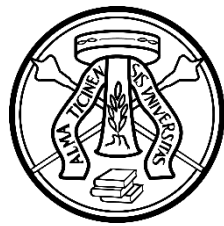


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The Pathologizing Problem: How Clinical Discourse Shapes ADHD Identity and Why It Matters

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Academic year 2025/2026

Abstract

Adult Attention-Deficit/Hyperactivity Disorder (ADHD) is currently caught between clinical psychiatry's deficit-based model and popular culture's reductive "superpower" narrative. Grounded in autoethnographic experience and an interdisciplinary synthesis of neuroethics, philosophy of medicine, disability studies, and phenomenology, this thesis examines how pathologizing discourse impacts neurodivergent identity and agency. By critiquing medicalized deficit models through capability theory, epistemic justice, and phenomenological insights into self-regulation, the study reframes ADHD traits as distinct cognitive styles rather than developmental lacks.

To resolve these conceptual and institutional tensions, the thesis proposes Strategic Dual-Framing: adopting the Neurodiversity Paradigm ontologically to foster affirmative identity and locate disability in environmental mismatch, while pragmatically leveraging the Pathology Paradigm clinically and legally to secure essential accommodations, treatments, and institutional support. Ultimately, integrating first-person phenomenology into medical education transforms clinical encounters from behavioral surveillance into collaborative, ethical care.

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Preface

ADHD is not a superpower.

That's the slogan I wish someone had handed me when I first dipped my toes into the ocean of ADHD discourse. Instead, the internet greeted me with glittery affirmations: "*Your struggles are gifts!*", "*Your brain is special!*", "*It makes you better than the rest!*".

Yet, each time I scrolled past those pastel-colored promises on TikTok or Reddit, I felt a sting, as if every "*you're exceptional*" was a knife twisted just a little deeper. Because I didn't feel exceptional. I felt exhausted. And alien.

So, I turned to the opposite field: science. Surely, the peer-reviewed world would have had answers. Instead, I found something colder: "*ADHD is a disease, a disability.*", "*Patients have reduced grey matter volume.*", "*Patients face shorter life expectancy, higher poverty, higher substance abuse.*". The tone was clinical, but the message landed hard: you're broken, and if you want to survive in society, you'd better wrestle your brain into submission.

Between the pastel positivity and the clinical pessimism, there seemed to be no room for the truth: that ADHD is real, often difficult, and deserving of both support and dignity. That medication can help without meaning you're broken. That you can need accommodation without being reduced to deficits.

Yes, buried in the literature were occasional bright spots — papers highlighting creativity, resilience, adaptability — but they were needles in a haystack. And the haystack was overwhelmingly negative, outdated, and lopsided.

This thesis is my attempt to navigate that impossible middle ground, and to argue that we desperately need a third path, one that recognizes both genuine challenges and genuine worth. I trace how ADHD has been framed across time and discourse — from deficit to difference, from disorder to diversity — and explore how these narratives shape the identity of those who live with it. I examine masking, the quiet art of blending in, and the psychological toll it exacts. And I step into philosophical and ethical territory: what does it mean when a society decides whether you are sick or simply different? Who gets to decide? And what happens to those caught between the categories?

What follows is not a memoir, but a philosophical and psychological investigation grounded in critical theory, neuroethics, and disability studies. Alongside theoretical analysis, I draw on published first-person accounts and publicly available narratives from ADHD communities —

voices that, unlike much academic literature, refuse to be neatly filed under either "superpower" or "tragedy." My own experience as an ADHD adult, formally diagnosed and medicated, informs this work not as confessional testimony but as an epistemological standpoint: I write from within, but with the analytical tools of neuroethics and critical psychology.

If you, too, have felt lost between "you're special" and "you're broken," *this thesis is for you*. It's an attempt to articulate what many of us already know but struggle to name: that we are neither.

Chapter 1: Introduction

1.1 The Ideological Battleground of ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) currently occupies a contentious position at the intersection of psychiatry, philosophy, and culture. On one side stands clinical psychiatry's dominant framework: a "monism of deficit" that reduces ADHD cognition to an executive dysfunction, an incomplete stage of human self-regulation, or a developmental lack. On the other side lies popular culture's counter-narrative: a "superpower" framework that reframes ADHD as an unblemished creative gift, often descending into a toxic positivity that erases genuine suffering, privileges those with socioeconomic safety nets, and re-commodifies neurodivergent traits for productivist ends.

Adults navigating ADHD are routinely forced to construct an identity between these two reductive extremes. This thesis addresses the complex environment surrounding adult ADHD by drawing from academic literature in psychology, philosophy of medicine, disability studies, and neuroethics, combined with qualitative analysis of first-person accounts selected from online communities and my own perspective as an adult formally diagnosed and medicated with ADHD.

This positionality does not grant me absolute authority—an issue regarding experiential knowledge that I critically interrogate in later chapters—but it does make me a particular kind of witness: one who has navigated the clinical encounter, received the diagnostic label, experienced the push-and-pull of deficit versus superpower discourses, and undertaken the difficult work of building an identity that fits neither extreme.

This inquiry is organized around a central research question: How does pathologizing discourse shape the identity, agency, and lived experience of adults with ADHD, and what ethical, epistemological, and clinical problems arise from this construction?

By "pathologizing discourse," I refer to the network of clinical, scientific, institutional, and cultural narratives that frame ADHD strictly as a disorder, a deficit, or a deviation from an unmarked normative baseline of human cognition. This includes formal diagnostic language, clinical manuals, academic literature, and the often unexamined assumptions that clinicians, educators, and employers bring to their encounters with neurodivergent individuals. This project investigates what this language *does*: how being repeatedly categorized through the

vocabulary of deficiency affects a person's self-understanding, what happens to agency when the primary narrative available is one of lack, and what ethical obligations arise for the institutions that produce and enforce this language.

1.2 Grounding Reality: Between Anti-Psychiatry and Pathologization

The theoretical position advanced in this thesis is neither neutral nor naive. It proceeds from the conviction that ADHD is a genuine neurodevelopmental reality—not a social construct, not a fiction invented by pharmaceutical capitalism, and not a convenient label for difficult children or distracted adults. The neuroscientific evidence for atypical brain connectivity is substantial, functional impairments across life domains are well-documented, and the lived experience of adults with ADHD consistently attests to profound, everyday struggle. To dismiss or minimize this reality under the banner of radical anti-psychiatry does a grave disservice to individuals whose daily lives are shaped by genuine neurological friction.

However, a core tension animating this thesis is that dominant pathologizing discourse remains ethically and existentially harmful even when the clinical facts it reports are empirically accurate. A descriptive framework can be scientifically grounded yet ethically problematic.

In the philosophy of medicine, frameworks like Jerome Wakefield's "harmful dysfunction" model attempt to anchor mental disorder in objective biological failure. Yet, as Lennart Nordenfelt's capability approach demonstrates, health and agency are better understood through an individual's capacity to realize their "vital goals" within their specific environment. When clinical psychiatry centers neurotypical functioning as the universal, unmarked standard against which all variation is measured as loss, it enforces a subtle form of social control. It reframes systemic, environmental incompatibilities as individual moral and biological failures, systematically excluding neurodivergent people from shaping the knowledge produced about their own minds. This thesis undertakes a critical examination of that framework—not to dismantle psychiatry, but to ask more of it.

1.3 Thesis Stance: Strategic Dual-Framing

To resolve the impasse between clinical pathologization and total diagnostic rejection, this thesis argues for a strategic dual-framing of ADHD that separates ontological self-understanding from institutional navigation:

- *The Neurodiversity Paradigm as Existential Horizon:* Ontologically and interpersonally, we must adopt the Neurodiversity Paradigm. ADHD represents a

natural, valid variation in human cognitive architecture rather than an inherent biological defect. This framework provides adults with an affirmative vocabulary, fosters community identity, dismantles internalized stigma, and locates functional disability primarily in the structural mismatch between atypical minds and neurotypical social environments.

- *The Pathology Paradigm as an Institutional Lever*: Institutionally, legally, and clinically, we must pragmatically retain the Pathology Paradigm as a strategic tool. In contemporary socio-economic structures, medicalization remains the primary key that unlocks legal protections, workplace accommodations, academic adjustments, and subsidized pharmacotherapy. Abandoning the diagnostic apparatus entirely would strip vulnerable individuals of essential material support. Thus, the pathology model should be utilized instrumentally—as a pragmatic lever to compel institutions into granting rights—without allowing its underlying deficit ideology to define the individual's worth or self-concept.

Under this dual framework, interventions like pharmacotherapy are neither instruments of forced behavioral normalization nor cosmetic enhancements; they are neutral tools of practical agency that reduce internal friction and allow individuals to pursue their own vital goals.

1.4 Methodology and Structure of the Thesis

From a methodological standpoint, a clarification is warranted regarding the status of the online testimonials, forum accounts, and personal reflections utilized throughout this study. These materials do not constitute a statistically representative or demographically generalizable sample of the adult ADHD population. Instead, they serve a qualitative, interpretative, and phenomenological function: providing rich experiential anchors that illuminate the lived texture of neurodivergent identity, ground abstract theoretical concepts in concrete human reality, and highlight recurring hermeneutical patterns within neurodivergent discourse.

To execute this critical critique, this thesis employs an interdisciplinary methodology combining conceptual analysis in neuroethics and philosophy of medicine, social epistemology, and phenomenological analysis of lived experience. The argument proceeds across four subsequent chapters:

- *Chapter 2: Competing Frameworks of ADHD Cognition*
Maintains a critical analysis of Russell Barkley's executive dysfunction model, contrasting its "monism of deficit" with Extended Mind Theory and Brown's concept

of the "univocity of attention." It simultaneously critiques the popular "superpower" narrative, exposing how both extremes fail adult ADHD identity.

- *Chapter 3: Epistemic Injustice and Knowledge Production*

Applies Miranda Fricker's concepts of testimonial and hermeneutical injustice to psychiatric diagnostic gatekeeping. It introduces Dilek Tekin's framework of *Participatory Interactive Objectivity* (PIO) to demonstrate why valid scientific knowledge about ADHD requires incorporating first-person neurodivergent perspectives.

- *Chapter 4: The Phenomenology of Adult ADHD Life*

Examines the interiority of ADHD through phenomenological analysis. Utilizing James Nelson's model of *immanent self-regulation*, it resolves the paradox of masking and explores the lived realities of motivational inactivity, temporal disorientation, lexical cohesion, and the transformative impact of adult diagnosis and medication.

- *Chapter 5: Conclusions and Clinical Re-orientation*

Synthesizes the strategic dual-framing stance, outlining how clinical education must be fundamentally overhauled to incorporate first-person phenomenology. It closes by establishing directions for future empirical and qualitative research to reshape the ADHD consensus from gatekeepers of power outward to society.

Chapter 2: Conceptual Foundations – Medicalization and Normative Health

2.1 Philosophy of Medicine and the Normative Scope of Health

Health, well-being, and quality of life are fundamentally normative concepts that express value judgments and establish standards for human life rather than merely describing empirical facts. When analyzing health, philosophers typically navigate three methodological frameworks—conceptual engineering, the philosophy of medicine, and the philosophy of well-being—each carrying distinct scopes, objectives, and conclusions (Lalumera, 2023). The coexistence of these frameworks often generates definitional confusion with profound real-world consequences, as medical definitions carry immense political and institutional authority. Language in medicine operates as a mechanism of inclusion and exclusion, deciding which forms of suffering are legitimated and which are dismissed.

This political weight is clearly illustrated by the historical declassification of homosexuality in the DSM. In 1974, Robert Spitzer, heading the American Psychiatric Association (APA) task force, redrew the boundaries of psychiatric classification by establishing that a disorder must involve not just functional deviation, but experienced harm, such as subjective suffering, disability, or social impairment. Jerome Wakefield (1992) later formalized this concept into the "harmful dysfunction" account, defining mental disorder as a factual biological dysfunction coupled with a culturally relative value judgment of harm.

However, Wakefield's account leaves crucial questions unresolved: who decides what constitutes harm, and who determines whether a symptom is inherently damaging or merely socially inconvenient? When clinicians, researchers, and patients operate under incompatible understandings of disorder, communication breaks down. This gap manifests as a form of epistemic injustice: a structural failure where the lived experiences of diagnostic subjects are excluded from the institutional processes that name, define, and treat their conditions. Conceptual clarity is therefore an ethical prerequisite for equitable clinical practice.

2.2 Medicalization as Social Control

Medicalization refers to the process by which non-medical problems become defined and treated as medical conditions using medical language, frameworks, and clinical interventions (Conrad, 1992). Beginning in the 1970s, critical theorists such as Irving Zola (1972) and Ivan

Illich (1995) documented how medicine began assuming social control over domains historically governed by religion, law, and community norms. As society granted medicine the authority to define the parameters of normality and abnormality, individuals grew increasingly reliant on clinical experts to interpret their own experiences (van Dijk et al., 2020).

According to Nelson (2026), ADHD is subject to a distinct mechanism of "invisible marginalization". Unlike visible marginalization—which marks individuals as fundamentally "other" and objectifies them—invisible marginalization ignores baseline cognitive disparities by evaluating everyone against a universal norm. Drawing on Stirner's converse mechanism of the principle of equality, this framework demonstrates how formal equality in competitive hierarchies (such as late-stage capitalism) functions to capture difference. For individuals to compete, they must first be assumed to stand on equal footing; the norm becomes an unquestioned principle of common sense that regulates identity for the majority while obscuring structural oppression. When ADHD individuals fail to adhere to these standardized expectations, their struggles are not recognized as neurodivergent differences, but are recast as individual moral faults and deliberate choices. By forcing atypical cognition into norm-oriented frameworks, society subjects ADHD individuals to an invisible disciplinary apparatus that enforces conformity under the guise of shared capability.

For ADHD, medicalization creates a contradictory landscape. On one hand, framing ADHD as a neurodevelopmental condition provides essential resources, legal accommodations, and explanatory frameworks that reduce self-blame. On the other hand, it positions medical professionals as the primary authority over the experience, reframing behavioral variations as internal deficits requiring clinical management, which might otherwise be understood as personality differences or context-dependent responses.

Furthermore, ADHD occupies a uniquely contested space within public and professional discourse: adults with ADHD must constantly navigate between a medical system that pathologizes their cognitive profile and a broader culture that frequently delegitimizes their lived reality as overdiagnosis or personal failure (Thompson, 2021). This tension between receiving validation through a diagnostic label and experiencing pathologization or dismissal profoundly shapes identity formation in adults with ADHD.

2.3 The Capability Approach vs. Biomedical Baselines

To address the limitations of strict medicalization, health must be re-evaluated beyond narrow biomedical baselines. Traditional clinical medicine relies on a "negative" concept of health,

defined strictly as the absence of biological disease or statistical pathology (Lalumera, 2023). This baseline is echoed in modern psychiatric standards, such as the American Psychiatric Association's (APA) definition of a mental disorder as a *clinically significant disturbance in cognition, emotional regulation, or behavior reflecting underlying psychological, biological, or developmental dysfunction associated with distress or disability*. While this clinical threshold aims to prevent the arbitrary expansion of medical authority, it creates a profound tension in contested conditions like ADHD, where the boundaries of medical legitimacy remain unresolved. On one hand, medicalization provides the essential mechanism through which individuals secure diagnosis, institutional resources, and validation. On the other hand, it risks recasting ordinary human variation as pathology. Evaluating individuals strictly against statistical biological norms fails chronic conditions, neurodivergence, and disability, as it assesses human value through inherent deficits rather than actual agency: what a person can *actually do and become*.

Lennart Nordenfelt's (2018) capability-based framework offers a philosophical resolution to this limitation. Nordenfelt defines health as the physical and mental state that enables an individual to pursue their "*vital goals*": those states necessary and sufficient for long-term minimal happiness under standard circumstances, such as sustaining relationships, maintaining a livelihood, and remaining free from debilitating distress. This person-centered model decouples health from strict biological conformity by prioritizing the individual's lived perspective over technical clinical judgment. Under this framework, a person with a chronic impairment or atypical neurology may fall outside biological normality yet remain fully "healthy" in any meaningful sense if they retain the functional capabilities required to realize their vital goals. Crucially, by shifting the question from what is absent in the body to what the person is able to do, the capability framework respects individual autonomy and accommodates diverse forms of embodiment. It resists treating disability as an inherent deficiency, reframing it instead as a relational difference that becomes limiting only in interaction with specific social and environmental contexts (Lalumera, 2023).

When applied to ADHD, the capability approach offers a nuanced lens to navigate the dualities of medicalization. It shifts the analytical focus from internal biological deficits to the dynamic interaction between individual cognitive traits and environmental structures. This framework holds together both the genuine relief a diagnosis can afford and the real risks of allowing medical authority to define acceptable cognition. By evaluating health through the lens of

functional capabilities, agency, and aspirations, the capability approach preserves access to necessary support while resisting rigid pathologization in favor of human flourishing.

Chapter 3: Competing Frameworks of ADHD

3.1 The Pathology Paradigm

Due to its diverse patient base, psychiatry's theoretical foundations, diagnostic tools, and professional scope have faced continuous debate since the discipline's inception. This tension culminated in the 1970s "crisis of psychiatry," where a proliferation of competing clinical approaches prompted practitioners to explicitly define the "medical model." This shift aimed to re-anchor psychiatry within mainstream medicine while systematically re-evaluating the scope and tools of psychiatric intervention (Marocchini, 2024).

“What distinguishes the medical model from non-medical models is not so much its reliance on the scientific method, but rather a philosophical orientation to the treatment of patients' symptoms and signs: namely, that a sufficient deviation from normality represents disease, that disease is due to known or unknown natural causes, and that the elimination of these causes will result in the cure or improvement of individual patients.”

– A.M. Ludwig, 1975

The Pathology Paradigm emerged from the online discussion taken on by the autistic community while first trying to form an autistic right movement, the Neurodiversity Movement. This concept is opposed to the Neurodiversity Paradigm, that will be discussed further in the next section of this thesis. The pathology paradigm rests on two core assumptions: that there is one "normal" way for human brains to function, and that deviation from this norm represents something wrong that needs fixing (Walker, 2021). This paradigm directly stands on the core characteristics of medicalization discussed earlier.

3.1.1 Barkley's Theory of ADHD

Barkley's theory of ADHD, first articulated in the late 1990s, remains one of the most influential conceptual frameworks in the field. Rather than merely cataloging isolated symptoms, it offers a systematic account of how the diverse behaviors associated with ADHD stem from a cascade of executive dysfunctions. At its core lies the mechanism of behavioral disinhibition. In neurotypical development, individuals acquire the capacity to delay their immediate response to stimuli, creating a temporary pause that enables deliberation and considered action. Barkley posits that in ADHD, this inhibitory mechanism does not develop at the typical pace, triggering a developmental sequence with broader cognitive consequences. Without this initial delay, individuals face greater difficulty establishing the mental space required for working memory—

the capacity to hold and manipulate information over time. Barkley frames this impairment as generating a form of "temporal nearsightedness," which reduces the capacity to draw on past experiences or anticipate future consequences. This model extends further to affective self-regulation, planning, and problem-solving, suggesting that each executive function relying on internal reflection becomes secondarily compromised. The downstream result, in Barkley's account, is an impairment in sustaining goal-directed behavior over extended periods.

While Barkley's model provides a cohesive explanatory framework, critical scholars emphasize that it relies primarily on a deficit-oriented conceptual vocabulary. Concepts such as "executive dysfunction," "behavioral disinhibition," "developmental delay," and "working memory deficit" structure the disorder through categories of absence and impairment. Barkley explicitly grounds his theory in an evolutionary context, characterizing neurotypical executive processes as evolved, species-typical capacities essential for self-governance. From a critical analytical standpoint, however, this framework carries broader implications: by defining standard executive development as the normative benchmark, it implicitly positions ADHD cognitive patterns as a departure from typical human development rather than as a natural variation in neurobiology. Furthermore, Barkley cautions clinicians and patients against attributing personal strengths or achievements directly to ADHD, maintaining that traits like hyperfocus or creativity are either distinct constructs or unsupported by empirical evidence. Scholars such as Brown (2023) critique this approach as a "monism of deficit," arguing that it risks interpreting all associated behaviors through a singular lens of impairment, implicitly evaluating cognitive functioning against social standards centered on standardized productivity, future orientation, and impulse control.

These theoretical foundations directly shape the practical interventions derived from Barkley's model. Because internal executive mechanisms are considered biologically impaired, Barkley advocates for externalizing these functions—relocating cognitive controls into the environment through timers, planners, visual cues, and interpersonal support. In contemporary contexts, this externalization manifests in practices such as "body doubling," where the presence of another person helps sustain task engagement, even while traditional tools like planners often fail due to the additional cognitive load required to maintain them. While environmental scaffolding offers clear clinical utility, critics argue that framing these tools exclusively as compensatory prosthetics for an internal lack can reinforce a narrative of fundamental inadequacy.

At the same time, Barkley's framework has gained widespread acceptance largely because it offers a rigorous, medicalized explanation that validates the genuine struggles of individuals with ADHD, securing crucial institutional recognition and clinical support. The ongoing theoretical challenge is to preserve this recognition of ADHD as a significant disability without strictly defining it through an ontological framework of complete deficit or incomplete development.

3.2 Conceptual Critique of the Deficit Model

Andrew Ivan Brown (2023) provides a conceptual critique of Barkley's model, examining both its theoretical assumptions and its practical implications for treatment. Barkley (1997, 2012) frames ADHD as a disorder of self-regulation wherein individuals struggle to internalize behavioral controls, concluding that they must rely on external environmental modifications to compensate for executive impairments.

Brown analyzes the implicit assumptions underlying this framework, noting how Barkley uses evolutionary terminology—such as comparing externalized regulation to earlier evolutionary stages—to illustrate the difference between internal self-governance and environmental dependence. Brown argues that this framing inadvertently constructs a developmental hierarchy, treating reliance on external scaffolding not as a neutral cognitive strategy, but as an indicator of incomplete executive maturity. This creates what Brown identifies as a conceptual asymmetry in how cognitive tools are evaluated. In contemporary society, external supports are standard features of human activity across populations. Brown illustrates this through the example of airline pilots, who rely on physical speed markers and cockpit checklists rather than unassisted memory. These tools are understood as optimal system architecture that mitigates universal cognitive limits under high-pressure conditions, rather than as evidence of individual deficiency.

Critiques like Brown's contend that under a strict deficit model, a distinction is drawn between neurotypical individuals using tools to optimize functioning and individuals with ADHD using similar tools to compensate for a defective internal mechanism. Brown suggests that this perspective naturalizes a specific idealized standard of the self-contained worker, pathologizing cognitive styles that diverge from standard operational norms.

This compensatory model can be re-examined through Clark and Chalmers' (1998) Extended Mind Theory, which demonstrates that human cognition routinely extends beyond the brain

into physical tools, symbols, and environmental structures. Applied to ADHD, an extended mind perspective offers three key insights:

- *Cognition is inherently distributed*: Environmental scaffolding is a general feature of human intelligence across diverse populations, rather than merely an emergency accommodation for internal impairment.
- *Focus on environmental fit*: The primary variable is not an absolute distinction between a "complete" neurotypical mind and an "incomplete" ADHD mind, but rather the degree of fit between specific cognitive styles and given institutional environments.
- *Reinterpreting implementation failures*: The breakdown of organizational systems in adults with ADHD can be analyzed not as an individual executive failure, but as a structural mismatch between the design of the organizational tools and the cognitive patterns of the user.

Practical interventions derived strictly from Barkley's model may encounter limitations when they impose linear, segmented structures onto cognitive styles that operate differently. Brown describes ADHD attention as "univocal"—characterized by a tendency toward deep immersion and unified engagement—contrasting with "equivocal" models that rely on frequent, deliberate task-switching across artificial time blocks. Forcing a univocal attentional style into rigid, time-blocked structures can generate ongoing friction. Ultimately, addressing ADHD effectively requires moving beyond purely deficit-based remediation toward environmental design that accommodates varied cognitive styles on their own terms, developing structures that align with univocal attention rather than focusing solely on normalization.

3.3 The Neurodiversity Paradigm

The Neurodiversity Paradigm was first articulated in the '90s in online autistic communities, in opposition to the Pathology Paradigm; neurodiversity is at the same time a concept, a movement and a paradigm (Botha et al., 2024) It functions as a specific interpretative lens to unhinge the Pathology Paradigm, on which clinical psychology was built (Marocchini e Dibennardo, 2026). Academics like Nick Walker helped formalize this position not only as an advocacy view, but also as a political and academic statement. In this chapter, the word autism will be used to correctly portray Walker's thoughts, but any principle explained applies to ADHD as well as any other neurominority.

In his book *Neuroqueer Heresies* (2021), Nick Walker articulates the fundamental principles of the neurodiversity paradigm in this way:

- *“Neurodiversity – the diversity among minds – is a natural, healthy, and valuable form of human diversity.*
- *There is no “normal” or “right” style of human mind, any more than there is one “normal” or “right” ethnicity, gender, or culture.*
- *The social dynamics that manifest in regard to neurodiversity are similar to the social dynamics that manifest in regard to other forms of human diversity (e.g., diversity of race, culture, gender, or sexual orientation). These dynamics include the dynamics of social power relations – the dynamics of social inequality, privilege, and oppression – as well as the dynamics by which diversity, when embraced, acts as a source of creative potential within a group or society.”*

The core idea is that humanity is neurocognitively diverse, just as humanity is diverse in terms of ethnicity, gender, culture or many other qualities. Neurodiversity, at its core, describes a fact rather than a value judgment: brains vary infinitely, and that variation is a normal, healthy part of biology – much as biodiversity sustains a specie’s survival. This framework covers both typical and atypical neurological functioning alike. In fact, despite how the term gets used today, often without much grasp of where it comes from or what theoretical and political work it was originally doing, especially in the Italian background, everyone with a brain belongs to neurodiversity, not just those labeled “atypical”. In this diversity we can find the *neurotypicals*, as the members of the dominant neurological group, and we can define that there are neurocognitive minority groups: the *neurominorities*. Examples of neurominorities are autism, ADHD, and learning disabilities like dyslexia. A *neurodivergent* is someone whose mind functions diverge significantly from the dominant societal standards of “normal”. Thus, neurodivergent is the opposite of neurotypical, and all neurominorities are also neurodivergent. However, one can be neurodivergent without being a member of a neurominority group, for example people with acquired traumatic brain injuries, and people with altered neurocognitive functioning through extensive use of psychedelic drugs (Walker, 2021).

The terms neurodivergent and neurodiverse are not exchangeable; citing directly from Walker’s book:

“Neurodiversity is a biological fact. It’s not a perspective, an approach, a belief, a political position, or a paradigm. That’s the neurodiversity paradigm, not neurodiversity itself. Neurodiversity is not a political or social activist movement. That’s the Neurodiversity Movement, not neurodiversity itself.”

The Neurodiversity Paradigm, similarly to other movements like Mad Pride, questions some core assumptions of (neuro)psychiatry: first, that what we consider an illness or a disorder can be framed differently, but also that it may not necessarily be something requiring treatment, especially at the individual level; second, that disorders may not be objective categories into which we categorize people with certainty, and that they are not so uncommon as it might sound like. What's clear from all social movements is that *what is less common is not necessarily pathological*. In this, the Neurodiversity Movement harks back to the early protests against cultural assumptions about disability: “statistical normativity quickly, and unfairly, went from being a descriptive value to a normative and imposed concept, laden with judgements veiled by the presumed objectivity of the data” (Marocchini, 2024; Cutler, 2019).

The language of the neurodiversity paradigm treats neurological difference as natural variations rather than medical problems. In this framework, one doesn't "have ADHD" or "suffer from autism" any more than one "suffers from homosexuality." Instead, one is autistic, just as one is black or lesbian. This linguistic shift acknowledges autism as an integral part of identity rather than an affliction to be separated from the self (Walker, 2021). In this view, the neurodiversity paradigm is an *anti-pathologizing stance*. The Neurodiversity Movement recognizes the biological components of mental disorders, while pointing at the social dynamics that bring to the disabilitation of neurodivergent people, no matter their “level of functioning”, that is pathology narrative. Neurodivergence is a neutral placement, the environment can make one more or less disabled in a given context.

When applied to the context of ADHD, the neurodiversity paradigm can help ADHD people form and identify into a community. Crucially, this paradigm shifts the location of the 'problem' from within the individual to the systemic barriers embedded in society. Rather than viewing ADHD people as inherently broken or missing essential capacities, the neurodiversity framework recognizes that struggles often stem from living in environments designed exclusively for neurotypical functioning: workplaces that demand uninterrupted focus in open offices, educational systems built around passive listening and rigid schedules, social expectations that pathologize different ways of communicating and organizing (Brown, 2023; Walker, 2021). By making these barriers visible rather than naturalizing them as inevitable, the neurodiversity paradigm provides the ADHD community with both language and legitimacy to advocate for genuine accommodation and fair treatment. Feeling part of a group can foster the development of positive outcomes for each individual, and a true paradigm shift will guarantee the ADHD community more dignity, as well as give ADHD folks the epistemic authority to

talk about their own diagnosis in their own terms and to demand changes in the systems that marginalize them.

It's important to note that the Neurodiversity Paradigm is not a proposal born from the clinical paradigm of pathology; rather, it is a radical proposal born from a social movement. The final meaning of the word "neurodivergent", then, is political. Anyone can be considered in their functioning and intersectional identity from a purely neutral perspective, one that does not involve pathologizing specific aspects of their functioning, which can therefore be seen as characteristics and not necessarily merely symptoms. The hypotheses we can scientifically test, to give the term clinical validity, concern our ability to treat certain characteristics perceived negatively by the individual or the social context. We can evaluate, for example, the interventions currently available to support and potentially treat people diagnosed with certain conditions or disorders, from a clinical perspective. It may also be the case that undergoing certain interventions has more negative effects on the person's health than positive ones in terms of potentially recovering from the disorder.

3.3.1 Why is a shift of language necessary?

"The limits of my language mean the limits of my world"

- Ludwig Wittgenstein (2005)

Language is never neutral. The words we use to describe ourselves and others shape not only how we communicate, but how we think, how we perceive reality, how we act within the world, and, ultimately, how we construct the social structures that govern our lives. In the context of neurodiversity, a shift in language is necessary because the current vocabulary, rooted in the Pathology Paradigm, actively perpetuates the marginalization and disempowerment of neurominorities. This shift is not merely cosmetic or politically correct; it is fundamental to achieving genuine equality.

Because a paradigm is a comprehensive framework of assumptions that determines how we interpret information, what questions we ask, and what answers we find meaningful, moving from the Pathology Paradigm to the Neurodiversity Paradigm requires a complete restructuring of how we talk about neurological differences. With terms like "disorder," "symptom," "treatment," and "epidemic" when discussing neurodivergences, the pathology paradigm manifests in language that medicalizes human diversity. Even seemingly benign phrases like "person with autism" or "families affected by autism" carry the implicit message that autism is

a disease, something separate from and harmful to the person. Every time someone describes autism and ADHD using medical terminology, they reinforce the assumption that neurotypical minds represent the healthy ideal and autistic and ADHD minds represent deviation and deficiency. In this way, the concept of “normal people” establishes one group as the default, the standard, the healthy, and relegates all others to inferior status, effectively reinforcing an intricate design of hierarchies and privilege. Language becomes a tool of systemic oppression.

Let’s consider how this works in practice by using Walker’s example. When communication breaks down between an autistic person and a neurotypical person, the language of the pathology paradigm ensures that this failure is always blamed on the autistic individual’s supposed “empathy deficits” or “impaired communication skills”—never on the neurotypical person’s inability to understand a different way of being. The language itself creates and maintains this double standard.

A shift in language is necessary because new language creates new possibilities for thought and action. The coining of the term “neurotypical” was revolutionary precisely because it provided a way to discuss the dominant neurological group without reinforcing their privileged position as “normal”. As Nick Walker explained, just as gay rights activists needed terms like “heterosexual” and “straight” to avoid having to describe their struggle as wanting “the same rights as normal people,” neurodiversity advocates need “neurotypical” to avoid implicitly accepting their own marginalization. Terms like “neurodiversity” and “neurominority” allow for conversations that were previously impossible. They enable discussions about privilege, power dynamics, and social justice without constantly reinforcing the very hierarchies being challenged. These words are not just labels: they are tools for dismantling oppressive structures and building more equitable ones.

Perhaps most critically, a shift in language is necessary to combat internalized oppression. The language we use to describe ourselves shapes our self-conception, our sense of agency, and our capacity for empowerment. When ADHD people spend their lives hearing themselves described in pathological terms, they internalize these toxic messages. They come to see themselves as broken, deficient, disordered. They have trapped themselves in a hierarchy they can never truly escape, because the very language they use defines them as lesser.

When an autistic person, instead, embraces the language of neurodiversity—when they can say “I am autistic” without shame, when they can recognize neurotypicals as simply a majority rather than a superior ideal—they open up entirely new possibilities for understanding

themselves and their place in the world. They can begin to see that their struggles may stem, not from inherent wrongness, but from living in a society designed for a different neurological type. They can recognize their true potential as unknown and theirs to explore. Hopefully, this shift will be possible for ADHD too in the upcoming years.

However, the de-objectification strategies championed by the broader neurodiversity movement encounter a distinct structural hurdle when applied to ADHD. In autism, a mechanism of *objectification* often occurs: the disorder is conceptually detached from the person, such that social miscommunication is attributed to "autistic traits" (Nelson, 2026). This separation enables identity-first language ("I am autistic") to function as an affirmative, non-pathologizing claim to difference.

Conversely, ADHD is governed by a mechanism of *subjectification*. Because core ADHD characteristics—such as inattention, emotional volatility, or forgetfulness—are moralized within neurotypical culture, symptoms are attributed to personal character flaws rather than neurological traits (Nelson, 2026). Consequently, asserting "I am ADHD" fails to achieve the same emancipatory shift; society reads the statement not as a legitimate neurodivergent identity, but as an individual admission of behavioral defect or lack of discipline.

Thus, the language of neurodiversity creates a world in which neurological differences are recognized as natural variations, in which different ways of being are valued rather than pathologized, in which genuine equality becomes possible.

3.4 Popular Discourse and the "Superpower" Narrative

Within online neurodiversity discourse, a narrative has emerged that frames ADHD not as a disability but as a cognitive "superpower," emphasizing traits such as hyperfocus, creative problem-solving, crisis management, and heightened adaptability as genuine advantages over neurotypical cognition. This framing has been actively promoted by certain neurodiversity advocates, likely as a corrective response to the historically stigmatizing and deficit-focused language surrounding ADHD — an understandable impulse to reclaim dignity and challenge low expectations. However, this narrative has met with significant and often impassioned resistance from within the ADHD community itself. Many individuals with the condition report that the superpower framing does not reflect their lived experiences and, more troublingly, functions to erase or minimize the very real, and often severe, impairments that define their daily lives. As one participant in an online discussion put it, traits like working well under pressure are "*not a good thing*" but rather an exhausting survival mechanism: "*it feels like shit*

mentally and physically to push myself that much to work well under pressure. It's not a gift."

Others described the long-term consequences of this dysregulation in stark terms, noting that *"the adrenaline I relied upon started to diminish over the years until I became frozen and paralyzed with shame and a deadline would do absolutely nothing to galvanize me into action."*

The critique extends beyond personal frustration to a structural argument: that the superpower narrative is only accessible to those with significant financial and social privilege. As one commenter observed, *"ADHD is only a gift when your lifestyle allows you to be solely responsible for yourself"*, a circumstance that becomes increasingly untenable as responsibilities multiply. Furthermore, the framing has been criticized for ignoring the many individuals for whom ADHD produces no discernible advantages whatsoever, only what one participant described as *"a lifetime of mental exhaustion"* from constructing workarounds for a brain that does not function as society demands. Taken together, these voices suggest that the superpower narrative, however well-intentioned, risks substituting one form of misrepresentation for another — trading stigma for a toxic positivity that leaves many feeling, as the original post articulates, not empowered but broken.

THE "SUPERPOWER" CRITIQUE		
Aspect	"Superpower" Framing	Experienced Reality
Crisis Performance	Natural gift under pressure	Exhausting survival mechanism
Hyperfocus	Unlimited productivity	Dysregulated, uncontrollable
Social & Economic Role	Universal cognitive advantage	Privilege-dependent luxury

Table 1- superpower vs reality

Another narrative often found in online threads is that *"everybody is a little ADHD"*. This view is obviously damaging, as it reinforces the idea that ADHD is a fake diagnosis. As presented in chapter 1, many have criticized the medicalization of the symptoms that make up the ADHD diagnosis, as they seem, to them, a collection of normal human behaviors. Being easily distracted is something that many "normal" people do; same goes for being fidgety, or forgetting things throughout the day... Hence, the internet gives space for this idea that "everybody is ADHD", and therefore, ADHD is not a real struggle. A linked idea is that by acknowledging the ADHD child's struggles, that are apparently *fake*, and proposing behavioral and pharmaceutical treatments, the child might get "too comfortable" and won't work hard to achieve their goals. This viral opinion is often accompanied by the fear of pharmaceutical treatments. A common fear traveling in and out of the internet forums is that ADHD medication, being a stimulant drug, will cause addiction in young children, most specifically, cursing them

to a lifetime of craving habits; some even shared their fears of ADHD being a governmental plot to turn the population into obedient addicts. This picture is usually laughed at by most ADHD users of the Internet (Fig 1). Personally, after over 5 consecutive years of being medicated, I still struggle every morning to remember about my pills, and it looks like this is a shared experience for many people with ADHD.

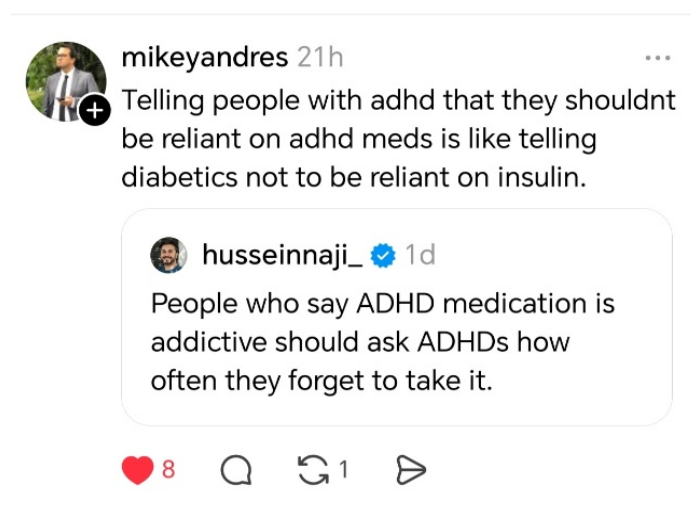


Figure 1- Threads post making satire on medicalization misuse

This public skepticism is typified by the ubiquitous claim that "everybody is a little ADHD." Far from a benign expression of empathy, this phrase serves as a weaponized normalization tactic. By weaponizing Stirner's converse principle of equality, the narrative flattens medical severity into universal human experience. It establishes a false baseline: if everyone experiences distraction or restlessness, yet the neurotypical majority manages to adhere to institutional norms, then the ADHD individual's failure to do so is reframed as a personal moral failing. The logic dictates that if we are all starting from the same baseline, failing to perform makes you "lesser than" by choice rather than by design.

I want to take a moment to reflect on the importance and absurdity of this phenomenon. Here, we are observing the real-life effects of the misunderstanding of ADHD as a disorder. People, parents, teachers, clinicians even, are refusing the label of ADHD because they don't understand what it entails, ignoring decades of research on the topic. With this paragraph, I don't intend to hold a crusade over these people; actually, I hope that the future will bring more awareness and education on the reality of living with ADHD, to allow as many people to get the aid they need and deserve. I will address in further detail in chapter 3 how late diagnosis can affect the experience of the self in ADHD people, and in chapter 4 I'll present more on the misunderstanding of ADHD.

3.5 Synthesis: Beyond the Binary

The tension between the Pathology Paradigm and the Neurodiversity Paradigm is clearest regarding pharmacological intervention. ADHD medications, primarily methylphenidate and atomoxetine, are well-researched psychiatric interventions that improve sustained attention, dampen impulsivity, and support emotional regulation (Childress, 2015; Shaw et al., 2016; Surman & Walsh, 2023).

Under the Pathology Paradigm, medication is too often weaponized to enforce behavioral conformity, particularly in children (Singh, 2013). When prescribed primarily to make an individual easier to manage within rigid institutional settings, treatment functions as a tool of compliance rather than therapeutic care.

PARADIGMATIC MODELS OF MEDICATION		
Dimension	Pathology Paradigm	Integrative / Neurodiversity Frame
Core Objective	Behavioral conformity and normalization	Autonomy and self-actualization
Primary Focus	Eliminating clinical deficits	Reducing friction between intention and execution
Target Outcome	Institutional compliance	Personal agency and vital goals

Table 2 - differences in how medication can be conceptualized

The Neurodiversity Paradigm does not reject medication; rather, it reframes its purpose. Medication should be conceptualized as a tool for self-determination, providing the cognitive scaffolding necessary for individuals to pursue their own goals. Reframing ADHD as a natural cognitive variation must not lead to the minimization of genuine suffering. The gap between intention and execution in ADHD is an intrinsic feature of its neurobiology, causing distress regardless of environmental accommodations.

A comprehensive framework must transcend the binary between pathology and natural variation by holding two truths simultaneously:

- *ADHD cognition is not inherently broken:* Difficulties stem significantly from structural mismatches with environments designed for neurotypical functioning.
- *Pharmacological support is valid and necessary:* Medication serves as a legitimate instrument to reduce internal friction and support personal agency.

Recognizing ADHD as a disability does not imply deficiency or reduced human worth. Disability describes a real, impactful encounter between a specific mind and an environment

unsuited to it. Integrating clinical insights with first-person experiential knowledge bridges the gap between external behavioral observations and internal lived realities, creating a more just and effective clinical practice.

Chapter 4: Epistemic Injustice and Knowledge Production in Psychiatry

“Nothing about us without us!” – Charlton, 1998

4.1 Testimonial and Hermeneutical Injustice in ADHD

A further dimension of the epistemic injustice experienced by people with ADHD lies not merely in how their condition is socially perceived, but in how knowledge *about* them has been systematically produced *without* them. As Brown (2024) argues, the field of ADHD research and clinical practice has historically been dominated by non-ADHD professionals who position people with ADHD as passive objects of study rather than as legitimate knowers of their own experience. This structural exclusion operates on multiple levels simultaneously. At the institutional level, access to the spaces where authoritative knowledge about ADHD is produced, like conferences, peer-reviewed research, clinical frameworks, has been gatekept by credentialing systems that privilege the MD or PhD over lived experience, effectively rendering the testimony of ADHD individuals epistemically subordinate before it is even heard. This constitutes what Miranda Fricker would recognize as a form of *testimonial injustice*: the systematic deflation of a speaker's credibility not based on the content of their account, but on the basis of their identity as an ADHD person, whose self-knowledge is preemptively dismissed as unreliable, subjective, or insufficiently rigorous. Compounding this is a deeper *hermeneutical injustice*, whereby the very conceptual tools available to interpret and articulate the ADHD experience have been developed by those who do not share it, meaning that ADHD individuals are left attempting to make sense of their own lives through frameworks — deficit models, executive dysfunction theories, behavioral checklists — that were never designed to capture their interiority, only to categorize their behavior from the outside. The consequences of this knowledge asymmetry are not merely academic: when the dominant narratives of ADHD are produced by non-ADHDers and filtered through therapeutic or neuropsychological lenses, the stories that circulate — even within ADHD communities themselves — tend to reproduce deficit-based framings, making it difficult for individuals to develop alternative, affirmative understandings of their own identity. This connects directly to the misrecognition at the heart of this thesis: the ADHD individual who has internalized neurotypical norms, performed competence to avoid judgment, and deferred to external authority for self-definition is not simply a product of personal psychology, but of a broader epistemic structure that has consistently told them that their own account of themselves does not count as knowledge. Challenging this structure, as Brown advocates, requires not only better research methodologies

but a fundamental reorientation of where epistemic authority is located — moving away from the individualistic expert model toward collective, participatory frameworks in which ADHD people are recognized as co-producers of the knowledge that shapes their lives.

4.2 Participatory Interactive Objectivity

The epistemic exclusion of ADHD individuals from knowledge production is not an isolated phenomenon but reflects a broader, structural bias embedded within psychiatric epistemology itself. Şerife Tekin's critique of the DSM's development process illuminates precisely this problem: despite the fact that the DSM serves as the foundational document governing the diagnosis, research, and treatment of mental disorders, the DSM-5 Task Force explicitly rejected the inclusion of patients in its revision process, operating under the assumption that first-person experiential knowledge would compromise scientific objectivity by introducing unacceptable subjectivity into what was imagined to be a purely technical enterprise. Tekin challenges this position at its root, arguing that the APA's conception of objectivity — premised on detachment from lived experience and total concordance among credentialed experts — is fundamentally ill-suited to psychiatry, a discipline whose objects of study are, by definition, irreducibly experiential. In place of this "detached objectivity," she proposes a framework of *Participatory Interactive Objectivity* (PIO), drawn from feminist epistemology, which reconceives scientific rigor not as the elimination of diverse perspectives but as their systematic inclusion through a process of transformative criticism across a broad and heterogeneous community of knowers. Central to this framework is the recognition of patients as *experts by experience* — individuals who possess unique, non-substitutable knowledge about how symptoms emerge within lived contexts, how treatments are actually experienced rather than merely measured, and how a condition shapes one's self-concept and relational world in ways that no external observer can fully access. The practical stakes of this exclusion are made vivid through Tekin's example of schizophrenia: where the DSM describes "affective flattening" as a diminished interest in social relationships, patient testimony reveals something categorically different — an intense, often painful desire for connection experienced alongside a perceived inability to initiate it. This is not a minor refinement; it is a reversal of interpretive meaning, and it demonstrates how diagnostic categories constructed without patient input can systematically misrepresent the very conditions they claim to describe. For ADHD, the implications are equally significant: a diagnostic framework built exclusively on behavioral observation and neuropsychological testing, without the integration of first-person accounts of attention, motivation, time perception, and emotional experience, risks producing a portrait of

the condition that is clinically legible but phenomenologically hollow. When people with ADHD are then asked to recognize themselves in this portrait — to accept deficit-based descriptions of their cognition as accurate and authoritative accounts of who they are — the result is not merely a misdiagnosis but a form of epistemic violence, one that compounds the misrecognition already examined in this thesis by granting institutional legitimacy to a framework that was never designed to reflect their interiority in the first place.

4.3 The Co-optation of Neurodiversity

A depoliticized and performative iteration of neurodiversity, largely constructed and sustained by clinical institutions and corporate interests, increasingly frames cognitive divergence through a narrow lens of "superpowers," valuing neurodivergent individuals only insofar as their unique functioning can be commodified within a productivist framework. Often termed "neurodiversity-washing," this practice dilutes the movement's transformative political power by reframing neurominorities as mere repositories of talent optimized for capitalist exploitation. Regrettably, this superficial acceptance is frequently internalized by advocacy groups who embrace an exceptionalist narrative to negotiate their own social legitimacy, actively distancing themselves from individuals with higher support needs. Consequently, this dynamic reproduces the exclusionary logic of the dominant system, forging new hierarchies of "normativity" that strip support from those whose neurodivergence lacks commercial utility. By neutralizing the radical critique of the neurodiversity movement, this framework echoes the eugenic legacy latent in contemporary research, where cognitive traits are selectively sorted into "preferred" subtypes, ultimately marginalizing anyone who falls outside the narrow canon of corporatized neurodivergence (Marocchini & Dibennardo, 2026).

Chapter 5: The Lived Experience – Masking, Diagnosis, and Identity Formation

After analyzing in such lengths how ADHD is thought to be and talked about, it's finally time to address how the people with ADHD experience their symptoms. In this chapter, the goal is to create a picture of the real problems experienced by ADHDers, and how they navigate through them. This chapter was mostly written by analyzing Cal Nelson's works, whose vision is not only shared by me, but that inspired a great portion of the reflections that have taken me to the final shape of this thesis.

5.1 The Phenomenology of ADHD Realities

As Cal Nelson highlighted in our personal correspondence, emotional dysregulation and working memory deficits represent two critically underappreciated aspects of adult ADHD that deeply distort both executive functioning and self-concept. He posits that emotional dysregulation extends to impairing core mechanisms of self-motivation, while working memory failures produce unpredictable cognitive gaps that distort temporal orientation and forward planning. Crucially, Nelson emphasizes that when individuals fail to attribute these volatile, inconsistent impairments to ADHD, they maintain unadjusted expectations, leading them to internalize recurring failures and ultimately lose trust in their own capacities and sense of agency. In the following paragraphs I will analyze other aspects of life with ADHD that are often misunderstood, misrepresented, or even ignored.

5.1.1 The Standard Conceptualization of Masking and the ADHD Paradox

The concept of "masking" was introduced by Ekman and Friesen (1969) to describe the deliberate concealment of disgust, later evolving within autism literature to signify the suppression or hiding of neurodivergent traits (Milton & Sims, 2016; Willey & Attwood, 2015). In the context of ADHD, masking is defined as the act of appearing "socially acceptable" by camouflaging symptoms, suppressing impulses, rehearsing social scripts, and mimicking neurotypical behaviors to avoid stigma and rejection (Ginapp et al., 2023).

However, applying this standard conceptualization to ADHD reveals a critical theoretical contradiction. According to Barkley's model of executive functioning, self-regulation depends on working executive capacities—specifically "self-directed attention" and meta-cognitive self-awareness. Standard academic literature predicates masking on conscious, volitional self-

regulation: an individual steps back, observes their behavior, and deliberately alters it to match social norms (Nelson, 2025).

Herein lies the paradox: if masking is inherently a conscious, volitional act requiring intact executive control, but ADHD is fundamentally defined by deficits in executive functioning and self-regulation, how can individuals with ADHD mask successfully?

This contradiction exposes an epistemic bias in traditional psychological literature. Standard definitions assume a consistent baseline of executive control, measuring masking strictly through neurotypical standards of self-awareness. By conceptualizing masking as a purely deliberate strategy, academic discourse inadvertently excludes the lived experiences of individuals with ADHD, who frequently mask without conscious intent or tactical awareness.

5.1.2 Resolving the Paradox: Transcendent vs. Immanent Self-Regulation

To resolve this theoretical impasse, Nelson (n.d., 2025) reframes self-regulation into two distinct operating modes: *Transcendent* and *Immanent*.

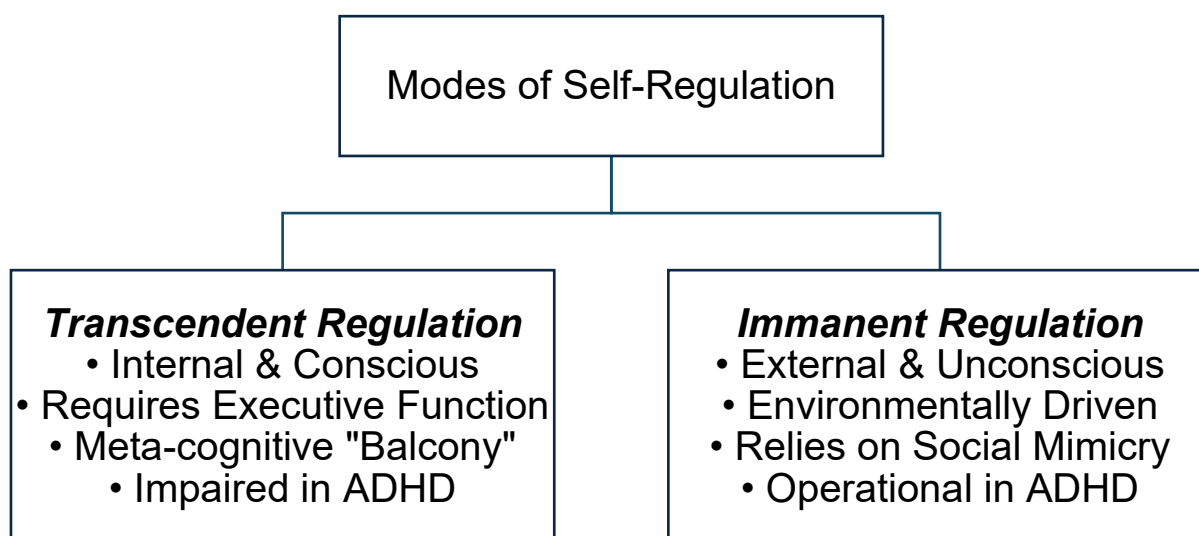


Table 3- Types of masking conceptualized by Cal Nelson (2025)

Transcendent Self-Regulation represents the traditional, internal model. It requires an individual to adopt a "self-reflexive" stance—climbing a mental balcony to observe, evaluate, and direct their behavior from an internal, managerial position (Nelson, 2025). Because this mode relies heavily on intact executive functioning, it is frequently impaired in ADHD. *Immanent Self-Regulation* is an externally oriented, passive mechanism. Rather than relying on internal executive oversight, immanent regulation operates directly through interaction with the

local environment. The individual absorbs and reacts to the behavioral norms around them without requiring meta-cognitive awareness.

Individuals with ADHD mask effectively not by utilizing impaired transcendent mechanisms, but by relying on immanent self-regulation. Masking in ADHD is rarely a top-down, deliberate plan; it is an automatic, environmentally driven reaction shaped by cumulative social conditioning.

5.1.3 The Socio-Normative Architecture of Immanent Masking

Because immanent regulation relies on environmental prompts rather than internal executive control, its operation must be analyzed within the broader social structures that enforce it. Masking does not occur in a vacuum; it operates within a *hegemonic social discourse* that positions neurotypical behavior as the unmarked, universal baseline of competency and emotional maturity. Within this framework, core ADHD traits—such as impulsivity, hyperactivity, and emotional dysregulation—are framed as inherently disruptive or deficient (Nelson, n.d.).

This structural asymmetry creates a distinct double-bind for the individual:

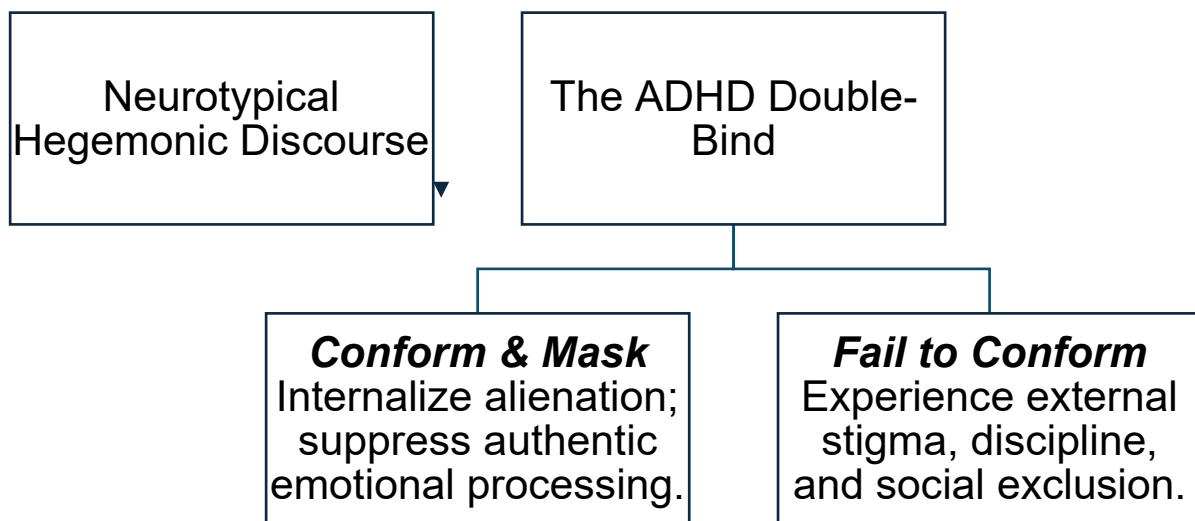


Table 4- choices the ADHD person must make to fit in society

Everyday social expectations function as implicit behavioral commands. For neurotypical individuals, the rules governing these prompts are intuitive; for individuals with ADHD, they represent opaque demands with severe social penalties for non-compliance. When ADHD traits disrupt these unspoken codes, social correction or institutional sanction follows.

Because emotional dysregulation is a core component of ADHD, negative feedback from others often triggers heightened emotional distress, which is itself socially penalized. This creates a destructive cycle: *trait expression* □ *social sanction* □ *emotional dysregulation* □ *amplified sanction*.

5.1.4 Internalization, Stigma, and Psychological Outcomes

Repeated exposure to this corrective feedback loop transforms external enforcement into internalized self-surveillance. Over time, social marginalization causes the individual to unconsciously devalue their authentic operational style, automatically positioning others in a position of authority.

This dynamic yields three primary psychological consequences:

- *The "Indefinite Other" and Automatic Deference*: The external gaze of social judgment becomes internalized as an *indefinite Other*—an imagined, generalized neurotypical observer whose perceived expectations regulate the individual's conduct even when alone. Immanent masking becomes an automatic reflex to avoid anticipated reproach (Nelson, 2025).
- *The "Responsible Adult" Façade*: To navigate environments that invalidate their struggles as moral failings or laziness, individuals construct a protective performance of the "responsible, functional adult" (Ginapp et al., 2023). Overwhelming emotional states are concealed, and executive paralysis is hidden behind strategic excuses.
- *Burnout and Ontological Insecurity*: Maintaining an externalized mask requires continuous inhibition of basic behavioral impulses. This perpetual energy expenditure culminates in severe emotional collapse and burnout.

Ultimately, prolonged immanent masking causes identity fragmentation or *ontological insecurity*. When behavior is continuously dictated by an internalized external gaze, the boundary between genuine preference and protective performance blurs, leaving the individual with a fractured sense of self and a diminished trust in their own lived experience.

5.1.5 Motivational Inactivity and Temporal Disorientation

In his manuscript, Nelson (n.d.) presented two very disorienting aspects of living with ADHD. The first one is what can be called "*motivational inactivity*": the experience of having a clear, conscious desire and yet being genuinely unable to translate that desire into bodily action. While all ADHD symptoms fall broadly under the umbrella of executive dysfunction, Nelson argues

that giving this particular experience its own name allows for greater precision in describing it. This is not laziness or indifference — the desire is fully present and recognized. One may be hungry, need to use the restroom, or know they must begin an important task, and yet remain stuck, unable to initiate the movement required to fulfill that need. What makes this experience particularly striking is that the body is not simply frozen in place. It remains capable of complex, sustained activity — scrolling between websites, fidgeting, or engaging in other forms of stimulation-seeking behavior — while remaining entirely unresponsive to the person's actual intentions. The body acts, but not on behalf of the person inhabiting it. This creates a felt disconnection between self and body that is difficult to articulate to those who have not experienced it. Rather than issuing commands that the body follows, the person with ADHD must negotiate, coax, or find indirect strategies to bring the body into alignment with their desires. External stimuli — a screen, a sound, an engaging train of thought — effectively seize control, holding the body in place against the person's wishes. The experience is one of being a passenger rather than a driver: *actions happen, but they do not feel authored*. This collapse of agency is not metaphorical. In the moment of motivational inactivity, the ordinary sense of being the one who acts is genuinely absent, replaced by the unsettling awareness that one's body is operating according to forces other than one's own will (Nelson, n.d.).



Figure 2- Social media post describing how ADHD is perceived vs how it is felt

A second and equally significant dimension of ADHD experience is “*temporal disorientation*”: a sudden, involuntary collapse of one's sense of continuity within time (Nelson, n.d.). Research such as that of Carelli et al. (2012) has investigated how adults with ADHD tend to be more present-oriented and relate to their past more negatively than neurotypical controls, and Barkley

et al. (2022) have described how ADHD disrupts working memory in ways that leave a person with little felt sense of time's passage, such that only the present moment seems to matter. Nelson's concept of temporal disorientation is narrower than these findings: it refers not to a general difference in temporal orientation, but to a specific, recurring experience of sudden discontinuity — a momentary collapse of one's sense of where one is in time. Without warning, the thread connecting the present moment to what came before it snaps, and everything in one's immediate surroundings presents itself as unfamiliar and strange. This is not merely forgetting — it is a more radical experience in which the context needed to make sense of where one is and what one is doing simply vanishes. The environment, the task at hand, even the conversation one was just part of, can all become momentarily unintelligible. The experience lasts only an instant before the mind moves quickly to reorient itself, but that instant carries a distinctive quality of groundlessness that is hard to overstate.

The reorientation that follows is far from reliable. The mind reconstructs a sense of continuity by reading available environmental cues and inferring, imaginatively, what must have been happening. But this reconstruction is necessarily incomplete, and prone to error. A new room suggests a new task; a nearby object implies a different priority; and before long, one finds oneself engaged in something entirely unrelated to the original intention, with no clear memory of how the transition occurred. This is why the experience of entering a room and immediately forgetting why is so common among those with ADHD — the new environment overwrites the previous context, and the mind latches onto whatever is present rather than recovering what was lost. Conversation poses a similar problem: spoken words disappear as soon as they are uttered, leaving no residue in the environment to anchor oneself to, making it easy to lose the thread of what is being said mid-sentence. It is worth noting that a common coping response to these disruptions in temporal perception is the development of heightened anxiety around scheduling and timing, which functions as an externally imposed structure to compensate for what is not felt intuitively (Nelson, n.d.).

Taken together, *motivational inactivity* and *temporal disorientation* reveal that the self, for those with ADHD, is a more fragile and effortful construction than it typically appears. What most people experience as a seamless, automatic unity — between intention and action, between one moment and the next — is for the person with ADHD something that must be actively and imperfectly maintained. The continuity of the self across time, and the felt ownership of one's own actions, are not given facts of experience but ongoing achievements that ADHD renders visibly unstable. Daily life thus involves a persistent, largely invisible labor

of self-reconstruction: piecing together what one was doing, redirecting a body that has gone its own way, and navigating a relationship to time that does not hold still (Nelson, n.d).

5.1.6 Misrecognition and Lexical Cohesion

To understand the depth of the systemic misreading of ADHD identity, it must be analyzed through Stirner's tripartite identity framework; the following formalization is an original contribution of Nelson (2026):

1. **Identity (A):** The dominant majoritarian norm (the compliant, self-regulating subject).
2. **Counter-Identity (*not – A*):** The recognized binary opposite, used for social control (e.g., the deviant, the rule-breaker).
3. **Non-Identical Unique (*other – than – A*):** An authentic mode of being that exists completely outside the majoritarian binary.

Institutional structures maintain social order by forcing all human variation into the binary between *A* and *not – A*. Because ADHD cognition operates outside this standard, it represents a *non-identical unique (other – than – A)*. However, majoritarian systems systematically misrecognize ADHD as a *counter-identity (not – A)*. Rather than recognizing that ADHD unfittingness is built into the design of the disorder itself, society interprets non-conformance as a deliberate, rebellious, or lazy rejection of the norm. This reduction strips the individual of their actual reality, moralizing their neurology and trapping them in the internal identity of being fundamentally "broken" (Nelson, 2026).

If the superpower narrative risks erasing the difficulties of ADHD through a kind of enforced optimism, an equally significant distortion operates in the opposite direction: the systematic misreading of ADHD behaviors as moral or intellectual failures. Brown (2023) argues that this misrecognition is not incidental but structural, rooted in the absence of any affirmative account of what ADHD actually *is*. Because clinical and cultural frameworks have historically defined the condition only through what it lacks, as explained in the previous chapter, every ADHD behavior becomes legible only as a negation, a falling short of some neurotypical standard. The result is that the experiences of ADHD individuals are perpetually misread, not through malice, but through the absence of any conceptual vocabulary adequate to describe them.

Brown's most striking example concerns attention itself. Let's refer to Brown's theory of *univocity of attention*: where an observer sees scattered, unfocused behavior — what he calls *equivocity* — the ADHDer is often doing something closer to its opposite: attempting to absorb

the entirety of their environment at once. The experience is not one of attention drifting away from its object, but of attention refusing to be narrowed to a single thread. This distinction matters enormously, because the remedies prescribed for inattention — focus, filter, attend to one thing — are precisely the wrong interventions for someone whose attentional experience is characterized by an overwhelming surplus rather than a deficiency. Similarly, what is commonly identified as hyperactivity or fidgeting — long understood as a failure of behavioral inhibition — may, Brown argues, be better understood as a response to sensory oversensitivity, a form of self-regulation in the face of too much arriving at once. In fact, fidgeting has long been recognized as a way to self-regulate in autistic communities, under the name of *stimming*. The misrecognition here is not merely clinical but deeply punitive: to tell someone whose nervous system is flooded to simply *be still* is to demand the impossible while framing the impossibility as a character flaw.

The same pattern of misreading extends to language and cognition. ADHD individuals frequently make conversational leaps that strike neurotypical listeners as non-sequiturs, abrupt changes of subject, or even signs of disordered thinking. Brown (2023) proposes that these leaps follow a coherent logic of their own, one he calls "lexical cohesion" — a rapid movement between ideas connected by word associations, homonyms, or shared semantic fields that the speaker processes faster than they can articulate the referential chain to others. What looks like flippancy or confusion is, on this account, a form of cognitive speed that outruns the conventions of neurotypical discourse. The social cost of this misrecognition is real: ADHD individuals are routinely expected to translate their thinking into neurotypical formats, while no equivalent expectation is placed on neurotypical interlocutors to slow down or unify their thinking in the opposite direction.

Perhaps the most damaging misrecognition, however, concerns emotional responses in social situations. When ADHD individuals struggle to comply with rules or procedures — a board game, a workplace protocol, an institutional requirement — they are frequently read as being deliberately rebellious or oppositional. Brown (2023) describes how even a minor correction can trigger what he calls a "monism of the memorable past": a sudden flooding of memory in which every prior experience of being corrected, shamed, or misunderstood arrives simultaneously, making the present moment feel like the culmination of a long history of failure. The outburst or withdrawal that follows is not defiance but overwhelm. Understood in these terms, the emotional dysregulation so commonly reported by ADHD individuals, and so frequently pathologized, begins to resemble something closer to what was described earlier in

this chapter: the fragile self-construction that results from motivational inactivity and temporal disorientation, a self that must maintain its coherence under conditions of constant, invisible strain.

Brown's analysis also extends to questions of memory and organization. Forgetfulness and difficulty with executive functioning are commonly attributed to a neurological inability to retain information. Brown reframes these not as biological deficits but as an inaccessibility to the specific processes through which neurotypical subjectivity organizes experience — processes so naturalized as to be rendered invisible. Neurotypical individuals routinely rely on external scaffolding: checklists, calendars, procedural protocols. These are not understood as compensations for cognitive deficiency but as ordinary tools. When ADHD individuals require the same external supports, their use is framed as evidence of incapacity. The asymmetry reveals, Brown argues, not a difference in cognitive capacity but in whose cognitive style is granted the status of self-sufficiency.

Taken together, these misrecognitions amount to what Brown describes as a failure of medicalized discourse to ask what it actually *means* for ADHD to exist — to treat it as a form of being in the world rather than a deviation from one. The diagnostic apparatus gives ADHD individuals "a place in medicine," as Brown puts it, but leaves them with no place in a broader critical culture capable of recognizing their experience as genuinely different rather than simply defective. This tension — between being named and being understood — may help explain why so many in the ADHD community reject both the deficit framing Brown critiques and the superpower narrative examined earlier in this chapter: both, ultimately, substitute a label for a reckoning with the actual texture of living with a mind that the world was not built to accommodate.

5.2 Diagnosis as a Social and Institutional Process

The diagnostic system is not neutral or universally accessible. Classification favors those with resources (time, money, knowledge, and energy) to navigate complex healthcare systems (Thompson, 2021; Jutel, 2009, 2011, 2015). Sociodemographic factors including race, employment status, and income influence both symptom interpretation and diagnostic decisions. Patients themselves rely on culturally prescribed models to perceive illness and interpret symptoms, with social and economic circumstances fundamentally shaping illness experiences, revealing that psychiatric classification is as much a social process as a medical

one. Nowhere is this more apparent than with ADHD, where diagnosis rates have risen dramatically in recent decades amid ongoing debates about the condition's validity.

Social stigma creates powerful incentives for symptom concealment (Thompson, 2021; Eccleston et al., 2019). Individuals may mask ADHD features during clinical evaluations, effectively hiding their struggles from the very professionals meant to diagnose them. This masking is not uniformly distributed: it varies by demographic factors in ways that systematically bias diagnostic outcomes. Gender represents a particularly stark example. Doctors often consider it less problematic for women to appear absent-minded, contributing to substantially lower ADHD diagnosis rates in women despite evidence suggesting comparable prevalence across sexes (Aronson, 2016). This reflects broader cultural narratives about appropriate gendered behavior: women's inattention may be dismissed as personality quirks while men's hyperactivity triggers clinical concern (Aronson, 2016). Students with troubled relationships with authority figures face similar diagnostic barriers. Those who have difficulty with teachers may be less likely to report inattention, even as their behavior draws reprimands. Rather than seeking diagnosis and support, these students learn to mask their inattentiveness, internalizing their struggles as personal failures rather than recognizing them as symptoms of a treatable condition (Thompson, 2021; Eccleston et al., 2019). The contested validity of ADHD as a diagnosis compounds these stigma effects. With prevalence estimates suggesting approximately, in the US, one student per classroom has ADHD (Thompson, 2021), yet ongoing public and medical uncertainty about whether the condition is real or over-diagnosed, individuals face a peculiar burden: they must simultaneously manage their symptoms and advocate for the legitimacy of their condition. This double burden—coping with disability while defending its existence—creates additional barriers to diagnosis and treatment. If we add the fact that ADHD presents high rates of comorbidity, the picture further complicates (Thompson, 2021).

Stereotypes of ADHD may include questioning the validity of the diagnosis, skepticism towards medications, and views that people with ADHD are unreliable and dangerous (Mueller et al., 2012; Ginapp et al., 2023). Previous qualitative work indicates that adults with ADHD are often not taken seriously regarding their diagnosis (Ginapp et al., 2023; Schrevel et al., 2016; Watters et al., 2018), and they often do not disclose their ADHD diagnosis to others for fear of stigma (Halleröd et al., 2015; Toner et al., 2006; Waite & Tran, 2010; Young et al., 2008). Other potential impacts from stigma in this population have not been well described. Although adults with ADHD frequently struggle with interpersonal relationships, social support has been

reported to increase functioning for this population. A supportive spouse has been described as helping adults with ADHD stay organized and keep up with life tasks (Ginapp et al., 2023; Nystrom et al., 2020; Toner et al., 2006). Among young adults with ADHD, having a close friend provides non-judgmental support assists with engaging in social activities in addition to helping them meet their responsibilities (Ginapp et al., 2023). More research is needed on how to best support adults with ADHD in navigating their symptoms and their interpersonal relationships.

Perhaps the most disturbing findings concern systematic racial and socioeconomic disparities in ADHD diagnosis and treatment. White children are significantly more likely to receive parent-reported ADHD diagnoses compared to Black, Hispanic, and other racial-ethnic minority children. Among those diagnosed, white children, males, and those with health insurance have higher odds of receiving medication. The pattern is paradoxical: teachers and parents rate ADHD symptoms higher in Black children and lower in Hispanic children compared to white children, in US schools, yet white children are more likely to receive formal diagnoses (Thompson, 2021; Bax et al., 2019). This discrepancy persists even when controlling for socioeconomic status, suggesting that factors beyond economic access—including systemic racism, cultural biases in symptom interpretation, and differential treatment by medical professionals—drive these disparities (Thompson, 2021; Bax et al., 2019).

Socioeconomic status operates as a powerful diagnostic gateway. While formal assessment tools show no correlation between socioeconomic status and ADHD symptomology (Bax et al., 2019), higher socioeconomic status provides greater opportunity for diagnosis through superior economic means, insurance coverage, access to specialists, and healthcare system literacy. Consequently, ADHD remains substantially under-recognized in non-white and economically disadvantaged populations (Thompson, 2021; Jutel, 2009, 2011, 2015), often going undetected until secondary issues like substance abuse force clinical intervention later in life.

The symptomatic overlap between ADHD and other conditions creates substantial diagnostic confusion. Restlessness, concentration difficulties, decreased attention, increased distractibility, mood swings, and anger outbursts appear in both ADHD and anxiety presentations. Research demonstrates that endorsements of hyperactive-impulsive items correlate positively with anxiety items on self-report symptom scales, creating opportunities for misdiagnosis in both directions (Thompson, 2021). This comorbidity and diagnostic ambiguity has serious consequences. Misdiagnosis leads not only to inflated false-positive rates for ADHD

but also to inappropriate treatment plans. An individual with anxiety misdiagnosed with ADHD may receive stimulant medication that exacerbates their condition, while someone with ADHD misdiagnosed with depression may receive treatment that fails to address their core difficulties with attention and impulse control (Thompson, 2021). The diagnostic challenge is further complicated by the subjective nature of symptom assessment. Unlike conditions with clear biomarkers, ADHD diagnosis relies on reported behaviors and clinician interpretation (Thompson, 2021)—processes vulnerable to the social factors discussed throughout this section.

Not all diagnostic pathways follow the same trajectory. Some individuals actively seek ADHD diagnosis, consulting multiple doctors until their experience receives medical legitimization. This diagnostic-seeking behavior suggests that motivation plays a role in who ultimately receives the label—those with greater determination, resources, and medical literacy are more likely to persist until diagnosed (Thompson, 2021; Conrad and Potter, 2000; Jutel, 2009, 2011, 2015). This pattern raises complex questions about diagnostic validity. Does diagnostic-seeking behavior indicate genuine suffering requiring recognition, or does it reflect other motivations—desire for academic accommodations, pharmaceutical interventions, or explanatory frameworks for life difficulties? The research cannot definitively answer this question, but it highlights how diagnosis results from complex negotiations between individuals and medical systems rather than objective symptom measurement alone (Conrad et al., 2000).

The environmental factors shaping ADHD diagnosis reveal psychiatric classification as a fundamentally social process (Thompson, 2021). Peer influence, stigma, racial bias, socioeconomic status, institutional structures, educational gatekeeping, and individual agency all determine who receives diagnosis and when, as mentioned before. These factors operate independently of symptomology, creating systematic patterns of over-diagnosis in some populations and under-diagnosis in others. This does not mean ADHD is not real or that diagnosis is arbitrary. Rather, it means that even when underlying neurological differences exist, their recognition and classification are mediated through social structures that reflect and reproduce existing inequalities. The same symptoms may be noticed in one child and overlooked in another, medicalized in one context and dismissed in another, treated with stimulants in one population and left unaddressed in another.

Understanding diagnosis as a social process demands critical examination of who benefits from current diagnostic practices and who is harmed by them. It requires us to ask why white,

economically advantaged children are dramatically more likely to receive ADHD diagnosis and treatment than equally symptomatic minority and poor children. It compels us to question whether teachers, often the first to suggest diagnosis, have the training and resources to make such consequential referrals. It pushes us to consider how pharmaceutical marketing shapes diagnostic patterns and whether diagnostic-seeking behavior represents empowered self-advocacy or problematic medicalization. Most fundamentally, recognizing the social dimensions of diagnosis reveals that improving ADHD identification and treatment requires more than refining diagnostic criteria or developing better assessment tools. It requires confronting the social inequalities, cultural biases, and structural barriers that currently determine which individuals receive recognition, support, and legitimacy for their struggles. Only by addressing these environmental factors can we move toward more equitable and accurate diagnostic practices that serve all who need them, rather than primarily those with the social advantages to navigate complex medical systems (Thompson, 2021; Bax et al., 2019; Conrad and Potter, 2000; Jutel, 2009, 2011, 2015; Aronson, 2016; Erlandsson and Punzi, 2016; Singh, 2013).

5.3 The Diagnostic Moment and Identity Transformation

For many people, receiving a diagnosis of ADHD is not simply a medical event, it is a profound act of self-discovery. Patients consistently describe the moment of diagnosis as a transformative sense-making experience, one that reframes a lifetime of inexplicable failures and the persistent, nagging sense of being fundamentally "different" (Singh, 2012; Halleröd, 2015; Sedgwick, 2019; Morgan, 2024). Yet this transformation is rarely uncomplicated. Alongside the relief of finally having an explanation comes a cascade of deeper questions about identity, authenticity, and one's place in the social world. The experience of being diagnosed with ADHD is, in short, distinctively entangled with identity.

5.3.1 Retrospective Grief and Narrative Reconstruction

Perhaps the most universal response to an ADHD diagnosis is relief. For adults especially, the diagnosis arrives as a long-overdue vindication. Where they once attributed their struggles to personal failings (laziness, stupidity, or some undefinable "craziness") they can now locate those same struggles within the framework of a recognized medical condition (Halleröd, 2015). This reframing is not merely semantic; it carries genuine psychological weight. Patients report measurable increases in self-worth, a newfound capacity for self-compassion, and a reduction in the guilt that had accumulated over years of apparent underperformance (Halleröd, 2015).

The diagnosis also carries social utility. When difficulties are legitimized by a medical label, patients find that family members, employers, and service providers often respond with greater understanding and adjusted expectations. Individuals find that a formal diagnosis makes it easier to communicate their needs, often resulting in kinder treatment and adjusted expectations from family, employers, and social services (Halleröd, 2015).

Relief, however, is only the opening chapter of a far more complex story. For many patients, the diagnosis initiates what might be called a process of "**narrative surrender**": a rewriting of one's personal history through a medical lens. Suddenly, the story of one's life must be retold (Thompson, 2021). Cherished explanations for past behavior are questioned. Achievements are re-examined. The simple but destabilizing question "Who am I, really?" moves to the center of daily life (Halleröd, 2015).

This tension is felt most acutely by adolescents who begin medication following their diagnosis. Many describe a disturbing dissociation: medicated, they are calmer and more productive, but they feel less like themselves — *more robotic*, as though encased in a bubble. Their authentic self, however chaotic, felt genuinely theirs. The managed self feels borrowed. This conflict between the medicated and unmedicated self is not merely an inconvenience; it strikes at fundamental questions of agency and personhood. (Singh, 2012; Eccleston, et al., 2019; Thompson, 2021)

Conversely, a significant number of patients (particularly high-functioning adults who have built careers and identities around their ADHD traits) *resist the diagnostic framing* altogether. For them, the high energy, creativity, and divergent thinking associated with ADHD are not symptoms to be managed but *defining strengths* to be celebrated. The diagnosis, rather than offering liberation, threatens to pathologize the very qualities they have come to regard as their greatest assets (Halleröd, 2015; Sedgwick, 2019).

Alongside the personal work of identity reconstruction, patients must also navigate a social landscape that remains deeply ambivalent about neurodevelopmental diagnoses. Stigma, both internalized and externally imposed, casts a long shadow. Adolescents frequently conceal their diagnosis and medication from peers, fearing the labels ("abnormal," "weird," "troublemaker") that they know await them. Adults harbor quieter but no less serious fears: that a formal record of their diagnosis could be weaponized by employers or authorities, foreclosing future opportunities before they have even been pursued (Halleröd, 2015; Eccleston, et al., 2019; Thompson, 2021).

For those diagnosed in adulthood, the relief of explanation is often shadowed by grief. The question that haunts many late-diagnosed individuals is not "What does this mean for my future?" but "What might my past have looked like?" Years of academic failure, fractured relationships, and substance misuse are reexamined through the lens of an undiagnosed condition, and the verdict is a painful one: much of this suffering, they believe, could have been avoided (Halleröd, 2015).

This retrospective grief frequently extends beyond the individual. Many adults, upon receiving their diagnosis, look at their parents or their own children and recognize familiar patterns: the same restlessness, impulsivity, and difficulty sustaining attention that went unnamed and untreated in previous generations. The diagnosis becomes, in this way, a multigenerational event, illuminating not only one's own history but the quiet suffering of relatives who navigated a world that had no framework to understand them (Halleröd, 2015).

There is also the subtler danger of what might be called the "*sick role*": the risk that a diagnosis becomes a *self-fulfilling prophecy*, eroding confidence and narrowing ambition. Some patients worry that by accepting the diagnostic label, they have inadvertently given themselves permission to fail, to retreat from challenges they might otherwise have attempted. The diagnosis that was meant to empower can, in certain circumstances, become a cage of its own construction (Halleröd, 2015).

Not all accounts of medication are fraught. Among younger children, particularly those between the ages of nine and fourteen, the experience of ADHD treatment is often narrated in terms of *moral agency* rather than identity loss. For these patients, medication is not a suppressor of the self but an *enabler* of it. Where they previously felt driven by impulse, or unable to choose the "right" action in the face of distraction, medication provides a mental clearing, a moment of pause in which genuine choice becomes possible (Singh, 2012).

For these children, the goal is not transcendence of the self but participation — the ability to finish homework, follow a lesson, and feel, at last, like a normal student. The diagnosis, far from being a burden, is experienced as a key: a means of unlocking access to the ordinary life that had previously felt just out of reach (Singh, 2012, Eccleston, et al., 2019).

An ADHD diagnosis is never simply a piece of paper. It is a story, one that must be integrated into every prior story the patient has told about themselves. That integration can bring relief, grief, liberation, confusion, stigma, and hope, often simultaneously. What the evidence makes clear is that patients are not passive recipients of a medical verdict; they are active interpreters

of its meaning. Whether the diagnosis ultimately becomes an anchor or a sail depends in large part on the quality of the support, understanding, and narrative space that surrounds it. To receive a diagnosis well, it seems, one needs not only a prescription, but an invitation to rethink, and ultimately reauthorize, the story of one's own life.

5.3.2 The Medicated vs. Unmedicated Self

“I feel like I’m floating in a void in space, in front of me are doors and windows, thousands of them, all are open at the same time, and I can’t do anything. The doors and windows are my inner thoughts, senses, the environment, everything... And when I take medication, like Ritalin, it feels like I gained the ability to move around, closing doors and windows that are not needed and only watching the one I choose to watch.”

– Anas Binni

These words were shared to me by my friend and colleague Anas, who also has ADHD. Anas phenomenologically conceptualized the lived experience of unmedicated ADHD through a spatial metaphor of overwhelming sensory and cognitive input, in a way that deeply resonated with me. This qualitative account, drawn from someone who completed an entire graduate program without pharmacotherapy, underlines medication not as a luxury, but as a critical instrument for existential relief and cognitive orientation. Both Anas and me share the feeling of medication as a necessary aid to complete our studies, as well as living a less stressful life. Medication gives us the ability to focus on one thing at a time, instead of a million at once. When evaluated through Brown’s theory of the univocity of attention, stimulant medication functions as a mechanism that allows individuals with ADHD to channel their focus intentionally, transitioning from chaotic, multi-directional stimulus processing to singular, self-directed engagement.

Despite the documented efficacy of stimulant treatment, public discourse and clinical hesitation regarding pediatric prescriptions remain heavily influenced by moral panics over addiction and dependency. These anxieties lack robust empirical backing; when diagnostic and prescriptive protocols are properly executed, the threat of substance dependence is drastically minimized—a reality frequently underscored in neurodivergent digital communities, where users often joke about the difficulty of maintaining daily adherence despite years of treatment.

In personal correspondence, Nelson critically analyzes this societal apprehension, attributing it to broader historical and socio-political frameworks rather than clinical realities:

"My view on medication is that people vastly overvalue the significance of medication and wrongly view the idea of taking meds as a kind of stance one takes. I'm extremely suspicious of how people in that discourse oftentimes are aghast at the idea of "forcing drugs on children", which I see as largely a product (at least in my country) of how the drug war created an apparatus of significance that gives so much weight to stimulant meds as a very dangerous thing that we barely have a hold over which people cannot be trusted with. I view medication far more neutrally: if meds on the whole empower you in the furtherance of your aims and interest, then you should take them; if they inhibit your ability to do what you need or want to do, then don't take them. So shifting the framework we are approaching the question from to an individual perspective focused on egoistic empowerment (in Stirner's sense) effectively renders the question of how it relates to masking as meaningless. I think this is a good example though of the shift in perspective I advocate for when discussing ADHD experiences, because it seems like viewing medication, which enables you to do the things you want when you want them, as potentially a way of conforming to neurotypical norms requires implicitly adopting a third-person neurotypical perspective on yourself so that you can understand something, that in all other ways is a benefit to you, as potentially objectionable. It requires a kind of self-alienation to pose the question, which I am skeptical of/reject outright."

5.3.2.1 Reconceptualizing Authenticity and Practical Agency

Beyond external socio-legal panics, neurodivergent community discourse frequently reflects internal anxieties regarding the erosion of personal authenticity; specifically, the fear that pharmacotherapy flattens baseline personality traits, such as spontaneity or high energy levels, which led individuals to seek a diagnosis in the first place. While dedicated empirical research on this subjective identity dilemma remains scarce and requires further academic investigation, the theoretical distinction between raw temperament and authentic agency is paramount.

Authenticity should not be conflated with unfiltered affective impulses or unmanaged executive dysfunction. Rather, genuine agency consists in the capacity for reflective self-direction: the ability to act consistently in accordance with one's long-term moral commitments, practical values, and self-chosen projects. Interventions that expand an agent's self-knowledge and practical reasoning capacity consequently promote, rather than undermine, individual authenticity.

Ultimately, pharmacotherapy is ethically defensible when it enhances an individual's capacity to cultivate coherent selfhood and autonomous action, whereas it becomes ethically compromised when deployed merely to enforce social compliance or suppress traits integral to an individual's self-concept. Synthesizing insights from digital ethnographic observations, peer dialogues, and lived experience, stimulant medication is best understood as a strategic tool for self-sovereignty. Whether administered to adults or children, pharmacotherapy should not be framed as a corrective fix for non-conforming behavioral traits, but as an empowering mechanism that reduces involuntary impulsivity, fosters psychological ease, and restores individual agency over mind and action.

5.3.3 Labeling Theory and Collective Identity Formation

The intersection of medical diagnosis and personal identity represents one of the most consequential yet underexplored dynamics in modern healthcare. When an individual receives a diagnosis, particularly for a contested condition like ADHD, they are not merely receiving medical information. They are being handed a lens through which they will interpret their past behaviors, understand their present struggles, and imagine their future possibilities (Thompson, 2021; Nielsen, 2018; Jutel, 2009, 2011, 2015).

Tannenbaum's labeling theory provides a framework for understanding how diagnosis itself shapes behavior. Once labeled as "a person with ADHD," individuals may gradually change their behavior to align with how they have been categorized. This self-fulfilling prophecy operates alongside institutional effects—schools categorize students with disabilities as "needing additional support," which helps normalize learning differences while simultaneously shaping how students understand themselves. As one researcher notes, "once a category has been created, there is a tendency to find people who fit into it, and whose identity may be shaped accordingly." Institutions play dual roles: providing necessary services and accommodations while simultaneously constructing the identities of those they serve. The diagnostic label grants access to extended time on tests and other accommodations, but it also imposes obligations—managing the diagnosis, navigating stigma, and incorporating disability into one's self-concept. This identity-shaping effect means that diagnosis is never merely descriptive. It is performative, actively constructing the reality it purports to describe (Thompson, 2021).

Identity is complex and can be defined in different ways. Contemporary philosophy characterizes identity as how individuals define themselves and their character, both in distinction from and in connection to collective groups. According to Wendt's framework

(1999), identities represent *"relatively stable, role-specific understandings and expectations about self"*. We construct these identities through *"ontological narratives"*: social and interpersonal stories that draw upon public narratives, institutional frameworks, and social networks to make sense of who we are. This identity theory posits that individuals have multiple identities within oneself, organized hierarchically in terms of salience. These include personal identity (our core sense of dignity and honor), role identities (expected behaviors and functions), and group identities (membership in collectives), as explained by Davis (2019). When a diagnosis enters this system, it can fundamentally reorganize this hierarchy, elevating what was once background noise into a defining characteristic. (Thompson, 2021)

Stigma profoundly affects how individuals experience their diagnoses. Mental health stigma is particularly virulent because psychiatric conditions lack observable markers or definitive tests. Labels function as *"representational systems of meaning"* recognized across society, carrying associations that shape both self-perception and social interaction (Thompson, 2021). The diagnostic label can have *"profound consequences for sense of self and social identity,"* but these consequences vary widely based on individual circumstances and access to quality services. Illness stereotypes further complicate this landscape. These socially constructed beliefs about diseases influence symptom reporting, shape diagnostic processes, and guide behavior in self-fulfilling ways. Individuals may unconsciously perform behaviors they associate with their diagnosis, or mask genuine symptoms to avoid confirming stereotypes. This dynamic can lead to misdiagnosis, inappropriate treatment, and a fundamental disconnection between lived experience and diagnostic classification. Masking can also have a detrimental effect on the person's mental health, with various implications on the sense of identity (Thompson, 2021; Nelson, 2019; Ginapp et al., 2023).

Individuals diagnosed with ADHD in adulthood experience significantly more depressive symptoms than those diagnosed during adolescence (Wilkinson, et al., 2016). This finding suggests that years of struggling without understanding or support—internalizing failures, facing repeated setbacks, and lacking effective coping strategies—creates lasting psychological damage (Eccleston, et al., 2019; Jones, et al., 2018; Halleröd, 2015). For populations where ADHD goes unrecognized, other symptoms often become the initial presenting concern. Substance abuse frequently emerges as the problem that finally brings individuals to clinical attention (Thompson, 2021; Livingston, 1999), by which point significant harm may have accumulated. While early diagnosis would not necessarily prevent substance abuse, it would provide access to resources for managing impulsive behaviors and understanding oneself,

potentially altering developmental trajectories (Thompson, 2021; Halleröd, 2015). These disparities, examined in 3.2.1, mean non-white adolescents disproportionately miss the early intervention window (Thompson, 2021; Bax, et al., 2019; Livingston, 1999).

However, the relationship between diagnosis and stigma is not uniformly negative. While some find their diagnoses limiting and stigmatizing, others discover that diagnostic labels provide access to accommodation, treatments, and communities that substantially improve self-perception, efficacy, and esteem (Thompson, 2021).

Beyond individual identity, diagnosis enables collective identity formation. Individuals with shared diagnoses often coalesce into communities that advocate for legitimacy and recognition. These collective illness identities provide narratives through which individuals construct their personal identities, situating themselves within public stories and shared experiences. The ADHD support community exemplifies this phenomenon. Through self-help books, online forums, and advocacy organizations, adults with ADHD have created a collective identity that has shifted public perception and personal experience of the condition. This collective identity evolves as individuals learn to accommodate their diagnoses into their self-concepts, negotiating between medical frameworks and lived experience (Thompson, 2021; Conrad and Potter, 2000; Brown, 2023). These narratives require defense and legitimization through reason, policy, and role models, often involving conflict and confrontation. Changing these narratives is possible but contested, as dominant medical frameworks carry institutional authority that alternative perspectives must challenge (Thompson, 2021; Jutel, 2009, 2011, 2015).

Chapter 6 – Conclusions

6.1 Synthesis of Findings: Beyond the Monism of Deficit

This thesis set out to investigate a central research question: how pathologizing discourse shapes the identity, agency, and lived experience of adults with ADHD, and what ethical, epistemological, and clinical problems arise from this construction. Across these chapters, the investigation has demonstrated that clinical and cultural narratives do not merely describe an objective biological reality; they actively construct the social and subjective terrain upon which neurodivergent identity is built.

In Chapter 1, an analysis of the philosophy of medicine revealed that concepts of health, disease, and functioning are fundamentally normative rather than purely empirical. While biomedical baselines and accounts such as Wakefield's "harmful dysfunction" attempt to locate mental disorders in objective biological breakdowns, Nordenfelt's capability approach provides a more humane, person-centered alternative. By prioritizing an individual's capacity to realize their "vital goals" over strict conformity to biological or statistical norms, the capability model demonstrates that neurodivergence need not be defined as an inherent deficiency. Furthermore, examining medicalization as a mechanism of social control highlighted how majoritarian systems enforce invisible marginalization—evaluating all minds against a single, unexamined neurotypical baseline while reframing systemic incompatibility as individual moral failure.

Chapter 2 explored the ideological tension between competing frameworks of ADHD. Barkley's executive dysfunction model, while clinically influential, constructs a "monism of deficit" that reduces ADHD cognition to an incomplete stage of human development and applies an asymmetric standard to cognitive scaffolding. Through the lens of Extended Mind Theory and Brown's concept of the "univocity of attention," this thesis demonstrated that ADHD traits reflect alternative, highly immersive cognitive styles rather than mere failures of self-control. Simultaneously, the critique of popular discourse revealed the traps of both extremes: while pathologizing language constructs individuals as broken, the popular "superpower" narrative enforces a toxic positivity that erases genuine suffering, privileges those with socioeconomic resources, and re-commodifies neurodivergent traits for productivist ends.

Chapter 3 addressed the structural exclusion of ADHD individuals from the production of knowledge about their own lives. Through testimonial and hermeneutical injustice, psychiatric frameworks have historically positioned neurodivergent people as passive objects of study

rather than legitimate knowers. Adopting Tekin's framework of Participatory Interactive Objectivity (PIO) showed that true scientific rigor demands the systematic inclusion of first-person experiential knowledge, offering a necessary safeguard against both diagnostic misrepresentation and the corporate "neurodiversity-washing" of neurodivergent identity.

Finally, Chapter 4 examined the granular phenomenology of living with ADHD. By resolving the theoretical paradox of masking, Nelson's model of "immanent self-regulation" exposed how adults with ADHD navigate hostile social architectures not through top-down executive strategy, but through automatic, environmentally driven reactions to anticipated social penalty. Unpacking the internal experiences of motivational inactivity, temporal disorientation, and lexical cohesion illustrated the persistent, invisible labor required to maintain a coherent self across time. Moreover, analyzing diagnosis as an institutional process revealed stark racial, gender, and socioeconomic disparities in access to care, while demonstrating that the diagnostic moment triggers a profound identity transformation—a complex dialectic of relief, retrospective grief, and the reclamation of practical agency through medication.

6.2 Strategic Dual-Framing: Neurodiversity as Horizon, Pathology as Lever

To resolve the ideological impasses identified throughout this work, this thesis proposes a pragmatic, strategic dual-framing of ADHD. Rather than forcing a rigid, binary choice between the Pathology Paradigm and the Neurodiversity Paradigm, critical psychology and neuroethics must adopt a two-pronged stance that honors both existential reality and institutional necessity.

On an ontological, conceptual, and interpersonal level, we must fully adopt the Neurodiversity Paradigm. Humanity is inherently neurocognitively diverse, and ADHD represents a natural, valid variation in human neurological functioning rather than a biological defect. The neurodiversity framework is essential for providing adults with ADHD an affirmative vocabulary, fostering collective community identity, dismantling internalized stigma, and recognizing that functional impairment stems largely from a structural mismatch between atypical cognition and neurotypical environments. It allows individuals to view their attentional styles, sensory processing, and emotional depth not as evidence of incomplete human development, but as authentic ways of being in the world.

Concurrently, on an institutional, legal, and clinical level, we must retain the Pathology Paradigm as a strategic tool. In late-stage capitalist societies, medicalization remains the

primary key that unlocks structural accommodations, legal protections, educational support, workplace modifications, and subsidized pharmacotherapy. To abandon the diagnostic apparatus entirely in the name of radical anti-psychiatry would prematurely strip vulnerable individuals of the material resources necessary for daily survival. Therefore, the pathology model must be utilized instrumentally—as a pragmatic lever to compel risk-averse institutions into granting rights and accommodations—without allowing its underlying deficit-driven ideology to dictate the individual's self-concept or moral worth.

In this framework, medication is neither a mechanism of forced behavioral normalization nor a cosmetic luxury; it is a neutral instrument of self-determination and practical agency. When freed from the demands of neurotypical compliance, pharmacotherapy simply serves to reduce internal friction, quiet cognitive noise, and empower the individual to direct their univocal attention toward their own vital goals.

6.3 Reshaping the Clinical Consensus: Education and Epistemic Authority

Achieving a broader societal shift in how ADHD is understood requires targeting the primary gatekeepers of diagnostic and institutional authority: clinicians. Because medical professionals hold immense political and cultural power in defining the boundaries of normalcy, a reshaping of the ADHD consensus must originate within clinical training and relay outward into schools, workplaces, and the wider public sphere.

Currently, clinical education remains heavily reliant on third-person behavioral observation, deficit checklists, and diagnostic manuals that view ADHD strictly through the lens of external disruption. Medical curricula must be fundamentally overhauled to integrate first-person phenomenological insights and critical neuroethics. Clinicians must be educated on the internal realities of adult ADHD—learning to recognize immanent masking, the exhaustion of constant social compensation, the paralyzing weight of motivational inactivity, and the profound impact of emotional dysregulation. When a clinician understands that a patient's conversational leaps reflect lexical cohesion rather than thought disorder, or that their struggle with time management is a structural temporal disorientation rather than laziness, the therapeutic encounter shifts from behavioral surveillance to genuine collaborative care.

Furthermore, clinical practice must operationalize Tekin's Participatory Interactive Objectivity by granting ADHD individuals epistemic authority in research and diagnostic formulation.

First-person accounts should not be dismissed as subjective anecdotal noise, but recognized as indispensable qualitative data that grounds medical science in lived context. By training psychiatrists, psychologists, and educators to view ADHD through this integrative lens, the clinical establishment can evolve from an enforcement mechanism of neurotypical conformity into an ally in neurodivergent liberation.

6.4 Directions for Future Research

While this thesis has established a conceptual foundation for bridging critical theory and ADHD phenomenology, significant empirical and theoretical work remains to be done. Future research should prioritize several key areas:

- **Qualitative & Phenomenological Methodologies:** Further qualitative studies utilizing Interpretative Phenomenological Analysis (IPA) and participatory action research are needed to map the lived experience of adult ADHD, particularly regarding the long-term psychological impacts of late diagnosis, retrospective grief, and masking burnout.
- **Intersectional Diagnostic Disparities:** Quantitative and sociological research must continue to investigate how race, ethnicity, socioeconomic status, and gender intersect with diagnostic gatekeeping. Specific attention should be paid to how racialized and low-income individuals are systematically excluded from early diagnostic windows or misdiagnosed within the correctional and psychiatric systems.
- **Development of Univocal Adaptive Scaffolding:** Applied cognitive science and occupational therapy should explore environmental and technological scaffolding designed specifically around ADHD cognitive architecture—building tools that accommodate univocal attention, hyperfocus, and non-linear task engagement rather than forcing compliance with neurotypical time-blocking.
- **Longitudinal Studies on Identity and Medication:** Longitudinal investigations are necessary to explore how long-term pharmacotherapy influences identity formation, self-concept, and subjective feelings of authenticity from adolescence through adulthood.

Ultimately, adults with ADHD are neither broken subjects requiring biological correction nor heroic figures possessing effortless superpowers. They are human beings living with a complex, real, and often exhausting neurodevelopmental difference within a world constructed for a different neurological baseline. By holding the neurodiversity paradigm as our conceptual horizon and leveraging the pathology paradigm as an institutional tool, we can construct a more

just, empathetic, and scientifically rigorous framework—one that affords individuals with ADHD the dignity, agency, and understanding they have long been denied.

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Acknowledgements

First and foremost, I need to thank my supervisor, Dr. Andrea Lavazza, for believing in this project from the very beginning. Even when my ideas were still confused, not more than a sketch, Prof. Lavazza filled me with motivation and put his full trust in my abilities. Thank you, then, for allowing me to pursue this topic, that is not just a thesis, but for me is the beginning of something much deeper. I hope to have made you proud with this work as much as I am proud of it, and I hope to find you again in my career to deliver you good news of my progress in academia, if not to work together again on another project.

Thank you, Cal Nelson, for sharing your time, thoughts and perspectives with me. Your appreciation for my work has boosted my energy when things felt impossible. Your additions made this project alive, and it wouldn't be the same without all that you've given me. I wish you all the best in your career, and I hope to meet you one day as colleagues.

I must thank my friend Selçuk Kaynak for the valuable feedback provided along the way; the endless hours on videocall, reading the same passage again and again to make it just as my mind envisioned. I will never forget the help you gave me, I'll treasure all the teachings and put them to use to become a better writer, hopefully a better professor. You're the best friend one could hope for.

Thank you, Ana, my dear friend, for making me forget about my problems during our nights out. In this short time, you became like a family member, and I'll hold our friendship close to my heart. Wherever the future takes us, I'll cheer on you to be the best version of yourself.

Thanks to Zeynep and Ilay for creating a home away from home. You brought some Turkish spice into my life, that I very much needed during all the struggles of this master degree. We'll see each other again soon, but this time we'll recreate some Italy inside of Turkey.

Thank you, Anas, for the long, deep, late-night conversations. Thank you for trusting your life story with me. I love you more than words can describe.

Thanks to Nina and Diego, for sharing all the lighthearted moments of the last year, as well as the endless lectures, and for giving me a safe space for my pain.

Grazie ad Andrea e Alessandro per essermi stati vicino in tutte le peripezie della vita da 14 anni a questa parte. Siamo cresciuti insieme, e solo voi sapete sempre come farmi stare bene. Siete parte di me.

Grazie ad Aurora, Nana e Daniela per tirarmi sempre su di morale, per farmi ridere della vita anche dopo mesi di assenze.

Grazie Giulia, per credere in me e ricordarmi ogni volta del potenziale che ho e che avrei potuto sprecare se non avessi seguito i miei sogni, e per continuare a ricordarmi di non sottovalutarmi. Sei l'amica che ognuno spera di avere, e sono grata di averti nella mia vita.

Thank you Serhat, for allowing me to vent for hours on end on the phone, sometimes without even understanding what I was whining about. Your support was essential to keep me sane. There's no distance that can make me forget about your love and devotion. Thank you for supporting my dreams and pushing me harder. Sonsuza dek seni seviyorum.

Grazie alla mia famiglia per avermi permesso di intraprendere questo percorso. Senza di voi, Mamma e Papà, tutto questo non sarebbe stato possibile, e vi meritate il più caloroso dei ringraziamenti. Vi prometto che i vostri sforzi verranno ripagati presto, anche se so che già questo traguardo vi ha reso fieri di me, e che per voi non abbia altro da dimostrare per sapere di aver fatto la scelta giusta nel supportarmi fino a qui. So che ci sono stati momenti, in questa corsa durata 5 anni, in cui sembrava che fossi più disperata che contenta, grazie quindi per non aver dubitato nella mia capacità di arrivare fino in fondo, e di aver sopportato tutte le mie lamentele. Grazie anche a mia sorella, Elena, per le volte in cui mi hai fatto ragionare, perché in fin dei conti non è stato così male come sembrava. Grazie ad Athena, la mia piccola stella, per avermi vietato di leggere e rileggere ad oltranza le stesse pagine, perché con il tuo pianto mi hai riportato sulla Terra, e ricordato che ci sono cose più importanti della ricerca alla perfezione.

Questa tesi è frutto di mesi di frustrazione e dubbi, ma allo stesso tempo di curiosità e conquiste. Trovare le parole giuste per descrivere le mie idee è stato difficile, ma la passione che ho per la ricerca accademica e l'argomento presentato mi hanno dato la spinta per superare le delusioni e paure che spesso sono sorte durante questo percorso. Se sono arrivata fino a qui, se posso dirmi fiera di questo risultato, lo devo soprattutto a me stessa. Non posso quindi terminare questi ringraziamenti senza rivolgermi un bel, grande, "Grazie".