

EXPERIENCING AND MANAGING STIGMA:
INSIGHTS FROM COLLEGE STUDENTS WITH ADHD

By

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(Under the Direction of James E. Coverdill)

ABSTRACT

Stigma has been defined in previous literature as a feeling of personal denigration or defamation due to the presence of a discrediting attribute, such as an obvious physical impairment or illness. The phenomenon seems to be categorized as a relatively stable experience, in which individuals are expected to either face an ongoing and full-strength manifestation, or none at all. Attention deficit-hyperactivity disorder (ADHD) has received a fair amount of stigma-related research interest owing to the negative social appraisals accompanying both the label of the condition and the associated behaviors. Qualitative interviews with 22 university students diagnosed with ADHD demonstrates that stigma is not a constant experience, but rather one that fluctuates in intensity and duration within the context of daily interactions. Further, students resist the stigma associated with ADHD by using strategic mechanisms common to the resistance of mental illness stigma.

INDEX WORDS: ADHD, Stigma, Resistance

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DEDICATION

For Mara, my grad school sidekick.

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CHAPTER 1

INTRODUCTION

Since Goffman's initial exploration of the topic (1963), stigma has remained a research topic of consistent interest, not only from a theoretical sociological perspective, but from a practical public health and medical perspective. While the biomedical understanding of mental illnesses and learning disabilities is constantly improving, researchers are also better able to define and measure the social effects of the diagnosis. Unfortunately, in spite of recent public health awareness campaigns promoting the "normalcy" of conditions like depression, dyslexia, and attention deficit / hyperactivity disorder (ADHD)¹, the stigmas associated with those conditions remain.

A moderate body of research has attempted to theorize and measure stigma, the majority relying on Goffman's 1963 definition of stigma: an attribute that "discredits" an individual significantly, marks a person as tainted, and allows the target to be denigrated. More recent theorists have elaborated Goffman's definition by identifying notable dimensions (Jones, Farina, Hastorf, Markus, Miller, and Scott, 1984), functions (Link and Phelan, 2001) of stigma or by imposing a variety of slightly varied definitions (Canu, Newman, Morrow, and Pope, 2008; Fleischman and Fleischman 2012). Link and Phelan (2013) and Pescosolido and Martin (2007) have theorized and measured the influence of social location and social networks, introducing the proposition that stigma is a somewhat relative experience, and that the experience and effect of

¹ The National Institute of Mental Health (NIMH) acknowledges both "ADD" and "ADHD" as accurate names for the condition in question. However, generally "ADHD" is used on their website and related information. This paper refers to the condition as "ADHD," but quotations from respondents have been left unchanged if students used the term "ADD." (NIMH 2013)

stigma differs among individuals. However, these ideas fail to represent the mutable nature of stigma within an individual, the intensity and effect of which maintains an inconstant influence on daily interactions. Given recent scholarly interest in ADHD, and long-term theoretical attention to conceptualizations of stigma by medical and mental health sociologists, an in-depth exploration of stigma in a population diagnosed with ADHD is justified. In their 2006 review article, Weyandt and DuPaul note the lack of scholarship regarding the psychological functioning of college students with ADHD, calling for detailed investigations of students diagnosed with ADHD, particularly with an emphasis on the effects of treatment with stimulants and other psychotropic compounds on the academic, interpersonal, and psychological outcomes among college students.

Drawing on rich qualitative data provided by 22 university students, the present study complicates the common understanding of stigma and identifies the strategic uses of resistance in response to stigma. This study identifies and analyzes the inconsistencies utilized by students to define their own stigma experiences and reveals complex and multifaceted responses to psychological distress caused by stigma. Rather than assuming that stigma is a constant presence in the lives of individuals with a stigmatizing condition, I argue that previous conceptualizations of stigma have neglected its dynamic and interactional nature and propose that stigma is present in varying intensities and forms throughout the span of an individual's daily interactions. Additionally, I assert that students exercise a fair amount of agency in resisting stigmatizing experiences.

In order to fully address this argument, I first explore prevailing conceptualizations of stigma in prominent literature. Then I delineate the commonly documented stigmatizing characteristics of the ADHD experience, followed by an explanation of Peggy Thoits'

framework (2011) for stigma resistance strategies. An exploration of the data will show students' denials of stigma juxtaposed against data that I believe represents a manifestation of stigma and a subsequent discussion of the prominent resistance strategies used by the students to counter stigma. There are three main aspects of ADHD that I draw out as relevant and contributing to a dynamic model of stigma: the nature of ADHD as a contested illness, the notable symptoms associated with ADHD, and the presence of stimulant medications meant for the treatment of ADHD. I also note the possibility of a gendered response to stigma regarding the use of educational accommodations.

CHAPTER 2

REVIEW OF LITERATURE

PREVAILING CONCEPTUALIZATIONS OF STIGMA

The majority of recent research on stigma relies on Goffman's (1963) classic definition: an "attribute that is deeply discrediting," marks a person as tainted, and allows the target to be denigrated. Goffman describes two forms of stigma: discrediting and discreditable. Discrediting stigma refers to an obvious, visible mark that causes others to be able to identify an imperfection and label an individual as being different. Discreditable stigma refers to a less visible indication that an individual is in some way different and deserving of social separateness.

Jones et al. (1984) described six dimensions of stigma, speculating that variation in these dimensions could help explain the severity of stigma effects experienced by an individual. Highly concealable stigmatizing attributes, for example, would result in lower stigma severity, while an attribute or condition that worsened over time, was highly disruptive or dangerous, violated commonly held aesthetic qualities, or was of disreputable origin would result in a higher severity of stigma experienced by an individual. These six stigmatizing circumstances illustrated the variable levels of stigma associated with specific conditions, as well as nodding to the varying stigma associated with time-related changes in stigmatizing conditions. Jones also contributed an understanding of stigma as deviant and postulated that an individual who experiences stigma may perceive herself or himself as flawed.

Conceptualizations of stigma by researchers since Jones et al. indicate an understanding of stigma as a consistent and stable experience on the part of the individual with the stigmatizing condition. Canu et al. (2008) conceptualize stigma as, variously, rejection or disengagement by others, and persistent negative bias, as well as an individual's feeling of being "defective." In addition, Fleischmann and Fleischmann (2012) note several other studies (Toner et al., 2006; Waite and Ivey, 2009) which frame stigma similarly. Martin, Pescosolido, Olafsdottir, and McLeod (2007) explored mental health stigma in the form of "the absence or presence of negative attitudes (prejudice) and predispositions to engage in exclusionary behaviors (discriminatory potential)." In a study of pre-teens and teenagers, Wiener et al. (2012) defined stigma as the belief (on the part of individuals with ADHD) that other people are bothered by their personal characteristics or behaviors and that they would be treated "differently" because of their condition, resulting in feelings of embarrassment.

Link and Phelan (2001) later conceptualized stigma as "the relationship between interrelated components of labeling, stereotyping, separating, emotional reactions, status loss, and discrimination." This description of stigma improves Goffman's definition by emphasizing the effect of social context, as well as the actual outcomes associated with the process of experiencing stigma. An additional aspect of stigma proposed by Link and Phelan (2001) is the dependence of stigma on power, such that an individual's experience of stigma is relative to her or his social location as well as the social location of the individual "sending" the negativity associated with stigma. While the consideration of social relations improves the overall understanding of stigma, the influence of power relations turns out to be a relevant theme in students' discussion of stigma experiences.

Research by scholars since Goffman's initial treatise on the subject has focused on defining, conceptualizing, and measuring stigma and stigma-related outcomes. Little attention seems to have been paid to the conditional and fluctuating nature of stigma. Goffman noted that an individual's experience of stigma might vary due to changing life circumstances: an obvious facial scar might fade, or surgery might correct a limp. These conceptualizations rely on the understanding that stigma either exists or not; individuals who experience stigma do so as a stable and persistent daily phenomenon. And although most theorists including and since Goffman have noted the possibility of escaping or avoiding stigma through a change in circumstance, the experience of stigma is universally framed dichotomously: it is experienced or not.

It certainly may be true that an individual with a discrediting condition finds that condition to be particularly salient to her identity, such that the condition acts as "background noise," wherein an individual internalizes her socially constructed "otherness" and recognizes that her condition affects all aspects of her life and all her daily interactions. But it is also possible that stigma is not a constant presence in the lives of individuals with discrediting attributes. Perhaps individuals' experiences of stigma fluctuate in intensity and salience, akin to the effect of a dimmer dial on a light, rather than a light-switch that simply orients to "on" and "off."

In "Labeling and Stigma," Link and Phelan use the example of a landlord refusing to rent to an individual suspected of having a discreditable condition in order to demonstrate the effect of stigma power, but this same example can be used to demonstrate the conditional nature of stigma. A face-to-face interaction with the landlord might provoke momentary intense discomfort or embarrassment. At the subsequent recollection or recounting to friends, if the

discomfort has faded, the individual might experience this interaction as an annoying incident, but without the intensity of the original situation. Alternatively, an individual might not realize until later, perhaps upon learning that the landlord was aware of their condition, that she had been discriminated against. The face-to-face interaction with the landlord would have been a normal conversation, with perhaps no stigma experienced by the individual, while the recollection might provoke stronger feelings of embarrassment and discomfort. This conceptualization allows for an individual to express the general sentiment “No, I don’t usually feel stigmatized because of my ADHD” while simultaneously identifying specific situations that remind the student of the stigma associated with her condition.

In this paper, I have used wording that emphasizes the conditional nature of stigma. I do not assume that individuals experience stigma as an on-going and universally full-strength experience. Therefore, I have referred to increases and decreases in the stigma experience, rather than an absence or presence. My hope is that doing so will reinforce the variability that I see as essential to the nature of stigma.

STIGMATIZING CHARACTERISTICS OF ADHD

Previous literature documents stigmatizing characteristics of ADHD as both the label of the condition and the behaviors associated with ADHD, as well as a unique process of medicalization. Researchers building on Goffman’s theory of stigma debated the origins of stigma as related to the act of labeling (Scheff, 1966) versus stigma due to social rejection as a result of the behaviors associated with their conditions, rather than the label itself (Gove, 1975). The modified labeling theory introduced by Link and colleagues (Link, 1982, 1987; Link,

Cullen, Struening, Shrout, & Dohrenwend, 1989) focused on the beliefs and perceptions of individuals regarding mental illness and the effects those beliefs would have on their actions toward individuals with a mental illness. In testing the effect of the label of ADHD, Canu et al. (2008) found that the application of the label of ADHD would lead to “negative appraisals” of the labeled individual. They found consistent negative appraisals of individuals with ADHD in their experimental setting, and their results indicated that college students regard individuals with ADHD negatively and “expressed hesitance to engage with individuals with ADHD across several situations.” They also noted that this hesitance was most marked in situations that involved teamwork in a professional or academic setting.

Visible and hidden cognitive and behavioral symptoms associated with ADHD have led to the stigmatization of children, particularly. Pelham and Bender (1982) found that children began to disengage from play after 30 minutes of contact with a playmate with ADHD. Problems in peer relations result from both hyperactive-impulsive and inattentive type behaviors, according to Sandler et al. (1993). Canu et al. (2008) list several studies showing that the social performance of children with ADHD is negatively reinforced by some of the cognitive tendencies associated with ADHD: deficient empathetic (Braaten and Rosén, 2000) and emotional regulatory abilities (Walcott and Landau, 2004), poor social problem-solving ability (Zentall, Cassady, and Javorsky, 2001), and a “positive illusory bias,” which contributes to a lack of social learning from rejection experiences (Hoza, Waschbusch, Pelham, Molina, and Milich, 2000).

As adults, individuals with ADHD do not necessarily experience improved social interactions, due to the same behaviors related to ADHD. Two studies with undergraduate respondents found that the respondents rated individuals with ADHD-like symptoms as less

desirable in many ways than individuals without those symptoms. Paulson, Buerneyer, and Nelson-Gray (2005) found that undergraduates indicated “lower levels of liking, less desire to interact, and more hostile affect” towards a woman depicting ADHD symptoms in a 20-minute video versus a non-symptomatic woman played by the same actress. Earlier, Canu and Carlson (2003) found that, after 1 minute of interaction, female undergraduates rated male undergraduates demonstrating IA² traits, less favorably than both non-diagnosed controls *and* those with combined HI and IA symptoms. It is no surprise, then, that young adults with ADHD have reported having fewer friends, deficits in heterosocial skills, and interpersonal and sexual problems (Weiss and Hechtman, 1993). Young adults who marry continue this pattern, showing elevated levels of marital dissatisfaction and dissolution (Robin and Payson, 2002; Murphy and Barkley, 1996). As behaviors associated with ADHD are observed or experienced by others, a sense of aversion or rejection may also develop, due to the difficulties in interacting with an individual who exhibits traits of impulsivity (Ratey, Hallowell, and Miller, 1995; Wender, 1995), inattention (Canu and Carlson, 2003; Robin and Payson, 2002), and antisociality (Mannuzza, Klein, Bessler, Malloy, and La Padula 1998).

The medicalization of inattention and hyperactivity problems has resulted in ADHD’s classification as both a normal and abnormal condition. Conrad (2007) described a similar phenomenon regarding seasonal affective disorder (SAD) and generalized anxiety disorder (GAD), perpetuated by GlaxoSmithKline (manufacturers of Paxil, used to treat both conditions). SAD and GAD were characterized by the pharmaceutical company in the media as *common*, in

² The Centers for Disease Control and Prevention recognize three types of ADHD. An individual with Predominantly Inattentive Type (IA) may be easily distracted and have difficulty organizing and/or finishing tasks, paying attention to details, following instructions and/or conversations, and remembering details of daily routines. An individual with Predominantly Hyperactive-Impulsive Type (HI) may be fidgety and talkative and have difficulty sitting still even for short periods of time, refraining from interrupting others while speaking, or waiting her turn. An individual with ADHD-HI may have significantly more injuries and accidents than others. An individual with Combined Type will experience symptoms of both IA and HI types roughly equally (CDC, 2010).

order to reduce any “mental illness” stigma associated with the condition, so that individuals would seek treatment in the form of medication. In doing so, SAD and GAD were also identified as *uncommon* as a way to inform individuals that this condition could be “subject to medical intervention,” or that it exists outside the normative range of human emotional experiences. ADHD shares this paradoxical classification. Among college students, ADHD is a common condition, and students maintain a certain cultural fluency surrounding the condition that seems to be absent in the broader culture, in which students consider themselves experts on their condition and feel distinctly comfortable discussing and critiquing all aspects of ADHD, including their own diagnosis and treatment. But the symptoms are still seen as uncommon enough, or outside the normative range of experiences, particularly in an academic setting, that medical intervention is indicated. ADHD can easily be considered both discrediting and discreditable, to use Goffman’s initial definition.

Symptoms of ADHD are often visible to friends and family, in the form of behaviors that appear distracted or hyperactive, or as manifested through academic difficulty. A diagnosis itself may be imputed through a combination of behaviors and the witnessing of medication consumption, although the label itself may remain either visible or hidden. Various other aspects of the diagnosis and treatment of ADHD may also be either visible or hidden, contributing to a complicated conceptualization of stigma. In what turns out to be an interesting twist on Conrad’s initial common/uncommon dichotomy, ADHD is also considered by students to be a highly desirable diagnosis, due to the access given by the diagnosis to stimulant medications, which are widely regarded as a valuable study aid.

FRAMEWORK FOR RESISTANCE

In her article “Resisting the Stigma of Mental Illness” Peggy Thoits emphasizes an agentic approach to managing stigma, in which she hypothesizes that individuals with a discrediting condition (mental illness, specifically) actively reject and reframe social stigma through a process of resistance in order to avoid the self-devaluation or low self-esteem generally expected as a result of stigma. Thoits describes several conditions that must pre-exist the use of resistance strategies and elaborates five mechanisms individuals may engage in order to resist stigma, as well as several factors that may affect their use of resistance strategies.

Individuals are able to employ resistance strategies only if several conditions have first been met. First, individuals must acknowledge that they might fit the objective “mentally ill” category. This acknowledgement would come after an individual receives a diagnosis of mental illness, or perhaps after they receive treatment for a mental illness. Thoits is careful to note that individuals are not required to accept such a categorization as a personal identity; it is sufficient that they have been diagnosed or treated. Individuals must also recognize that such a label may be applicable to them by others if their diagnoses were to become public (Link et al., 1989). Individuals must finally acknowledge “stereotype awareness” (Corrigan et al., 2006), meaning that they understand that their diagnoses carry certain cultural and social connotations that could result in their losing credibility or legitimacy if their condition were revealed.

In categorizing five groups of individuals who resist stigma, Thoits focuses on two forms of resistance – challenging and deflecting – while mentioning three others in lesser detail: self-stigmatization, avoidance, and self-restoration. While self-stigmatization and challenges are directly cognitively and behaviorally opposed, the remaining three mechanisms exist in a

somewhat non-linear order. Individuals who *challenge* stigma strongly dispute public perceptions of discrediting conditions, both in regard to self and to others. Individuals who engage in challenging as a form of resistance may make comments that indicate their belief that public perceptions about individuals with a discrediting condition are wrong, not only where the individual herself is concerned, but also regarding the entire population experiencing the discrediting condition. Individuals who engage in challenging stigma may compensate for their perceived shortcomings by excelling in areas contraindicated by their condition, educating senders of stigma about the lack of truth to public perception and/or the reality of their condition, and confronting individuals who perpetuate negative stereotypes about people with their condition. Conversely, *self-stigmatized* individuals are those who agree with both “broad cultural conceptions” of mental illness as well as the accuracy of those conceptions as applied to themselves; self-stigmatized individuals accept and internalize the public’s perceptions of their condition (Corrigan et al., 2006). Though Thoits does not elaborate self-stigmatization, we may assume that common assertions on the part of self-stigmatizers might include statements that indicate agreement with prominent cultural stereotypes about individuals with a specific condition, like “Yes, that’s me!” or “Yeah, we’re like that.”

Individuals using the remaining three mechanisms may or may not agree with society’s perceptions regarding individuals with a discrediting condition, though they universally reject those perceptions as descriptive of self. *Deflection* involves a disregard of public perception as simply inapplicable or irrelevant to self, asserting “I’m not like that,” while acknowledging the potential for harm from those perceptions. Individuals who use deflection make statements that indicate their personal dismissal of stereotypes: “That’s not me.” “I’m not like that.” “I’m different from most [mental] patients.” “That’s only one part of me.” “[My diagnosis] doesn’t

define me.” “My symptoms are due to something else.” Individuals who strategically refrain from disclosing their diagnosis or treatment history in an effort to elude an experience of discrimination, or who fill their social circles with individuals who share their condition, may or may not internalize stereotypes about their condition but definitely exercise *avoidance* as a way to escape the effects of the stereotypes. And finally, individuals may undertake a process of *self-restoration*, which allows a person to recover lost self-esteem by shifting his social comparisons to other, less able populations, such as other persons with a mental disorder, or by withdrawing from activities at which they may not be successful. Self-restoration allows an individual who has already experienced “rejection and devaluation” to regain a sense of value by reframing their investments and relative successes as compared to a less capable or well-considered social group. Thoits closes her descriptions of these forms of resistance by suggesting that individuals will likely orient themselves primarily toward one distinct form while incorporating other forms when called for.

Although ADHD is generally classified as a learning disability, rather than a mental illness, I find Thoits’ framework appropriate for analysis for several reasons. She clearly states that mental illness is only her case in point in an attempt to elaborate theoretical concepts, and these theoretical concepts can be applied broadly to other types of stigma. But comparatively speaking, ADHD and mental illness are similar in several theoretically consistent ways. Goffman described three characteristics that influence the level of stigma directed toward a condition: that they are highly visible, that they are perceived as controllable, and that they are misunderstood by the public. Technically, mental illnesses and learning disabilities are conditions based on the neurochemistry of the brain, and as such could be classified as hidden disorders, rather than as a physical condition such as a limp or a scar, that provide clues to

observers about the “wholeness” of the individual. However, both mental illness and learning disabilities have the potential to manifest in obvious behavioral and cognitive mannerisms that might indicate to an observer that an individual has a diagnosis. An individual living with schizophrenia, for example, might appear in public speaking to herself, which is generally considered a behavior that would alienate observers. Learning disabilities, and ADHD in particular, may also manifest in behaviors that alienate observers, such as an individual’s inability to hold a conversation without constantly interrupting his partner, or an individual’s hyperactive tapping of a pen or other object. Additionally, mental illnesses and learning disabilities like ADHD face questions of legitimacy, in which they might be commonly considered “made up” or lacking in gravity in their effects on an individual’s well-being.

Thoits provides not only a description of the forms of resistance used by individuals, but also a number of factors that could be categorized as independent variables. For example, the course of the condition and the treatment setting may affect the forms of resistance undertaken by individuals with a specific condition. And although she does not theorize extensively regarding the effect of specific factors, it is still possible to extrapolate those concepts as analytic tools, particularly given the rich data available for this research.

CHAPTER 3

METHODS AND DATA

Survey and interview data were collected in two rounds during the 2011-2012 academic year using a combination of random and snowball sampling, and recruitment through advertising. During the Fall 2011 academic semester, an online survey was created and tested by the research team, which included myself, James Coverdill, PhD, and undergraduate researcher Nathan Albright. While this project focuses on interview data, the survey acted as both a source of data and a screening tool for identifying potential interviewees.

The use of both survey and interview methods served the function of gathering sufficient data to respond to several hypotheses related to the research topic. Survey questions requested that students share their attitudes and beliefs about ADHD and stimulant medication use on campus, while interview questions focused on respondents' personal histories and experiences with diagnosis and use of stimulant medications (see Appendix A for interview schedule). The survey provided a broad perspective of students' understandings of the medical etiology of ADHD and the social ramifications of a diagnosis, as well as their interpretations of the fairness of disparate access to and use of stimulant medications among students.

During the Spring 2012 academic semester, the research team requested from the university registrar a random sample of 2000 names and email addresses of undergraduate

students³. This sample contained only undergraduate students who were enrolled full-time during the Spring 2012 semester. All 2000 students were contacted by email, using their university-affiliated email addresses, and invited to complete an online survey. Of the 2000 students contacted, 241 (12.1%) completed the online survey. I selected students for interviews if they indicated in the survey that they had both 1) ever been diagnosed with ADD or ADHD; and 2) ever taken stimulant medication (Ritalin, Adderall, Vyvanse, etc.) that had been prescribed by a physician for ADHD symptom management. No time frame for either condition was specified in the survey questions. Students were asked in the survey whether they would consent to being contacted for an interview; I only contacted students to schedule a face-to-face interview if they indicated in the survey that they were willing to elaborate their survey responses. Interviews were limited to students between the ages of 18 and 24. The Spring interview sample of 9 students consisted of 6 female and 3 male students.

After the initial round of interviews was completed and prominent themes arose from the data according to a grounded theory method (Charmaz, 2006), I modified the interview schedule to reflect emerging ideas (see Appendix B), and another random sample of 2000 students was requested from the campus registrar. This sample included undergraduate students enrolled full-time during the Summer 2012 semester. After eliminating 279 students whose names were provided in both the Spring and Summer samples, 1721 students were solicited by email and asked to complete the same online survey as the Spring survey cohort. 168 students (9.8%) completed the online survey. Again, students were selected for face-to-face interviews according

³ The prevalence of ADHD in the adult population has been established as approximately 4.4% (Kessler et al., 2006); a smaller sample size might have precluded a sufficient survey response rate from which interview respondents diagnosed with ADHD could have been drawn.

to their survey responses. The Summer interview sample of 13 students consisted of 9 female students and 4 male students.

Several students who were interviewed in either cohort indicated that they were aware of other students in their own social circles who fit the “diagnosed and prescribed” conditions of this study. I asked those students to pass along my contact information to those friends, with the understanding that their interested friends might schedule an interview. I conducted one interview with a respondent collected through snowball sampling. Additionally, in order to increase the sample of interviewees, flyers were posted in campus buildings to alert students to the study. One student opted into the study after seeing a flyer on campus.

Table 1 Respondents and Selected Individual Characteristics

Student Name	Class Level	Length of diagnosis	Student Name	Class Level	Length of diagnosis
Anna	4	6 years	Olive	4	2 years
Celine	3	3 months	Naomi	3	18 months
Brandon	4	4-5 months	Russell	3	14 years
Megan	2	12-18 months	Stacie	3	13 years
Willa	1	2 months	Tara	4	9-11 years
Lucy	4	12-13 years	Hannah	4	4-5 years
Phillip	4	3 years	Vern	1	3 months
Franklin	3	14 years	Ivy	4	3 years
Ethan	5	3 years	Karen	4	6 months
Jenn	5	5 years	Georgia	2	6 months
David	4	10-15 years	Maddie	1	12 years

In sum, a total of 3721 students were solicited by email to complete the online survey. 409 (10.9%) did so. Of those respondents, 40 students fit the conditions that placed them in the category of interest for qualitative interviews, and 27 completed interviews, though only 22

interviews are included in this study.⁴ The interview cohort included students who had been diagnosed and treated as early as first grade, and some as recently as a few months before their interview. The elapsed time between diagnosis and interview therefore ranged from three months to 14 years.

Both the survey and interview response rates were lower in the summer, but this difference is not worrisome, as it is very likely that students were simply less motivated to spend their summer leisure time on non-essential academic endeavors. There is no reason to believe that significant differences related to the research topic exist between the samples. Further, there is no reason to believe, apart from standard self-selection bias, that a difference exists between students who opted to participate in the online survey and students who opted not to. Both the survey and interview samples were imbalanced by gender. Of the 409 students who completed the online survey, 274 (67%) were women. Of the 22 students who completed interviews, 15 were women (68%). At the source university, 6 in 10 students are female, which provides some explanation for the imbalance.

I conducted semi-structured interviews in private study rooms in the student center on campus. Students were offered an incentive of \$10 for their participation in a face-to-face interview. Interviews were recorded using a digital voice recorder and later transcribed by the researcher. In sum, interviews provided 1377 minutes of data, equaling 454 pages of typed transcripts. Interviews ranged in length from 17 to 94 minutes, with a mean length of 59.8 minutes and a median of 64.5 minutes.

⁴ One interview audio file was of such poor quality that it could not be transcribed. Other data was excluded because it was collected by other members of the research team.

CHAPTER 4

RESULTS

In my interviews with undergraduates, I found that students overwhelmingly directly denied experiencing stigma, while subsequently describing experiences related to ADHD that had created a personal sense of being discredited. By all accounts, individuals with ADHD are stigmatized in society, so students' general insistence that they do not experience stigma is puzzling. This paradox is partially explained by the specific circumstances of incidents in which students do describe a sense of personal degradation. When attention is drawn to the contested nature of ADHD in a social interaction, such that the legitimacy of the condition or the diagnosis is questioned, students identify that interaction as increasing their sense of stigma. Behaviors that might indicate the presence of ADHD, such as poor academic performance and stereotypical hyperactivity or distractedness, also seem to increase students' sense of stigma. Further, the presence of prescribed stimulant medications creates a legal and social complication that students often find impedes their "normal" function as college students.

Another explanation for this paradox may be students' reliance on stigma resistance strategies. Students rely primarily on avoidance as a resistance strategy as a means of managing stigma associated with ADHD's contested nature, in which they strategically disclose their diagnoses only to trusted associates. Where notable symptoms increase the experience of stigma, students rely on deflection and challenges, in which stereotypes are rejected or their influence minimized. The presence of stimulant medications reveals the use of multiple resistance strategies, including a strong reliance on self-restoration to counter the possibility that

diversion of medication will be considered drug dealing. Overall, students demonstrate a variety of responses to stigmatizing interactions, providing insight into the nature of stigma as flexible and inconstant.

STUDENTS' DENIAL OF STIGMA

In spite of evidence that ADHD carries a significant stigma, the students I interviewed generally denied experiencing stigma related to having ADHD. Student denial of stigma takes three forms: a denial of stigma in general; or an acknowledgement that stigma exists followed by an indication that either an individual has never felt it or is not scared of the effects of stigma. Of the 22 students interviewed, 16 (73%) interviewed specifically either rejected the existence of stigma or denied that they experienced stigma or that stigma constituted a personal challenge. Brandon, a senior with a relatively recent diagnosis, stated: "I don't really think there's any negative stigma that I've experienced...I don't think there's any sort of stigma. Nobody's made fun of me." Brandon's lack of personal experience with stigma has led him to believe that neither a diagnosis of ADHD nor the accompanying behaviors indicate his denigration as an individual.

Another student, Georgia, stated "I guess there are stigmas but I just am not bothered by them," expressing a clear understanding that ADHD is widely known to be associated with negative connotations. Georgia's assertion that she is "not bothered by them" indicates that, to her, the stigmas associated with ADHD are easily avoidable. In describing his patterns of disclosure to friends, Ethan asserted that "I never had any feelings of insecurity about having ADHD." Senior David denied his own experience of stigma and also expressed surprise that

individuals are actually affected by ADHD stigma: “I don’t think I’ve ever felt stigma. Do a lot of people feel stigma?” His comments demonstrate not only the lack of individual perception of stigma, but an implicit expectation that his position is common among other individuals with ADHD. Lucy described the lack of stigma she experiences even when dealing with professors:

...normally I just say, “I have ADD, and I have a hard time paying attention, and it helps me to have extra testing time.” And they read this [letter from the CDS] and they’re like, “Okay, whatever.” A lot of them are just “Okay, the CDS can handle you.” *So you’ll share with your professors that you need certain accommodations, but not specifically what they’re for.* I mean, sometimes [I’ll tell my professor]. It’s not really a big deal. I mean, I know that I have [ADD]. All my friends know I have it; it’s not really a big deal to talk about it. I don’t mind.

Lucy’s denial of stigma exhibits her internalization of her diagnosis, which she considers “not a big deal.” She expresses no concern that a professor’s knowledge of her condition might cause a hit to her reputation as a student, or that she should be concerned about such knowledge becoming public.

In circumstances in which disclosure is avoided, students often express awareness that ADHD is associated with specific stigmas, and assert that their lack of disclosure is unrelated to those specific stigmas. Any failure to disclose their diagnosis is based not on negative cultural attributions toward individuals with ADHD but on a desire to protect all of their medical information. Tara rejects the idea that stigma prevented her from sharing her diagnosis widely, beyond her best friend and her mom:

I had a few friends that had been diagnosed with ADHD, but their cases were a little different from mine. The one boy was just super hyperactive...my case was a little different from his. So I didn’t really relate to him that much. For the most part it was kind of my family that I talked to. I wasn’t ashamed of it, if that’s what you’re getting at. I just didn’t.

Students' reluctance to share their personal medical information is not strictly an indicator of stigma. It is reasonable to think that individuals would want to protect their history of diagnoses and medical treatment, regardless of the details of the condition. However, many students rejected the idea that ADHD was any different from other medical conditions, and it clearly is, as described above. A student who behaves in ways that obviously mark her as having attention problems would likely be sanctioned by observers in a different way than someone who experiences regular migraines. So the attempt made by students to categorize ADHD as an unremarkable condition, to normalize the documented "differentness" of ADHD, constitutes a denial of stigma.

STUDENTS' EXPERIENCES OF AND RESISTANCE TO STIGMA

Contested Nature of ADHD as a "Real" Condition

Students demonstrated full understanding that ADHD is a contested diagnosis. Clues that show their understanding are their acceptance or rejection of the medical model of ADHD, their sense of the normalcy of the condition, and their responses to individuals who challenge their internalized understanding of the condition. Compounding the sense of uncertainty associated with ADHD in my sample are some well-documented challenges surrounding identity management (Loe and Cuttino, 2008), academic ability (Rau and Durand, 2000), and personality (Nigg, Oliver, Blaskey, Huang-Pollock, Willicut, Hinshaw and Pennington, 2002; Martel and Nigg, 2006). David, who had been on and off medication over a period of 13 years, described his recent challenges functioning without medication in the college setting: "I don't know if that's my lack of keeping up with [schoolwork], or if it's my recurring ADD." Some students

struggle to quantify the impact of ADHD on their daily activities of living and their academic success, while others are certain that ADHD is responsible for much of the dysfunction in daily life and academics. Georgia notes: “I’m totally consumed by it; it consumes every part of my behavior and my mind-frame.” Uncertainty about the legitimacy of the disease and its effects on daily life might therefore create a sort of “background noise” for students who have ADHD. This background noise may be a stigmatizing aspect of the condition, as it constantly reminds students that their lived experiences are different from those of students without the condition and requires students to filter the meanings of their personal interactions through the lens of ADHD.

Students simultaneously accept and question the medical model of ADHD with dizzying ambivalence, as demonstrated by Hannah’s lack of certainty about both the legitimacy of the diagnosis and the need for medication:

There is scientific evidence that there is a such thing as ADD, that it is a real issue that some people struggle with, but if meds can be avoided I think they probably should be avoided. I’m not sure, I guess I haven’t completely formulated my opinion on whether or not it’s a completely real legitimate thing that needs meds sometimes. I think probably sometimes it does need meds.

Hannah’s comment reflects her reliance on medical research to support her belief that ADHD is a legitimate diagnosis and a real condition that creates real challenges for those with the condition. And while her concern is ostensibly one of appropriate treatment, it is also possible to understand her comments in the broader context of ADHD’s contested nature, so that questioning the legitimacy of an established medical treatment associated with the condition can be interpreted as an indictment of the medical model.

This uncertainty often originates from students themselves, who express doubt at their own diagnoses or at the prevalence of ADHD in the general population. Anna rationalized her denial of a widespread stigma experience by referring to the large size of the university, implying that she felt able to hide her condition because “there’s lots of people who have this issue,” and that the (presumed) high prevalence of ADHD on campus assisted in creating an atmosphere in which students felt as though their condition was not stigmatizing, but actually quite normal. Other students view the (presumed) high prevalence of ADHD as troubling, expressing skepticism that the diagnosis is applied properly to themselves and to friends and family members. These skeptics questioned the medical legitimacy of the diagnosis and the ability of medical professionals to detect it accurately, asserting that the prevalence of the condition is inflated by doctors who over-diagnose in children.

Another characteristic of ADHD that some students find discrediting is its popular categorization as a childhood disease. While adult diagnoses are not uncommon, Vern expressed skepticism and discomfort at his diagnosis during college: “I was kind of like, ‘Eh, there’s no way. I’m in college. That’s weird.’ I just felt like it would be weird if I had ADHD.” And while “weird” is a somewhat imprecise term, it clearly conveys certain connotations that indicate this student’s sense of being discredited by his ADHD diagnosis.

Students also commonly described both the skepticism and disbelief they encountered from “uneducated” or “old school” family members, neighbors, or casual observers, who may misunderstand or refuse to accept the medical model of ADHD, relying instead on tropes of personal responsibility, hard work, and discipline:

Yeah, well, I mean I guess it’s not that they were all unilaterally unsympathetic; it’s that most of them were ignorant of it. They

either didn't know what it was and thought that it was a serious thing, and treated me like it was a serious thing "Oh I'm so sorry!" or they're like "Oh, that's a bunch of baloney. Do your homework." The whole "lazy stupid crazy" stereotypes about that kind of thing.

Stacie, in describing common reactions to her adolescent disclosure of ADHD, notes that the contested nature of ADHD has contributed to interactions in which she has experienced an increased sense of being discredited by her diagnosis. In this interaction with her hairdresser, Stacie was confronted with a clear sense that outsiders often do not know how to respond to the disclosure of an ADHD diagnosis, and that they do not predictably respond with either sympathy or derision. The unpredictability associated with other peoples' responses to ADHD is one aspect of ADHD's contested nature. She also acknowledged the widespread belief that individuals with ADHD are not legitimately afflicted, but either lazy, stupid, or crazy; these characterizations of individuals with ADHD are clearly negative. According to Stacie, then, a disclosure of ADHD may illicit either an overly concerned response, a confused response or a negative one, all of which are due to ADHD's contested nature, and none of which are appropriate. Further, a belief on the part of an observer that ADHD is "a bunch of baloney" challenges the medical legitimacy of the diagnosis, leaving Stacie to reconsider her own understanding of the seriousness of her condition. It is safe to assume from the above quotation that Stacie individual places her faith in the medical model, since she criticizes an interaction in which the model was challenged, but the refrain of "lazy stupid crazy" as the public's perception of ADHD seems like a persistent impetus for an individual's re-evaluation of one's own diagnosis.

Misconceptions about ADHD on the part of family members is fairly widespread throughout my sample. The effects of family support for diagnosis and treatment ranged from

full support to absolute rejection and resulted in quite complex familial relationships in some cases. Several students described their parents' attempts to dissuade them from pursuing a diagnosis.

Um, well, they didn't want me to get tested, and so I ended up leaving home this summer. I lived in Palm Beach, Florida and I got into a big argument about it, and I literally packed my car and drove to my cousin's in Atlanta and started it not with their support and I paid for the whole thing by myself. Paid for my medications in the beginning. They were not supportive until really after I got my results and they got educated on what it is. (Georgia)

My parents, too, are like very Greek. They didn't really believe in having a problem. (Anna)

These families' objections were grounded in a desire to prevent their students being labeled as inferior in some way to other students. Parents who discouraged their students from pursuing ADHD diagnoses and treatment were reacting against the stigmatizing effect of the label of the condition. Parents' unfamiliarity with the medical condition and their aversion to label their children as deficient contributed to interactions in which students' experience of stigma was increased. Celine noted that the people (family members) she has told about her diagnosis have been "supportive," although her characterization of support is based on their outright rejection of her diagnosis: "You don't have ADHD." The clear message to Celine is that her doctor screwed up in diagnosing her, and that her doctor is therefore incapable of treating her effectively, and that her family's support is contingent on her rejecting her doctor's diagnosis. This is a particularly stigmatizing situation for a student; if she seeks further treatment, she is rejecting her family's support. If she accepts her family's judgment, then she will either reject treatment or avoid relying upon her family for support.

The stigma related to ADHD becomes responsible for creating distance between an individual with ADHD and those who might offer support and acceptance. Students

acknowledge other aspects of ADHD that contribute to the label-oriented stigma associated with the condition, including the troubling characterization of the diagnosis as a “crutch” that individuals might use to gain unwarranted assistance or accommodations. Vern stated that he doesn’t really talk about being or having ADHD, because “I don’t wanna give people a sob story or, like, use it as an excuse or anything, that I have this ...” He clearly feels that his disclosing his diagnosis will be seen by others as an attempt to excuse his inabilities and reflects a distrust in those to whom he might disclose that they are capable and willing to accept him fully in spite of his diagnosis.

Resisting the Stigma Associated with ADHD’s Contested Nature

It seems to be common for students to strategically disclose their diagnoses to individuals who they assume would be supportive and understanding (usually friends, sometimes family, rarely professors or authority figures), while avoiding disclosure to individuals who they anticipate would be less than supportive. In this way, students are able to avoid the stigma associated with the contested nature of ADHD by filling their social circles with individuals who either share their condition or who are familiar enough with the condition that it evokes no negative sentiment. Georgia, who travelled from Palm Beach to Atlanta to seek support for her screening process, clearly demonstrates the allure of avoidance. The other side of this coin, of course, is a form of resistance in which individuals actively seek support; rather than casting stigma resisters as running away from unsupportive people or hiding their diagnoses and treatment histories, perhaps it is more accurate to classify this type of behavior as “strategic disclosure” or “support-seeking,” if an individual’s actions show them to be proactively utilizing those coping mechanisms. Essentially, students disclose to individuals who support their own

views on the legitimacy of the medical diagnosis and who do not threaten their sense of personal capability.

Other students echoed Georgia's avoidance as a form of stigma resistance in describing their relief at being accepted socially because of and in spite of their diagnoses, attributing that lack of discrediting sentiment specifically to their own deliberate disclosure patterns.

I think, honestly, for all the people that I've told, they either...most of them are happy that I'm getting treatment that I need that will make me what I need to be or what I'm supposed to be. Get me back to normal. Most of the people who are about me like to see me happy. And I'm happy. I don't really think there's any negative stigma that I've experienced. And that may be because the only people that I do tell are people that I'm close to.
(Brandon)

Even for individuals who initially may prefer secrecy, a potential loss of privacy to friends seems not to be particularly troubling, though the inadvertent disclosure of their diagnosis or medication use to a professor or employer increases their sense of stigma. In fact, many students revealed that they specifically did not tell professors about their difficulties, owing to the individual responsibility they felt to manage their condition as well as the assumption that their reputations as competent students would be diminished in their professors' or employers' eyes. Karen describes a friendly conversation with a professor who inquired about her regular presence in the front of the classroom:

Have you told any of your professors about your diagnosis? I've started to. Dr. Williamson was the first person I actually came out to. He was like, "Why do you always sit on the front row?" And I was like, "I have to. I can't pay attention." And that was right after I'd been diagnosed. And then, Dr. Baker knows I'm in the CDS because I had to ask him about testing accommodation. But I just feel like, I don't know, sometimes the teachers are like...look down on you. (sighing) It's like, I don't want people to think that...I don't want the fact that I'm a member of the CDS to reflect poorly on me. I don't want people to say, "Oh, she has a

learning disability, so her degree doesn't mean as much as the other kids.'" So I didn't really wanna ask for any other accommodations other than registering early. So I really don't talk to my teachers about it."

Karen avoids sharing her diagnosis unless necessary to claim the minimal accommodations that she believes are a necessary part of academic success. Moreover, an interesting characteristic of this student's explanation to Dr. Williamson regarding her choice of classroom seating is that she revealed not her *diagnosis*, but *behaviors* related to her diagnosis that could explain her distractedness without actually revealing the presence of a specific condition. After all, any number of factors could contribute to a student being unable to pay attention, like pleasant weather, chronic insomnia, disinterest in the course material, or another student surfing the internet nearby; Karen's avoidance of stigma related to ADHD is reliant on her disclosing troubling behaviors, but not revealing her actual diagnosis.

Students seemed divided on the benefits of disclosure to employers. Ethan, in explaining how a possible friendship with his boss would make a difference in his response to an inadvertent disclosure, ultimately decided that he would prefer to keep information about his diagnosis to himself:

...it always comes back to, regardless of how he feels about it, regardless of how he feels about certain things, it's always in the back of your head. You always know it. So you may be predisposed to think a certain way in favor or discriminating, but, so, no. I'd rather him just not know....I'd rather him just not know and just judge me on my work, opposed to judge me on my personal thoughts.

The assumption on Ethan's part is that clearly the information a supervisor might have of his condition would inevitably impact his impression of the student in a negative way, or hold him to standard which is different or in some way marked as "abnormal." So, by simply keeping his diagnosis a secret, this student resists the stigma associated with ADHD.

Brandon, who has an interest in finance, describes a clear sense of disinvestment from any workplace in which a disclosed diagnosis – whether inadvertent or deliberate – would affect his supervisors’ assessments of him as a worker: “If that’s gonna reflect negatively, then I’m not gonna work there.” This absolute disinvestment from a potentially hostile workplace allows Brandon to resist stigma by insisting that employers and co-workers treat him as if he were not discredited by his condition, because, in fact, he believes that he is not discredited. In this example of self-restoration, Brandon represents an individual who is devoted to his professional success, but not at the risk of self-degradation – at least within the context of a hypothetical circumstance.

Hannah, however, revealed that, in employment interviews, she has responded to the common question “What are your weaknesses?” with a frank assertion that she has been diagnosed with ADD, but that, in her experience, people with ADHD are very creative and able to think “outside the box,” and that with minor workplace accommodations she could make a significant contribution to any workplace. It should be noted that this response is extremely uncommon among my sample, but I include it here to emphasize that students in my sample simply do not see ADHD as the stigmatizing experience that the public considers it to be. This student attempts to subvert the stigma associated with her condition by disputing public perceptions of ADHD in regard to herself and others with the condition. While acknowledging the truth that her condition *could* be a liability, Hannah also attempts to educate her interviewers about the potential benefits of working with an individual with ADHD. Additionally, she expects that her potential employers will look past her diagnosis and make accommodations for her in the workplace in order to benefit from the contributions she is able to make. This is quite a different picture of individual stigma experiences of ADHD than the literature would paint.

Notable Behaviors Associated with ADHD

ADHD can encompass a wide variety of behaviors that might indicate a diagnosis, some of which may be cognitively and behaviorally opposed: hyper-focus, inattention, physical restlessness, zoned-out stillness, talkativeness, and reticence are all diagnostic indicators of ADHD. Students expressed feelings of discomfort at behaviors that marked them as different from their peers, including behaviors that indicated that they might be poor students, behaviors that might unwittingly reveal their diagnoses to observers, and behaviors that interfered or impacted their social lives.

Behaviors that indicate to others that an individual might be a “poor student” seem especially troubling to students. Recollections of trouble in elementary school remained salient as individuals attempted to understand their experiences of ADHD in college. Placement into remedial learning programs due to low academic achievement, or problematic symptom-related classroom behaviors discredited students at all levels of instruction. Talkativeness, slow completion of class-work, and inappropriate attention to non-academic materials all indicated to other students and teachers that an individual was different in some way.

I was very talkative... like, I would go up and talk to my teacher about random things when we were supposed to be doing stuff. And just, I just wasn't paying attention ever. Usually reading something else other than what we were supposed to be doing. And it was mostly like disciplinary. Nothing deviant, but just loud outbursts, not raising my hand. Fidgeting. Things like that. (Franklin)

So, then, like, one time in middle school, yeah, I was in middle school, somebody had to tap me on the shoulder cuz I was reading a book and everybody else was standing up saying the pledge. So it was just stuff like that. (Laughing.) (Hannah)

Franklin describes not only his attention to “random” topics during class time, but also notes that his behaviors in the classroom violated rules and disrupted the learning environment for other students. His recollection indicates that, to his mind, these actions were clearly outside the realm of expected classroom behaviors. In spite of her laughter, Hannah can easily recall a situation in which she felt as though her normal efforts at being an appropriate student were insufficient. Both of these students were years out of elementary and middle school, and yet they maintained clear memories of standing out due to behaviors that they associated with ADHD.

Teachers who were unaware of an individual’s challenges may have reinforced the “different-ness” of students with ADHD, even those who may have been academically advanced, due to behavioral issues in the classroom. Karen described being sent from her kindergarten classroom to read to the older classes when she misbehaved in the classroom, which she claimed became a persistent pattern through much of her educational career. She describes her confusion at receiving disciplinary attention for her perceived strength:

I was disrupting the classroom in a different way than the boys were. I was not paying attention. I was doing my own thing. I was reading. You know, I’m like, “How can I get in trouble for reading, that’s supposed to be good, at school?”

ADHD contributed to a sense of “different-ness” for this student by challenging the value and meaning of her academic success in the classroom setting.

Lack of academic achievement seemed to be a major source of stigma for students. Their comparisons of their own abilities to those of their classmates, or to an arbitrary standard they might set for themselves, emphasizes feelings of inability. Maddie described her self-consciousness regarding speaking to an instructor regarding course material:

I think one of my professors has an inkling [of my diagnosis]. That's because I have to ask her some of these questions that... in class...like, if I could focus more on the small details, small details build up to big details. A good example of that would be my biology class, where I'm studying genetics. And I'm sitting in lecture. I guess I wasn't paying attention to the word "sequence." And there was one sentence about sequencing of genes, how that relates to inversion, translation, and all that, duplication...and I wasn't understanding it. So, one thing I don't like about the ADHD is that it makes me sound retarded. Because, like, [to professor]: "Okay, cool, can you explain this to me AGAIN? Cuz I wasn't paying attention to that ONE PART." Which screwed me over for that big concept on a test.

Asking for additional help outside class time and still failing to understand class material enhanced Maddie's experience of stigma, particularly because she also assumed that her instructor has appraised her scholastic abilities negatively. Her experience of ADHD necessitated more intervention outside the classroom than she would desire, and having to ask for clarification of course material more than once emphasizes her status as a "bad student."

Testing and diagnosis removed this cause of stigma for many students, including Georgia, by providing "validation that I wasn't dumb." Karen, who was frequently ejected from her kindergarten classroom and encouraged to read to older classes, describes her disappointment in herself for her low college GPA, which she attributes to undiagnosed ADHD. She strongly believes that her symptoms impaired her academic function, in spite of her long-term investment in her education and clear ambition:

If you take out the classes I did poorly on and replace them with the grades I have now, my GPA would be phenomenal. And it kind of sucks to finally realize "Oh, I really screwed up. How can I do what I want in life when I can't?" So it's just gonna be a really hard thing for me to do. But I mean, it's not unheard of for

someone to get into medical school with a 3.5, even though it should be a 3.9.

Karen considers her grade point average of 3.5 to be low, too low to assure her of a spot in medical school, even though 3.5 is still a GPA that many students would aspire to. In spite of her best efforts at maintaining high grades, she is disappointed that ADHD has marked her as a poorer student than she wants to be and feels she is.

At this university, students with specific disabilities are eligible for a number of academic accommodations including designated note-takers in the classroom, extended time for test-taking, and the option to complete exams in the Center for Disability Services (CDS). In order to claim these services, students are required to notify the professor of each course in which they are enrolled that they will be using those accommodations. Students note several stigma-related barriers to using the accommodations to which they are due. First, the accommodations must be visible to students and seen as necessary. As Anna notes, she was unaware of the accommodations she could use, and she reported enthusiasm upon finding out, mid-way through her college career, that there was extra help available for her.

I was like, “Wow, you can get accommodations? You can get extra time? I should probably definitely get this!” And then, like I said, my family didn’t want the stigma attached.

Her enthusiasm was tempered, however, by her family’s wariness of the stigma associated with acknowledging her ADHD in a non-medical institutional setting. Other students expressed concern that their use of accommodations would reflect badly on them in the future. Willa, who had not taken advantage of the accommodations, asserted that she would use those services, as long as her use would go undocumented on transcripts and her diploma:

Yes, because it would help me, but I think that they shouldn’t put that on there, because people, if you need it, they shouldn’t be like

“Oh, this person had note-taking” because it makes it seem like they have an unfair advantage.

For Willa, working with a note-taker is an indicator of a discrediting condition for multiple reasons. Note-takers at this university are recruited by professors at the beginning of the semester and paid a stipend by the Center for Disability Services for providing their class notes to students who access that service through CDS. This service is confidential but not anonymous: students who use this service are required to interact regularly with their note-taker in order to retrieve their class notes.

I was not embarrassed by it, and it is a little bit embarrassing when you're in class of 300 hundred people and you have to go talk to the teacher and say, “Listen, I need a note-taker” and they don't understand.... They didn't understand why they were signing these papers, and they're confused, and they called the CDS [asking] “Why does she need this? This is ridiculous.”

The additional reinforcement of stigma is grounded in the unpredictability of instructors' responses to requests for classroom accommodations. Here, Jenn indicts her professor's troubling response. Confusion and outright hostility from instructors who were either unfamiliar with how CDS accommodations would affect their classroom or who were familiar with those accommodations but clearly considered them burdensome to deal with frequently created a situation in which students experience greater levels of stigma. Lucy, who previously asserted that her disclosure to a professor of her diagnosis would not be a big deal, in fact took an entire semester to think over applying for CDS accommodations, because “I didn't want it to affect me getting into dental school; [I had concerns] that that was all gonna stay private, before I looked into it.”

Several students observed that simply speaking with professors on the first day of class indicates to other students that an individual might have some condition requiring special

accommodation. Further, Lucy described a common exchange between herself and her study-mates when they go to class to take exams, and she goes to the CDS: it's a quick jump from "I take my tests in the CDS...I have ADD" to "Oh, you have Adderall." She assumes that since students know she's not there for the test, and they see her asking for note-takers, "they probably realize 'Oh, she's probably got Adderall.'" And as stimulant medication has become a form of currency on college campuses, the identification of a student with ADHD serves as a boon for students who might be seeking medication. In fact, the treatment of ADHD with stimulant medications is a major source of stigma-inducing behaviors for these college students, as described below.

ADHD creates challenges in individuals' lives both inside and outside the classroom, causing feelings of personal devaluation. Although her grades were fine, Hannah registered the complaint she had in high school before her diagnosis and treatment: "I have no life because it takes me so long to do everything!" Other students also noted discrediting impairments in social situations related to cognitive and behavioral symptoms of ADHD. Georgia describes the discomfort she feels at being a noticeably poor fit within the socially normative behaviors of other people her age:

Yeah, I have a really hard time putting my words together, because my mind races a lot faster than I think most peoples. So, words are really hard for me. I can't read long sentences. I have to break them up. Cuz I just lose...I can only deal with small things at a time. And almost no attention span. I can't sit still. I can't sit through movies. I can't play games or video games or...games. I HATE Facebook... I just...a lot of the social norms for a 20 year old female, I just don't fit.

Difficulties regulating mood and emotion also serve as indicators to individuals that their conditions are in some way outside the norm of expected interactions. Brandon explains how

disclosure regarding the diagnosis can be compelled by a need to explain inappropriate emotional responses or mood swings caused by the condition.

Who have you told about having ADHD? Ah, just my close friends, people that I think should know, my girlfriend, stuff like that. Um, people who would be around me long enough to know, or to where, I could possibly piss them off, if I was in one of those weird moods or funks. I'll let them know, so they'll at least understand.

If ADHD manifests in the disruption of personal relationships, an individual may disclose his or her diagnosis in order to protect the relationship. Brandon's "weird moods" impede his normal his daily interactions with friends and loved ones, and he hopes to minimize possible damage to his relationships by managing his ADHD and revealing his diagnosis as an explanation for his unexpected emotional responses. Stacie noted, as part of her explanation of her own social experience in college, that "people thought I was a little weird, and told me that they didn't want me to come to their parties." Stacie also relayed that, as a child, her mother had encouraged her eccentricities, viewing them as a permutation of her intelligence, although in a university social setting, her childhood habit of wandering off on conversational tangents, failure to censor inapplicable conversational contributions, or her pattern of providing an on-going narration of her internal thoughts has influenced the alienation she has experienced as a college student. Social rejection because of behaviors related to ADHD indicates an interaction that has increased Stacie's sense of stigma.

Resisting Stigma Associated with ADHD Behaviors

Whether or not students describe their efforts in this way, they resist the stigma associated with ADHD behaviors using several mechanisms suggested by Thoits, including

deflecting, challenging, and sometimes a combination of internal and external resistance based on more than one resistance strategy. Details regarding these strategies are provided after an examination of a possible gendered pattern in stigma resistance.

Given the small sample size, it is prudent to theorize conservatively regarding any gender differences, though this pattern does reinforce strong existing gender stereotypes related to help-seeking behaviors, in which women are more likely to accept help than are men, even if the assistance increases their sense of stigma (Sheu and Sedlacek, 2004). None of the male students interviewed for this project had ever used CDS accommodations⁵, compared to seven of the female students who were currently using accommodations at the time of the interview. This pattern demonstrates a stronger reliance on deflection among male students than female in regard to the prominence of the effects of ADHD in a classroom setting.

Among the 13 women in my sample, 10 viewed the CDS accommodations as desirable; only 2 of the 7 men thought so. The male students provided a variety of reasons for their not utilizing CDS accommodations. David had been diagnosed as a child and did not have a current diagnosis, though he had been planning for a time prior to his interview to seek a new diagnosis, as he felt his needs for intervention were increasing. He noted that he might seek out CDS accommodations eventually, but his lack of action in seeking out a diagnosis, and the fact that he only had a few semesters left before graduation makes it seem unlikely that he would actually use those accommodations. Phillip had not gone through the process of using accommodations due to misconceptions about how the CDS process works and concerns about financial obligations for additional testing.

⁵ One student did not provide explicit information regarding his use of CDS accommodations; interview context suggests he has not enrolled at CDS or sought accommodations.

The four other male students denied their need for the accommodations based on a variety of reasons that indicate their desire to avoid stigma. Ethan's pride kept him from utilizing the services. Franklin viewed these services as "a crutch." Vern felt that his situation was not so drastic that he needed extra help. Brandon cited his short tenure remaining at the university, as well as his sense that his condition is under control and does not need additional intervention. These rationales exhibit a strong sense of resistance to stigma related to ADHD accommodations. Essentially these male students are minimizing the impact of their condition and thereby deflecting stigma associated with the accommodations that could provide relief from the most challenging academic aspects of the condition. The condition is not *so* troubling that students need classroom intervention.

Among the eight female students not utilizing CDS accommodations, Willa and Megan did not know that services were available and seemed ambivalent regarding their future use. Ivy was interested in the extra help but had not known upon entering the university that such assistance was available. Celine wanted to leave behind every accoutrement of her diagnosis, including her medication, and refused accommodations on those grounds. Olive sought accommodations early in her college career but failed to complete all the necessary paperwork; she further suggested that her "decent grades" indicate that services are not necessary after all. Anna regretted not signing up with CDS when she entered the university and acknowledged that her parents' conservative approach to disclosing her condition had influenced her not registering. Both Stacie and Tara expressed a belief that the accommodations are unnecessary because they can handle the academic challenges that may accompany ADHD without intervention.

Unrelated to the gendered help-seeking behavior, other patterns of resistance to stigma associated with behaviors related to ADHD emerged. Within the boundaries of the interview

situation, it was common for students to outright challenge the perception of individuals with ADHD as poor students. Challenging, in the context of stigma resistance, involves directly confronting or educating senders of stigma about the stereotypes they perpetuate, which in the case of ADHD, often equates to “lazy stupid crazy.” Students were incredibly forthcoming with me about their high levels of ambition in an attempt to counter the public perception that individuals with ADHD are “lazy.” As Franklin noted, “The ambition’s there but I just still can’t always do it... In a way I was really smart in certain things.” With this comment, Franklin challenges both the notion of “lazy” *and* “stupid.”

Students also deflected the stigma associated with ADHD by ignoring the label of the condition and emphasizing instead how the condition affected them in the classroom. Deflecting stigma involves the marginalization of the condition to only a minor aspect of an individual’s entire identity; deflection requires an individual to minimize the influence of the condition. Franklin, who above claimed to be both ambitious and smart, went on to explain that he earned Cs in his courses because he didn’t do the required work. By emphasizing his lack of effort as the reason for his poor classroom performance, he deflects the stigma of ADHD and resists the stigma associated with being a poor student. Phillip describes a persistent test-taking challenge of his:

I don’t know if this is my ADD, but every test, no matter how prepared I am, I feel like I’m the last one to hand in the test. I’ll stay for the entire test. Sometimes I don’t finish it. And that’s because I read a question three times to understand it. So I think I’m a slower test-taker than other people.

Phillip’s characterization of himself as a slow test-taker allows him to somewhat avoid the stigma associated with ADHD. He can legitimately claim that he doesn’t know whether the ADHD causes him to be a “poor student,” because his personal history shows him to be a slow

test-taker. Deflecting the stigma of ADHD in this case involves this student reframing his learning disability as “maybe an important part of me” but definitely not the only possible explanation for his difficulty in the classroom.

Students also tend to deflect based on a sense of pride in accomplishing their educational goals without the assistance of interventions. Vern explains why he has not sought accommodations through the Center for Disability Services:

It would be awesome to have extra time on tests, but I don't know. I guess I would. But I don't think my situation's so drastic. ...I'm sure it would be great and helpful, but I feel like perhaps that would a little over-diagnosis for my situation.

This student describes his situation as not “so drastic” that he needs additional intervention. He is engaging two forms of resistance: deflecting and self-restoration. By claiming that his condition is not drastic, he attempts to minimize and marginalize the effect of ADHD on his life. He also implicitly compares his own situation to that of a nameless and faceless group for which CDR accommodations are not over-diagnosis; there are students worse off than himself, and those benefits should be saved for them. As Thoits noted, shifting comparison groups is a form of self-restoration, another mechanism sometimes used to resist stigma.

However, students rarely recounted having actually *openly* challenged senders of stigma, in any setting. This form of stigma resistance is more of an internal cognitive coping strategy than a behavioral pattern that would be witnessed in personal interactions. Thoits also lists “educating” as a form of “challenge,” and though students have not generally recounted taking advantage of a stigmatizing setting in order to educate, students in fact do educate their friends about ADHD, particularly when a friend might be wondering whether their own classroom difficulties might be due to an undocumented case of ADHD.

I did have a friend who I kinda thought was going through it, and he brought [ADHD] up, so I told him how I felt and how I approached it, and went to my counselor and doctors. I shared that. I didn't keep it a secret. I thought he needed help. (Phillip)

For these students, their familiarity with ADHD and their diagnoses allow them to consider themselves “experts” about ADHD. Small wonder, then, that they do not consider ADHD a liability: their expertise endows them with a useful tool to assist friends who may be concerned about their own poor classroom performance and the accompanying emotional distress.

Treatment Setting Defined by Stimulant Medication

Stigma related to characteristics of the treatment setting contributed to a sense of discredit among students, both in early life and as college students. The use of stimulant medication specifically seems to create a unique set of challenges for students as they grapple with the usual social and academic challenges of a university setting. Because stimulant medication affects individuals differently, and because students' health insurance varies in which medications and dosages are covered, and because stimulant medication has obvious physical effects on the body, the adjustment to taking and managing medication can foment a sense of differentness. The strict governmental control of stimulant medications like Adderall and Ritalin requires students who use these medications to be concerned with the legal implications of diversion in a way that students who take anti-depressants or other prescription medications are not necessarily concerned. Additionally, because stimulant medications are so highly prized among college students, any public knowledge that an individual has a regular prescription will likely lead to requests for diversion from friends, introducing a new dynamic into the already complicated social realities of college life.

With early formulations of stimulant medication, both morning and afternoon doses may have been necessary. Among students who were diagnosed at a young age, the necessity of taking a dose of medication during the school day stood out as a stigmatizing characteristic of their condition. A sense of being different from their classmates was enhanced by the need to visit the nurse's office, emphasizing the irregularity of their personal needs. Russell noted his difficulty remembering to go to the nurse's office every day for his medication:

So it was hard to go into the nurse and take it, and I'd miss it, and it was very irregular, and my grades suffered again.

For this student, the second dose of the medication was necessary both for behavioral and academic success. Any irregularity in dosing would have led to inconsistent learning in the classroom, resulting in poorer grades. A poorly designed medication increased this student's sense of stigma.

The stimulant medications used to treat ADHD are troubling to students because of the physical effects they have on students' bodies, particularly in the context of the previously mentioned contested nature of ADHD.

My dad doesn't believe in it. He believes that it's not a real disorder, even though he has it. And he refused to take medicine for it. And that's why he lets [my brother] choose. You know, he didn't want to take it...he thinks the medicine's horrible for you. And I do, too. (Naomi)

I wish doctors would make these parents medicated before they medicated their kids. (Georgia)

Both of these students express a strong wariness surrounding the actual medication used to treat their diagnosed condition. After experiencing the effects of stimulant medication, they questioned its effectiveness, necessity, and safety for growing bodies, causing them to conclude

that, given that ADHD might not even be a “real disorder,” a need for such troubling medication might be vastly overestimated.

Students are engaging in a trade-off between some incredibly uncomfortable side effects of the medication in exchange for the ability to discipline their bodies to perform in an academic setting, with many students describing attempts to function without the medication or to find an alternative treatment to manage their symptoms. Lucy describes the preparations she undertakes in order to “survive” the medication, including personal care and communication with her physician and parents:

I really don't like taking it if I have to. Because it's a lot of preparation if I'm going to take it. I have to have a big breakfast because I'm not gonna eat all day. And I can feel myself getting dehydrated, and just weak.... I'll alter my dosages for the days. Like, if I have to study, I'll take more, and then that's what I have the Focalyn for, for days when I need to take it all day. And then the Adderall I'll do for half days. It's taken me a lot of talking to my dad and my doctors about how to manipulate it so I can sleep and eat and survive taking it.

The acts of having to plan the day around taking this medication and making allowances for the effects of the medications increases Lucy's sense of stigma. Having experience the physical effects of the medication, Lucy knows that her appetite will disappear and she will become dehydrated throughout the day; her comment above reflects the planning that goes into countering the side effects of the medication. Further, she describes how students are often left to their own judgment regarding how much medication to take. This decision is highly variable, depending on how much concentration and focus a student anticipates she will need over the period of a school day. Basic bodily functions – eating and sleeping – are subject to disruption if medication is taken at the wrong time or the wrong dosage. This presents a significant challenge

for students who take stimulant medications and increases the sense that ADHD makes them different from other people.

Additionally, students describe their dislike of the medication for other reasons, including the sense that the medication was necessary to mold them into acceptable and appropriate individuals.

I always didn't like taking my Adderall. I really didn't like it. It just...I felt that my parents were making me take it because they didn't like who I was. And I didn't ever want to eat. And I was just kind of introverted and really pessimistic...And then when I got a bit older, cuz when I got to a certain point, I hit that puberty and I was like "Screw everything. I'm not gonna do what you want me to do." When I got to high school, they started reasoning with me. My mom tried to bring up some alternatives that I would have to show interest in trying before she would just let me not take Adderall. So it was just an option, she put it on the table. "If you don't like these things..." And my mom's kind of into the whole spiritual herbal stuff like that, and you know, alternative medication and stuff like that.

Franklin has described not only the impact that medication has had on his body, but also on his relationship with his parents, who insisted that he be medicated. Personality and physical changes are just the tip of the iceberg; for this student, the medication fundamentally challenged the basis of an otherwise loving parental relationship, because he felt that his parents wanted to "medicate away" part of his personality.

Alternatively, students attempt to distance themselves from their medicated selves and to understand the differences between their own abilities and the effects of the medication.

I don't like feeling like I need it. (Tara)

I feel like the biggest thing is just realizing that the medication is what is making you kind of be overly confident, or if you feel

depressed under it, it's the medication doing that. It's not reality. So that's kind of what I've thought. I've been able to teach or tell myself, "Okay, this is just what the medication does to you, and it's not a big deal now." It doesn't really affect me anymore. (Vern)

Tara's comment reveals her preference that her daily life not include reliance on a medication in order to function, while Vern struggles to define the personality changes caused by his daily medication. This is an interesting and difficult challenge of taking any mood-altering pharmaceutical: determining the boundaries of one's own personality and the effects of the chemicals. Stimulant medications have the unique property, additionally, of wearing off after several hours, or losing or gaining effectiveness over the course of a day. Other mood-altering medication may not share this particular characteristic; anti-depressants often need several weeks to function effectively, and a missed dose is generally not significant in overall mood stability. But stimulant medications allow for a rapid back-and-forth cycle between "me" and "medicated me" that some students find difficult to manage.

The presence of stimulant medications may increase students' experiences of stigma, because the knowledge that an individual is in possession of the medication targets them as a possible source for students seeking to procure the medication. Particularly in situations where an individual is asked to share their medication, students may feel "othered" even when they feel comfortable refusing to share their medication.

That's the thing--I thought a lot of people would start asking me for it. Because my other friends who had it always got asked for it. And they said it was very annoying. But I haven't actually. Weirdly, surprisingly, I've only been asked by one guy at work. None of my roommates; they know I have it, but they've never even thought about trying to take it. I haven't given it to anyone, and they've never taken it. (Vern)

Even for a student who is not pressured by friends to share his medication, the initial expectation existed that “people” would begin requesting that he divert his medication to them. And while stimulant medications are surely not the only diverted prescription medications on a college campus, there seems to be a different sort of expectation on the part of non-prescribed students that their friends will be willing to “help” them by diverting stimulants. Both of these expectations mark holders of prescriptions as different or special in some way.

Students also reported that the presence of medication often creates a situation in which they feel pressured to lie to friends and roommates. White lies about their supply protect the friendship or relationship, where a flat refusal to share would harm it:

I lived with a girl last year, and she was like, “Hey, finals are coming up, can I get some Adderall?” And then a friend of hers was like, “Hey I’ll give you a gram of weed for 4 Adderall.” And, I was like, “Uh, you guys, I only have 6, and there’s 6 days of exams, so I really can’t give it away, but I thought I heard so-and-so say they had some...” which was a complete lie. But I don’t know how to approach people. And I don’t wanna come out and just blatantly [say], “No.” I have a hard time doing that. So I kind of beat around the bush. But I guess I’m stingy, like I knew I only had 6 days of pills left, and I’m not gonna give it to them. Which, really I have more, but that’s what I said to them. “Sorry, I have exams, too.” ... So, I more like, play it off to them... (Karen)

This student also recognizes her own limitations in upholding boundaries regarding her medication, noting that she has a hard time simply refusing to share. Instead of refusing, then, a small fib protects her supply of medication, her own moral code, her reputation as a “helpful” person, and her relationship with the person asking for her medication. Clearly, though, she would prefer not to be asked at all, and being singled out by her roommate and her roommate’s friend increased her feeling of being different, which was only brought on because of the

presence of stimulant medication. Students also disclosed that they had purchased lockboxes in which to store their medication, that they regularly take precautions to hide their medication in their personal spaces, and that they prefer roommates who also take the medication, as it leads to fewer awkward conversations.

Students also expressed discomfort at being considered “privileged” by having access to stimulant medication, particularly because of the misconceptions surrounding the need for it.

I don't want people to know that I have ADHD, especially when I'm working and stuff, because I don't want them, one, to think I'm on Vyvanse and think... some people do think it gives you a leg up over everyone else, when in reality it kinda just helps me get to where I should have been in the first place, instead of just giving me a one-up on everyone else. But I know a lot of people think that, so I probably wouldn't tell anyone. And that's why, when you said earlier about getting longer on the LSAT, I wouldn't want my law school to know, necessarily that I had that advantage, because I still want to be considered on the same pedestal as everyone else who earns that grade that they get, or the job that they get, kind of thing.

Ivy also references the possible stigma she would face in the workplace if an employer were to know of her diagnosis (as mentioned above), as well as the possibility that her academic success is related to assistance she received as a student. Ivy's comment illuminates the tension felt by many students between the need for medication in order to succeed, and their desire to claim their success as an individual effort not reliant on medication. Not only do students desire to claim their success as individual efforts, but they feel compelled to function without accommodations in order to do so.

Other students describe their reliance on medication as an equalizer, rather than an enhancement, due to ADHD's encompassing nature. Russell describes ADHD as “a huge

deficit” that impacts every aspect of his life and justifies his refusal to sell his medication with that in mind.

I mean, I NEED my ADD medicine. My ADD medicine helps me to enjoy the life that I have, and to the extent that it is stable, emotionally, physically, spiritually, that I am. I have self-control. I am the person that I understand myself to be. That person is the same but more frustrated when I'm off my meds. And so I value my serenity much more than I would value that, however much money I would get, which wouldn't be much.

Russell describes his use of medication as allowing him to access his own identity, which would remain hidden or otherwise frustratingly inaccessible. Stimulant medication creates the opportunity for him to experience his academic abilities and his personality as they actually are, rather than giving him an advantage in some way.

Because the diversion of medication on college campuses is widespread, I was unsurprised to hear students admit to sharing their own medication. 13 students in my sample had ever received or shared diverted medication; 8 had never received or diverted their medication⁶. Of the 13 students who participated in diversion, three stated that they had only ever received diverted medication before their own diagnosis, as a sort of informal diagnostic procedure. Two others stated that they had only shared with other family members who also had ADHD diagnoses. Essentially, eight students admitted to diverting medication on campus, compared with eight students who denied ever diverting medication on campus.

Of the 13 students who *ever* participated in diversion, three expressed concerns that I would share that information with public safety officials, though only one seemed seriously concerned about the possible legal ramifications of her disclosure. A related concern among diverters was that they would be portrayed in this research as drug dealers, though students'

⁶ One student did not provide explicit information regarding her diversion patterns.

conceptualization of “drug dealing” deviates sharply from what a law enforcement official might be obligated to address. There is a strong sense, though, that an individual who does not discriminate between close friends and mere acquaintances is engaging in behavior that could be described as drug dealing.

Maddie, who has sold her medication in the past, insists that she has never “hand[ed] them out like candy.” The point at which she stopped selling her medication was a minor epiphany, in which two events claimed her attention: the realization that her friends were seeking her out for medication *for other people*, and her boyfriend’s outright referring to her as a drug dealer. Maddie insisted, though, “I’m not like that.” She also shed light on the casual and unexpected way that her sharing meds with her friends turned her into a pill peddler:

You’re just helping out a friend. But then they tell other people, and then they’re like, “You wanna make 5 more bucks?” I can’t tell you how many times I’ve got that text... And at that point, it’s like, you have clientele, and you are a drug dealer. You are a pill peddler. You’re selling to multiple people.

Maddie’s comment reveals the common understanding that diverting medication to friends is normal; diverting medication to multiple people straddles the line between expected diversion and drug dealing. Widespread indiscriminate sharing of medication is considered “dealing,” while sharing with a friend or roommate does not qualify an individual as a criminal (although technically *any* medication diversion is a criminal act). Ivy shares regularly with friends and sorority sisters, but draws the line at sharing with someone she doesn’t know well or trust, and regularly reminds her friends: “Yeah, here you go, but don’t tell anyone you got it from me... I don’t want everyone to know that I gave people Vyvanse.” Ivy also specifically denied that she is a “source” of diverted medication – although she obviously is. Clearly students find the label

“drug dealer” stigmatizing, in that they attempt to avoid the behaviors they feel are associated with that label.

Resisting Stigma Related Associated with Stimulant Medications

Students recognize that their access to stimulant medication creates a unique social situation in which other students view them as a “source” of medication. Students are encouraged by parents and physicians not to disclose their condition to friends and acquaintances in an effort to avoid this uncomfortable situation altogether, as Phillip notes:

I know when I got it, my mom was like, I think my mom kind of told me not to tell people.

Rather than refusing to share their diagnoses, as recommended by family and physicians, students reported that they attempted to differentiate between associates who could be trusted to maintain their privacy and those who could not be trusted:

I shared [my diagnosis] with some. I wasn't particularly embarrassed about it, if somebody wanted to know. But the only thing that I was concerned about was that somebody would use me to try to get to my ADD meds, because a lot of people try to do that. So I wouldn't share [my diagnosis] with people that I didn't trust to not try and steal my meds from me, or tell somebody else who would then try to steal them from me. That was the only caution that I had. Otherwise I would just tell people. I didn't care.

Hannah resists the stigma related to her treatment by avoiding discussions specifically about her medication except with trusted friends. The diagnosis itself, in her mind, did not increase or decrease her sense of stigma, but the possibility that she would be targeted for her medication “concerned” her. In order to avoid being targeted, she avoided discussion of her treatment with individuals of unknown trustworthiness.

Again, the nature of ADHD as a contested diagnosis plays a strong role in the strategies of stigma resistance used by students where medication is concerned. If a student considers ADHD to be a real, legitimate diagnosis, for which their medication is absolutely necessary, then requests for diversion of medication may be resisted with a direct educational challenge:

I'm like, "Dude, am I just gonna go without these meds that I need for a couple of days? No. That's ridiculous. Sorry, I'm ADD." And I'll explain that to them. "I'm ADD, and I can't just be without meds. And you've got a test problem? Go home and study every day. Like I do." (Russell)

This challenge allows the student to express their own need for the medication by invoking the medical model of the condition, as well as suggesting that the request for diversion is due to the friend's failure to adequately prepare for a test rather than a genuine "need" for the medication. In this way, the student is able to avoid the stigma associated with being targeted for stimulant medication diversion by educating others that his medical condition requires that he not be deprived of his medication.

In an interesting twist, some students seem particularly uninterested in resisting feelings of stigma related to their use of stimulant medication. Thoits might characterize this strategy as self-stigmatization, in which individuals simply accept the stigma associated with a condition and accept themselves as lesser individuals because of it. What these students demonstrate, however, is that the reliance upon stimulant medications is actually a form of self-restoration, in which the medication is re-framed in terms of its benefits to the student.

[My friends and I] just talk about how it's annoying. But the medication does help, so, I'm thankful to have it. (Vern)

The benefits of the medication outweigh any increase in feelings of stigma due to its presence. Regardless, it is also common for students to anticipate the end of their medication use, though

some do plan to continue utilizing stimulant medications indefinitely. In fact, Vern went on to further elaborate his conflicted relationship with his medication:

I wouldn't wanna live being constantly on this medication if I didn't have [ADHD]. Even with the diagnosis I don't always want to take Vyvanse. I just don't always wanna be on it. I don't need the effects all the time and I don't want them all the time. So I can't imagine just taking it if I didn't need it.

The physical effects of the medication are burdensome and unnecessary, and even with the mental clarity and scholastic success associated with the medication, the daily decision to actually ingest the medication seems to be a challenging one. Karen laughed, imagining herself as an 80 year old lady, taking Vyvanse alongside the expected litany of prescription medications associated with diseases of old age, such as osteoporosis and menopause. A career-oriented adulthood reliant upon the use of medication for survival seems to be one that most students desire to avoid, and they maintain vague though insistent claims that they will not rely on meds for an entire lifetime.

While “sharing medication” is not seen as a behavior that carries negative connotations, students take great pains to distance themselves from the identity of “drug dealer” or “pill peddler” even while describing their diversion practices. A common response to the stigma associated with being considered a drug dealer is a form of self-restoration in which an individual changes her or his comparison group. Franklin compared the diversion of stimulant medications to the sale of methamphetamines, stating:

Honestly, if you ask me, if somebody wasn't diagnosed with [ADHD], and they were 18, and they wanted to take it, I don't see a problem with it... So, I mean, as far as its legality status, I couldn't really care. There's way worse crap going on out there. Not to belittle it, what it can be, but it's just like, if you put it next to meth, it's like, “Come on.” There's bigger fish to fry.

By asserting that the dealing of meth on campus is a more significant problem than prescription stimulant medication, Franklin exhibits a shift in the comparison group with which he associates himself, namely meth dealers versus ADHD diverters. Although, it must be noted that this comparison group seems poorly chosen, considering both the chemical similarity of stimulant medications to methamphetamine and the rate of diversion of stimulant medication across college campuses. Franklin's assertion that there are "bigger fish to fry" seems naïve and ill-informed, as he and other students in my sample are quick to justify their illegal and dangerous behavior by minimizing the physical danger of the drug as well as the social ramifications of drug use more broadly.

In addition, students seem fairly unconcerned that their diversion might be brought to light, as if they expected authority figures, including campus officials and public safety officers, to understand that sharing this medication is so common that it does not constitute an illegal act. Olive asserts that she would not care if she were caught diverting her medication:

Did you expect them to keep that quiet, where they got it from...or were you okay having it known that people could come to you for medication? No, I wouldn't really care. I wouldn't care. Because there's people texting for Molly, and there's people texting people for weed. I would almost just be embarrassed if I got in trouble for selling Vyvanse. Like, "Really? Seriously?"

Again, the use of comparison groups allows students to re-frame their own actions as "not as illegal as selling weed" and "not as troubling as selling Molly." Olive also references the non-existent stigma toward campus diverters by implying that she wouldn't care if people considered her a "source." Her use of the phrase "in trouble" seems to reveal a very poor understanding of the possible legal ramifications of her actions, which might be completely justified on a practical level, given that students are rarely sanctioned for the diversion of stimulant medication.

However, by shifting comparison groups, students are able to resist the stigma that might be associated with the identity of drug dealers.

Students also define who they will and will not share with in order to counter the “drug dealer” stereotype that a dealer will sell to anyone who asks. Sharing with close friends, roommates, and romantic partners is not cast by students as problematic diversion. Again, by shifting their comparison group from “people who only share with friends” to “people who share with anyone” students may avoid classifying their behaviors as those consistent with drug dealing. It should be noted, however, that most students assumed other individuals were more generously diverting their medication than they themselves were. In point of fact, only two students in my sample were willing to share their medication with most anyone who asked, and even they drew the line at “random people,” or individuals to whom they are not at all connected through a friend or classmate. Those among the rest who shared reserved their diversion for close friends, roommates, and/or romantic partners.

CHAPTER 5

DISCUSSION

Data provided by undergraduate students reveal a new understanding of a concept relevant to several areas of research. Previously, stigma has been conceptualized and measured as a binary; individuals with a discrediting attribute are expected to experience stigma either all the time or not at all. Some theorists have acknowledged the possibility that changing life circumstances would result in a change in the stigma experience, such as when a visible scar fades, or a when a stigmatizing condition is cured. Generally, the existing research conceptualizes stigma as an on/off experience. Interviews with undergraduates support this theory, in that they largely denied experiencing a sense of personal degradation due to their diagnoses. And some undergraduates *did* characterize their experiences of stigma as full-strength, a kind of lens through which all their daily interactions are filtered, or background noise that they hear on an on-going basis.

However, the variety of situations in which students describe experiencing feelings that they are somehow “different” from students undiagnosed with ADHD strongly indicates that stigma is present for students with ADHD, but not universally, not to the same degree, and not in the same circumstances for every student. ADHD is a contested illness, in that the general public seems to question whether or not it is a legitimate medical condition, and even the students diagnosed with the illness are often uncertain about the legitimacy of the condition and of their own diagnosis, as well as the necessity of stimulant medication. Interactions with family

members who express similar doubt or uncertainty seem to increase individual students' experiences of stigma.

Some of the symptoms associated with ADHD, such as talkativeness, incessant movement, and distractedness may be so far beyond the social norms of college-age individuals that they significantly contribute to a sense of differentness, which increases stigma in interactions where those symptoms are significant or particularly noticeable. For some students the presence of an authority figure, such as a parent or professor, seems to increase their experiences of stigma, while social situations in which students are surrounded by friends are less stigmatizing, possibly due to other students' cultural fluency with ADHD and stimulant medications. Conversely, situations in which parents are supportive of students and professors accept disability accommodations letters without negative commentary allow students to escape, in that moment, the stigma associated with ADHD.

Additionally, the presence of stimulant medication creates a unique set of challenges for students diagnosed with ADHD, in that students are required to spend effort guarding their medication in ways that are not normative for the majority of students on campus. Student may also feel pressured to participate in illegal diversion of medication in order to maintain friendships. The presence of stimulant medication seems to be stigmatizing to students, in that they are universally aware that they are targeted by other students in a way that students without the medication are not, but even this constant presence of medication is only particularly stigmatizing when its presence is noted by another person. A physician's reminder to a student that the medication is dangerous to share, for example, or a parent's reminder to a student that the medication is illegal to share, serves to reinforce to the student that they are different from the general population by their access to a highly desirable substance.

This research supports Link and Phelan's concept of "stigma power," which seeks to explain how authority figures who wield some form of social power may influence an individual's experience of stigma. Academic or work settings in which students are open to evaluation may influence an individual's experience of stigma, which could also be affected by an individual's comfort level with their professors or supervisors. This research also supports claims made by other scholars that students are affected by stigma related to both the label of their condition and the behaviors associated with it. Knowledge of an individual's diagnosis of ADHD may be enough for a family member to express doubt about the condition's "realness," which may lead to the diagnosed individual being forced to defend the legitimacy of the condition and their own diagnosis. Any observation of ADHD-related behaviors could result in social rejection, a sure indicator of stigma.

This research also hints at a possible gendered use of deflection in regard to the use of classroom accommodations. My sample, though imbalanced, suggests that male students are more likely than female to invoke a resistance strategy in which they deflect the severity of their conditions in order to avoid "needing" classroom accommodations. None of the male students in my sample had used the standard institutional arrangements available for students with ADHD, due to a belief that their conditions weren't disruptive or troubling enough for them to need help. On the other hand, half the women in my sample utilized classroom accommodations of some sort, indicating an internalization that ADHD is a condition which limits their cognitive abilities and justifies the implementation of academic interventions. A greater percentage of female students viewed the classroom accommodations as desirable than did male students – 77% versus 29%. Female students did not deflect regarding the severity of their limitations to the extent that male students did.

In spite of their denials that they experience stigma, these undergraduates identified numerous interactions that could be classified as “stigmatizing.” While certain interactions represent for students a high level of stigma, once that interaction is over, the experience of stigma may become less salient until the next similar interaction. Stigma, therefore, is highly situational and not the constant presence that it has been characterized in previous research.

In terms of management, individuals included in this sample clearly identified the ways in which they internally and externally resist the stigma associated with ADHD. Peggy Thoits’ framework for the resistance of the stigma of mental illness provides a context for the classification of these students’ stigma management practices. Thoits categorizes five groups of individuals who resist stigma: challengers, deflectors, self-stigmatizers, avoiders, self-restorers. Individuals who challenge stigma believe that public perceptions of individuals with mental illness are wrong, both in regard to self and to others. Individuals who self-stigmatize accept and internalize public perceptions of individuals with mental illness. A deflector may disregard public perception as inapplicable to oneself, while acknowledging that others may be “like that.” Other individuals with mental illness engage avoidance as a strategy, in which they may simply keep their diagnoses and treatment histories a secret, or they may only tell trusted associates. An individual who undertakes a process of self-restoration recovers lost self-esteem by shifting her social comparisons to other, less able populations, such as other persons with a mental disorder, or by withdrawing from activities at which they may not be successful. Thoits suggests that individuals will likely orient themselves primarily toward one distinct form while incorporating other forms when called for.

My data show that students utilize specific forms of resistance based on a variety of factors related to the experience of living with ADHD. In interactions where ADHD’s contested

nature is in question, students rely primarily on avoidance, in which they strategically disclose their diagnoses only to trusted associates. Stereotypes are rejected or their influence minimized in interaction where notable symptoms increase the experience of stigma, as students rely on deflection and challenges. Where the presence of stimulant medications is a troubling aspect of an interaction, students utilize multiple resistance strategies, including the invocation of self-restoration to counter the public perception that diversion of their medication is tantamount to hardcore drug dealing.

Additionally, students in my sample sometimes differentiated between the forms of resistance they found helpful when extraverting and when intraverting. That is, within both the circumstances of the research situation and their daily thought processes, students educated me and demonstrated their own understanding of their condition as a way to challenge the stereotypes associated with ADHD. When dealing with friends who ask for medication, or strangers who challenge the medical model of the condition, students seem likely to avoid a direct challenge and opt for deflection or avoidance. They educate and challenge internally, while deflecting externally. This tendency hints at an interesting pattern of resistance, in which individuals may demonstrate knowledge of how they could resist stigma, if they so desired, while choosing not to do so. In my sample, it is completely plausible that students' relationships with their parents, their comfort level with medication, and individual personality characteristics would influence their decision to hold themselves back from openly resisting stigma associated with ADHD. Thoits might call a refusal to resist "self-stigmatization," but I suggest that students may selectively resist according to a number of variables, and this selective resistance is also agentic and self-aware. A lack of resistance might not indicate that an individual internalizes stereotypes about their condition, but that they adapt their resistance strategy

according to specific characteristics of individual interactions. Overall, students demonstrate a variety of responses to stigmatizing interactions, providing insight into the nature of stigma as flexible and inconstant.

This research is limited in several ways. First, the relatively small sample size prevents generalizations to a larger population. However, the theoretical contributions made in this research can easily be considered on a broader scale. Second, this sample is fairly homogenous with regard to race and socioeconomic status. Representative of the larger university population, all respondents were white and from middle or upper SES homes. I suspect that socioeconomic status might play a significant role in students' resistance strategies. Parents who are educated and practiced in dealing with medical professionals and institutions will offer a different kind of support to their students than parents who lack a medical understanding of the condition (Lareau 2003). Students with class privilege may internalize their diagnoses and subsequent academic successes, or lack thereof, in a different way than students who lack class privilege. It is also possible that patterns of diversion are different among students who lack financial resources, and therefore the stigma that my sample associates with "drug dealing" may exist in a different permutation among students of lower SES, or not at all. Third, the gender imbalance in the sample prevents an authoritative identification of a gendered pattern in stigmatizing interactions or resistance to those interactions. Gender themes were engaged throughout the analysis without definitive results except regarding the use of educational accommodations.

Future research could take many directions. An obvious and necessary direction would be to explore class differences that elaborate specific patterns of stigma and resistance. It may also be helpful to further identify the specific characteristics of interactions that increase or decrease students' experiences of stigma. I have identified a few characteristics specific to

ADHD – the contested nature of the condition, the notable symptoms, and the presence of stimulant medications – as well as several more broadly applicable characteristics – the presence of an authority figure; the environment, whether academic, employment, or social – that may have affected students’ experiences of stigma. Focusing on one arena specifically might allow for a greater sociological understanding of how individuals with a discrediting condition experience and resist stigma. Additionally, ADHD is used here as a case study; it is likely that careful explorations of other medical conditions would provide insight into how stigma experiences vary across diagnoses. Information gleaned from such research could also provide medical professionals and other administrators with helpful patient practices for the management of stigma.

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APPENDIX A
INITIAL INTERVIEW SCHEDULE

1	<i>ADHD diagnosis and early experiences</i>
	<ul style="list-style-type: none"> • How did you come to be diagnosed with ADHD? <ul style="list-style-type: none"> • Who was involved? • How old were you? • What symptoms? • How did your family respond to your diagnosis? • Were you responsible for taking your meds on your own, or was someone else responsible for reminding you or giving you your meds? • When you started taking medication, did you experience any personality changes due to the medication? • Did you try any other strategies to manage ADHD apart from medication? • Did you share your situation with other people (kids or adults), or did you try to keep it private? • Did you experience a sense of “stigma” or a fear of being “picked on” before or due to the diagnosis?
2	<i>Pre-College Settling In: establishing routines and perhaps autonomy re: ADHD</i>
	<ul style="list-style-type: none"> • What was your most common routine with respect to meds and managing ADHD? • It’s fairly common, apparently, for young people who are using stimulant medications like Ritalin or Adderall to go through periods in which they experiment with their dosage. Have you ever skipped doses, or doubled up, just to see how the meds would affect you? <ul style="list-style-type: none"> • When? • Why? • Did anyone help make that decision? Who suggested / oversaw? • Did you experience any changes over time regarding who called the shots with respect to your medication or other ADHD management? • Did you experience an on-going sense of physical or psychological changes due to the meds? <ul style="list-style-type: none"> • <i>If so:</i> how did you / others view and respond to those changes? • In the period after your initial diagnosis, when you had sort of settled into a routine of taking your meds and functioning, did you share your situation with friends or adults, or did you try to keep it private? • In this period after your initial diagnosis, were you aware of a sense of “stigma” or being “picked on” due to ADHD?
3	<i>Transition to College: early experiences</i>
	<ul style="list-style-type: none"> • What were your expectations about continuing to take meds in college? • Did your experience of having ADHD shape your choice about where to go to college, or

	<p>what to study?</p> <ul style="list-style-type: none"> • Were you concerned about the academic or social pressures of college? • When you knew that you'd be going away for college, did you anticipate any changes in the way you would manage your symptoms of ADHD? <ul style="list-style-type: none"> • Medication routine? • Did you talk with anyone or get advice about college pressures and ADHD? • Did you make other preparations, like looking for a new physician in the local area? Or were you planning to use the campus health center? • Did you get advice, or have oversight, from your parents or others back home about your ADHD? • When you arrived on campus, did you have anyone here who you could or did talk with about ADHD issues? • When you arrived on campus, did you disclose your diagnosis and med use to new friends? <ul style="list-style-type: none"> • For what purpose? / Under what circumstances? • Why? / Why not?
4	<p><i>Settling in at College: establishing routines surrounding ADHD</i></p> <ul style="list-style-type: none"> • Since you've been on campus, what has been your most common routine with respect to meds and managing ADHD? • Have you done any experimenting with your dosages? <ul style="list-style-type: none"> • When? • Why? • Did anyone help make that decision? Who suggested / oversaw? • Have you experienced any changes over time regarding who calls the shots with respect to your medication or other ADHD management? • Did you experience an on-going sense of physical or psychological changes due to the meds? <ul style="list-style-type: none"> • If so: how did you / others view and respond to those changes? • How much of your situation do you share with your friends or other adults, like professors or mentors, and how much do you try to keep it private? • Are there social settings in which it's easier / more common to talk about it? <ul style="list-style-type: none"> • Common to discuss chronic illness? • Since you've been on campus, how much have you felt a sense of "stigma" or being "picked on" due to ADHD? • You mentioned earlier your expectations about social and academic pressure. Since you've been here, have you found that those pressures matched your expectations? Have they been easily managed or really challenging?
5	<p><i>Post-College: plans or concerns about transitions to work or additional schooling</i></p> <ul style="list-style-type: none"> • Do you have any sense of your plans for life after college? • Do you plan to continue taking meds for ADHD? <ul style="list-style-type: none"> • <i>If continue:</i> do you have any concerns about how your diagnosis or med use might be viewed by others in a work environment, graduate school, or professional training? • <i>If stop:</i> any concerns or plans as to how to manage ADHD issues?

6	<i>General Thoughts: advice for others, confidence in medications, etc.?</i>
	<ul style="list-style-type: none"> • Surveys of other colleges suggest a fair amount of sharing and informal use of ADHD, often by students who don't have an ADHD diagnosis. Is it your sense that that's common here? • As a student with a diagnosis or ADHD and a documented medical "need" for the meds, what's your response to that kind of informal usage? • What's your reaction to the characterization of ADHD meds as "performance-enhancing drugs?" • In your perception, within your circle of friends, how do students on campus feel about this type of drug use? • Do you think that students here who don't have ADHD but who use Ritalin or Adderall face any sort of widespread stigma for their use of meds? Or are most students pretty accepting of this type of drug use? • How much confidence do you have that the meds you've decided to use are safe and effective? • Do you have any concerns about the short- or long-term effects of ADHD meds on your brain or body? • Some people argue that our society relies too often and too quickly on pills, and that we ought to exhaust, or at least try other options first. Do you agree with that, or disagree? Why? • What advice would you give to a kid who had just been diagnosed and was considering medication? • What advice would you give to a student starting college? • One last question: there are a several different "types" of ADHD, and the different types are based on whatever the most prominent symptom seems to be. Do you happen to know what type of ADHD you have? <ul style="list-style-type: none"> • Inattentive Type; Hyperactive-Impulsive Type; Combined Type

APPENDIX B

REVISED INTERVIEW SCHEDULE

1	<i>ADHD Diagnosis and Early Experiences</i>
	<ul style="list-style-type: none"> • How did you come to be diagnosed with ADHD? <ul style="list-style-type: none"> • Who was involved? • How old were you? • What symptoms? • How did your family respond to your diagnosis? • Were you responsible for taking your meds on your own, or was someone else responsible for reminding you or giving you your meds? • When you started taking medication, did you experience any personality changes due to the medication? • Did you try any other strategies to manage ADHD apart from medication? • Did you share your situation with other people (kids or adults), or did you try to keep it private? • Did you experience a sense of “stigma” or a fear of being “picked on” before or due to the diagnosis?
2	<i>Transition to College</i>
	<ul style="list-style-type: none"> • What’s your routine with your medication? • It’s fairly common for young people who are using stimulant medications to go through periods in which they experiment with their dosage. Have you ever done any experimenting with your medication dosage, like doubling up or skipping, just to see what would happen? • Did your experience of having ADHD shape your choice about where to go to college, or what to study? • Were you concerned about the academic or social pressures of college? <ul style="list-style-type: none"> ○ Did you talk to anyone about that? • How much of your situation do you share now? Talk to professors / mentors?
3	<i>Sharing (Campus Trends)</i>
	<ul style="list-style-type: none"> • Surveys of other colleges suggest a fair amount of sharing, and informal use of ADHD meds, often by students who don’t have an ADHD diagnosis. Is it your sense that that’s common here? • As a student with a diagnosis and a documented medical need for the meds, what’s your response to that kind of informal usage? • Within your circle of friends, how do student on campus feel about this type of informal

	drug use?
4	<i>Sharing (Individual Patterns)</i>
	<ul style="list-style-type: none"> • How often have you shared your medication? <ul style="list-style-type: none"> ○ Have you ever been approached to share your meds? • How do you make the decision about who to share with, and who not to? • How confident do you feel in identifying symptoms of ADHD in another student? • How do you tell when someone has legit ADHD? Differentiate between “need” and “desire”? • How willing are you to share your meds generally? • Can you tell me about a time that you regretted sharing your meds with someone? <ul style="list-style-type: none"> ○ Do you consider yourself responsible for any complications they experience? • When you share meds with a friend, do you expect them to keep that quiet or would you be okay being known as a source of meds? • Have you ever found out that a friend “misused” your meds in a way that made you feel uncomfortable or perhaps, taken advantage of, or tricked? How did you respond?
5	<i>Safety of Medication</i>
	<ul style="list-style-type: none"> • How much confidence do you have that the meds you’ve decided to use are safe and effective? • Do you have any concerns about the short-or long-term effects of ADHD meds on your brain or body? • What sort of information about the medication do you provide to someone who asks you for it? • How much of a disclaimer do you offer about the meds when you share them? (do you take a medical history?)
6	<i>Post-College Plans</i>
	<ul style="list-style-type: none"> • What are your plans for your life after college? Grad school, work? • Do you plan to continue taking meds for ADHD? <ul style="list-style-type: none"> ○ Do you have any concerns or plans as to how to manage ADHD issues without medication? • Do you have any concerns about how your diagnosis or med use might be viewed by others in a work environment, grad school, etc.?
7	<i>General Thoughts</i>

- Some people suggest that ADHD meds amount to “performance-enhancing drugs” in an academic setting. Do you see it that way?
- Some people argue that our society relies too often and too quickly on pills, and that we ought to exhaust, or at least TRY other options first. Do you agree with that, or no? Why?
- Can you think of any advice you might give to someone in your place? Anything you wish you’d known?