Americans defined ADHD. There were also variations to the interventions and outcomes. African-American parents are less likely to assign system problems to ADHD behavior and express less worry about ADHD school problems than their Caucasian counterparts.

### **Poston.**

Much of the literature on the development of multiple identities focuses on race and ethnicity, or even gender, but often neglects sexual minorities. The emerging body of research in the 1990s has begun to provide a solid foundation of theory to support working with college students with multiple identities (Renn, 2008). There was a shift in looking at more ecological models of development rather than linear models. Most of the

research on racial, ethnic, or sexual minority development relies on qualitative research and limited sample sizes.

Poston (1990) proposed a positive model of minority development with five levels. The first level, *personal identity*, involves young children holding a personal identity that is not necessarily linked to a racial reference group. *Choice of group categorization* is the second level where an individual chooses a multiracial existence that includes either parents' heritage groups or dominant culture from one background based on personal factors and factors defining perceived group status and social support. The third level is *enmeshment/denial*. At this level, guilt arises at not being able to identify with all aspects of one's heritage. This guilt may then lead to anger, shame, or self-hatred. According to Poston (1990), one must resolve the guilt in order to move beyond this level. *Appreciation* is the fourth level where individuals broaden their racial reference group through learning about all aspects of their backgrounds. Individuals may choose to identify with one group more than with others. Finally at the fifth level, *integration*, the individual values all of their ethnic identities and represent a multicultural existence.

***Root.***

Building on the Minority Identity Development Model put forth by Atkinson, Morten, and Sue (1998), Root (1990) developed an alternate model of development for biracial individuals. She altered the last stage of development because biracial individuals are not capable of fully rejecting the majority culture. They are not able to immerse themselves fully into a minority culture either. A period of "dual existence"

occurs when individuals are popular but do not fit into any one social group according to Root (p. 200). This period is influenced by racism and oppression that has been internalized. According to Root, tokenism and dating surface for teenagers. Gender also influences the effects of racial discrimination, causing it to be alleviated or intensified. She introduced the possibility of an individual forming a biracial or multiracial identity. Considering the impact of racism, Root postulated that individuals might be fluid, self-identifying in more than one way at any one given time. Her model is empirically derived and proposes a non-linear approach to identity development.

There are four resolutions of tension individuals must master in developing a biracial identity according to Root (1990). These four resolutions are: acceptance of the identity society assigns identification with both racial groups, identification with a single racial group, and identification as a new racial group.

***Acceptance of the identity society assigns.***

Typically, the acceptance by a minority racial group and tight family ties provide support for the individual forging a biracial identity. The majority or dominant culture tends to assume that the individual belongs to this other racial group (Root, 1990).

***Identification with both racial groups.***

During the second resolution stage, it may be possible for the biracial individual to identify with multiple groups of heritage. This identification is only possible depending on the level of support from society and the levels of the individual's personal ability in the face of possible resistance from others (Root, 1990).

***Identification with a single racial group.***

One group must be chosen by the individual to identify with during the third resolution stage. This choice must occur independent of social pressure. Self-identification in this particular way is similar to the aspects of the first resolution in this model (Root, 1990).

***Identification as a new racial group.***

Fluid movement by the individual amongst various racial groups is the key task in the final resolution stage in the Root model. During this resolution, the individual identifies strongly with other biracial people. It is not important for the individual as to which heritage background the other biracial people with whom they identify with come from (Root, 1990).

**Phinney.**

Phinney (1993) describes a three stage model of ethnic identity development. This model was based on research with minority adolescents combined with other ego identity and ethnic identity models. She references the works of Marcia and Erikson. Three levels of ethnic identity development were uncovered in her research with adolescents in primary education settings (Phinney, 1993). Unexamined Ethnic Identity is the first stage. This stage is characterized by a lack of exploration. Diffusion or foreclosure occurs for students in this stage. Students experience a lack of interest in ethnicity or a general acceptance of others opinions. Ethnic Identity Search/ Moratorium is the second stage. Ethnic identity begins to develop through personal encounters and

exploration. This stage can be often initiated by a harsh or indirect event. Ethnic Identity Achievement is the third and final stage. The successfully navigate of a bicultural identity is the key developmental task. Students have a clear sense of what their ethnic identity is. The theory's applicability may be questionable to the transference to the college students' experience. Phinney (1993) based her model from the experiences of adolescent students, making her theory less generalizing.

### **Overview of Gay and Lesbian Identity Development Models**

Cramer and Gilson (1999) highlight that there are many similarities and differences in the identity development for people with both disabilities and who identify as a sexual minority. Being able to "pass" as normal, whether that means nondisabled or heterosexual, is a unique experience for this particular population. They are faced with issues of disclosure that can affect their identity in a potentially stigmatized way. While both invisible groups suffer discrimination, there are state and federal laws that provide legal protections to disabled persons. Disabled people often encounter pity from those that are nondisabled and LGBT individuals often experience disapproval or rejection from heterosexuals.

The focus of literature in this section of the study has been on the sexuality of people with disabilities who identify as homosexual. There is a lack of literature that specifically addresses the needs of individuals who identify as sexual minorities with a disability and how they progress in their identity development (Allen, 2003). Research that does consider gay men's issues with disabilities tends to focus on issues related to

HIV/AIDS (Cambridge, 1997). When it comes to lesbian women, the literature is non-existent. For people with disabilities, lesbian sexuality is one of the least understood and research forms of sexual expression (McCarthy, 1999). The recognition of a sexual identity for people with disabilities has been a recent phenomenon. There is even less progress for people with disabilities who may identify as lesbian or gay (Shakespeare et al., 1996).

Prejudice and harassment are common in the daily lives of people with disabilities (Mencap, 1999). The discrimination experienced by people with disabilities is similar to the experiences of those who identify as lesbian or gay (Mason & Palmer, 1997). It can be assumed that there are higher levels of discrimination and harassment for disabled people trying to forge a sexual minority identity (Davidson-Paine & Corbett, 1995). Many people may not be supportive of people with disabilities having a sexual identity as well, and may face even more opposition in seeking a same-sex partner. Baxter Magolda (2001) found there is cultural and religious issues that affect forging a health sexual minority identity. Often within the sexual minority community, there is additional discrimination against sexual minority disabled people by other sexual minorities. Thompson, Bryson and Castell (2001) found that gay men with disabilities were seen to have the lowest status within the gay community. Compared to their non-disabled peers, people with disabilities are more likely to be social isolated. The lack of support by other sexual minorities is an additional factor that can be further isolating.

Harley et al. (2002) cite that approximately one in six college students are lesbian, gay, or bisexual. One might assume this percentage affects those students with disabilities population equally on most college campuses.

Whitney (2006) sheds light on the consideration of how both a disability identity and a sexual minority identity. The author's project involved looking at women with a disability who also identified as a sexual minority and how their subjective experiences shaped their identity development. The study highlights that the community of sexual minorities with disabilities may be larger than what research has indicated and that this population may be eager to share their experiences. The research gives hope to the fact that merging of identities is possible. The study reminds researchers that not all disabilities are visible, such as ADHD in the case of this study. It is important to remember that identities overlap and this provides evidence to the challenges faced in the present study. The author encourages future research on individuals with multiple identities. Henry, Fuerth and Figliozzi (2010) urge that more studies, both qualitative and quantitative in nature, must be done to address the multidimensional aspects of having several marginalized identities. The article gives support for the need of the current study. Their study incorporated the framework of Reynolds and Pope's (1991) Multidimensional Identity Model. The findings in the study illuminate the need for additional integrated support services for LGBT students with disabilities.

**Cass.**

Vivienne Cass' (1979) model of homosexual identity formation has been the base for many theories of identity. Most of the research on the development of LGBT students cites the work of Cass (1979). The model assists faculty and professionals working with the LGBT college student populations. This model is important to the research community as it offers an explanation of behavior through a specific stage model for identity development.

Cass (1979) suggests that gays have a unique identity development. She suggests that non-heterosexuals move through a series of six developmental stages, usually in the younger years of life. The Cass theory describes the developmental process undergone by individuals as they first consider, then acquire, a gay identity as a relevant aspect of self. Important to Cass' theory is her assumption that the basis for both change and stability in individual behavior is found in the interactions between self and society. Since individuals' desire congruency between personal and societal perceptions of self, developmental growth occurs when individuals work to rectify incongruence arising between these two perceptions. The first stage is *identity confusion* and the developmental task is figuring out who one is, and accepting it, denying it, or rejecting it. Dealing with social isolation from a gay identity is the task for stage two called *identity comparison*. *Identity tolerance* is stage three. In stage three, the task is decreasing social isolation by seeking out other gays or lesbians. In stage four, *identity acceptance*, the individual deals with inner tension of no longer subscribing to society's norms and

attempting to bring congruence between private and public view of self. *Identity pride* or stage five involves dealing with incongruent views of heterosexuals. Finally, stage six is called *identity synthesis*. The task for this stage is integrating gay and lesbian identity so that instead of being the identity, it is an aspect of self (Cass, 1979).

In summary, Cass (1979) characterizes homosexual identity as a progressive development motivated by the need to make sense of one's sexual orientation and how, or if, it will be revealed to the world around them. While Cass' model does not explain how LGBTQ students learn, the model sheds insight into how the various levels of development in this stage model can affect possible learning outcome for students in higher education. Cass' (1979) model is linear; individuals must go through the stages one at a time, and consecutively. The university environment and the sexual identity LGBTQ students might reveal within the boundaries of this system could be significant factors in their ability to successfully learn.

### **D'Augelli.**

The social and political consequences of models make it difficult to develop a single theory to understand the phenomenon of lesbian and gay identity development. One reason is that over time complex human lives change and evolves. According to D'Augelli (1994), there is no formal database on lesbian and gay development that can provide a foundation for one congruent theory. To consider lesbian and gay development in the context of traditional models of human development is fundamentally distorted. Lesbian and gay development must be seen as multidetermined. D'Augelli's model has

the potential to represent a wide range of experiences than other theories, including the experiences of students coping with ADHD. D'Augelli's takes into account social contexts in understanding the development of sexual orientation over the life course (Renn & Bilodeau, 2005). Self-concept, relationships with family, and connections to peer groups and the greater community are concurring paths that unfold in persons who identify as gay or lesbian according to D'Augelli (1994).

There are six stages in the D'Augelli (1991) model: (a) exiting heterosexual identity, (b) developing a personal lesbian/gay/bisexual identity, (c) developing a lesbian/gay/bisexual social identity, (d) becoming lesbian/gay/bisexual offspring, (e) developing a lesbian/gay/bisexual intimacy status, and (f) entering a lesbian/gay/bisexual community. In this theory people are able to navigate from one stage to another in their attempt to develop a sexual and self-identity. Cass's (1979) model is chronological and the D'Augelli (1991) model is flexible, moving without chronological order necessarily.

Stage one (heterosexual identity) is the point at which people realize their same-gender attractions. In stage two (personal lesbian/gay/bisexual identity), one develops a lesbian/gay/bisexual identity. In stage three (developing a lesbian/gay/bisexual social identity), they begin to explore homosexual community networks and friendships. Stage four (lesbian/gay/bisexual offspring) explains how they decide to tell their friends and family members about their homosexual identity. At this stage, dealing with the ramifications

of this disclosure occurs. In stage five (developing a lesbian/gay/bisexual intimacy status), they develop intimate same-gender relationships but find the invisibility of same-gender relationships frustrating. In stage six (entering a lesbian/gay/bisexual community), they become active in the homosexual community.

The unique and individualized experiences influence the developmental process and are key to identity formation. They can be detrimental and positive, as one navigates each stage (D'Augelli, 1991).

### **Stevens.**

Using grounded theory methodology, Stevens (2004) investigated how the environment contributed to the exploration and development of a gay identity for male college students. He discovered that finding empowerment was the central category in his model. Self-acceptance, disclosure to others, environmental influences, individual factors, and exploring multiple identities were five other integrative categories. Stevens suggests that sexual identity is complex and integrated. He further suggests that one's sexual identity is often incongruent with other aspects of an individual's identity.

Within the context of the college experience, sexual identity development is often prominent. It can occur often in conjunction with race, gender, and spiritual identity development. Many students choose to hide parts of their identity depending on the perceptions of their environment. They must navigate their environment with concerns for contextual issues such as homophobia (Evans & Broido, 1999). Many environmental models do not address minority issues. According to Stevens (2004), the context of the

environment must be considered to understand gay identity exploration as an entity. Stevens' model allows for the inclusion of environmental influences on gay identity development in college.

The Stevens (2004) model of gay identity development within the college environment illustrates a cycles through which individuals pass. However, it does not represent the number of times one may pass through the central category of self-empowerment and the five integrative categories of self-acceptance, disclosure to others, individual factors, environmental influences, and multiple identities exploration. The development of a healthy sexual identity is a complex process. Stevens found this process to be non-linear. He found that one can move back and forth in the model. Depending on the context of the environment, varying degrees of empowerment are expressed.

Coming out to self was one of the entrance points in the Stevens (2004) model. This process includes the recognition of being unique by the individual, including an abandonment of heterosexual privilege and the initiation of a sense of what a gay identity could be. Disclosure to others of a gay identity often highlighted self-acceptance. Disclosure often occurs for individual after the acceptance of a gay identity.

Self-acceptance and disclosure to others summarizes the concept of coming out. The acknowledgement of an individual's gay identity, whether verbal or written, describes disclosure, the second integrative category in the Stevens (2004) model. Often, individuals disclose to close friends or other sexual minorities. Disclosures to parents are

the most significant disclosures and play significant roles as environmental influences. Fear of rejection from family is intense for individuals and influenced first disclosure of sexual identity to be with someone other than family member. Guilt also contributes to the difficulty in disclosure. With disclosure to others, the support network was developed that was essential of the central category of empowerment in the Stevens model of gay identity development within the college environment.

The assessment of personal supports and liabilities is how the Stevens' (2004) model defines individual factors. These factors include: perceived social networks, confidence and self-assurance, personally held stereotypes, feelings of rejection, isolation, and invisibility, and internalized homophobia. These individual factors are personal beliefs and also the center for processing environmental influences.

Relationships, locations, signs, symbols, and resources, discrimination, and stereotypes are all environmental influences in the Stevens (2004) model. External influences are the most critical for individuals developing a gay identity in the college context. The context of individual factors are set and manipulated by environmental influences. Influences can be both internal and external to the college setting.

Finding empowerment is the central category in the Stevens (2004) model of gay identity development. It the core category in the model; all the other categories develop out of this focal point. Empowerment is an inner strength that varies depending on the status of the environment. Internal feelings and motivation along with the actions associated with these feelings contributes to finding empowerment.

The fifth integrative category in this model is exploring multiple identities (Stevens, 2004). Sense of empowerment needs to occur first before an individual can explore other facets of their identity. Empowerment does not necessarily equate to an individual exploring multiple identities. A sense of empowerment in a gay identity can occur when an individual explores the multiple facets of their identity. Exploring multiple identities first begins a result of experiencing empowerment according to Stevens. Then, the interaction of empowerment and exploring multiple identities becomes a consequence. All five of the integrative categories serve as conditions for developing a sense of empowerment within individuals forging a gay identity.

### **Overview of Gender Identity Development Models**

Several major theories explain the development of gender identity. One is psychoanalytic theory (Freud 1927) and another is cognitive-developmental theory (Kohlberg, 1966). These theories involve a two-part process. First, the child must come to know that they are female or male. Second, the child comes to know what being female or male means in terms of concepts of feminine or masculine behavior.

Gender identity develops through identification with the same-sex parent according to Freud (1927). The Oedipal stage of psychosexual development hallmarks this occurrence. A child develops a strong sexual attachment to the opposite-sex parent by the age of three years old. Parallel to this occurrence, negative feelings emerge for the same-sex parent. Desires are relinquished for the opposite-sex parent and identification with the same-sex parent occurs by age six years and the conflict is resolved.

It is extremely difficult to how gender impacts a disability identity process, as in the case of ADHD, because the majority of the literature examines this phenomena from the view of only a single gender (Zitzelsberger, 2005). Most of the research has been criticized for the inability to make conclusions from the data collected. Men face more negative consequences to identity development than women regarding their disability. It is related to the process of enacting a masculine identity. Men are more likely to try to hide a disability, such as ADHD. Women tend to be more flexible in incorporating a disabled identity (Charmaz, 1994). Based on these finding, it may be possible to assume men have a more difficult time negotiating an ADHD identity over their female counterparts. For women, having an identity as a woman with ADHD leaves one to be faced with two marginalized identities. The literature also suggests that disabled women tend to be more isolated socially and have less access to resources than their male counterparts (Charmaz, 1994).

Females are diagnosed more with the inattentive type of ADHD than males, but the literature has focused more on males affected by ADHD. The symptoms of ADHD are the same for both males and females (Rucklidge, 2008). Rucklidge highlights that there are some slight gender differences: adolescent girls have lower self-efficacy and poorer coping skills; rates of depression and anxiety are higher for girls; and physical aggression is lower for females than males. The researcher also cautions that there is not enough research on the effects of ADHD on females and that existing studies suffer from problems around sampling and diagnostic proceedings. It is suggested by Rucklidge that

future research should include equal representation of both males and females in the literature. It can be hypothesized for the convenience of this study that this finding may also be true in investigating the identity development for people with disabilities, such as ADHD, in that the focus has been more supportive of males versus females.

**Kohlberg.**

In order to begin to understand the process of gender identity, Kohlberg's (1966) cognitive developmental theory must be considered. In his three-stage model, a child's understanding of gender progresses in a linear fashion. According to Kohlberg children believe characteristic schemas about gender at each of the consecutive stages. With the progression through each stage, the understanding of gender becomes more and more complex. Gender Identity is the first stage. This stage typically is achieved by age two years. In stage one, a child is able to identify its own biological sex. Gender Stability is the second stage of development. The child reaches approximately four years of age in this stage. The realization that gender remains constant across time is a developmental task in this stage. External features, like skin color and material possessions, heavily influences the understanding of gender. Gender Constancy is the third stage in Kohlberg's model. In this stage, the developing child's gender is independent of external features. This stage is usually reached by the age of 7 years. Maturation is the driving force in gender development according to Kohlberg. The current stage the child is at determines how the interpret information on gender. It is not until Kohlberg's final stage that children actual begin to process gender information.

**Spence.**

Spence (1993) suggests that gender identity development is multifactorial. Men and women have cultural distinctions that include various attributes, attitudes, and behaviors. They are not singularly linked according to Spence. Gender Identity, defined by Spence, is one's sense of being masculine or feminine. Personality traits, physical attributes, abilities, and occupational preferences all contribute to one's gender identity. These unique and individualized combinations are culturally defined.

As one develops a gender identity according to Spence (1993), one chooses the qualities of certain gender characteristics that are compatible. One's own masculinity and femininity tends to be more variable, even if there maybe be a standard from society as to how masculinity and femininity are defined. Spence maintains that formal rating scale with items that define masculinity and femininity tap into socially desirable instrumental and expressive traits in men and women. Gender traits just affect the development of a gender-based self-image. It is the belief of Spence that these traits do not define the development of a gender identity.

**Overview of Multiple Identity Development Models**

Frale (1997) highlights that the literature focus on the personal meanings of such social categories as gender, sexual, racial, ethnic, or class one unit at a time. She argues that this cause fragmentation and is exclusionary. Longitudinal studies are rare, and theory testing is essential in the field of understanding identity development, lending to the significance of the current study. Frable cites how gender research is focused on

middle class, excluding racial and ethnic minorities. This is true for the research on sexual identity. Frable encourages new theoretical conceptions and that research must capture accounts of excluded groups, such as adults with ADHD, and must attend to sociohistorical contexts.

**Abes, Jones, and McEwen.**

Abes, Jones, and McEwen (2007) provide a reconceptualized model for understanding a more complex conceptualization of multiple identities model. They build on their original model that assists in understanding an individual's core sense of personal identity that considers multiple identities (Jones & McEwan, 2000). Social constructionism is being increasingly relied upon on the exploration of the meaning of identity development (McEwen, 2003). The model of multiple dimensions of identity (MMDI) was the first of its kind in the literature explaining a students' development among personal and socially constructed identities (Jones & McEwan). In the reconceptualized model of multiple dimensions of identity (RMMDI) integrates students' intrapersonal, cognitive, and interpersonal domains of development. Incorporating meaning-making capacity now adds a richer portrayal within the model of what students perceive and how they come to perceive them. The original MMDI provides a holistic representation of the intrapersonal domain, including meaning-making capacity. The RMMDI provides a holistic representation as well. In the RMMDI, there is now and integration of intrapersonal development with the cognitive and interpersonal domains (Abes et al., 2007).

There is a wide array of theories on student development, but most fall into categories such as psychosocial, cognitive, and social identity theories. According to Abes et al. (2007), very few theories exist to understand the spectrum of development for most students in their entirety. Heath (1969, 1980) studied college development of male students. He considered four domains of development and five sets of developmental tasks. Baxter Magolda (2001) looked at student development towards adulthood and the development of self-authorship. Her model provides a contemporary perspective on the intersection of epistemology, intrapersonal, and interpersonal aspects of development. The RMMDI is placed within the context of some of the few models of holistic development in the literature on student development (Abes et al., 2007). The RMMDI highlights how students' development is performative in nature and fluid. It considers changing identity salience and the capacity of meaning-making.

### **Reynolds and Pope.**

Reynolds and Pope (1991) created the Multidimensional Identity Model. Their model draws attention to the importance of multiple identities through their discussion of multiple oppressions. Several case studies were used by the authors to provide examples of how individuals might deal with their multiple oppressions. Their model extends Root's (1990) model on biracial identity development to multiple oppressions. Reynolds and Pope suggest four possible ways for identity resolution for individuals belonging to more than one oppressed group. These four options were created from a matrix with two dimensions. The first concerns whether one embraces multiple oppressions or only one

oppression. The second concerns whether an individual actively or passively identifies with one or more oppressions.

The four quadrants or options look like: (a) identify with one aspect of self (society assigned-passive acceptance), (b) identify with one aspect of self (conscious identification), (c) identify with multiple aspects of self in a segmented fashion, and (d) identify with combined aspects of self (identity intersection). In the first quadrant, identifying with only one aspect of self (society assigned-passive acceptance, individuals react in a passive manner to such aspects as race, sexual orientation, or gender. Society, the college environment, family, or others assign aspects of self to the individual. Identifying with only one aspect of self that is determined by the individual occurs in quadrant two. For example, the individual may identify as a gay man, a woman, or African-American without including other identities. Identities, such as these, that are particularly oppressive are typical. The third quadrant involves identifying with multiple aspects of self in a segmented fashion. It is frequent that only one identity at a time is expressed. The identity that is expressed is determined more passively by the context rather than by the individual's own wishes. For example, in one setting the individual identifies as Asian, yet in another setting as transgender. The final quadrant is identity with combined aspects of self (identity intersection). Here, the individual chooses to identify with the multiple aspects of self, especially multiple oppressions. The individual has both consciously chosen the identities. They have also integrated them into one's sense of self (Reynolds & Pope, 1991).

**Atkinson, Morten, and Sue.**

Atkinson, Morten, and Sue (1998) proposed a five-stage Minority Identity Development Model (MID). Their model attempts to identify common features that cut across the population-specific proposals. The Racial/Cultural Identity Development Model (R/CID) is what the Minority Identity Development Model is now called. There are five stages of development in the R/CID: conformity, dissonance, resistance and immersion, introspection, and integrative awareness. The role that oppression plays in a minority individual's development is essential in understanding racial and cultural identity development according to Atkinson et al.

***Conformity stage.***

The following are characteristics of individuals at the conformity stage: (a) self-depreciating attitudes and beliefs, (b) group-depreciating attitudes and beliefs toward members of the same minority group, (c) discrimination toward members of different minorities, and (d) group-appreciating attitudes and beliefs toward members of the dominant group (Atkinson et al., 1998).

***Dissonance stage.***

Individuals in the dissonance stage are characterized by: (a) conflict between self-depreciating and self-appreciating attitudes and beliefs, (b) conflict between group-depreciating and group-appreciating attitudes and beliefs toward members of the same minority, (c) conflict between dominant-held views of minority hierarchy and feelings of

shared experience, and (d) conflict between group-appreciating and group-depreciating attitudes toward members of the dominant group (Atkinson et al., 1998).

***Resistance and immersion stage.***

The rejection of the dominant views and the acceptance of minority-held views is the task of the resistance and immersion stage. Individual's behavior during stage three is to attempt to eliminate the oppression felt by being part of a minority group. Guilt, shame, and anger are the most common feelings in this stage. Characteristics for individuals in stage three are: (a) self-appreciating attitudes and beliefs, (b) group-appreciating attitudes and beliefs toward members of the same minority group, (c) conflict between feelings of empathy for other minority group experiences and feelings of culturocentrism, and (d) group-depreciating attitudes and beliefs toward members of the dominant group (Atkinson et al., 1998).

***Introspection stage.***

The intensity of feelings becomes psychologically draining at the fourth stage, called introspection. This drain does not permit one to devote critical energies to understanding one's life or one's own racial or cultural group. Feelings of discontent and discomfort occur at this stage. Characteristics of individuals in stage four include: (a) the basis of self-appreciating attitudes and beliefs, (b) the unequivocal nature of group appreciation toward members of the same minority, (c) ethnocentric bias for judging others, and (d) the basis of group depreciation toward members of the dominant group (Atkinson et al., 1998).

***Integrative awareness stage.***

The development of an inner sense of security, for the minority individual, is the hallmark aspect of the integrative awareness stage. The individual can appreciate aspects of both mainstream and their own cultures or race that are special. The minority person has a strong commitment and desire to eliminate all forms of oppression. In the integrative awareness stage, individuals demonstrate: (a) self-appreciating attitudes and beliefs, (b) group-appreciating attitudes and beliefs toward members of the same minority group, (c) group-appreciating attitudes toward members of a different minority, and (d) attitudes and beliefs of selective appreciation toward members of the dominant culture (Atkinson et al., 1998).

**Summary**

This review presented an overview of ADHD. It presented existing theories and models of development, focusing specifically on identity development theories, including theories on race/ethnicity, sexual identity, gender, disability, and multiple identities. The literature review and theories provide a significant background and framework for the current study. It highlights the current gaps in research. Chapter 3 will provide the research method that was employed to investigate this study's research questions.

## Chapter 3: Methodology

### Design Summary

The proposed study on the identity development of adults with ADHD will be approached through a psychosocial theoretical perspective using phenomenological qualitative methodology. Psychosocial theory frames identity development. Chickering and Reisser (1993), Erikson (1959), and Gibson (2005) will provide the theoretical strips that provide the framework for the proposed study. Chickering and Reisser's (1993) psychosocial theory that views development as a series of tasks or stages dealing with thinking, feeling, believing, and relating to others. The seven-vector model explains the development of students while in college. The seven vectors are (a) developing competence, (b) managing emotions, (c) moving through autonomy toward interdependence, (d) establishing identity, (e) developing mature relationships, (f) developing purpose, and (g) developing integrity (Chickering & Reisser, 1993). Erikson's (1959) theory of development has a specific stage that is relevant for the inclusion within the framework. Stage six is considered by Erikson to be the stage of individual identity versus individual identity confusion and occurs around the ages of 18-22 years. The developmental tasks at this stage are: (a) autonomy from parents, (b) sex role identity, (c) internalized morality, and (d) career choice. Gibson (2005) offers a theory of development to be included in the framework specific to disability identity. She has three stages by which a disabled person comes to form a positive self-identity. The three stages in the Disability Identity Development Model are: (a) passive awareness,

(b) realization, and (c) acceptance. By examining the identity development of adults with ADHD from a psychosocial theoretical perspective, this study will be conducted in the hopes of gaining a better understanding of how identity development is formed for this subpopulation.

Many factors impact the development of an identity over the course of a lifespan. Gender models, sexual identity models, racial and ethnic models, and multiple identity models all consider ones' identity development for one or several facet of understanding. There is significant research on the challenges one with ADHD may face in the college environment (Shames & Alden, 2005), but there has been little effort to consider a model of identity development for those with ADHD. There is currently inadequate literature that explores the environment's impact on the identity development of adults with ADHD. Due to the gap in the literature, the importance of this proposed study is even more significant. It is the intent of the current study to increase the understanding on the identity development of adults with ADHD.

The following research questions guided this study: (a) how do adults with ADHD come to understand their identity development; (b) how does other dimensions of identity, such as gender, race/ethnicity/culture, and sexual identity intersect with ADHD identity development; and (c) how does this process inform the embracement or rejection of a ADHD identity?

Chapter 3 details the research methodology that was used to conduct this study. The chapter includes: (a) a description of the participants and setting, (b) the instrumentation, (c) the data collection, and (d) the data analysis.

### **Participants and Setting**

A qualitative approach provides a venue for understanding the connection between adults with ADAD and their development of identity. Phenomenological research identifies the unique experiences of the human condition. It is a qualitative methodology. It will be used in this study to highlight the phenomenon of ADHD as described in the experience of the participants (Creswell, 2009). Phenomenological research is useful in examining identity development because is it expansive rather than limiting in the inquiry and exploration into how identity is constructed. Increased familiarity with the data collected should inform analysis and the analysis should therefore increase familiarity in this approach (Charmaz, 2006). Using this approach, adults with ADHD can identify important characteristics and events that were meaningful to them. Instead of testing a prior hypothesis based on previous research, the method of phenomenological research allows for the exploration of ADHD identity development to evolve throughout the research (Stevens, 2004).

In qualitative sampling, the statistical sample is the strength. Reliability is consistent with obtaining information that is consistent and trustworthy. Information-rich cases are crucial for in depth analysis. “Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry”

(Patton, 2002, p. 230). These cases provide deeper knowledge rather than empirical generalizations in quantitative research. In the proposed study, the use of purposeful sampling in focusing on information-rich cases will hopefully illuminate the research questions proposing an understanding as to how adults with ADHD develop a sense of identity.

Several different sampling strategies, in-depth structured open interviews, and phenomenological qualitative methods will be implemented for this study. It is essential to establish trustworthiness for this study. Through qualitative methods, the goal of this study was to establish that the identity development for those with ADHD is worthy of examination (Creswell, 2009). “The empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essence of the experience” (Moustakas, 1994, p. 13). The approach “seeks to disclose and elucidate the phenomena of behavior as they manifest themselves in their perceived immediacy” (van Kaam, 1966, p. 15). The aim in utilizing a phenomenological approach for this intended study “is to determine what the experiences mean for the persons who have had the experience and are able to provide a comprehensive description of it” (Moustakas, 1994, p. 13).

The measurement, design, and analysis for this study will be of a qualitative method strategy. Three specific sampling strategies will be utilized for this study: critical case sampling, snowball or chain sampling, and criterion sampling. Critical case sampling is recognizing key dimensions, such as an ADHD diagnosis, which makes for a

case. Critical case sampling is also important to this study, as this study is focused on a specific environment and region, looking specifically at individuals with a particular diagnosis. Snowball or chain sampling is another sampling approach that helps to locate critical cases. Converging on a small number of critical cases in a particular region could then lead to a chain of many more information-rich key informants. Snowballing occurs by asking participants in this study to identify other critical cases, allowing the study to grow with information-rich cases to then analyze. Criterion sampling is also important to the methods of this study. Studying all cases of ADHD in a particular environment is the logic behind criterion sampling. Having a diagnosis of ADHD is a criterion for being a participant in this study (Patton, 2002). Due to ADHD often being a hidden diagnosis, a combination of these three types of sampling will be key to this study.

The unit of analysis for this study is people focused. Male, female, and transgender individuals were the participants for this study. All the participants were identified as meeting the DSM-IV-TR diagnostic criteria of ADHD. The students were recruited from a secondary learning institutions in the Western United States and the surrounding region. The institution was a large research university in a metropolitan area.

Participants sampled were diverse demographically regarding age, gender, race/ethnicity/culture, and sexual identity. The institution has a support program for students with disabilities. All participants were asked to self-identified some aspect of self, specifically age, gender, race/ethnicity/culture, and sexual identification. The

criterion for participation in the study was that the participant must have been diagnosed with ADHD by a mental health professional during some point in their life and that they were eighteen years old at the time of participation. All thirty-one of the participants were in the process of obtaining or had obtained a minimum of a bachelor level education. Eight of the participants were in the process of obtaining or had obtained the level of master degree in their education.

From the study's participants, rich cases of information provided a detailed description around identity development for adults with ADHD. Age, gender, race/ethnicity/culture, and sexual identity were factors that increased the maximum variation of the sample. Using maximum sampling was important for this research study. It allowed for information-rich informants around the characteristics of identity development (Patton, 2002).

Table 1 outlines the descriptive characteristics of the 31 participants for the sample used in this study.

### **Instrumentation**

The perspectives of the participants in this study were meaningful and knowable is the assumption of qualitative interviewing (Patton, 2002). The researcher in this study was concerned with gathering their story. This was the purpose of interviewing. "The quality of the information obtained during an interview is largely dependent on the interviewer" (Patton, 2002, p. 341). The data for this study was collected through

Table 1

*Descriptive Characteristics of Participants (N=31)*

| <b>Variable</b>            | <b>Frequency (<i>n</i>)</b> | <b>Percent of Sample (%)</b> |
|----------------------------|-----------------------------|------------------------------|
| Age                        | 18-29 22                    | 70%                          |
|                            | 30-39 4                     | 13%                          |
|                            | 40-49 3                     | 10%                          |
|                            | 50-59 1                     | 3.5%                         |
|                            | 60+ 1                       | 3.5%                         |
| Gender                     | Female 17                   | 55%                          |
|                            | Male 13                     | 42%                          |
|                            | Transgender 1               | 3%                           |
| Race/Ethnicity/<br>Culture | European-American 18        | 58%                          |
|                            | Latino/Hispanic-American 7  | 23%                          |
|                            | Asian-American 3            | 10%                          |
|                            | African-American 2          | 6%                           |
|                            | Mixed 1                     | 3%                           |
| Sexual Identity            | Heterosexual 24             | 77%                          |
|                            | Non-Heterosexual 7          | 23%                          |

interviews. Participants were recruited for this study through a flyer (Appendix C) and word-of-mouth (snowball sampling).

This study employed the use of interviews. According to Patton (2002), there are three types of open-ended interviews in collecting qualitative data. They are the following: the informal conversational interview, the general interview guide approach, and the standardized open-ended interview. The spontaneous generation of questions is a concept in the *informal conversational interview*. The participants in this study, when this method was applied, might just thought they were having a conversation with the researcher and may not have felt like they were being interviewed. In the *general interview guide approach*, it is important to make sure all important topics are covered during the interview. Using a basic checklist ensured this, before the interview began, there was a set of issues that were explored with each participant. The final approach used in this study was the *standardized open-ended interview*. Each participant went through the same sequences of questions, with each question being asked the same exact way. This approach was used to maximize variation in the questions. In this approach, the words in the questions were arranged with specific intention and were carefully worded (Patton, 2002).

A combination of these three approaches is often the situation for much of the qualitative research that involves interviewing. For this study, the interview with the participants had factors of these three approaches. The *informal conversational interview* was used in this study, followed by aspects of the two other interviewing approaches:

*general interview guide approach* and the *standardized open-ended interview* (Patton, 2002). Appendix D describes the questions for the interview protocol.

### **Data Collection**

This study involved an extensive interview with each of the study's participants. Each interview lasted approximately 30-60 minutes. The interview was digitally recorded and transcribed by the author and a third-party transcriber. Participants were able to ask questions. This also allowed for credibility in the study.

“Often the phenomenological interview begins with a social conversation or a brief meditative activity aimed at creating a relaxed and trusting atmosphere” (Moustakas, 1994, p. 114). Following this opening, the investigator suggests that the co-researcher take a few moments to focus on the experience, such as having an identity with ADHD, and then describe the experience fully, including moments of awareness and impact. “The interviewer is responsible for creating a climate in which the research participant will feel comfortable and will respond honestly and comprehensively” (Moustakas, 1994, p. 144).

This was an exploratory study. Broad open-ended questions were employed. This type of questioning allowed for the gathering of thoughts surrounding identity development for those diagnosed with ADHD. During the initial part of the interview, rapport was established with the participant (Patton, 2002). At the beginning of each of the interviews, a brief overview of the study was provided and a verbal consent to participate in the study was confirmed. The participant was given a copy of the IRB

approved *Information/Facts Sheet for Non-Medical Research* form (Appendix B) before the interview via an electronic copy and a second paper copy at the time of the actual interview.

After the interview, data was reviewed. Peer debriefing was used to ensure the credibility of the emerging theory. It provided trustworthiness for this study (Lincoln & Guba, 1985). Emerging topics from the interview were analyzed. Details and rich descriptions were explored. Closure for the process of the interview was also conducted. In parallel with the ethical principles of a phenomenological approach, clear agreements with the study's participants were established, with the recognition of the importance of confidentiality and informed consent. The study developed procedures of insuring the full disclosure of the nature, purpose, and requirements of the study. Participants were volunteers and were considered co-researchers. They were free to withdraw from the study at anytime.

### **Data Analysis**

Data analysis is essential when using a phenomenological theoretical approach. According to Moustakas (1994), any phenomena, such as ADHD, is worthy as a starting point for investigation. It was the basis for constructing the interview. It helps a researcher to build the components of a theory, such identity development (Strauss & Corbin, 1998).

Moustakas (1994) stated the following about qualitative research methods:

Organization of data begins when the primary researcher places the transcribed interviews before him or her and studies the material through the methods and procedures of phenomenal analysis. The procedures include *horizontalizing* the data and regarding every horizon or statement as relevant to the topic and question as having equal value. From the horizontalized statements, the *meaning* or *meaning units* are listed. They are *clustered* into common categories or *themes*, removing overlapping and repetitive statements. The clustered themes and meanings are used to develop the *textural descriptions of the experience*. From the textural descriptions, structural descriptions and an integration of textures and structures into the meanings and essences of the phenomenon are constructed (p.118-119).

The following seven steps were the methods of the analysis of data for this study as outlined by Moustakas (1994). In accordance with phenomenological data analysis each complete transcript of each research participant followed the seven steps as outline by Moustakas: 1) *Listing and Preliminary Grouping*, 2) *Reduction and Elimination*, 3) clustering and thematizing the invariant constituents, 4) final identification of the invariant constituents and themes by application, 5) *Individual Textural Description*, 6) *Individual Structural Description*, and 7) *Textural-Structural Description*. Lastly, taking from each of the *Individual- Textural-Structural Descriptions*, the research developed a *Composite Description* of the meaning and essences of having an ADHD identity that represented the entire sample.

All interviews were transcribed by the researcher or a third party and then reviewed by the principal investigator of the study for accuracy. All transcribed interviews were entered into Atlas.ti. Atlas.ti was used to systematically relate the integrated themes to demographic variables such as age, gender, race/ethnicity/culture,

and sexual identity. To protect confidentiality, all participants were asked to provide a four unit alpha-numeric identifier. Age, gender, sexual identity, and race/ethnicity/culture provided more detailed background information for each participant. There was no personal identifying information gathered from the participant that was reported in this study. Participants remained anonymous.

Chapter 4 will present the results and findings of the study. Chapter 4 includes the presentation of the data, followed by a description of the data analysis process. The eight textural descriptions, which developed from the themes and codes in the data, will be highlighted. Chapter 4 will conclude with a summary and a discussion of the study's findings.

## Chapter 4: Results

### Presentation of the Data

Chapter 4 is the presentation of the data for the current study. The presentation that follows is in keeping with the tradition of qualitative research. According to Moustakas (1994), the researcher has an active role. Chapter 4 will describe 3 things: (1) the type of data analysis employed, (2) manner of analysis performed, and (3) the findings of the study.

### Data Analysis Process

Data analysis for this study was conducted using a phenomenological analysis. Moustakas (1994) describes the following seven steps that were utilized in this study: 1) *Listing and Preliminary Grouping*, 2) *Reduction and Elimination*, 3) clustering and thematizing the invariant constituents, 4) final identification of the invariant constituents and themes by application, 5) *Individual Textural Description*, 6) *Individual Structural Description*, and 7) *Textural-Structural Description*.

Utilizing the phenomenological approach and Atlas.ti software, transcriptions for the 31 interviews were coded and analyzed using the seven steps outlined by Moustakas (1994). The phenomenological approach was selected because it is preferential for understanding the different ways in which people describe phenomenon, such as identity development. It is also extremely accessible for a new qualitative researcher (Morse & Richards, 2002). Finding patterns within a framework or create a deeper understanding of ADHD is the purpose of using a phenomenological approach. The focus of using a

phenomenological approach is to bring all the themes on the same topic of ADHD identity development together, which aligned well with the research questions of this study.

Data analysis began with completing the transcriptions of the recorded interviews from each of the 31 participants. The interviews were transcribed within approximately 2 weeks of the interview by either the researcher or a third party transcriber. This was employed so that the information received was novel and details were accurately reflected. After the transcriptions were completed, each participant unfortunately was not allowed to review their transcript due to the large sample size and anonymous nature of the study. The interviews were transcribed verbatim. Appendix G contains a sample transcript for review.

Atlas.ti was the qualitative analysis program utilized to code the 31 finalized transcripts. The researcher began to go over all of the transcripts for the purposes of identifying textural descriptions, themes, and meaning units or codes. That process yielded a total of 8 textural descriptions, as follows: 1) diagnosis and symptoms, 2) ADHD identity development, 3) disability identity development, 4) ADHD affects, 5) treatment, interventions, and accommodations, 6) ADHD relationships, 7) education, career, and extracurricular activities, and 8) demographic identification. Twenty-eight (28) themes became predominant textural descriptions after the researcher coded and analyzed the transcripts. The codes initially focused on interview questions asked of the sample, for example, when was the age of diagnosis with ADHD, and whether this

diagnosis was prior to the age of 18-years-old or after. Seventy-two (72) codes were developed out of this initial round of coding. Table 2 lists all of the codes. Appendix F provides a sample coded Atlas.ti report from one interview.

A peer reviewer, who was a Ph.D. and a researcher from a large urban research university in Southern California and the United States Veterans Administration assisted with this study. The researcher and reviewer met for a total of three hours, during two separate occasions, to review the themes and the resulting codes. The reviewer made a number of suggestions for coding the transcribed data. This process assisted the researcher in viewing the data from an alternate perspective. It helped the researcher identify new themes and validate those themes and codes that had already been established.

Table 2

*List of Initial Data Codes*

|  |  |  |  |
|--|--|--|--|
| Coping                                       | Emotion-Anger  | Friends with ADHD                          | Embrace ADHD Identity  |
| Impact of ADHD                               | Emotion-Anxiety                                      | Number of Friends with ADHD                | Reject ADHD Identity   |
| Impact of ADHD on Identity                   | Emotion-Cynical/Apathetic                            | Friends with ADHD-Gender                   | Relevant Personal Additions                                    |
| Negative Reactions from Others               | Emotion-Disappointment                               | Friends with ADHD-Race/Ethnicity/Culture   | ADHD Effects   |
| Opinion of Others re: ADHD                   | Emotion-Embarrassment                                | Friends with ADHD-Sexual Identity          | Diagnosis-Adulthood  |
| Positive Support from Others                 | Emotion-Feeling Different                            | Friends from College                       | Diagnosis-Age  |
| Beliefs About ADHD                           | Emotion-Frustration                                  | Friends from Grade School                  | Diagnosis-Childhood  |
| Stereotypes About ADHD                       | Emotion-Isolation                                    | Friends from both College and Grade School | Diagnosis-Denial   |
| Definition of Disability                     | Emotion-Sadness                                      | Utilization of Accommodations              | Diagnosis-Helpful/Relief                                       |
| Disability-Mixed Feelings                    | Emotion-Shame  | Influence of Accommodations on Identity    | Diagnosis-Mixed Emotion  |
| Disability-No                                | Emotion-Stupid/Ignorant/Dumb                         | ADHD Effects on Romantic Relationships     | Diagnosis-Real   |
| Disability-Yes                               | High School Easy Effect                              | ADHD Effects on Career/Aspirations         | Diagnosis-Cognitive Development and Understanding of Diagnosis |
| Hide Diagnosis                               | Incongruence of Perception by Others re: Having ADHD | Career/Aspirations                         | Impact of Treatment/Interventions on Identity                  |
| Shared Diagnosis Positive Experience         | Pivot Experience                                     | Activities                                 | Treatment/Interventions for ADHD                               |
| Aspects of Identification with the DID Model | Resistance Complex                                   | Influence of Activities on Identity        | Awareness  |
| Stage in DID Model                           | Social Problems                                      | Accept/Neutral ADHD Identity               | Compartmentalization of Identities                             |
| ADHD Influence of Gender                     | Theme  | Both Embrace/Reject ADHD Identity          | Creative/Positive Spin/Benefit of Having ADHD                  |
| Difference for Males vs. Females             | Transition of Symptoms Related to Age                |  |  |
| ADHD Influence of Race/Ethnicity/Culture     |  |  |  |
| ADHD Influence of Sexual Identity            |  |  |  |

### **Textural Descriptions**

Eight (8) textural descriptions were constructed from 28 overall themes. The researcher set about initially horizontalizing the data. The researcher then constructed initial meaning units or codes from the 31 transcripts. Seventy-two (72) codes emerged from this initial horizontalizing. Base on similarities with-in the meaning units or codes, 28 overall themes where developed from the data. In the end, 28 themes were established from the 72 initial codes. The resulting themes are highlighted by textural description in Table 3.

Table 3

*Themes by Textural Descriptions*

| <b>Textural Descriptions (n=8)</b>                       | <b>Themes (n=28)</b>   |
|--|--|
| <b>Diagnosis and Symptoms</b>                            | <ol style="list-style-type: none"> <li>1. ADHD Mindfulness</li> <li>2. Childhood vs. Adulthood Circumstance</li> <li>3. Cognitive Level Comprehension</li> <li>4. ADHD Upshot</li> </ol>       |
| <b>ADHD Identity Development</b>                         | <ol style="list-style-type: none"> <li>1. Pivot Experience</li> <li>2. Positive Creative Spin</li> <li>3. ADHD Emotions</li> <li>4. ADHD Identity Amalgamation</li> </ol>                      |
| <b>Disability Identity Development</b>                   | <ol style="list-style-type: none"> <li>1. The (Non-) Disabled Self</li> <li>2. Defining Disability</li> <li>3. The DID Model ID</li> </ol>   |
| <b>ADHD Affects</b>                                      | <ol style="list-style-type: none"> <li>1. Coping Issues</li> <li>2. Social, Behavioral, and Academic Issues</li> <li>3. Psychological and Cognitive Issues</li> </ol>                          |
| <b>Treatment, Interventions, and Accommodations</b>      | <ol style="list-style-type: none"> <li>1. Treatment/Interventions Type</li> <li>2. Treatment/Interventions Impact</li> <li>3. Accommodations Type</li> <li>4. Accommodations Impact</li> </ol> |
| <b>ADHD Relationships</b>                                | <ol style="list-style-type: none"> <li>1. Reaction Response</li> <li>2. Incongruences of Perception Consequence</li> <li>3. Friend Mirror Factor</li> <li>4. The ADHD Heart</li> </ol>         |
| <b>Education, Career, and Extracurricular Activities</b> | <ol style="list-style-type: none"> <li>1. Primary Education Easy Effect</li> <li>2. Career (Aspirations) Effect</li> <li>3. Extracurricular Activities Effect</li> </ol>                       |
| <b>Demographic Identification</b>                        | <ol style="list-style-type: none"> <li>1. Unveil vs. Unmask</li> <li>2. R.E.C. Identification Influence</li> <li>3. S.I. Identification Influence</li> </ol>                                   |

### **Diagnosis and symptoms.**

The researcher asked participants about their symptoms related to ADHD and questions about the specifics of their diagnosis. Questions were linked to attempt to understand these factors' impact upon identity development. Four (4) themes emerged within this textural description that affected all 31 participants. The following themes emerged: 1) ADHD mindfulness, 2) childhood versus adulthood circumstance, 3) cognitive level comprehension, and 4) ADHD upshot.

#### ***ADHD mindfulness.***

Fifteen (15) of the 31 participants indicated they had some awareness or mindfulness about their potential symptoms and diagnosis of ADHD during the course of their development. The following quotations are examples of supporting commentaries.

I am learning better aspects of who I am so I can gauge my reactions better based on my experiences with ADHD. I need to recognize my strengths which compliment my ADHD.

I mean, I knew there was something was wrong. It's like if you can't do this, there's got to be something wrong. Anyone can do it [psychological test]; a five-year-old can do it. No intellectual demand whatsoever.

There where so many years that I was unaware that I had ADHD. I struggled a lot in grammar school and even to get myself into college.

I'm sick [with ADHD], but I always thought it was a part of my personality and something you just have to deal with, like the color of your skin and the color of your eyes and just you adapt and you kind of figure out the way around it.

#### ***Childhood versus adulthood circumstance.***

Sixteen (16) of the 31 participants indicated they had been diagnosed with ADHD in adulthood (over the age of 18-years-old). Fifteen (15) of the participants responded

that they had been diagnosed during childhood (under the age of 18-years-old). The median time of age of diagnosis with ADHD for the sample was 21. The age range of time of diagnosis was 7 to 56. The researcher asked the participants about the symptoms of ADHD related to the time in their development when they were diagnosed.

Participants' characteristics related to either childhood or adulthood diagnosis and its effect upon identity development are subsequently illustrated.

#### Diagnosed in adulthood:

I think just as I've gotten older and things have started to really come into more of my conscious awareness, that my behavior has kind of manifested in a way where I was being anxious around other people, so I would say that now that I do have a different kind of awareness, that is will probably be easier.

I moved out when I was twenty-three and then everything fell apart, and I was like, "Oh, great, all of these things that I never thought of." And then I just fell into rubble and then building it back up again whereas I feel like if I had been diagnosed sooner, I would have built the scaffolding myself, rather than depending on my mother.

I am a lot bolder now that I am older because I know now [about ADHD] and I have experience now. My self worth is not based on the things that I do and what I accomplish anymore. In the youth that is a big thing. Myself is that I feel satisfied that I have accomplished what I have accomplished.

#### Diagnosed in childhood:

I never really felt like I had a problem and now I do. So definitely there were questions that I asked myself, but ultimately, my sense of identity and I think they've [parents] been a big part of that process, although they might have confused me at first.

Well, when I was younger, I didn't really ever talk about it. I guess that wasn't on my mind. I wasn't old enough to think like that yet, I guess. I was just still kind of a kid, so it was just like part of me, but it wasn't something I paid a lot of attention to.

### *Cognitive level comprehension.*

The apparent impacts of the diagnosis and symptoms of ADHD appeared to have been influenced by the cognitive developmental level the participant was at during the time of their diagnosis. Levels of cognition over specific periods of time in development were related to the levels of comprehension or understanding of the nature of ADHD and what the diagnosis meant. Eight (8) participants in the study reported experience related to understanding their diagnosis and related symptoms that were linked to their levels of cognitive development at the time. The following statements exemplify these occurrences.

It's hard to say how I was told about the diagnosis at 8 years old. I don't think anything was ever really hidden from me. It was just like kind of difficult for like my eight-year-old self to kind of comprehend what it was, but it wasn't something that really bothered me really. I was always just like, yeah, give me whatever you want to give me.

Well, when I was younger, I didn't really ever talk about it. I guess that wasn't on my mind. I wasn't old enough to think like that yet, I guess. I was just still kind of a kid, so it was just like part of me, but it wasn't something I paid a lot of attention to.

You know, just as a kid, it seemed to come out of nowhere to me. But I think that was interesting. It's sort of like one day you just realized, "oh, you've got to take this medication." You know, I don't recall it being clearly explained to me. Like it's kind of a blur. Like I think a lot of-if you're a kid, I think you learn about it-it's sort of like you're just kind of told you have it more than you understand it.

When I was 16, I was a junior and that was when I was really cracking down in high school and I had a lot more on my plate. I started doing my own independent music and I don't know, just the high workload kind of helped me -- showed me I had maybe a problem concentrating sometimes, but I mean, I still managed. So I understood -- the fact that I understood what I had or have kind of helped me through a - at 16 I had better cognition and increased intelligence.

I was annoyed in the beginning but that's just because I was a child and I didn't understand what was going on, and it was annoying to me that I would have to sit still and talk to these people that I didn't want to talk to.

***ADHD upshot.***

A key assumption made by the researcher was that there was an outcome or upshot on the shaping of identity depending on the diagnosis delivery to the participant. Expectations and emotional responses about having the diagnosis were important components to understanding their experiences in development. It was important to understand how these earlier experiences came to shape their future rejection or acceptance of an ADHD identity. An overwhelming majority of participants (22) reported during the interview that receiving their official ADHD diagnosis from a mental health practitioner was a *relief*. One (1) participant described the experience as being in *denial* of the diagnosis and 1 participant described having *mixed emotions* in relation to the information. The following quotations are examples of the remarks made.

Relief of the diagnosis:

I kind of wanted to have a sense of denial when I was given my diagnosis. I welcomed the diagnosis. I was like when you receive the diagnosis and you know about it, for example an addict, an addict has to identify the problem first, and it was comforting for me to sit down with a doctor and have him say that you have ADHD, it helped me realize that I did, I kind of suspected already, but it was confirmation and from like there, I worked to try and fix my problems.

I think the not knowing is what the worst part was, so as soon as I was diagnosed, I was able to be treated, and the treatment worked. I was able to succeed very well actually.

It's kind of a bit of a relief in terms of -- well, it's not being like an idiot. It's just a condition and it couldn't be treated and -- what was say -- yes, basically talking

to people and helping to realize that mine is not the worse possible scenario that could happen, but in general, again, every day -- I don't feel like I need to be meeting with people regularly.

It was kind of scary finding out because it was a lot of money and I was starting to get convinced that I did have it and things were making sense and then when I did find out I did have it, it was a relief and things her explain about the way I processed just kind of made sense.

But, I mean after I got tested, it was kind of a relief, just because I knew that it wasn't my background, I guess. It was kind of something I couldn't control.

#### Denial of diagnosis:

So it kind of made me push away. It was almost like a little bit of denial that I had a problem, because it was like seeing the varying degrees, it was like "wow, mine is so minute that like I don't need to be around you." I was kind of reluctant to accept that I had ADHD back in the day, because my parents first told me about it in a way that made it sound like it was just because I was acting out. Like I would be jumping outside of classrooms and things like that, and it wasn't really sort of there was a big disconnect with what they were trying to help me fix and what they were telling me it was fixing.

#### Mixed emotions regarding diagnosis:

Honestly it is double edge. It was helpful on the one hand but on the other it was very sad. Hearing it be official doesn't make it better. It doesn't help me feel better, it just kind of eats at me. It helps confirm things but not alleviate anything.

#### **ADHD identity development.**

The second textural description in the study was revealed from 4 themes when participants began to answer question number 11, 25, and others that related specifically to the impact of ADHD on their identity development. The themes that emerged were: 1) pivot experience, 2) positive creative spin, 3) ADHD emotions, and 4) ADHD identity

amalgamation. This textural description ties back into 2 of the main research questions for this study: (a) how do adults with ADHD come to understand their identity development, and (b) how does this process inform the embracement or rejection of an ADHD identity?

Highlighted earlier, identity development is considered a critical task to master during young adulthood and throughout the lifespan. Experiences during this time of development are influenced by past experiences. Current experiences are very powerful in shaping one's identity as discovered in this category. The theories of Erikson (1950, 1968, 1982) and Chickering and Reisser (1969, 1993) identified in Chapter 2 are useful in helping to understanding identity development in this diverse sample. Theories, however, consider broad frameworks and may miss unique individual experience that shape identity development.

The *later adolescence* stage of development according to Erikson (1982) was highlight by individual identity construction being the main developmental task during the age range of 18 to 22. Fifteen (15) of the 31 participants (nearly half) in this study, at the time of participation, fell within this developmental stage. Autonomy from parents, sex role identity, internalized morality, and career choice are viewed as the tasks at hand for this period of time in human development. The researcher made assumptions that this key developmental period would also be reflective of the experiences in forging an ADHD identity. For the other 16 participants who fell outside of this age range for Erikson's *Individual Identity versus Identity Confusion* stage, it was assumed that

significant markers in development during this range in their past developmental histories would surface during the interviews.

This significant stage just discussed in Erikson's model is also closely linked to Chickering and Reisser's (1993) vector of *Establishing Identity*. Chickering and Reisser, while not placing age range constructs on this vector, identify several characteristics that occur during student development. These characteristics include: comfort with body and appearance, comfort with gender and sexual orientation, sense of self in social, historical, and cultural contexts, clarification of self-concept through roles and life-style, sense of self in response to feedback from valued others, self-acceptance and self-esteem, and personal stability and integration. A second of Chickering and Reisser's vectors, *Managing Emotions*, was illuminated during the data collection and analysis in this study. In this vector, students become aware of their emotions and learn identify and accept feelings. Twenty-two (22) of the participants identified themselves as current students at the time of being interviewed. The following 4 subsequent themes, including quotations, help further support the above theoretical constructs in this textural description of *ADHD identity development*.

***Pivot experience.***

Nearly half of the participants (15) described having 28 coded *pivot experiences* during the course of their development with ADHD.

In school at least, where I've had problems with ADHD, but right now probably-I mean obviously thinking back, I think that I had problems when I was grade school, but *now* is probably the most pivotal moment where I'm like "this is like really bad."

Probably like middle school-ish, elementary school times was the pivotal age. Then in high school, everybody was just like whatever. There were more important things to worry about, I guess.

At 17, 18-that was one point in my life that was like a turning point.

But in college, now that I'm surrounded with people all the time, I just -- I guess at some point, probably really early on, realized that it doesn't really bother me. I became more aware of what it was probably early college and became more about it. So the pivotal age shift was from high school to college.

Fifth grade was a pivotal age for me. There was a significant shift in my thinking about being a person who has ADHD.

I did have a pivotal moment when I was diagnosed at 33. That was a pivotal point for me because I was diagnosed later on, not like when you are 7.

ADHD is helping me follow through with sober ideas.

It's been up and down, hard to say if there was a pivotal year. In the 8<sup>th</sup> grade when I stopped the medication, I kind of told myself, like "I think I can do this, I think I've got this."

### ***Positive creative spin.***

Forty-one (41) specific examples were extrapolated from the interview data related to the theme of having a *positive creative spin* from living with ADHD as part of their identity. Seventeen (17) participants reported this reoccurring theme during their respective interviews with the researchers. Often, it was reported that others tried to get the participant to focus on the positive qualities that came with having ADHD; many of these people were mental health providers in the participants' lives. Many times, the participants had their own clear insights as to how ADHD has been beneficial and created

a positive impact upon their identity development. The following are examples of quotes signifying this phenomenon:

You'll come up with things that are very creative that wouldn't have been created otherwise. And if we didn't have that, the world would be a lot duller of a place. The strength of that, that makes me resilient, that creativity aspect, I think that in turn then has a positive effect on my identity development or my sense of self.

It was kind of refreshing to be reminded that I am quite optimistic actually and so I never think of it that way actually. Again, with the creative thing, it gives me an extra edge. I am not on my meds right now if I didn't tell you. Yes, creative aspect has a positive aspect on self-image. That is weird, it is like drilled into you in therapy.

So it gave me kind of an appreciation for education and a desire to drive and to make a lot out of it, if that makes sense.

I think it makes me more creative. I think that it helped me develop some interests. I really like to draw and run. This could be a fun part of my personality. I think that I have certain traits that may or not be favorable but sometimes the ADHD enhances it. I think it makes me more creative.

I would say it has maybe made me kind of second-guess myself on a few different time periods. I wouldn't say it negatively hurt my self-esteem or anything like that, but I guess I'd rather not have it than have it, but I realize that it does -- there are certain strengths that people say you have if you have ADD or ADHD, sort of like people tend to be more creative or think outside the box more or whatever. This has sometimes been used as a positive belief.

I have helped some parents with their own children identifying ADHD based on my own experiences with my children. I have helped some mothers with their kids. This was a positive thing to help others.

I am very creative. I am a lefty and left brained. I think some of this plays into it. Having ADHD hasn't shaped my life I think it is more like I think that it has made me more of an active person. The creativity has helped me have a positive sense self. My therapist calls it ADHD mind.

My therapist, they said that the positive side to ADHD is being creative, being up on your feet, go get her kind of thing, a person who like person, and that's -- I feel I am this person. I am very quick. I am a quick decision-maker and maybe

decisions like software, but I can make decisions very quick and I'm really quick under pressure. And that's why I'm thinking maybe that's the kind of work I should be doing, rather than just the tedious bullshit.

I think the ADHD thing makes you open to everything, because there's some aspect about pretty much everything that you're going to find interesting. And then, I think it makes it easier to understand other people's viewpoint, see why they get upset, you know, like sympathize-is that the word?

### *ADHD emotions.*

Eleven (11) different emotional reactions were uncovered from the review of the data in this study related to the participants' experiences with ADHD. The 11 emotions identified that were part of the participants' developmental history were: anger, anxiety, cynicism/apathy, disappointment, embarrassment, feeling different, frustration, isolation, sadness, shame, and stupidity/ignorance/dumb. Seventy-two (72) various meaning units for emotions were coded from the 31 interviews. Twenty-five (25) of the participants reported having some time of emotional experience in relation to their development with ADHD. Listed are these emotions along with exemplifying quotations:

#### Anger:

I'd often get very frustrated, angry with myself sometimes, loss of-total loss of confidence.

I really have-there's been points when I have been more angry-when I was in this crisis mode, I was a lot more frustrated. I put a couple holes in the house.

#### Anxiety:

I get a lot of anxiety for just having to sit still or having to concentrate or focus.

### Cynicism/apathy:

You know, so I've kind of maybe become a little cynical and a little, you know, about the whole process, because as an ADHD child, at twelve years old, being diagnosed, not like an adult being diagnosed, I didn't want to sit and talk to somebody.

It's made me more apathetic because I just lose interest in things so quickly, and there's not that many things to do. So you're kind of apathetic about the general world and a whole bunch of interests.

### Disappointment:

So I had to make decisions that were really hard like, do I study for this test and get a C or do I not study for this test and have fun with my friends and have fun and then get a D. There is not much difference honestly. I just kind of getting disappointed as to why those are my only 2 choices.

### Embarrassment:

When I was younger, I was kind of embarrassed. I remember being in middle school when I was young especially and I was on Ritalin and I would have to take it at school and the nurse would have to give it to me. And it was like after lunch and I was always really embarrassed about it, so I would try to hide it.

### Feeling different:

And the other thing I wonder about, if I had been receiving accommodations, was I might -- that feeling of difference that I had already felt from so many other things might have just increased exponentially because I was being treated different than other kids because I had an exception. So I wonder if that would have -- I don't know if that would have been a good thing.

I kind of like being strange, it is fun for me. I actually like being different as opposed to saying I am different and pretending you are different. This has a positive aspect, way more than being negative.

I think maybe it's [ADHD] made me feel like I'm different. I remember thinking when I heard that information that I was somewhat morally deficit or it was a character flaw.

It kind of gives you a different perspective -- not perspective, but a different way of handling yourself and a different persona when you're around people.

#### Frustration:

I get things done and I have been successful but it probably takes me longer to do things than the average person which is very frustrating.

And so that's frustrating, but it generally doesn't bother me because it's not something I had-I'm sure I had signs of it younger-but it's not something I was dealing with when I was younger, when it could have been more obvious.

It's made me frustrated in general. I just get frustrated that I have difficulty reading anything over four pages, and I'll do it when I have to, but I feel like -- I just get frustrated and then I get frustrated about not being able to maintain relationships with people because I feel like there's some kind of a disconnect. I just feel a disconnect from the world. I feel frustrated.

The other thing that frustrating is when someone wants you to have instant recollection, this is something that I have never been able to do.

It is hard and frustrating when I am in classes when I am trying to focus on what the teacher is says. It is even hard to focus with people.

#### Isolation:

So when you have that going on with family, your needs are completely not met, so that can definitely affect identity development, and it left me at least feeling empty and lonely as a child and I had the places later in life for that.

I felt like more isolated as a kid. I remember specifically I wanted to stop taking it-because I'd be in school and I could definitely focus-I was just like-it was almost like I'm zoned into language arts at the time, or math or whatever it was.

#### Sadness:

Again, just a lot of impulsivity, emotional aspect-I mean being-and by emotional I mean, I'm pretty level headed, so when I feel the full effects of ADHD, it's like I jump to conclusions or I jump to kind of-not extremes-but I'll get sad easily. I felt badly about myself, a bad student, when I got into trouble. It had a negative impact.

It definitely felt relieving did and I found the explanation to be convenient and I think I almost was just using it as an excuse almost, or at least initially, I was feeling pretty sorry for myself.

Shame:

And so I feel like part of what I'm working through in analysis right now is working through the shame that's developed over the years, not only growing up trans or growing up in the LGBT community, but also the shame of having to deal with [existing] functioning problems with ADHD.

For a long time, I was ashamed of what was going on with me.

Right now, I just-even at work, you know, it took me a while to submit disability paperwork to them, saying, you know, I need some accommodations, due to my ADHD. I mean, just this year, so-there's still some shame, some fear, you know, of what other people think.

Stupidity/ignorance/dumb:

So I think that that weighed very heavily on me and, you know, I think that I've been treated in the past, just made to feel like I was dumb, like I was-I've been let go from jobs before.

It would make me feel really stupid and then I started reading and highlighting and taking down notes because when I write things this helps me remember.

Sometimes I give myself a hard time because I'll make mistakes, that "oh, I'm so stupid," but then it's like, "ok, calm down," like "I'm just not thinking; it's not that I'm stupid." So, a part of that is like, ok, I'm a very confident person and I think that it's helped me if I just think to myself-it's made me ok with myself.

I always categorized myself as not stupid but dumb.

***ADHD identity amalgamation.***

The researcher began with the initial expectations that the development of an identity inclusive of ADHD would eventual lead to either and embracement or rejection of this identity. This section will address the third research question within this study:

how does this process [of ADHD identity development] inform the embracement or rejection of an ADHD identity?

What was uncovered from the data for 31 interviews was that the overwhelming majority of the participants (27) had a positive connection to their ADHD identity. Sixteen (16) of the participants acknowledge that they *embraced* their identity with having ADHD. None of the 31 participants stated they outright fully *rejected* their identity with the diagnosis. What was uncovered, which was miss diagnosed by the researcher, was that 15 of the participants reported having a more neutral acceptance of their ADHD identity and some even reported mixed feelings of both embracement and rejection. Eleven (11) of the participants identified an *acceptance or neutral* feeling toward their ADHD identity, contributing to the total of 27 participant reporting non-rejecting identifications. Four (4) of the participants reported feelings of having a *mixed* identification with ADHD. Mixed feelings include having both aspects of rejection and embracing of their ADHD identity. The subsequent quotes are illustrative of these identifications.

Embrace:

I think that I'm towards the embracing side, but I think I have moments where I'm like grumbly about it, but for the most part, I'm of the embracing part of the ADHD identity because it is part of my identity. It's part of who I am and it's part of how I developed and it's part of the way that I process the world.

I embrace it and also I embrace all the approaches to getting over it, except for medicines so far, but I'm really on the track to getting into medicine.

Well, I mean, I have to embrace it. I don't want to, but I have to. I embrace it out of necessity. I'd way rather just say I don't have a problem and just not have to

ever worry about ADHD and just be a retired old person not having to worry about anything, but that's not me. I definitely need to worry about it and address it, so yes, I embrace it.

I try to embrace it because I just see it as more of a challenge and something else that I have to overcome. You know, I have to work a little harder with things.

I embrace it because it has made me a lot happier and given me a lot more confidence. I think it is going to make a really big difference in the long term.

I think right now I'm embracing it. I think it's because it's kind of new to me, so I'm still doing a lot of researching, and I want to get better, and I want to take care of myself, so I'm definitely embracing it right now. And I don't see myself rejecting it in the future. I am kind of moving forward with it making it help me be more resilient and stronger.

#### Accept or neutral:

I wish I didn't have it. Do I embrace it? It is what I have to live with. I accept it, it is what I am, it is who I have been.

I accept it, I don't think I would ever really embrace it. It is part of me and it is never really going to change. But, it is not like I am horribly can't stand it and I want to trade lives or anything.

I guess I embrace it. I don't really -- I don't know if embrace is the right word. It's just accepting it, yes.

I can't embrace it and I can't reject it. I seek to manage it. If I reject it, it is part of who I am, it is integral.

#### Mixed:

75% embrace, 25%-you know, because it's more towards neutral. I'm not running off to everybody telling them that I have ADHD. I don't know how much it affects my life. Sometimes it does in terms of school and then-but I would say more towards embracing it.

I feel like I am beginning to embrace it. I am aware of it and I am beginning to understand it. It is not one of those things I don't throw out there, just like my sexual is identity. I don't hid it but I don't throw it out there either. It is just part of who I am that I am not going to hide. Maybe initially in grade school I was rejecting, I was uncertain then.

The subsequent comments highlight some of the responses heard for Question 11: How do you think ADHD has shaped your sense of self or identity? This question from the interview provided the significant data that formulated the meaning units that developed the themes and then textural description of *ADHD identity development*.

I guess I looked at myself as a failure, like I said, incompetent compared to other people, resentful. I looked at myself as a loser, you know, and all those things. I looked at myself as fearful of the future, not being able to really launch, you know, failure to launch, that type of thing.

I think so that this experience [of having ADHD] has helped shape a positive experience.

It's like part of my personality. It helped me to understand the facets of who I am. Oh, this might be a symptom of ADHD. Ok, it's not just me.

Absolutely [ADHD has impacted my identity], the strength of that, that makes me resilient, that creativity aspect, I think that in turn then has a positive effect on my identity development or my sense of self.

It is just one facet [ADHD]. I mean, it's just kind of there. I mean, I don't really ever think about it. It's just something I've had to do. I've dealt with it for so long, it's just kind of become just there and I don't even think about it. It's just automatic, I guess.

Well I spend a lot of time telling myself what a fuck up I am. There is a lot of negative self-talk. I have these negative self-talk mantras.

Well, that break again that we were talking about, when I was like 16, 17-I kind of had like an emotional questioning of myself. Because I had been on medication for so long, I wondered "who am I without the medication?" What does that mean to be without medication? I just couldn't remember. I had been on medication literally every day for 10 years at that point. So I kind of lost my sense of self in a way in terms of my ADHD. I didn't really know what to do. I had been told by doctors not to go off medication-it was like basically backtracking. That was kind of hard to overcome a little bit.

It's made me more stubborn because I'm much less willing to compromise-I guess we're straight with that.

I'd say that it's probably always given me the sense that I'm fighting uphill in education and that it kind of makes me not take things for granted. So I think that's, I guess, somewhat of an effect of my identity, yes.

I think this had a positive effect on my identity. It make me more immersed in my school work because I know I have too or else I will do a complete one eighty. I don't think it is an important component of my life in that it defines me. I think it is a part but doesn't define.

I wouldn't say it negatively hurt my self-esteem or anything like that, but I guess I'd rather not have it than have it, but I realize that it does -- there are certain strengths that people say you have if you have ADD or ADHD, sort of like people tend to be more creative or think outside the box more or whatever. This has sometimes been used as a positive belief.

Knowing others with the disorder would be helpful to my self-esteem. I am a real believer that being with other people who are struggling with the same thing is good because you can help each other with what you are struggling with. Being alone is never a good thing.

Like I'm just curious about everything and subjects and being kind of entertaining in that way, but at the same time, the negative thing, it's just constantly being someone who's behind and catching up productive expectation.

I think it did a little bit of a negative impact upon my identity. In fact, really I can't see myself in a classroom setting because of the trouble that I got in before at school.

I don't think that it has affected it that much, I think that if I didn't, if it wasn't that I had ADHD, I think everyone would be like I am hyper and I have a lot of energy. So if anything, I feel like for some people it is not hindering but for me it is a personality thing.

I think initially I think it shaped it like I saw myself as sort of "less than" only because it was like-you know, I had to take this pill in order to pay attention.

I mean, I'm sure-I've never thought about it actually, how being ADHD has-I mean it's made me a person just by reacting to my surroundings in a different way, but I don't think it's changed me. I think I would have been a silly person anyways, with or without ADHD.

I was learning self-care. Learning self-care translates into positive self-identity.

I think it has made me kind of not perseverant, there is some definite times where it made me not want to study. It made me self disciplined I guess and detailed oriented. I feel like it is making me better all around because self-image and confidence make you happier and a better friend and family member. I feel I ma making better choices because I am more sure of my self and I feel I don't need to do things for other people as much.

Absolutely, it helps me to not beat myself up too much about it. I'm still going to take responsibility, but it's also like, "ok, it's not the end of the world." You know, there's reasons for this and I've just got to be vigilant, constantly, constantly, constantly vigilant.

Yeah, I think it makes it a lot easier, it is a positive thing for my identity -if I could actually care enough to think about it, it makes it a lot easier to understand people.

It has an impact on my self-esteem. I feel a little insecure. In conversations, I will feel that this is really important and when I actually get to say it is not as important as I had imagined it.

For identity, I do not know. I feel I am the same person, but I am more educated about who I am. Having the diagnosis had made me more self-reflective and have helped clear my mind by doing yoga.

I guess it's made me pretty eccentric, I guess, just like out there. When people meet me, they get -- they can tell that I'm not like a lot of people. A lot of people can just tell I'm pretty out there, far out, I guess. I'm just -- I don't know, I guess I give off this different vibe to people. This has been a positive aspect to my personality.

### **Disability identity development.**

Drawing from the theoretical framework of Gibson (2005) from Chapter 2, this textural description of *disability identity development* was constructed from themes that came from questions in the structured interview. Participants were specifically asked if they identified has having a disability. Participants where then shown a chart containing Gibson's Disability Identity Development Model (Appendix E). They were asked to

state which of the three stages of development they felt best represented them in their current developmental context.

***The (non-) disabled self.***

Participants in this study (15 out of 31) largely considered themselves as *non-disabled*. Nine (9) of the participants stated they identified themselves as being *disabled*. Seven (7) of the participants stated they had *mixed feelings* of both identifying as disabled, as well as having a non-disabled identity.

Using the family grouping function within Atlas.ti to look at specific demographics, gender responses for this theme were explored. Of the 17 participants within the gender *female* family, 8 participants responded as identifying as non-disabled. Five (5) identified as being disabled and 4 as having mixed feelings. Of the 13 participants within the gender *male* family, 6 participants identified as non-disabled. Four (4) participants stated they considered themselves as disabled. Three (3) identified with mixed feelings of being both disabled and non-disabled. One (1) participant fell within the gender *transgender* family, this participant identified as being non-disabled.

Analysis of the demographic of race/ethnicity/culture revealed the following statistics when considering this question of having a disability identity. Of the 2 participants in the race/ethnicity/culture *African-American* family, 1 participant considered themselves as disabled and 1 participant considered themselves non-disabled. Of the 3 participants in the race/ethnicity/culture *Asian-American* family, 1 participant reported having mixed feelings and 2 participants reported seeing themselves as non-

disabled. No participants in this family considered themselves as being disabled. Of the 18 participants in the race/ethnicity/culture *European-American* family, the majority of the participants (9) identified as being non-disabled. Five (5) participants in this family identified as being disabled and 4 identified as having mixed feelings. Of the 7 participants in the race/ethnicity/culture *Latino/Hispanic-American* family, 3 identified as being non-disabled, 2 as being disabled, and 2 as having mixed feelings. The final race/ethnicity/culture family of *Mixed* included only 1 participant who identified as having a disability.

The final consideration in this section is regarding the breakdown within the sexual identity families. Of the 24 participants in the sexual identity *heterosexual* family, the majority of participants (12) identified as being non-disabled. Six (6) participants identified as being disabled and 6 identified as having mixed feelings. Of the 7 participants in the sexual identity *non-heterosexual* family, there was a varied response. An equal number of responded said they either had a disability or non-disability identity, three participants respectively in the two categories. One participant identified as having a mixed identity.

#### ***Defining disability.***

Thirteen (13) participants in the study provided information during their interview that created the theme of the *defining disability*. Of these 13 participants, 5 identified as being non-disabled, 5 as having mixed feelings, and 3 as having a disability identity. The

following quotations shed light onto the schemas about what is considered disabled by the participants in this study.

There's just something shaming about disabilities and I am not a big fan of the term, but I am differently abled, yes, not disabled. "Dis" means not abled; it's not that I'm not abled, I'm just differently abled, so that's kind of where I come at it from – it's the perspective I come from, but it's just like someone who can't walk, they still have mobility.

It's just that someone who has a disability must be mentally, seriously, just having problems with daily life, like serious problems. And I have felt that I was like that [with my ADHD].

I said it was a disorder and I don't know if I have ever really thought about the difference between a disability and a disorder. I always associated being disabled as more with having a physical issue and a disorder as more mental or processing issue.

### ***The DID model ID.***

Gibson's (2006) model of disability identification (ID) encourages the environment to take responsibility and create the accommodations the disabled person requires. Gibson (2005) introduced the Disability Identity Development (DID) Model which helps clinicians understand people with disabilities and helps them better serve this population with effective treatments. The model gives insights as to the crises a disabled person may struggle with. The model contains three stages and identity development according to Gibson can be fluid, which was evidenced from the results of this study. Participant were given a copy of the chat during their interview and allowed to look over the model. Participant were then able to reflect on the model and asked to select a stage of identification (ID) in the DID model.

Two (2) participants described themselves as somewhere in between Stage 1 and Stage 2 of the DID Model. Three (3) participants described being between Stage 2 and Stage 3. The majority of the participants in the study (20) identified as being in Stage 3 or the *Acceptance* stage of the model. None of the participants in the study stated they were in Stage 1 or the *Passive Awareness* stage. Three (3) participants acknowledge their place in the developmental model was at Stage 2 or *Realization*. Three (3) participants stated they felt their current identity spanned all 3 stages in the model.

### **ADHD affects.**

The textural description of *ADHD affects* was shaped by the presences of 3 themes that emerged from the data. The resulting themes were: 1) coping issues, 2) social, behavioral, and academic issues, and 3) psychological and cognitive issues. These themes led the researcher toward conceptualizing the impact of having an ADHD diagnosis as a result of a combination of an internal and external developmental processes for the participants in the study. Having an ADHD identity appeared to develop along normative biological, psychological, and cognitive trajectories that appeared as internal factors for the participants. External factors, conceptualized as social and environmental, appeared to influence this internal developmental process of forging an identity inclusive of ADHD. Both negative and positive external factors appeared to have an influential impact on ADHD identity development. External factors also appeared to impact academic, social, and behavioral problems. Subsequent quotes illustrate this phenomenological textural description of *ADHD affects*.

### ***Coping issues.***

The theme of *coping issues* result from 106 codes highlighted from the information rich interviews. Participants were asked how ADHD impacted them and what coping strategies have been developed which have ultimately shaped their sense of self. The following are rich textural descriptions of coping related issues that influenced ADHD identity:

I deal with it by trying to be organized. Keep my room in order. If my environment is off, it sets the tone for how I do things. Keeping things in place helps with control. My making lists is very helpful. I put reminders on my cell phone or post-its on my laptop. I'm going to exercise more because it's kind of gotten to be a bit of a habit for me to just get out there and walk my dog in the morning, even before I go in for work so I can kind of get the blood circulation flowing through my body. And I see the benefits of it, but also just focusing on getting sleep if I can get it. Like even if I know I have a lot of work to do, I try to stay on a specific schedule, stay scheduled.

I try to set up so that I'm not doing anything for that long. I'll maybe do an hour of reading-an hour and a half of reading-and then take a break for 15 minutes, you know, eat a snack or check my email, go on Facebook, whatever, just so that I'm having a mental break and can kind of clear my head a little bit and then go back into it.

So I've been -- my productivity has gone up since I got diagnosed because then I was able to go "Oh, this is how I function. This is why I'm functioning the way that I function and this is how I can use it to my advantage."

So I try to come at it from a strength-based perspective. It's a different way of processing, but there's something beautiful about being different because you have a perspective that other people don't have.

Deep breathing is a coping technique. Reminding yourself, when I was younger I used to get panicky when I wasn't able to sleep and then I would have a full out panic attack and that is never fun. I have learned after some really horrible sicknesses that I can deal with stuff now. Deep breathing, drink a lot of water, and remind your-self I will catch up on my sleep during the weekend.

I thought about going on meds for a long time, I am unsure about that. A lot of the times I put sticky notes all over my computer, I have to download the self control app, so I can type all the websites in that I can't be on, when I am supposed to be studying. I lock myself into my room, I go to the library a lot, I am obligated to be in an environment where I am supposed to do what I am supposed to do. I signed up for a tutor, for a weekly tutor, so it would be easier for me to remember. I like force myself to go to a place that would be helpful and beneficial to me to do work and talk with someone about learning and this would get me into a learning mood. Sometimes I have to turn off my phone because the text messages are distracting.

I think my other talents maybe overcompensated for this slowness. The time thing wasn't seen because I could compensate in other areas.

Tricks that I did before going on medication was doing something in class to stay focused and be able to pay attention. I can't study in a quiet room, I need to study in a room with a lot going on. I would go to the coffee house. In class I would eat to class. Being on computer would help or taking notes during class would be helpful during class. I can't just sit and listen to the teacher.

I was working out and started losing weight and I am not sure if that was due to the medication but it was improving my self-esteem. Working out and the medications all helped in my positive identity, it all interrelated to help.

So I actually have to force myself to slow down. Like in high school I'd smoke a lot of weed. I could feel it dumbing me down, but my grades would get better just because it-since I was dumber, I had to slow down.

I would say just reminding myself that I have ADHD, reminding myself that I need to focus and it's hard, but it's happened a lot, so I'm kind of used to it.

### ***Social, behavioral, and academic issues.***

With in the textural description of *ADHD affect*, the researcher found there a reciprocal dynamic that occurred between the internal and external developmental process. This theme of *social, behavioral, and academic issues* were formulated from the question that focused around issues related to social, behavioral, and academic

functioning. Participants were asked to discuss the impact ADHD had upon their development. The impact of having ADHD had a combination of both positive and negative factors that influence the internal and external worlds for participants in this study. External factors became those that presented as social, environmental, overt behaviors, and problems with academic functioning. Those factors that the researcher observed as internal became issues such as psychological, biological, and cognitive processes and are discussed in the next section of this study.

ADHD development appears as a dynamic processes influence by the interplay of both internal and external forces. This postulation is supported by the empirical evidence but forth in Chapter 2 that gives structure to how an individual navigates the process of development. The following quotes represent statements made by the participants in the study that demonstrate the impact of ADHD upon their social, behavioral, and academic issues that affected their development. This impact includes both positive and negative influences upon the process of forging an ADHD identity. Seventeen (17) of the participants reported having social problems related to having an ADHD diagnosis. This was coded 22 separate times in the data.

It has impacted my life in a negative way. It honestly hasn't done anything good for me. It slows me down and keeps me distracted.

I mean, aside from after I graduated-I mean in high school I had some issues too, but after I graduated high school I was just really unmotivated, but I've just kind of always been really unmotivated and-I don't know. I think that's kind of part of it.

Just like the medication, it makes me closer to being normal, but it is never going to make me the same speed as the other kids. Knowing academically that I could

learn just as much but it would take me longer is kind of a bummer. No matter what you do you will kind of be behind and this has had a negative impact on my identity.

It is just, it all has to do with time. Everything comes down to time.

It makes it more difficult to stay focused when I'm reading. Really, it impacts my life, I think the most, in terms of school where I'm demanded to maintain focus and not space out during class. I also think it affects me socially sometimes.

I am very impulsive. This has a negative impact upon my sense of self.

It wasn't until years later as an adult that I can learn but I learn in a different way. I am more of a sight person. I am a visual learner. I didn't find this out until much later. The diagnosis was a good thing. I didn't get diagnosed until my fifties.

Another thing that I noticed was just in general focusing when I was speaking to people or remembering conversations, that was another thing because so many times, people would speak to me and I'd hear it.

I can't manage my time. It was negative I would probably say in maybe the fifth grade, because I would get in trouble at school for talking.

And that's really when my weaknesses came out, you know, in terms of my writing ability and being more aware of being distracted easily. I'm this social, very social, outgoing person, so maybe that covered up a lot of these weaknesses that I had. So-I'm at a point where I'm becoming more accepting of myself. I've just got-I'm really just focusing on living a balanced life and doing well in school.

One thing a person said to me was ADHD could have caused me, I am a loner, someone who knows me very well made the case to me that ADHD can cause people to miss subtle communication cues and that would help with that. Basically, this link has not been clear to me but it might be hard to connect with people maybe.

It makes it more difficult in general to connect with people, just maintaining focus. That can be such an important thing to feel -- for somebody to feel like they're less into -- it matters, being a good listener and if you lack that -- or if you're talking to somebody that lacks that, you might kind of withdraw.

And the social piece for me kind of dropped out a little bit. I didn't feel like being social or I didn't really even notice.

The only thing that's really a drag, I think I interrupt people a lot because of the ADD. And the reason I interrupt is because I'm so fearful of losing the idea and I don't like -- and it scares me to have an idea and to have lost it.

Then as far as people, I get bored of people really quick. They can feel like I'm kind of an asshole. I'm either not completely listening to what they're saying or like-especially in college, you make new friends, right-so you meet them and then a couple weeks later, they're like "oh, we're going to be great friends." By that couple of weeks, I'm already like over it. It is a hindrance sometimes.

### ***Psychological and cognitive issues.***

This section focuses more on the internal process of developing identity while affected by ADHD. Participant interviews were coded when they discussed the negative and positive impact of having ADHD on their psychological and cognitive functioning. The beliefs, stereotypes, and the effects of hiding their ADHD diagnosis are explored. The concept of ADHD being a "real" diagnosis is also introduced and the ramifications this perception has upon healthy psychological and cognitive functioning. Twenty-six (26) of the 31 participants reported on belief and cognitive schemas regarding ADHD. This was coded a total of 56 times in the data. Sixteen (16) of the participants reported cognitions surrounding stereotypes that they had been aware of regarding ADHD. These reports were both directly said to the participants or were more macro in nature. The concept of stereotypes and their effects were coded 28 times in the data analyzed. All of the participants in the study (31) reported some relationship to hiding or covering up their diagnosis. This was at times a positive, negative, or neutral on their psychological or

cognitive development. Eleven (11) of the participant discussed the concept of ADHD being a “real.” “Real ADHD” was often internally constructed or impressed upon by a social or environmental relationship. These stereotypes and external messages had an impact upon ADHD identity development for the participants of this study.

Beliefs and fears:

Again, just a lot of impulsivity, emotional aspect-I mean being-and by emotional I mean, I’m pretty level headed, so when I feel the full effects of ADHD, it’s like I jump to conclusions or I jump to kind of-not extremes-but I’ll get sad easily.

I know it just impacts my self-esteem and impacts whether I can achieve goals with that because I hardly ever finish doing -- or I always run out of time to do things, and I tend to want to do a lot at once. But I want to do everything, and sometimes I sign up for stuff and then I want to do something else later, but the motivation for that thing or I get all disorganized.

I think it does help shaped a positive identity, because when I am able to talk to somebody, I am completely removed from the situation, it helps me solidify my thoughts. I think with my ADHD I am easily persuaded too.

Therapy and medications can help you. I believe everyone with ADHD should have these 2 things especially in the sever range. It is a disease.

It makes me trapped in my head a little bit.

There’s still such a stigma in America about it, it seems. And ADHD is certainly preferable to any number of other things one could have, but it is still stigmatized, and I think there are a lot of people who don’t think it’s a real thing.

I’ve come to believe that ADHD is not necessarily a disorder, it’s just a way of processing that’s different, and because it’s different, it’s considered a disorder.

I am a bit skeptical. Sometimes you think it is in your head, there are other people with mysterious diseases and it makes you wonder. This is unfortunately in a way it is good now to have this issue now because people are more aware of it and it has almost crossed over that line now that it is a joke. I would imagine in other place that this currently a luxury disability.

I like to believe it is real, and I know it is real, but I want to know the scale in life, how much do I have? I feel like when you say you have ADHD it is so black and white. I believe the diagnosis is real. I know there is science behind it, that it is a combination of different chemicals that are imbalanced or something like that. I have been explained it.

I think like anything, to some degree, it can affect you as much as you let it in terms of it being a negative. I think it's probably much more unique to each individual than other, I don't know, learning disabilities or whatever you want to call it. So I think there's probably not like any textbook case where every person with ADHD is the same or will behave the same. So that's probably -- how it shows itself is probably very unique, I think.

I believe it is a diagnosis, but I also think it doesn't need to be. I think many people have taken advantage of it. I feel that there are a lot of things that have a negative affect with the label.

I feel like there are a lot of people who have it and I feel like everybody kind of has ADHD or ADD to some extent. Everybody has trouble focusing.

You can't explain it any other way other than something was off. I don't think any 15 mg of Adderall would do such a switch if it were not a disorder or a problem.

I think ADHD just gives me a different way to fit in everything. You know, your model of the world-I think it just gives you a different way to organize it.

#### Stereotypes:

I feel like it's losing a lot of legitimacy given today's culture. The abuse of the medications is ridiculous, like absolutely ridiculous. So I feel like the people that actually do have it are being pushed aside because if you had a thousand people screaming at you the same thing, and there's one person that's screaming the truth, unless you're lying, then you're going to lose that one person. I feel like all the programs that are set up to help people with ADHD are going to disappear or be so overrun that they lose their effectiveness.

I think it occurs more in men and boys and it's noticed younger, more often in young kids, young males.

I definitely believe that there's some over-diagnoses where some kids are really just spastic kids, but I also believe that ADHD is a true-and ADD-is a true disability.

#### Hiding the diagnosis:

A couple of my close friends know but I don't like to tell anyone, especially since it's so much later in life that it happened. I wouldn't say I'm ashamed of it, but I just feel like it's not really their concern.

I mean, I don't share it. I mean, if people know, it's like whatever. Most people don't really care that I've talked to. No one's really asked about it. They're like, oh, okay, cool.

I got bad advice from a psychologist, to basically open up and tell my employer and what I found was that my boss thought it was a load of crap. It became a much worse situation.

I just don't tell people because I don't want them to feel sorry for me. If they ask, I will tell them, it is not like I will hide it.

When I was younger I have hidden it. Throughout high school I hid it. Then in junior and senior year I was like why hide it. Who cares? The pivot came around 16/17. I had a really bad girl time in middle school and that kind of made a huge wall go up for years, until I realized I should do what ever I want.

I haven't really told many professors. I don't tend to tell my professors that I would tell them that. I try not to throw it around probably because I'm afraid of a negative reaction where someone might not believe me.

I actually haven't told my parents and I am planning to tell them over the break. I didn't want them to worry because they worry a lot.

For the most part, I'm pretty open about it [ADHD] with people and I would rather people understand why I am the way I am than just thinking I'm some weird like different guy, you know?

#### **Treatment, interventions, and accommodations.**

Treatment, interventions, and accommodations types and their impact upon

ADHD identity development represented a significant proportion of the overall interview

focus for this study. The researcher asked the co-investigators in this study a variety of questions related to the types of treatment received over their course of being diagnosed with ADHD. They were also asked to describe the specifics of the interventions they received, as well as the accommodations that had been provided either in the academic or workplace environments. Four (4) key themes emerged from this textual description: 1) treatment/interventions type, 2) treatment/interventions impact, 3) accommodations type, and 4) accommodations impact.

All 31 of the co-investigators within the study had received some type of treatment as some point in their course of development. The requirement for participation in this study was that at some point during the course of their development the participant had to have been diagnosed with ADHD by a mental health professional. All 31 of the participants self-reported they had interfaced with a professional at least 1 time in their life in order to have been diagnosed. A psychiatrist had diagnosed the majority of participants. Educational psychologists and testing centers for ADHD, as well as primary care doctors, neurologists, social workers, and psychologists were all included as being mentioned to have provided some type of treatment for study participants.

***Treatment/interventions type.***

All 31 participants reported receiving a range of various treatments and interventions. There was a range of medical and mental health professionals that provided the treatment to the participants. There was a range in duration of treatment

from a few sessions to long-term treatment. The majority of participants also reported receiving interventions such as talk therapy and medications. Twenty-seven (27) of the participants were currently taking medications during the time of the interview or had taken them in the past. Four (4) of the participants stated they had never tried medications for ADHD as in intervention. Fifty-seven (57) times this theme was coded during this analysis. Some of the treatments and interventions received by participants in this study are highlighted below.

I did attend one educational course through my HMO and it gave me lots of materials.

I see the psychiatrist on-going.

I was only on medications for like a week and my mom and my dad were like “no, we don’t want you on this.”

I took on some behavioral strategies [from therapy] and that has been incredibly helpful.

I take Strattera every day.

I am not in therapy anymore, but I am still prescribed medication. I have been taking medications consistently ever since I was seven.

I did a group therapy session. I did two of them. Back in the 9<sup>th</sup> grade where kids like myself and other kids with different variations and tendencies of ADHD would come, and it would basically be like a group interactive therapy.

I see a psychologist and then occasionally at school I see a psychiatrist too. I have chosen to not be on medication because I don’t know if I fully believe it.

I current am [in talk therapy] and I have been in the past. I see a therapist, and in addition to that therapy, I am also prescribed medication.

I went to a counselor, you know, kind of like therapy counseling. And then I went to the biofeedback, which I hated.

I have never taken medications until recently. I do talk therapy with a psychologist counselor. I find writing helps and I like to write which helps me blow it all out. Adderall is the major intervention.

***Treatment/interventions impact.***

Individually and collectively, the impact of treatment and interventions for this sample was surprisingly positive on their development of an ADHD identity. All 31 of the participants reported that receiving treatment and interventions for ADHD had some impact upon their identity development. This theme of highlighting the impact of treatments and interventions on ADHD identity occurred 65 times within the data analyzed. Eighteen (18) of the participants reported that the treatments and interventions they had received for their ADHD during their development were helpful to developing a positive identity with ADHD. Four (4) participants in the study reported that they had a negative impact. Five (5) reported that the treatments and interventions had a mixed impact of both positive and negative influences upon their identity. Four (4) participants described the impact upon their identity as neutral or unsure. Listed are some examples that illustrate these experiences:

That is probably that is something that I am counting on to help me out, the meds and therapy. On my own I haven't made any progress. This diagnosis has really worn me down in a sense.

I've felt that my confidence level has gotten better with it. I think that I've actually started to really make changes in my life in terms of taking control of my life through medication. I have not had therapy or anything.

I don't think the meds have hindered my sense of self. I don't know, I've always been kind of wary to take meds because in the past because I have anxiety too, and I was freaking out.

I think they helped immensely [shape my sense of identity], because before it was very shame-based. I felt shame because I cannot function.

When I went to see the second doctor, on our first meeting, he said briefly OCD, but then he said you are a textbook case and I was walking out the door he said I was about 35 years too late [for an ADHD diagnosis]. I lost it in my car. How does one [medical doctor] say that to someone? It was the most irresponsible thing to say to someone as they walk out the front door.

Really both [negative and positive impact], because for kids, especially since I was seven, so you grow up with this idea that you are different, so you kind of have to talk about it. So this is not so good. In a way I did need to go talk through it, but at the same time, I don't know, it kind of gave you this idea that no other kid has to do this. I am the only one who has to go to therapy at eight years old and stuff like that.

I think it does help shape a positive identity, because when I am able to talk to somebody, I am completely removed from this situation, it helps me solidify my thoughts. When I talk to someone it helps me form more of a concept like who I am, which then helps me stay more focused.

Oh, meditation is unbelievable. It is one of the best things I have ever done. I am hopeful that they might have a positive effect upon my identity [preparing to take medications for the first time].

Absolutely, it has helped. I have a better insight into myself and I'm still learning about myself.

***Accommodations type.***

Thirty (30) out of the 31 co-investigators reported on utilization of accommodations either in the workplace or academic environment. There was an equal divide amongst the participant who reported on this question. Fifteen (15) stated they were receiving accommodations in the academic or workplace environment. The

academic environment was the gross majority of where these accommodation were received. Fifteen (15) of the participants stated they had never received accommodations over the course of their development. Comments to support statements made are now presented.

So I received accommodations, but not because I was registered as disabled and part of the reason I never registered as disabled was because it was a little difficult since I was diagnosed so late in life and I functioned fairly well.

I am registered with Student Support Services. So that's kind of the limit of my interaction with them and that's also a big thing, to sign up for extra time for exams.

I have not received accommodations. At one company that I worked at, I sat on the accommodations board and I could fight for the person with a disability. I was an advocate. But I never asked for accommodations because I knew the attitudes that they had. They were very negative to anyone who asked for accommodations having to do with ADHD. There was a stigma.

I am not receiving accommodations although my psychiatrist encouraged me to get tested and receive services.

So technically, I have the accommodations for a note taker, extra time on tests, no consecutive tests, and online textbooks. The only one I have ever utilized was the note taker, just if I didn't go to class or if I missed a PowerPoint. I haven't really used them.

No, mainly because it's too much work, because the process is so long. I should have done it in summer. I just-it's kind of a point of pride to not do it.

No, I do not get accommodations. I did not know I could do this. No one has ever told me about this.

Yes. One of the things I'm actually getting right now are e-texts or tape recorded books.

*Accommodations impact.*

Forty (40) times in the data incidents were reported that contributed to the theme of *accommodations impact*. Participants were asked about how they believed the accommodations they had received over the course of their development influence their identity development with ADHD. Twenty-nine (29) of the 31 participants described that the accommodation had in some fashion influenced their identity.

The majority of the sample (21) stated they felt receiving accommodations had a positive influence on their developing an ADHD identity. Four (4) participants stated it had a negative impact. Three (3) participants report they were unsure of the impact and 1 participant stated they believed there was no influence at all. The following quotes demonstrate these influences:

It frustrated to dance between the two, should I say what is up and keep going and do not disclose. If I were to tell another teacher, I feel like they would be ok, cool, so I don't give you extra points. I worry they would think I am trying to get special attention or something extra.

It's definitely been helpful. I mean I actually can finish exams now versus never finishing them. So yeah, I definitely think it's been helpful. It's helped shape my sense of identity. I've felt better about myself *because* I'm actually able to finish exams. I would get so-I'd have so much anxiety taking exams before because I knew I'd never finish, because I rarely ever did. And so I'd get so anxious during it, I would often do worse than even-you know, I would do worse because I was so anxious about it all.

It's kind of not so such a nice reminder that you need all that help and you're in that position. I guess as I'm turning over another side of it, it's like there's some -- it might not be the most pleasant thing to deal with for people.

I think that I would have used it and it would have hindered me, I would have used it, it would have made me lazier and would have been an excuse. I would have gotten more time on a test when I didn't really need it. I would have hindered me rather than help me, but I can't say that at the time. I could see myself complaining to my mom or friends.

Yeah, I think so that it hindered my performance by not having accommodations. I think just when teachers deal with you, they deal with you in a different way, and they'll understand that sometimes you just kind of slide off to the side, and forget about you. Because you're distracted-you get distracted and you start doing your own thing. A lot of times they don't know why you're not focused, why you're not doing the right thing.

So because my school and everything was accommodating to me, I was able to get my degree. I think that was the best thing ever. So I was very happy that I was able to do that [register for accommodations] and that they were accommodating to my disability.

It may have, but it also may have just given-making it easier to be lazy, if that makes sense. You know, to maybe-or giving myself an excuse like, "oh, well, I didn't do well because I didn't have the proper whatever."

### **ADHD relationships.**

Various factors emerged associated with the nature of the participants' relationships related to their diagnosis with ADHD. Family relationships, romantic relationships, friendships, and social support networks were affected to varying degrees because the participant identified with some aspect of having ADHD. Participants described in this study beneficial and detrimental social experiences associated with disclosing their ADHD identity. Four themes emerged from the data subsequently shaping this textural description. The themes were: 1) reaction response, 2) incongruence of perception consequence, 3) friend mirror factor, and 4) the ADHD heart.

#### ***Reaction response.***

Co-investigators were ask about what others thought about them having ADHD. Others included: family, friends, significant others, and other members of their social support network. Thirty (30) of the 31 participants report that there was some type of

reaction from someone that had a relationship with. These themes occurred as 148 incidents in the analysis of the data. Of the various types of reactions, an overwhelmingly 26 of the participants reported having a positive *reaction response*. Sixteen (16) of the participants indicated having negative *reaction responses*. Twenty-five (25) of the participants indicated that there was some type of opinion others had about them having ADHD at some point during their development. Quotes following from the data collected indicate these *reaction responses*:

Positive:

There were a couple professors that I chose to tell just because they were either professors I had had multiple times-and the one was like I had a professor I had had and I didn't do so hot the first time because I didn't have accommodations or anything yet, I was still in the testing phase. So when I had him the second time was last semester, so I was on medicine and all that, and I did significantly better in the class. And he was like, "oh, you're doing a lot better than you did in my other class."

Telling professors here at the University has been a lot more positive than from before. That helps me create a better sense of self.

My husband is the one person in my life who has believed in me. When I struggle, the one thing that frustrates him is when I go all over the place. He draws me back in and tells me to focus, particularly when we shop. He has always told me I could do it.

Everyone has been supportive. Even friends that don't have it are generally supportive. So I have a lot of good, I think, role models to embrace in this house and that's kind of been positive and they recognize that I have a problem and they get down on me when I do things that I should be doing and they're very supportive of me in general.

They understand what it is, but they always push to go see a psychiatrist or to deal with the medical-or without medicine, medication. Those are things that sometimes I'm not so keen on, but they're always supportive. It's good to have a good family base.

At the time, I cried. I felt bad. My professor actually was really supportive and was really cool, and kind of normalized the day and was like, “you know, I’m really glad you told me. I totally understand how that is,” and it was nice. And kind of didn’t even doubt it or anything.

I guess for the most part, it’s pretty good. Most people have been pretty supportive and they understand where I’m coming from. Most people get used to it.

#### Negative:

My mom doesn’t think it’s a real thing. So that was an extra negativity that was kind of unnecessary.

So when you have that going on with family, your needs are completely not met, so that can definitely affect identity development, and it left me at least feeling empty and lonely as a child and I had the places later in life for that.

Well, my husband thinks that I don’t. He goes on the assumption-he just says that he thinks that I was over-diagnosed and that everybody-I mean, my husband’s a teacher to give you a little background-so to him, every kid is hyperactive.

I went to see a doctor in FL and she didn’t believe that women were affected by ADHD. This was during my transition from grade school to high school.

By not telling people in the past it has maybe had a negative impact, I think I may have lost interest because of the ADHD. I remember this one guy at a party, but he asked for some of my meds and then I was turned off from the question. Once people find out about the diagnosis sometimes people are not really nice to me but because they want the medications I have.

#### Opinions of others:

There’s still such a stigma in America about it, it seems. And ADHD is certainly preferable to any number of other things one could have, but it is still stigmatized, and I think there are a lot of people who don’t think it’s a real thing.

He doesn’t like the fact that I have to take medication, he is super against it. He figures that because he got by what do you have to be medicated to get by. He doesn’t really believe in any kind of medication. My mom is the complete opposite. My dad is supportive, but just not of the medications. Again, in his

time school wasn't that hard in comparison, so it is like, you might not have been medicated but you would never have survived today.

Also, my mom also offered me, when I was 14, to get tested, but I just blew her off kind of and rejected the test actually. Looking back, she should have just made me do it.

I wouldn't say -- I don't think I've told every friend I have outright. Some -- many I have shared it with, but it's just sort of on a need to know basis or whatever, although I have to say I don't know whether awareness about ADHD has grown over the years and stuff, but I've just noticed -- or most of my friends have said they've been able to pick up on certain behavior, that they could sort of figure it out.

Oh, it's pretty new [the ADHD diagnosis] and I guess the family and how they feel about that would contribute to it being new because of the whole family background being and they're just not familiar with any sort of vaguely mental health capacity things or counseling.

So, yeah, I mean I think the people that I've talked to, like my family and my friends, I think they've been pretty understanding about it, but I don't know how I would feel telling people who are just classmates or professors. I feel like I would have to come out and say it in a way that sounds credible, so that they don't think that I'm just faking it or something.

***Incongruences of perception consequences.***

Eight (8) participants reported on 16 occasions *incongruences of perception consequence*. The consequence was defined as a negative reaction due to an incongruence that someone had regarding the participants' diagnosis with ADHD. Being told about an ADHD identity by the participant to another was not inline with how that person perceived the participant. The following remarks demonstrate this consequence:

She thinks I do not have it because I am successful and able to do my work. She thinks I am crazy.

I struggle with it and most people don't see it, but I don't get bad grades or sanctions at work.

The problem with this disorder is that when you are normal in all other ways, then when you tell people that you struggle with doing something they would not believe me. I got people that were surprised when I told them about my ADHD. I have had people that tell me I am full of it.

When I was growing up and I thought I had it, my grandfather who is a psychologist, he always said to my mom there was no way she could have ADHD and still get through school like I was doing.

Then I talk to my mom about it and she had thought once or twice before that I could have had ADD, but she had always thought because things were going well so it wasn't an issue.

Not to be cocky, but people usually realize I'm pretty intelligent, so it comes out as "you don't have ADD, you're smart." Their beliefs are not congruent about me then.

At the same time, I think of ADHD as a stereotype and I don't see myself as this typical stereotype. So it is hard to then see myself because of this. When I tell people I have ADHD they sometimes do not believe me because I do not fit the stereotype of someone rolling on the floor.

***Friend mirror factor.***

The researcher was originally interested in whether or not participants had friends in their social environment that were reflective of their own individual ADHD identity. Participants were asked if they did have friends, and if so how many friends did they have with ADHD. Also, participants were asked if these friends with ADHD were also similar to the participants' own demographic identification that included gender, race/ethnicity/culture, and sexual identity. All 31 of the co-researchers responded to the question about having friends with ADHD. Participants indicated that 20 of them had friends with ADHD and 11 stated that they did not have any friends. Eighteen (18) participants responded to the questions as to what the total number of friends with ADHD

was. The median number of friends with ADHD amongst these 18 participants was 3.25. The range for the number of friends was 1 to 10. The participants were also asked if the friends were from primary or secondary educational environments. Nineteen (19) of the participants responded to this question. Ten (10) indicated that their friends were from secondary, 3 indicated from primary, and 6 from both secondary and primary.

Nineteen (19) participants reported on the gender of their friends with ADHD. Participants reported having a total of 29 female friends and 33 males. Nineteen (19) participants also reported on the race/ethnicity/culture of their friends with ADHD. Participants reported having 52 friends that were European-Americans, 3 Asian-Americans, 3 African-Americans, and 1 Latino/Hispanic-American. Sixteen (16) participants reported on the sexual identity of their friends with ADHD. They reported having 33 friends with a heterosexual identity and 6 with a non-heterosexual identity.

These statements demonstrate the *friend mirror factor*:

Knowing others with the disorder would be helpful to my self-esteem. I am a real believer that being with other people who are struggling with the same thing is good because you can help each other with what you are struggling with. Being alone is never a good thing.

Having friends is like holding up a mirror, which can be positive.

### ***The ADHD heart.***

The researcher was initially curious as to what the impact of having an ADHD identity might exert on romantic relationships. All 31 participants responded to this question during the interview, with a mix of responses. Fifteen (15) of the participants stated that they felt there was a neutral or no effect at all on relationships. Fifteen (15)

stated they felt there was a negative impact on romantic relationships due to ADHD.

Only 1 participant stated she felt there was a positive impact. Here are some illustrations:

Negative:

It has made me forgetful. I am not great at remember anniversaries.

It has affected my romantic relationships in that I've tended to date people who are also really impulsive and financially, that's really not a good idea because when you have two impulsive people together, it becomes very uncontained and then, you have all this debt.

I just get frustrated and then I get frustrated about not being able to maintain relationships with people because I feel like there's some kind of a disconnect. I just feel a disconnect from the world.

I may have ended some relationships sooner than later, like I don't-I've never really had anything serious just because I don't want-like even if-it probably isn't even the person, just the idea-like as soon as you're tied down, then that drives me crazy.

Neutral or none:

I don't have romantic relationships so it really doesn't intrude that part of my life, but I would say that in the future I wonder-I'm, you know, I've been comfortable with people in the past.

I'm not sure. It could just affect them the same way it affects my other relationships, just friends, the type of people that I gravitate towards. I'm not sure if being perceptive is an ADHD thing, but I tend to go by gut feelings in relationships and they tend to be okay or they tend to know what's going on.

I don't know, it's hard to say too. I don't know in which way it normally does. I'm not the best when it comes to my relationships.

Positive:

I think if anything it has made me more of an outgoing person. The outgoing part is positive for me. It has never hindered my relationships.

**Education, career, and extracurricular activities.**

A key assumption made by the researcher in exploring ADHD identity development was that individuals' perceptions of their identification was not solely based on just internal or external forces. Family, friends, and social supports played an influence, as well as treatment, interventions, and accommodations in this development. Activities such as going to school, engaging in the workplace, and having hobbies were likely to shape the participants in the study as well, along with having a diagnosis of ADHD. To understand the experiences of adults with ADHD it was important to know about their educational, career, and extracurricular experiences, particularly as the impact from having ADHD might be of significance. The researcher explored through the structured interview how ADHD may have affected their experiences in school, in the workplace, and the hobbies they chose to engage in. Three (3) themes characterized this textual description: 1) primary education easy effect, 2) career (aspirations) effect, and 3) extracurricular activities effect. The question was did these themes interplay with the overall development of an ADHD identity for the sample.

***Primary education easy effect.***

Ten (10) participants describe meaning units during their interviews that shaped the theme of *primary education easy effect*. One-third of the sample acknowledged how ADHD had little impact upon their performance in the primary school setting. Only once this segment of the sample reached the secondary educational environment, the impact of having ADHD began to affect them in a negative way. Six (6) of the participants who

reported this effect were diagnosed in adulthood with ADHD and 4 were diagnosed in childhood. The subsequent comments are illustrative.

It's definitely-it's made college, especially higher education, far more challenging than I ever assumed. I was a late-I was identified late. I guess because I had always been in easy schools. I noticed problems in high school to some extent, but still my school was easy enough that I did fine. It wasn't until I got to college and really needed-you know, I was reading hard challenging readings and having to sit and focus for hours and hours at a time, and actually I had real study habits that just started slipping-my grades went really downhill.

In high school, I just didn't have that much work so I could take my time and read at a very slow rate and get everything done and still have time to do other things. When I got to college, I kind of got my butt kicked; I couldn't get all the reading done.

I've actually never had them and I don't-I mean high school was a breeze. Community college was a breeze. I'm finding it really hard here, but it's because I'm not adequately studying.

But I'd started noticing it in college. But in high school I noticed it, just because I thought high school was boring, but it was easy so I just thought I was bored.

***Career (aspirations) effect.***

Thirty (30) of the respondents commented on what they did for their career or what they aspired for it to become following the completion of their secondary or post-secondary education. Some of the careers or career aspirations reported were: Russian language specialist, forensics specialist, marketing, business, accountant, editor, nurse, actor (2 occurrences), teacher (3), medical doctor (3), attorney (4), and social worker or counselor (5). Twenty-nine (29) of the participants indicated that their career or career aspirations were somehow impacted or affected by having ADHD.

This theme developed out of 50 codes out of the data analysis. Thirteen (13) stated they felt having ADHD created negative experiences for their identity development. Nine (9) were able to confirm positive experiences with ADHD that affected their career or career aspirations. Seven (7) from the sample stated they had neutral or no effects. Quotations from the co-investigators were selected to exemplify these experiences.

Negative:

I really haven't been able to hold down a stable job.

I used to work routinely twice as many hours as anyone else, and to the outside world if I keep my mouth shut, it looks like I am a really hard worker, but what it really is I have to spend all these hours afterward fixing the mess I created during the day.

I've heard that about people with ADHD, it said it's not uncommon for them to change jobs often or to -- out of their own choice, or to either be fired from a job or something like that. So when I looked back at sort of my different career trajectory and stuff like that, I feel like maybe I would have been further along had I not had it, but -- so I guess in that sense, that would have -- I think maybe my self-esteem would have been better had I been further along, but I don't think it was only ADHD that had anything to do with that. I can't blame it solely on that. It was a number of factors and not any one thing.

I think that I definitely tanked in school one semester because I wasn't really getting adjusted well because of my ADHD and it's going to hurt my future career opportunities, or if I decide to go to graduate school. I think it's going to hurt my chances of applying to graduate school, so I'm still working right now to just even counter-balance or pull myself out of that tailspin. So it's a work in progress unfortunately.

Having ADHD makes it so-I mean I want to go back to school, but I don't because school is so hard. School was so difficult, you know. And so I've chosen my work, you know, kind of because of my disability, you know, moving around, not sitting behind a desk. I'm in the lab. I'm on my feet.

I think it has put a hindrance on it. It has been an obstacle, others do not have the fence I have to climb. I know I could a whole lot better if I could just focus and stay in the moment.

Positive:

It is something that is constantly interesting and it is something that people who have ADHD have succeeded in and it is not something if I were to be an engineer, it would be incredibly difficult. Anything that demands time, you have to get this in by this time, then forget about it, it is just not happening.

That I'd be interested in dealing with problems similar to mine because I think about problems of the brain, neurological problems is that they hit very close to home and they affect your identity and how you interact with your environment and who you are, etc. And because of that, they have a really profound effect on people and people's development and I think that makes it very inspiring and an interesting issue to tackle.

Being a nurse was a perfect position for me with my ADHD. It served me well and had a positive influence. I think once that knew what I was doing I had enough intelligence to put it into gear. It was successful thing rather than I could have done another thing in life that I was not as successful at.

Right now it is helpful but that is because I am old enough to understand and not just take a negative label. My school is insight oriented which is good. The type of school program I am in is empowering, it is helpful and educational. You change drastically in this program. It makes you think it is not taboo if you go to therapy or do medication or talk about it.

ADHD has had a positive influence on my career aspirations, it's almost like a strength in this field, because it's an experience that you know, you're encouraged to accept about yourself, and sort of-I mean, but I didn't-I can't say I'm like "oh, I have ADHD, let me do social work." It's not like a correlation like that, but it definitely-I'd say my selection has made it easier to kind of live with ADHD.

Neutral or none:

It is a facet of my identity, there's no one solid thing that I've decided on. I'm kind of all over the place, like maybe I want to go into government or go into academia, and I don't know.

*Extracurricular activities effect.*

Twenty-nine (29) of the participants reported some type of extracurricular activity. These activities could include, but were not limited to such things as clubs, sports, work or internships, and spiritual or religious affiliations. Some specific examples of the extracurricular activities that the participants of this study were involved with are the following: school caucus, family, pre-law society, public radio, collecting medieval weapons, going to movies, golf, marathon team, political internship, medical research, mentoring, CalPerg, drawing, honor society, attending church, Model UN, dancing, Boy Scouts, attending mosque, swimming, cheerleading, non-profits, horseback riding, and fraternity.

Twenty-eight (28) of the participants responded when asked if their extracurricular activities had any impact upon their identity development. The majority of participants, totaling 24, stated they felt the extracurricular activities they had been involved in had had a positive impact upon their identity. None of the participants noted any negative effects. Four (4) participants acknowledge that there was no effect or the effect was neutral. Quotations following reflect these findings:

Positive:

Time with my family is good for my identity.

As someone who felt very different from others, animals were the one place that I felt accepted, so horses were actually a huge part of my identity development. I felt empowered like I could be on a 2,000-pound animal and be in control and in horseback riding.

They require intense training and mental focus so that's kind of something I have to challenge myself with, especially given my ADHD. It has pushed me forward and made me stronger, resilient.

100% for the better [the impact of extracurricular activities]. I think each activity in its own way, whether it's me playing sports and it's just a release, a good release, rewarding myself for that hard work, that's how that's positive.

I do a Shakespeare group on campus, there is a play writing group. I like to make my own films and put them on my YouTube page. These involvements have been good things for my identity, they are positive.

Neutral or none:

Well, both myself and my family, we've always-we're-we like giving back to the community, helping out our church, volunteering where we can. So, that was who I was before I even got formally diagnosed. So, I just try to continue my life, managing with the attention deficit. It's just added one more aspect to my life.

The reason I want to do the accounting thing is because I want to network. And I want to-I'm going to be here for three years, so I'd like to network and get to make contacts with the different firms and stuff like that. But, no, I don't think so [that it has had an effect on my identity].

### **Demographic identification.**

Identity development is a component of overall adult development as highlighted by the theoretical frameworks of Erikson (1982), Chickering and Reisser (1993), and Gibson (2005) in earlier sections of this study. Such development not only serves to assist the individual in gaining insight into one's own life, it also provides a foundation as to how internal factor will interplay with external factors in creating an overall developmental experience. Positive interactions with external forces have the potential to serve individuals well, while negative ones may hinder identity development. Often those with an ADHD diagnosis have difficulty in negotiating external factors such as

social relationships. Others often view someone with ADHD as disorganized, impulsive, disruptive, and fully of uncontrollable energy.

The final research question proposed for this study was: how does other dimensions of identity, such as gender, race/ethnicity/culture, or sexual identity intersect with ADHD identity development? From the review of the literature in Chapter 2, a wide array of theories were presented that highlight human development. Very few theories have been able to capture the phenomenon of the development of multiple identities (Abes et al., 2007). The assumption made by the researcher that based on the review of the literature was that ADHD identity could not exist without the consideration of other factors that may contribute or delay overall identity development.

Participants in the study were asked to describe how their ADHD identity might have been impacted by other demographic identification they may or may not have possessed. All 31 sample participants were asked if his or her stated gender had any influence on his or her identity development with ADHD. They were also asked during the interview if their race/ethnicity/culture or sexual identity (sexual orientation) had any impact upon this development as well. Four (4) themes emerged: 1) unveil versus unmask, 2) R.E.C. identification influence, and 3) S.I. identification influence.

***Unveil versus unmask.***

In the theme that became titled *unveil versus unmask*, the researcher was curious as to how the influence of gender identity could also interplay with the development of an identity with ADHD. There was a question as to whether this process was different or

similar for both males and females. Eleven (11) of the participants stated they felt there was no influence of their gender on their ADHD identity. Ten (10) participants stated there was an effect or influence and 9 were unsure or did not know if gender had any impact. Twenty-four (24) of the participants cited concrete examples during the interview as to how ADHD might be different for males versus females. This developmental phenomenon became labeled as the themes *unveil versus unmask*, to illustrate the difference in the development of an ADHD identity inclusive of the gender demographic.

Of the 10 participants who stated that there was an influence from the gender on ADHD identity development, 9 of these 10 respondents were female or transgender, only 1 male said that he believed gender influenced ADHD identity development. Of the 9 participants who were unsure, 3 were female. Female and male participants seemed to evenly report that there was no influence of gender on ADHD identity development. Six (6) of the 11 that said there was no influence identified as female.

These quotes illustrate the gender influence:

I think that part of the reason I wasn't diagnosed was because I was born female and they tend not to be diagnosed as much as males. So I think that was influential for me in particular, I was quiet, but the reason I was quiet was I was daydreaming and off in own little world because I was bored and not stupid, and if I had been born male, then maybe some more attention would be paid to that. I don't know.

For some reason, guys are always think of girls being stupid, so having a disability is even worse when you are a girl because you are already a girl, but in a guys' minds this is a lower IQ, but then you have a disability which is then super low IQ. It is weird that way.

Maybe. It's a possibility. I never thought of that.

Well, I think masculinity comes into play a little bit in society that people are much less willing to say, "oh, I have something wrong with me," because I'm a man. Like "why should I show anything that uses like-why give in."

I think so [gender has an influence on ADHD identity]. Especially, since being told by a doctor that girls do not have ADHD. I guess too because I am all over the place. When I am at parties, I can never really stay focused in a conversation, because of that, I think guys see that as being easy because I am a girl.

These quotes illustrate the difference between male versus female:

I know that they say it's more common in boys, although I was always like an outlier in that sense anyway because my problem wasn't ever really being hyper.

I was always chatty, even as a little kid, in elementary, middle school, I would get in trouble for talking in class a lot, but I wasn't being rowdy necessarily-just I was talkative, so in that sense, no. Probably, it is different for men and women, I mean I would imagine it is, especially because it does seem like such a-I mean you don't often hear of girls with ADHD. I'm sure there are plenty of them, but I can see it being more stigmatized for them.

Maybe it is different for guys and girls. I haven't really thought about it at all. I could probably identify more if I had to sit down and look at someone, I think a guy would be ADHD more than a girl, I guess. Just I don't know, maybe because I've been through that or whatnot, I guess.

Yeah, kind of, the H in ADHD, especially the H, I am more ADD the way they diagnosed it, it is a boy thing usually.

Well, I don't feel like it's easier for females, but I feel like society is kind of sexist. They're kind of a little bit more accepting.

I think that females tend to be more prone to engage in a dialogue with their friends and sharing things like of a more personal nature, and being more open about -- maybe I'm generalizing and it's not fair to say, but I think guys tend to keep things like this a little bit more to themselves.

I don't think so, although one of the things that I've learned recently about ADHD, the genetic component of it anyway, is that it happens to males more often than female, and that it's carried usually on the father's side of the family.

I remember reading something that women have it more than men -- oh, no, the other way. It's diagnosed more in men because guys are more hyper. Boys are more hyper and girls, if you're not hyper, they won't be diagnosed with it at all, and I'm real hyper. I used to be hyper as a kid and one of my childhood memories is like my mom brought me to school the very first day.

I don't think that just the ADHD itself is different for men or women, maybe the perception from other people maybe, but that just has to do with gender bias anyway. I mean sometimes males tend to be more favorably responded to versus females, depending on the setting, so I don't think that ADHD specifically-that there's a difference between males and females as far as anything like that.

I feel like the guys end up being hyperactive and just-like my brother is always jumping from sport to sport, he's always "on," so I feel like-I don't know if it's a girl thing or me-but I feel like we get the other side where you're just in your head. People either think you're coming off as shy or you're being a slacker. But it's really like you are doing something, but it's entirely in your head.

I feel ADHD is more accepted for men, maybe from my own experience. For women, they are just written off as neurotic bitches or something. With guys there is an understanding, ohh you need to play video games. For women there is not that understanding, it is like the thing with doctors, when a woman comes in with pain they do not take it as serious as a man. I think that is also why people are surprised when they find out that I have ADHD. It doesn't fit their stereotype.

I have compartmentalized those a bit. I don't really know why, but they have been compartmentalized. If this is my ADHD identity and this is my [gender] identity and I think I've put ADHD more with the biology simply because I've been like, well, ADHD just has been neurotransmitter issues.

***R.E.C. identification influence.***

When asked about the influence of the participants' racial, ethnic, or cultural identification's impact upon an ADHD identity, about two-thirds (20) of the sample cited they felt there was no influence or interplay between these 2 factors. Nine (9) of the participants stated they definitely felt that the demographic of race/ethnicity/culture has

come influence upon their identity with ADHD. Only 2 from the sample were unsure as to the influence.

Of the 1 participant who identified as Mixed, he responded that race/ethnicity/culture had no influence on ADHD identity. Two (2) participants identified as African-American. One (1) stated that she believed there was no influence and the other was unsure. Two (2) of the Asian-American participants stated there was no influence and 1 stated there was an influence. The responses from the Latino/Hispanic-Americans were split. Three (3) stated they believed that there was an influence, 3 stated there was no influence, and 1 was unsure. Within the 18 participants who identified as European-American, 13 said there was no influence and 5 said that there was an influence due to the demographic factor of race/ethnicity/culture.

Highlights from the interviews on this influence:

I haven't thought about that. I think it's kind of hard to articulate when you're talking about the way that American culture has stereotyped African-Americans, maybe as not being as educated or not being as smart, or you know, I didn't really connect the two-I just kind of-I don't know.

I come from a Polish background, so Polish people are renowned for being very stoic, not showing emotion, being very contained, whereas ADHD is not that. It's very, very emotional and very intense emotionally and so my family just kind of thought I was this freak because I was feeling emotions on every extreme.

I take an extra step proving the diagnosis based on my race or ethnicity. It is the idea that you don't really have it but you wanted it so you got medicated for it and got the benefits of it and people tell me you are so lucky. Other students see me in the extend time room and think I am lucky.

Only in terms of the negative connotations of ADHD, like "white people get all the best SAT tutoring" and "they will do anything they can to go get fake diagnoses" or whatever all of that is. So to do anything they can to get ahead, so

it's kind of like, use your-ADHD is a resource. That's basically been the one negative thing that's come out.

No, I couldn't say so just because I don't identify strongly as being a member of either culture of my parents because I grew up in a largely secular environment and I never really was like mostly Hispanic or mostly Mexican, this and that.

As far as culture is concerned, education is important in my family and so attention to that has been emphasized and especially, I think when I was learning how to read and it took so long. My parents were there with "Hooked on Phonics" and we were sounding out words and I would just be up in arms saying, "Oh, I'll never learn how to read," frustrated. There was a persistence to it that helped, so as far as that culturally, that helped.

Well there is an aspect of the ethnicity. Due to the social stigma with Hispanics for being Mexican. I see this as opportunities were not as available to us as maybe others. The think was that they are "dumb." They don't know English. I think that was why my mom was so adamant that we learn English and she didn't teach us Spanish.

Feeling different might have prompted me to have more resentment towards my background also because I have quite a bit of resentment of the whole fitting-in culture and the comparing yourself to others and always -- I see the Chinese culture as being extremely keeping up with the Joneses and extremely, at the same time, not standing out too much, and so always being criticized for being different or not matching up accomplishment markers. And so maybe the ADD has made me different and that's created more friction for me within my cultural identity as well, and so it's kind of a create a lot of tension for each other. And I have a lot of resentment towards my background because of it and it's made it harder for me to accept it now, and I think also that I also came from an educational background that was quote, unquote "gifted," so I kind of went through all my life surrounded by the smartest people in my class and things like that.

No, I am mixed. Both my parents are super accepting of everything. I don't think so. I have no idea if it were or not. Yeah, I don't know about that. No, because I would say I'm a gay white guy from Connecticut and I would never put ADD in there, right?

I grew up around the South LA area, and so I went to high schools and middle schools that had a lot of students who didn't pay attention, who never read, or if they tried to read, it would take them forever to read. And I think that I always kind of considered that to be South LA culture. So like I said, when I got to college, I thought it was just my South LA culture that I was sort of displaying things of my inability to pay attention or read, or understand what I was reading.

But, I don't know if race would be it. I think it's more like where I grew up and the environment I grew up in.

I'm not atheist, but to me I see religion as different viewpoints or people's perspectives on the world instead of something set in stone. I think it influenced also by my ADHD.

I don't think so. No. I have never really thought it as having a racial connection.

***S.I. identification influence.***

When asked about the influence of sexual identity (sexual orientation) on their ADHD identity the majority of participants (27) stated they felt it had no influence. Two (2) participants stated they thought that sexual identity did have an influence on their identity development with ADHD and 2 in the study felt they were unsure of the influence. All 4 of the participants who state they did believe it had an effect or were unsure self-identified as part of the non-heterosexual demographic in the sample. The 2 that stated they were unsure both identified as bisexual and female. Following are quotes from those 4 participants:

I think there's an acceptance within the LGBT community of difference and there's a freedom that comes with being sexually different, and an example, like in hetero-normative couples, the gender roles that are -- the man does this and the woman does this. In lesbian couples, there's a little more freedom of what you want to do and how do you want the relationship to look and things like that. But there's a freedom that comes with being LGBT at least in sexual expression, as well as gender expression, and with ADHD, there's lots of expressiveness that can happen, especially due to the impulsivity. So I felt actually very welcomed by the community because there is more open-mindedness to creative thinking, there was more open-mindedness to thinking outside the box. And that was very normalized within that community.

I think there a homophobic element to it because then I didn't talk, and if you didn't talk, I wouldn't reveal myself. Being gay is just a facet. So having to accept my gayness was a bigger issue for me than having to accept ADHD. Having to accept ADHD kind of relieved me with that.

I've wondered, because I am bisexual, but I don't think so. I really think that ADHD is 'up here' and bisexual is just how I am attracted to people. I think they're mutually exclusive facets of my identity. I don't think that they intermix or anything. I've wondered, but I've never ever thought-never ever had an instance or something where some sort of thought was like "oh, that was weird," or something, like some sort of revelation or something. I can't-I think that they're separate. But they both construct who I am.

I do not know. I know because I am bisexual a lot of people think it is because I want attention or it is especially because I am a girl or I am bi because I am drunk. So it is written off as not being serious, "She is just a slut or an attention whore." She can't make up her mind. Even lesbians say that they don't believe I am bisexual. I do not know. I don't really attribute ADHD to it, but I could see how one could attribute ADHD to it. Oh because she is distracted or bored with one sex. I see both the identities as very separate. They are 2 facets of whom I am.

### **Summary and Discussion of Findings**

This chapter presented the analysis of a structured open-ended interview with adults with ADHD. This chapter also presented information gathered from interviews with 31 co-investigators. All the co-investigators were US citizens. All participants were either in the process of obtaining a secondary or post-secondary education or had already accomplished this level of education.

The data clearly indicated that adults with ADHD go through specific channels in their development of an ADHD identity. Factors, such as the timing of diagnosis (either being in childhood versus adulthood) influence this development, as well as the cognitive developmental level of the participant. There are outcomes as the result of having ADHD and typically most participants discussed pivot experiences related to the outcomes. A positive or at least neutral relationship with the ADHD identity was reported by almost the entire sample.

The Gibson (2005) model of Disability Identity Development also shed light into understanding the identity development of those with ADHD. Most participants experienced themselves at some point in their development as having a disability. They largely identified as being in *Stage 3: Acceptance* in the DID model.

Coping issues, social, behavioral, and academic issues, and psychological and cognitive issues were all seen as affecting the development of an ADHD identity. Treatment, interventions, and accommodation had both negative and positive influences up the sample's identity development with ADHD. ADHD affected relationships in some manner for all 31 of the participant. ADHD had a negative impact on romantic relationships for nearly half (15) of the sample.

Education, career, and extracurricular activities were all found to have an effect upon identity development. For 13 of the sample, ADHD was found to have a negative effect on their career or aspirations for career. Twenty-four (24) participants believed that their extracurricular activities contributed in a positive fashion to their identity.

The final research question under investigation was considering the factors of gender, race/ethnicity/culture, and sexual identity upon the development of an ADHD identity. The data also indicated that these factors influenced this development in some fashion. Those in the sample that tended to view gender influencing their ADHD identity were largely female or transgender. Regarding race/ethnicity/culture, the dominant group in the sample, European-Americans, felt that there was no influence from the race/ethnicity/culture factor. Considering sexual identity, all of the 24 participants from

the dominant group, heterosexuals, along with 3 from the non-heterosexual group, felt there was no influence from sexual identity upon their ADHD identity. Four (4) of the 7 non-heterosexual identified participants stated they did believe sexual identity influenced their identity with ADHD. Further analysis of the data is found in the following chapter.

ADHD identity development is a complex process. Participants move from different identifications or concepts through this phenomenological inquiry, highlighting identity development is not linear. The interplay of internal and external forces, as well as environments that include strong social supports, access to treatment, interventions, and accommodations, free from discrimination surrounding disability are necessary for individuals to gain a sense of their personal identity with the diagnosis of ADHD.

## **Chapter 5: Discussion**

### **Summary of Findings**

This phenomenological study explored the process of identity development for adults living with an ADHD diagnosis in the southern region of California. The purpose of this study was to understand the essence of the process of forging an ADHD identity and, in doing so, provide guidance to individuals, researchers, instructors, medical and mental health providers, and the community-at-large as to then what services, supports, and strategies may be more effective in helping ensure success to this vulnerable minority population. The experiences of 31 participants, who were over the age of 18 and diagnosed with ADHD by a mental health or medical provider, were captured through a structured personal interview, classified into 8 textural descriptions with a further breakdown into 28 themes.

The knowledge gained from this inquiry is expected to benefit the ADHD community of individuals, couples, and families. It was also conducted for the education, health, and mental health institutions that are working to provide the most optimal services to adults affected by this disorder. Chapter 5 provides a summary of key findings, implications for practice, notes the study's limitations, and makes recommendations for future research, as well as renders implications to clinicians working with those diagnosed with ADHD or those affected. This chapter wraps up with a final conclusion.

**Purpose of the study.**

Restated, the purpose of this study was to describe the experiences that influence the identity development of adults with ADHD. Complex theoretical resources such as Erikson (1982), Chickering and Reisser (1993), or Gibson (2005) fail to adequately describe the development of an ADHD identity entirely. These theories also guided the inquiry for this study, while providing a starting point when referencing identity development. By examining the identity development of adults with ADHD from a psychosocial theoretical perspective, this study was conducted to gain a better understanding of how identity development is formed. Phenomenological theory was incorporated to understand the process of identity development for adults with ADHD.

The following research questions guided this study: (a) how do adults with ADHD come to understand their identity development; (b) how does other dimensions of identity, such as gender, or race/ethnicity/culture, or sexual identity intersect with ADHD identity development; and (c) how does this process inform the embracement or rejection of a ADHD identity?

**Methodology.**

This study used a qualitative model in order to collect information. Qualitative data was collected via in person one-to-one interviews with the researcher. These interview were conducted on the campus of a large urban research university or via Skype in the southern California region. Participants answered a series of 26 structured questions, including basic demographic information. The questions were formulated

using a phenomenological research framework, combining the work of Moustakas (1994). The following 7 steps were the methods of the analysis of data for this study: 1) *Listing and Preliminary Grouping*, 2) *Reduction and Elimination*, 3) clustering and thematizing the invariant constituents, 4) final identification of the invariant constituents and themes by application, 5) *Individual Textural Description*, 6) *Individual Structural Description*, and 7) *Textural-Structural Description*. All interviewees were advised that their responses would be kept confidential and anonymous.

### **Sample population.**

Thirteen (13) male, 17 female, and 1 transgender individual were the participants for this study. All the participants were identified as meeting the DSM-IV-TR diagnostic criteria for ADHD, had been diagnosed by a mental health or medical practitioner, and were 18-years-old or older at the time of the interview. The sample was recruited from a large urban secondary learning institution in the South Western United States and the surrounding region. Participants sampled were diverse demographically regarding age, gender, race/ethnicity/culture, and sexual identity. The median age of the sample was 28, with a range in age from 18 to 61.

### **Data collection.**

This exploratory study involved an extensive structured interview with each of the study's participants. Each interview lasted approximately 30-75 minutes and included 26 open-ended questions. The interview was digitally recorded, transcribed, and analyzed using Atlas.ti. Verbal consent to participate in the study was asked of each participant

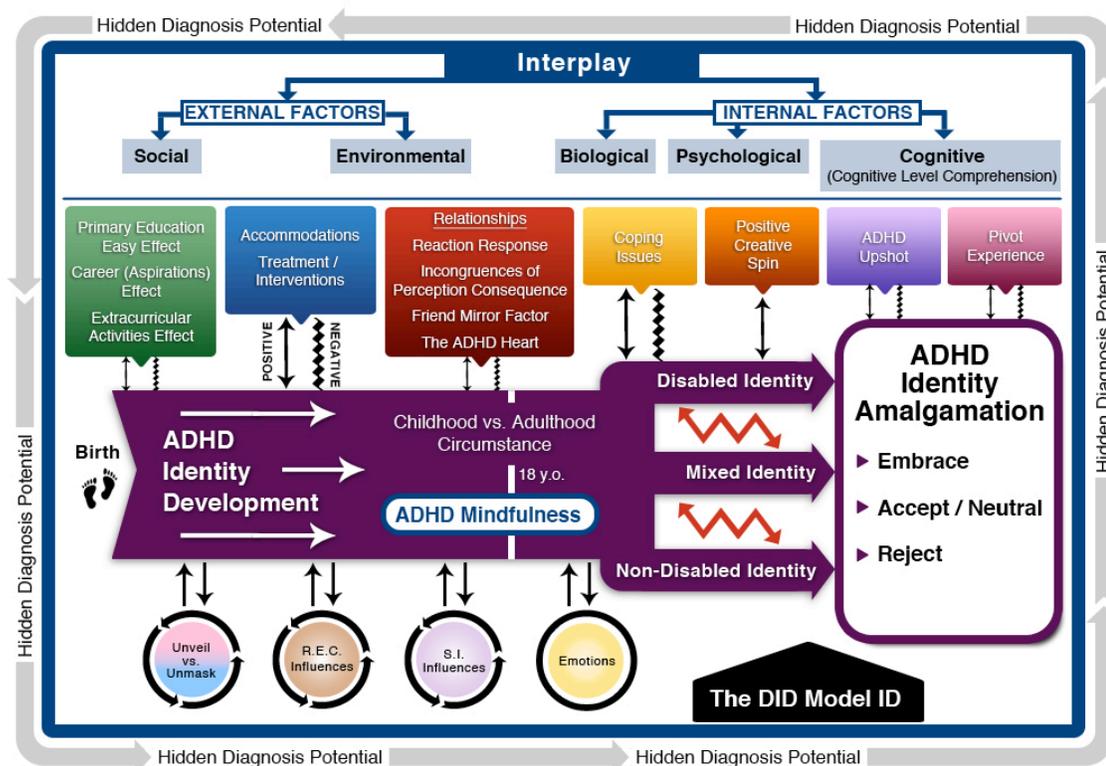
and they were given a copy of the IRB approved *Information/Facts Sheet for Non-Medical Research* form on two separate occasions.

Data was reviewed, emerging topics were analyzed, and details and rich textural descriptions were explored. Participants were considered volunteer co-researchers and were free to withdraw from the study at anytime.

### **Key findings.**

The key findings were based on the analysis of the data from Chapter 4. The 8 textural descriptions that emerged from the interview data were the following: 1) diagnosis and symptoms, 2) ADHD identity development, 3) disability identity development, 4) ADHD impact, 5) treatment, interventions, and accommodations, 6) ADHD relationships, 7) education, career, and extracurricular activities, and 8) demographic identification. Within these textural descriptions, 28 themes emerged that illuminated the process of developing an ADHD identity for those in the sample. Figure 1 illustrates the key findings in a conceptual developmental model.

This was an exploratory study to understand the experiences for those adults with ADHD and how those experience go on to shape and influence their identity. The results generate a conceivable model of ADHD identity development that considers the interplay of 8 integrative textural descriptions and 28 themes. This project allowed for the voices of 31 participants living with ADHD to be heard through the stories told during the



## ADHD Identity: A Conceptual Developmental Model

interview. These findings highlight the conceptual developmental experiences of an ADHD identity exploration. Other dimensions of identity, such as gender, race/ethnicity/culture, and sexual identity, were not ignored in the examination of an ADHD identity. The model explored aspects of developing an ADHD identity without discounting the influences of internal and external factors.

The participants described the negative impact from relationships and the invisibility of having an ADHD diagnosis. The findings of this study suggest a need for efforts to reduce stigma around an ADHD identity. Further research investigating the

utility of intergroup dialogue for addressing disability discrimination may be valuable in academic, mental health, and medical settings.

The following sections highlight the key findings within each of the 8 textural descriptions of this phenomenological study.

***Diagnosis and symptoms.***

Being aware or mindful of their experiences with ADHD was a significant finding for this study, indicating a certain level of personal insight. These insights appeared to be linked to the participants' level of cognitive comprehension. The more developed in their cognition, the more insight or mindfulness participants appeared to have. Another interesting finding was that relief for 22 of the participants was the upshot an ADHD diagnosis, which in turn lead to the potential shaping of a more positive ADHD identity.

The point of diagnosis with ADHD was evenly distributed between childhood and adulthood. This finding indicated that ADHD is more and more a disorder of adulthood as well a childhood. More attention needs to be paid to the unique aspects of ADHD in adulthood, where traditionally the focus in the ADHD community has been on childhood. Twenty-one (21) was the median age for diagnosis, with a range from 7 to 56 years in this sample.

***ADHD identity development.***

The majority of the sample had *pivot experiences* with having ADHD. *Pivot experience* were defined as those occurrences that had significant and lasting impacts on shaping ADHD identity for those reporting. Seventeen (17) participants identified

aspects of ADHD having a *positive creative spin*. This finding suggested that ADHD may not always be externally stigmatizing, but internally could present a positive influence on shaping identity. Eleven (11) different emotional responses were identified from the data.

*ADHD identity amalgamation* was significant in highlighting that the large majority, 27 participants, experienced their ADHD identity as non-rejecting. Sixteen participants embraced it, 11 accepted it or had neutral feelings, 4 were mixed, and none rejected it.

***Disability identity development.***

An interesting finding in this study was that the majority of the participants identified as non-disabled. This finding indicated the ability for some to pass as non-disabled and for the potential for ADHD to remain a hidden disability. Identifying as non-disabled, disabled, or mixed appeared to occur evenly over the demographic of gender. This identity seems to be even for the demographic of African-American and Latino/Hispanic-Americans.

Another interesting finding, was that within the Asian-American demographic family, the entire sample found themselves all to identify as not being disabled. Highlights from the interviews indicated strong racial, ethnic, and cultural beliefs regarding disability in general. These findings indicate the need for further research on the interplay of multiple factors upon identity development. Also significant, half of all the European-American family identified as being non-disabled.

With in the sexual identity demographic, the non-heterosexual family appeared to have an even distribution across the identification of being disabled versus non-disabled. Interestingly, in the heterosexual family half of the sample, 12 out of 24, identified as non-disabled. The underlying affects of institutionalized homophobia, sexism, and racism could potential be linked to these fascinating results. Again, further research is essential to flush out these nodes of additional inquiry.

An astonishing 20 out of the 31 participants identified themselves in the *Acceptance Stage* of the Gibson (2005) Disability Identity Development model, with none of the participants identifying with the first stage. These results indicate an overall general positive aspect to the influence of ADHD on individual identity development.

***ADHD affects.***

A variety of coping issues were identified by all 31 of the participants. These coping skills went on to serve the individuals in this study with tools to further develop a sense of self with ADHD. Seventeen (17) of the participants stated that ADHD affected their identity due to social problems from ADHD. Twenty-six (26) reported schemas or cognitions and 16 on stereotypes regarding ADHD. All of the sample talked about hiding the diagnosis at some point during their development. Eleven (11) of the participants had questioned or were questioned about the validity of the diagnosis; wondering if it was “real.” These affects from ADHD constituted an interplay of both internal and external factors that influence one’s identity development with ADHD.

### ***Treatment, interventions, and accommodations.***

All of the participants interfaced with some type of treatment or intervention during the course of their development. Twenty-seven (27) were taking or had taken medications at some point in their life, making medications the most common form of intervention. Treatment typically came from medical or mental health professionals.

Findings indicated there was some impact of treatment and interventions for all of the participants. For the large part it was a positive impact upon identity development with ADHD (18 participants reporting). Regarding accommodations, the impact was even more significant, with 21 of the participants indicating the impact was positive in nature. Thirty (30) of the participants indicated they had received some type of workplace or academic accommodation over the course of their development. This finding was interesting in that it signaled the connection to resources. Even when accommodations had not been received, the perception was that they would have had a positive impact upon the identity development of the individual. Half of the sample had received accommodations and the other half had not.

### ***ADHD relationships.***

The findings from the data regarding the reaction of others were overwhelmingly positive. Conclusions were that these positive social interactions contributed to a positive self-identity with ADHD. Twenty (20) of the participants had other friends with an ADHD diagnosis and it was the assumption of the researcher that having others that mirror similar behavior in turn had an influence on identity development. This notion

was supported by the theoretical frameworks of Erikson (1982), Chickering and Reisser (1993), and Gibson (2005).

While having friends that were “like” the participants was positive, the influence of ADHD had a significant negative impact. Fifteen (15) of the sample stated that negative experience in romantic relationships contributed to their identity development. Only 1 participant described ADHD as having a positive influence on romantic relationships and identity development.

***Education, career, and extracurricular activities.***

Findings indicated that the majority of participants believed their ADHD had a negative impact upon their career or career aspirations. This effect was believed by the researcher to have a negative influence on overall identity development. In contrast, extracurricular activities overwhelmingly were reported to have positive effects upon identity development. Twenty-four (24) participants acknowledged this as a positive occurrence in their development.

***Demographic identification.***

The findings for the theme of *unveil versus unmask* relating to the influence of gender on ADHD identity were mixed. There was an even divide between participants: feeling there was an influence, there was no influence, or they were unsure or did not know. What was interesting in the findings is that within the group that stated there was an influence of gender on ADHD identity development, 9 out of the 10 participants identified as female or transgender. These identities have institutionally been

marginalized within American culture and society. Additional research must explore in greater detail these influences. Those that said there was no influence of gender were evenly distributed across both males and females. About twice as many males than females (6 versus 3) reported that they were unsure of or did not know the influence gender had on ADHD identity development. This finding is interesting in that it could potentially reflect the changing cultural milieu of the role of women.

Regarding the influence of race, ethnicity, and culture, findings showed 20 participants believed there was no influence from this factor on ADHD identity development. Thirteen (13) of the 20 were identified as European-Americans. This finding is interesting because they are from the dominant group that holds power in this society. European-American males typically have gone unexamined in the United States, leading this finding to require further exploration (Katz, 2006). Intriguingly, there appeared to be an even distribution over the other race/ethnic/cultural families regarding the belief of having an influence, no influence, or unsure for all the other families within this demographic textual description.

Finally, when considering the influence of sexual identity upon an ADHD identity development, a surprisingly 27 out of the 31 participants stated there was no influence. Of the 24 participants within the heterosexual group, all of them stated there was no influence. This again may appear to be reflective of the institution of dominance for heterosexuals in American culture and society. Like males, the heterosexual community may often go unexamined (Katz, 2006). Four (4) of the 7 non-heterosexuals had a varied

response. Three (3) stated there was no influence. Two (2) stated there was an influence and 2 stated they were unsure. The 2 participants that were unsure identified both as female and bisexual.

### **Implications for Practice**

A number of implications for practice were developed over the course of conducting this study that will aid individuals with ADHD, educators, researchers, mental health, and medical professionals. It is clear from the findings of this study that adults with ADHD experience unique aspects of identity development. These findings provide many opportunities to create more hospitable environments for those with ADHD. It was a hospitable environment created by the researcher during the interview that allowed the participants to disclose their potentially hidden ADHD diagnosis and explore what it meant to identify with ADHD. Professors, doctors, and social workers for example, play powerful roles the lives of participants living with ADHD.

Implications for the ADHD community and those involved for this study are: (a) become more knowledgeable about ADHD, (b) include ADHD and disability in definitions and discussions of diversity, (c) clinicians and educators can display indicators of support, for example a poster announcing ADHD Awareness Week, (d) providers can confront discriminatory behavior and respond to it in the same way as sexual harassment or racial/ethnic/cultural incidents, (e) include disability questions on survey instruments in the mental health, medical, and educational settings, and (f)

consider the stigma involve for those disclosing a hidden diagnosis and allow these individuals to have a safe and private way to disclose their identity.

### **Limitations**

The exploration of an ADHD identity is a complex process. It cannot be studied in a sample of 31 participants only. Racial, ethnic, and cultural identity influence, while considered in this study, was at times limited to one or two voices for each demographic. Socioeconomic status was not incorporated. The study include all participants that identifying as American citizens, who had a minimum of a bachelors degree in their education or where in the process of obtaining the degree. Eight (8) of the participants had a post-secondary degree or were close to obtaining the advance degree. The level of education could warrant being a limitation under the assumption that education had provided tools to gain better insight into personal development.

The study is limited in that it only examines the experiences of adults with ADHD, primarily college students. The sample was limited due to recruitment from an urban university. This was done due to methodological reasons. The understanding of the process of identity development for those outside the sample is limited therefore. Identity construction, such as one of ADHD, may be paired with where one is at in their lifespan development. A diagnosis at 8 years old may be different than someone who was diagnosed at 19 or 53 years old for example, when considering all aspects of development. Given the retrospective design of the study, participants higher in age may have gained more insight over the course of their development regarding their identity

and may present another limitation. They may have had more time to reflect upon their experiences and perceptions may have been altered with time.

ADHD is a very specific type of disorder that affects academic and psychological functioning and is the only focus for this study. Other learning disorders or disabilities, such as Dyslexia or physical exceptionalities, may not influence identity development in the same way as having an ADHD diagnosis. Generalizing the results of this study to populations of individuals with ADHD outside of this sample may be a limitation. Future research should expand this model to include other specific types of disabilities like Autism. Many of this study's participants had other disorders than ADHD, such as anxiety or depression. This is a limitation in that it makes it difficult to isolate the impacts of ADHD upon identity development from the other conditions.

This study was not longitudinal, presenting a limitation. Without longitudinal data, it is impossible to determine how one completes an ADHD identity in later adulthood. The researcher of this study does not have ADHD, which is a potential bias in the data. An additional bias is the researcher is a psychotherapist, which could lean toward making the interview more of an assessment or intervention. This could also be a positive in that the researcher had proficient interviewing skills and can provide containment and referrals for participants if required during the study interview. Similarities and differences between the interviewer and respondents can affect the validity of the data (Tourangeau, Rips, & Raninski, 2000); the researcher is affected by the disorder in that they have several family members with ADHD.

Due to the constraints of the study, the sample was one of convenience. There were restrictions involved in finding participants that meet the qualifications for this study. Compared to the overall larger context, the population of individuals with ADHD within this region may be relatively small or larger than average compared to other university settings. Self-reporting may be subject to response bias, which was the basis for inclusion in this study. Participants were required to be over 18 years and have been diagnosed by a professional with ADHD which were requirements for the study that were self-reported and not verified by any other manner.

Participants were recruited from the academic support center and from flyers that presented another limitation. Many of participants have received some type of support services, either in the academic or workplace environments. Respondents were given cash compensation which affects motivation for participation.

One key limitation was the size and scope of the sample. Thirty-one (31) participants were recruited from a very specific location in an urban area of Southern California. A much larger sample from across the United States would provide more detailed data and make the finding more generalizable. Further, California has a reputation for being more liberal, possibly related to the stigma of having ADHD. With the sample coming from Southern California, participants with ADHD may feel more comfortable sharing openly about their experiences with ADHD due to the liberal nature of their environment. They may have access to more resources and supports due to living in one of the most accessible and wealthy areas in the country.

The textural descriptions and their validity created from the interviews could be questioned. What the participant intended to convey in the interview may be different from the researcher's analysis of the data.

Informative results from this study might be the catalyst for more in-depth investigation into how an ADHD diagnosis affects the identity development.

### **Recommendations for Future Research**

There is a need for a large-scale study and further research into adult ADHD development. Less is known about ADHD in adulthood compared to the research on childhood (Weyandt & DuPaul, 2006). While this study was well designed and had significant findings, the need for more to be done in the research community is optimal.

First, further research that expands the geographical and demographic boundaries of this study is essential. This additional research could make the results more generalizable to other ADHD populations, outside of Southern California and outside the college age demographic. By conducting more research, the finding of this current study could be validated.

Secondly, the relationships between ADHD and other aspects of identity, such as gender, race/ethnicity/culture, and sexual identity are complex and intricate. In order to improve academic, workplace, and mental health outcomes, more research must be done to determine how multiple identity intersection occurs and develops.

Third, the concept of *positive creative spin* uncovered in the ADHD identity model was an interesting cohesion within the sample. New areas for additional research must explore this link between having a diagnosis of ADHD and one's creativity output.

Finally, this study could be expanded to include quantitative data in conjunction to the rich qualitative data collected during the interviews. A mixed methods study on ADHD identity could further enhance the knowledge in this field. Detailed mental health files, for example, could have deepened the understanding into the workings of identity development, along with surveys or assessment tools.

### **Conclusion**

This study added to the existing body of literature on identity development, paying particular regard to influential factors such as gender, race/ethnicity/culture, and sexual identity. Despite the often marginalization for those with a hidden disability like ADHD, many of the participants in this study reported positive identity formation over the course of their developmental trajectories. While many various factors appear to enhance or limit the identity development for adults with ADHD, it is the researcher's hope that these findings are the starting point to many future conversation aimed at uncovering and capturing all the dynamics that forge an ADHD identity, individually and collectively.

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**Appendix A: IRB Approval Letter**

UNIVERSITY OF SOUTHERN CALIFORNIA UNIVERSITY PARK  
INSTITUTIONAL REVIEW BOARD FWA 00007099  
Exempt Review

Date: Sep 28, 2011, 09:09am  
Principal Investigator: [Erik Schott](#)  
Faculty Advisor: [Patricia Tobey](#)  
Co-Investigators:  
Project Title: [ADHD Identity](#)  
USC UPIRB # UP-11-00374

The iStar application and attachments were reviewed by UPIRB staff on **9/28/2011**.

The project was APPROVED.

Based on the information provided for review, this study meets the requirements outlined in 45 CFR 46.101(b)(2) and qualifies for exemption from IRB review. The study is not subject to further IRB review. IRB exemption of this study was granted on **9/28/2011**.

The following documents were reviewed and approved:

Certified Information Sheet, dated 09-28-2011  
Certified Recruitment Advert, dated 09-28-2011  
Certified Recruitment Email, dated 09-28-2011  
Certified Recruitment Flyer, dated 09-28-2011

Minor revisions were made to the recruitment and consent documents by the IRB Administrator (IRBA). The IRBA revised documents have been uploaded into the relevant iStar sections. Please use the IRBA revised documents if an amendment is submitted and future revisions are required.

**To access IRB-approved documents, click on the “Approved Documents” link in the study workspace. These are also available under the “Documents” tab.**

Sincerely,

RoseAnn Fleming, CIP

**Funding Source(s):** N/A - no funding source listed

**Appendix B: Information/Facts Sheet for Non-Medical Research**

University of Southern California  
Rossier School of Education  
3470 Trousdale Parkway  
Los Angeles, CA 90089

**INFORMATION/FACTS SHEET FOR NON-MEDICAL  
RESEARCH****ADHD Identity Development: A Model for Understanding College Students*****PURPOSE OF THE STUDY***

More and more students with disabilities, such as ADHD, are entering college in the United States. This study will focus on investigating the process of forging an ADHD identity as a college student. Other factors to be considered in the study will be gender, sexual identity, and race/ethnicity.

***PARTICIPANT INVOLVEMENT***

In order to be eligible you must be diagnosed with ADHD and aged 18 or older.

If you agree to participate, you will be asked to participate in a one hour interview. The interview will be audio-recorded with your permission. If you do not want the interview to be recorded, handwritten notes will be taken.

***PAYMENT/COMPENSATION FOR PARTICIPATION***

You will receive \$30 at the end of your participation. You do not have to answer all of the questions if you agree to be interviewed.

***CONFIDENTIALITY***

There will be no identifying information collected from you, your name, student ID number or other identifiable information will not be collected or linked to your responses.

The members of the research team and the University of Southern California's Human Subjects Protection Program (HSPP) may access the data. The HSPP reviews and monitors research studies to protect the rights and welfare of research subjects.

***INVESTIGATOR CONTACT INFORMATION***

Principal Investigator: Erik Schott, [eschott@usc.edu](mailto:eschott@usc.edu) or Faculty Advisor: Dr. Patricia Tobey, [tobey@usc.edu](mailto:tobey@usc.edu)

***IRB CONTACT INFORMATION***

University Park IRB, Office of the Vice Provost for Research Advancement, Stonier Hall, Room 224a, Los Angeles, CA 90089-1146, (213) 821-5272 or [upirb@usc.edu](mailto:upirb@usc.edu)

Date of Preparation: September 28, 2011  
UPIRB#: UP-11-00374

## Appendix C: Study Recruitment Flyer

# ADHD Study

## Do You Have ADHD?

Would you like to volunteer for a research study on ADHD identity development? You will be compensated for your time

PI: Erik Schott  
Faculty Advisor:  
Dr. Pat Tobey

**YOU MUST BE AGED 18 OR OLDER**

eschott@usc.edu  
323-252-6037

## Appendix D: Questions to be Asked of Participants in the Study

### Questions to be asked of participants in the study

**Legend: Bio-Psycho-social dimensions (BPS); Racial/Cultural dimensions (RC); Academic (A); Gender (G); Sexual identity (SI); Disability (D); Chickering & Reisser (1993) Vectors of Student Identity Development (V1-7); Erikson (1982) Early Adulthood Stage (E)**

The questions to be asked to designed to tap into the certain domains of interest as it helps to inform the psycho-social and racial/ethnic/cultural, gender, and sexual identity experiences of individuals with ADHD and the coping strategies that have been created and implemented to negotiate their academic environment and develop a sense of identity.

1. Please identity a 2 letter and 2 number code for your identification anonymously in the data. Have you been diagnosed with ADHD at some point during the course of your lifetime? Are you 18 y.o. or older? (D)
2. What is your age? (BPS)
3. What is your gender? (G)
4. What is your racial/ethnic/cultural identification? (RC)
5. What is your sexual identity (sexual orientation)? (SI)
6. What is your current class level and major? Or what was the highest level of education obtained? (A)
7. a) How has the experience of having ADHD affected you?  
 b) Are there dimensions that stand out for you? (BPS), (RC), (A), (G), (SI), (D), (V 1)
8. a) When did you find out that you had ADHD (how old)?  
 b) What was the process (Primary MD, psychotherapist, psychiatrist, school counselor)? (BPS), (RC), (D), (A), (V 1)
9. a) Are you currently in treatment for your ADHD or have you been in the past?

- b) What does it consist of? (psychotherapy, psychopharmacology, behavioral, etc.)
- c) Have these interventions helped or hindered your identity development? (BPS), (A), (V 1, 2, 3)
10. a) How does ADHD impact your life and how do you cope?
- b) What changes do you associate to having ADHD? (BPS), (RC), (A), (V 2, 5)
11. How do you think ADHD has shaped your sense of self or identity? (BPS), (D), (V 5), (E)
12. What does your family, friends, or significant others think about you having ADHD? (BPS), (RC), (A), (V 3), (E)
13. What are your beliefs and feelings regarding ADHD?
14. Do you identify as being disabled? (BPS), (RC), (D), (V 2)
15. Have you or do you hide your diagnosis? (From family, friends, academically, or occupationally)? (BPS), (A), (V 7)
16. In the Disability Identity Development Model there are three stages, which stage do you feel is applicable to your own identity as a person with ADHD? (BPS), (D), (V 5)
17. Do you think your identity with ADHD has been influenced by your gender? (BPS), (G), (V 5), (E)
18. Do you think your identity with ADHD has been influenced by your race/ethnicity/culture? (BPS), (RC), (V 5)
19. Do you think your identity with ADHD has been influenced by your sexual identity (sexual orientation)? (BPS), (SI), (V 5), (E)
20. a) Do you have friends with ADHD?
- b) Are of the same gender, sexual identity, or race/culture?
- c) Are they friends from college or primary school or non-school related? (BPS), (RC), (A), (G), (SI), (V 4)

21. a) Are you utilizing any disability services or receiving accommodations for your disability?
  - b) If so, how do you think this has enhanced your academic or work performance and influenced your identity development? (A), (BSP), (D), (V 3)
22. Has ADHD affected your romantic relationships? (BPS), (V 4), (E)
23. a) What are your future career aspirations?
  - b) Has having ADHD influenced this at all? (BPS), (V 6), (E)
24. a) Do you belong to or participate in any clubs, organizations, sports, extracurricular activities, work, internships, spiritual/religious affiliations?
  - b) How do you think this may have influenced your identity? (BPS), (RC), (A), (V 4, 6)
25. Do embrace or reject your ADHD identity? (BPS), (D), (V 5), (E)
26. a) Are there any questions or issues that I did not ask you about that you feel may help further explain how ADHD has impacted your life? (BPS), (RC), (A), (G), (SI), (D), (V 1-7)
  - b) Is there anything relevant you wish to add?

## Appendix E: Gibson DID Chart

### Gibson (2006) Disability Identity Development Model

| Stage 1:<br>Passive<br>Awareness                                | Stage 2:<br>Realization                        | Stage 3:<br>Acceptance  |
|---|--|---|
| (a) no role models of disability                                | (a) beginning to see self as having disability | (a) a shift to embracing self away from a negative focus on “being different” |
| (b) medical needs are satisfied                                 | (b) self-hate occurs                           | (b) one begins to view self as relevant and equal to others                   |
| (c) learning to deny certain social aspects of one’s disability | (c) anger is displayed                         | (c) one begins to incorporate others with disabilities into one’s life        |
| (d) the disability remains in denial within the family          | (d) a concern with how others perceive self    | (d) one becomes involved in disability advocacy and activism                  |
| (e) co-dependency occurs  | (e) concern with appearance occurs             | (e) self is integrated into the able-bodied world                             |
| (f) one shies away from attention                               | (f) “Superman/woman” complex takes place       |   |
| (g) one does not associate with others who have a disability    |  |   |

Source: Gibson, J. (2006). Disability and clinical competency: An introduction. *The California Psychologist*, 6, 5-10.

## Appendix F: Sample Coded Atlas.ti Report

### All (48) quotations from primary document: P10: t-DS12.rtf (C:\Program Files\Scientific Software\ATLAS.ti\ADHDdata\t-DS12.rtf)

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HU: ADHDstudy  
 File: [C:\Program Files\Scientific Software\ATLAS.ti\ADHDdata\ADHDstudy.hpr6]  
 Edited by: Super  
 Date/Time: 2012-01-13 04:13:14

---

#### **P10: t-DS12.rtf - 10:1 [eight years old.] (37:37) (Super)**

Codes: [8 Dx-Age] [8 Dx-Childhood]  
 No memos

eight years old.

#### **P10: t-DS12.rtf - 10:2 [I think that early on -- I was..] (13:13) (Super)**

Codes: [10 Impact of ADHD] [12 Opinions of Others re: ADHD] [7 ADHD Effects]  
 No memos

I think that early on -- I was diagnosed pretty young, so my recollection is that in school when I was young, my performance was like very low around first grade and I remember I wasn't really on par with the other students, and it was some distress to my parents and stuff.

#### **P10: t-DS12.rtf - 10:3 [So it gave me kind of an appre..] (15:15) (Super)**

Codes: [Creative/Positive Spin/Benefit of Having ADHD] [Pivot Experience]  
 No memos

So it gave me kind of an appreciation for education and a desire to drive and to make a lot out of it, if that makes sense.

#### **P10: t-DS12.rtf - 10:4 [I don't take things for grante..] (15:15) (Super)**

Codes: [Theme]  
 No memos

I don't take things for granted.

#### **P10: t-DS12.rtf - 10:5 [So it's like when I was in hig..] (17:17) (Super)**

Codes: [10 Impact of ADHD] [7 ADHD Effects] [Transition of Sx Related to Age]  
 No memos

So it's like when I was in high school, I was not doing well in the beginning and then worked really hard and push as hard as you can go, and ended up doing pretty well.

College, the same thing -- my first two years, my performance was not good and now, I'm on dean's list and stuff and whatever comes with that.

**P10: t-DS12.rtf - 10:6 [I anticipate kind of a slump i..] (19:19) (Super)**

Codes: [10 Coping] [10 Impact of ADHD] [7 ADHD Effects]

No memos

I anticipate kind of a slump in the beginning until I get used to it because it takes a lot of time to build kind of coping mechanisms to deal with kind of like a new challenge. So for example, I find that it's really hard for me to pay attention in class for more than [90] minutes, so for my longer lectures, I tend to -- and when I'm taking notes and stuff, that's hard for me because it's hard to stay focused.

**P10: t-DS12.rtf - 10:7 [So I manage through class and ..] (21:21) (Super)**

Codes: [10 Coping]

No memos

So I manage through class and just lectures and it's very different from what I see as a traditional approach to class, but for me, it took me a while to develop a method of doing that and doing so efficiently, but as soon as I got that down, it's a huge step up.

**P10: t-DS12.rtf - 10:8 [So I found that just bringing ..] (27:27) (Super)**

Codes: [10 Coping]

No memos

So I found that just bringing a recorder to class, especially classes that are longer than 90 minutes, which I think is probably like -- far exceeds the limits of my attention span -- I'd just record the class, and if there's something that I'd miss, I'd just go back to it and listen to it word for word, and maybe listen to it at two times speed or something.

**P10: t-DS12.rtf - 10:9 [I found out when it's appropri..] (29:29) (Super)**

Codes: [10 Coping]

No memos

I found out when it's appropriate because a lot of my classes involve a lot of visual aids for the professors to show something in PowerPoint, so learning how to do that was a big kind of coping method.

**P10: t-DS12.rtf - 10:10 [But it would be helpful to als..] (33:33) (Super)**

Codes: [10 Coping]

No memos

But it would be helpful to also -- learning environment is a huge thing, so I found that

trying to study in the dorms freshman year was like a terrible idea for me because I was living in basically a [hall] with like 36 probably other guys and it's just kind of a nest of distractions. And there's always something that's going to shoot your focus from trying to study math or something.

**P10: t-DS12.rtf - 10:11 [So probably because I was bein..] (43:43) (Super)**

Codes: [9 Treatment/Interventions for ADHD]

No memos

So probably because I was being treated by a neurologist, my treatment was limited to medication pretty much.

**P10: t-DS12.rtf - 10:12 [So I was on all these differen..] (51:51) (Super)**

Codes: [9 Impact of Treatment/Interventions on Identity]

No memos

So I was on all these different medications and none of them worked out really well. Had all these nasty side effects, a lot of which were like stuff with decrease in appetite, not being able to sleep, a laundry list of things, and those caused a lot of other problems.

**P10: t-DS12.rtf - 10:13 [I think it's helped. I think i..] (59:59) (Super)**

Codes: [9 Impact of Treatment/Interventions on Identity]

No memos

I think it's helped. I think it's a very -- just bottom line, maybe I tend to like it. The truth is that I like it because it makes things easier for me and the effect of it are very subtle, so maybe it's had some -- it's not a medication -- one thing that's notable is that it's not a medication that you're ever really supposed to be up.

**P10: t-DS12.rtf - 10:14 [Somewhat and maybe a little bi..] (61:61) (Super)**

Codes: [9 Impact of Treatment/Interventions on Identity]

No memos

Somewhat and maybe a little bit more intense of a person in terms of what I'm trying to do and stuff, but I don't consider it to be a hindrance because I don't think it's affected me negatively, hasn't slowed me down.

**P10: t-DS12.rtf - 10:15 [No, I don't think that there w..] (62:62) (Super)**

Codes: [8 Dx-Denial]

No memos

No, I don't think that there was ever a point when I was in denial about my diagnosis, just

because the symptoms were so that -- I mean, of course, sometimes questioned it, because -- just because everybody questions it and wonders if it's like just normal behavior to be a little bit inattentive, but I think I'm probably on more the extreme side of the spectrum. And when I'm not on medication, I'm just very, very loopy, so probably it would be hard to deny it just because the effects of that, the symptomology have such an extreme effect on my performance.

**P10: t-DS12.rtf - 10:16 [It's hard to say how I was tol..] (64:64) (Super)**

Codes: [8 Dx Cognitive Deve. & Understanding of Dx]

No memos

It's hard to say how I was told about the diagnosis at 8 years old. I don't think anything was ever really hidden from me. It was just like kind of difficult for like my eight-year-old self to kind of comprehend what it was, but it wasn't something that really bothered me really. I was always just like, yeah, give me whatever you want to give me.

**P10: t-DS12.rtf - 10:17 [All my stuff, from my computer..] (66:66) (Super)**

Codes: [10 Coping]

No memos

All my stuff, from my computer to my materials for school, I kind of use these methods of keeping everything organized, like color-coding and stuff, and my inbox emails is all labeled and stuff.

**P10: t-DS12.rtf - 10:18 [But I can't really -- it's dif..] (68:68) (Super)**

Codes: [10 Coping]

No memos

But I can't really -- it's difficult to separate what I do for ADHD versus what I do for myself because it's kind of one and the same, but I guess maybe that's acceptable sort of.

**P10: t-DS12.rtf - 10:19 [I'd say that it's probably alw..] (70:70) (Super)**

Codes: [11 Impact of ADHD on Identity]

No memos

I'd say that it's probably always given me the sense that I'm fighting uphill in education and that it kind of makes me not take things for granted. So I think that's, I guess, somewhat of an effect of my identity, yes.

**P10: t-DS12.rtf - 10:20 [Yes, generally people have bee..] (76:76) (Super)**

Codes: [12 Positive Support from Others]

No memos

Yes, generally people have been supportive in my family. I joke about it in a positive way. It's never been mean--

**P10: t-DS12.rtf - 10:21 [It's hard to say. I think beca..] (79:79) (Super)**

Codes: [13 Beliefs About ADHD]

No memos

It's hard to say. I think because I do have somewhat of -- I'm very early in my studies of this kind of stuff, but it is within kind of my field, and my opinion is that there's definitely something there that some people are dealing with, but it obviously -- to some extent, it exists on a spectrum.

**P10: t-DS12.rtf - 10:22 [Yes, yes, I guess you could sa..] (83:83) (Super)**

Codes: [14 Disabled-Yes]

No memos

Yes, yes, I guess you could say that.

**P10: t-DS12.rtf - 10:23 [And I guess to add to that, I ..] (85:85) (Super)**

Codes: [14 Definition of Disability]

No memos

And I guess to add to that, I try not to put down other people with disabilities and stuff. That's certainly not my [tent], but I try not to consider it an excuse to fall short. I guess it's something that I, in congress with other people, I try not to hold me back from getting anything accomplished, or try not to use it as an excuse for anything.

**P10: t-DS12.rtf - 10:24 [Yes, especially when I was you..] (87:87) (Super)**

Codes: [15 Hide Diagnosis] [Emotion-Embarrassment]

No memos

Yes, especially when I was younger, I was kind of embarrassed. I remember being in middle school when I was young especially and I was on Ritalin and I would have to take it at school and the nurse would have to give it to me. And it was like after lunch and I was always really embarrassed about it, so I would try to hide it

**P10: t-DS12.rtf - 10:25 [But yes definitely when I was ..] (89:89) (Super)**

Codes: [8 Dx Cognitive Deve. & Understanding of Dx] [Pivot Experience] [Transition of Sx Related to Age]

No memos

But yes definitely when I was young, but when I got older and I became more aware of

what the problem was and what I'm dealing with, it's not really my fault, and then I kind of took it for what it is and now I really don't hide from anybody. And I don't go around announcing it to people or people mention that they have ADHD or something, depending on the circumstances, I may or may not share that I have the same thing, but it really doesn't bother me to be honest about it.

**P10: t-DS12.rtf - 10:26 [But in college, now that I'm s..] (93:93) (Super)**

Codes: [Pivot Experience] [Transition of Sx Related to Age]

No memos

But in college, now that I'm surrounded with people all the time, I just -- I guess at some point, probably really early on, realized that it doesn't really bother me. I became more aware of what it was probably early college and became more about it. So the pivotal age shift was from high school to college.

**P10: t-DS12.rtf - 10:27 [stage three] (95:95) (Super)**

Codes: [16 Stage in DID Model]

No memos

stage three

**P10: t-DS12.rtf - 10:28 [Yes, probably, just because I ..] (97:97) (Super)**

Codes: [17 Differences for Males vs. Females]

No memos

Yes, probably, just because I think that females tend to be more prone to engage in a dialogue with their friends and sharing things like of a more personal nature, and being more open about -- maybe I'm generalizing and it's not fair to say, but I think guys tend to keep things like this a little bit more to themselves.

**P10: t-DS12.rtf - 10:29 [But as I've grown, I've become..] (99:99) (Super)**

Codes: [17 ADHD Influence of Gender]

No memos

But as I've grown, I've become more -- I guess there is, to some extent, something that you might refer to as machismo in dealing with it, just keeping it to myself, and when I have problems with it, I don't go and start venting out to people. Yes, I guess it probably has.

**P10: t-DS12.rtf - 10:30 [No, I couldn't say so just bec..] (101:101) (Super)**

Codes: [18 ADHD Influence of Race/Ethnicity/Culture]

No memos

No, I couldn't say so just because I don't identify strongly as being a member of either culture of my parents because I grew up in a largely secular environment and I never really was like mostly Hispanic or mostly Mexican, this and that.

**P10: t-DS12.rtf - 10:31 [No, no, I don't think so.] (103:103) (Super)**

Codes: [19 ADHD Influence of Sexual Identity]

No memos

No, no, I don't think so.

**P10: t-DS12.rtf - 10:32 [one of my good friends has it] (105:105) (Super)**

Codes: [20 Friends with ADHD] [20 Number of Friends with ADHD]

No memos

one of my good friends has it

**P10: t-DS12.rtf - 10:33 [Yes, same gender, yes.] (107:107) (Super)**

Codes: [20 Friends with ADHD Gender]

No memos

Yes, same gender, yes.

**P10: t-DS12.rtf - 10:34 [Yes, pretty much everything is..] (109:109) (Super)**

Codes: [20 Friends with ADHD Race/Ethnicity/Culture] [20 Friends with ADHD Sexual Identity]

No memos

Yes, pretty much everything is the same, but Caucasian.

**P10: t-DS12.rtf - 10:35 [Yes, from college.] (111:111) (Super)**

Codes: [20 Friends from College]

No memos

Yes, from college.

**P10: t-DS12.rtf - 10:36 [Yes, I am registered with Stud..] (117:117) (Super)**

Codes: [12 Positive Support from Others] [21 Influence of Accommodations on Identity] [21 Utilization of Accommodations]

No memos

Yes, I am registered with Student Support Services. So that's kind of the limit of my interaction with them and that's also a big thing, that sign up for extra time for exams. That's extremely helpful because I'd run out -- I'd take these bio exams or something and get them half done. That accommodation is the limitation of my interaction with them.

I'm really. But I typically just ask the professor for accommodations and never had a problem.

**P10: t-DS12.rtf - 10:37 [It's kind of not so such a nic..] (121:121) (Super)**

Codes: [11 Impact of ADHD on Identity] [21 Influence of Accommodations on Identity] [Emotion-Shame]

No memos

It's kind of not so such a nice reminder that you need all that help and you're in that position. I guess as I'm turning over another side of it, it's like there's some -- it might not be the most pleasant thing to deal with for people.

**P10: t-DS12.rtf - 10:38 [The current person I'm with, w..] (123:123) (Super)**

Codes: [22 ADHD Effects on Romantic Relationships]

No memos

The current person I'm with, when she found out that I have it, which was like really early on, she just asked and I said yeah. And she thought it was kind of funny and she thought that it kind of explained how I think, I guess, in a way or how you kind of get carried away with ideas or how I carry on conversations. And she said things make a lot more sense because usually when I'm in conversations, it's not difficult for me to go off and I mean, it's common for me to caught up on tangents or get really caught up in a single idea.

**P10: t-DS12.rtf - 10:39 [A physician, more I'd say 80% ..] (125:125) (Super)**

Codes: [23 Career/Aspirations]

No memos

A physician, more I'd say 80% driven to be a physician, 20% to be a surgeon maybe, depending on how that all pans out, but yes, definitely if I have go to medical school and possibly go to something mind-related or brain-related, depending on how you look at it, but yes, it's definitely the extent of it. And I don't really -- I'd be interested in going to academic medicine as well and being in kind of a university-hospital environment specifically, but I guess it's more peripheral.

**P10: t-DS12.rtf - 10:40 [That I'd be interested in deal..] (133:133) (Super)**

Codes: [11 Impact of ADHD on Identity] [23 ADHD Effect on Career/Aspirations] [Creative/Positive Spin/Benefit of Having ADHD]

No memos

That I'd be interested in dealing with problems similar to mine because I think about problems of the brain, neurological problems is that they hit very close to home and they affect your identity and how you interact with your environment and who you are, etc. And because of that, they have a really profound effect on people and people's development and I think that makes it very inspiring and an interesting issue to tackle.

**P10: t-DS12.rtf - 10:41 [Yes, for sure.] (127:127) (Super)**

Codes: [23 ADHD Effect on Career/Aspirations]

No memos

Yes, for sure.

**P10: t-DS12.rtf - 10:42 [I was on the marathon team.] (135:135) (Super)**

Codes: [24 Activities]

No memos

I was on the marathon team.

**P10: t-DS12.rtf - 10:43 [I do research in the Departmen..] (135:135) (Super)**

Codes: [24 Activities]

No memos

I do research in the Department of neurosurgery

**P10: t-DS12.rtf - 10:44 [I also do help kids in educati..] (137:137) (Super)**

Codes: [24 Activities]

No memos

I also do help kids in education through [JP], so right now, for example, I'm mentoring a single student in NIA, the Neighborhood Academic Initiative.

**P10: t-DS12.rtf - 10:45 [It's value working at an inter..] (139:139) (Super)**

Codes: [24 Influence of Activities on Identity]

No memos

It's value working at an interpersonal level and it's definitely -- it feels good to be or push someone in the right direction, and I mean, I've found myself -- I've been doing this really for four years, or three years maybe. So I've got with a lot of different so it's given me an appreciation for what -- the situation I'm in and that I'm school I should go and my stuff and it's kind of nice. So it makes me -- it puts all my problems into perspective.

**P10: t-DS12.rtf - 10:46 [I guess -- I don't know if I e..] (141:143) (Super)**

Codes: [25 Accept/Neutral ADHD Identity]

No memos

I guess -- I don't know if I embrace it. I don't reject it though.

It's acceptance. It's not an extremely positive feeling, but it doesn't bother me.

**P10: t-DS12.rtf - 10:47 [I think it affects people diff..] (147:147) (Super)**

Codes: [13 Beliefs About ADHD]

No memos

I think it affects people differently throughout the course of their treatment,

**P10: t-DS12.rtf - 10:48 [Yes, personal coping mechanism..] (149:149) (Super)**

Codes: [10 Coping]

No memos

Yes, personal coping mechanisms. Especially today's kids, technology is probably a big. It wasn't around 10 years ago, but everybody has access to their laptops and stuff and --

## Appendix G: Sample Interview Transcript

### Interview Protocol

Project: ADHD Identity Study

Time: 12 noon

Date: 11/2/11

Interviewer: Erik Schott

Participant: DS12

### Personal Interview Questions

*1. Please identify a 2 letter and 2 number code for your identification anonymously in the data. Have you been diagnosed with ADHD at some point during the course of your lifetime? Are you 18 y.o. or older?*

DS12. Yes. Yes.

*2. What is your age?*

22

*3. What is your gender?*

Male

*4. What is your racial/ethnic/cultural identification?*

Mixed-Middle Eastern (Israeli or Ashkenazi Jewish )/Latino(Mexican)

*5. What is your sexual identity (sexual orientation)?*

Straight/Heterosexual

*6. What is your current class level and major? Or what was the highest level of education obtained?*

Senior-Neuroscience

*7. a) How has the experience of having ADHD affected you? b) Are there dimensions that stand out for you?*

a) I think that early on -- I was diagnosed pretty young, so my recollection is that in school when I was young, my performance was like very low around first grade and I remember I wasn't really on par with the other students, and it was some distress to my parents and stuff. And it kind of followed me throughout my early education till middle school and because of that, I wasn't really -- I guess until my first year of high school, I wasn't ever kind of at the same level as my peers in school.

So it gave me kind of an appreciation for education and a desire to drive and to make a lot out of it, if that makes sense. I don't know, maybe I'm leaving something out of the equation there, but I guess I didn't really even take doing well for granted. It is a theme that continue. I don't take things for granted.

b) Yes, there's a theme of performance an upward trend that repeats itself. So it's like when I was in high school, I was not doing well in the beginning and then worked really hard and push as hard as you can go, and ended up doing pretty well. College, the same thing -- my first two years, my performance was not good and now, I'm on dean's list and stuff and whatever comes with that.

And it's like whenever I go into. So I decided back to graduate school. I don't want it to be, but it follows [the turn]. I anticipate kind of a slump in the beginning until I get used to it because it takes a lot of time to build kind of coping mechanisms to deal with kind of like a new challenge. So for example, I find that it's really hard for me to pay attention in class for more than [90] minutes, so for my longer lectures, I tend to -- and when I'm taking notes and stuff, that's hard for me because it's hard to stay focused.

So I manage through class and just lectures and it's very different from what I see as a traditional approach to class, but for me, it took me a while to develop a method of doing that and doing so efficiently, but as soon as I got that down, it's a huge step up.

I said that I found note-taking to be very difficult in lectures, so when I got to college, I was going to these lectures and they--

So what I was saying is that I found that starting college and stuff, the lecture environment was really a challenging one to learn in, so in taking notes, I found that it was really difficult to stay, to keep my attention in one place. And I'd find that I'd get too -- I don't know, maybe it's a common problem with students, but I found that interest doesn't work with kind of the way I think, and I'd miss a lot of stuff at lecture and take very shoddy notes.

So I found that just bringing a recorder to class, especially classes that are longer than 90 minutes, which I think is probably like -- far exceeds the limits of my attention span -- I'd

just record the class, and if there's something that I'd miss, I'd just go back to it and listen to it word for word, and maybe listen to it at two times speed or something. And I think that it took a while to develop that method and to do so efficiently and get to doing it, but once I did that, I think that was change.

I found out when it's appropriate because a lot of my classes involve a lot of visual aids for the professors to show something in PowerPoint, so learning how to do that was a big kind of coping method.

But beyond that, I was also -- I don't know if I'm including more than I should, but --

But it would be helpful to also -- learning environment is a huge thing, so I found that trying to study in the dorms freshman year was like a terrible idea for me because I was living in basically a [hall] with like 36 probably other guys and it's just kind of a nest of distractions. And there's always something that's going to shoot your focus from trying to study math or something.

So learning the places on campus worked. I know that I could just sit down and focus and stuff. It was a big deal in terms of allowing for more progress, allowing for me to be a better student.

8. *a) When did you find out that you had ADHD (how old)? b) What was the process (Primary MD, psychotherapist, psychiatrist, school counselor)?*

a) I think eight years old. It was definitely in childhood.

b) I went to a neurologist who I was still checking up with prior to college. His name is - he's in New York. His name is Dr. Pseudonym and he's in pediatric neurology, so used some kind of -- what's it called -- electro-encephalography. They put electrodes in your scalp, so I remember doing that and they probably used the [Dadas] method in addition to probably the [Weston] scale or something due to various tests like neuropsychological test assessment.

So after that went through, they put me on a series of different medications, none of which were great until just like Ritalin and this and that, and that probably answered your question.

9. *a) Are you currently in treatment for your ADHD or have you been in the past? b) What does it consist of? (psychotherapy, psychopharmacology, behavioral, etc.) c) Have these interventions helped or hindered your identity development?*

a) So probably because I was being treated by a neurologist, my treatment was limited to medication pretty much. All the combinations always came with that and stuff, but I was never really -- I had never been to talk therapy or anything like that or utilized any of those kind of remedies, but I was on Ritalin at first, I think, not a great. And I just went from this to that and I can't tell you the specifics because I really don't remember the names of the specific. This or that throughout my childhood and then probably at the beginning of high school, I switched from the [methaphenodate] kind of and really the only change in that is that going from probably being in high school so freshman year or maybe eighth grade, starting taking it. And in college, growing up, probably putting on--

So the last medication, I started taking in around the beginning of high school, about 60 milligrams. It's called atomoxetine.

The drug name -- the marketing name is Strattera.

So Strattera at 60 milligrams.

So I was on all these different medications and none of them worked out really well. Had all these nasty side effects, a lot of which were like stuff with decrease in appetite, not being able to sleep, a laundry list of things, and those caused a lot of other problems.

And we switched to this other medication called atomoxetine, which is marketed as Strattera and I think that it works on a different -- it's believed to work on a different underlying system, so it's not even considered to be a controlled -- I don't know if it would be the right terminology.

Yes, yes, so the regulations and dealing with prescriptions and stuff are a lot more lax and it works really well. There are no side effects that kind of stick out to me.

And it's the only thing that -- the only combination that I've kind of -- the only change that we've made is to change from 60 to 80 milligrams and that's from the time -- that's within an eight year -- so I probably did that freshman year of college to maybe three years ago. So I think over eight years, increasing the dose that much, I don't see as that big of a deal, but it works really well, bottom line.

c) I think it's helped. I think it's a very -- just bottom line, maybe I tend to like it. The truth is that I like it because it makes things easier for me and the effect of it are very subtle, so maybe it's had some -- it's not a medication -- one thing that's notable is that it's not a medication that you're ever really supposed to be up. So it's something you take

every day and it even takes two weeks to kick into your system, so you can't really just choose not to take it.

Somewhat and maybe a little bit more intense of a person in terms of what I'm trying to do and stuff, but I don't consider it to be a hindrance because I don't think it's affected me negatively, hasn't slowed me down. No, I don't think that there was ever a point when I was in denial about my diagnosis, just because the symptoms were so that -- I mean, of course, sometimes questioned it, because -- just because everybody questions it and wonders if it's like just normal behavior to be a little bit inattentive, but I think I'm probably on more the extreme side of the spectrum. And when I'm not on medication, I'm just very, very loopy, so probably it would be hard to deny it just because the effects of that, the symptomology have such an extreme effect on my performance.

It's hard to say how I was told about the diagnosis at 8 years old. I don't think anything was ever really hidden from me. It was just like kind of difficult for like my eight-year-old self to kind of comprehend what it was, but it wasn't something that really bothered me really. I was always just like, yeah, give me whatever you want to give me.

*10. a) How does ADHD impact your life and how do you cope? b) What changes do you associate to having ADHD?*

Yes, and I think that habits that I could add to that redundant, habits, maybe -- I don't know, this doesn't have anything to do with ADHD, but habits of organization. All my stuff, from my computer to my materials for school, I kind of use these methods of keeping everything organized, like color-coding and stuff, and my inbox emails is all labeled and stuff.

And it's not to the extent that some disorganization bothers me, but I feel like it kind of smoothes out the process of trying to get things done, but I guess that's probably true for everybody to an extent. But I can't really -- it's difficult to separate what I do for ADHD versus what I do for myself because it's kind of one and the same, but I guess maybe that's acceptable sort of.

*11. How do you think ADHD has shaped your sense of self or identity?*

I'd say that it's probably always given me the sense that I'm fighting uphill in education and that it kind of makes me not take things for granted. So I think that's, I guess, somewhat of an effect of my identity, yes.

*12. What does your family, friends, or significant others think about you having ADHD?*

It really depends on what I'm talking about. I mean, I think that with my brother, he kind of thinks it's funny and sometimes -- my older brother and I are very close in age and sometimes we'll think about it and he'll say, well, it's like this concept of being on medication or you kind of talking to me, kind of being very spacey when, for example, I'll forget to take my medication. Between the two of us, it's kind of a funny thing. But I guess with my mother, probably it's more like a sense of relief for her that things are working out and I guess in terms of family, that's pretty much --

I guess with significant other, she thinks it's kind of funny, but I don't know, we don't take it too seriously. Sometimes, it's kind of a funny thing to, but it's kind of been part of my identity for so long that I deal with this and it doesn't bother me and I'm pretty much open to talk about it with anybody.

Yes, generally people have been supportive in my family. I joke about it in a positive way. It's never been mean--

*13. What are your beliefs and feelings regarding ADHD?*

It's hard to say. I think because I do have somewhat of -- I'm very early in my studies of this kind of stuff, but it is within kind of my field, and my opinion is that there's definitely something there that some people are dealing with, but it obviously -- to some extent, it exists on a spectrum. It leads a lot of people -- like, for example, personality disorders, you see this all over the place in psychiatry because -- or psychology or just dealing with mental health, that to some extent, a lot of those disorders are normal and it makes a lot of people -- it leads a lot of people to question are you just treating normal behavior?

And kind of just -- it probably exists on the spectrum and to some extent, medications might be over-prescribed, but in my case, I'd say that I'm far enough on the spectrum, being like more an extreme case that it doesn't really lead me to question my symptoms. But I get maybe out of convenience, I'm not thinking about it and the medication worked for me really well.

*14. Do you identify as being disabled?*

Yes, yes, I guess you could say that.

And I guess to add to that, I try not to put down other people with disabilities and stuff. That's certainly not my [tent], but I try not to consider it an excuse to fall short. I guess it's something that I, in congress with other people, I try not to hold me back from getting anything accomplished, or try not to use it as an excuse for anything.

*15. Have you or do you hide your diagnosis? (From family, friends, academically, or occupationally)?*

Yes, especially when I was younger, I was kind of embarrassed. I remember being in middle school when I was young especially and I was on Ritalin and I would have to take it at school and the nurse would have to give it to me. And it was like after lunch and I was always really embarrassed about it, so I would try to hide it. But then they were giving me like a little cracker or something like ginger ale to take with it, so not so much.

But yes definitely when I was young, but when I got older and I became more aware of what the problem was and what I'm dealing with, it's not really my fault, and then I kind of took it for what it is and now I really don't hide from anybody. And I don't go around announcing it to people or people mention that they have ADHD or something, depending on the circumstances, I may or may not share that I have the same thing, but it really doesn't bother me to be honest about it.

I'd say that going -- so I started the Strattera, which is the first medication I don't have to take during the day probably, in high school, so throughout happened, no one really knew I was taking it because I'd taken it in the beginning of the day. I'd take it as soon as I got up and that's it, and so I guess that was like a long period of not really having to -- throughout high school and being at home and stuff, and not having to really deal with sharing with other people. So I guess I still kept it to myself, but wasn't -- probably more comfortable with talking about it.

But in college, now that I'm surrounded with people all the time, I just -- I guess at some point, probably really early on, realized that it doesn't really bother me. I became more aware of what it was probably early college and became more about it. So the pivotal age shift was from high school to college.

*16. In the Disability Identity Development Model there are three stages, which stage do you feel is applicable to your own identity as a person with ADHD?*

Yes, I'd say stage three. Yes, that's pretty -- I'll give you a pretty confident answer there.

*17. Do you think your identity with ADHD has been influenced by your gender?*

That's a good one. Yes, probably, just because I think that females tend to be more prone to engage in a dialogue with their friends and sharing things like of a more personal nature, and being more open about -- maybe I'm generalizing and it's not fair to say, but I think guys tend to keep things like this a little bit more to themselves.

But as I've grown, I've become more -- I guess there is, to some extent, something that you might refer to as machismo in dealing with it, just keeping it to myself, and when I

have problems with it, I don't go and start venting out to people. Yes, I guess it probably has.

*18. Do you think your identity with ADHD has been influenced by your race/ethnicity/culture?*

No, I couldn't say so just because I don't identify strongly as being a member of either culture of my parents because I grew up in a largely secular environment and I never really was like mostly Hispanic or mostly Mexican, this and that. My friends tend to be of different ethnic backgrounds and I don't know that I identify those lines at all.

*19. Do you think your identity with ADHD has been influenced by your sexual identity (sexual orientation)?*

No, no, I don't think so.

*20. a) Do you have friends with ADHD? b) Are of the same gender, sexual identity, or race/culture? c) Are they friends from college or primary school or non-school related?*

a) Hard to say, but I guess my close friends, no, no, none of my close friends have it actually, but I definitely have a few acquaintances, more acquaintances, friends, but I guess my closer friends. Actually, one of my good friends has it, but that's off the top of my head because I don't know how criteria there.

b) Yes, same gender, yes.

Yes, pretty much everything is the same, but Caucasian.

c) Yes, from college.

Yes, yes, a few from high school. Again, you only spend a handful of hours together and. Yes, it's really hard for me to say because that point, it's so long ago that I don't really remember.

*21. a) Are you utilizing any disability services or receiving accommodations for your disability? b) If so, how do you think this has enhanced your academic or work performance and influenced your identity development?*

a) No I have not used the quiet room, I haven't and I may have them at some point because I always get emails and stuff from them.

Yes, I am registered with Student Support Services. So that's kind of the limit of my interaction with them and that's also a big thing, that sign up for extra time for exams. That's extremely helpful because I'd run out -- I'd take these bio exams or something and get them half done. That accommodation is the limitation of my interaction with them. I'm really. But I typically just ask the professor for accommodations and never had a problem.

b) Absolutely. I think it's really great that they're there for people and maybe it's -- I usually just go online, to be honest, and do it through there. I don't really go to the office and it's nice that it's there because some people don't feel so comfortable going to an office and dealing with that whole kind of thing.

It's kind of not so much a nice reminder that you need all that help and you're in that position. I guess as I'm turning over another side of it, it's like there's some -- it might not be the most pleasant thing to deal with for people. So the fact that they have that --

*22. Has ADHD affected your romantic relationships?*

The current person I'm with, when she found out that I have it, which was like really early on, she just asked and I said yeah. And she thought it was kind of funny and she thought that it kind of explained how I think, I guess, in a way or how you kind of get carried away with ideas or how I carry on conversations. And she said things make a lot more sense because usually when I'm in conversations, it's not difficult for me to go off and I mean, it's common for me to be caught up on tangents or get really caught up in a single idea.

*23. a) What are your future career aspirations? b) Has having ADHD influenced this at all?*

a) A physician, more I'd say 80% driven to be a physician, 20% to be a surgeon maybe, depending on how that all pans out, but yes, definitely if I have to go to medical school and possibly go to something mind-related or brain-related, depending on how you look at it, but yes, it's definitely the extent of it. And I don't really -- I'd be interested in going to academic medicine as well and being in kind of a university-hospital environment specifically, but I guess it's more peripheral.

b) Yes, for sure.

but the way I see things as mental health and neurological disorders. I don't really myself out of that category even though I'm fortunate not to suffer from something that's had a lot worse impact, but not to downplay how ADHD can affect people, but I think that

something like -- I don't know, I mean, having a neurological disorder would be a lot worse.

Affect your brain, depending on how you look at it again, is that they affect your identity how you think your environment. They hit so close to home that I think that that's why inspired to kind of try to help and so whether or not it's research or focusing on one person at a time.

That I'd be interested in dealing with problems similar to mine because I think about problems of the brain, neurological problems is that they hit very close to home and they affect your identity and how you interact with your environment and who you are, etc. And because of that, they have a really profound effect on people and people's development and I think that makes it very inspiring and an interesting issue to tackle.

*24. a) Do you belong to or participate in any clubs, organizations, sports, extracurricular activities, work, internships, spiritual/religious affiliations? b) How do you think this may have influenced your identity?*

a) Yes, I do research in the Department of neurosurgery and I've been doing that for probably a [year]. The lab just opened up, so I've been around since we started, but beyond that, I'm involved in running and stuff. I'm injured at the moment, but before that, I was on the marathon team.

And then I also do help kids in education through [JP], so right now, for example, I'm mentoring a single student in NIA, the Neighborhood Academic Initiative. I'm sure you're familiar with it. I go out to local schools, like manual arts, for example, and I've been a TA and I've taught classes, but my preference is to work with people one at a time.

b) It's value working at an interpersonal level and it's definitely -- it feels good to be or push someone in the right direction, and I mean, I've found myself -- I've been doing this really for four years, or three years maybe. So I've got with a lot of different so it's given me an appreciation for what -- the situation I'm in and that I'm school I should go and my stuff and it's kind of nice. So it makes me -- it puts all my problems into perspective.

*25. Do embrace or reject your ADHD identity?*

I guess -- I don't know if I embrace it. I don't reject it though.

It's acceptance. It's not an extremely positive feeling, but it doesn't bother me.

26. a) *Are there any questions or issues that I did not ask you about that you feel may help further explain how ADHD has impacted your life?* b) *Is there anything relevant you wish to add?*

a) No, I think the questions are very good. It's a good level of perhaps there's a little repetition or maybe that's because answer the question being open-ended and helping focus, but I'd say perhaps maybe if you're still in the same -- kind of molding the questions to indicate a little bit more of what's the spectrum in terms of like how things work on the timeline, how this affected me.

It's definitely -- I think it affects people differently throughout the course of their treatment, and I think maybe a question on technology might be a good idea.

Yes, personal coping mechanisms. Especially today's kids, technology is probably a big. It wasn't around 10 years ago, but everybody has access to their laptops and stuff and --

Yes, I mean, it's extremely -- I could just download the PDF and takes me 10 minutes. I mean, it's faster. I don't have to make a trip there or have to go to campus. It's just great.

b) Uh-uh, no.