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Co-Constructing Stigma: Treating Trauma in Adolescence

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Abstract

Public stigma and self-stigma are major factors that impede the seeking of mental health treatment as well as the development of an effective therapeutic alliance. This paper explores the co-creation of stigma dynamics from an intersubjective systems theory lens suggesting these dynamics may play a role for adolescent clients who have experienced significant trauma. Specifically, the potential overlooking and/or misdiagnosis of trauma-related experiences and symptoms often occurring with adolescents diagnosed with ADHD may be contributing to a co-constructed dynamic between the therapist and client to avoid an exploration of trauma that would be experienced as more stigmatizing, more threatening, and more difficult to treat. A clinical vignette is offered to exemplify this co-construction and the potential impact on the therapeutic relationship. Recommendations are then offered in order to prevent possible misdiagnosis and decrease stigma within the therapeutic relationship.

Keywords: public stigma, self-stigma, therapeutic alliance, intersubjectivity, adolescence, ADHD, trauma

Introduction

The development and maintenance of the therapist-client relationship, specifically as it pertains to adolescent clients, is paramount to the ultimate success of adolescent psychotherapy. The therapeutic relationship or alliance is commonly understood as the relational, emotional, and cognitive connection that takes place between the therapist and the client. When the therapeutic relationship between mental health provider and adolescent is experienced as supportive and connected, clients are less resistant and more engaged in treatment (Schectman, Vogel, & Strauss, 2018).

The therapeutic relationship is critical across the lifespan of clients; however, research has shown that it is especially critical when working with adolescents (Chandra & Minkovitz, 2006). Recent studies have illuminated that unmet mental health needs among adolescents is shockingly high, as more than 70% of adolescents who require mental health care do not receive services (Chandra & Minkovitz, 2006). Research has shown that youth involvement in treatment tasks, which is often facilitated by a strong therapeutic alliance, is a significant predictor of clinical treatment gains (Karver et al., 2008 & Henderson et al., 2013). Karver, Handelsman, Fields, and Bickman state, "developing strong therapeutic relationships with young clients and/or their family members may facilitate engagement and lessen resistance to treatment by providing a stable, accepting, and supportive context within which therapy may take place" (Karver et al., 2006, p. 51).

Despite the widely known importance of the therapeutic alliance, adolescents and therapists may encounter barriers to establishing and sustaining a strong and understanding bond. Although there may be several reasons for this (over-formality with

clients, generational gaps in understanding, and perceived inauthenticity on the part of the clinician), stigma dynamics, particularly as they pertain to the diagnosis or lack of diagnosis regarding trauma-related symptomatology, may play a significant role in creating obstacles within the creation of the therapist-client relationship (Karver et al., 2008). For example, if a clinician chooses to diagnose an adolescent client with ADHD based on behavioral symptoms, instead of potentially viewing their symptoms from a trauma-informed lens, the clinician unconsciously conveys to the client that their trauma history is unseen and invalidated by their therapist, making them feel stigmatized and establishing barriers to connection. Further, the failure to recognize trauma experiences may also be reinforced by the client's reluctance to report them and/or the social and interpersonal pressure to deny them. In addition, stigma dynamics may also serve a role in the potential overlap in the diagnosis and treatment of attention deficit hyperactivity disorder (ADHD) versus trauma-related symptomatology, such as post-traumatic stress disorder (PTSD) in adolescent populations.

There is a significant lack of research examining the reasons why clinicians may unconsciously disregard the experiences of trauma within their clients' histories. For the purposes of this paper, trauma will be defined as an experience that is extraordinary, not due to infrequency in occurrence, but due to the way a traumatic experience "overwhelms the ordinary human adaptions to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence or death. [Traumatic experiences] confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe" (Herman, 1992, p.33). In

summation, trauma overwhelms the individual and disrupts their senses of control, connection, and meaning.

What function does it serve then, for both the therapist and the client, to attempt to erase trauma in favor of more seemingly tangible and straightforward diagnoses and conceptualizations? Author and researcher, Judith Herman has written prolifically on the topic and her writings provide a framework from which to begin to explore this question. Her work has been taken up by clinicians and researchers and utilized as the backbone for trauma therapies. Through her expansive research, Herman has demonstrated that "the study of psychological trauma has a curious history – one of episodic amnesia. The study of psychological trauma has repeatedly led into realms of the unthinkable and foundered on fundamental questions of belief," (Herman, 1992, p.7). The function of disregarding trauma and the engagement in mutually reinforced stigma dynamics can then be understood as an attempt to enter into a conscious state of amnesia in order to deny the existence of trauma.

Actively acknowledging and confronting trauma in a clinical space would not only force the client to dwell in the seemingly unbearable pain of their history, but it would also require that the therapist witness and step into this pain with them. Herman states that "from those who bear witness, the survivor seeks not absolution but fairness, compassion, and the willingness to share the guilty knowledge of what happens to people in extremity," (Herman, 1992, p. 69). Bearing witness to trauma and the various systems and forces that allowed said trauma to take place, could make the clinician feel as though the trauma is contagious and powerful in its ability to infect all who hear about and engage with it. The therapist, as well as the adolescent client may then feel they have

been stained by the stigma of trauma. The fear and shame associated with the stain of trauma may then encourage the therapist and client to engage in a co-constructed process of denial.

Mutually reinforced stigma dynamics between therapist and adolescent client also provide useful insight into why a diagnosis of trauma-related symptoms often gets overlooked and/or mis-diagnosed in favor of diagnoses with more easily observable behavioral symptomology, like ADHD. Herman's writings illustrate the core tenant that likely guides the overlooking and/or misdiagnosis of trauma, which is trauma's unspeakable quality. Herman states "the ordinary response to atrocities is to banish them from consciousness," (Herman, 1992, p. 1). The banishment of atrocities within public consciousness means that trauma often gets denied, even by clinicians. Misdiagnosing or overlooking trauma in favor of ADHD is a type of denial created by the therapist, which may make the adolescent feel mis-attuned to by their provider because their full selves, including their trauma histories, are experienced as not to be allowed or welcomed into the therapy room. This mis-attunement may then encourage the adolescent client to be less open with their provider for fear that speaking "publicly about one's knowledge of atrocities is to invite the stigma that attaches to victims," (Herman, 1992, p. 2). This mutually reinforced denial of trauma therefore leads to further stigmatization because the avoidance of naming trauma implies there is something dangerous and wrong about the experience of trauma itself. In order to treat clients who, have experienced trauma more successfully, clinicians must be aware of the various ways personal, professional, and social knowing and not knowing about trauma influence recovery. Clinicians must explore their own willingness or lack thereof to address difficult and often unspeakable

truths surrounding trauma in order to create space for their clients to be fully witnessed and known.

In this paper, I will explore the co-construction of mutually reinforced stigma dynamics as a potential barrier to the development of the therapeutic alliance between therapist and adolescent client from an intersubjective-systems framework. I will introduce the concepts of public and self-stigma, particularly as they apply to a denial of trauma within the therapeutic relationship and I will use a clinical vignette to illustrate the aforementioned co-construction of stigma.

Clinical Application

Ms. S worked as a therapist in a public high school setting. She saw her clients in an empty classroom, covered in humorous Math posters, positioned at the end of an exceptionally long hallway. Ms. S received the cursory file on a new 15-year-old female client (Britt) from the school's social worker. Britt's file stated she was a sophomore student, recently transferred from out of state, who had gained the attention of her teachers due to "forgetful and distractible" behaviors, which typically manifested as Britt "zoning out" while in class. Outside of Britt's notable forgetful behaviors, her file showed she was a good student (B+) average, soccer player, and member of the school band and cheerleading team. When Ms. S consulted briefly with the referring social worker, it was heavily implied Ms. S should perform psychological testing for ADHD and then consult with the school's psychiatrist. Ms. S was agreeable during the consultation and unconsciously filed Britt's case into the "easy assessment" category she held within her mind. Ms. S noted the phrase "complex family history" in Britt's file, but decided to ignore the phrase so as not to make the case more complicated.

Britt arrived in Ms. S's office for her first appointment right before the morning bell rang at 7:57am. She marched into the office holding a coffee, a massive water bottle, a juice, and her cellphone. She was somewhat brash in her tone, yet she avoided making consistent eye contact with Ms. S. She announced, bluntly, she had never been in therapy before. In Ms. S's estimations, she did not appear unfocused or distractible at all. Instead, she appeared direct, unwavering, and a bit anxious. At the end of the first session, Britt stated she would feel "okay enough" coming back for a second meeting but said she did not want Ms. S to behave like "a movie version of a therapist" who was "touchy feely and sickly sweet." She reported wanting unflinching honesty. Ms. S liked her almost immediately, as Britt's dry humor and sass appealed to her own personality traits. Ms. S briefly doubted the suggestion of ADHD that had been presented during the consultation but shrugged her doubt away, deciding to focus on Britt's behavioral symptoms instead of pursuing her observable anxiety and sadness in order to focus on the assessment and referral to psychiatry.

Ms. S's caseload was large and demanding and she felt constantly busy and on the verge of burnout. The large public high school in which she worked had limited resources and Ms. S had worked within the system long enough to observe that ADHD assessment cases were deemed "more straightforward" than other therapy cases. The majority of students at the school accessed therapeutic services through Medicaid, meaning that Ms. S had a session limit of 6-8 sessions per student. ADHD cases were seen as more manageable to conduct successfully within the brief model. Ms. S had internalized the system's model somewhat and therefore felt motivated to be seen as productive, despite the limited sessions she was able to access.

Intersubjective Systems Theory

Intersubjective systems theory is a psychoanalytic perspective within the field of depth psychology, that was founded by several analysts in the 1980s in the United States, including Atwood, Orange, and Stolorow. This theory emphasizes the rich and layered "psychological field formed by the interplay of the patient's transference and the analyst's transference" (Stolorow, 2013, p. 383). This idea illustrates a shifting away from the more classical Freudian one-person model of therapy to an increasingly dynamic and collaborative two-person model. Within this model, personality development is considered as "recurring patterns of intersubjective transaction within the developmental system, which give rise to principles (thematic patterns, meaning structures) that unconsciously organize subsequent emotional and relational experiences" (Stolorow, 2012, p. 383).

Significant within the intersubjective systems theory, is the concept of organizing principles, which can be defined as the often-unconscious emotional conclusions that an individual has drawn from their experiences within their subjective, emotional environments (Orange, 2009). Stated differently, developmental experiences with significant others allow individuals to create organizing structures of experience, which they then utilize to create meaning within contemporary relationships. Intersubjective systems theorists posit that until these organizing principles are made available for conscious and active reflection, and until novel emotional experiences are helped to take place, an individual's organizing principles will often dominate the sense of self (Orange, 2009). A significant element of this open engagement and creation of novel experiences lies with the therapist, who must be willing to acknowledge and understand their own

subjective experience and potential biases and the ways in which they interact with the client's perspectives. Intersubjective systems theorists explore the idea that therapists do not have a privileged access to a true reality. Practicing intersubjectively implies giving up the search for certainty in favor of the search for deeper understanding and open interaction.

Intersubjective Systems Theory and the Therapeutic Alliance

Therapeutic relationships, between therapist and adolescent client, viewed through an intersubjective lens, can then be understood as a "dialogic attempt of two people to understand one person's organization of emotional experience by making sense together of their shared experience" (Buirski & Haglund, 2010, p. 26). This then posits that the therapeutic dyad is a sphere of mutual influence, in which various reciprocal factors, which include elements of the larger cultural context (such as courtesy, public, and self-stigma) may influence the experience of an adolescent client's organizing principles as well as the therapist's organizing principles.

In summary, intersubjective systems theory is centered around the idea that an individual's experiences of themselves are incredibly fundamental to the ways in which they organize and operate in the world (Buirski & Haglund, 2010). It is also significant to recognize that an individual's experience of themselves, or their subjectivity, is informed by repeated emotional interactions, which, in time become patterns. These repeated emotional interactions can exist both on a larger cultural scale and within a smaller two-person interaction. This idea is exemplified by Herman's quote stating, "the knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long. Denial, repression, and dissociation operate on a social as well as individual level,"

(Herman, 1992, p. 2). This statement illustrates that a client could be negatively impacted by the repeated denial of her trauma on a societal level that is then repeated and reinforced in a two-person therapeutic interaction. An individual's subjective experiences are not only constructed out of past experiences but are also formed in the individual's present context (Buirski & Haglund, 2010).

The clinical example of Ms. S and Britt illustrates this co-created experience. Just as the therapeutic relationship is co-created, mutually reinforced stigma dynamics and their subsequent consequences may also be co-created between therapist and adolescent client. Potential consequences regarding stigma dynamics are vast and will be further explored. They include mis-attunements, relational ruptures, shame, blame, misdiagnosis, emotional pain, treatment impasses, etc.

Previous research has demonstrated that the stigmatization of an adolescent's mental health problems may become a potentially detrimental organizing principle of experience that is created between the therapist and the client (Karver et al., 2008). The process of stigmatization in regard to adolescent mental health, is a nuanced and multi-faceted issue that involves individual, interpersonal, and cultural interactions that may go on to significantly impact the therapeutic relationship and the client's mental health. For example, if the adolescent client feels as though they are overwhelming or scaring their therapist by sharing their experiences of trauma, they may then distance themselves from her therapist. The therapist may interpret this distance as treatment avoidance or disengagement, which may then frustrate the therapist, reinforcing the client's sense that they are too much for her provider. This co-constructed loop illustrates the intersubjective process of stigma construction.

Clinical Application

Ms. S was obtaining the relevant assessment materials to prepare for her second session with Britt. While she was in the school's assessment closet, she ran into one of the other therapists employed through the school, Dr. K. "Another ADHD one huh?", Mr. K asked after observing the WAIS kit and Conners screening booklets under her arm. Ms. S nodded, not thinking about the chance Britt may not be "another ADHD case," at all. Ms. S had only met with Britt once, and although she had liked Britt's directness, sarcasm, and intellect, these qualities were no longer at the forefront of her mind. Ms. S thought only of the protocol she was meant to follow, the short amount of time she had to work with Britt, and her goal of getting her to "zone out" less while in classes.

In the lunchroom, Britt was thinking of her upcoming therapy session with Ms. S. She had also liked Ms. S, which felt surprising to her. Britt struggled to trust most adults and she still felt somewhat out of her sorts at her new school. During their first session, Ms. S had asked Britt questions and looked at her in the eyes. This had made Britt feel vulnerable, but also engaged. She wondered to herself what it would feel like to have a person in her life to whom she could tell the truth. She felt nervous anticipation and tentative excitement about their upcoming second session.

Stigmatization and Mental Illness

The role of stigma has a long and layered history within the field of psychology. Goffman, one of the earliest researchers in the field of stigma dynamics defined stigma as "an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one" (Link & Phelan, 2001). More contemporary stigma literature defines stigma as "the co-occurrence of its components – labeling,

stereotyping, separation, status loss, and discrimination" (Link & Phelan, 2001, p. 377). Hinshaw (2007) found that stigma dynamics are constantly at play in everyday life. He argued that "language patterns in conversations, stereotypes in public media, attitudes and practices of mental health professionals (e.g., enforcing institutionalization, lack of recognition of mental health care workers), and policies and laws exemplify some indicators of stigma in everyday life" (Koro-Ljungberg & Bussing, 2009, p. 1177).

In order for stigma dynamics to occur within a relationship, like a therapeutic relationship, several interrelated components must converge. First, individuals must distinguish and label human differences. Second, dominant cultural beliefs connect the aforementioned labeled individual to some undesirable characteristics or stereotypes. Third, the labeled individual is placed into a distinctive category in order to achieve some degree of separation, which can take place in the form of diagnosis. Finally, the labeled individual experiences some form of discrimination and negative consequence, such as social distancing, due to the categorization and subsequent separation. The process of stigmatizing is "entirely dependent on social, economic, and political power – it takes power to stigmatize" (Link & Phelan, 2001, p. 375). Stigma dynamics that occur within the context of a relationship between an adult and an adolescent can be viewed as more complex because the stigma of adolescent mental health disorders must contend not only with stigma related to the diagnosis, but also the low status of children and adolescents throughout history (Hinshaw, 2005). In addition, the process of stigmatization may influence the identity of adolescents in particular because adolescence is a critical time in the development of autonomy and self-worth.

Courtesy Stigma and its Impact on the Therapeutic Alliance

Contemporary researchers such as Corrigan and Hinshaw have made relevant distinctions within the field of stigma between courtesy stigma, public stigma, and self-stigma. Courtesy stigma can be defined as "the prejudice and discrimination that is extended to people not because of some mark they manifest, but rather because they are somehow linked to a person with the stigmatized mark" (Corrigan & Miller, 2004, p. 538). Courtesy stigma is most commonly experienced by parents, family members, and spouses of individual's with mental health diagnoses. Experiences of courtesy stigma have been found to lead to various negative outcomes such as, parents being blamed for causing their child's mental illness, siblings and relatives being blamed for not helping the client adhere to treatment plans, and friends and peers becoming fearful of being contaminated by the mental illness of someone close to them (Fox, 2012). Stated differently, courtesy stigma often leads to feelings of shame, social distancing, inferiority, and othering.

When working with adolescent clients, courtesy stigma is most prevalent in regard to parents and caregivers. Current research illustrates that parents and caregivers are often blamed by others, including mental health professionals, for their child's mental health diagnoses. The feelings of shame and contamination associated with courtesy stigma can be pervasive. A recent national study showed "that when the general public blames family members for the relative's mental illness, the public decreases its pity and in turn withholds help for family members" (Larson & Corrigan, 2008, p. 88).

The Origins and Effects of Public Stigma

Public stigma is defined as referring to various negative attitudes and beliefs that often prompt individuals to fear, avoid, discriminate, and distance themselves from individuals diagnosed with mental illness (Corrigan & O'Shaughnessy, 2007). Similar to courtesy stigma, public stigma fosters an in-group versus out-group mentality, in which the public (institutions, communities, mental health providers, etc.) characterizes individuals with diagnosed mental health issues as different from themselves and then responds accordingly to these assumed differences. Public stigma can be wielded as a powerful and corrosive force, negatively impacting individuals with mental health diagnoses in several ways, including limiting employment options, decreasing self-esteem, and limiting options to medical and mental health care.

Corrigan's research shows that the public's behaviors are determined by a cognitive and emotional process, in that "people make attributions about the cause and controllability of a person's illness that lead to inferences about responsibility. These inferences lead to emotional reactions such as anger or pity that affect the likelihood of helping, avoidant, or coercive behaviors" (Del Olmo-Romero et al., 2018, p. 327). When interpreted through an intersubjective systems lens, Corrigan's research illustrates that when mental illness is diagnosed and made known in the public sphere, collective organizing principles regarding mental illness are activated and performed, which then go on to shape the organizing principles of the individual being stereotyped (Corrigan, 2007; Fox, 2012). Mental health providers are a part of the public realm and therefore can be seen as critical figures in the creation and felt experience of public stigma dynamics.

Disidentification is often inherent within the experience of public stigma. Disidentification is defined as "the process of characterizing persons with mental illness as easily recognizable and different from 'normal' individuals while characterizing oneself as normal and not susceptible to mental illness" (Servais & Saunders, 2007, p. 214). By engaging in this process, the public is able to distinguish themselves as separate from mental illness, which can reduce the potential threat of being vulnerable to mental illness and the resulting life changes that may occur after a diagnosis. Disidentification may occur when therapists diagnose clients with a mental illness, thereby placing the client into a category and then viewing all clients in said category as possessing the same set of qualities. These perceptions may then inhibit the therapist's ability to demonstrate authentic and genuine empathy for their clients, which may then be felt by clients and negatively impact treatment outcomes. This process is more likely to occur when mental health providers are unaware of their unconscious biases, making them inadvertent agents of stigma. Therapists might also display these aforementioned categorical beliefs about their clients outwardly, which may then perpetuate the larger public's stigmatization of individuals with diagnosed mental illnesses.

Self-Stigma and Adolescent Clients

Self-stigma refers to the internalization of public stigma, resulting in the stigmatized individual feeling othered, shamed, and inferior when they are labeled and viewed from within a stereotyped category (Watson et al., 2007). The experience of self-stigma can be felt as profound and demoralizing. Self-stigma can lead to dangerous consequences such as decreases in self-worth and self-efficacy, the narrowing of opportunities, and the avoidance of mental health treatment. The potential avoidance of

receiving a mental health diagnosis has been cited as a significant barrier to seeking help (Oexle et al., 2018). This is particularly salient when considering adolescent clients, as rejection by others and the subsequent isolation, is particularly detrimental during the adolescent phase of development. Examples of situations in which therapists may unintentionally contribute to self-stigma, specifically in regards to adolescent clients include: referring to the adolescent by their diagnosis, focusing on deficit models of the client's symptomology, holding treatment meetings without the adolescent present, and focusing exclusively on the mental illness without taking the whole of the adolescent into account (Shectman et al., 2018).

When examined through an intersubjective systems lens, the process of self-stigma takes on deeper significance. If, as posited earlier, the development of the self is in part the result of complex psychological interactions between the individual and their environments, then other people (the public) may play a crucial role in said development. Other individuals, including therapists, are mirrors in which images of the self are reflected and internalized, leading to the formation of organizing principles (Syzmanski & Sapanski, 2011; Fox, 2012). This implies, that to some degree, self-worth is based on evaluations of the public, meaning that the internalization of stigmatizing attitudes can lead to pervasive self-stigma.

Diagnosis may be experienced as a negative evaluation made by a therapist, which if not understood meaningfully together between therapist and client, can lead to mutually reinforced stigma dynamics. This especially occurs when a clinician misdiagnoses a client in order to avoid or deny the more complex clinical picture. Goldsmith et al. stated "psychologists are ensconced in a diagnostic system that

frequently pathologizes individuals rather than explicitly acknowledging the ways problems in society, may contribute to dysfunction. Psychologists themselves must attend to the functions and effects of their own unawareness," (Goldsmith et al., 2004, p. 458). For instance, a client may perceive an ADHD diagnosis as an incorrect and shallow understanding of their current experience, making the client feel judged and stigmatized, pulling them farther away from their therapist, who is then less able to see and understand them. Herman has described this concept, stating "attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment. All too commonly, chronically traumatized people suffer in silence; but if they complain at all, their complaints are not well understood," (Herman, 1992, p. 119). If the adolescent client feels unable to be understood by the significant people in their life, including their therapist, the client is less likely to openly engage in treatment and is therefore less likely to be able to heal in an open and safe way.

Clinical Application

When Britt entered Ms. S's room for her second session, she saw the tables had been rearranged. She then noticed an array of boxes and booklets set out before her. She felt confused and disappointed. Britt could tell the two of them would not just get to talk as they had in the first session, but that there was now an agenda that included the boxes and the booklets. Ms. S explained to Britt they would be beginning an assessment process in order to better understand Britt's symptoms and the ways in which they were potentially affecting her school performance. Britt suddenly felt hurt. Since she was a child, adults in her life either didn't pay attention to her, or only paid attention when they

thought she was doing something wrong. Britt realized she had been referred to therapy, not solely because her teachers wanted her to have a safe space in which to express herself, but also because they wanted her to perform better. Britt quickly internalized this message and believed it easily, because it fit with what most of the adults in her life had told her previously.

Ms. S was not aware of Britt's history at this point. She assumed that Britt would be excited about the assessment because it would give her tangible answers and allow her to perform more highly. Ms. S also assumed Britt would find some value in an ADHD diagnosis because it would give her a simple solution. Despite her assumptions, Ms. S observed Britt's facial expressions during the assessment battery. She watched as Britt's affect became more and more restricted, as if she was trying to protect herself from the questions. For a moment, Ms. S felt frustrated. Why was Britt not engaging more? Did she not want a solution to her problems that would help her classroom participation? Ms. S's frustration detracted from her focus and she became less engaged with the assessment questions regarding Britt's early history of ADHD symptoms. Britt, amidst her feelings of hurt, observed Ms. S's growing disinterest. She felt ashamed of herself for having to be in therapy at all. Ms. S's eyes stayed on the booklet in front of her, causing Britt to fix her gaze on the ground, counting down the seconds until she could leave the room and hopefully never return.

Introduction to ADHD and Trauma-Related Symptomology

The potential profound effects of mutually reinforced stigma dynamics that can be co-created between mental health provider and adolescent client may impact the diagnosis and/or treatment of mental illness. As illustrated through the case study, mental

health providers often assess for behavioral symptoms, while failing to understand and address possible underlying causes of said symptoms. This potential failure may take place due to the roles of public and self-stigma within the therapist-client relationship and will be explored as it pertains to the diagnostic overlap of Attention Deficit Hyperactivity Disorder (ADHD) and trauma-related symptomology, such as Post-Traumatic Stress Disorder (PTSD).

ADHD and PTSD share many diagnostic features; however, these shared features are often overlooked by providers. Research indicates that ADHD is one of the most common childhood mental disorders, affecting an estimated 8.7% of youths in the United States (Lebowitz et al., 2012). The diagnosis of ADHD is separated into two types: inattention and hyperactive/impulsive. The main symptoms related to the inattentive type of ADHD are as follows: failure to attend to details, difficulty sustaining attention, difficulty listening when spoken to, difficulty organizing oneself, frequent distraction, and forgetfulness. The main symptoms related to the hyperactive/impulsive type of ADHD are as follows: frequent fidgeting and restlessness, difficulty in engaging with leisure activities, excessive talking/interruption, and difficulty waiting (DSM-V American Psychiatric Association, 2013). All aforementioned symptoms of the two types of ADHD can be observed in various settings including school, home, and the community.

The criteria necessary to meet a diagnosis for PTSD are as follows: exposure to actual or threatened death, serious injury or sexual violence, recurrent, involuntary, and intrusive memories connected to the traumatic experience, dissociative reactions, intense or prolonged psychological distress, physiological reactions to internal or external cues

connected to the traumatic experiences, avoidance of stimuli connected to the traumatic experiences, negative alternations in cognitions and mood, and alterations in arousal and reactivity (DSM-V American Psychiatric Association, 2013). Although the diagnostic criteria for PTSD may not appear obviously similar to the above-mentioned criteria for ADHD, when understood together, it becomes clearer that the behavioral symptoms of ADHD may be misunderstood or overlooked manifestations of a trauma response.

Clinical Application

Halfway through the clinical interview Ms. S was conducting with Britt, Ms. S realized she had not asked about Britt's parents. Due to ADHD's possible biological origins, Ms. S knew she needed more information regarding Britt's family in order to have a more holistic conceptualization. When Ms. S asked Britt about her parents' academic histories, Britt stated she did not know. Ms. S then looked up at Britt and noticed her once brash and sarcastic façade had faded. Ms. S observed that Britt's eyes were still focused on the floor. Ms. S felt herself begin to slow down and she attempted to attune to Britt's discomfort and overwhelm. Softening her tone, looking at Britt, Ms. S asked about what she did know about her parents. Ms. S then noticed Britt's eyes get a far away look. This must be what her teachers call "zoning out," Ms. S thought to herself. After about 2 minutes in silence, Britt seemed to pull herself back into focus. Instead of moving on to another question, Ms. S asked, "where did you just go, Britt? It felt like you were here and then suddenly you were gone." Britt began to cry.

Overlapping Diagnostic Criteria

An adolescent client, such as the one discussed in the case study, who has undergone a traumatic experience or been exposed to recurrent trauma such as neglect or

abuse, may respond to said trauma through emotional numbing, avoidance, or disengagement from others in a variety of settings. These reactions can be understood as a defensive response to the cognitively and emotionally overwhelming experiences of trauma, however in a school or community setting, said symptoms may look like the distraction and forgetfulness commonly associated with the inattentive type of ADHD (Szymanski & Sapanski, 2011). Additionally, the symptoms of hypervigilance, irritability, and exaggerated startle responses, which may also develop after a traumatic experience, can look extremely similar to the fidgeting, restlessness, and excessive interruption associated with the hyperactive/impulsive type of ADHD (Szymanski & Sapanski, 2011).

Examined cohesively, children and adolescents who have experienced traumatic events may develop alternative ways of coping and responding to stimuli that can appear maladaptive or disruptive and may present with symptoms commonly associated with ADHD. The symptom similarity between the two disorders could then lead to insufficient or incorrect diagnoses, conceptualizations, and treatments. It is therefore possible mental health providers may label the aforementioned symptoms as evidence of ADHD without acknowledging or obtaining a comprehensive trauma history. A clinician may unconsciously prefer to diagnose a client with ADHD because it means they do not have to engage in the arduous and often painful experience of taking a trauma history. In her writings, Herman shows that to "study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events," (Herman, 1992, p. 7). Taking this point further, if a clinician opens the door to trauma,

they must bear witness to the trauma themselves, meaning they are no longer able to act as a neutral observer and instead must take sides.

The taking of sides often comes with steep accountability on the part of the therapist, including possible legal responsibility, in the form of mandated reporting. The therapist may then be unconsciously avoiding this moral and logistical battle by denying trauma and instead focusing on the behavioral symptomology of an ADHD diagnosis. Statistics show that approximately "40% of mandated professionals have failed to report child/adolescent maltreatment at some point in their careers," (Alvarez, et al., 2004, p. 564). There are numerous reasons impacting the potential failure to make a mandated report, including lack of training in reporting procedures, lack of knowledge regarding the signs of abuse and trauma, negative attitudes toward reporting agencies, potential negative consequences for the client, and lastly, potential negative consequences for the professional making the report. Research has illuminated that various professionals, including therapists, may feel burdened by the time required to make a report, which means they may collude with the client and the various systems with which they work to eradicate and/or avoid a history of trauma and abuse, (Alvarez, et al., 2004). The lack of engagement with mandated reporting then perpetuates mutually reciprocal stigma dynamics in that the client may internalize that their experiences of trauma are so unacceptable to the therapist as to not be spoken aloud within the legal system.

Clinical Application

Through her tears, Britt explained to Ms. S that she did not know about either of her parent's academic histories for many reasons. Britt's mother and stepfather had been arrested when Britt was 6 years old for possession and the intent to sell cocaine and

marijuana. They were incarcerated for 4 years, during which time, Britt and her younger brother went to live with her father. Britt told Ms. S that her father was also a drug addict who was rarely home, leaving her and her younger brother to fend for themselves. Britt described her father, who was kind when sober, as having had an abusive streak when he was high. After a year of living with him, Britt's maternal grandparents were alerted to the situation and took her and her brother to live with them in another state. Britt stated the 3 years she lived with her grandparents were "the most peaceful" of her life. Right before Britt's eleventh birthday, her mother and stepfather were released from prison and she and her brother went back to live with them. Britt's parents struggled to find work and she described having to frequently move to new apartments due to eviction notices. When Britt was fourteen, her mother and stepfather obtained employment in a new state, and so Britt and her family moved across the country. One month after the move, Britt received news that her biological father had overdosed and died. Britt had started school at the high school where Ms. S worked, during this time.

If Ms. S had not obtained this history from Britt, she likely would have moved on with the ADHD assessment battery and referred Britt to a psychiatrist in order to get a prescription for stimulant medication meant to help her "zone out" less while in class. After gathering Britt's history, Ms. S was able to realize that Britt was not distracted nor forgetful, she was instead dissociating due to overwhelming emotional and cognitive experiences. Britt did not have ADHD. In actuality, Britt was reeling from a long and layered history of trauma. What the school and Ms. S had at first labeled as distraction, was in fact emotional numbing, avoidance, anxiety, and dissociation. Ms. S quickly realized her treatment plan needed to shift swiftly and completely. She felt a pang of

hesitation enter her body. Would she have to undergo child reporting procedures? She felt anxiety about the potential legal and logistical hoops she may have to jump through and felt unsure of the ways in which reporting might negatively impact her reputation within the school. Ms. S attempted to push her feelings of hesitation aside and focus on Britt. What was needed was not a concrete solution, but a warm, reflective relational space in which Britt would be able to feel seen, safe, and contained.

Mutually Reinforced Stigma Dynamics and Misdiagnosis

The relevant question in connection to this symptom criteria overlap, is why would trauma-related symptomology be ignored or unexplored in favor of an ADHD diagnosis? The answer lies within the mutually reinforced field of stigma dynamics, specifically public and self-stigma and the co-constructed denial of trauma. Public stigma creates an "us versus them" mentality in which the public, including mental health providers, view themselves as different than their clients and are then able to distance themselves from them. This often occurs through the process of disidentification. Diagnosis may be used as an inadvertent distancing strategy in response to unconscious stigmatizing beliefs held by providers. When witnessing symptoms such as restlessness, hyperarousal, or dissociation, a provider's unconscious bias may be activated and in response they turn to diagnosis in order to solidify their separateness from their client. As discussed above, a diagnosis of ADHD may feel preferable to a provider than diagnosing a trauma-related symptomology. There are several reasons for this preference, the most salient being the societal denial of trauma and the various consequences of said denial. Herman states, "unfortunately, because of the history of denial within the mental health professions, many therapists find themselves trying to work with traumatized patients in

the absence of a supportive context. Therapists who work with traumatized patients have to struggle to overcome their own denial," (Herman, 1992, p. 151). Clinicians may unconsciously downplay trauma and its effects in order to not threaten the status quo of psychology and of the larger culture.

ADHD has increasingly been understood in biological terms, meaning that researchers have identified a biological etiological explanation for the disorder (Liston et al., 2011). There is a growing perception that individuals whose psychiatric diagnoses are caused by biological factors have limited control over their actions and symptomology (Lebowitz et al., 2012). This limited control in the expression of symptoms may then remove blame from the client for their behaviors and place it onto biological causes that can be treated with tangible strategies, such as psychiatric medication. In contrast, the diagnosis of PTSD is made after the experience or recurrent exposure to trauma and does not have a clear biological etiology. The public, including mental health providers, may therefore view the experience of trauma as more corrosive and/or chronic than that of ADHD because it does not have concrete biological origins that can be ameliorated rapidly through medication or other more straightforward treatments. In regard to medication, distinguishing between the two diagnoses (ADHD and PTSD) is also crucial because a diagnosis of PTSD may be considered a contraindication to stimulant medication, which is typically prescribed to treat ADHD symptoms. This means if a provider does not rule out trauma before prescribing stimulant medication, a client's trauma symptoms may be dangerously exacerbated by the incorrect medication.

The belief that an adolescent with ADHD may have limited control over their maladaptive behaviors may then reduce stigma within the therapeutic relationship. When

examined through an intersubjective systems lens, if a provider can attribute a client's disruptive or impairing symptoms to a biological cause, they may feel less of a need to disidentify themselves from the client and will then be able to connect more empathetically.

Research shows that mental health issues attributed to biology are perceived as less contagious than other forms of mental health issues. (Liston et al., 2011). This implies that ADHD requires less of a need for social distancing, which is a consequence of public stigma, because the public feels less susceptible to contracting the illness. The diagnosis of ADHD may then feel like a safer and less mutually stigmatizing diagnosis than trauma-related symptomology, which does not have clear origins. A provider could then, consciously or unconsciously, be attempting to protect their adolescent client and themselves from the potential stigma of trauma. If the provider's organizing principles regarding the ambiguity and chronicity of trauma-related symptomology are activated instead (public stigma), they may attempt to distance themselves from the client, which the client will then perceive and possibly internalize (self-stigma), resulting in a ruptured therapeutic bond. Kaushik, Kostaki, and Kyriakopoulos found that "self-stigma increased in adolescents who perceived less control over their mental health difficulties and believed their problems to be life long, (Kaushik, Kostaki, Kyriakopoulos, 2016, p. 491). The unconscious desire, shaped by public stigma, to attribute a client's symptoms to a biological origin, is a likely factor in the overlooking of trauma-related symptomology in favor of an ADHD diagnosis.

Misdiagnosis (of ADHD) may negatively impact the therapeutic relationship between therapist and adolescent client and could create feelings of distrust between the

two parties. When an adolescent client is misdiagnosed by their provider, they are in effect misunderstood by them, and this misunderstanding may lead to feelings of shame, low self-worth (self-stigma), and the belief their provider will be unable to help them effectively. This rupture may then negatively impact treatment trajectory, as the client will feel less committed to therapy and less able to meet their treatment goals. The provider may then experience their decreased engagement as part of their maladaptive symptomology, further solidifying the provider's organizing principles regarding the client and their mental health, which the client may then further internalize, increasing their own experience of self-stigma. A mutually reinforcing stigmatizing loop is then created, in which therapeutic connection and success becomes increasingly more difficult to actualize.

The therapeutic relationship is especially critical when working with an adolescent client with a trauma history. In his robust research, Perry has found that a "recurring observation about resilience and coping with trauma is the power of healthy relationships to protect from and heal following stress, distress, and trauma," (Perry, 2009, p. 246). This finding implies that healthy and supportive relational interactions with safe and trusted individuals, such as therapists, can help buffer and heal trauma-related problems. If a mental health provider responds to the traumatized client from a space of stigma and distancing, the client may internalize the separation, which can then exacerbate trauma, making the client feel contaminated or unworthy of healing.

Clinical Application

Ms. S felt grateful to Britt for her ability to open up about her trauma history, despite Ms. S's previous sole focus on the ADHD assessment. Ms. S soon realized that

had she not observed Britt's "zoning out" through a new trauma-informed lens, she would have been just another adult in Britt's life who tried to categorize her and make her feel ashamed for what she had been through. Ms. S was instead able to attune to Britt and address the rupture she had created within the therapeutic relationship. Britt felt relieved by her own honesty, but still wanted to maintain a protective apprehension regarding therapy, so as not to be disappointed again.

Ms. S suggested that during their third session, they meet outside, so they could walk while talking, attempting to change the external landscape and take them out of the room that held their co-created stigma dynamics. Britt agreed and exhaled in a release of tension. After this meeting, Ms. S reflected on her time with Britt and brought the case to her supervision group. Ms. S asked the group to help keep her accountable in regard to her potentially stigmatizing attitudes and various unconscious organizing principles that may have obstructed her from obtaining an adequate trauma history during their first meeting.

Before their third session, Britt felt nervous. However, she hoped it would be possible to trust Ms. S. She had liked that Ms. S had openly discussed her previous errors and talked about ways in which they could try and make therapy a more curious space for both of them. They both resolved to connect more with each other in order to foster a genuine and hopefully healing relationship.

Recommendations

Direct measures, such as education, training, and the thoughtful and intentional utilization of psychometric screeners may all work to positively address the co-creation of stigma dynamics and the subsequent treatment and relational consequences manifested

by said stigma, specifically as it concerns ADHD and trauma-related symptomology. The first way to decrease stigma (public and self-stigma) within the therapeutic relationship and increase comprehensive and nuanced diagnosis and treatment is through education. By educating the public, including mental health providers and clients, corrosive myths regarding mental health are challenged and replaced by facts. Stigma dynamics can only be reduced when deeply held attitudes, biases, and organizing principles are changed. Larsen and Corrigan found education to be a particularly appealing approach to positive change because "a standardized curriculum can be designed and exported to venues across the country relatively quickly (Larsen & Corrigan, 2007, p. 89). Education regarding mental health myths in order to reduce stigma, may be particularly critical for adolescent clients. Research has shown adolescents' beliefs regarding mental health are not as firmly developed as those of adults' and adolescents therefore are more likely to be responsive to educational efforts (Corrigan & Miller, 2009). This implies the self-stigma experienced by adolescents regarding their mental health diagnoses is malleable and could be altered by access to empowering educational resources. Education is particularly important when considering trauma denial and trauma stigma. Herman states "to hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victims and witness in a common alliance. For the individual victim, this social context is created by relationships with friends, lovers, and family. For the larger society, the social context is created by political movements that give voice to the disempowered," (Herman, 1992, p. 9).

Another positive approach to change may be through training, specifically the training of mental health professionals. Current models of training in psychology,

psychiatry, and other helping professions at times convey a superior attitude, which can contribute to the us versus them mentality that is often a part of public stigma. It then follows that awareness training, which will help trainees reflect upon and transform their potentially biased organizing principles regarding various mental health diagnoses, will be paramount to creating change. Syzmanski and Sapanski found that "viewing patients positively through the realm of recovery rather than cultural stereotypes can help combat the negative consequences of stigma" (Syzmanski & Sapanski, 2011).

If trainees are given spaces, through classroom settings and/or supervision relationships, to reflect and explore their own implicit biases regarding trauma, they will likely become more observant of the ways in which stigma operates systemically and within their own narratives, which will allow them to work more holistically with clients. Training programs should also incorporate opportunities for trainees to reflect on stigma while working clinically. Training programs should also directly face the idea of trauma denial through specific implicit bias trainings and the creation of curriculums that directly acknowledge and teach about trauma and theories associated with trauma. Trauma cannot be properly healed until it can be seen and spoken, which must begin with clinicians and training programs.

Herman found that "the therapist's first task must be to conduct a thorough and informed diagnostic evaluation, with full awareness of the many disguises in which a traumatic disorder may appear," (Herman, 1992, p. 157). Several studies demonstrate that contact, meaning interactions between a person with a mental health diagnosis and the public, also helps to diminish stigma. Contact likely works because it makes a diagnosis more human and therefore more nuanced and worthy of empathy. Awareness training and

contact also help to bolster the provider's ability to attune to their client, which in turn allows the client to feel more seen and understood, reducing self-stigma.

Once clinicians are provided sufficient training on trauma and implicit bias, they can then begin to more deeply explore various interventions to implement when working with clients who may have a history of trauma. The most significant intervention is the adequate obtainment of a trauma history. Often times, clinicians feel rushed or ill-equipped to take a trauma history, and if they take a history at all, often approach the process from a place of checking boxes and answering fill-in-the-blank questions. If clinicians were able to move away from being focused on questions regarding specific symptoms and behaviors, they may then ask more open-ended and curious questions that lead to more vulnerable and honest answers from the client, allowing deeper healing to take place.

In addition, after being provided with sufficient implicit bias training regarding trauma, clinicians may then be better equipped to use themselves and their reactions as valuable and illuminating clinical tools when working with adolescent clients. The often unspeakable and unbearable nature of trauma can breed avoidance and discomfort. A salient clinical recommendation is for the clinician to monitor their own discomfort and anxiety when working with clients. When they find themselves having the impulse or desire to distance themselves from the client or to avoid asking certain questions, specifically regarding trauma, the recommendation would be for the clinician to acknowledge this desire with themselves and then face it head on, in order to elucidate potential trauma instead of further colluding with the client in silence. If the clinician continues to feel ill-equipped to explore a potential trauma history or if the system within

which they work does not supply enough space and time to do this, relying on a referral network of outside trauma specialists could also be extremely helpful.

Implementing validated and comprehensive psychometric screeners when beginning therapy could also help to ensure thoughtful diagnoses and reduce stigma. There are several assessments and self-report measures used to diagnose ADHD in adolescents, including the Vanderbilt ADHD Diagnostic Rating Scale (VADRS) and the Conners Comprehensive Behavior Rating Scale (CBRS). These measures are given to adolescent clients, their caregivers, and their teachers in order to assess behaviors and evaluate them as they connect to ADHD symptomology. Neither the VADRS nor the CBRS, nor the majority of ADHD measures were meant to assess, let alone screen for a history of trauma or PTSD. When providers are then beginning their work with adolescent clients who are expressing symptoms that may be related to ADHD and/or trauma-related symptomology, they are most commonly utilizing measures that disregard trauma and its impacts. In addition, assessors may miss many trauma experiences "in part because assessment methods such as the Structured Clinical Interview use PTSD definitions geared toward single-incident traumas perceived as life-threatening. Clinician discomfort, lack of time and resources, or a dearth of training regarding trauma are some of the reasons healthcare providers fail to ask about trauma," (Goldsmith et al., 2004, p. 456). In order to more effectively parse apart ADHD and PTSD diagnoses, providers could implement a screener for trauma (such as the Trauma Symptom Inventory, TSI) during intakes, which would allow them to quickly assess for a trauma history. The implementation of assessments within the therapy relationship should be done intentionally and transparently. As the clinical vignette shows, when the client is not

informed of the trajectory of treatment, they may feel further stigmatized. If and when clinicians implement psychometric screening measures, they should first discuss the goals of doing this with the client and empower the client engage in the assessment process from a curious and open place. Utilizing a brief trauma screener will also encourage providers to obtain trauma histories from their clients, which helps providers to understand their clients more in-depth, increasing connection and decreasing stigma.

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