



Identity

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ADHD Identity: How Age, Race, and Socioeconomic Status Shape Rejection or Acceptance

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ABSTRACT

Whereas previous research on Attention-Deficit/Hyperactivity Disorder (ADHD) has predominantly focused on behavioral and pharmacological management, we explored how age of ADHD identification and the presence of co-occurring conditions and life events affect how individuals relate to their ADHD identity. We analyzed data from a diverse sample of 653 adults with formal or self-identified ADHD. Older age at the time of ADHD identification was associated with more positive ADHD identity integration – an individual's likelihood of accepting or rejecting ADHD as part of their identity. There was a moderation effect of co-occurring diagnoses; those with additional mental health diagnoses and disabilities showed a weaker relationship between age and rejection of ADHD identity. Black and male participants reported higher levels of rejection of their ADHD identity. The results reveal a complex interplay between the age of identification and other demographic factors in people's ADHD identity configuration. Given our findings, we advocate for continued research on ADHD with diverse samples and the de-stigmatization and supportive policies that recognize the varied experiences of individuals with ADHD. This study contributes significantly to a more holistic understanding of ADHD, paving the way for future research that could explore identity integration processes in other neurodevelopmental disorders.

ADHD and neurodiversity are increasingly recognized in both cultural and scientific discourses. This study contributes to ongoing inquiry into ADHD's role in shaping identity, emphasizing how individuals experience and adapt to recognizing their ADHD within social and identity frameworks (Eddington & Badillo-Winard, 2024; Zapata & Worrell, 2024). These perspectives complement the medical model by integrating clinical aspects of ADHD and the unique ways individuals internalize their understanding of having ADHD (Jones & Hesse, 2018). Despite conceptual advances, an ADHD diagnosis carries considerable stigmatization (Berga et al., 2019; Lebowitz, 2016). This stigma parallels challenges faced by other concealable stigmatized identities, like being LGBTQ+, creating a complex, multifaceted experience for those diagnosed (Schmitt et al., 2014). Recognizing ADHD as a component of identity, rather than solely a disorder, may reduce stigma and promote acceptance.

Understanding ADHD as a variable of identity involves examining how stigma and adaptation shape self-perception. Identity is a dynamic self-concept shaped by personal traits and external influences, including how others perceive someone (Baumeister, 2011). Our research integrates the minority stress model (MSM) and concealable stigmatized identities (CSI) to explore how broader social and individual contexts intersect with ADHD to influence identity (Meyer, 2003; Quinn &

Chaudoir, 2015). Identity integration for people with ADHD is often complex, as this new identity intersects with other aspects of identity.

ADHD's stigmatization complicates adaptive identity formation (Mueller et al., 2012). For younger people, who are still developing their self-concepts, integrating ADHD as part of their identity may be particularly challenging, especially when it intersects with other identity aspects (Babakr et al., 2019; Ringer, 2020). Fear of rejection and a tendency to mask symptoms further complicates the integration process (Meyer, 2003). As a CSI, ADHD can heighten psychological distress due to fears of social devaluation, making self-acceptance more difficult (Quinn & Chaudoir, 2015). The circumstances surrounding diagnosis also influence identity integration, especially when a diagnosis occurs during a traumatic or stressful period, particularly for individuals with multiple marginalized identities or co-occurring conditions (Corrigan & Watson, 2002). Despite these challenges, the neurodiversity movement validates ADHD as a meaningful identity component, promoting adaptive coping and self-acceptance (Sonuga-Barke & Thapar, 2021).

Personal Disability Identity (PDI), which encompasses disability acceptance and affirmation, helps mitigate negative psychosocial outcomes related to stigma (Zapata & Worrell, 2024). Specifically, disability affirmation is linked to higher life satisfaction among adults with ADHD, while disability acceptance is associated with greater self-efficacy. These findings highlight the importance of these constructs as protective factors (Zapata & Worrell, 2024). Mental Illness Identity (MII) similarly influences behavior and health outcomes (Eddington & Badillo-Winard, 2024). MII considers how a mental illness becomes a part of a person's self-concept and includes internalized stigma and the dynamic processes of acceptance, rejection, centrality, and salience of the condition. Greater identification with a mental health condition can facilitate treatment engagement although it may be associated with poorer functioning in some cases (Eddington & Badillo-Winard, 2024).

Viewing ADHD as an integral part of identity can enhance self-understanding and acceptance, improving life satisfaction. However, individuals with high internalized ADHD stigma may struggle with this process, particularly if they externalize ADHD, viewing it as separate from their core self. When ADHD is externalized people may struggle to accept the diagnosis. Lower acceptance can lead to diminished life satisfaction and reduced self-efficacy (Zapata & Worrell, 2024). We sought to explore how ADHD identity integration varies by age of diagnosis and the impact of significant life events at diagnosis. Building on research suggesting that age of first ADHD diagnosis may impact ADHD identity integration (Ringer, 2020), we aim to inform holistic approaches that align medical treatment with identity-based support, ultimately enhancing both clinical outcomes and overall well-being.

ADHD presentation, etiology, and treatment

ADHD is classified as a neurodevelopmental disorder characterized by symptoms of inattentiveness (e.g., difficulties with focus, organization) and hyperactivity-impulsivity (e.g., restlessness, excessive talking; American Psychiatric Association [APA], 2022). Increasingly, ADHD is viewed as a variation in neurodevelopment that reflects differences in executive function, motor skills, sensory processing, and emotional regulation (Delgado-Lobete et al., 2020; Fabio et al., 2024; Rubia, 2018). ADHD's etiology has been linked to a complex interplay of genetic (Thapar, 2018), neurobiological (Lei et al., 2015), and environmental factors (Guney et al., 2015; Langley et al., 2007). Trauma exposure further complicates diagnosis due to symptom overlap (Boodoo et al., 2022).

Recognizing this multifactorial nature, current clinical guidelines advocate for a personalized approach to diagnosis and treatment, emphasizing individual strengths and reducing stigma (Dell et al., 2021; Posner et al., 2020; Zapata & Worrell, 2024). Standard treatments, including medication (Dodson, 2005), cognitive-behavioral therapy (CBT), and behavior modification (Pan et al., 2019), can be effective but may lead to masking, which can be emotionally and cognitively taxing (Ginapp et al., 2023). Psychoeducation and helping clients connect adaptively with their inherent desires for competence, autonomy, and relatedness are other viable treatment approaches (Champ et al., 2023).

Educational adjustments and other structural support resources can also help foster academic success (Gualtieri & Johnson, 2008).

ADHD identity integration

Newly diagnosed individuals commonly undergo a transformative process, necessitating the integration of a new identity dimension into their overall sense of self (Babik & Gardner, 2021). This process varies greatly across life stages and is influenced by contextual factors, such as race, gender, culture, and unique life events (Botha & Gillespie-Lynch, 2022; Ringer, 2020; Stenner et al., 2019).

Developmental considerations and emergent events

Age at diagnosis significantly influences ADHD identity integration, with people under the age of 19 often struggling to internalize their ADHD diagnosis. They typically rely on external perceptions to shape their self-concept and tend to exhibit an external locus of control (Ringer, 2020). By contrast, people diagnosed in adulthood are more likely to engage in retrospective thinking and reframe past experiences in ways that promote self-understanding and acceptance (Hansson Hallerod et al., 2015; Stenner et al., 2019; Young et al., 2019). These findings suggest adults are more likely than children and adolescents to internalize their diagnosis, allowing for more fluid identity integration.

Researchers have highlighted the developmental impact of age at diagnosis on identity formation and psychological well-being. ADHD diagnosis timing does not appear to directly impact life satisfaction (Zapata & Worrell, 2024), suggesting a complex relationship between ADHD integration, demographic variables, life circumstances, and well-being. For instance, women diagnosed in adulthood often report relief and increased self-compassion and acceptance (Attoe & Climie, 2023; J. Morgan, 2023), while late-diagnosed adults may struggle with internalized stigma (Hansson Hallerod et al., 2015; Stenner et al., 2019; Young et al., 2019) and regret over missed interventions, affecting self-esteem and coping skills (Attoe & Climie, 2023; J. Morgan, 2023).

Emergent events are significant life occurrences that disrupt routine and provide new perspectives, creating a *before and after* in one's life (Mead, 1932/1980). Emerging events allow one to experience life through a different lens, encouraging reflection on differences that likely would have gone unnoticed otherwise. For example, parents of newly diagnosed children may recognize ADHD traits in themselves, leading to a reevaluation of past experiences, potentially facilitating identity integration (Stenner et al., 2019). More research is needed to understand how emergent events moderate the relationship between the age of diagnosis and internalization of an ADHD diagnosis.

Racial and cultural influences on ADHD identity and stigma

People from marginalized communities often face unique challenges regarding ADHD diagnosis and identity development (Botha & Gillespie-Lynch, 2022). Black, Indigenous, and People of Color (BIPOC) are frequently underrepresented and misdiagnosed due to cultural biases, such as labeling Black boys with conduct disorders instead of ADHD (Ghoshal, 2022; Weinberger, 2023). This misdiagnosis restricts access to appropriate care and complicates ADHD identity integration (Cenat et al., 2020; P. L. Morgan et al., 2014; Shi et al., 2021). For instance, Black parents may experience increased stigma and limited access to resources, affecting both their own and their children's ADHD identity development (Ringer, 2020).

Stigma surrounding ADHD is pervasive, often fueled by cultural prejudices that attribute symptoms to poor parenting or moral failings. These misconceptions are particularly harmful to people from marginalized groups, as they reinforce negative self-perceptions and hinder identity development (Masuch et al., 2019; Mueller et al., 2012). Cultural variations also shape how ADHD symptoms are perceived. For example, some Latinx/e parents may view ADHD as fate-driven and self-resolving, while Asian cultural norms may emphasize conformity, adding pressure to mask

symptoms (Lawton et al., 2016; Lung et al., 2019). These cultural and societal stigmas influence how individuals integrate ADHD into their identity, underscoring the need for an intersectional approach that acknowledges the impact of both racial and cultural factors (Botha & Gillespie-Lynch, 2022).

The present study

Current scholarship indicates that adults diagnosed with ADHD may experience empowerment and enhanced self-understanding, contrasting with the often disempowering diagnostic experiences of childhood. For marginalized communities, additional barriers and opportunities for growth influence how they integrate an ADHD diagnosis into their identity. Emergent events also shape this process. While previous studies have focused on qualitative methods, our research aims to expand on these findings using quantitative measures with a larger, more diverse sample, allowing for broader generalization of the results. Consequently, we proposed the following hypotheses to expand our understanding of ADHD identity development experiences:

- (1a) There will be a positive relationship between the age of ADHD identification and adaptive ADHD identity integration.
- (1b) There will be a relationship between historically marginalized identities (gender, ethnicity, social class) and adaptive ADHD identity integration.
- (2) The relationship between age of identification and ADHD identity integration will show additional variation when accounting for emergent events and co-occurring disorders.
- (3) Endorsing emergent events and co-occurring conditions precipitating or occurring at the initial time of ADHD identification will moderate the effect of age of diagnosis on adaptive ADHD identity integration.

Method

Participants

We recruited participants aged 18 and older with formal or self-identified ADHD from listservs, organizations, and ADHD-related social media groups. Power analyses using the “pwrss” (Bulus, 2023) and “InteractionPower” (Baranger et al., 2022) packages in R indicated a minimum sample size between 379 and 682. We ran a .7 reCAPTCHA software risk analysis to filter survey responses detected to be bots, duplicates, incomplete data, and failed attention checks, resulting in a sample size of 671 participants. Eighteen participants who scored below 10 on the ASRS-5 were removed from all subsequent analyses, resulting in a total sample size of 653. An ASRS-5 score ranging from 10 to 13 indicates mild to moderate symptom severity. Among these participants, 494 (75.7%) reported having a formal diagnosis. See Table 1 for full participant characteristics.

Procedure

This study was approved by our university’s institutional review board (IRB-FY2024-85). Participants accessed the instruments via Qualtrics after responding to an eligibility questionnaire and providing informed consent. Eligible participants were entered into a drawing of 90 \$50 gift cards. We collected data on age, gender, ethnicity, emergent events (e.g., parenthood status, transition to college), co-occurring conditions, social status, and age of ADHD self- or formal diagnosis. Participants also completed the ADHD Self-Report Screening Scale for DSM-5 (ASRS-5; Ustun et al., 2017) and a modified version of the Illness Identity Questionnaire (IIQ; Oris et al., 2016) to assess ADHD identity integration.

Table 1. Participant Characteristics and ADHD Identity Integration Variables.

| Participant Characteristics | n | % | | | |
|------------------------------------|----------|-------------|-------------|----------|-----------|
| Gender | | | | | |
| Female | 472 | | | 72.3 | |
| Male | 113 | | | 17.3 | |
| Non-Binary/Trans | 68 | | | 10.4 | |
| Ethnicity | | | | | |
| White | 404 | | | 61.9 | |
| Black/AA | 91 | | | 13.9 | |
| Hisp/Latinx | 60 | | | 9.2 | |
| AAPI | 33 | | | 5.1 | |
| Bi/Multiracial | 32 | | | 4.9 | |
| NAAI | 7 | | | 1.1 | |
| Other | 24 | | | 3.7 | |
| Education | | | | | |
| Less than HS | 10 | | | 1.5 | |
| HS/GED | 32 | | | 4.9 | |
| Some college | 173 | | | 26.5 | |
| Associates/tech | 99 | | | 15.2 | |
| Bachelor's | 241 | | | 36.9 | |
| Graduate/professional | 98 | | | 15 | |
| <i>Participant Characteristics</i> | <i>n</i> | <i>Min.</i> | <i>Max.</i> | <i>M</i> | <i>SD</i> |
| Current age | 601 | 18 | 60 | 29.47 | 7.92 |
| Age of self- identification | 151 | 10 | 45 | 20.78 | 8.32 |
| Age of formal dx | 494 | 3 | 60 | 21.43 | 11.08 |
| Subjective Social Status | 651 | 1 | 10 | 5.17 | 1.65 |
| Total co-occurring dx | 653 | 0 | 8 | 1.64 | 1.35 |
| Total emergent events | 653 | 0 | 11 | 2.59 | 2.09 |
| ASRS Scores | 653 | 10 | 24 | 16.74 | 3.14 |
| IIQ Scores | | | | | |
| Rejection | 652 | 1 | 5 | 2.32 | .91 |
| Acceptance | 650 | 1.2 | 5 | 3.65 | .62 |
| Engulfment | 651 | 1 | 5 | 3.33 | .81 |
| Enrichment | 651 | 1 | 5 | 3.19 | .80 |

N = 653. Ethnicity is missing 2. Black/AA = Black or African American. AAPI = Asian American or Pacific Islanders. NAAI = Native American or American Indians. SSS = Subjective Social Status. ASRS= Adult ADHD Self-Report Scale. IIQ = Illness Identity Questionnaire.

Measures

ADHD identification

ADHD identification was assessed using the ADHD Self-Report Screening Scale for DSM-5 (ASRS-5; Ustun et al., 2017) and a question about self- or formal diagnosis. The ASRS-5 consists of items rated on a 5-point scale (0 = *never* to 4 = *very often*), with total scores classifying symptom severity: 10–13 (mild to moderate), 14–17 (high), and 18+ (very high). Cronbach's alpha was .58, consistent with previous studies and its coverage of distinct constructs (hyperactivity and inattention; Somma et al., 2021).

We included self-identified ADHD individuals, regardless of formal diagnosis to address known diagnostic barriers and ensure a more inclusive sample (Ghoshal, 2022; Slobodin & Davidovitch, 2019; U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation [ASPE], 2025). Self-reporting captures personal agency and introspection, essential for understanding ADHD identity formation. The act of self-reporting represents an individual's recognition and acknowledgment of their experiences, which are foundational steps in integrating ADHD into their broader identity. By incorporating self-diagnosed individuals who met the ASRS-5 criteria (Ustun et al., 2017), we aimed to create a more inclusive sample that better reflects the diversity of people with ADHD.

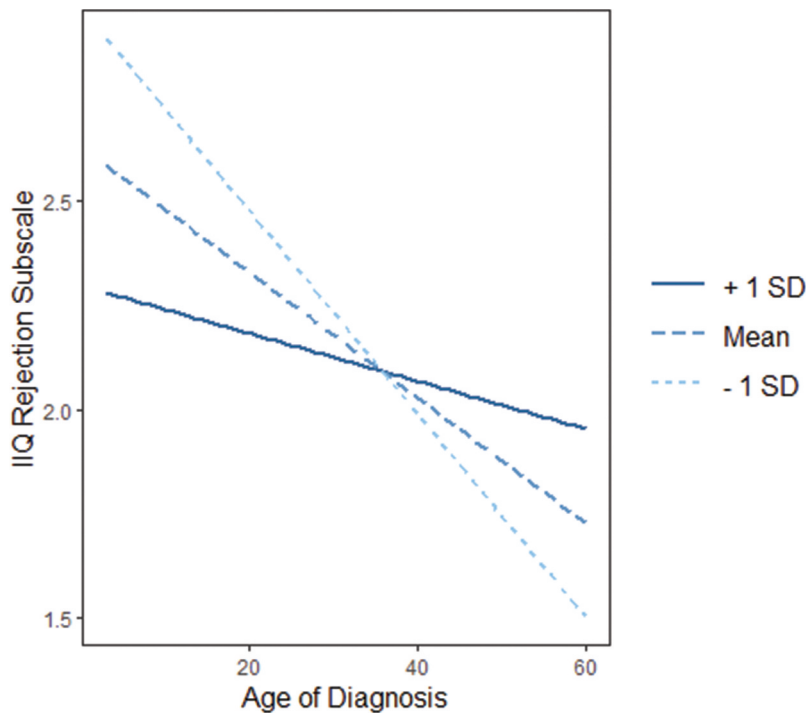


Figure 1. The moderating effect of participants' total number of Co-occurring diagnoses. Total co-occurring diagnoses among participants: $M = 1.64$, $SD = 1.35$. IIQ = Illness Identity Questionnaire. Participants chose from the following co-occurring conditions: mood disorder, autoimmune disorder, intellectual disability, learning disability, trauma related disorder, sensory processing disorder, autism, personality disorder, OCD, schizophrenia, epilepsy, and Persistent Drive for Autonomy (PDA).

Co-occurring conditions & emergent events

Participants were asked to identify co-occurring conditions from a list generated from our review of the literature (e.g., APA, 2022; Centers for Disease Control and Prevention, n.d.; Pehlivanidis et al., 2020), and consultations with experts in the field (see Figure 1). A total sum of co-occurring conditions was computed.

Participants were also asked if they experienced any of the following emergent events (determined following consultations with experts in the field) prior to their diagnosis: became a parent, started college or technical program, started graduate school, unanticipated career change, major relocation, had a death in the family, received a medical diagnosis that significantly impacted quality of life, functioning, or life expectancy, got married or moved in with a partner, experienced a traumatic event, and had the option to select "other" to self report an event in a textbox entry. A total sum of emergent events was calculated.

Social status

We assessed participants' social status using the MacArthur Scale of Subjective Social Status (SSS; Adler et al., 2000). Participants were asked to rank themselves on a ladder from 1 to 10 based on their subjective impression of their access to opportunity, education, employment, etc. People who rate themselves at the top of the ladder (10) have the highest standing in their community whereas the bottom of the ladder (1) represents the lowest standing in their community (Adler et al., 2000). SSS scores from a large multiethnic national sample (Operario et al., 2004) indicated typical scores to be on average above the midpoint of the scale ($M = 5.85$).

ADHD identity integration

We assessed participants' ADHD identity integration using a modified version of the 25-item self-report Illness Identity Questionnaire (IIQ; Oris et al., 2016). The modification included changing "illness" to "ADHD" to increase scale validity. The IIQ uses a 5-point Likert scale ranging from 1–5 (*strongly disagree* to *strongly agree*; Oris et al., 2016). The IIQ's four subscales are rejection, acceptance, engulfment, and enrichment. High rejection scores (RS) indicate a state of denial and non-integration of one's ADHD, high acceptance scores (AS) are reflective of high integration of one's ADHD and a neutral appraisal of the identity, high engulfment scores (ES) suggest that the ADHD identity feels overwhelming and negatively overshadows other aspects of their identity, and high enrichment scores (ENS) indicate that an individual's ADHD identity is integrated into their global sense of self and viewed as a positive aspect of their identity (Oris et al., 2016, 2018). Cronbach's alpha for the subscales were: RS = .88, AS = .70, ES = .85, ENS = .86.

Data collection and statistical analyses

We analyzed data from a final sample of 653 participants and checked categorical variables for normal distribution. To test Hypothesis 1a, we examined unconditional associations among variables. To test Hypothesis 1b, two gender variables were created (male, scored 1 if male and 0 otherwise; trans/nonbinary, scored 1 if trans/nonbinary and 0 otherwise; female was the reference group). In the same way, six dichotomous variables were created for race/ethnicity (Black, Hispanic/Latinx, Asian American/Pacific Islander, Biracial/Multiracial, Native American/American Indian, Other), using White as our reference group (all variables scored as 0). Four separate hierarchical regression analyses were conducted to answer three hypotheses. Hypothesis 1b was tested in Step 1 by examining the relationships among ADHD identity integration represented by the IIQ subscales (Rejection, Acceptance, Engulfment, Enrichment), age of identification, gender, ethnicity, and social class. In Step 2, the impact of co-occurring disorders and emergent events was assessed for Hypothesis 2. Step 3 was run twice with two different interaction terms to test Hypothesis 3 (labeled Step 3a and Step 3b). The first interaction term was age of identification and total co-occurring diagnoses (3a). The second interaction term was age of identification and total emergent events (3b).

Results

Hypothesis 1a

The analysis revealed a significant negative correlation between age of identification and IIQ Rejection subscale scores ($r(644) = -.180, p < .001$), indicating that older individuals tended to have lower rejection scores. Age of identification was not correlated with other aspects of ADHD identity integration. Therefore, the hypothesis was partially supported.

Regression analyses

Hypothesis 1b

Results are shown in Table 2. Step 1 revealed that age of identification, ethnicity, and gender significantly contributed to how individuals with ADHD integrate their identity across the IIQ subscales, explaining variances of 12.3% for Rejection, 4.0% for Acceptance, 4.9% for Engulfment, and 4.3% for Enrichment. Black and Native American/American Indian participants reported higher Rejection scores than their White counterparts. Nonbinary and trans individuals scored lower on Rejection, while men scored higher, compared to women. On the Acceptance subscale, nonbinary and trans individuals scored higher and men scored lower compared to women. Higher socioeconomic status was associated with lower Acceptance and Enrichment scores but higher

Table 2. Hierarchical regression models.

| Predictor | Outcome variable | | | | | | | | | | | |
|-------------------------|------------------|--------|---------|------------|--------|---------|------------|--------|---------|------------|--------|--------|
| | Rejection | | | Acceptance | | | Engulfment | | | Enrichment | | |
| Step 1 | Step 1 | Step 2 | Step 3a | Step 1 | Step 2 | Step 3a | Step 1 | Step 2 | Step 3a | Step 1 | Step 2 | Step 3 |
| SSS | .03 | .04 | .03 | -.04** | -.05** | -.05** | .10** | .09** | .09** | -.06** | -.07** | -.07** |
| Black/AA | .41** | .40** | .38** | -.05 | -.04 | -.03 | -.06 | -.04 | -.05 | .01 | .02 | .02 |
| AAPI | .22 | .21 | .22 | -.22* | -.21 | -.21 | .32* | .33* | .32* | -.06 | -.04 | -.05 |
| NAAL | 1.40** | 1.34** | 1.38** | .11 | .13 | .12 | -.14 | -.12 | -.16 | .28 | .31 | .30 |
| Bi/Multiracial | .14 | .13 | .12 | -.22 | -.23 | -.22 | -.17 | -.17 | -.16 | .22 | .22 | .21 |
| Hisp/Latinx | .21 | .17 | .17 | .04 | .07 | .07 | -.06 | -.03 | -.03 | .23* | .27** | .26** |
| Other | -.26 | -.23 | -.25 | -.01 | -.03 | -.02 | .10 | .08 | .07 | -.15 | -.17 | -.17 |
| NB/Trans | -.31** | -.23* | -.21 | .17* | .11 | .10 | -.03 | -.12 | -.12 | -.07 | -.14 | -.14 |
| Men | .27** | .24** | .24** | -.17** | -.15* | -.15* | -.01 | .01 | .01 | -.30** | -.28** | -.28** |
| Age of ID | -.01** | -.01 | -.01 | .00 | .00 | .00 | .00 | .00 | .00 | .00 | -.01 | -.01 |
| Step 2 | | | | | | | | | | | | |
| Co-occurring | | -.06* | -.07** | .06** | .06** | .06** | .09** | .09** | .09** | .07** | .07** | .07** |
| Emerg. events | | -.05** | -.06** | .02 | .02 | .02 | -.02 | -.02 | -.02 | .03 | .03 | .03 |
| Step 3a | | | | | | | | | | | | |
| Int. co-occ | | | .01** | | | .00 | | | .00 | | .00 | |
| Step 3b | | | | | | | | | | | | |
| Int. emerg. | | | .01 | | | .00 | | | .00 | | | .00 |
| R | .35 | .38 | .39 | .20 | .25 | .25 | .22 | .26 | .26 | .21 | .24 | .24 |
| R ² | .12 | .14 | .15 | .04 | .06 | .06 | .05 | .07 | .07 | .04 | .06 | .06 |
| Adjusted R ² | .11 | .13 | .13 | .03 | .04 | .04 | .03 | .05 | .05 | .03 | .04 | .04 |
| ΔR ² | .12** | .02** | .01** | .04** | .02** | .00 | .05** | .02** | .00 | .04** | .02** | .00 |

$p < .05$, ** $p < .01$. Int. co-occ = the interaction term between co-occurring events and age of identification. Emerg. events = Emergent Events. Int. Emerg. = the interaction term between emergent events and age of identification. SSS = Subjective Social Status. Black/AA = Black or African American. AAPI = Asian American or Pacific Islanders. NAAL = Native American or American Indians. NB/Trans = Non-binary or transgender. ΔR² indicates the change in R² from the previous regression step. Bolded coefficients remained statistically significant after excluding self-identified participants.

scores on the Engulfment subscale. Asian American/Pacific Islander participants had higher Engulfment scores, and lower Acceptance scores, relative to White participants. Hispanic/Latinx/e participants reported higher Enrichment experiences compared to White participants, and men reported lower Enrichment.

Hypothesis 2

After adding co-occurring disorders and emergent events, all predictors accounted for 14.3% of the variance in Rejection subscale scores, 6% of Acceptance scores, 6.9% of Engulfment scores, and 6% of Enrichment scores. Both co-occurring diagnoses and emergent events were significant predictors of Rejection scores. Co-occurring diagnoses were a significant predictor for all other subscales, while emergent events were not.

Post-hoc analyses identified mood disorders (64.8%; $n = 423$) and trauma disorders (20.4%; $n = 133$) as the most common co-occurring conditions. Endorsing a mood disorder ($r = -.14, p < .001$) or trauma disorder ($r = -.11, p = .004$) was negatively correlated with Rejection scores. Mood disorder was also positively correlated with Acceptance ($r = .13, p < .001$) and Engulfment ($r = .15, p < .001$).

The most common emergent events before ADHD identification were starting college/technical school (52.1%; $n = 340$), experiencing trauma (32.2%; $n = 210$), and getting married/cohabitation (23.4%; $n = 153$), all negatively associated with Rejection ($r = -.20, p < .001$; $r = -.18, p < .001$; $r = -.20, p < .001$).

Hypothesis 3

In Step 3a, the interaction between the age of identification and co-occurring diagnoses on the Rejection subscale (Figure 1) added 1.1% variance, totaling 15.4%. In contrast, the interaction of age of identification with emergent events entered in Step 3b did not yield significant results. No interactions were significant for Acceptance, Engulfment, and Enrichment. Consequently, Hypothesis 3 was largely unsupported.

Follow-up analyses

As a follow-up analysis, the regressions were estimated after excluding self-identified participants ($n = 494$). Of the 62 significant estimates across all steps in the full sample, 11 were no longer statistically significant after removing self-identified participants. Robust estimates are bolded in Table 2. Some gender-related effects found in the full sample were attenuated after removing self-identified participants. Specifically, nonbinary/trans identity was no longer a significant predictor of rejection in Step 2 or acceptance in Step 1, and being male was no longer significantly associated with acceptance after Step 1. Co-occurring diagnoses remained a significant predictor of rejection in Step 3a ($p = .06$ in Step 2, Step 3b), but were no longer a significant predictor of engulfment ($p = .08$ in Steps 2, 3a, 3b). Emergent events were not a significant predictor of rejection in Step 2 ($p = .05$) but were significant in Steps 3a and 3b.

Discussion

We examined relationships between ADHD identity development and age, gender, ethnicity, and socioeconomic standing. Older age at identification was associated with lower ADHD identity rejection, supporting our hypothesis. Black participants reported higher rejection compared to other groups, indicating difficulties in integrating multiple stigmatizing identities. Men similarly demonstrated high rejection and low acceptance and enrichment, reflecting challenges related to stigma and perceived deficits (McKenzie et al., 2022). Conversely, trans/nonbinary participants demonstrated lower rejection and higher acceptance, highlighting significant gender differences in ADHD identity integration. Furthermore, individuals reporting higher social class were more likely to experience their ADHD as overwhelming and negatively impacting their overall identity, suggesting maladaptive

internalization, a pattern also observed among Asian American/Pacific Islander participants who reported higher engulfment and lower acceptance. In contrast, Hispanic/Latinx/e participants reported higher enrichment, indicating a more positive integration of the ADHD identity.

Co-occurring diagnoses and emergent events were negatively associated with rejection, suggesting they may reduce self-rejection related to ADHD. However, only co-occurring diagnoses significantly predicted acceptance, engulfment, and enrichment, indicating that additional mental health or developmental conditions have a broader impact on ADHD identity integration, while emergent events did not affect these aspects. Moreover, only one expected interaction between age of identification and co-occurring diagnoses was significant, and emergent events did not moderate age of diagnosis. These findings suggest that while co-occurring diagnoses and emergent events contribute to the landscape of ADHD identity development, these factors alone are not sufficient to transition from an externalizing and unintegrated ADHD identity to an integrated and adaptive ADHD identity.

To further explore the robustness of our findings, we conducted a follow-up analysis excluding participants who self-reported ADHD. We aimed to assess the potential influence of self-identification on the observed relationships among the variables. While this exclusion led to changes in the significance of several predictors, likely due to reduced statistical power, our overall pattern of results remained consistent.

Implications

Findings underscore the importance of viewing ADHD beyond a medical model, as identity integration significantly influences self-perception and well-being. ADHD, when adaptively integrated or maladaptively unintegrated, stands to uniquely impact someone's global sense of identity. The association between later identification and reduced rejection underscores the potential benefit of framing ADHD as an aspect of identity, which can promote acceptance and empowerment rather than simply focusing on symptoms and deficits. Poorly integrated identities are linked to increased internalizing symptoms and health risks (Schwartz et al., 2015), reinforcing the need for intersectional approaches to clinical care.

Our study's findings suggest that professionals should integrate ADHD into broader identity frameworks that consider cultural and social contexts to allow for a collaborative co-construction of identity (Botha & Gillespi-Lynch, 2022; Meyer, 2003). Reducing stigma through neurodiversity advocacy and education can help reframe ADHD as a cognitive difference, mitigating negative self-perceptions and fostering adaptive identity development. Understanding the role of co-occurring conditions in ADHD identity integration can help clinicians tailor interventions to address the multifaceted experiences of individuals with ADHD.

These findings enhance our understanding of identity theory by documenting how various facets of identity influence the integration of ADHD. Practically, the results underscore the need for personalized interventions that account for diverse ADHD experiences (Attoue & Climie, 2023; Shi et al., 2021). Policy efforts should prioritize mental health inclusivity and accessibility, aligning with best practices for social program implementation (Goodman, 2000). Moreover, training healthcare providers to recognize the nuanced needs of ADHD populations is essential to promoting positive identity integration and reducing stigma.

Strengths and limitations of the study

One of the principal strengths of this study is its comprehensive analysis of the interrelationships among demographic variables and ADHD identity integration, utilizing a large, diverse sample that enhances the generalizability of the findings. The use of contemporary identity and stigma theories to frame the study also adds a novel dimension to ADHD research, highlighting its implications beyond traditional clinical outcomes.

We intentionally included participants who self-identified as having ADHD and met the cutoff criteria on the ASRS (Ustun et al., 2017). Self-identification is particularly relevant in identity research, as it captures the introspective and agency-driven process by which individuals recognize and integrate ADHD into their sense of self. Given systemic barriers that prevent many individuals from obtaining formal diagnoses, excluding self-diagnosed participants would have significantly narrowed the sample and overlooked a crucial segment of the ADHD community (Underhill & Foulkes, 2024). By including those who self-identified and met symptom thresholds, the study more accurately captured the diversity of ADHD experiences and improved the generalizability of findings. To assess the robustness of our data, we conducted follow-up analyses with only formally diagnosed participants and found that the overall pattern of results remained consistent. These methodological choices provide scientists and clinicians with critical empirical data to help understand the evolving social phenomena of ADHD identity acquisition, which has surged in prevalence over the last decade.

That said, the study's reliance on self-report measures introduces potential biases (e.g., social desirability, inaccuracies in self-assessment), which could affect validity. While we screened participants to include only those with a formal diagnosis or self-reported ADHD, we acknowledge that some participants may have joined the study without a legitimate ADHD diagnosis, motivated by the financial incentive.

Directions for future research

Researchers should continue to explore the process of ADHD identity integration using longitudinal methods to better understand how this process evolves over time and in response to various life events and developmental stages. Researchers should also look into how other disorders, particularly mood disorders, affect ADHD identity integration due to their high prevalence. Specifically, we encourage researchers to explore in greater detail how decreased self-rejection relates to co-occurring diagnoses and emergent events, to clarify whether these events function as coping mechanisms or if other factors shape this relationship.

The finding that increased age of identification is linked to more successful integration of ADHD identity may reflect societal changes influenced by the neurodiversity movement. Researchers should examine whether exposure to neurodiversity perspectives, rather than deficit-based views, contributes to these outcomes. Studies are also needed to explore the link between higher social class and increased feelings of being overwhelmed by their ADHD, which could offer greater insights into how socio-economic factors influence the integration of ADHD. Additionally, continuing to study men, who showed poorer ADHD identity integration, could clarify the role of gender norms and expectations in shaping identity processes related to health conditions. Research should also revisit the experiences of BIPOC participants to better understand the challenges these groups face in integrating their ADHD identity. It would be particularly beneficial to revisit this study within a child or adolescent population to assess whether our findings generalize to this population, offering valuable insights for parents raising children with developmental disabilities (Iovino et al., 2021). Finally, investigating why Hispanic/Latinx/e individuals may feel more enriched by their ADHD could uncover cultural or community strengths that support positive identity integration.

Given that the IIQ has several subscales that represent distinct aspects of ADHD identity integration, future research should develop scale-specific hypotheses to identify their unique contributions and interactions. This approach would allow for more nuanced insights into the mechanisms of ADHD identity integration, providing clearer hypotheses and targeted interventions for specific subscale dynamics. Future research should also examine potential differences between self-identified and formally diagnosed individuals with ADHD, including how these pathways shape identity integration, perceived legitimacy, and access to support.

Conclusion

This study provides critical insights into the complex effects of age, race, gender, and social status on the integration of ADHD into personal identity. Our findings highlight the importance of understanding ADHD beyond a clinical condition to include an identity shaped by multiple, often intersecting, factors. The age of identification, co-occurring conditions, and emergent life events influence how individuals come to terms with their ADHD identity, and these influences are further shaped by sociocultural factors such as race, gender, and social status. These findings underscore the importance of recognizing ADHD as part of a broader neurodiversity spectrum, where experiences of marginalization and stigma can profoundly affect self-perception and overall identity.

Given these findings, it is clear that traditional clinical approaches focused solely on symptom management fall short. To support individuals with ADHD, especially those from diverse backgrounds, strategies must address the broader social context, including the stigma that hinders positive identity integration, and understand ADHD's role within an individual's overall identity. By viewing ADHD as an additional facet of identity and not solely a deficit, we can promote environments that reduce stigma, encourage self-acceptance, and allow for individuals to better progress toward a well-integrated identity that includes ADHD. As our understanding of ADHD evolves, so must our approaches, ensuring tailored support that promotes identity integration and mental health across all communities.

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Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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