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Science, Symptoms, and Support Groups: ADHD in the American Cultural Context

By

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INTRODUCTION

Attention-Deficit Hyperactivity Disorder, more commonly known as “ADHD” is a neurobehavioral mental disorder that is best known for affecting school age children. Despite the commonly held belief that ADHD is something that most children “grow out of,” psychiatric experts have agreed that ADHD is likely to affect an individual throughout their entire life (Conrad and Potter 2000; McGough and Barkley 2004), even when certain symptoms seem to dissipate with age and treatment (Brahman et al. 2012; Martel et al. 2012; Bailey 2010; Gregg 2010:57-60). Symptoms associated with ADHD are often abilities related to self-regulation. Some examples include the abilities to: listen to directions, control impulses, start and finish tasks, stay organized, follow through on assignments, resist fidgeting, manage time, and stay mentally present. In the United States, ADHD directly affects about 9.5 percent of children between ages four and seventeen (Pastor et al. 2015:201) and around 4.4 percent of American adults (Kessler et al. 2006:716). With so many people being diagnosed with ADHD, research on the disorder is of growing interest to those affected. In addition to those who have received a diagnosis of ADHD, there are a number of other stakeholders when it comes to the disorder. Stakeholders include friends and family of those with ADHD, teachers, doctors (including psychiatrists), mental healthy specialists, lawyers, policy-makers, drug manufacturers, regulatory agencies, social workers, and many others. The way that the disorder is understood, discussed, and presented in American culture then has implications for plenty of people.

This research critically engages with how ADHD has been constructed as a disorder by examining how it is addressed in communities created to provide support for

those struggling with its symptoms. Due to the stigma and controversy surrounding Attention Deficit Hyperactivity Disorder in the United States, individuals who identify with this diagnosis suggest that their behavioral differences become a source of tension in their personal and professional lives. In this essay, I will argue that this is the case because the traits or “symptoms” associated with ADHD can be considered particularly deleterious in the context of American culture. This is due (at least in part) to the fact that the inability to pay attention or resist impulses can severely affect one’s ability to function according to values held in American education and work structures. This inability to function and meet certain societal standards thus results in the medicalization of these behaviors that deviate from the “norm.” To explore this issue further, I attended a variety of ADHD-related public support group meetings and informational events throughout the state of New York over the course of ten months.

To understand American culture as it relates to ADHD, it will first be important to look at how science came to be *the* source of authoritative discourse and knowledge production in the West. This will then lead into a discussion of the establishment of psychiatry as a cultural institution in the United States and how diagnostic tools for mental disorders (namely the Diagnostic Statistical Manual of Mental Disorders) were developed in response to the influence of modern biomedicine. This can show how ADHD behaviors came to be grouped together and categorized as a “disorder”—an important part of understanding ADHD in the United States today. The second section of this paper will cover the history of ADHD as a diagnosis in the United States, highlighting important moments that have led to current understandings of the disorder. The next point to be explored is how the media shapes popular understandings of ADHD,

and in doing so, creates controversy concerning ADHD's legitimacy as a medical diagnosis. The following portion will be based on my ethnographic research in support groups, and focus on why ADHD symptoms are particularly noticeable and cause problems for individuals in American education and labor systems, (as compared to other countries and cultures), and try to illuminate why symptoms may be affecting the personal lives of attendees. One of the most important determinations that a doctor must make in making a diagnosis is assessing whether the ADHD-like traits that someone is exhibiting are having a negative impact on the life quality of the individual, so understanding the source of suffering becomes relevant here.

Ultimately, our understandings of ADHD shape the way that we address it in society. Since there is no single coherent understanding of the disorder, there is no single coherent response either. Instead, there is an array of responses to different aspects of ADHD. Some of these responses are negative and can end up causing controversy among people and in the media. This leads to a need for support groups as there is some degree of stigma and blame associated with ADHD's public image. This makes it so that, beyond refining our understanding of the disorder, it is important to consider implications of each perspective and how people with this ADHD might then be affected for each.

SCI-CHIATRY IN AMERICA

In the United States the primary way that we collectively generate knowledge about the world around us is through science. According to Western history, the development of science as a process via the scientific method came as an important turning point that brought Europe from the Middle Ages into the Renaissance, thus kicking off the beginning of the Early Modern Era. Science gained significant authority by being contrasted against previous modes of “knowing” and “truth” based in religion and divinity.

In the first half of the 17th century, French philosopher (and scientist) René Descartes, played an important part in laying the foundation for much of Western thought today. Not only did he advocate for rationalism, but he also articulated a way of understanding humanity that remains relevant in many parts of the world today—the Cartesian dualism. This dualism, in its most basic form, concerns a supposed division between the body and the mind. In their article ““The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology,” Nancy Scheper-Hughes and Margaret Lock highlight its importance in biomedicine when they write: “A singular premise guiding Western science and clinical medicine...is its commitment to a fundamental opposition between spirit and matter, mind and body, and (underlying this), real and unreal,” (Scheper-Hughes and Lock 1987:8) and go on to explain that this way of thinking has played a part in the development of a “radically materialist” (ibid.) orientation in Western biomedicine that looks to the body as the locus for both illness and potential treatment. This is notable because these are not a universal conceptions of the self, illness, or

health—something that can be easily forgotten where biomedicine is heavily integrated in society.

In the United States—a nation where the separation of church makes for many secularized public spaces—science has become a sort of authoritative discourse that often serves to mediate between different belief systems across an incredibly diverse nation. In the United States, scientists are often relied upon to produce “objective” knowledge and truth—(ideally) free from special interest or religious belief. At its core, science aims to “discover” some kind of truth (Luhmann 2000:181) through conducting research that purports itself to be as impartial as possible. While some scientists and philosophers, particularly feminist scholars, have taken on this notion of “objectivity” in science, managing to reveal that even knowledge produced through science is subjective and imbued with values (Longino 1990; Martin 1991; Harding 2006; Wylie, Kincaid, and Dupré 2007), many scientists and the public at large still largely view science as the ultimate generator of objective fact(s). Almost anywhere we look in the United States, there seems to be this notion that science is the ultimate determinant of truth.

In support groups, the authoritative nature of scientific discourse in American culture was demonstrated through phrases like “You can’t argue with the science!” and repeated efforts to encourage the dissemination of scientific literature as definitive evidence of ADHD as a legitimate, neurobiological disorder. With the coupling of ADHD and the scientific authority of biomedicine, the disorder shifts away from the image of the “problem child” of the past. According to anthropologist Marc Goodwin, “The problematic behaviors associated with problem children in the early twentieth century often reflect the current symptomatology of ADHD as outlined in the DSM-

IVR—hyperactivity, distractibility, impulsivity, and inattentiveness” (Goodwin 2010:53).

This switch from seeing certain behaviors as problems to seeing them as symptoms is important and reflects a change in cultural attitudes toward problematic behavior.

While ADHD has been variously classified as a neurological, biological, developmental, behavioral, genetic, and learning disorder, for contextualization purposes, it is most useful to think of its broad classification as a “mental disorder” (a term that covers an impressive range of disorders with diverse etiologies). The disorder’s inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) developed by the American Psychological Association also justifies this classification. Since ADHD is a medicalized disorder in the United States, meaning it is seen as being best-treated by biomedical specialists (who are heavily influenced by scientific thought and discovery), it is important to further explore the role of science in American medicine, as well as psychiatry more specifically. In her ethnography of American psychiatry, *Of Two Minds: The Growing Disorder in American Psychiatry*, Tanya Luhrmann explains the role of scientific research in medical knowledge production in the United States when she writes: “The practice of medicine rests on scientific knowledge. That knowledge is the justification of the practice. Yet the practitioners, the pure clinicians, do not produce the knowledge. Knowledge is produced by research...Researchers then are the sine qua non of contemporary medicine” (Luhrmann 2000:159). Here, she refers specifically to medical researchers, as they have become the most important scientists in terms of producing knowledge about mental illness and its treatment. Because these scientists are often looking for material evidence of disorders, and thus, ways to treat the body, it becomes possible to see how proposed solutions to these problems have aimed to “fix”

neurotransmitter functioning in the brain (body), constituting medication as the only or “best” option.

To better understand how a biomedical perspective became dominant within psychiatry (which is the medical specialization that defines and treats ADHD), it will be important to delve further into the field’s history. Before mental illness as we understand it today truly began to gain recognition in the West, symptoms of such illnesses that played out until the late 19th century to early 20th century would best thought of in terms of social deviance and maladjustment. This meant that those who deviated from the norm enough often had to face consequences for their condition (directly through means like imprisonment/institutionalization or indirectly through social exclusion). In the late 19th century, ideas of heritability based in Mendelian genetics became a scientific alternative to understandings of deviant behavior based in morals. At the turn of the 20th century German psychiatrist Emil Kraepelin, played a key role in bringing attention to the heredity of mental problems by creating “an important taxonomy of psychiatric illness by studying symptom clusters and by collecting family histories to trace heredity of traits” (Luhrmann 2000:226). Because these problems were heritable, they were not able to be fixed and there was no hope for ill individuals. It is easy to see how this way of thinking might easily lend itself to eugenic principles, which, though increasingly controversial, remained prominent in Western scientific thought until World War II.

This connection between mental illness and eugenics is confirmed by Harry Laughlin’s *Eugenical Sterilization in the United States* published in 1922, in which he explains that sterilization may be worthy of consideration when one is “socially inadequate.” In this book, Laughlin outlines the ten main forms of “social inadequacy”

that he believed warranted legalized sterilization at the time: 1) feeble-minded, 2) insane 3) criminalistic or delinquent, 4) epileptic, 5) inebriate 6) diseased 7) blind, 8) deaf, 9) deformed or crippled, and 10) dependent including homeless individuals and orphans (Laughlin 1922:430). Criminals and the insane then were not seen as “at fault” for their behavior, but if their problems were seen as a fixed matter of genetics, this also doomed them to a life without the possibility for redemption. Since it was thought that inherited mental illnesses were fixed and incurable, responses included confinement, restraint (Scull 1996:695), and forcible sterilization (Herman 1996:108).

In the early twentieth century, before such genetic explanations completely fell out of favor, the mental hygiene movement and Freudian analysis began to affect the understanding and treatment of mental illness in the United States. The mental hygiene movement was made official in the U.S. in 1918 when John’s Hopkins’ Psychiatrist-in-Chief, Adolf Meyer, in 1918 described the need for a “sympathetic and hopeful attitude on the part of the public” toward mental illness. The “hopeful” attitude here is very important as it pushed for the public to shift its understanding of the cause of mental illness from genetic and inherent to environmental factors such as parenting and diet. Marc Goodwin succinctly describes the objective of the mental hygiene movement when he writes: “The goal of the mental hygiene movement was to apply principles of human psychology to help reform those suffering from mental illness and also prevent mental illness, particularly by addressing focus on detecting problems in early childhood” (Goodwin 2010:55). Here, it is notable that this is the first time that childhood becomes a topic of scientific interest—an important step toward the study of childhood disorders. The mental hygiene movement then created a category of people who were still not

considered “normal,” but many began to believe that these individuals could be helped.

Through the application of the psychoanalytic theory (largely developed and heavily influenced by Freud), psychiatrists began to make an effort to understand mental illness and treat it with psychotherapy so that “by the end of World War II, psychoanalysis completely dominated American psychiatry and was nearly synonymous with it” (Luhmann 2000:212). It is important to note that at this time, psychoanalysis was regarded as scientific and was almost exclusively taught to medical doctors or those training to be doctors. This enthusiasm continued for the most part throughout the 1960s (Luhmann 2000:214) as psychoanalysis remained the preferred method of treatment despite the introduction of the psychotropic drugs like thiorazine (developed in 1954) or lithium (in 1949) which, then, carried considerable side effects (Luhmann 2000: 225-6).

During these years when psychoanalysis reigned as the most popular method of treatment, intense scrutiny of parenting, particularly on the part of mothers, came to the forefront both in academic and popular circles. Mothers (with little mention of fathers) were being held responsible for their child’s behavior. Every aspect of a mother’s child-rearing could potentially affect the well-being and “normal” development of their child (Grinker 2006:79-88). One possible reason that (cis) women are seen as the primary caretakers for children, and thus responsible for their upbringing, may be a matter of biology. This is suggested by anthropologist Michelle Zimbalist-Rosaldo in her paper “Woman, Culture, and Society: A Theoretical Overview” this may be a matter of biology as, typically, mothers are the only ones capable of giving birth to and nursing young children and “are constrained by the responsibility of childcare” (Rosaldo 1974:24). While this biologically deterministic explanation is not entirely satisfying for explaining

why mothers in particular are blamed for children's behavioral deviations, it may still play an important role in determining which parent traditionally spends more time raising (and influencing) children.

Throughout American history, there have been many contradictory messages concerning child-rearing, and quite a number came up at this time. In some ways, this literature seemed to point to the growing trend of constituting the body as inherently "ill" and only achieving "normality" through conscious effort and work toward it. This notion of the natural body being "sick" and requiring work to maintain health is brought up by Scheper-Hughes and Lock in their 1987 article where they write: "Health is increasingly viewed in the United States as an achieved rather than an ascribed status, and each individual is expected to 'work hard' at being strong, fit, and healthy. Conversely, ill health is no longer viewed as accidental...but rather is attributed to the individual's failure to live right," (Scheper-Hughes and Lock 1987:25). The psycho-analytic era (1940s to 1960s) produced moralizing accounts of how to attain and keep good mental health. Anthropologist Roy Grinker first describes mother-blaming among psychoanalysts by explaining that "When mothers weren't being attacked for being too cold, they were being attacked for being too affectionate" (Grinker 2006:86). This shows that in some ways, mothers may have served as a sort of scapegoat for any problem arising in a child's development since parenting "correctly" would require meeting subjective criteria that might vary depending on who you ask. Grinker goes on to demonstrate this point with an anecdote about when he and his wife brought their autistic daughter to a psychoanalyst who spent most of their appointment asking Grinker's wife very specific questions about her early bonding with their daughter, where, any slight

misstep could be used to argue that she was to blame for problems with their child's development. Grinker wraps up the story with: "The doctor told us we weren't doing it right. And that's the last thing I remember about him" (Grinker 2006:101). The notion from psychoanalysis that there many ways to parent incorrectly and that these incorrect ways can have a serious impact on one's child made the line between health and illness impossibly fuzzy or fluid. Behavior and mental health then became a spectrum where "healthy" lay somewhere (imprecisely defined) between extremes. While the doctor visited by Grinker and his family was practicing in the 1990s, psychoanalysis largely fell out of favor by the end of the 1960s.

In the 1970s, there was a crisis in American psychiatry that prompted change in how mental illness was addressed. Grinker gives a satisfying explanation of this newly emerged preference, stating that "There are many reasons for the decline [of psychoanalysis], among them a preference for new and effective drugs over talk therapy and evidence-based medicine that relies on neuroscience, clinical trials, and the scientific investigation of falsifiable hypotheses rather than abstract, unfalsifiable theories like those that fill the psychoanalytic literature" (2006: 99). At this time psychiatry had come to be seen as "less scientific" than other medical professions, and mental illnesses was considered less valid than other ailments. Luhrmann illuminates this point with reference to an official statement from Aetna, an insurance company in the 1970s that began to cut funding for mental health initiatives because "compared to other types of service there is less uniformity of terminology concerning mental diagnosis, treatment modalities and types of facilities providing care" (2000:224). This can be seen as a jab at psychiatry's scientific legitimacy as compared with other types of medicine where "less uniformity"

implies that there is a lack of empiricism.

Indeed, there were two main challenges to dominant psychiatric theory and practice during this time; the first came from within psychiatry. In the mid-1970s, psychologists and other mental health specialists such as social workers and counselors that hadn't previously existed (or were not formally recognized) began to come onto the scene. Once permitted by the government, these new specialists began to test Americans for mental illnesses and even provide treatment with psychotherapeutic methods (Luhmann 2000:225) which came at a much lower cost than the prices charged by psychiatrists (Goodwin 2010:62). Political scientist Rick Mayes and sociologist Allan Horowitz suggest that the separation of psychiatry and psychoanalysis may have propelled the field toward a more materialist, psychopharmacological approach, as the main distinguishing feature of psychiatry was that they had the authority to write prescriptions while others, such as clinical psychologists and social workers, did not (Mayes and Horowitz 2005:265).

Additionally, many emerging psychiatrists in the 1970s wished to reclaim the medical prestige that psychiatry had held in the past, and now felt that science in the form of psychopharmacology served to distinguish their approach to mental illness from "psychoanalysis, to which many of them were openly hostile and which few of them regarded as scientific... They were determined to create a psychiatry that looked more like the rest of medicine, in which patients were understood to have diseases and in which doctors identified the diseases and then targeted them by treating the body" (Luhmann 2000:225). These psychiatrists saw their scientific orientation as both more efficient and prestigious as they were now able to use drugs to treat disorders that did not seem to

improve with psychoanalysis (Luhrmann 2000:203).

By the time that this crisis from within American psychiatry was happening, the field had already garnered heavy criticism from those outside the field as the “antipsychiatry” movement gained popularity. This movement essentially claimed that “the mentally ill were not ill, just unconventional” (Luhrmann 2000:223) and non-comforming. During this time, “groups of ex-patients—always the fiercest critics of psychiatry—armed themselves with moral positions derived from scholars” such as Michel Foucault, Erving Goffman, and Thomas Szasz to argue that they were not sick, but instead just unfortunate enough to have the label of mental illness thrust upon them (Grinker 2006:115). Popular works such as the books (and later, films) *One Flew Over the Cuckoo’s Nest* and *Girl, Interrupted* exemplified and promoted this perspective by normalizing psychiatric symptoms and framing them as a result of, or reaction to strict social and moral expectations.

Overall, this may have been an imprecise critique of psychiatry, but the movement helped bring a number of issues in the field to light. The antipsychiatry movement highlighted biases among psychiatrists when it came to race, noting that the behaviors of people of color were disproportionately pathologized (Potter and Zachar 2008:28-9)—an issue that remains sensitive today (Knowles 1996; Thompson 2010; Harry and Klingner 2014). The dubious inclusion of “homosexuality” as a mental illness in the DSM-II (and its subsequent removal) also ended up being an easy target to attack for those involved in the antipsychiatry movement as this raised questions about the reliability of diagnostic guidelines for mental illness (Grinker 2006:116).

In an effort to further legitimize psychiatry’s scientific viability, psychiatrist Robert

Spitzer headed a committee that set out to create a stronger version of the DSM* that would provide the sort of “uniformity” that was sought by creating rigorous checklists that could be used as diagnostic tools (Grinker 2006:116-117). This committee then aimed to make the DSM-III “a defense of the medical model as applied to psychiatric problems” (Luhrmann 2000:228). It is worth noting here that with the release of this third edition of the DSM in 1980, Attention Deficit Disorder (ADD, the original equivalent of today’s ADHD) was officially included as a diagnostic category for the first time. This attempt to use the empiricism seen in other fields of medicine to understand, classify, and address mental disorders then can be understood as an effort toward producing more accurate or “true” diagnoses. It is here that we begin to see people taking mental health more seriously once again.

Since the release of this powerful diagnostic tool in 1980, Grinker describes how American insurance companies now require the use of DSM* codes. Without them, “insurance companies will not reimburse any patient or doctor for psychiatric care without a DSM diagnosis” (Grinker 2006:110), thus prompting a new phase in the political economy of psychiatric illness. Interestingly, this creates a situation where, affordable access to psychiatric, or even psychotherapeutic care, one must be

* The Diagnostic and Statistical Manual of Mental Disorders, or DSM was first published in 1952 and was essentially intended to be a very basic list of identifiable mental disorders and some associated attributes. The second version (DSM-II) was very similar to the DSM-I in that it was very basic and did not list symptoms for specific disorders in an explicit way, but new disorders were added and there were some shifts in the understanding of mental health between the DSM-I and DSM-II. The DSM-III, however, is closer to what we use to diagnose mental illness today as it contains more specific diagnostic criteria for each disorder, and more in-depth descriptions of what to look for. Since then, the DSM has undergone two major revisions. Notably, in the DSM-IV, ADD and ADHD were no longer separate disorders—instead, ADHD was divided into three subtypes: 1) Inattentive, 2) Hyperactive/Impulsive, and 3) Combined. The DSM is now in its fifth edition. Changes to the diagnosis in this edition included defining it as a “neurodevelopmental disorder” (instead of a “behavioral” disorder), more illustrative examples of what symptoms would look like, changes to requirements for age of onset (now before 12), and the inclusion of information on severity levels.

“diagnosed” with an illness. Given this scenario, what should a mental health specialist do when they have a patient who needs treatment but doesn’t technically meet the criteria for any reimbursable diagnosis? Or what about the ones who need a certain diagnosis so that they can obtain appropriate accommodations for whatever they are struggling with? Grinker answers these questions with a quote from a psychiatrist who was trying to ensure the best possible care for a patient: “With the broad criteria psychiatrists now use, I can legitimately diagnose her with autism and get her into a more appropriate classroom” (2006:133). Here, we can see that this psychiatrist takes advantage of the “broad” or vague language included in the DSM to fit the needs of a young patient who may not fit neatly into one category, or may more appropriately be described with another diagnosis that wouldn’t result in appropriate classroom placement.

It now seems that the validity and empiricism of this diagnostic processes is then undermined by this sort of necessary component involving human judgment and subjectivity, making a number of mental disorders less “real” than more physically manifested illnesses. Here, we are reminded of a tension that arises when illness cannot easily be mapped onto the body. From examining this history of psychiatry in the United States, this tension can be seen when empirical understandings and classifications of the mind prompt oppositional response that highlights the fluidity of human consciousness and behaviors, making it hard to pin down what is “normal” or “healthy.” Such tension plays a role in the development of what anthropologist Marc Goodwin calls “commonsense” critiques (which is to say, they are “non-scientific” or “non-expert”) of mental illnesses that become particularly relevant in discussing ADHD (Goodwin 2010:70). Similar to the way that the antipsychiatry movement dismissed diagnoses as a

way of pathologizing non-conformity, commonsense critiques of ADHD as a diagnosis claim that people, namely children, are only being deemed “ill” because they do not conform to the standards set for them by society. While social context may be important, this “constructed” perspective is often used to argue against treating and accommodating those who exhibit ADHD symptoms. Today, these critiques remain at odds with an increased effort to provide materialist, scientific explanations, full of technical vocabulary in order to “prove” that ADHD is a valid diagnostic category with neurobiological components. This leaves an important question to be answered; can we take differences in human behavior seriously (whether or not they have any biological basis) by both accommodating individuals who exhibit them and treating behaviors that result in suffering, without pathologizing them? Or does this justify its status as a disorder in its own right? To best understand ADHD in America today, it may be important to reconcile the perspectives that are often pitted against one another, even if the result is a bit chaotic (since it would encompass internal contestations that are not so neatly woven together).

ADHD AS A DIAGNOSTIC CATEGORY

ADHD is not a universally recognized pathology, but it is diagnosed in places where “biomedicine is prevalent,” and “the United States makes up a disproportionate percentage of diagnoses of the disorder and disproportionately consumes medication for treating ADHD” (Goodwin 2010:6). As with most other mental disorders, the primary method of diagnosis for ADHD is with the expertise of a psychiatrist or otherwise qualified individual. Unlike more physically manifested ailments (e.g. a bacterial infection or broken bone), there is currently no technology or scientific procedure that can reliably confirm or rule out a diagnosis of ADHD, though studies have indicated that there are some neurobiological and genetic differences between those with ADHD and “normal subjects” (Dos Santos 2014; Moss 2014; Spencer et al. 2007; Tye et al 2014; Weyandt et al. 2013) Still, technologies that provide “medical readings” such as positron emission tomography (PET) scans, functional magnetic resonance imaging (fMRI), histochemical fluorescence, quantitative electroencephalography (qEEG) and even genetic testing are not necessarily useful as diagnostic tools, as they primarily just reflect differences in functioning or structure and interpretation is what gives these differences meaning (Coscina 1997; Dumit 2004:17; Gregg 2009:57-58; Luhrmann 2000:10; Weyandt 2013). Instead human assessment becomes a key in determining whether an individual is affected by the disorder. It is here that subjective criteria may become a powerful determinant in deciding what it means to have a mental disorder and how it will be addressed.

There is notable emphasis placed on diagnosis in biomedically-based psychiatry. This makes it important to consider the factors that go into making such determinations,

like, whether a psychiatrist believes that a patient would feel better if they were to receive medication. Interestingly, when it comes to stimulants American psychiatrists, to some extent, seem believe that these drugs have the potential to increase attentiveness and focus among those who technically do not have ADHD. Through an interview with Dan Pine, a clinical psychiatrist and researcher at the National Institute of Mental Health, Grinker illuminates a potential trend among clinical psychiatrists as Pine discusses how he might approach a situation where a 12-year-old boy is struggling with his rigorous school curriculum:

Now you know this kid shouldn't really have a diagnosis of ADHD...But you think: "wouldn't a little Ritalin or some other stimulant actually help him?" It might. He might do better at school. And the parents are pushing you to do something ... And so maybe you medicate him, and have insurance reimburse for it, and you give a diagnosis of ADHD...see how easy it can happen? (Grinker 2006:135)

In an effort to help their patients, clinicians like Pine then create an awkward category of individuals who technically have a diagnosis on the books (and may even have some symptoms) but are unlikely to have ADHD. As far as Grinker's book *Unstrange Minds* is concerned, the interviewee never reveals how he explains the diagnosis to his patient and the patient's parents. A number of questions can be raised here: What if the boy goes through his entire life convinced that he has this disorder? Is there an acceptable way to explain this situation? What (if any) role would controlled substance laws play here? Should this patient be counted in diagnostic statistics? Can we accept providing medical or pharmacological assistance to those who are really struggling but do not technically meet the requirements for a diagnosable disorder?

While ADHD was not classified as a separate disorder until the release of the DSM-III in 1980, there were a few preceding disorders that bore resemblance to ADHD that are

worth noting. In the first half of the 20th century, “deviant” behaviors associated with ADHD (such as impulsivity and short attention span) were noticed among children (in particular) with certain types of brain damage—particularly frontal lobe ablation (Lange et al. 2010). By the 1950s hyperactivity in particular (now one of the most notable symptoms of ADHD) began to attract medical attention. It was believed that hyperactivity, along with impulsivity and short attention span, was caused by neurological dysfunctions in the frontal lobe rather than “damage” that implied injury (Lange et al. 2010). ADHD symptoms as we now know them came to be included in the DSM-II (published in 1968) under both “Minimal Brain Dysfunction” (MBD) and “hyperkinetic reaction of childhood,” the latter of which was characterized by restlessness and hyperactivity along with some inattentive symptoms such as distractibility and short attention span (Conrad and Potter 2000:562). According to a 1976 study done in which a group of young rats were injected with 6-hydroxydopamine and desmethylimipramine to artificially induce the depletion of dopamine levels and then compared to a control group, scientists found that the rats who had depleted levels of dopamine exhibited hyperactivity and delayed learning. This led scientists to believe that Minimal Brain Dysfunction could be caused by reduced levels of dopamine in the brain (Kalat et al. 1976). This parallels with ADHD today, which is thought to be, at least in part, caused by a certain degree of dopamine deficiency along with decreased neurological activity in the prefrontal cortices (Goodwin 2010:27).

Historically, it is important to note that before 1980, ADHD symptoms remained relegated to disorders of childhood and were believed to improve with age. This changed in 1980, but not due to an explicit diagnostic expansion of ADHD into adulthood in the

DSM-III. According to Conrad and Potter, the third version of the DSM contained vague language, which, they cite in their explanation of the expansion of ADHD into adulthood: “Both subtypes of ADD permitted courses of the disorder in which ‘all symptoms persist into adolescence or adulthood’ or that ‘hyperactivity disappears, but other signs persist into adolescence or adulthood’ ... Thus, the DSM-III definition expanded... criteria” (Conrad and Potter 2000: 562). This is important because it allows criteria for adult and childhood ADHD to remain the same, but also indicates that, as is consistent with other research, the disorder is likely to have different manifestations depending on one’s age and stage of development (Bailey 2010).

The diagnostic expansion of ADHD to adulthood lends credence to locating ADHD in the permanent body, as opposed to a fixable disorder of the mind, so once diagnosed the disorder is present and cannot be fully “recovered” from. This then opens for the possibility of those diagnosed with the disorder being treated with psychotropic drugs throughout their lives. The growing trend of treating disorders with medications for life is explored in depth throughout Joseph Dumit’s book *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Here, Dumit discusses how “treatments” are more profitable than “cures” and for research to continue, drug companies need to continue bringing in profit, meaning that more people must buy and take medications (2012). Thus, since 1980 when ADHD became an open-ended diagnosis, it has made for a very profitable drug market.

Since the 1990s, ADHD has received a great deal of public attention as ADHD has become “the most commonly diagnosed mental disorder among minors” (Mayes, Bagwell and Erkulwater 2008:309). Over the past 25 years, there have been notable

increases in the rates at which ADHD is diagnosed among children (Akinbami et al. 2011) and adults (Conrad and Potter 2000) in the United States. According to statistics reported by the National Ambulatory Medical Care Survey, the cases of ADHD being diagnosed and treated with medication increased 3.2 fold between 1990 and 1995 (Robison et al. 1999), so not only are rates of diagnosis rising, there have been major increases in the sales of stimulant medications over time. Methylphenidate sales alone increased by five-hundred percent between the 1980s and 1990s (Goodwin 2010: 65). Even as America entered the 21st century, stimulant sales and distribution continued to rise in the United States, with a shift from short-acting pills to those considered “extended release” over time (Sheffler et al. 2007:454). This contrasts with the preference for short-term medications among those who misuse stimulants, meaning that they use them without a prescription (Weyandt et al. 2014: 223). This suggests that the surge in medications consumed in the late 90s to early 2000s are likely due to an increase in diagnoses among both adults and children.

This sort explosion of ADHD diagnosis and treatment that has so far primarily affected the United States, although diagnostic rates and stimulant sales are beginning to rise worldwide, particularly in OECD Countries, and even more so in those that are English-speaking (Sheffler et al. 2007). This has drawn the attention of the public and prompted people to start asking what created this situation. One perspective that attempts to explain this occurrence among children, adolescents, and even adults enrolled in school points to disability law and policy in public education.

Starting in 1991 with the expansion and renaming of the “Education for All Handicapped Children Act” to the Individuals with Disabilities Education Act (IDEA),

mental disorders like ADHD that affected school performance were officially considered a disability under federal law. This meant that schools were legally required to provide accommodations for students (with disabilities) such as extra time on tests, private testing rooms, seats at the front of the classroom, and other ways that would allow these students a better chance to fulfill their potential.

Since ADHD “is associated with...poor reading and math standardized test scores, and increased grade retention” (Loe and Feldman 2007:643), there are arguable deficits in functioning when it comes to testing and meeting academic expectations and requirements. Because of this deficit, students with “mild” disabilities like ADHD (that were not explicitly acknowledged under the IDEA and thus were left to the interpretation) were then at odds with the expansion of standards-based educational reforms that were growing increasingly popular across the United States in the 1990s (Minskoff and Allsopp 2003:18). These educational reforms set minimum achievement requirements for completing grade-levels in school and graduating from high school. Amendments to the act made in 1997 included a wider variety of “mild disabilities” than previous laws (Minskoff and Allsopp 2003:11-2), thus bringing attention to the existence of disabilities that had largely been overlooked, while making accommodations accessible for more individuals in the education system. With this amendment, schools were also legally required to provide individualized education programs (IEPs), where educators, specialists, and parents would work together to determine what accommodations would be appropriate for students with disabilities (Minskoff and Allsopp 2003:19).

This brings us to the bigger question of how society determines what it means to be

“disabled.” According to Noel Gregg: “By law, a person with a disability must be compared to ‘the average person.’...The ‘average person’ in the ‘general population’ must be used as the benchmark for determining...functional limitations” (Gregg 2010:48). It seems almost impossible to set a meaningful standard as so much must be based on qualitative data. This is because by using a quantitative cutoff model (as has been suggested) whereby those scoring in the 16th percentile on various cognitive tests are all considered “disabled”, there would be a great number of false positive cases (Gregg 2009:25-26). In practice, it becomes very difficult to differentiate between who is simply struggling with academic material and who is affected by a disabling mental disorder (especially without collecting in-depth qualitative data).

Even with qualitative data, it is still difficult to tell and there is considerable variation in performance amongst those suffering from the same disorder. In understanding and defining disability by contrasting it with the function of “average” individuals, low achievement then has the potential to become a determining factor in deciding that someone is “disabled” and thus in need of accommodation or treatment. Narrowing ideas of “success” and “achievement” have made it so that “low achievement” in academic settings (“a condition manifested theoretically by 50% of the population,” [Kavale and Forness 1998]) has become the primary indicator (and justification) for disability in the classroom. Eloisa Cleaveland eloquently elaborates on how narrowing ideas of what constitutes success in the United States with reference to the rise of “smart drugs” (stimulants used to treat ADHD) as an effort to improve academic performance:

Yet smart drugs lend themselves to a very narrow definition of success: one defined by comparison and measured by external results. To be this kind of successful, we must be better than: better than our coworkers, our classmates, our natural self. The more people we surpass, the more successful we become...It is a symptom of our

increasingly narrow definitions of success and achievement that being average is not good enough. But the problem is that not everyone can be above average: if we measure success by this rubric, half of everyone must necessarily fail and only a small percentage can ever be truly successful. (Cleaveland 2016:238)

In the same vein, Conrad and Potter argue that underachievement has been pathologized and medicalized because tolerance for traits or symptoms associated with ADHD in America has decreased (Conrad and Potter 2000). While some sources claim that drugs used to treat ADHD have different effects on those with the disorder versus those without (Lakhan and Kirchgessner 2012; National Institute on Drug Abuse 2014). This is reminiscent of the interview that Grinker conducted with Dan Pine, a clinical psychiatrist who explained how easy it can be to prescribe drugs in an attempt to ease the suffering associated with not being able to keep up with a rigorous curriculum. This is the perfect example of how underachievement can be medicalized in the name of easing academic struggle, for which, there is now a supposedly lower level of tolerance. Grinker also brings up the subject of parents who push doctors to do something to help their children. It seems that, in some ways, parents of academically “low achieving” students, preferring to imagine their child as exceptional but hindered by disability instead of “below average” then turn to learning disabilities (such as ADHD) as a scapegoat for their child’s low achievement. If they managed to find someone to diagnose their child with ADHD for example, since the treatment and accommodation of this disorder can help anyone regardless of the presence of a disability, the child’s chance of academic success improves. This potential scenario may be a way to conceptualize the dramatic increase in cases of ADHD in terms of cultural values and changing meanings of disability within educational institutions. This sort of perspective tends to incite bitter responses to ADHD as a diagnosis as they create fear that people, particularly “wealthy

white families” are using their privilege to go “diagnosis-shopping” and “game the system” by holding an unfair advantage over others who do not receive treatment or accommodation (Goodwin 2010:94).

DIFFERENTIAL DIAGNOSIS: THE ROLE OF IDENTITY IN ACCESS

This brings up the important issue of access when it comes to ADHD diagnosis, particularly at a young age when interventions are most effective. Referral and diagnostic rates, along with treatment methods, are all likely affected by factors such as race, socioeconomic status, and gender. To understand the current status and politics surrounding ADHD in the United States today, it becomes important to look at who is being affected, how people are being affected, and how it is being talked about. According to journalist Peg Tyre, ADHD tends to be most commonly diagnosed within two populations: 1) wealthy white boys attending schools with overwhelming expectations for academic achievement, and 2) poor black boys attending overcrowded, under-funded schools (Tyre 2008:111). Thus there seems to be an interesting trend with race among those diagnosed with ADHD.

RACE AND SOCIOECONOMIC STATUS

One example of a diagnosed case of ADHD within the affluent group exists within Blake Taylor's autobiographical text *ADHD and Me: What I learned from Setting Fires at the Dinner Table*. In this book, Taylor—a young white male from a privileged, upper-middle class background who attends schools with intense academic expectations in Connecticut and California—describes the manifestation of his ADHD symptoms throughout his life, and the treatment he received that has helped him cope with problems related to this disorder. On the other hand, the film *I am a Promise* (Raymond 1993) is about an underfunded, mostly black and impoverished elementary school in Philadelphia. In this film a young boy named Cornelius is known for having behavioral issues. Cornelius is on medication for ADHD so that his behavior can more easily be managed. However, it seems that either treatment is not going according to plans set by his doctor

(for any variety of reasons) or that the pills prescribed are not effective. In this film, unlike Taylor's book, we are getting an outside perspective on what it is like to have ADHD. While in Taylor's case, his ADHD allows him access to disability accommodations and services, young Cornelius instead is threatened with suspension and strongly encouraged to take his medication; meanwhile, his parents face repeated calls and meetings with school officials about Cornelius's behavior.

There is also an interesting trend with who is making decisions regarding referral and diagnosis. The role of schools in referring suspected cases of ADHD for diagnosis, particularly among children, is important to consider as it shapes how ADHD is identified. In her dissertation "Gender and Ethnicity Referral Bias for ADHD: The School's View," Dahl Rollins examines referral bias for ADHD among teachers and outlines some interesting trends. According to her study, while black teachers would refer students for ADHD diagnosis (by either contacting parents or informing administrators and counselors) at consistent rates across all racial categories, white teachers would disproportionately refer students of color, citing behavioral issues as the main reason for referral. This suggests that there are race-related biases among white teachers who disproportionately view the behavior of students of color as potentially pathological.

At the same, in their article "Racial, Ethnic, and Language Disparities in Early Childhood Developmental/Behavioral Evaluations: A Narrative Review," Zuckerman et al. raise concern over the fact that children from racial/ethnic minorities tend to be diagnosed with developmental and behavioral problems at lower rates and at later stages (with more severe symptoms) than racially privileged children. According to the authors, Latino and African American children are less likely to be diagnosed with ADHD, and,

when they are, they are less likely to receive proper treatment (Zuckerman et al. 2014:619). Similarly, the article “Are Minority Children Disproportionately Represented in Early Intervention and Early Childhood Special Education?” by Morgan et al., there are significant racial disparities in early childhood special education where minority students are underrepresented. In laying out potential explanations for the low rates of early ADHD diagnoses among black students, the authors cite the following: 1) black parents are more likely to have a negative attitude toward mental illness and pharmacological treatment, 2) black parents may be more reluctant to utilize mental health services, and 3) medical practitioners are less likely to determine that an illness necessitates treatment among racial and ethnic minorities (Morgan et al.2014:909-910). The noted differences and conflicting data regarding representation (in Morgan et al. and Zuckerman et al.’s works) and referral bias (as demonstrated by Rollins) may be explained by a trend that has yet to be examined more closely. Nonetheless, medical racism has been and continues to be well documented (Hoberman 2012).

GENDER

Gender also plays an important role in determining who receives diagnostic referrals and ADHD diagnoses. Given the prominence of the Western gender binary the majority of the literature on the subject compares referral and diagnostic trends among boys and girls, with boys being diagnosed with ADHD at higher rate than girls. In one study, it was revealed that in the 1990s 80 percent of children diagnosed with ADHD in primary school were boys (Pellegrini and Horvat 1995:13). A number of authors argue that this disparity means that girls are being underdiagnosed, or diagnosed later because

their symptoms are different from boys' and less likely to be disruptive (Adams 2007; Dunkin 2009; Gurian 2016).

Professor of child and adolescent psychiatry Anita Gurian argues that because girls are socialized to behave quite differently (and in a way that is less disruptive) than boys, their ADHD behavior is less likely to get noticed (2016). Gurian demonstrates how this may easily occur (especially when most ADHD references come from teachers) by describing two potential scenarios between female and male students; While the girl is quiet, doodles in her notebook, sits in the back of the class, and sometimes gets distracted resulting in a failure to finish work on time, the boy in Gurian's scenario interrupts the teacher, fidgets, and frequently struggles with academic material. Gurian seems to imply that these behavioral differences are primarily learned behaviors rather than being based in developmental or hormonal differences.

On a similar note, some individuals like Abigail Norfleet-James believe that some boys diagnosed with attentional problems are actually "normal boys" and that "the diagnosis has become a popular way to deal with very active boys whose behavior can be disruptive and who show little interest in school" (Norfleet-James 2007:89). With this, Norfleet-James seems to imply that boys are over-diagnosed, rather than girls being underdiagnosed. In a Huffington Post article: "Why Boys Are Failing in an Educational System Stacked against them," educational psychologist Lori Day refers to evolutionary reasons for "disruptive" behavior in school that might lead to a diagnosis of ADHD, comparing boys to "young hunters" who need their brains to be stimulated by physical interactions with different environments (2011). She even goes on to pose the question: "How much Ritalin could remain on the shelves if we created schools that are ready for

boys rather than boys who are ready for schools?” Day implies that boys are not “ill” or “disordered” but instead, they are participating in a system that does not accommodate certain gender-specific behaviors.

Regardless of whether boys or girls are “under” or “over” diagnosed; primarily learned or based in biology—everyone seems to agree that gendered behavioral differences exist and notable impact on ADHD diagnosis. Mary Dunkin does a different take on these “differences” by examining them in relation to the three types of ADHD (inattentive, hyperactive/impulsive, and combined). As might be predicted, she claims that boys are more likely to have hyperactive-impulsive or combined types of ADHD, girls are more likely to display predominantly inattentive symptoms (Dunkin 2009).

According to more recent work, it seems that the diagnostic ratio has evened out significantly as children meeting the diagnostic criteria for ADHD in 2008 (when the DSM-IV [with text revisions] was being used) were 51 percent boys and 49 percent girls (Mahone 2012: 34). It seems possible that, diagnostic trends have shifted due to raised awareness and attention to this issue of disparity between genders. Another possibility worth considering is that the three types of ADHD may be gendered according to normative gender-specific understandings of problematic behaviors.

FUELING CONTROVERSY: PUBLIC SOURCES OF INFORMATION ON ADHD

In a piece entitled “American Culture and ADHD” the journalist Ethan Walters states: “In certain historical moments, a given diagnosis will hit such a resonant cultural note that it catches fire. This, I believe, is the story of ADHD.” This quote reflects how ADHD has proliferated in the media and among members of the American public as a popular topic of conversation. So where are most people getting their information about ADHD from? These sources might include newspapers, magazines, blogs, and other forms of widely available and easily accessible media.

In addition to print media, some radio stations like National Public Radio (NPR) also air informational pieces where radio hosts will first attempt to draw the listener in by hinting at what a given research study has found. The radio host(s) then proceed to summarize the main findings of the study in lay terms with the help of either the author(s) of a given study or experts in the subject matter at hand. Many of these pieces attempt to highlight why the information being discussed may be important and who it affects, often prompting listeners to consider how it could be relevant in their own lives.

One recent example of this was a piece done on adult ADHD which has largely gone undiagnosed (Neighmond 2016). This four-minute segment starts by informing the audience that ADHD can affect even older adults (which may come as a surprise to some as it has long been considered a “childhood disorder”). Then, the audience hears an older woman named Kathy talk about her experience as an adult and how she came to be diagnosed with ADHD. Neighmond interjects at some points to succinctly summarize important parts of the story, which helps keep it from feeling too drawn-out. After the narrative gets to the point of diagnosis, the program brings in a highly regarded

psychiatrist to discuss ADHD diagnostic trends and facts, highlighting why it is good for even older adults who are no longer working or in school to get a diagnosis and seek treatment.

This sort of reporting seems to focus on disseminating information directly from experts, while including the perspective of people that a phenomenon, in this case, long-undiagnosed adult ADHD, affects, thus making itself an appealing and accessible option for those who listen to the radio. While they are not go into much depth, they do provide a fairly accurate overview of an issue that may prompt listeners to do their own research should they desire to. The audience targeted by pieces like this seems to be fairly broad (the American public).

Interestingly, response to this radio segment (and its corresponding article) seem to be largely in response to hearing Kathy's symptoms and diagnosis. A number of comments seem to claim that if the symptoms she discusses on the air mean she has ADHD, then they (along with everyone else) likely have ADHD too because forgetting things is, to some extent, part of human nature. Others seem to claim that American lifestyles and technology lead to a state of disjointed multi-tasking that is bound to result in forgetfulness. These comments reflect the prevalence of skepticism regarding ADHD as a medicalized diagnosis. Other commenters refute these claims, using scientific justification and the gravity of some of ADHD's consequences.

Beyond journalism, another important source of information about ADHD that is available to the public are pharmaceutical ads. Direct-to-Consumer advertising (DTCA) is the advertisement of prescription drugs to the public (rather than directly to health professionals who prescribe drugs—as it had been) that grew in popularity most notably

from the late 1990s through the 2000s (United States Senate Special Committee on Aging 2008: 3). These ads have become so ubiquitous in the United States that they hardly seem notable to many Americans today. However, the United States is somewhat unique in its relationship with DTCA. The only other country where this type of advertising is legal (New Zealand) is already engaged in serious discussion on banning this practice (Hoffman and Cooper 2003).

This becomes relevant in discussing the popular perception of ADHD. Lawrence Diller is one of ADHD's most prominent critics or "skeptics". Diller uses his authority as a Medical Doctor to create a convincing narrative (citing statistical data, history, international comparison, and other research) that prompts Americans to be suspicious of Direct-to-Consumer marketing trends that may have influenced the rise of ADHD in the 1990s and the ever-increasing rates of treatment with stimulant medication (Diller 1996; 2001). Marc Goodwin makes an important note about how the kinds of journalistic pieces that tend to be produced promote ADHD's controversial image, often by engaging in "false balancing" where the arguments of a handful of ADHD skeptics are posed as having equal weight to a vast majority of experts in related fields. To emphasize his point, Goodwin even brings up an analogy drawn by one of his interlocutors who claimed that ADHD skeptics were comparable to climate change deniers (Goodwin 2010:16,74). This is demonstrated through the prevalence of Diller's work which receives a disproportionate amount of attention in the press.

In his book *Drugs for Life* Joseph Dumit details DTCA practices and explains that the promotion of self-diagnosis, destigmatization, and alignment with sufferers in advertisements all help pharmaceutical marketers to boost drug sales while giving

patients “the tools to convince their doctors [that they are ill]” (Dumit 2012:77). It seems that when presented with the vague, subjective, and relatable criteria for illnesses like ADHD, this begins to raise flags that their behavior might be pathological if they feel that their (or their child’s) behavior does not fit within the range of “normal.” These individuals then are likely to seek a diagnosis. Doctors, not wanting to turn a patient away without trying to help them, may comply with the patient’s desires to be treated (which have been prompted by Direct-to-Consumer campaigns).

To understand the way that drug marketers influence consumers’ understanding of and desire for certain medications, it becomes helpful to think about cognitive accessibility. According to Ruth Day, “Cognitive accessibility is the ease with which people can find, understand, remember, and use medical...Information, and do so in a safe and effective manner. Cognitive inaccessibility occurs when people have trouble with one or any more of these processes” (United States Senate Special Committee on Aging 2008:43). In her study of the DTCA of prescription drugs on television, Dr. Day found that risks presented in the advertisements were much less cognitively accessible than the benefits due to a number of factors such as presentation speed and language accessibility. In a recall assessment, people scored an average of 80 percent questions correct for benefits of advertised drugs, while only answering 20 percent of questions about risk correctly (Day 2006:5). In a similar study testing consumer knowledge of stomach bands for weight loss subjects performed well when asked about what the device is, how it works, and the benefits it provides; however, when asked about risks or who should not have such a device, subjects performed quite poorly (United States Senate Special Committee on Aging 2008:41). Dumit aptly summarizes the objective of

pharmaceutical companies and advertisers as maximizing the number of new prescriptions while ensuring that patients stay on medications for as long as possible (Dumit 2012:6). Because of this, drug companies and partnered marketers invest a great deal of time and money (the latter being a material privilege that successful companies have) While evidence suggests that the effects of DTCA on consumers can be positive; creating a more informed public (and more informed patients), prompting people to seek treatment for undiagnosed illnesses, de-stigmatizing certain disorders, and promoting shared decision-making between doctors and patients (ibid.:3), as we have seen it can also exaggerate benefits while underplaying risks of what is being advertised, and even strain the doctor/patient relationship (with the patient having unrealistic expectations and demands). Studies even show that doctors may be more likely to prescribe requested prescriptions, rather than more appropriate treatments (United States Government Accountability Office 2006:16).

By examining how Americans are exposed to information about health and ADHD in the media, it becomes possible to see how these sources that use vague examples and ask Americans whether they relate to a slew of symptoms can have implications on understandings of diagnosis and biomedical credibility. Some Americans may relate to an ad or story and go to doctor with concern that they are ill (and may or may not receive a diagnosis and/or prescription). Others might recognize the broad and relatable criteria, and begin to dismiss the disorder at hand all together. These interactions with the media are important to understanding some of the dynamics behind ADHD's status as "both the most extensively studied mental disorder and the most controversial" (Wolraich1999:163).

ETHNOGRAPHIC OBSERVATIONS: AN INTRODUCTION

ETHNOGRAPHIC CONTEXTUALIZATION

For the following two chapters, I would like to bring more life to the discussion of ADHD in the United States. These chapters are based on my participant-observation at public ADHD support group meetings—both as a researcher, and as someone who has received treatment for “ADHD characteristics” in the past. My position as someone with a diagnostic status that was legitimate, yet unclear, granted me an interesting perspective as both an insider and outsider at meetings. Having had experiences with the symptoms of ADHD allowed me to build rapport with other attendees as we bonded over shared experiences and a shared interest in matters related to the disorder. Interestingly, like my psychiatrist’s seemingly uncommitted ADHD diagnosis, support group attendees would occasionally “diagnose” my ADHD symptoms themselves, and at other points, jokingly question whether I “actually” had ADHD.

At meetings, I fully engaged with other group attendees, and made an effort to follow meeting norms to the greatest extent possible (for example, if no one else used a notebook in certain groups, I would avoid using mine during the meeting and instead frantically write down important highlights afterward). When presented with the opportunity, I consistently disclosed my position as a graduate student conducting research in support groups for my thesis, which, was often met with congratulatory responses and offers to provide additional resources. Throughout these ethnographic chapters, I aim to highlight common themes that show how ADHD is defined and experienced by American ADHD support group attendees.

This first ethnographic chapter will highlight the primary symptom-groups related

to ADHD—hyperactive, impulsive, inattentive, and executive-functioning related. I have chosen to structure the ethnographic chapters by symptom because this is how a great deal of popular informational sources lay out descriptions of ADHD. Through this chapter, I intend to elaborate on what each of these symptom groups entail, give examples of observations from support group meetings where these symptoms played out, discuss the effects of symptoms from narratives and comments provided by group participants and organizers, and contextualize these symptoms within American culture more broadly using academic and popular literature.

The second ethnographic chapter draws attention to common sources of tension outside of symptoms themselves that arise in relation to ADHD discussed at support group meetings. These sources include issues like comorbidity of ADHD and other illnesses, shame and stigma, difficulty obtaining accommodations at work and in school, and finally, qualms over the ability to control what will change when attempting to “treat” ADHD because for some, there are some positive aspects of the disorder. Since these issues are primarily based on events outside of the support group setting, this chapter will rely on accounts given by support group members combined with literature-based analysis to reveal how these problems play out in the lives of Americans with ADHD.

Before I go on to describe the atmosphere, functions, populations and types of support groups in more detail, I would like to share a reflexive account of my first support group meeting, so that readers can be introduced in a similar way that I was, before knowing exactly what to expect.

A WELCOME TO THE WORLD OF ADHD SUPPORT GROUPS

As I am leaving work for the day (and very ready to go home), my cell phone's calendar alarm goes off with the event reminder "ABDGHKDW!!!" With no idea what *that* could mean, I proceed to open the attached link my web browser. Suddenly, I'm reminded that I have to make my way to my first ADHD support group meeting (it was only after seeing the meeting webpage that I remembered that every other letter in my reminder spelled out ADHD, and the letters in-between were alphabetically-organized, indirect reminders of the meeting location and theme). Despite the fact that I likely received two emails reminders from the organizer about the meeting time and place in the preceding 24 hours, the information felt very new at the time. Once I realized that the meeting started in ten minutes, I ran to the closest drug store to pick up a reliable notebook and some pens and made my way to the meeting, which (thankfully) was nearby.

The meeting was being held in a private meeting room of a busy restaurant. As a general rule, and when possible, attendees are supposed to purchase food from the establishment. Since I had rushed over in a panic when my alarm went off and forgot to eat dinner, I decided to purchase an entire meal before heading to the meeting room. As I arrived to the room with my tray of food, I found three white women sitting at two different tables and began to ask: "Am I in the right place for the-" but before I could finish my sentence I received an enthusiastic response: "If you're here for the ADHD meeting, then yes you are. Welcome!"

"Oh perfect!" I said with nervous excitement, just before putting down my tray of food and pulling my new notebook and pen out of my bag. While I was doing this, the

silver-haired woman across from me exclaimed, “Look at YOU!” At first, I’m a little confused as to what this is supposed to mean: “Is she talking to me? Did I do something wrong?” I worried. Thankfully, and before I had the chance to respond, she elaborated. “You have your whole set up!” she says, pointing to my plate full of food and notebook. She continues. “You’re even on-time, have clean, unwrinkled clothes, and are organized enough to not have pages falling out of your notebook! You’re doing great, kid! Are you sure you’re not neuro-typical? Ha!” The woman sitting beside her interjected. “What does *that* mean?” The other woman responded with a laugh and explained. “I’m not entirely sure to be honest! It’s kind of just another word for normal, or people who, unlike us, are able to behave normally—I was mostly just excited to try and use the new vocabulary that I’m learning from the internet as well as this GREAT book!” She pulled *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder* by Edward M. Hallowell M.D. and John J. Ratey M.D. out of her tote. I would soon come to find that this is a sort of “must read” in the ADHD support community.

ABOUT SUPPORT GROUPS

Each support group that I attended was a little different, and even the same groups would tend to vary meeting to meeting. Most meetings had some kind of suggested donation, membership fee, purchase requirement, or other form of monetary contribution that would be paid upon entry or toward the end of meetings. These contributions would usually go toward the maintenance of the group by paying for refreshments, using a space, compensating speakers/organizers for their time and expertise, or covering the costs of maintaining a web presence.

As a diagnosis, ADHD itself is broken down into three “types”— 1) Inattentive, 2)

Hyperactive-Impulsive, and 3) Combined. Similarly, support group meetings can be broken down into three categories as well: 1) Informational 2) Shared-Experience based and 3) Some combination of the first two types. Almost all meetings would include at least a bit of both, but very few had an even distribution of time spent presenting information and sharing experiences.

Informational meetings usually meant that the meeting would be in presentation format meaning with a primary speaker (or two) and with or without a PowerPoint for visual aid or reference. Most often, support groups that tended to cater to parents of children or teens with ADHD would fall into this “informational” category. The number of attendees at these meetings could range from as little as seven (myself and the presenters included) to enough to fill a 150-seat room. Presenters at these meetings were often researchers, experienced educators, psychologists, life/ADHD coaches, doctors, advocates, or other specialists who have a great deal of experience with and/or knowledge about ADHD. Usually there would be themes such as: Comorbidity with other disorders, tips for students with ADHD transitioning to college, alternatives to medication, navigating the process for getting a child with special needs “in the system” at their school, tips for timeliness, how to improve organizational skills when normal methods don’t work, tips for parents on how to deal with the (neuro-typical) sibling(s) of a special needs child, what rights one has under the Individuals with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA), and the different types of diagnostic testing and how to access them. At these meetings, introductions tend to be very brief or non-existent. Generally, the larger the group, the less likely it is that attendees will learn about one another. During these informational meetings, it is

common that only a few people are able to talk at any length. Often, attendees who take the floor are individuals who came to the meeting for a specific purpose and have a question or series of questions that they want to have answered. Often, they will not stay for the entire meeting and will leave after asking their questions. When there is a guest speaker, regular attendees and group organizers tend to make an effort to ask broad questions that are likely to be relevant for most of the group.

Shared-experience based meetings were primarily geared toward adults with ADHD and individuals who identified with ADHD symptoms. Attendance for these meetings usually ranges from 11 to 20 participants. Rather than everyone facing a single presenter or screen, as was the case with informational meetings, at shared-experience based meetings attendees are seated in a more intimate arrangement: an approximate circle where everyone is able to see one another. Occasionally there are planned themes at these meetings, though they served more as a guide for when people are unsure of what to talk about. Other times, the group would decide on a topic that to work on or discuss that day. This could be decided through suggestions, where attendees would make “bids” for their topic of choice, or it would be determined by the group organizer.

One commonality that shared-experience based meetings all had was that we would go around the room and introduce ourselves, one person at a time. These introductions are usually initiated by meeting organizers five to ten minutes after the meeting is supposed to have started (often, with an understanding acknowledgement that people with ADHD often have trouble making it to places on time). The organizer would usually start these rounds by asking everyone to say their name, explain a little about themselves and their ADHD (or lack thereof), why they chose to attend the meeting, and what they

are looking to get out of it. Everyone is allowed to “skip” if they are uncomfortable, but most people give at least a brief introduction. If not during the introduction, there would always be a round in which everyone would talk about issues related to their ADHD that have been coming up for them recently.

As might be expected in a group where a significant number of individuals struggle with impulsivity, it can be difficult to get through a round without interruptions. In her ethnography *Bipolar Expeditions: Mania and Depression in American Culture*, Emily Martin describes the acceptance of what would normally be considered aberrant behavior within support groups for bipolar disorder: “related to the groups shared diagnosis, group members tolerate strikingly unusual behavior, up to a point” (Martin 2007:144).

Similarly, in the ADHD support groups that I observed, many attendees tended to be patient and understanding about interruptions, disruptions, and other deviations related to ADHD. Unfortunately, this can sometimes cause those with attention issues to lose track of what they were saying entirely. This is where the tolerance of symptoms becomes somewhat limited, because interruptions can inhibit the supportive functioning of the group and lead to unfair domination of the conversation. In response to symptom-based derailments, group organizers often act as facilitators, and occasionally put rules in place to ensure that everyone gets a chance to speak. The most popular of these rules seems to be: “raise your hand when you relate to something instead of responding verbally.”

Organizers may also ask that everyone turn off and put away electronic devices, and that attendees leave the room if anyone feels the need to move around or use their phone.

When rounds are “broken” by interruptions, the group organizer will usually gently remind the group of who was talking, what they were saying, and about how we should

let them finish so that we can get around to everyone. In a different setting, authority figures in the room may not be so tolerant, patient, or understanding.

Similar to bipolar support group meetings, attendees at every type of ADHD support group would “tolerate descriptions of extreme behavior in an unruffled manner,” (Martin 2007: 145). This supportive and relatively judgment-free environment seemed to be one of the most appealing factors of attending support groups.

On top of a tolerant and accepting atmosphere, all support groups lent themselves to a certain brand of relatable humor that helped people ease into meetings and make light out of the stress in their “disordered” lives as parents of children with ADHD and individuals with ADHD. A memorable example of this occurred at an informational meeting, where a guest speaker posed the following question to a room full of parents of children with ADHD: “Has anyone seen a functional three-ring binder of a child with ADHD?” After a brief pause, he followed with:

This, my friends, is because they simply do not exist. They’re a disaster waiting to happen. All the papers need holes, the teachers often don’t the punch holes, this results in kids shoving things into the binder all willy-nilly, or, even worse: simply dumping loose papers into a backpack. A backpack that likely has other loose papers, writing utensils, maybe some lunch wrappers or a sock. It’s a sight I’m sure you’re all familiar with.

The room broke into a polite but genuine round of laughter while many began to knowingly nod their heads. Murmurs of “Yup!” and “So true,” filled the room. It is easy to see how this would be appealing to any struggling parent—it takes a distressing aspect of day to day life and turns it into something that can be bonded over and laughed at. This can help to create a sense of community and belonging among people who, in other venues, may feel alienated by their child’s differences from the “norm.” According to

anthropologists Rayna Rapp and Faye Ginsburg describe this community building when they write about communities concerned with Learning Disabilities around New York City: “Parenting with a difference first reverberates through family life, creating new understandings and orientation of...’life as we know it’...Over time, many use the idioms available to them to reach out beyond the world of kinship to forge a new arena of public intimacy where atypicality is the norm” (2011:406). This public intimacy and the situational normalizing of differences both occur in the support group setting and make them a comfortable setting that is (relatively) judgement-free.

In shared-experience based groups, similar jokes are made in an effort to relieve tension. One example of this was when someone in a group was on the verge of tears. Discussing how she was fired for not being able to listen to instructions and focus on work when someone retorted, “Hey now, I can tell you: been there, done that! I mean, is there anyone with ADHD who *hasn’t* been fired? It should really be part of our group initiation at this point!” Smiles broke across faces around the room. Being fired is usually a topic that is embarrassing and difficult to talk about, but with a sense of humor and pride, this group opened up as others began to chime in about their experiences. At one point, the organizer asked us to raise our hands if we had ever been fired. Hands began to go up all around the room with only two exceptions—myself and another attendee. The jokes continued, this time aimed at me and the other individual who failed to raise their hand: “Give us your secrets!” and “Are you sure you belong here?! Ahhh, I’m just messing with you!” After a bout of laughter, the conversation shifted to techniques that could be used to “pass” or otherwise cover one’s symptoms so that they had minimal negative effects on the workplace.

ETHNOGRAPHIC OBSERVATIONS: THE SYMPTOMS

HYPERACTIVITY:

Hyperactivity is often one of the first symptoms of ADHD identified by parents and teachers that is believed to warrant some type of intervention. If one is “hyperactive” this means, as the name implies, that they are functioning at an activity level that is considered above or beyond average. The manifestation of hyperactivity is often clear from the outside. At support group meetings, among those who were identified (or who had children who were identified) as having symptoms of ADHD at a young age, almost all were hyperactive as children. This meant that they were in a sort of constant state of action. These actions tended to include getting up from one’s seat, talking too much, shaking, fidgeting, rocking, doodling, or otherwise engaging their body in some sort of activity.

To my disappointment, during my time in meetings I never observed any behaviors that I could clearly identify as “hyperactive.” From what I had read, I had prepared for this symptom to be the most noticeable, and yet I was unable to find it. Interestingly, while I had trouble finding hyperactivity “in action,” potential signs of my own hyperactivity were pointed out to me by other group attendees on multiple occasions. The first time this occurred was at a shared-experience based meeting, where, the same woman who “welcomed” me to the group with “Are you sure you’re not neuro-typical?” came in late and got settled into her seat next to mine. I was writing down helpful tips that were being given by the group organizer at the time and hadn’t realized that my foot was shaking rapidly as I wrote. As she looked for a place to set her purse, she noticed my shaking foot (which may have prevented her from being able to put her

purse down on the side I was on—unfortunately something I hadn't thought about in the moment). I then heard her trying to speak loud enough so that I would hear, but quiet enough to avoid completely interrupting the speaker: "You know," she started, "even that can be a symptom of ADHD! Your leg, I mean. But don't worry, I do it too!" She gave me a friendly smile, and I, now aware that others were noticing my leg, whispered an apology. For the rest of that meeting I made a conscious effort to stop shaking my leg and foot as I was reminded that it is a habit that can bother or otherwise affect those around me. To redirect my nervous energy, I began to doodle and shade in parts of the page in my notebook while listening. Of course, this only garnered a second response from my neighbor at the table who commented that "doodling can help channel the need to move among people with ADHD." I took her using the phrase "need to move" as an indication that she was referring to hyperactivity symptoms.

The third time that hyperactivity came up in a very direct way for me was at a combined-type support group meeting where the group of about ten attendees was mostly composed of parents/guardians of children with ADHD. We quickly went around and did introductions to give speakers a little bit of information about ourselves. I introduced myself as a graduate student who was looking to learn more about ADHD in American culture through support groups, but who also, after being asked a series of questions by a psychiatrist at the age of 17 along the lines of: "do you often get in trouble at school for forgetting about or losing your assignments?" was prescribed stimulant medication that came out of a bottle that read: "take three times a day for ADHD." After my introduction, a mother at the meeting replied: "You know, I was tempted to ask if you were ADHD, 'cause my son does that same thing with the leg." Before I could respond to her

comment, the guest speaker at the front of the room exclaimed: “Ah! A researcher, but a little on both sides!” and proceeded to ask what my field of study was.

I remain unsure as to whether my leg-shaking or margin-drawing truly embody hyperactivity. Regardless, the fact that others noted these behaviors serves as a reminder that, activity itself (whether or not is within the norm) is observable and can be potentially disruptive. Since hyperactivity is activity that goes above or beyond average, it is easy to see how “extreme” physically manifested symptoms can be noticeable and disruptive. One common manifestation of hyperactivity found by anthropologist Marc Goodwin is what he describes as “body-rocking,” which is “a repetitive rhythmic action whereby the trunk of the body acts as a lever or motion arm, usually by it being bounced off the back of a chair, or cushion, which is used like a spring” that serves as a form of self-stimulation (Goodwin 2010:33). Noticeable symptoms like body-rocking, constant talking, or always being on the move make it possible for even the busiest teachers with large class sizes to pick up on potential cases of ADHD. I mention this, because those at meetings with ADHD diagnosed at an earlier age tended to be incredibly hyperactive as children, but from listening to the varied experiences of adults with ADHD, it seems that hyperactivity changes forms over time.

When adult support group attendees described their own experiences with hyperactivity, they often brought up experiences from childhood where they used phrases like “constantly buzzing” or “couldn’t sit still.” A comparison to the “Energizer bunny” was drawn more than once. Among adults who discussed their experiences with hyperactivity, it seemed that many described it in a way that made it sound as if it was no longer a major concern. One woman said that her hyperactivity issues dissipated as she

got older. This seems to fit the common narrative of kids “growing out” of hyperactivity (one of the primary reasons that it was long considered a “childhood disorder”). One suggestion of why this may be the case, according to a study released in 2007, is that overall, the brains of those with ADHD are maturing at a slower rate than average, with the exception of their primary motor cortex; as the rest of their brains “catch up” they begin functioning at a more appropriate level (Shaw et al. 2007: 19651). While this biological explanation may explain some cases of why ADHD is “grown out” of, some support group attendees report dealing with hyperactivity into adulthood, indicating that this may not explain every case. Two men at different meetings claimed to still have hyperactive symptoms. One man claimed that he was still hyperactive, but that, once he was out of school and able to choose an active and social career that suited him, it was no longer a problem.

This sort of story plays into the narrative of ADHD as a social construction—symptoms are symptoms because of the structures and rules that we use as a society to regulate physical and social bodies. Adam Rafalovich, for example is a sociologist who argues for this perspective, claiming that the medicalization of childhood or treating deviance as a medical problem, and has led to the prevalence of ADHD diagnoses (Rafalovich 2013). This helps explain what happened with the man from the support group because growing up, he was unable to fit into the school structure that was imposed on him, so he was deemed “ill” because he was unable to stay in his seat like a supposedly “normal” student. While this may oversimplify a complex matter, there remains some value in this perspective.

Unfortunately, many Americans are not as fortunate as the previous speaker who,

once out of school, was able to enter into an “active” career, and it seems in some ways that hyperactive individuals trapped within these structures suffer more in their professional lives

The second example of hyperactivity that persisted into adulthood speaks to this point. Here, a man explained that while his hyperactivity “changed forms” and became more manageable, the drive was still there. A number of others in the group raised their hands when this was said, indicating that they related to this assertion. It then becomes easy to see how coping becomes key for getting by for those with ADHD in American society. This effort to make symptoms more manageable is one of the primary goals of support groups, as everyone tries to share tips with one another about how to cope with their symptoms or prevent them from bringing about serious consequences for their well-being.

An understanding of how stimulation works with ADHD is salient in a discussion of coping with hyperactivity. The primary way of satisfying the urge to engage in hyperactive behaviors when one is in a setting that is not amenable to hyperactivity (such as an office, where a full-blown display of symptoms could be perceived as a problem) is to find a way to find a non-disruptive form of stimulation that works for the individual. In support groups, a few attendees have suggested listening to music (without lyrics, which, could become a distraction) as a way to do this when hearing others is not necessarily required. As a study on ADHD and music would suggest, listening to music did not improve task performance for everyone and instead served as a distraction for some individuals with ADHD (Pelham et al. 2011:1094).

Other attendees who have sought coping mechanisms for bouts of hyperactivity

have tried to keep “fidget items” to use at their desks (such as stress balls, magnets, or silly putty) to engage with and to find ways move around inconspicuously. While these forms of stimulation may seem like it could make it harder to pay attention—and according to a study conducted by Sarver et al. (2015), this is true for typically developing children engaging in “higher rates of gross motor activity” who would hit their optimal task performance threshold while less active, however, remaining active through movement and “fidgeting” would often have a positive effect on the ability of children with ADHD to perform a task, particularly those involving working memory (1029-30).

At informational support group meetings where the audience is largely composed of parents and educators who wish to learn more, it is not uncommon to hear their voice frustrations that come with trying to keep hyperactive children out of danger and trouble. One example of this arose in children who display hyperactive behaviors often. Many times, medication is recommended to address the behavioral issues related to hyperactivity. Stimulants are the most commonly used variety of drug to address ADHD. This is because, according to the medical literature, the ADHD brain is naturally under-stimulated and according to a neuropsychologist who spoke at a combined support group meeting: “the ADHD brain [also] lacks dopamine receptors.” Hyperactive behaviors help satisfy this under-stimulated brain, and arguably enable it to function in other ways (e.g. working memory).

However, hyperactive behaviors can become dangerous, disruptive, and out of control. When these behaviors fall into any of these categories and become difficult to monitor and manage (as they often do in a classroom of about 20 or more children per

teacher), the same benefits gained from moving around (for individuals with ADHD) can be provided with stimulant medications that imitate the chemical changes (increased levels of dopamine) that occur when individuals with ADHD engage in high levels gross motor activity. While this can be effective in keeping students from distracting others and requiring constant vigilant monitoring on behalf of the teacher, it may not help students to actually learn or improve performance—especially when students also struggle with inattentiveness (McCormick 2003:623).

Between brain maturation and developing coping skills, many adults seem to have more of a handle on their symptoms of hyperactivity than they did when they were younger (if they are affected at all). Studies on hyperactivity continually use children as their population of interest. This indicates that hyperactivity, ADHD's most noticeable symptom, is primarily thought to affect children. This would have a number of implications. If ADHD's most notable symptom mostly affects children, it is easy to see how it is believed that children will inevitably "grow out of it," something that itself has further implications to be discussed later in this chapter. This also means that individuals with ADHD who did not display symptoms of hyperactivity as a child are more likely to go undiagnosed for a longer period of time. Because ADHD affects one's ability to function in American society, this may have implications for them, especially if they are not diagnosed until they reach adulthood.

According to philosopher Susan Hawthorne, there is an institutionalized intolerance of ADHD in the United States, meaning that our established systems do not typically value traits related to ADHD or their manifestations (Hawthorne 2010). One way that we can see this is that in the United States, sedentary desk jobs are increasingly

seen as the way to financial stability or the middle class. This has become especially true as more physically active jobs in manufacturing have been on the decline for the past three or four decades (Martin 2007:41). This can make it very difficult for adults with hyperactive and impulsive tendencies to follow office etiquette, which could lead to social or functional consequences at work. Even more than in offices, it is important to note that many classrooms do not support, or in some cases, do not even tolerate hyperactivity or impulsivity as children are required to sit still for extended periods of time.

IMPULSIVITY

There are two ways of being impulsive: 1) acting without considering results and 2) acting with minimal concern over the outcome. It is best, however, not to get caught up in this distinction, as it lays somewhere in a murky moment of the mind. This mindset is often difficult to access or make sense of when reflecting. At support group meetings, it is not uncommon for people to explain that they are constantly asking themselves why they did something or how they could do something. Often, they seem genuinely confounded by their own past behaviors and are unable to access their reasoning from the time. For those with ADHD, impulsivity can mean that courses of action are chosen based on what seems more gratifying at any given moment, rather than considering what would be best in the long term—this gratification, can, like other forms of stimulation, raise dopamine levels in the brain. The impulsive frame of mind has been succinctly described by a group organizer (with ADHD) who likes to say: “For people with ADHD, there are two times—*now* and *not now*.” Hearing this usually brings a bout of laughter and wide-eyed nods to the table. This joke is funny in this moment, and sometimes there is a

certain “freeing” appeal of “living in the now,” but it’s not usually so funny having to see the way that this plays out in the lives of individuals with ADHD where the consequences are often anything but appealing.

On the less severe (low-risk) end of symptoms and results of impulsivity, there are behaviors that violate social norms that dictate what is polite or expected versus rude or deviant. Sanctions for these violations tend to be informal and inconsistent. A number of common low-risk deviations related to impulsivity that serve as a source of tension for those with ADHD were both discussed and on display at support group meetings. These low-risk deviations include actions such as interrupting others, getting up from one’s seat at inappropriate times, acting impatiently, and making careless comments to others.

Interrupting others and getting up at inappropriate times are two low risk deviations that played out in support groups. Because support groups are “hyper-zones” of ADHD, these deviations are generally well-tolerated by attendees. One example of impulsive interruption that was brought to my attention was at a shared-experience based group meeting where a woman with wide and tired eyes who was shaking slightly began to talk about an issue related to ADHD that had been bothering her: the inability to fall, and stay asleep. She continued: “You know, I don’t know what it is, but even my manager—” I guessed that she was going to discuss how having trouble with sleep was affecting her in the workplace, but before she could finish her sentence, a man sitting next to me on the couch jumped in. “But are you taking medication?” he started. Before she had time to answer, he went on, “Because, you know, I had trouble sleeping after I started taking the meds. I just had to talk to my doc about it—switched me over to extended release doses, only to be taken in the morning. Problem there is, by the time the evening rolls around,

it's completely worn off!" It seemed fitting that such an interruption would occur during a meeting in the late evening when he claimed that his medication had usually worn off. This led to a young man chiming in that he also took extended release in the morning. Soon there were too many conversations in the room to keep track of: "Have you tried melatonin?" "I tried Adderall and Ritalin, now I'm on Strattera" "My dog raced over, full speed..." "I'm trying to read The Power of Now, but I'm not the most consistent reader..." As the hum of the room grew louder, the group organizer requested that the group "bring it back," meaning, let the original speaker finish what she was saying, practice active listening skills, and speak in order until the round is over. While in the group, interrupting people was accepted as a symptom that participants have little control over, and, therefore, sanctions or consequences for such actions are minimal.

Another low-risk impulsive behavior that has come up at meetings is the sudden need to get up from one's seat and move somewhere else, even when it would normally be considered inappropriate to do so. This has some clear overlap with hyperactivity, but since it is usually discussed among adults as an inability to control an impulse, I have decided to include it in this section. One of the more memorable times that this came up was in a small meeting of about eleven individuals. An older man at the meeting stood up suddenly several times while different individuals were speaking, thereby drawing attention to himself. Three of the times that he did this, he sat back down soon after, but twice he left the office where the meeting was being held. While this would occasionally draw eyes or surprise others at the meeting, no one seemed offended. The man who kept standing up and the organizer had some rapport, so, when he stood up, it seemed as if the organizer tried to make eye contact with him as a signal that he should sit down. At one

point, the organizer asked him if there was a problem to which he responded: “A problem? Y’know, there’s just always problems and never problems!” which seemed to be his way of saying that he did not have any more problems than usual.

In situations outside of hyper-zones of ADHD, consequences for these “low risk” deviations from the norm may be more considerable. Two more examples of impulses that tend to break social norms in a way that isn’t necessarily dangerous but still carry the risk of offending others and compromising interpersonal relationships are being impatient with others and making careless comments (i.e. saying things “without a filter”). While this never really became an issue in the support group setting itself, those who discussed this being an issue for them claimed that it had a serious impact on their ability to maintain a romantic relationship. One of the younger men at the meeting once claimed that it can be difficult and boring to sit through a dinner with someone. One time he found himself bored by a date who was telling him a story, so he told her that he was bored and asked to talk about something else. While they managed to get through dinner, she went home immediately afterward and he never heard from her again. In the United States, dinner dates are usually seen as an opportunity to get to know someone, and a certain degree of politeness is usually expected, especially on a first date. A young woman in the group related. She said that she had been on dates that went awry because she didn’t feel like sitting through the rest of them. Requesting to leave a restaurant in the middle of a meal because she felt the urge to do something else apparently did not go over well. Having either asked someone on a date or agreed to a date, it is clear that both the young man and woman mentioned here had a desire for some sort of romantic or at least satisfying interpersonal connection; however, their failure to control their impulses

got in the way. The group responded sympathetically and asked questions in hopes of being able to give constructive advice.

Consequences for impulsive behaviors in the lives of those with ADHD may come in the form of eventual social isolation after repeated offenses toward peers, acquaintances, and loved ones, but it may also lead to institutional disciplinary action in certain settings where social relations are unequal. I am relieved to report that no specific incidences of interrupting, randomly getting up and moving around, losing patience, or making careless comments was directly related to any serious consequence in the workplace. In classrooms, however, a stricter code of discipline may be in place so that teachers can more easily manage students.

This was discussed at a combined-type support group meeting where parents and teachers of children with ADHD were in attendance. Here, a speaker posed impulse-driven disruptions that were generally not too dangerous (such as interrupting the teacher or peers, making paper projectiles, randomly getting out of their seat, drawing on desks, being impatient, and making tactless remarks), but they posed a problem in the classroom that teachers felt was difficult to solve. He rhetorically asked, “What is the best way to deal with a child who continually blurts out answers, interrupts the teacher, and derails a lesson?” While the speaker went on to explain that this might be okay or manageable when the child is responsive to behavioral management efforts, tensions may build if it is “excessive and persistent.” This could eventually result in the child being removed from class and sent to an administrator.

During the discussion portion, parents voiced that they generally dreaded having to meet with or receive calls from their children’s teachers. If the behaviors are persistent,

teachers will often prompt the parents to have their child tested for learning disabilities or any disorder that would require accommodation. The process for acquiring accommodations for any disability can be daunting, frustrating, and usually involves many parties (Grinker 2006:263-282). When a child is found to have “special needs,” it often leads these children to being placed in a special education classes for at least part of the day where there are fewer students per teacher and thus each student can be given more attention and teachers are able to manage behavioral issues more effectively. While this can be positive for many students, it may have some consequences.

One of these consequences may be that depending on their school’s resources, they may share a special education teacher with students who are at a different level or have needs that are very different from theirs. Taking them out of normal classes for only parts of the day at random times may result in missing certain lessons from class, leading them to have trouble with homework and on tests because they may not have learned the same material. This also may increase frustration in an already impatient child. Additionally, this separation may fail to properly prepare those with ADHD and learning disabilities for inclusion in mainstream society after they complete school.

Rayna Rapp and Faye Ginsburg (2013) address the issue of “transitioning to nowhere” after high school in their article “Entangled Ethnography: Imagining a Future for Young Adults with Learning Disabilities.” Here, Rapp and Ginsburg envision a potential future where discussing, accepting, and accommodating cognitive and other differences may become more mainstream and help the growing number of young adults with these differences.

At one point, the authors are invited to attend a workshop that aims to have the needs of those with ADHD and learning disabilities addressed in more public spaces where they “experienced what material accommodations designed by the people who use them might look like: baskets of rubber squeeze equipment were widely available, as were frequent “stairs running breaks” intended to keep people with ADHD on task and energetically comfortable during intense, lengthy meetings” (Rapp and Ginsburg 2013:192). Here, we can see an active attempt to show how inclusion might work. Would putting these accommodations into practice help create more inclusive classrooms? Could stairs running breaks curb the impulsive behaviors of a child with ADHD enough to get through lessons?

Beyond the low-risk impulse-driven behavioral deviations that come up for those with ADHD, there are mid-level risks that may or may not have a serious effect on one’s quality of life and well-being in the long term. Some examples of these “medium risk” impulsive behaviors include impulse-driven procrastination, impulsive spending, spending time with the “wrong” people, and impulsive sex. None of these behaviors were exhibited at meetings, but all were discussed to some extent.

The most common of these issues that was brought up at support group meetings was procrastination. Here, it is important to clarify that there can be a number of reasons for procrastinating: impulses, anxiety, distractions and time-blindness. For this section, we will focus on impulse-driven procrastination. This often occurs as one attempts to focus and do work, but find themselves unable to control the drive to engage in other (usually more satisfying) activities. The support group organizer’s saying about there being two times for people with ADHD (now and not now) becomes particularly salient

here. There are so many examples of impulse-driven procrastination from support group meetings that it is difficult to choose which to include here. This was a significant source of distress for individuals with ADHD and their caretakers and loved ones across the board. During an informational support group meeting, an ADHD specialist even claimed that “ADHD should really be considered a disorder of implementation” that makes it difficult to turn intentions into realities.

One of the most memorable times that this was brought to the fore was when a woman claimed that ADHD was a “disorder of self-control.” She went on to explain that she was unable to complete projects at work by deadlines (and eventually lost her job). She began to break into tears as she explained that she didn’t know how she would be able to apply for jobs when she wasn’t able to stop herself from making short-sighted decisions. Her voice quivered as she said that she could not stop turning on Netflix, eating, cleaning, shopping, calling people, playing games on her phone, or picking up new hobbies that she failed to pursue in any serious way. She claimed that she wasn’t able to fight sudden impulses to do something in the moment, and she always convinced herself that she would get right back to job applications “as soon as” she did whatever she wanted to do. Even when she did go back to what she was supposed to do, it usually didn’t last very long. The way she explained it made it seem as if the newest thing that came to her into mind was suddenly the most important, thus relegating all other activities into the realm of “not now” while she took care of the moment’s priority. She was frustrated by her engagement in these activities because her lack of foresight would lead her to neglect the activities that she felt logically, should have been a priority. While procrastination is something that a number of people can relate to, and sometimes even

like to joke about, during this meeting it was clear that there was potential for serious consequences. This woman's family was struggling to pay the bills as they went from being a two-income household to one. She explained that she tried to hide her habits from her husband and built up credit card debt in an effort to maintain the family's standard of living while she remained unemployed. While this woman was fortunate enough to share somewhat of a safety net (a spouse with income and decent credit history), others are not so lucky. For some, even as adults they must depend on their aging parents to provide shelter, food, and other necessities because their symptoms are so severe.

A related mid-level risk related to impulse control that many with ADHD experience are issues with finance management. On top of issues with employment, money problems can arise due to impulsive spending, investing, and gambling. While many support group members would claim that they had financial issues, few would go into much detail. The only example that really illustrated how this might happen was initially posed as a question by a young man who asked: "Does anyone else find themselves spending money on impractical things regularly, when they really need to save?" Hands around the room started going up. He continued:

You know, it's like, I'm really trying to save up and move out of my parents' place, but every time I even come close, suddenly there's a new and expensive hobby that I'm completely obsessed with. Next thing I know, I've somehow spent all my money on instruments, memberships—I think I even have a pile of fancy rock climbing gear that I used maybe three times and never touched again sitting in my closet. I should know by now that that's what happens but, it's like, in that moment I can't help it. I always convince myself that it could finally be a good investment.

He went on to explain that he was embarrassed that he sometimes lost track of how much money he actually had and then was forced to rely on his parents for help when he overspent. Not only can spending issues lead to debt or impoverishment, but if these

impulses remain uncontrollable it becomes impossible to escape debt and even poverty unless these behaviors can be reformed. Spending beyond one's means can be considered a problem almost anywhere in the world, but the United States can be particularly unforgiving when it comes to giving chances to those with a history of creating bad debt. While some attendees at support group meetings with ADHD tended to toe the line of financial insecurity, most seemed to have some sort of support network that allowed them at least create a semblance of living comfortably. This is not too surprising, since many aspects of the meetings (transportation to and from meetings, suggested donations, fees, dues, host venue purchases, etc.), and arguably even the diagnosis itself, require some amount of disposable income. Those with ADHD who are not fortunate enough to be able to make it to support group meetings are likely the ones in a more dire situation. Nonetheless, financial instability and bad spending habits can be a significant source of stress.

Another category of mid-level risk that was commonly discussed among adults with ADHD was a habit of “being with the wrong person” or “getting in with the wrong crowd.” While the idea of “wrong” people may seem ambiguous at first, based on descriptions given by attendees, it becomes possible to get a clearer picture of what this might mean. The first example came from a round of introductions where a college student discussed her struggles with both finishing work and depression. She explained that she had only been diagnosed recently, but that the signs of ADHD were there her whole life. She was a hyperactive but “gifted” child. Since her intelligence allowed her to get by without studying or doing homework early on, she was never able to build up the skills necessary to succeed when struggling to learn something she didn't know. Even if

she was constantly distracted in class, if she was able to get the context for a teacher's question, she was usually able to answer it. This sort of compensation continued to help her through the school system until she completed middle school. Once she began high school and her coursework became more difficult, she didn't know how to handle it. Her impulsivity led her to skipping class—a choice that felt better at the time than having to face potential failure and humiliation in the classroom. Once she started skipping class, she began spending time with the “wrong crowd,” who she described as: “You know, the kids who go cut class to go smoke cigarettes throughout the day.” She explained that at first she spent time with these students because it gave her something to do when she was avoiding classes she struggled with. Soon enough, she got wrapped up in the “bad kid” culture, and instead of just spending time with the “wrong” people, she saw herself as becoming one of them. This fits in with Grinker's explanation of how new classifications of deviance can come as a relief. “Before 1980, children with the symptoms of what we now call ADHD were seen as bad kids whose problems, often blamed on their parents, caused them to do poorly in school, and in some cases, to become criminals or develop drug addictions” (Grinker 2006:110). Before she was diagnosed, the young woman's “bad behavior” created significant tension at school and at home. She had just barely managed to graduate and when she eventually sought help for her problems, receiving a diagnosis of ADHD came as a relief. For her, this explained her disinterest in school and attraction to the “wrong crowd,” which she came to see as a result of a problem with the functioning of her brain rather than something that was entirely her fault. Another woman at a different meeting explained that she often ended up with the wrong people because she would fall in love with drug addicts (who also had a tendency to be impulsive) and

end up hanging out with other people with similar problems who were both breaking the law and engaging in potentially dangerous and damaging activities.

Another source of problems related to impulsivity falls around mid-level risk for adults with ADHD: a propensity for impulsive sex. Sex in this context brought different problems for different individuals. Sexually transmitted infections and diseases were not brought up as a concern in the group, but one attendee did explain that he believed that impulse-driven sex may have been the reason that he became a parent at a young age. According to psychological researcher Noel Gregg: “High teenage pregnancy pregnancy rates are...characteristic of the population of adults with ADHD” and that “68% of females [with ADHD] had been involved in a [teenage] pregnancy...as compared to 38% of males with ADHD and only 16% of control group members” (Gregg 2009:10). Early pregnancy and parenthood can come with a great deal of stress in the United States today and teen pregnancy has even been called “one of the great public health challenges of our time” (Shaw 2015: 196). In the United States, young parenthood is often stigmatized and frowned upon; young fathers are characterized as “predators,” “absent,” and “selfish and uncaring”(Beggs Wever 2012:900-1), while young mothers are seen as “unmotivated, irresponsible, and incompetent” (Smithbattle 2013:235). It is possible that the stigma that comes with having a child at a young age (teen) does not preside so strongly in non-Western cultures, but with most sources written in English, many seem to highlight risks that we associate with teen pregnancy.

This single case of impulsive sex leading to teen parenthood contrasted the others who brought up sex in relation to ADHD. Instead, others tended to be more concerned with how impulsive sex affected their relationships with others. For an older man in

attendance, he claimed that he spent his life "chasing skirts," but he was never able to "settle down," leading him to feel very isolated as he ages. A woman at the same meeting explained that impulsive sex becomes emotionally straining for her, as she would often feel close with or even "get attached" to the people she slept with. She repeatedly found that these men would not be interested in anything serious with a woman who they think is "easy." It seems to be worth mentioning that gender likely plays an important role in the consequences of impulsive sex where men stand to be rewarded while women are more likely to be shamed.

Impulse-control related problems that I have decided to define as "high risk" are categorized as so because there is potential for both direct bodily harm (that could lead to death) and incarceration. These include: substance abuse or addiction, dangerous driving habits, and playing with fire (literally and figuratively). Once again, risks that fall into this category did not occur within the support group context, but members did describe experience with these impulse-related issues.

One study done by British psychiatric researchers tells us that numerous studies in the past have proven that there is a link between ADHD and higher rates of nicotine use Biederman et al. (2012) argue that nicotine use increases chances of substance abuse, and then go on to show that there are increased rates of substance abuse among individuals with ADHD. In support groups, only two people talked about their history of alcohol and drug use. Both were older and described their reliance on drugs and alcohol in terms that seemed to be a form of self-medication. One woman who discussed this described her history as a dancer and actress; the drugs helped her feel better and stay thin. She knew about the risks associated with cigarettes, cocaine, and alcohol, but she felt that she

needed them to survive in the moment—even if it meant dying in the process. She claimed that this wasn't helped by the fact that she was often surrounded by these things in show business. She explained, “It was difficult enough to stop the desire, but on top of that I was surrounded—how could I say no?” Another man only briefly made reference to “problems with” and “reliance on” alcohol that started young, but it was clear that this had a significant impact on his life.

Another problem falling into this high risk category is reckless driving. For certain support group attendees, a series of car accidents was actually what prompted their ADHD diagnosis. Studies show that there are positive correlations between ADHD and problems with driving, such as increased collisions and road rage (Jerome 2003:16). Between impulsivity and distractibility, it is easy to see how a car can easily turn into a multiple-ton death trap when an individual with ADHD is behind the wheel. Unfortunately, in some parts of the United States, driving can arguably be considered a necessity—especially in places where important locales are sprawled out over a great deal of space and there is little to no public transportation. Statistics even indicate that about 90 percent of Americans used a car to get to work in 2009 (Winston 2013:779), showing that driving is a part of life for a vast majority of people in the United States and, to some extent, may be difficult to avoid. Driving accidents that occur due to impulsive decision-making behind the wheel of a car can be expensive and lead to license suspension—two things that can cause serious financial (and even social) problems alone, but they can also cause serious injury and death.

Impulsivity can lead anyone to do things that could be considered erroneous, and dangerous, but those with ADHD are more likely to engage in high-risk activities. Many

male group attendees explained that they had experiences playing with fire, explosives, and chemicals in an uncontrolled setting. Many laughed telling stories of singed hairs and retrospectively silly decisions, but these stories reported real dangers resulting from impulsive decisions. The predisposition for perilous activities that broke windows and bones put the lives of these individuals at risk. These miscellaneous and dangerous activities can be summarized with the phrase “playing with fire,” which refers to both the saying and to *actually* playing with fire. This phrase also brings to mind a popular piece about ADHD that was recommended to me by a school psychologist at an informational support group meeting: Blake Taylor’s autobiographical piece: *ADHD & Me: What I Learned from Lighting Fires at the Dinner Table*. In the second chapter of his book, Taylor discusses his experience in 9th grade, when, acting on an impulse, he added eyeglass cleaning fluid to a flame that proceeded to engulf half the dining room table in fire. From this story, it is clear that “playing with fire” and other related activities can present a great deal of danger, thus making impulsivity a potentially deadly symptom for those with ADHD.

INATTENTIVENESS

Another major symptom group of ADHD (and arguably the most-stubborn) has to do with inattentiveness and distractibility. According to a variety of speakers, inattentiveness in people with ADHD means that they have poor short-term, or working memory (though according to an informational speaker and anecdotal evidence from meetings, people with ADHD reportedly have excellent long-term memory). Having a poor short term memory can mean regularly forgetting things like meetings, dates, new schedules, assignments, passwords, and any materials that one might need to be prepared. It can also mean repeatedly losing (sometimes very important) things like keys, wallets, planners, phones, laptops, glasses, paperwork, and just about anything else.

During meetings, there were times where attendees were distracted from the central conversation by outside stimuli. This could be seen as some attendees would stop talking (or, less obviously, but still noticeably, stop listening) when any sort of light or sound would catch their attention. This could be car lights or noises, people outside the room, cellphones that attendees forgot to turn off, a dropped writing utensil, someone adjusting themselves in their seat, or anything else that might draw attention. For someone with ADHD, their difference from “neuro-typical” individuals was that after acknowledging the source of distraction, many attendees would be lost when trying to come back into the conversation and have to ask those who maintained focus for clarification on what was being discussed. One speaker at a support group meeting claimed that this sort of distraction is a problem for people with ADHD because their mind is not able to keep anything “on the back burner.” Once their mind fixates on something new, whatever was there before may be gone. Many with ADHD claimed that

they could not have desks with a window view or near the entrance to an office or room as this often led to being distracted from work. In situations where desk placement is out of one's control, it is easy to see how not being able to focus on one task for an extended period of time could become a problem when working a job that has deadlines or other productivity requirements.

Even when there is no external stimulus, those with ADHD are still easily distracted by either fast-moving or wandering thoughts. Fast-moving thoughts often come with impulses and can bring anxiety. When one is not able to do anything about them—these impulsive thoughts can be intrusive and distracting. On the other hand, wandering thoughts tend to embody the stereotype of “ADD” (what inattentive-type ADHD was called before the DSM-IV) where the affected individual may be “zoning out” and staring at a random point in the room and appearing to be daydreaming. According to one speaker, “ADHD individuals are unable to tolerate boredom in a normal way.” This seems to ring true with the way that some have wandering thoughts. It seems that this is more likely to happen when the brain is not stimulated at normal levels. At one support group that regularly begins with a brief meditation session, a number of attendees reported struggling with thoughts, claiming that they were anxiety-provoking.

Distractibility became quite apparent through group discussions. In many cases when someone with ADHD is interrupted during a task, it is likely to take awhile to get back on track, or the person may forget entirely. Not only does this result in delays, but it can also lead to a failure to adhere to directions—something that can be particularly damaging in academic and professional contexts. At meetings, attendees would often talk about themselves (and their children) as being described with words like “spacey,”

“flighty,” “unreliable,” “not all there,” and “careless.” One woman at a meeting overheard her coworker make a comment about her along these lines, which she felt “completely disrupted” her “professional self-image.” She thought that she had managed to cover most of her symptoms at work, so it came as an unpleasant surprise when she found that others had caught onto her symptoms.

Many with ADHD at support group meetings lamented the increased use of technology in the workplace and at school. As one woman put it, “I couldn’t escape, even if I wanted to!” Interestingly, there were two regular support group attendees (in two different groups) who tended to be distracted by their phone and tablet during meetings respectively (despite the guidelines asking that no one use technology in the rooms except if necessary due to dysgraphia or some other reason). In both cases, they switched between playing games and checking their emails over the course of meetings. As technology becomes an increasingly necessary part of schools and offices, it seems that it becomes more difficult for those with ADHD to manage their symptoms as there is often an easily accessible source of distraction with various stimulating activities within arm’s reach.

Being easily distracted with a poor working memory can also lead to communication issues that arise when someone with ADHD forgets what they were planning to say. I recorded this occurring at at least five different support group meetings, and it often happened when there was a popular discussion topic and everyone had something to contribute. Usually, by the time it was someone’s turn to speak, they would have forgotten what they had been excited to say initially. At one meeting, a speaker recommended that adults with ADHD create a brief list of bullet points when they have

something important to talk about, particularly with their boss or manager, and to rehearse it to the greatest extent possible (with the hope of having it “stick” with practice). In employing this strategy to compensate for an attention-deficit, someone with ADHD then must put extra time and energy into something that can likely happen without much thought for “normal” people.

This sort of energy and time-consuming compensation method seems to be ubiquitous among those with ADHD, particularly those who went undiagnosed until they were older. A number have described “working harder” than a “normal” person to get through their daily activities. Many claimed that they failed to realize that other people were not struggling to the same extent for years. One woman who regularly attends meetings likes to tell a humorous story to illustrate this point. As a young and new parent, she had no idea how she was supposed to be able to care for an infant, let alone herself. In order to ensure that she was keeping both herself and the baby alive and in good health (and taking care of whatever errands she had to run that day), she would make a to-do list that included *everything* she had to do: feed the baby, burp the baby, feed self, make note of food in fridge, brush teeth, go to dresser, choose new clothes for baby, change diaper, dress baby, put baby in seat, shower, get dressed, play with baby...” She thought this to-do list was normal for any new parent until she had a friend stop by. Her friend glanced over the list while waiting in the kitchen. While the attendee was trying to make herself presentable, she heard her friend incredulously ask, “Are you kidding me with this list?!” The attendee made her way into the kitchen with her daughter and questioned “What, doesn’t everyone have a list like that?” Needless to say, that was the day she realized that she needed more help than the average person just to remember to do mundane tasks.

Like with both hyperactivity and impulsivity, the concept of stimulation also comes up with distractibility. One man compared his brain to a television that was constantly “changing channels,” in a way that he felt was out of his control. The less exciting he found something, the faster his brain would switch modes and cause him to lose whatever he was previously paying attention to since, as he claims, his brain “doesn’t have TiVo” (a system capable of recording television programs for later viewing). From being distracted behind the wheel of a car to not paying attention to what someone is saying, this can become a serious issue in the work place and in one’s personal life.

Several young men at meetings said that a number of arguments with their romantic partners started due to issues with being distracted while their partner was talking, as listening is often a highly valued skill in many personal relationships. At work, this can become a problem when it comes to both getting things done and listening carefully to instructions. Being easily distracted affects school performance, and many anecdotes told of mocking and scolding from teachers when students were having trouble focusing. One woman recalled that she became known as the “airhead” of her grade among teachers because she was constantly distracted and never knew what was going on during lessons. According to attendees, this type of shaming and the poor grades that come with not being able to pay attention made them hesitant to attend class, and as a result, many either barely finished high school or dropped out. The fact that many attendees struggled through, or dropped out of high school is unsurprising since only about 59 percent of individuals with ADHD complete high school—a percentage that is notably low, even when compared to other learning disabilities (Gregg 2010: 4). The fact

that 41 percent of individuals with ADHD end up dropping out of high school makes it clear the symptoms of this disorder affect the potential for attaining traditional “success” in the American education system.

In discussing the inability to concentrate, one woman was reduced to tears when she discussed her struggle with unemployment, job applications, and starting her own business. Despite appearing to be in her 40s or 50s, she remained dependent on assistance from her parents to survive. She explained that she has trouble following through with anything that has too many steps because she is not able to maintain concentration or switch between tasks and remember what she was doing. In order to start her own business as she would like to do, she must earn enough capital to invest in her own company or to at least begin a decent line of credit. To gain said capital, she must find a source of income, likely a line of employment that she has experience in. Since her social network is minimal, she is unable to find a job (or investor) through anyone she knows. This leaves her struggling to find work in a highly competitive job market in New York City where an individual must often send out dozens of emails, cover letters, resumes, applications, and other materials in hopes of getting just a response or two. Here, it is easy to see how task management could get difficult for anyone, but this becomes especially true for someone with ADHD who usually cannot maintain focus on tasks for an extended period of time. Almost everyone at every group could relate to this struggle. When it didn't have to do with job applications, it had to do with taxes, studying, completing projects, or even trying to coordinate insurance and medical appointments.

Inattentiveness and distractibility also make it more difficult to form and break habits. Habits tend to be embedded in long-term memory, whereas intended changes to

said habits are within working memory—a place of struggle for those with ADHD. This means that often times when the opportunity to change a habit comes up, it can be difficult to even remember what the intended change was. Even when successful to some extent, it can be difficult to carry actions over so that they are consistent over the long term. For many support group attendees, distractibility meant not being able to get through chores. While most people do not particularly like engaging in tidying or cleaning, for individuals with ADHD it seems exceedingly difficult. One woman described her experience with cleaning as “unfortunate.” She claimed to actually enjoy it, but had trouble getting started and being able to continue for more than two minutes at a time. Eventually, this led to disturbing buildup of dishes in the sink and an overflowing garbage can in her kitchen (as she repeatedly forgot to take it out). As a result, she decided to hire someone to clean her apartment out of fear that she would end up living in squalor if her and her husband (who also has ADHD) were left to their own devices. In response, the organizer suggested that people who have trouble sustaining attention while cleaning set a timer (starting with maybe five to ten minutes at a time) and commit to cleaning until they hear the timer go off. Alternatively, she said they could try to “race” the timer, and complete one tangible and reasonable task before it goes off. The organizer went on to explain that, “even if you get distracted, hearing the timer go off might remind you, and it provides another chance to try again.”

Memory problems can also cause significant issues with financial management. One man explained his problem with paying bills: “You know, I don’t think anybody wants to think about their bills. My problem is that when I don’t think about them, I don’t pay them. They come in the mail, then I go sit down and turn on the TV, and as far as my

mind is concerned, the bills are gone...at least until the cable goes out.” As the room began to laugh, he completed his thought: “*then* I notice.” While this attendee’s experience seemed funny in this context, it’s easy to see how problems could arise if one fails to keep track of their income and expenses. While in this case, he talks about his cable going out, other types of bills may have more serious consequences if they go unpaid like gas, electricity, water, or even rent. Additionally, forgetting to pay credit card bills can result in high interest fees and poor credit—something that has serious consequences in the American economy today. Credit scores affect one’s ability to access certain housing as well as all kinds of loans (at least, without astronomically high interest rates). In response to problems with remembering to pay bills and forgetting about debts and spending, one middle aged woman proudly announced, “I let my husband pay all the bills! He doesn’t seem to mind and it saves us both the trouble!”

Many people at different meetings were very familiar with the “one-touch” rule for bills. This is a coping tactic where if an individual picks up a bill, they are required to read and pay it before setting it back down. This helps those with ADHD from having bills “hanging over” them. One woman claimed that she had tried this but asked what to do when it wasn’t feasible, like if she had to check her bank account or knew she didn’t have enough money to pay the bill at that time. Another attendee suggested scheduling bills, assuming her bank had online bill pay options, to which she exclaimed, “That sounds great! Here’s to hoping I can remember that!” as she appeared to type the information into her phone. One group organizer said that for many “the one-touch approach can be too anxiety-provoking to be productive” and instead it makes sense to

try and break paying bills down into small steps and create a system, though, for some, having many steps creates its own problems.

Just as many with ADHD had a sort of “out of sight, out of mind” effect when it came to addressing bills, similar problems arose for support group members when it came to “getting through” and “getting back to” emails. As work and school become increasingly reliant on web-communication, it can sometimes seem as if inboxes are becoming more and more crowded by the day, and indeed, there are indicators that this is likely the case (Sewell 2004). Individuals with ADHD often found that when they did not act upon an email immediately, it was quite common that they would forget to respond or complete tasks related to their emails at all. This certainly seems to be an inconvenience at best, but it can also have deleterious consequences.

As humans, we don't always have the perfect response, and in person, this often plays out in the moment and once the moment passes, it is over and there is not much to be done about it. With emails, there tends to be more room for crafting a well-thought response, and doing so has become somewhat of an expectation. According to a speaker at one meeting who works as a psychologist and ADHD coach, “People with ADHD tend to try to compensate for their shortcomings elsewhere and can be somewhat perfectionistic.” This becomes especially true when they are unsure of what to say, and want to avoid saying the wrong thing. Since most people with ADHD are familiar with their symptoms and have tried to come up with coping mechanisms, they're often left with a decision when they encounter emails that they are unsure how to react to: should they risk trying to invest a great deal of time now (even if they have other immediate obligations) or “save it” for later when it's likely to be forgotten about? While “mark

unread” can become a handy tool here for some, it’s no longer helpful once there are over 100 emails in their inbox.

With regard to email, one woman from a support group meeting found that she had to turn off her email notifications, so as not to be distracted by the noise or sight of an incoming message (which would make it difficult to return to a task she was working on). While this was useful to ensure that emails would not serve as a distraction in the workplace for this attendee, it also increased inbox buildup, which she claimed made it more and more daunting to read and respond to emails as the volume increased. Unfortunately for the attendee, this email management technique was not always helpful. She recalled a time when her manager sent an email with an update for a project (with an upcoming deadline) that she was working on. She ended up not reading the email until after she had completed the brochure she was working on, only to find out that her boss decided to push that project back while giving her an extensive writing assignment that was to be completed by the end of the day. Since she received the email so late, she ended up missing the deadline and had to cancel dinner plans to stay at work late.

OTHER EXECUTIVE FUNCTIONS

In ADHD support groups, it is almost impossible to ignore the existing overlap between issues of executive functioning and the symptoms of ADHD. So what is executive functioning exactly? According to psychologist Sam Goldstein and research professor Jack Naglieri in their *Handbook of Executive Functioning*, executive functioning is “an umbrella term used for a diversity of hypothesized cognitive processes, including planning, working memory, attention, inhibition, self-monitoring, self-regulation, and initiation carried out by prefrontal areas of the frontal lobes” (Goldstein

2014:3) While a number of these functions have been discussed, particularly in the “Inattentiveness” section, it is important to cover the other executive functioning issues that arise for individuals with ADHD.

One symptom that was apparent at meetings and fits under the executive functioning umbrella is disorganization in relation to space. This became particularly noticeable when, as one support group meeting was drawing to a close, everyone began rummaging through their pockets and bags. One man searched through several pockets, and eventually managed to come up with a wad of receipts and crumpled dollar bills with a collection of coins. At the same meeting, a woman frantically rifled through several bags to look for her wallet. After a couple frustrated rounds of searching, she finally found her wallet and apologized to the group organizer for taking so long. As she opened the different compartments of her bulky wallet to find cash, some change spilled out and onto the floor. Other attendees helped to pick up the spilled contents; she thanked them and made fun of herself for “making a mess.”

Decision-making is another executive function with which people with ADHD struggle. Indecisiveness made itself most evident at a support group meeting where attendees are expected to purchase food from the restaurant that hosts the group. Here, one attendee had so much trouble deciding what she wanted to eat that she ended up changing her mind about what she wanted to eat multiple times. She ordered (and paid for) about four different food items throughout the meeting, and only ended up eating a bit of one before determining that she did not want anything from the restaurant. Not only did indecisiveness result in this attendee paying more money than necessary, but the lack of planning involved in ordering multiple meals before deciding not to eat them resulted

in wasted food, as she did not want to bring the food with her to run errands. Fortunately, this benefited other support group attendees who were happy to take her leftovers.

One of the most common problems related to executive functioning that could be seen at ADHD support group meetings was showing up late which can occur due to issues with planning, self-monitoring, and self-regulation. No matter how much extra time organizers (aware of lateness being common among those with ADHD,) granted for latecomers to “trickle in,” at every single shared experience-based meeting that I attended (where attendees all identified with an ADHD diagnosis), there were always people who showed up after meetings had already begun.

Not only were attendees often late to meetings, but meetings also became a place to talk openly about struggles with lateness. As one informational meeting speaker put it, those with ADHD have a “sluggish cognitive tempo” and thus experience and perceive time in a different way than neuro-typical individuals. This leads to having problems with planning ahead, keeping track of time, and meeting deadlines—all incredibly important skills in today’s fast-paced world. Many participants at different meetings voiced their concerns about being late. Some were afraid that they might be fired for consistent lateness, or miss important events, appointments and opportunities. There were also concerns that this came off as unprofessional, careless, and inconsiderate. One woman managed to make light of this habit of being late shared by many with ADHD by telling a story:

“As per usual, I was running late for work the other day when I noticed that I always run into the same man from my floor at the elevator who seems to be in even more of a rush than I am. I used our brief encounter in the elevator to ask if he was a late-person too, and he ended up telling me that he had ADHD! I have to be honest, I didn’t expect a guy who wears a suit every day to have ADHD, but we got so caught up in talking about our habits that we were even more late to

work. My boss of course probably wasn't too happy about it and said that I was receiving my last warning, but I was excited to discover a new ADHD friend out in the wild!"

Here, the attendee highlighted being late (and being easily distracted) as something that people with ADHD often have in common (and indeed, from support group meetings, this seemed to be the case). She managed to tell her story in a way where the bond she formed with her neighbor seemed to balance, or even outweigh the fact that her lateness was putting her job at risk. This also then brings up the way that executive functioning can impair one's ability to prioritize. While this attendee may have chosen to put bonding with neighbors above getting to work on time based on her values, it is also possible that getting to work at the time was more important, but that she had trouble making that determination and implementing a plan that put that as the priority. With these possibilities in mind, it becomes clear that executive functioning deficits have the potential to harm the individuals who exhibit them. According to a quote from ADHD expert Russell Barkley in a *Time* article by Denise Foley, it seems that the two in this story are hardly unusual as he claims that when "you have an ADHD practice, a third of your patients are late or never show" (Foley 2016). Here, we can see that notable impairment in time management skills when it comes to those with ADHD is not uncommon.

Another executive functioning problem that tends to plague individuals with ADHD is difficulty with transitioning from one thing to another. This can make it particularly difficult to do anything that involves a number of many different steps or components. One attendee came to a support group meeting specifically because he was struggling to complete his taxes. To describe why he was frustrated by his tax situation

and having trouble, he said: “It’s just a huge process and there are so many steps that it gets overwhelming and I avoid it all together because I can’t figure out where to start. Even when I do start, every time I have to go find something, I have trouble going back and filling out the form, so it’s like I’m back to square one—what’s the point?” Hands went up around the room as he spoke to indicate that others were able to relate. This difficulty with switching tasks has implications that go beyond ensuring that one’s taxes have been properly paid for. This panic of being unsure how to handle moving between steps involved in a task affects one’s ability to complete, or even start anything. From taxes to even cleaning one’s living space—having difficulty with anything that involves too many steps can have considerable consequences

In trying to manage their executive-functioning related symptoms, extreme rigidity in planning and routine became the reaction of one participant in her attempts to avoid the consequences caused by symptoms. that she would find others who could relate to rigidity in planning when she began:

Does anyone else become almost too rigid in planning? Like, if a friend calls me and asks to push something back, I’ll flip out because, even though for most people it would probably be a small shift, it feels like this throws off my schedule for the entire day. It’s like I’m afraid of being flexible because once I stray from my plan, I can’t figure out how to adjust and end up stuck and nothing gets done.

As she said this, two other attendees and I raised our hands to show that we could relate to this point. Because executive functioning issues cause individuals with ADHD to have trouble prioritizing, planning, keeping track of time, and making adjustments, it becomes easy to see how once there is a plan or routine they may be inclined to stick to it. From the example given, however, it is clear that “sticking to it” is not always feasible as situational dynamics change. This lack of flexibility can create tension in both personal

and professional relationships.

ETHNOGRAPHIC OBSERVATIONS: COMMON ISSUES

COMORBIDITY, COMPARABLE CASES, AND INTERRELATED ISSUES

In a lot of cases, it is hard to tell whether ADHD causes, or if it is comorbid with a number of illnesses and syndromes such as depression, anxiety, hoarding disorder, addiction, severe mood dysregulation, and hypersensitivity. A number of support group attendees had laundry lists of current and past diagnoses. Interestingly (though not surprisingly), attendees at these meetings tended to feel that ADHD was the primary source of whatever other problems they had. As discussed in the “impulsivity” subsection of the previous chapter, impulsivity related to ADHD was seen as the culprit behind substance abuse problems for individuals with ADHD.

Even more prevalent among attendees than substance abuse and addiction were high rates of comorbid depression, especially among women. Here, it is useful bring in an example that illuminates how many attendees with comorbid mood and personality disorders tended to think of their mental health diagnoses. An example that exemplifies this perspective comes from an older woman’s introduction to the group where she said:

“I have female-type ADHD, meaning that I have problems with attention, organization, and implementation. I spent my whole life with my symptoms going unnoticed as symptoms because I don’t really draw much attention to myself. People instead thought I was lazy. I have struggled with severe depression and some anxiety for a number of years, and I really feel like undiagnosed ADHD may have been a big part of that as I spent so many years being told that I was lazy, stupid, and worthless that I actually began to believe it. As soon as I started treating the ADHD, I really felt like I discovered the real source of my problems.”

Here, since the attendee claims that ADHD was the “real” source of her problems, she identifies that as her primary diagnosis that caused her depression. According to Nadeau, Littman, and Quinn, depression is a common coexisting diagnosis among women with ADHD, particularly those who were shy, timid, withdrawn, and lacking self

confidence at a young age (Nadeau, Littman, and Quinn 2011:27). While it is possible that men at meetings also struggled with depression, only one was open about this being the case. According to statistics cited by Noel Gregg, between 16 and 31 percent of adults with ADHD also have major depressive disorder, and between 19 and 37 percent have dysthymic disorder (Gregg 2009:103) meaning that about one in six to one in three adults with ADHD also have a depressive disorder.

In the same vein, a number of attendees voiced that they struggled with anxiety. This makes sense given that adolescents with ADHD are three times more likely than average to have generalized anxiety disorder (ibid.: 102). During meetings, attendees often brought up concerns about their inability to manage their symptoms and function properly. As one attendee put it: “I’m always afraid that I’m missing or forgetting something. I can’t trust my brain to do what it’s supposed to, so I live in constant fear of facing consequences for things I can’t control.” From this perspective, it comes as no surprise that ADHD support group attendees would consider ADHD to be their primary, and most impairing diagnosis.

Additionally, from hearing stories and experiences at support group meetings, it seems that ADHD often coincides with a number of learning, cognitive, and developmental disorders. There is a lack of reliable statistical data on the comorbidity of ADHD and LDs (ibid.:101) and overlapping symptoms of ADHD and disorders like autism spectrum disorder (ASD) can make it difficult to differentiate and determine whether there is comorbidity (Ronald et al 2014). Nonetheless, between anecdotal evidence from ADHD specialists and the number of support group attendees who revealed that they also had been diagnosed with a variety of other problems that impair

functioning, it seems that the coexistence of ADHD and disorders like ASD, dysgraphia, dyslexia, dyscalculia, sensory processing disorder, and auditory processing disorder is far from uncommon. Unlike with mood, anxiety, personality and addiction disorders, those with coexisting learning, cognitive, or developmental disorders generally did not view ADHD as a potential source of their other problems, but instead saw it as a complicating factor that caused them to struggle even more.

SHAME, BLAME, AND STIGMA

For meeting attendees, shame seems to cause just as many, if not more problems than the symptoms themselves. Nancy Scheper-Hughes and Margaret Lock succinctly describe how this sort of shame can become a sort of secondary illness itself in writing about AIDS, arguably one of the most stigmatized illnesses in American history, “the societal and cultural responses to disease create a second illness in addition to the original affliction, what we are calling the ‘double’: the layers of stigma, rejection, fear, and exclusion...now twice victimized, further into the cage of his or her illness: shunned, silences and shamed in addition to being very sick” (1986: 137-138). While Scheper Hughes and Lock are more concerned with “dreaded” contagious diseases, it becomes relevant for ADHD as, due to the history of the disorder, the diagnosis comes with some implication of moral failure and thus is stigmatized.

It also becomes important to talk about how ADHD fits into the category of “invisible illnesses,” that is, illnesses where symptoms do not have appear to have any significant (or sometimes even detectable) physical manifestation. ADHD falls into this category (despite the physical nature of symptoms like hyperactivity) because its etiology remains unclear and contested and it is not possible to detect the disorder by simply

looking over the body of an affected individual with the naked eye. According to Kirby Brennan and Ann-Marie Creavan who write about social support for individuals with the invisible illness commonly known as lupus: “invisibility can reduce the social support received from network members and adversely affect the quality of life...and sufferers are vulnerable to negative reactions such as disbelief,” which, they claim can lead to loneliness (Brennan and Creavan 2016:1227,1229). Its status as an invisible illness make it easier to dismiss the disorder’s legitimacy, a phenomenon that individuals with ADHD (and their parents) found distressing and isolating (likely prompting the need for support groups). If their disorder is not seen as legitimate, they are not able to take up a sick role, and thus, sufferers and their caregivers become the target of blaming and shaming for various symptoms and behaviors.

More than one parent expressed that they had received unwarranted parenting advice when their child was “acting out” and exhibiting symptoms of ADHD, leading them to feel as if they were being blamed for their child’s disorder—a phenomenon that is likely exacerbated by virtue of having this “invisible” status. At a number of informational meetings, parents would exchange tips on how to deal with people blaming them for their child’s symptoms, as well as how to avoid unnecessarily blaming their children for ADHD-related behaviors, which, one speaker claimed was “hurtful” and “unproductive.” The same speaker explained that it can be useful to use statements that make the parent and child a team when trying to address issues, i.e., “Let’s work on not interrupting others when they speak, since we know that doing that can hurt peoples’ feelings” rather than “Why do you keep interrupting people? You know better than that.”

In the same vein, adults with ADHD at support group meetings all seem to share a sense of shame and frustration when it comes to their symptoms. For some, their struggles with school and work have left them feeling that they are unintelligent and incompetent. One woman who was diagnosed with ADHD in her 50s explained that she lived most of her life thinking that she was “just dumb” because she was unable to absorb information the same way that others could. Since she values intelligence, this was detrimental for her self-esteem.

A handful of adults with ADHD also described how even after they received a diagnosis, there was pressure from the people in their lives to simply “get better,” as if having a diagnosable and treatable disorder meant that suddenly they would be “cured” and all traces of symptoms would go away with management. In one case, a young man explained that while his parents were sympathetic concerning his ADHD diagnosis early on, after being on medication and going through therapy for a while, they began to put a great deal of pressure on him to “be normal.” According to his account, because he was being treated, he should not have an “excuse” for struggling anymore. This caused him to feel a great deal of shame over his inability to overcome ADHD. One potential reason for this phenomenon can be explained by Brea Perry’s article about the “sick role” (that is, a social role where, if an ill individual complies with treatment, they are not to be held responsible for their illness and may request help) when it comes to mental illness. Perry explains how the sick role may be more easily exhausted for relatively less severe, chronic behavioral disorders like ADHD: “the degree to which the ill are freed from social responsibilities is relative to the nature and severity of the illness...Evidence suggests that the theory is a good fit for acute physical illness but is less well suited for

mental illness and forms of social deviance” (Perry 2011:462). This explanation makes it possible to see how the incurable but treatable chronic nature of ADHD can cause stress in interpersonal relationships as individuals may be blamed for their symptoms and feel a great deal of shame for failing to stop abnormal behavior.

ACCESS DENIED: CHALLENGES IN OBTAINING AND ACCEPTING
DIAGNOSES, ACCOMMODATIONS AND TREATMENT FOR ADHD IN THE
UNITED STATES

At four different informational meetings, the importance of accommodations for students with ADHD (especially when it came to standardized testing) was the central focus of the conversation. In the eyes of the speakers, parents, and individuals with ADHD in these meetings, accommodations were a way of giving “students with a disadvantage” a “fair” chance to succeed. This conception of fair, however, remains controversial as some view accommodations as an undeserved and unfair advantage that fails to hold individuals accountable for what they “should” be able to do. Generally speaking, those with this point of view seem to be on the more conservative side, where there tends to be less of a desire for a “safety net” for individuals who do not perform as well as others.

Similarly, at combination meetings where organizers and speakers teach advocacy skills to parents of children with ADHD, parents who have children that are struggling in school often ask about how to acquire an aide so that they can get the attention and direction that they need to succeed. While many agree that this is ideal, and in some cases legally mandated by the ADA through provisions included in a student’s Individualized Education Plan (IEP), a great deal of the time there are simply not enough resources to provide necessary accommodations at every school. While it may not sound like it would be too hard to provide a handful of special needs children with extra attention or special

tasks and permissions in the classroom, two teachers who attended an informational session explained that this can raise contestations from the parents of other children who worry their children will be neglected or not challenged enough if classrooms are inclusive of those with special needs. Due to a fear that students with ADHD is not actually disabled and that these students and their parents (particularly their mothers) are “gaming the system” simply to get an unfair advantage over others with accommodations, there are a number of people who aim to restrict access in the interest of what they think is fair (Goodwin 2010:94-95).

Not only are there people looking to restrict access to accommodations, but many parents at meetings have reported running into bureaucratic issue. This left a number of them frustrated and confused about what to do after trying to keep the process moving along for months, or sometimes years. One mother who believed her child had ADHD claimed that she repeatedly reached out to school administrators in hopes of having her son tested, but she was having trouble getting a response. A couple at the same meeting had a similar problem with their son’s school. Their son had already been diagnosed with ADHD and the guidance counselors at the school had agreed to set up an IEP for him. After months of checking in on the progress toward create a plan for their son so that he could get the help he needed, it seemed that the school still had not done anything. This problem is what prompted their decision to drive over an hour to the support group meeting, so that they could receive advice on the best course of action.

For parents to older students with ADHD, there were added complications when it came to communication with their child’s instructors. In American middle schools, high schools, and colleges, there tend to be different departments that students must transition

between. One speaker at an informational meeting brought attention to this as a source of problems for students with ADHD when he explained the increase in student responsibility to parents: “Unless a special system is in place, making sure that your kid is bringing home and completing all the correct assignments is no longer as simple as contacting their one teacher anymore.” He went on to discuss how, as students get older, students have more teachers, and teachers have more students, and interdepartmental communication is usually sparse. This creates a situation where student workloads can be unpredictable, and teachers are not able to get to know a student and their needs quite as well when they see them for 45 minutes per day as compared with five to six hours as is the case in elementary schools.

During a talk for college-bound high school students with ADHD and their parents, one speaker mentioned that at most colleges, professors and school officials will be hesitant to provide parents of students with any of their child’s academic information as there could be legal repercussions for doing so. “This will mean that there will be no calls home, no report cards” the speaker continued, and in response, one high school student in attendance excitedly let out a “Yesss!” under his breath, with a hand motion to go along with it. His mother gave him a quick look as if to say “Excuse me?” before breaking into a smile and nudging him lightly with her elbow. Given the young man with ADHD’s reaction, it seemed that he was expressing excitement that his mother would no longer be involved in his academic life as an adult. While it is clear why this might be appealing for students who have struggled in school on the surface, there may be academic (or other) consequences when their primary source of advocacy and discipline is no longer in the picture.

Because American values of independence and privacy in the United States have been codified into laws such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Education Rights and Privacy Act (FERPA) have made it so that once an individual is an “adult,” they are legally granted certain privacies that affect a parent’s ability to be involved in their child’s academic and medical matters. The United States tends to promote a sense of autonomy and the independence that begins at the age of 18, though this is changing alongside the economy as young adults are increasingly financially dependent on their parents for longer periods of time (Raphelson 2014). Still, the notion that an individual is an adult who is capable of making their own life decisions, independent of their parents’ will and consent at the age of 18 is particularly American (though it pervades in other Western cultures). While parents have full access to their child’s health and education status from birth until their teen years, this comes to a sudden stop at either eighteen, or once they graduate from high school. This makes it so that unless an adult child wishes to share information with their parents or there are extenuating circumstances, it is not technically legal for schools or healthcare professionals to disclose certain information. For parents of children with ADHD, this can become nerve-racking as they have likely spent much time advocating for their child and providing close supervision so that their child has a greater chance at success.

At a number of combined-type meetings, it seems that parents all had different views about medication and how it should, or should not be used. For the most part, it seemed that discussion about medication was primarily about the side effects that their children faced because of it. For the most part, it was mothers who would exchange tips on how to address issues with side effects. When one woman announced that her child

couldn't sleep at night once he began taking medication, others suggested that she change his medication schedule or talk to a psychiatrist about trying either a different version of the same drug, or a different drug all together. When another woman said that medication suppressed her daughter's appetite, other attendees encouraged her to start feeding her daughter small meals or snacks throughout the day rather than just at traditionally designated meal times. While a number of attendees had children that were taking medication to address their symptoms, when one couple expressed hesitation to medicate their child, many other attendees sympathized with this position and did not push the couple to make a decision one way or the other. One of the group organizer's concluded this discussion by saying that "only you and your child's pediatrician can really know what's best in your situation." It is important to mention here that attendees at this particular support group meeting were from relatively affluent, mostly white, suburban towns and had access to a variety of options and resources that were not so easily available to less-wealthy residents living in urban areas.

Medicating children is part of what makes ADHD particularly controversial, and may play a role in creating hesitation to address problems through pharmaceutical means. One tactic employed by ADHD critics to raise skepticism about medication is to prey upon fears that medicating (especially young) children with stimulants for a "chronic" disorder (which, would then require long-term treatment with drugs) is a that is commonly believed to "go away on its own" with age. Given the supposed side effects of drugs used to treat ADHD (such as increased heart rate, nervousness, headaches, and appetite loss), along with the addictive quality of stimulants, this concern seems valid regardless of what one thinks about ADHD as a disorder. This has led to a rise of people

searching for alternative ways to treat or prevent symptoms of ADHD from appearing. One way that many have sought to aid (and explain) ADHD symptoms that avoids medication is through dietary changes and supplements which we see when Millichap and Yee write: “Omitting [food] items shown to predispose to ADHD is perhaps the most promising and practical complementary or alternative treatment of ADHD” (Millichap and Yee 2012: 330). With all these discussions about what substances should, and should not go in the body, it can be easy to overlook the fact that other methods, such as play therapy (Ray, Schottelkorb and Tsai 2007) and organizational skills training (Gallagher 2014) can be just as effective. This notion that medication should be the first line of treatment for ADHD reminds us of psychiatry’s turn toward biomedicine and away from psychotherapy beginning in the 1970s. This biomedical preference can clearly be seen in Steven Meier’s teaching materials for his class “Abnormal Psychology” (used to lecture aspiring psychologists and psychiatrists) where his lesson plan for “Childhood and Adolescent Disorders” offers only drug-based treatment to address ADHD. While this preference has been justified by drugs being a fast-acting, and potentially cheaper option.

FOR ADULTS

While obtaining accommodations for children can be a daunting task, obtaining accommodations for adults with ADHD is exceedingly difficult. According to one support group speaker who helped students with learning disabilities and ADHD transition from high school to college or a career, the process for obtaining accommodations “only becomes more difficult with age.” This assertion seems to align with a statistic laid out by Gregg about accommodations in the workplace: “Only four percent of young adults with LD [learning disabilities] and ADHD reported availability

of accommodations on the job” (2010:4). Whether this absence of accommodations in the workplace is due to a lack of awareness, resources, or desire to accommodate, it is likely to make the working environment more difficult for individuals with ADHD. One group organizer (who also happens to be an ADHD coach) stated that being diagnosed with ADHD in adulthood makes it more difficult to access accommodations. She claimed that “some people will require an extensive, documented history of disability” before they are willing to provide requested accommodations. Many at shared-experience based meetings with ADHD claim that they do their best with direct supervision from manager, with one-on-one direction being best. While this would then be a useful work accommodation for individuals with ADHD (and one attendee claims to be part of a special program where managers supervise less people), this is not realistic for every workplace. These very real constraints must be considered when trying to create more ADHD-inclusive spaces in society.

At one meeting, an older woman who was diagnosed with ADHD as soon as she got a desk job in her 50s described people with ADHD as being “not debilitated, but righteously different. It’s the old ‘trying to fit the square peg into the round hole’ and that just doesn’t really work for anyone.” Here, we can see how this woman with ADHD notes that the habits, behaviors, and talents of individuals with ADHD deviate from the norm, but she does not believe that this qualifies her and others as “debilitated.” By the same logic, this woman argued against the use of accommodations in the workplace, instead explaining that it is important to either figure out coping strategies, or try to find a career that fits your lifestyle. She saw enough spaces for people with ADHD as already

existing, and thus, believed that those with ADHD should be responsible for finding those spaces where they are most likely to be successful.

At a combined-type meeting for adults with ADHD, a behavioral therapist seemed to make a similar, though less pointed claim: “You have to ask yourself: If you can’t do the work you’re supposed to, or that you’re expected to be able to do, should you really be at this job? Is it going to make you feel fulfilled if you constantly feel like you’re not enough? Probably not.” Like the “American Dream,” (which essentially claims that all Americans have the opportunity to achieve success if they just work hard enough) this idea that an individual has a great deal of choice when it comes to work is appealing, but it fails to consider many social, political, and material constraints that may restrict options.

At a handful of support groups, ADHD experts (psychologists, researchers, ADHD coaches) encouraged attendees to be willing to rely on trustworthy friends and loved ones to help compensate for shortcomings. As one behavioral therapist said “While it’d be nice if you could manage everything yourself, when you know you can’t, don’t be afraid to ask someone who can. Chances are, if it’s something small like having them remind you earlier in the day that you’re supposed to meet for lunch, they’ll likely be happier to help than they would be if you accidentally stood them up.” While this in some way violates the American value of independence, by creating a network of interdependence, Finding ways around individual accountability through creating a sense of companionship/community/mutual aid and asking for help from an “accountability buddy” to help keep people in line and on track before they get in trouble is helpful for those with ADHD. One woman explained that her sister was her accountability buddy

because she trusted her to “be happy” for her successes and encourage her when she failed to meet goals. Similarly, a male attendee in another group explained that he felt his wife managed to hold him accountable for things so that he could get things done.

For many adults with ADHD at support group meetings, there seemed to be a general consensus that medication was usually helpful, but not the most important way to address ADHD. Nonetheless, medication is often sought because it can be an instant (if partial) solution, whereas other methods for addressing ADHD can take a great deal of time and energy.

CHILDREN & ADULTS

In discussing the structures in American work and education that do not allow for much deviance from the norm, it is important to consider a number of traditional American values that determine the goals and functions of various institutions. Some of the values that are revered in American culture worth noting here are: personal output of energy, individualism, competitiveness, and efficiency (Gillin 1955:108-9). For support group attendees, there seemed to be trouble in trying to live up to these cultural values. Since a number of symptoms of ADHD can affect productivity in relation to education and various lines of work, many adults with ADHD explain that they struggled with being deemed “lazy” throughout their lives, regardless of how much they might want to get done. Similarly, competition that involves cognitive functioning could put those with ADHD at a disadvantage. The stories of various shared-experience group attendees who barely managed (or did not manage) to make it through the American education system speak to this.

As individuals who deviate from the norm, those with ADHD tend to have trouble meeting standards the way that “normal” or “neuro-typical” people do. While disability

advocates Law Partner Freedley Hunsicker takes this perspective in his article “Learning Disabilities, Law School, and Lowering the Bar,” where he claims that the Americans with Disabilities Act (ADA) passed in 1974 has “fostered a spirit of entitlement that is suspicious” and prompted schools to provide accommodations that he claims could create “a false prediction of how that student will perform in the workplace” as these accommodations can cover a deficit in a necessary skill in their field of choice (Hunsicker 2000:4,6). People seem to hold the view that it’s okay to use accommodations to “get by” and avoid failing, but resent those who, with the help of accommodations, are able to rise to the top, claiming that if that’s all they needed to succeed, they probably don’t really need accommodations and thus are undeserving of them. Another argument for not making classrooms and workplaces more accommodating and accepting of different individuals is that it will distract or detract from productivity of others.

This leads to the question of why we tend to be afraid of helping people in American culture. One argument that could be made is that, by living in a society that extends beyond the capacity of the natural human social network (which, according to anthropologist Robin Dunbar [based upon human neocortex size] hovers around 147 people [Dunbar 1992]) we do not always, or even, usually, know the people around us very well, and thus it becomes easier to feel apathetic rather than empathetic when it comes to others who are struggling.

In American schools and workplaces, there is a great deal of departmentalization and bureaucratization that restricts communication between various parts. While this can be useful or even necessary when it comes to managing large numbers of people, it can create barriers between people. While smaller communities tend to be more closely-knit

with less extreme specialization, many American towns and cities have become hyper-specialized, and thus, segmented. Additionally, in these settings, it may be easier for an individual with ADHD symptoms to thrive as more people are likely to be aware of their needs, talents and weaknesses and it can be easier to include them in the community this way.

There is an interesting mix of people in terms of diagnosis at meetings: there are self-diagnosed individuals who have not gone to a doctor, those who are looking to get diagnosed but aren't exactly sure how to do it, those that have gone for diagnosis and been told that they do not have ADHD but they still identify strongly with it, there are some people that have only been recently diagnosed and finally—a number that were diagnosed early on (usually those diagnosed in childhood were hyperactive and started having serious problems in school from the beginning).

Many insurance companies do not cover psychiatric care or medications. This creates problems of access where affluent individuals have privilege as they are able to pay for ADHD-related expenses and specialty care. This means that those with less time and money usually go to primary care physicians to receive help with hyperactivity and inattentiveness. Due to time constraints, with short appointments, a number of doctors and even some psychiatrists have a tendency to prescribe medication in order to alleviate symptoms and immediately address concerns.

Unfortunately, it can be even more difficult to get these services covered than it is to find a psychiatrist on one's health plan. On top of being controversial, stimulant medications generally fall into the category of Schedule II drugs as set out by the Drug Enforcement Administration. Attendees who take medication or who have children that

take or have taken medication generally mention that there are side effects to consider, making medication a less appealing remedy for even those who can afford it. As a result, some attendees even attempt to minimize (or avoid aggravating) ADHD symptoms through dietary means by curtailing or eliminating the intake of sugar, caffeine, dyes and preservatives, while increasing the amount of healthy fats (particularly omega-3s), vitamins, and minerals.

Money seems to play a major role in who ends up having access to resources and accommodations and for how long. The older an individual with ADHD gets, the more likely it is that they will be required to undergo a battery of tests to confirm their diagnosis. These tests often require specialists with expensive services (that usually aren't covered). Additionally, specialists such as neuropsychologists are able to diagnose behavioral, learning, and other neurological and cognitive disorders, but they are not trained to treat them through therapeutic or pharmaceutical means. This is further evidence of departmentalization in American culture where specialists become so specialized that obtaining a diagnosis and subsequent treatment can involve a team of many people. An additional resource consumed by this diagnostic process is time. According to one speaker, a psychologist specializing in neuropsychological evaluations, some of the testing can take up to 8 consecutive hours, and many offices only offer them during the week. For many people, it is not possible to take this time off of work in order to be tested, or take their child to be tested for ADHD so that they can get accommodations.

QUALMS OVER LOSING QUALITIES

A few attendees came with qualms over learning new ADHD coping methods and taking medication as they were worried that they might lose the few positive qualities that they associated with their ADHD. One man voiced concern that if he were to try to change, he might lose his natural self and personality and he was afraid that he wouldn't know what was left if that were to happen. Positive traits that attendees associated with ADHD included entrepreneurship and innovation, the ability to "hyper-focus," enthusiasm for new things, living an active lifestyle, and having more energy than others.

This becomes interesting when we consider traits related to ADHD impulsivity where, depending on degree and context, can be debilitating, but there are also instances in which it can be beneficial. Impulsivity, for example, has been shown to fall into the categories of both "functional" and "dysfunctional," which, obviously differ in their ability to "function" normally, but also in their personality and cognitive correlates (Dickman 1990:101-2). In discussing those with ADHD, this is an important distinction, because many individuals with ADHD are impulsive, however, those diagnosed at an older age seem to present with more "functional impulsivity," allowing them to go undiagnosed for a longer period of time. Dysfunction, or when people hit a "ceiling" with their coping and management skills and mechanisms, is usually when they decide that it's time to see someone about finding out what is "wrong" with them. For many diagnosed with ADHD later in life, their constellation of behavior and traits suddenly starts to make sense and there is a sense of relief that usually comes with having a name for their problem. One memorable example of this that came up at a support group meeting was when a fairly successful lawyer came in seeking advice for his ADHD. In his career life, he seemed to find ways to make his ADHD characteristics

work for him; his ability to hyper-focus helped him get through cases, his impulsivity helped him to pick up new projects and talk to/network with everyone around him regardless of their position, his hyperactivity allowed him to stay up and active and kept him from losing energy. He even managed to avoid exacerbating these symptoms to the point where they would be considered “dysfunctional” by avoiding caffeine and having a great number of systems in place to keep him on track.

Unfortunately, however, his traits related to ADHD also deeply affected his personal life and even led to a divorce. He struggled to maintain relationships—he laughed at himself as he explained that most women were not incredibly understanding when he forgot to get back to them for weeks at a time or would not show up to dates. He explained his concern that taking medication would dampen the potential benefits that he has derived from having ADHD, and thus he was looking for other ways to address the ways in which his traits could be considered “dysfunctional” that wouldn’t affect the ones that were functional in the workplace.

From meetings of adults with ADHD, at least five attendees had started, and were (more or less) successfully running their own businesses, and one had even been recently admitted into a prestigious MBA program and intends to eventually start her own business. This entrepreneurial drive and success has made it easier for these individuals to have control over their schedule and work environment which tended to be helpful, but this also raised the stakes for symptoms for some, especially when their businesses expand and they must then manage various employees. One entrepreneur in attendance discussed an event that raised suspicion about her potential ADHD diagnosis; at one point, she left a safe that contained all of the cash from her business open, because she

had simply forgotten to lock it. She said that those around her had always mentioned that she should get her symptoms checked, but it never really fazed her until this event. While she struggled in school growing up and was known for being “scatter-brained,” she had managed to start a successful business where she was physically active and constantly doing new things. In this case, she managed to create a situation where her attributes that may be related to her ADHD work in her favor for the *most* part—but she also has a couple issues that could lead her into serious trouble. She too wonders how she would be able to “fix” issues like forgetfulness and distraction, without affecting her energy and enthusiasm.

Hyper-focus, or the ability to focus on one thing for a long period of time was something that was claimed to be useful for many when it came to certain things, particularly when they were working on a new project or idea. One behavioral specialist who contrasted the different extremes of attention that arise among those with ADHD: “You know, kids and adults with ADHD are so funny—like sometimes it is incredibly difficult to pay attention—but other times you see them working and it’s like ‘HELLO!’ and you find out they’ve been working in their own world for 11 straight hours and haven’t even gotten up to pee! It’s incredible! But also not always the most practical.” At one meeting, a college professor with ADHD explained that she struggled with school until she was allowed to become more specialized and study something that interested her. Because she found the material in her field stimulating, she said that she could easily go long stretches of time researching and writing, often without sleeping for days. Since she has gotten older and is now expected to fulfill more professional expectations and take on more responsibility in her personal life, she is struggling to reconcile her old

work habits and new expectations. She worries that if she were to take medication or try to create more balance, she may not be able to handle the workload in the same way, but at the same time, she recognizes that things cannot go on the way that they have been as it has left her exhausted and facing potential problems in the workplace and home.

One speaker claimed that some people with ADHD can sometimes juggle many things at once because their brains are “constantly flipping between channels” and “as you make rounds, you can get a little bit done at a time until things get boring”. While a few people in group made comments to affirm that they experienced this ability to multi-task, one mentioned that it tends to be more detrimental than useful, while another said that it was incredibly valuable to her and she felt it kept her “young” and “always learning”, but she wished she was able to control it better.

Discussing these kinds of habits or traits that people associate with their ADHD often helps group members to focus on their strengths and positive attributes. Many attendees seem to fear losing their traits, or in some ways, their sense of self through trying to “fix” parts of them with medication or therapy. Unfortunately, there isn’t much scientific literature on what happens to these “positive” traits when using medication or behavioral therapy. While there may not be many controlled studies on the subject, a number of parents in support groups have shared anecdotes about how medication in particular changed their child’s behavior, most often claiming that medication made their child seem “sedated,” “sluggish,” or “zombie-like” which, usually contrasted their child’s naturally “vibrant” personality. In using the word vibrant to contrast the “zombie-like” state brought on by medication, it is clear that there is something that parents tend to appreciate about their child’s usual demeanor and energy. Here we see another case

where people wish to selectively control extreme symptoms. Many parents at support groups were relieved to report that lowering doses tended to address the sluggishness that concerned them and their child was “back”.

Control became an important component in thinking about how symptoms or traits associated with ADHD could come to be seen as beneficial in schools, homes, and workplaces. While they see potential in therapy or medication to control these symptoms, they worry that it may also affect the way that they have adjusted to functioning in a society where many of their traits are regarded in a negative light. According to one organizer who is also a psychologist, negative interference with life activities is a key component that prompts doctors and psychiatrists to determine that a person has ADHD. Most ADHD specialists who speak at meetings assure attendees when qualms over losing their positive qualities come up that the benefits of properly addressing ADHD outweigh any potential harm that would come of it, while explaining that it “shouldn’t change your personality”.

CONCLUSION

ADHD is a medicalized mental disorder that disproportionately affects Americans as compared with the rest of the world. In the United States, defining ADHD as a biomedical disorder is an important step in reinforcing its validity in American culture. This materialistic perspective, however, fails to recognize the disorder's legitimacy as a contextually-based problem that can cause a great deal of distress among those affected. The intertwined histories of science, biomedicine, and psychiatry in the United States have played an important role in the way that mental disorders are understood and perceived among Americans today.

ADHD in particular, developed as a diagnosis that aimed to understand the presence of certain traits that deviated from the norm (namely hyperactivity) among children. The importance of cultural context in diagnosis when it comes to ADHD can be seen in the dynamic nature of the disorder, which has expanded its criteria so that the label can include adults and a wider variety of symptoms. This paper highlights how the switch from "traits" to "symptoms" with the development of the diagnosis points to the fact that these habits and behaviors have some sort of harmful effect for the individual with ADHD or those around them.

To support this understanding of ADHD as a diagnosis that deserves attention and accommodation (for reasons beyond its potential biological and neurological underpinnings), I provided a variety of ethnographic examples pertaining to symptoms of the disorder, as well as secondary, or potentially related problems related to ADHD. These examples indicate that the hyperactive, impulsive, inattentive, and executive functioning-related symptoms of ADHD can be considered, rude, disruptive, dangerous,

or otherwise harmful. Importantly the severity of symptoms, or how deleterious they are, depends heavily upon the context in which they present themselves.

Due to the controversial status of the disorder in popular culture, the stigma that comes with having a mental disorder, and ADHD's manifestation as an invisible disorder, suffering is thus doubled. Additionally, in the United States, there is an idea (often thought to be universal by Americans) that the individual is the primary social body and one is only responsible/accountable for their own actions. In other cultures, this is not necessarily the case and other social units are more important and help foster a different sense of both community and mutual accountability (Scheper-Hughes and Lock 1987:11). This may have implications in that there is resistance against being interdependent (even if it may foster satisfying social relationships) because independence and autonomy are so highly valued in American culture.

This calls into question how we (as a society) care for those who are disabled or suffering. While it may be difficult to find certain kinds of support from certain kinds of people, it is likely possible to find specialized support groups for a whole range of issues. When it comes to ADHD, support groups help attendees make light of suffering, share coping strategies, and bring people together in an effort to create spaces where those who exhibit symptoms of ADHD can be included and thrive. Some support group members even prove that in some ways, their ADHD can set them apart from the norm in a positive light.

In American culture, ADHD is a highly complex disorder that should be considered from multiple, seemingly conflicting perspectives that may each provide partial truths. Ultimately, what may be more important than trying to form a cohesive

understanding of ADHD, is to consider how we might let current or potential understandings of the disorder impact the lives of those with ADHD (and their loved ones). To what extent should an individual try to work with the system that is in place? The answer to this question has varied over time and space, and from individual to individual. This prompts us to think about the ways that we could change the way our education and work systems function—would it be possible to include those who are not able to fit in so easily? These questions bring to light what is at stake in assigning social, political, and legal meanings to a disorder most commonly conceptualized as neurobiological.

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