Mental Diagnosis:
The Double-Edged Sword

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Introduction

In this research project, we delve into the intricacies of mental health diagnoses through a qualitative approach, specifically focusing on semi-structured interviews. Our study aims to explore how individuals aged 21 to 25, diagnosed with various mental health conditions, perceive and navigate their diagnoses within societal contexts. .

The methodology of our study was meticulously designed to ensure a comprehensive understanding of our subjects' experiences. We adhered to the principles outlined by Adams *(Adams, 2015)* for conducting effective semi-structured interviews, including the creation of an interview guide with open-ended questions and a focus on maintaining a comfortable and empathetic environment for the participants. This approach was crucial in allowing us to gather in-depth and candid responses from the participants.

The selection of participants was driven by both purposive and convenience sampling methods, ensuring a diverse representation of diagnoses while also considering practical constraints. By engaging friends and acquaintances with relevant diagnoses, we were able to create a comfortable setting that encouraged honest and open dialogue.

Our theoretical framework is grounded in the ideas of Michel Foucault, particularly his concepts of discourse, power/knowledge, and the medical gaze. Foucault's insights provide a critical lens through which we examine the societal implications of mental health diagnoses and the power dynamics inherent in psychiatric practices. His theories on biopower and governmentality offer a nuanced understanding of how mental health diagnoses function within broader strategies of social control and regulation.

The thematic analysis of our interview data, guided by Foucault's theories, aims to uncover the underlying discourses that shape the experiences of individuals with mental health diagnoses. By identifying recurring themes and patterns in our participants' narratives, we seek to contribute to a deeper understanding of the social construction of mental illness and the impact of psychiatric institutions on individual subjectivities.

The key components of our study, including its objectives, methodology, theoretical framework, and analytical approach. The subsequent sections will provide a detailed account of our findings and their implications for the broader discourse on mental health and society.

Dimensions

Subjectivity and learning

Utilising the thematic frameworks of the Subjectivity and learning dimension in the project, interviews were conducted to gain a comprehensive understanding of the interview participants' experiences with diagnosis and labelling. Our goal was to understand how the participant's subjective experiences with their diagnosis have influenced their societal treatment and self-perception. The subjectivity aspect of the dimension allows the project to capture the personal feelings and perspectives of the participants, adding depth and insight to the project. Mental health is deeply personal and varies from person to person. By incorporating subjectivity into the project, it can emphasise how each participant perceives and experiences their diagnosis differently. Additionally, the learning component emphasised the educational value of the interviews, guiding us to look beyond the surface information and gain a deeper understanding.

Text and Sign

The text and sign dimension is utilised for conducting a thorough thematic analysis and to help interpret the language. The central focus of our project involves analysing transcribed interviews, which will be portrayed through thematic analysis. We will identify codes and themes by extracting quotes, sections, and potentially individual words from the interviews under different focuses such as “Role of institutions in shaping the self” and “Emotional impact of the diagnosis”. By doing this we connect the theories with the interviews to gain valuable insights into the experiences of individuals diagnosed with mental disorders. Additionally, the dimension also explores how language and signs are used to construct and communicate personal and social realities. There are various participants with different diagnoses in the interviews, and the text and sign dimension will help us better understand and interpret both the visible and non-visible words and signs.

Methodology

This segment of our project aims to present the research methodologies employed in our data collection phase. We delve into each method, delineating their strengths and weaknesses, and substantiate their relevance to our research objectives.

This study aims to understand the experiences of individuals with different mental health labels through in-depth interviews. By talking to three participants who had different diagnoses, we wanted to explore what this ‘label’ means for people and how it has affected their identity and experiences. We conducted qualitative interviews to capture the unique stories of each participant and gain insights into the complexity of their experiences. Our goal was to provide a deeper understanding of the human aspects behind clinical labels by using a qualitative approach.

Qualitative Approach to The Data

Qualitative research serves as a methodology for delving into the complex realm of human experiences, particularly in contexts as nuanced as mental health diagnosis. Bryman (2012) highlights a defining aspect of researchers engaged in qualitative research:

“Epistemological position described as interpretivist, meaning that, in contrast to the adoption of a natural scientific model in quantitative research, the stress is on the understanding of the social world through an examination of the interpretation of that world by its participants”(Bryman, 2012, p. 380)

Qualitative research was chosen for its ability to explore the nuanced and subjective aspects of individuals' lived experiences with mental health diagnoses, providing a holistic understanding beyond numerical data (Nassaji, 2020). Interviews, in particular, were favoured over surveys because they allow us to see personal narratives and subjective stories. Through interviews, participants can express themselves in their own words, revealing the language they deliberately use to describe their experiences and the emotions tied to them.

It is important to note that, in conducting these interviews, we remained mindful of the potential impact of creating a friendly atmosphere. Recognizing that a mood of friendliness might cause respondents to answer questions in a way that is aimed at pleasing the facilitator, we had to navigate this delicate balance and avoid the below:

"the mood of friendliness may result in the respondent answering questions in a way that is designed to please the interviewer. The achievement of rapport between interviewer and respondent is therefore a delicate balancing act." (Byrman, 2012, p. 218).

The choice of qualitative research methodology is based on its ability to provide a naturalistic perspective to examine phenomena without the limitations of numerical data or statistical analysis. (Nassaji, 2020). Mental health diagnosis involves subjective factors such as emotions, perceptions, and personal narratives that cannot be captured through numerical data or statistical analysis alone. Rather than seeking to explain and manipulate variables, qualitative research prioritises understanding and exploration, emphasising the process and patterns of development inherent in individuals' experiences (Nassaji, 2020). Given the deeply personal nature of mental health experiences, this approach is appropriate because it allows for a deeper understanding of individuals' challenges, benefits, and trajectories as they navigate their mental health label.

In the realm of mental health research, qualitative methods are essential in revealing insights that may be overlooked by quantitative approaches. Qualitative data collection tools, such as interviews, provide a holistic understanding of the investigated phenomena through accessing individuals' subjective experiences. Moreover, qualitative research allows for the exploration of questions and issues for which quantitative methods may not be suitable, offering flexibility and adaptability to the complexities of human experiences *(Nassaji, 2020).*

Rigorous attention to methodology and ethics is critical in qualitative research. Similar to quantitative research, qualitative inquiry follows a systematic process, encompassing data collection, analysis, interpretation, and evaluation. *(Nassaji, 2020)*.

Semi Structured Interviews

A semi-structured interview has been referred to as a 'conversation with a purpose' (*Burgess, 1984).*

According to Adams, this entails that the participant and facilitator engage in an official interview. Additionally, the facilitator prepares an interview guide, which includes a list of open-ended questions and topics that need to be discussed during the conversation. The open-ended nature of the question defines the topic under investigation but provides opportunities for both facilitator and participant to discuss some topics in more detail. The facilitator follows the guide, but is able to follow relevant lines of enquiry in the conversation that may stray from the guide when they feel this is appropriate.

By following Williams Adams' approach to conducting semi-structured interviews (Adams, 2015), the SSI is carried out conversationally with one respondent at a time. It utilises a combination of closed and open-ended questions, frequently supplemented with follow-up "why" or "how" questions (Adams, 2015).

The flexible structure of a semi-structured interview allowed researchers to encourage the participant if we were looking for more information or found what they were saying interesting. Adams states that, "if a conversation unexpectedly turns from the first to the fourth topic, by all means, reorder the topics on the y and return later to pick up the ones that were skipped" *(Adams, 2015, p.498*). The ability to adapt the conversation based on the participant's responses leads to increased engagement.

The semistructured approach allowed participants to share their unique personal narratives and perspectives without any constraints caused by a pre-established set of queries. Unlike structured interviews, which adhere to a predetermined set of questions, semi-structured interviews provide a balance between flexibility and guidance, allowing for both in-depth exploration and the emergence of unanticipated insights (*Bryman, 2012; Galleta, 2013*). This approach is well-suited to the inherently subjective nature of mental health experiences, where participants' narratives often defy simple categorization or linear trajectories. Our goal with this methodology was to provide a platform that allowed participants to express themselves freely and convey the aspects of their experience that are most meaningful to them.

Semi-structured interviews adhere to an interview guide comprising a set of predetermined questions covering specific topics (*Bryman, 2012*). Despite the predetermined content, Bryman contends that the participant retains autonomy in crafting responses. While the interview protocol may sequence questions, their order can vary based on the context. Additionally, as previously discussed, semi-structured interviews afford greater flexibility for active listening and the spontaneous generation of new questions during the interview process (Bryman, 2012). This approach enables us to capture independent thoughts.

While we initially leaned towards a structured approach for its clarity, we agreed that flexibility allowed participants to shape the conversation according to their experiences. While a structured approach offers consistency in data collection, we recognised that it could hinder the organic flow of conversation and limit participants' ability to express themselves fully (Bryman, 2012). Semi-structured interviews emphasise exploring research concepts while also allowing participants the opportunity to contribute their perspectives or introduce interpretations not previously considered by the researcher *(Bryman, 2012*).

In other words, the flexibility of semi-structured interviews allows participants to shape the dialogue according to their lived experiences giving more authentic responses. With the shift towards open-ended questions, we ensured that the number of questions didn't overwhelm participants. The questions served as a guide to help explore different dimensions of the topic during the interview.
An inherent advantage of employing open-ended questions lies in their capacity to unveil unforeseen insights that might not have been initially contemplated. Through affording participants a degree of latitude in their responses, the research endeavour was able to unearth latent dimensions of the subject matter that might otherwise have remained concealed or overlooked. This approach not only enriches the depth and breadth of the inquiry but also fosters a more comprehensive understanding of the phenomena under investigation. (*Bryman, 2012).*

Overall, we asked open questions, one for each of our different perspectives, and adapted and followed the participants' lead if the conversation naturally veered in a direction that aligned with their interests and experiences.

Behind the Scenes: The Methodology of Our Semi-Structured Interviews

"*You must create the agenda for the interview guide, the outline of planned topics, and questions to be addressed, arrayed in their tentative order*" (*Adams, 2015).*

Prior to the interview, preparation involved familiarising with the interview guide. This guide consisted of open-ended questions addressing specific topics intended for analysis in the project.

We adhered to Adams' handbook by avoiding the tendency to overload the agenda with too many issues (*Adams, 2015, p. 496).* We made a deliberate decision beforehand to identify which ones were essential and which ones were optional.

The chosen setting for the interviews was an informal area with a relaxing ambience. It was comfortable and quiet, which helped us to develop a rapport with the person that was questioned.

We opted to gather data through recording equipment rather than note-taking, prioritising direct eye contact and presence during interviews to enhance the depth of our interactions, rather than being preoccupied with writing down the interview. "*A small digital recorder, if permission is granted, allows the interviewer to be more actively engaged in the conversation as well as to ponder the best next question instead of having to concentrate on writing down answers"* (*Adams, 2015).*

"At the start of the interview, the matter of confidentiality must be addressed clearly" (*Ibid, 2015, p. 496*). Before the interview we provided a brief explanation of the study and confidentiality allowing the participant to be informed and consent to take part in the project. Throughout the interview, we remained attentive to subtle shifts in body language and non-verbal signals, which is important within the context of discussions surrounding mental health diagnoses. Given the sensitive nature of the topic, our awareness allowed us to create a more empathetic and supportive atmosphere.

Participant recruitment

When conducting interviews on sensitive topics, it is essential to consider a variety of factors to ensure the integrity and depth of the research. The primary objective of these interviews was to elicit candid and personal responses regarding the questions posed. In the selection of participants, we meticulously accounted for factors such as age, diagnosis, gender, and accessibility. Participants were carefully chosen to include both male and female individuals aged 21 to 25 years, representing a range of diagnoses. This particular age group was selected to investigate diagnostic perspectives and experiences during early adulthood, a period often critical for the onset of various conditions. By incorporating participants with diverse diagnoses, we were able to broaden the scope of our project and enrich our findings. This diverse recruitment approach enhances the relevance and depth of our results, making them applicable to a wider audience.

Purposive and convenience sampling

Purposive sampling and convenience sampling are two methods used in qualitative research to select participants. Purposive sampling involves intentionally choosing individuals who have relevant experience or a characteristic or quality related to the research topic. This method ensures that the sample is relevant and can provide in-depth insights on the matter, focusing on specific characteristics defined by the research objectives, such as age, gender, or in our case a diagnosis. On the other hand, convenience sampling involves selecting individuals who are easily accessible to the researcher, often for practical reasons such as availability, making it an efficient approach (*Andrage, 2020).*

For this project, both convenience and purposive sampling were utilised to create a robust and effective approach to participant recruitment that we thought would suit this project best. To ensure that our participants possessed a specific characteristic needed for this project, we selected individuals known to members of the group. We knew these individuals had a quality which would be useful. This is referred to as purposive sampling. Purposive sampling was crucial in ensuring that the participants included in the interviews had the main quality we were looking for, namely, a diagnosis. We collectively decided to reach out to friends and acquaintances who we knew had a diagnosis and invited them to share their experiences. This approach enabled us to centre the participants' perspectives, emotions, and insights, which were essential to our research topic.

In addition to this, convenience sampling was employed because it was the most efficient, comfortable, and easy method. The participants are all either friends or acquaintances of members of the group. This decision was based on several reasons. Firstly, the group agreed it would be easiest to interview acquaintances considering our schedule and the time given to finish the project. Secondly, the subject matter is sensitive and could perhaps be painful for some participants. Therefore, it was crucial to ensure that the participants felt comfortable with the questions and the interviewer before, during, and after the interviews. The group agreed beforehand that the participants would be more at ease if they knew the person conducting the interview. It can also be argued that perhaps sharing personal experiences and feelings with someone you know, might invite more honesty and openness than sharing them with a stranger.

By combining purposive sampling and convenience sampling, our participant recruitment and the finished interviews benefited from both the depth of purposive sampling and the practical advantages of convenience sampling.

The Participants

In this project, the participants have been carefully selected to represent a spectrum of different diagnoses. The participants have been diagnosed with a total of three different diagnoses. In conducting these interviews for this particular project, our goal was to ensure diversity and appeal to a wider audience by including individuals with various diagnoses, as will be discussed further in the analysis. In order to protect the privacy of the individuals involved, we will refer to them as "Participant 1 (P1)," "Participant 2 (P2)," and "Participant 3 (P3)," based on the sequence of their interviews. Using anonymous identifiers is a good approach to maintaining the confidentiality and privacy of the participants while allowing the members of the group to discuss their cases in detail. Below is a breakdown of the participants, including their interview order, age, gender, and diagnosis:

Participant 1 (P1): A 23-year-old female diagnosed with ADHD

Participant 2 (P2): A 25-year-old male diagnosed with depression and anxiety

Participant 3 (P3): A 21-year-old female diagnosed with ADHD

Ethics and Limitations

When working with the semi structured interview, there are some questions that are worth taking into consideration when it comes to the limitations. Having come up with the base questions, we wanted to give the freedom to the participants to be able to take the topic into their desired directions, as we did not walk into the interviews knowing what result we wanted, with the intention of being able to learn what each person associated with their mental diagnosis and it's relation to society.

The main ethical concern when it comes to semi structured interviews is that the questions that we have come up with could show our bias and encourage the participant to follow a certain path. We wanted to avoid this as much as possible, since we are interested to hear what each individual's interpretation was and hoping to learn different perspectives. In order to prevent this, we workshopped the questions together, paying close attention to the wording in order to make sure that our personal bias was minimised and tried to avoid leading questions whenever possible. As the project moves forward and we move on to different parts of working with the interviews, we will have to remember our personal biases when it comes to the research topic and help each other keep that from influencing the direction of the project.

Outside of bias, one of the big ethical questions that comes with interviews is data storage and usage. We have kept subject's names anonymous, providing only their age, gender and diagnosis, which are the parts that are most relevant to our research and need to be present in the analysis. None of the participants are identifiable beyond this and we are complying with GDPR rules when it comes to storage, keeping the recording of the interviews only as long as we're working with the project. We have also avoided mentioning specific locations, like places of study and such, in order to make it easier to keep the participants anonymous.

Regarding the ethical considerations pertaining to the interviewer-participant dynamic, it is imperative to underscore that our involvement did not exert any form of influence upon the subjects. Participation was consistently voluntary in nature, ensuring that individuals engaged in the study of their own volition. The Aluwihare-Samaranayake paper does mention that some people might feel obliged to participate in surveys and project of this kind because they have a responsibility towards the researcher or the research subject, but unfortunately that bias is not something that we can actively avoid at the moment, and the most we can do as we write this project is to make sure that the participants know the research topic that the paper will be covering and that they are able to give informed consent. We value the comfort of our volunteers, so they were given the option not to answer questions they might be uncomfortable with, since discomfort was always balanced against knowledge acquired and would always come out on top.

From the point of view of ethical reflexivity, a subject brought up in the Roth and Unger paper, we believe this is a topic that will maintain and increase its relevance as we move forward in time, this being a subject that gets more attention every day. Neurodivergence is more prevalent now than it has ever been and every day people get diagnosed with mental health issues that affect their day to day lives. This research aims to compare neurodivergent people's experience in relation to the world around them taking into account their diagnosis, which is very much a part of them and shapes them as people. This means that the information we extract from the interviews could hopefully help somemen that is struggling to be understood to realise that they are not alone and that a lot of people with mental diagnoses have similar experiences and they only need to find a mechanism that works for them,

Transcription

Our approach to conducting the interviews involved developing a set of guideline questions, allowing participants to expand on these themes organically. Following the completion of each interview, we transitioned to the transcription phase. Transcribing interviews entails numerous methodological choices; we elected to preserve the verbatim responses of participants, deliberately excluding any interpretative comments on their attitude or behaviour, which would make our transcriptions data transcriptions and not qualitative data transcriptions. This format was selected due to a higher level of familiarity and expertise in its application for transcription. Opting for video interviews instead of audio-only recordings would have facilitated the observation and analysis of participants' behaviours.

However, the decision to use audio interviews was made to better preserve participant anonymity. Commentary on body language and other non-verbal cues was intentionally avoided, as these elements were not evident on the recordings. Furthermore, to prevent participants from feeling uncomfortable or self-conscious, such observations were excluded from the official record. When it comes to data transcription, we were only interested in the words the participants were using, so we would directly transcribe the audio recordings into a written format.

The interviews were intentionally limited to a duration of 15 minutes to facilitate a more manageable transcription process. We employed an audio transcription technique, which involved listening to the recordings and transcribing the content into a separate document. The primary objective of transcribing the interviews was to streamline the qualitative data analysis for our project.

Thematic analysis

Thematic analysis offers a systematic approach to interpreting and ascribing meaning to qualitative data, such as interviews, by categorising the raw data into "codes" and subsequently assigning themes to these codes. The development of themes is based on the researcher's subjective interpretation of the transcribed data, granting the researcher the creative authority to determine which themes are prevalent, which themes warrant further investigation, and how to label these themes. Consequently, thematic analysis rejects the notion of an "objective truth" that must be uncovered by the researcher. Instead, it requires the researcher to immerse themselves in the data they have collected, allowing for the subjective interpretation of this data. As stated by Wæraas *(2022, p. 155),* " themes should be "generated from the data rather than discovered in the data."

Codes serve as the foundation for thematic analyses, which entails labelling words or phrases from the raw data that seem relevant to the problem area. A *coding unit* refers to a text segment from the data which can be anywhere from one word to several paragraphs. Codes can be determined deductively, by selecting theories *prior to* the analysis and using these theories to frame which codes are selected and how they are interpreted. An inductive method may also be employed, which entails freely selecting codes *during* the analysis, in which the codes selected aren't determined by any theoretical framework chosen prior to the analysis (ibid; p.155). In the case of this project, a deductive approach will be employed, as Foucault's theories on mental illness, psychiatric institutions, and disciplinary power have been selected before analysing the data.

Once a series of codes have been labelled or extracted from the transcribed data, codes that convey similar meanings are grouped, and these groupings are called *themes* (ibid; p.157). Once a collection of themes is extracted by the researcher, the researcher can proceed by exploring if there is any relationship between the themes found (ibid; p.158). Prominent themes can be identified in a series of ways. Firstly, researchers can formulate themes by *grouping synonyms*, or in other words, grouping words with similar meanings that many participants articulated (*ibid; p.163*). Another way of extracting themes from qualitative data is *Grouping codes of the same type*, in which any similar topics that were brought up into discussion or ways that participants articulated themselves, are grouped into one theme. For instance, participants may all have expressed being a part of similar activities, have similar values, and practices, or share common views of their self-identity. This approach requires focusing on the content of the interviews as opposed to focusing on specific word choices (*ibid; p.164*).

Theory

Foucault

Michel Foucault, a distinguished French philosopher, is celebrated for his extensive analyses of various social institutions, spanning from psychiatry and policing to the humanities, sexuality, and prison systems. A cornerstone of Foucault's scholarship is his exploration of the concept of 'discourse,' which he conceptualises as a complex social phenomenon deeply entrenched in historical contexts. According to Foucault, discourse serves as a dynamic system that shapes the production, dissemination, and interpretation of knowledge and meaning within society. It encompasses the diverse ways in which individuals and institutions communicate, discuss, and make sense of a wide array of topics and ideas, reflecting broader power dynamics and societal norms. Through his work, Foucault illustrated how these discourses are pivotal in shaping our understanding of the world, highlighting their influence in both maintaining and challenging power structures within society *(Adams, R, 2017).*

Linking Michel Foucault's ideas to the topic of mental health diagnoses presents a fertile area for investigation. This is especially true when employing interviews, which can yield detailed perspectives on the ways mental health diagnoses are understood, formulated, and implemented in daily life. Foucault is also renowned for his incisive examinations of numerous societal institutions, such as psychiatry, and his insights into the interplay of power, knowledge, and discourse.

Michel Foucault's seminal work on the history of madness, particularly articulated in "Madness and Civilization," offers a critical framework for analysing the evolution of mental illness diagnosis and treatment within a socio-political context. This text elucidates how societal perceptions and treatments of mental illness are deeply intertwined with historical power structures and cultural norms. Central to Foucault's theoretical contributions is the concept of Power/Knowledge, which examines the symbiotic relationship between power and knowledge, and how this interplay shapes social norms and practices, including those related to mental health.

"For Foucault, power and knowledge not only regularly reinforce one another but are inextricably bound; therefore, rather than speaking of power or knowledge as single, independent concepts, he introduces his own concept of 'power–knowledge' to reflect the indissociable nature of power and knowledge." (Foucault, 1998, pp. 98–99).

This shows that according to Foucault power and knowledge are inevitably connected and one can't be expressed without the other. This is also very relevant when it comes to psychiatric institutions. First of all, there has been negative connotations connected to mental diagnoses for many years and society has judged people within the psychiatry and thereby created a power relationship between diagnosed people and the rest of the society. Having a mental diagnosis could for some be seen as a weakness and therefore beneath them. Also, there are many power relations within the psychiatric institutions as for example the one between the patient and the medical professionals. In this case the medical professionals will be seen as the ones with the knowledge educating the patients and thereby they will be the ones in power.

Foucault's analysis reveals that psychiatric diagnoses extend beyond mere medical categorizations; they are inherently socio-political constructs that reflect and perpetuate existing power relations. By focusing on the narratives and personal experiences of individuals with mental health diagnoses, interviews can provide profound insights into how these power dynamics manifest in everyday life. Such qualitative data can illuminate the processes through which certain behaviours are deemed "normal" or "abnormal," demonstrating that psychiatric diagnoses are not solely objective medical facts but are also influenced by broader societal forces.

Through the perspective of Foucault's Power/Knowledge framework, it becomes evident that mental health diagnoses can serve as mechanisms of social control, reinforcing dominant power structures by pathologizing deviations from established norms. This perspective underscores the importance of considering the socio-political dimensions of mental health, highlighting how diagnoses and treatments are shaped by and contribute to maintaining power hierarchies within society. Consequently, exploring these narratives enables a deeper understanding of the complex interplay between mental health, power, and societal norms, ultimately challenging the notion of psychiatric diagnoses as purely scientific or neutral categories.

In relating Foucault's theory to mental diagnosis, the concepts of biopower and governmentality emerge as indispensable components. Biopower refers to the ways in which the state exercises control over bodies and populations, including through practices of health and illness management. Governmentality, on the other hand, involves the techniques and strategies used by governments to regulate behaviours and manage populations. Interviews can reveal how mental diagnoses are integrated into broader strategies to govern individuals' behaviours, often pathologizing deviations from the norm and reinforcing conformist behaviorThe "*medical gaze*," a concept Foucault introduced, refers to the dehumanising and reductionist way in which medical professionals view patients, focusing solely on their symptoms or diagnosis rather than seeing them as whole individuals (*Foucault, 1963*). This concept can be linked to personal stories of diagnosis, where individuals may feel objectified or devalued by their interactions with psychiatric institutions. Interviews can provide a platform for those affected to articulate their experiences of being subjected to the medical gaze and to critique the impersonal nature of their diagnostic encounters.

In '*Discourse and the Construction of Madness'*, Foucault argued that madness is constructed through discourse, *(Foucault, 1961)* with language and societal dialogue playing key roles in defining what constitutes mental illness. Interviews with both individuals diagnosed with mental conditions and professionals in the field can shed light on how mental health diagnoses are framed and discussed in society. This exploration can reveal the shifting boundaries of what is considered "madness" and how these boundaries are influenced by cultural, historical, and social contexts.

Lastly, in '*Resistance and the Role of the Patient'*, Foucault's notion of resistance is crucial when discussing mental diagnoses through interviews. This perspective highlights the ways in which individuals resist or challenge the labels and limitations imposed by psychiatric diagnoses (*Ibid)*. Personal narratives provide valuable insights into the strategies individuals employ to navigate and negotiate their identities within the confines of their diagnoses. These stories reveal how individuals challenge and occasionally subvert the categories imposed upon them by psychiatric labels. This approach demonstrates that mental health diagnoses extend beyond mere medical categorizations; they are deeply imbued with social, political, and ethical implications.

Connection with interviews

Linking Michel Foucault's theoretical framework to interviews about mental health diagnoses facilitates a multifaceted examination of these issues. Foucault's concepts of power, knowledge, and discourse enable a critical analysis of how psychiatric diagnoses function within broader societal structures. Diagnoses are not merely neutral medical assessments; they reflect and reinforce existing power relations and societal norms.

Through the application of Foucault's theories, one can conduct a critical examination of how mental health diagnoses shape individual identities and experiences. This analytical exploration sheds light on the substantial influence exerted by societal power dynamics in delineating behaviours as either "normal" or "abnormal." It delves into the intricate mechanisms through which societal norms and values shape perceptions of individual conduct, thereby establishing criteria for what is deemed socially acceptable or deviant. Additionally, this examination underscores the multifaceted role played by psychiatric diagnoses in this process, serving as tools wielded by institutional frameworks to both reinforce and challenge prevailing power structures. Through the lens of Foucauldian analysis, the interplay between societal norms, psychiatric classifications, and individual experiences emerges as a complex terrain ripe for scholarly inquiry, offering insights into the broader dynamics of power and knowledge within society.

Nevertheless, employing Foucault's theoretical framework to analyse personal narratives regarding mental health diagnoses yields a comprehensive understanding of the profound implications these diagnoses hold for individuals and society at large.

Foucault on Disciplinary Power

Foucault illustrated power dynamics through his analogy of the structure of panopticons, which is composed of a central observation tower that “supervises” the prison cells below it. This is a form of “corrective training”, and the function of it is to instil fear in subjects that they are continually being monitored. The simple prospect of being monitored incentivizes the prisoners to regulate their behaviour in accordance with what is expected of them, without the need for any direct forms of discipline by authority figures (*Robert, 2005; p.34).*

According to Foucault, panoptic structures transcend prison cells and are applied to many other institutions of society, including psychiatric institutions. Mental health institutions employ panopticism, which is a system of control where individuals are constantly observed, when treating and diagnosing patients in that they instil the idea into patients that any form of abnormal behaviour detected requires corrective training, which inherently perpetuates a power relation that aims for patients to regulate their behaviour in accordance with the norms of psychiatric institutions.

Continuous monitoring is facilitated by psychiatric institutions through the establishment of alliances and connections with other institutions and the client’s close relations. Family members, friends, significant others, and other individuals within the client's "personal sphere" are often enlisted by psychiatric institutions to observe the client, ensuring adherence to the norms and expectations set forth by these institutions, *(ibid, p.36).*

There are also power relations inherent in psychotherapeutic practices. For instance, one of the tenets of psychotherapy is the obligation that clients must "confess" their feelings, and that any reluctance to confess by the client is symbolic of a "constraint" of the "innermost self" which must be liberated via confession. Moreover, what is confessed by the client is only of value once it has been recorded and interpreted by psychiatric professionals who possess knowledge on normality and abnormality. Conducting interviews with individuals who have been diagnosed with mental illnesses allows us to capture their experience with the various therapeutic institutions that have been involved with, and give them an opportunity to provide an assessment of how efficient mental health institutions are with accommodating their mental illness.

Foucault contends that mental health professionals wield authority in interpreting a client's confession due to their knowledge *(ibid, p. 37)*. Clients are guided to interpret and monitor their thoughts using the prescribed terminology by these professionals (ibid, p. 37), thereby adjusting their thoughts and behaviours accordingly. Moreover, psychiatric institutions, according to Foucault, possess a paternalistic mentality that drives them to think of clients as being incapable of governing themselves due to their mental illness. Clients internalise this idea that their mental diagnosis limits their autonomy which triggers their overdependence on professional advice, treatment, and medication (*ibid, p.38)*. The conducted interviews conducted with the participants allows a more authentic investigation of these approaches taken by Foucault, through asking participants how receiving a mental diagnosis has affected their level of autonomy, and how their involvement with various psychiatric institutions has affected how they perceive themselves.

Some individuals may experience a sense of dehumanisation by psychiatric institutions due to their tendency to conduct superficial assessments. These often involve a limited set of compulsory questions followed by a diagnosis, rather than a comprehensive exploration of the patient's emotions and experiences. This approach can vary depending on the type of mental health professional. For example, psychologists are more likely to engage patients with in-depth questions to gain a thorough understanding of their feelings and life contexts.

In contrast, psychiatrists may focus on more direct and succinct questioning to expedite the diagnostic process. This practice can be critically examined through Foucault's concept of subjectivity, which explores how individuals are shaped and categorised by societal and institutional norms.

Foucault claims that humans are being made into subjects. *""My objective", he writes, "...has been to create a history of the different modes by which, in our culture, human beings are made into subjects" (1982a: 208). ...the idea of "the subject" is itself a historical construction." (Taylor, 2011, p. 6).* The concept of "the subject" is historically constructed through cultural, societal, and communal influences. In this context, psychiatric institutions play a pivotal role in subject formation. These institutions wield substantial authority, thereby exerting significant power. Foucault's theoretical framework on power relations elucidates the multifaceted nature of power within society. For instance, the hierarchical dynamic between a monarch and their subjects exemplifies a clear demarcation of power, where the monarch's decisions profoundly impact society. Similarly, psychiatric institutions possess the authority to diagnose individuals and prescribe treatments or interventions, thus exercising considerable influence over their subjects.

Foucault claims that subjectivity is very connected to power relations. *"...Foucault helps us to see the extent to which the idea of being a subject is implicated in power relations." (Taylor, 2011, p. 6).* The subject will most likely be the one who is below in the relationships because the term has negative connotations. But Foucault argues that the subject can reclaim power by questioning who and what they are. Thereby, power can also be a positive thing which Foucault gives a lot of attention to. He talks about power as a productive thing. *"...for Foucault, power is productive: certain power relations give rise to or produce the definition of subjectivity." (Taylor, 2011, pp. 6-7).* Therefore, according to Foucault we can use power relations to understand and explain different aspects of subjectivity. But who are subjects and who are not? This is a difficult question to answer and even though every being could have been subjects the idea was explained differently in the time Foucault introduced it. It makes good sense because a subject is explained to be a term given by cultural circumstances and can be associated with something material and distant from being a "complete" human being. It is also well connected to power relations because subject's could be someone or something that is owned, controlled or forced.

“Thus, while all rational beings are purported to be subjects, the reality of the situation is that the Enlightenment understanding of subjectivity excluded a wide group of people, including, for example, women and the people of land that had been colonised by white European men.” (Taylor, 2011, p. 7).

This illustrated that there was a power relation between men and women and inequality between them. This is inevitable when it comes to all human beings but in this period it was clear to see who had the power. Even though the term ‘subject’ can be given to a person it can also be something we create for ourselves. Society is built in a specific way and humans tend to put other people into a box but they also have a need to put themselves into a box in order to feel a sort of belonging. *“Foucault also makes clear that subjectivity is not simply imposed externally. We take up and occupy the subject positions that our socio historical context makes available to us: subjects are not only made, we make ourselves.” (Taylor, 2011, p. 7).* This suggests that individuals possess the agency to reconstruct their identities and transform themselves into something different. Despite external perceptions imposed by others, individuals can retain a significant degree of control over their self-conception and the roles they choose to inhabit. This viewpoint offers a constructive interpretation of power relations and the self's relationship to these dynamics. He elucidates how societal structures can be harnessed to reconfigure notions of subjectivity.``*...we can use the norms and values of our society in new ways, work on creating totally new forms of subjectivity, or even dispense with “the subject” as a mode of existence.” (Taylor, 2011, p. 7).* This is an interesting way to look at the subject and it creates some kind of hope for the future. If the power relations could change so that some people would’n have as much power over other people. We know that norms and values are an important factor when it comes to humans and how their societies and communities are built. Thereby, they also affect the power relations within society which mean that if we change the concept of subjectivity we can change the norms, values, and power relations.

“Maybe the target nowadays is not to discover what we are,” Foucault writes, “but to refuse what we are. We have to imagine and build up what we could be to get rid of this kind of

political ‘double bind,’ which is the simultaneous individualization and totalization of modern power structures” (1982a: 216).” (Taylor, 2011, p. 7).

This way of looking at subjectivity is showing how an individual has some power of what they are and the sentence with “what we could be” is motivating and showing another way of seeing ourselves. Thereby, subjects can reclaim power and reconstruct the power structures that are imposed on them in a way that benefits and liberalises them. *“Foucault makes clear that experimenting with being other than what we currently are is not only possible but also an integral part of navigating power relations in a way that both constitutes and in turn promotes the practice of freedom.” (Taylor, 2011, p. 7).* So, by looking at what we could be we can actually change the power relations and learn how to navigate in them and understand them. The word ‘freedom’ is an important word and is a positive word, so, that means that Foucault highly recommends doing this experiment and thereby makes it possible to create more freedom for the individual. This means that the term ‘subjectivity’ and its meaning can change over time and possibly be turned into something good.

Resistance and Agency in Patient Identity

This section delves into the nuanced processes by which individuals diagnosed with mental health conditions actively resist or renegotiate the labels imposed upon them. Informed by Foucault's later theoretical inquiries into ethics and the notion of "technologies of the self," this discourse aims to elucidate the multifaceted strategies through which these individuals engage in the reconstruction or redefinition of their identities in response to prevailing psychiatric taxonomies. Such endeavours highlight the dynamic agency inherent in patients' interactions with diagnostic frameworks, challenging the normative boundaries prescribed by conventional psychiatric classifications. Expanding the scope of analysis, attention is directed towards exploring alternative discourses and therapeutic interventions within contemporary mental health care landscapes. These alternative paradigms, divergent from traditional psychiatric methodologies, encompass initiatives like the burgeoning recovery movement and the establishment of peer support networks. These initiatives not only dissent from established psychiatric norms but also champion alternative therapeutic approaches that prioritise principles of recovery and mutual support.

By amplifying diverse perspectives and prioritising patient autonomy, such initiatives reflect a broader paradigmatic shift towards more patient-centric care approaches, fostering collaborative partnerships between individuals and mental health care providers. In delving into these alternative discourses and therapeutic strategies, we gain deeper insights into the evolving terrain of mental health care provision and the latent potential for transformative change therein. Recognizing and valorizing the agency of individuals diagnosed with mental health conditions, alongside embracing the plurality of therapeutic perspectives, constitutes pivotal steps towards fostering a more inclusive and empowering mental health care milieu that prioritises the holistic well-being of patients. Through the critical examination of resistance narratives and alternative therapeutic frameworks, scholars and practitioners alike can contribute to the ongoing discourse surrounding mental health care provision, paving the way for innovative approaches that centre on patient empowerment and recovery-oriented practices. This scholarly endeavour holds immense promise in reshaping dominant narratives surrounding mental health, ultimately fostering environments where individuals feel validated, supported, and empowered in their journey towards mental well-being

Analysis

This section is dedicated to presenting a thematic analysis of the interviews conducted. The analysis looks at 5 different categories which include, firstly *“The emotional impact of the diagnosis”*, where immediate emotional responses that participants had after receiving their diagnosis, as well as the enduring impacts it has had, will be investigated. The second category is titled *“Perception of Self and Identity”*, which addresses how individuals’ diagnoses have affected their self identity, agency and perception. The third category is *“Social Interactions and Relationships”*, which delves into how participants’ diagnoses have affected their relationships with family and friends, as well as who they choose to share their individual experiences with. The fourth category is *“The Role of Institutions in Shaping the Self”*, where participants’ experiences with healthcare providers, schools, workplaces, etc, will be investigated.

The last category is titled *“Societal Attitudes”*, where broader societal views, language and narratives of mental diagnoses will be analysed in relation to how they impact individuals who have a mental diagnosis. Thematic analysis was approached in this project by carefully inspecting the interview transcripts to generate a list of codes based on the phrases and word choices used by participants which were considered worth investigation. Thereafter, the different codes that were considered related on some level were grouped into clusters, and themes were ascribed to each cluster of codes. The codes and themes that were generated are illustrated within tables that were made for each of the 5 categories. Our analysis then follows by presenting quotes from the interview transcripts, explaining how they are related to the codes and themes generated, and relating the statements made by the participants to concepts introduced by Foucault.

Social Context and Social Attitudes

Codes	**Themes**
● Lack of Awareness ● Frustration with Society ● Experiential Understanding	Fear of Misunderstanding
● Communication Barriers ● Validation of Experiences ● Societal Attitudes ● Generational Differences	Empathy Gap

Desensitization Ambiguity of Labels Using diagnosis to seem ‘edgy’. Perception of Labels Degradation of Meaning Overuse of Terminology	Trivialisation Social Media Influence
Empathetic Conversations Cultural Shift Complexity of Experiences Supportive Dialogue	Social Media Influence
Connection with others Shared identity through diagnosis Acceptance Community	Community Support Networks Normalisation Empowerment
Increased Awareness Gender Inclusivity Positive Reframing	Changing Societal Perspectives:

P3 diagnosed with depression and anxiety highlighted a concern regarding the terms used around mental health labels. He states that their overuse has led to a loss of proper meaning. This reflects a negative view of how these labels are currently perceived in society.

“I don’t know. I was neutral about it. The label didn't affect me either negatively or positively, and it didn't give me clarity. I guess the term depression has been so widely used that the

word kind of lost its meaning."

The participant suggests that the term "depression" has become so common that it has lost its specific meaning and impact. This perspective is important in understanding the social context of mental health labels. It highlights a potential desensitisation to the term "depression," possibly due to its frequent and sometimes casual use in everyday language. This introduces the theme of trivialisation. This widespread usage can dismiss the seriousness of the condition, affecting how individuals perceive their own mental health and how society responds to those diagnosed with it. In the broader social context, this response suggests that while mental health awareness has increased, there may be a need to address how mental health terms are used and understood, encapsulating the theme of mental health education. When the participant was asked, why he needs to explain his diagnosis properly to his family, he responded:

"*I guess I feared they would misunderstand me. That they wouldn't see it as a big deal. I was worried they would be like "well why don't you just do this or that?. I feared they would neglect it. They are from a different time when mental health issues were looked at differently. But even my brother I felt wouldn't understand it, who isn't that much older than me. I tried to tell them at the start about my diagnosis, but they didn't understand the severity of it. I guess the diagnosis label doesn't mean the same to them as it does to me."*

The participant expresses a fear of being misunderstood and dismissed by others, particularly due to generational differences in attitudes towards mental health. This highlights the theme of fear of misunderstanding. He worried that people, including those close to them, would trivialise his condition and suggest simplistic solutions, not understanding the severity of his diagnosis. The concern extended even to their brother, who is relatively close in age but still lacked understanding. This conveys the theme of the empathy gap. Furthermore, this highlights a significant social context issue: the varying perceptions of mental health labels across different age groups and even among peers. Foucault's work explores how individuals are "made into" subjects by their social, historical and political environment. He favours the notion that individuals are shaped substantially by their sociocultural norms and values and disfavours enlightenment notions of a pre- given, rational subject that is distinct from its social environment (Taylor, 2011; p.6). Given our social environment, and the discourses that are fed to society are ever-changing, this may explain the generational disparity in how to manage mental health, and the overall understanding of the significance of it. As illustrated in the quote above, The diagnosis label, which holds significant meaning for the participant, did not carry the same significance for those perhaps subjected to different sociocultural, political and historical environments around them. This underscores the challenge of communicating the seriousness of mental health conditions to individuals with different cultural backgrounds that may not fully recognise or respect these labels.

He was then asked the question, “So for you, it's hard with the label in terms of people not properly understanding?” To which he responded:

“I just think some people don't take it seriously in society. But that also makes sense, because if people haven't experienced it for themselves, then how can they know what you mean?”

The common theme in this response again conveys the theme of trivialisation. The participant highlights a significant societal issue: the general lack of understanding and seriousness given to mental health labels. He expresses frustration that people in society often do not take mental health diagnoses seriously, which can undermine the experiences of those with such conditions.

Again, the key theme in the participant’s response is the empathy gap between those who have experienced mental health issues and those who have not. The statement, *"if people haven't experienced it for themselves, then how can they know what you mean?"* encapsulates this gap. This theme suggests that personal experience plays a crucial role in understanding and validating mental health conditions, highlighting a societal need for greater empathy and awareness. The participant suggests that without personal experience of mental health issues, individuals may struggle to fully comprehend their significance. This theme underscores the importance of personal experience in shaping one’s understanding of mental health, suggesting that those without such experiences may inadvertently contribute to the stigma and misunderstanding of mental health labels. He notes that even family members, such as his brother, who is not much older, fails to grasp the severity of the diagnosis. This theme indicates that there is an empathy gap between people because there are varying levels of awareness and acceptance of mental health issues, influenced by the societal attitudes prevalent during their formative years.

When asked, “what was nice about talking to people who have been through it?”, he responded:
“It created a deeper connection to them I guess, a sense of belonging, and a feeling of ‘being normal’

The participants' positive experience of connecting with others who have faced similar challenges highlights the theme of community support networks. These networks allow for an understanding, empathy, and solidarity for individuals dealing with mental health issues. By fostering connections among individuals with shared experiences, these networks contribute to a supportive social environment that counters the stigma and isolation often associated with mental health struggles.

The concept of normalisation is another important theme. The participant expresses the feeling of being 'normal' through interactions with others who understand their experiences, which highlights the significance of shared experiences in normalising mental health issues within society. By sharing their stories and finding common ground, individuals challenge stereotypes and misconceptions surrounding mental health. This normalisation creates a greater acceptance and understanding in society, reducing the stigma associated with mental health labels. Engaging with people who have experienced similar emotions, thoughts, or mindsets, empowers individuals by giving them validation and a sense of agency over their own narratives. In that sense, seeking refuge in people who share similar experiences can serve as a strategy to challenge dominant discourses surrounding mental diagnoses, and a means by which individuals can construct an identity that is distinct from discourses that may not properly represent their lived experiences. In *"Resistance and the Role of the Patient"*, Foucault talks about ways in which individuals resist, or distinguish themselves from dominant discourses and the ways in which they are categorised within society (Foucault, 1961; Foucault, 1976). Perhaps seeking refuge in people who have had similar experiences is a way in which individuals who have a mental diagnosis can distance themselves from psychiatric professionals and institutions, and is an alternative to coping with their mental diagnosis and by extension, is a way of "resisting" institutional power. In the larger social context, this contributes to a shift in societal attitudes towards mental health, showing the importance of lived experiences in shaping perceptions. As more individuals start to share their stories and support each other, the societal dialogue around mental health increases in inclusivity, which leads to positive societal change.

The next response provides insight into societal attitudes towards mental health labels, particularly regarding their overuse and misuse of everyday language and social media:

"I really dislike when people say things like "Argh I am so depressed" or "This gives me OCD", "The weather is bipolar" and so on, because the mental health label loses its proper meaning and makes it feel less serious than it is. In some way, it feels degrading almost, not to sound weird.. I just think the words have become overused, which causes them to diminish in their meaning. I also think people use the label to sound special or unique sometimes, for example on TikTok and so on. In my experience, I really dislike it. Mental diagnosis shouldn't be something that is 'cool' or 'edgy' when some people genuinely really struggle with it."

Continuing with the theme of trivialization, the participant expresses concern about the casual and often incorrect use of mental health labels in everyday conversation. This reflects a broader societal trend of trivialising mental health conditions by using diagnostic terms flippantly. The normalisation of such language contributes to a lack of understanding and seriousness surrounding mental health issues, perpetuating stigma and diminishing the experiences of those who genuinely struggle with them. The theme of Trivialisation is also notable in this quote since there is a sentiment of frustration with the devaluation of mental health labels due to their overuse and misuse. The participant perceives this as degrading, suggesting that the true severity and significance of mental health conditions are undermined when these labels are casually thrown around. This highlights a societal disregard for the impact of language on mental health discourse and suggests a need for greater awareness and sensitivity.

The next important theme is Social Media Influence. The mention of platforms like TikTok suggests an acknowledgment of the role of social media in perpetuating misconceptions about mental health. The participant observes that some individuals may use mental health labels for attention or to appear unique or 'edgy'. This theme reflects broader concerns about the influence of social media on shaping societal attitudes towards mental health, including the glamorisation or trivialization of mental health issues for online validation. Overall, there’s an implicit critique of the influence of the media and on societal attitudes towards mental health. The participant's comment about mental health terms being used for entertainment portrays the normalisation of trivialising mental health issues in mainstream media. This theme underscores the need for media literacy and responsible portrayal of mental health in popular culture to diminish harmful stereotypes.

His next response delves deeper into the issue of oversimplification of mental health conditions in societal discourse:

“I just think there's still a tendency to oversimplify mental health conditions, especially when they're used casually or inaccurately in everyday language.”

The theme of trivialisation is visible since the participant expresses concern about society’s tendency to oversimplify mental health conditions in everyday language. This theme suggests that very nuanced experiences are somewhat reduced to simplistic labels, ultimately leading to a shallow understanding of mental health issues. The oversimplification can contribute to misconceptions and trivialisation, possibly hindering important discussions and support for those affected by mental health conditions. In the participant’s response, there is a clear critique of the casual and inaccurate usage of mental health terms in everyday conversation. In essence, this theme highlights the pervasive nature of language that doesn’t accurately represent the complexities of mental health experiences. The participant's observation suggests that such casual usage contributes to a normalisation of misunderstanding and minimisation of mental health issues. Linking this to Foucault's *"Discourse and the Construction of Madness"*, he talks about how mental illness is constructed in society, and how discourses frame our understanding of mental diagnoses. Dominant institutions may disseminate to society certain perceptions of what mental illness means, but these perceptions differ from those who actually experience living with a mental disorder.

This also relates to the theme of mental health education. The participant's comment conveys broader societal norms and language habits that choose simplicity over accuracy and sensitivity when discussing mental health. This theme underscores the need for a cultural shift towards more respectful language use. Because the participant portrays an oversimplification of mental health conditions, the participant shows a deep understanding and appreciation of the complexities involved. Overall, this theme conveys the importance of raising awareness efforts to promote accurate and empathetic language use and combat stigma associated with mental health. Foucault confirms that broader discursive practices that exist, for instance on an institutional level, were firstly triggered by local and individual choices, interactions and behaviours, which eventually became considered societal norms. Foucault refers to this micro-level impact on larger societal patterns as "Microphysics of Power" *(Taylor; 2011; p.22)*. It would therefore follow that discursive practices and language habits that are performed on a local level may in fact have an impact on language habits on mental health on a macro scale. Foucualt's work suggests that discursive practices and other forms of power is not simply a top-down process, with larger institutions having sole authority over the types of discourse that are disseminated to society about mental health; Subjects themselves have the agency to resist discursive practices on mental health and replace it with language habits which tie more sensitivity to the topic. It is therefore not far-fetched or out of reach, according to Foucault, for a cultural shift to in fact occur in the kind of language used about mental diagnosis.

Lastly, when he was asked., "How would you like to see society deal with mental health labels in the future?, he responded:

"*I suppose we need to move away from using mental health terms as catchy and funny phrases. Instead, we should try to have more nuanced and empathetic conversations that recognize the complexity of individual experiences. In general I think it's about understanding, acceptance, and support rather than reducing mental health issues to pure labels. That sounded negative, I do of course recognise the importance of mental health labels, I just think they are thrown around too easily in society."*

The participants' advocacy for straying away from using mental health terms as "catchy and funny phrases" reflects a broader cultural shift in language use. Through rejecting insensitive language, the participant expresses a need for a cultural change towards a more respectful discourse on mental health, which again highlights the theme of trivialisation.

Overall, the quotes from P2 suggest that reframing language use can contribute to larger cultural shifts towards greater awareness and acceptance of mental health issues.

In our interview with P1, she states:

"The way society sees people with ADHD is changing. Before the diagnosis it was mostly men who had it but now there is more focus on women. I try to focus on my hyperfocus as a positive ability. I remember specific details like dates and time. On this exact day I know what I did last year on this date. I don't really allow myself to think of how society sees me. People in my community could be telling me 'ADHD person'. Before I saw it as a good thing but now I see it as a negative thing."

This introduces the theme of changing societal perspectives. The phrase "*The way society sees people with ADHD is changing*" conveys that there is a shift in societal perceptions of ADHD. This suggests that current attitudes are different from those in the past, indicating a transformation in awareness. The mention of ADHD being predominantly diagnosed in men, and the increasing focus on women now, shows there has been a shift in societal recognition. This reflects broader changes in how ADHD is understood across different genders, moving towards a more inclusive perspective.

Emotional Impact of the Diagnosis

Codes	**Themes**
● External pressure ● Internal pressure	Reaction to criticism
● Self doubt ● Guilt ● Loneliness	Feelings toward diagnosis
● Management of expectations ● Coping mechanisms	Reaction to diagnosis
● Tarnished accomplishments	Disappointment
● Acceptance	Hopeful result

Starting the process of a mental health diagnosis can be incredibly challenging and stressful, especially for people who get diagnosed later in life. The Young et al article provided a lot of context throughout this project, as it used a similar system to ours and has a smaller participant pool. The analysis of the emotional impact of the subjects has been very important, but it's something that oftentimes gets overlooked in research papers and it's one of the aspects that affects people the most. Before a diagnosis, the subjects would typically experience a lot of external and internal pressure to succeed and oftentimes the amount of work and stress that they would have to put into their task in comparison to neurotypical people was exponentially bigger.

This would lead to a lot of feelings of self doubt and criticism, which would affect their relationship to work down the line. When P1 says *"I wished that I would be better at decision-making. I need to buy a new coffee table but I can't do it, there are too many opportunities. It gets overwhelming so I end up not buying it"* she's talking about the struggle with making decisions and how that causes her a lot of self doubt and distress, that the inability to make the decision makes them feel overwhelmed. As subjects reported in the Fleischmann and Fleischmann article, both starting and completing tasks proved to be one of the biggest challenges to people diagnosed with ADHD later in life and that there was no obvious explanation or reason for this had caused them a lot of distress, often being blamed and called "lazy" as a result. In childhood, a lot of people with ADHD would have been considered naturally intelligent, but often criticised by their teachers when it came time to hand in homework that they were not able to accomplish, not because of laziness (like it would have been said to them), but because the task seemed insurmountable and the pressure put on them day after day of this would be too much. The weight of this was carried with the subjects throughout their lives and all accomplishments tainted with the voice in the background that would critique the time or effort something had taken when it came easy to others around them. This is something that Participants 1 and 2 talk about as well in their interview when they say "*I am afraid of how people see me and maybe think I'm stupid*". Their perceived view of how society sees her causes distress to P1 about how her condition is seen. P2 on the other hand, says: "*I tried to tell them at the start about my diagnosis, but they didn't understand the severity of it*" in the context of his family, the worry about the lack of understanding and the external judgement permeates the feelings of the participants throughout their experience.

After getting diagnosed with ADHD, the most common reaction is relief. Finally there's a reasonable explanation to why things have been happening, something to justify the external and internal comments. After their diagnosis, the participants started on their own research about the topic, often looking at people with a similar experience and understanding that there is a way forward for them and that there are tips that can help them manage their expectations and goals. P1 talks about having a coach that helps her, saying "*He gives me some answers to my problems*", demonstrating the importance of a support system, be it a professional or the feeling of community, as is the case with P2, who says: "*It created a deeper connection to them I guess, a sense of belonging, and a feeling of 'being normal'*". Through learning about experiences of other people with ADHD and depression, the research subjects were able to give themselves some space to understand themselves better and to learn more about why they struggled in the past and how to fix that in the future.

All three of our subjects have found that having a diagnosis has helped them find more tools to cope. Foucault explains this phenomenon through his theory of technologies of the self. He explains that there are four kinds of "technologies" that are used in the context of interaction with the world. The one that would most fit this situation is the fourth one which *"permits individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls…so as to transform themselves in order to attain a certain state of happiness…"* (Foucault 1988b, p18). Subjects 1 and 3 have more of a connection on the subject, since they're both women diagnosed with ADHD and that relates better to the most common research topics that come with mental health diagnostics. Both women with ADHD have a perspective on their diagnosis that differs a little from each other. The first subject does confirm that their ADHD diagnosis did have an impact on her mental health and that maybe their self worth was *"maybe a bit less"* now, implying that the fact that they now had a diagnosis of their condition made them somehow less than before. For subject 3 the opposite was the case. While both of the participants found comfort in their received diagnosis, participant 3 was clearly more comfortable with it, since she never brought up negative feelings in the context of the diagnosis. As well as that, she feels comfortable with the label and considers it a big part of her identity, saying specifically that she wouldn't change it for anything. This builds a good connection to Foucault's theories on the relationship between power and knowledge, as the participants consider the diagnosis to be a part of them, something that shapes them as people and becomes a core part of them. It could be interpreted as the participant’s need for this knowledge to be provided by a figure of authority to clearly define aspects of themselves, creating a sense of dependence on the diagnosis itself to help shape their persona. In the case of Participant 2, he said “*It makes you understand yourself more as an individual*”, having learned more about himself through his diagnosis of depression and learning to cope with it every day.

In the case of participant 2, diagnosed with depression and panic attacks, the situation is a little different. The topic of depression is more stigmatised than that of ADHD, as people consider it more of a taboo subject than other diagnoses, making it harder to talk about socially and harder to find advice on, since the topic is so stigmatised. This participant felt rather neutral about getting themselves diagnosed with depression, saying that it didn’t change much for them, saying the word itself had been so overused that it had lost its meaning. The subject did say that it had helped him in a family context, but that it’s not something he had chosen to share with his school in order to get support because there was seemingly no point. When it comes to other people, they did explain that it allows for a deeper connection with someone if they’ve also experienced it, since you no longer feel like a stranger and the feelings are relatable.

A very important factor in the emotional impact of the diagnosis is what Fleischmann and Fleischmann call the “release of guilt”. This means that the new diagnosis gives people the space that they need to not be as harsh on themselves and allow for some kindness toward themselves. Learning through others' experiences diagnosed people better understand that they’re not alone and that other people experience similar things and they manage by utilising certain techniques. This allows the subjects to focus more on “forgiveness” of themselves, realising that what they’ve struggled with most of their lives wasn’t a character flaw, it was just a part of them that was never meant to work the same way as someone else’s. Some even reach the point where they credit themselves and their diagnosis for new things they might be able to do and different ways to work outside of the “normal”. Participant 1 says ‘*‘I have done so many different things. Travelling, courses, schools, etc.*” in the context of their diagnosis, citing it as very helpful in these experiences, even if it has challenged them in other aspects of their life, like decision making or their day to day routine.

Similar to stages in grief, Young et al. talk about the different stages of acceptance of the diagnosis. The paper brings up an interesting point that we didn’t perceive through our interviews, which is the confusion that comes after the relief. The authors explain that the subjects of their interviews had to face all their feelings about their childhood alone with no support from their medical practitioners. Oftentimes, with people that get diagnosed later in life, a common feeling is the ‘‘how come no one saw this sooner? I didn’t have to struggle like this’’. This comes with a lot of frustration and anger about the past, which sometimes can be directed at caregivers, guardians or parents. In addition to the array of emotional responses, a discourse exists concerning the profound sense of regret stemming from the perceived wastage of time attributed to the difficulties accompanying diverse mental health diagnoses. This regret is compounded by a prevailing sentiment of frustration regarding the perceived insufficiency of assistance received, which could have ostensibly ameliorated the coping process. The contemplation of time lost and the absence of adequate support underscores the broader societal conversation surrounding mental health management and the imperative need for more comprehensive and accessible resources. Similar to stages in grief, Young et al. talk about the different stages of acceptance of the diagnosis. The one after sadness would be the realisation that this is something that they will have to deal with the rest of their lives, that the diagnosis helped and they knew what they were facing, but that this was only the start of a very long road to management of their diagnosis. Last step of someone’s diagnostic journey would be acceptance that this is who they are and who they’ve always been and that there is no changing that their brains work differently, just learning to live with it.

Perceptions of Self and Identity

The impact of a diagnosis on self-identity, agency and perception.

Codes	**Themes**
• Diagnosis gave more clarity on who they are and explanation for why they behave in certain ways • Viewing oneself differently after being diagnosed • Diagnosis became a big part of self-understanding	• Viewing oneself through a different lens than before being diagnosed
• Feeling more distinct from others • Shameful of diagnosis and fear of telling people • Feeling overly defined by diagnosis by others	• Identity is overly defined by diagnosis

P1 mentions that she experiences the feeling of being the other.

Participant 1: "I am more aware of the fact that there is a "them" and an "I"."

It is clear to see that P1 in some ways sees herself as an outsider, and that she is aware that she is different from some people. This implies that mental diagnosis can tend to enhance the feeling of otherness. Even P1 themselves see mental diagnoses as a taboo and they use a lot of energy on wondering what people might think of them.

Participant 1: "I see the diagnosis as a taboo, and I am afraid of how people see me and if they might think that I am stupid."

For (P1), interpersonal dynamics are characterised by power imbalances, where external influences shape her feelings of insecurity and fear. This phenomenon underscores the pervasive nature of social scrutiny, wherein individuals frequently encounter external judgments impacting their self-esteem. This evaluative process is intricate, influenced by factors including familial upbringing, environmental context, and community norms. The developmental trajectory, encompassing childhood experiences and familial validation, significantly influences one's ability to navigate social interactions and foster positive self-perceptions. Those who receive validation and acceptance from their family environment tend to exhibit heightened levels of self-assurance, while those lacking such affirmation may experience increased insecurity and reduced self-esteem.

Getting a mental diagnosis will automatically affect how you see yourself and your identity. Though, it will vary from person to person how you receive it, but it will for sure have an impact. P1 experiences a feeling of blame connected to their mental diagnosis and doubt themselves.

Participant 1: “I will always blame myself down on my ADHD and how I do things. "What is wrong with me?"”

These are feelings connected to P1’s self-worth and it will inevitably affect their identity. P1 talks about her self-worth and whether or not getting the diagnosis has helped. P1 also explains about being confused when it comes to their self-worth.

Participant 1: “My self-worth has stayed a bit the same, but I am still confused. Maybe a bit worse but still, it has only helped me getting the diagnosis.”

(P1) articulates a nuanced perspective on their self-worth, indicating a degree of stability yet acknowledging residual ambiguity. However, P1 unequivocally acknowledges the beneficial impact of receiving a mental health diagnosis. This diagnostic revelation has precipitated a transformative shift in P1's self-perception, prompting a reevaluation of their identity. Moreover, P1's perception of mental diagnoses as a whole has undergone notable evolution. They elucidate that their conceptualization of mental diagnoses has been positively refined, leading to a discernible alteration in their discourse surrounding mental health conditions compared to their predisposition prior to diagnosis.

Participant 1: "I see myself kind of different after getting the diagnosis. Before me and other people would joke about it but now I would never do that now."

This is a clear picture of how some people view mental diagnoses. P1 explains that they have experienced people joking about it and that they did as well. This is a natural reaction because humans tend to reflect themselves in others and behave in a similar way in order to fit in. A part of the self is also the understanding of who they are and their identity. P1 has had the experience of getting a larger understanding of themselves and that it had a positive effect on them.

Participant 1: "Getting the diagnosis had a positive effect on me and it gave me more understanding of myself."

Understanding oneself is an important factor when it comes to self-worth and the way you see yourself will automatically affect your identity. Getting a diagnosis will also affect your understanding of yourself. In P1's situation it has had a positive effect and it has improved her understanding of herself. When talking about psychiatric discourses it is well connected to a person's identity and in a book by Reich (2000) there is an explanation of how important psychiatric discourse are to a person's identity and how they and other people view them.

"Psychiatric discourses and their associated practices therefore can be seen to produce a person's 'subjective identity' in so far as those discourses and practices serve to transform and delimit who or what a person understands themselves to be and, importantly, who or what others understand that person to be. An important element in this process is diagnosis, commonly understood as the correct application of classification that simply 'mirrors' or corresponds to an 'objective' 'disease' or 'disorder'." (Reich, 2000, p. 38).

Once again, we observe a clear connection between identity and mental diagnosis. An individual's self-perception significantly influences their self-worth, as does the perception of others. The manner in which one views oneself is a crucial determinant of self-esteem and personal value. Equally important is the way individuals are perceived by others in their social environment. Although receiving a mental diagnosis inevitably impacts a person's identity, (P1) elucidates that she endeavours to minimise the influence of others' opinions on her self-concept. P1's perspective highlights the ongoing tension between internal self-assessment and external judgments, underscoring the complex interplay between personal identity and societal perceptions in the context of mental health.

Participant 1: "I try not to allow myself to think of how society sees me.

Receiving a mental diagnosis has given P1 a larger understanding of themselves and why they sometimes struggled when doing things. P1 expresses that they were confused about why they couldn't do things properly or why it took them a long time. Now P1 is more secure of themselves and who they are. In that way it has been positive for P1 to get the mental diagnosis and they explain about how they now motivate themselves instead of doubting themselves.

Participant 1: "Before I got my ADHD I was always wondering why I couldn't do things probably. Nothing was fully accomplished, or it took me a long time. Now I motivate myself to do stuff."

By getting the mental diagnosis P1 has gained more understanding of themselves and acceptance of who they are and how they behave. In the end of the interview P1 expresses that they want to receive more help than they are doing now.

Participant 1: "In the future I want to get more help, as much as possible."

In contrast to Participant 1 (P1), Participant 2 (P2) delineates a contrasting viewpoint regarding the necessity for additional assistance, particularly in academic assessments such as examinations.

Participant 2: "I don't feel the need to get extra time on exams for example."

Depending on who you are you will naturally experience having a mental diagnosis differently and you might not want the same things. You deal with it in different ways as well and P2 has a different view on getting help than P1 has. P2 has had a more neutral way of receiving their mental diagnosis and neither sees it as a negative or a positive thing.

Participant 2: "I don't know. I was neutral about it. It didn't affect me either negatively or positive, and it didn't give me clarity."

Unfortunately, the process of receiving a mental diagnosis does not universally lead to increased clarity or profound self-understanding. While P1 found that the diagnosis facilitated a deeper understanding of themselves, P2 presents a different perspective. P2 acknowledges that the diagnosis made sense to them, but it did not significantly broaden their understanding of their own identity.

Participant 2: "and then I got told this is what it is, "depression", which makes sense, but not because I understood more about myself."

Getting the diagnosis made sense for P2 maybe because they already knew a lot about depression and about themselves. P2 looks at mental diagnosis in a different way than P1 and they don't see it as a label but more as a way of defining yourself.

Participant 2: "No. I haven't thought of it as a "label". All the terms in relation to mental health, adhd, ocd etc, are more a way of defining how you are as a person."

P3 sees a mental diagnosis as a way of finding out more about yourself but expresses that they don't identify completely with depression.

Participant 2: "A part of me, yes. I don't identify myself completely with the label, because it is such a broad term, and you can't put yourself in a box. But it still somehow tells you something about yourself."

During the interview, P3 mentioned how they felt marginalised and distinct from others during their schooling years prior to being diagnosed with ADHD, partly because teachers always alluded to their lack of conformity with educational norms and behaviour expected of students.

Participant 3: *"Everyone around me did well in school but I never really managed, I felt stupid and actually useless sometimes. While everyone else paid attention in class, for me it was a struggle to understand anything at all."*

Participant 3: *"People such as teachers always deemed me as lazy and stupid, when in reality I just didn't know what to do or where to begin."*

These quotations underscore the constriction of individual autonomy within the educational milieu and suggest a disciplinary approach adopted by authoritative figures, notably educators, towards their subjects. According to Foucault, power and disciplinary policies are practised on subjects so that they can be *"subjected, used, transformed, and improved" (Bunton, 1998; p.114)*. Foucault terms this behavioural regulation of individuals the *"Anatomo-politics of the human body"*, which refers to the goal of institutions to maximise the docility and usefulness of individuals, which in turn increases individuals' productivity in domains such as economic and social life (*ibid; p.115-116)*. To achieve this, disciplinary power must permeate institutions that the subject is involved with such as schools. Disciplinary power in schools manifests itself by having authority figures watch, examine, record, and assess the behaviour of students, and the aim of this is for subjects to reach their full potential in productivity which prepares them for the high demands expected of them from other institutions such as the workforce. The behaviour of subjects is regulated to the point where it is predictable and synchronised to other subjects (*Taylor, 2011; p.133)*. From a Foucaudian perspective, therefore, signs of atypical behaviour or lack of compliance by students with educational norms are dismissed as unproductive. Moreover, these statements made by the participant insinuate that schooling employs a standard and universal method of teaching that it expects all students to adhere to, which not doing so prompts criticism and being deemed incompetent, rather than tailoring educational methods to the individual needs of students.

Furthermore, P3 expressed how being diagnosed facilitated a better understanding of themself, which alludes to medical institutions' influence over individuals.

Participant 3: *"I got a lot more understanding of why I am the way I am, and why I react the way I do."*

Foucault speaks extensively of how biopower prevails over medical institutions, in that they have the authority to govern and manage individuals' lives, deaths, and health (*O'Farrell; 2012; p.106)*. The psychiatric practice of diagnosing is one form of biopower, which aims at classifying behaviours of individuals as normal or abnormal while normalising or regulating other behaviours considered desirable. This practice of labelling behaviour facilitates the creation of an identity that encompasses that label, and, as the participant claims, aids in creating a better *"understanding of why I am the way that I am"*. This demonstrates the power that psychiatric institutions possess, in that the knowledge they disseminate and labels they assign to individuals are internalised by subjects and acts as a lens through which they understand themselves.

This excerpt also echoes Foucault's correlation between power and knowledge. Foucault posits that systems of knowledge production are contingent upon power networks, implying that power dynamics play a pivotal role in shaping the creation and distribution of knowledge. Simultaneously, networks of power produce certain types of knowledge (*ibid; p.102)*. Using this line of reasoning, the knowledge that the participant gained about themself from being diagnosed demonstrates a power dynamic between subjects and medical institutions, in that the improved self-understanding that came with being diagnosed shows the participant's dependency on the knowledge provided by psychiatric institutions.

Contrary to the positive experience that P3 has with psychiatric institutions and their practice of diagnosing, they spoke quite negatively of the impact that medication has had on their conception of subjectivity.

Participant 3:*"I felt like I lost parts of myself while being medicated so in the end it wasn't worth it for me."*

Interpreting this through Foucault's theory of biopower, this statement highlights the experience that the participant has had with institutions' exertion of power over their mind and body. The participant's statement suggests that there is a misalignment between their own understanding of themself and their medicated self that was imposed on them by psychiatric institutions. Moreover, this statement captures the impact that disciplinary power has on subjects. Institutions aim at disciplining subjects by controlling their behaviour and aptitudes and improving their capacities in certain domains (*O' Farrell; 2012, p.103)* . In this participant's case, the medication prescribed to them serves as a disciplinary technology which regulates and normalises certain behaviours which institutions consider desirable. The participants' remark that they feel that they have "lost parts" of themself while being medicated suggests that there is a lack of concurrence between the self that has been constructed by technologies of disciplinary power and their authentic sense of self.

Social Interactions and Relationships

The influence of the diagnosis on their relationships with family and friends, as well as their decisions around the disclosure of their medical condition.

Codes	**Themes**
● Comfort in talking to people who can relate	● Comfort in people who relate
● A sense of belonging	● A sense of community and belonging
● Feeling more understood by other people when receiving a diagnosis.	● To be understood in a group of friends or family

Participant 1. *"My friends have received the fact that I have a diagnosis in a good way."*

In this extracted quote from the interview, P1 talks about how her friends have received and understood the fact that she has a diagnosis in a good way.

Participant 2: *"I feel the best thing for my diagnosis is to talk to someone who has been through it themselves or can understand."*

Participant 2: *"It created a deeper connection to them I guess, a sense of belonging, and a feeling of 'being normal'."*

Participant 2 talks about how it felt best for him to talk to someone who has been in a similar situation themself, someone who can relate. He goes on to say that he felt like it created a deeper connection to them with a sense of belonging. With this sense of belonging came a feeling of *'being normal'*. Being part of a community or having people around you experiencing similar things can make it easier to talk about. The theme here is a sense of community and belonging.

Participant 2: *"The label also connects me to others in society, which can be a powerful thing. It reminds me that I'm not alone and that others feel this way too"*

Participant 2 was asked if he thinks it is a good feeling to learn something about himself, to which he responded *"The label also connects me to others in society, which can be a powerful thing. It reminds me that I'm not alone and that others feel this way too"*. This shows that P2 believes that by being diagnosed it is easier to connect to other people in society, and that this ability holds power. P2 ends this part of his interview by saying that having this ability and power reminds him that he is not alone, there are others who feel the same way. The theme is comfort in people who can relate.

Participant 3: *"Other people have more understanding as well. I have many good friends around me who understand me good, and who take it into consideration that I might have a different range of emotions and feelings than they have"*

Participant 3 was asked what was positive for her about being diagnosed. Amongst other things she talks about how people around her had more understanding once she told them she had a diagnosis. She got a lot more understanding as to why she is the way she is and why she reacts the way she reacts. She says she had many good friends surrounding her who would take her diagnosis into consideration, such as the fact that she might have a different range of emotions and feelings than they have. The theme here is to be understood in a group of friends or family.

Role of institutions in shaping the self

Codes	Themes
● Feeling academically incompetent	● Feeling excluded and distinct from other people
● Frustration about why they behave differently than other people (prior to diagnosis)	● Positive outlook on psychiatric institutions; i.e, the information they provide on mental diagnoses and their practice of diagnosing
● Really feeling the “presence” of one’s diagnosis in a school climate	
● Feeling that school doesn’t accommodate people with mental diagnoses	
● Feeling very supported by psychiatric professionals	

● Feeling more validated as more people are being diagnosed	
● Feeling that there is plenty of information/material about mental diagnoses that can better help people understand it	

The influence of institutional behaviour towards mental diagnosis:

Institutions play a crucial role in shaping individual identities and experiences, particularly concerning mental health diagnoses. This analysis examines how institutional settings, such as universities and healthcare providers, influence individuals' perceptions and management of their mental health conditions. By applying Foucault's concepts of biopower and governmentality, this study explores participants' experiences to understand the broader implications of mental health labelling within institutional contexts.

University and Structure

The participant underscores the university's role in providing a structured environment that significantly contributes to their comfort. They express appreciation for the organised framework the university offers, suggesting that institutional structures can positively impact individuals by offering stability and support. This observation aligns with Foucault's notion of governmentality, wherein institutions govern individuals' behaviour by establishing norms and routines that facilitate the management of their lives.

Participant 1: "*I realised that it helps me to have the structure that the university gives me*."

The structured environment provided by the university not only supports the participant's academic ambitions but also fosters their personal development. This illustrates the significant impact of the institution in shaping individuals' self-concept, indicating how a well-structured framework can improve overall comfort. By offering a reliable and predictable structure, the university creates a conducive environment for personal and intellectual growth, which is particularly beneficial for individuals navigating the complexities of young adulthood.

Institutional Support and Labelling

The participant’s interactions with healthcare and educational institutions reveal a nuanced perspective on mental health labelling. They acknowledge the potential benefits of a formal diagnosis, which can facilitate access to necessary resources and accommodations. However, they also report limited experiences with institutional support, primarily due to the recency of their condition. This duality underscores the importance of timely and consistent institutional interventions in mental health care.

Participant 1: "*I wished that my primary school and high school would have more focus on it.*"

The absence of adequate institutional support in earlier educational settings highlights a significant gap in addressing mental health needs during formative years. This lack of focus on mental health in primary and secondary education deprived the participant of essential coping mechanisms and resources that could have mitigated the challenges associated with their condition. The participant’s reflections indicate that earlier and more robust institutional support could have provided a foundation for better mental health management, emphasising the critical role that educational institutions play in early mental health intervention.

The participant's experiences serve as a compelling case for the integration of structured mental health support within educational institutions. By offering a stable and supportive environment, universities can facilitate not only academic success but also holistic personal development. The reflections on primary and secondary education reveal the long-term benefits of early mental health interventions, highlighting the necessity for educational policies that prioritise mental health awareness and resources from a young age.

In summary, the participant's narrative underscores the critical impact of institutional structures on mental health. The university's role in providing stability and support is a testament to the positive influence that organised frameworks can have on individual comfort. At the same time, the lack of sufficient mental health focus in earlier educational settings points to a significant area for improvement. This discussion emphasizes the importance of a cohesive and comprehensive approach to mental health across all stages of education, advocating for policies and practices that support the mental health needs of students throughout their academic journeys.

Professional Support and Stigma

Despite limited institutional intervention, the participant has received significant support from a personal coach who provides practical tools and insights. This individualised support highlights the importance of tailored interventions beyond conventional institutional frameworks. However, the participant’s neutral stance on mental health diagnoses and their reluctance to disclose their condition to the university reflect concerns about potential stigma and misunderstanding.

Participant 2: "There are no advantages in telling people. I don't feel the need to get extra time on exams, for example."

This sentiment reflects a broader societal issue where mental health conditions are often trivialised or misunderstood, leading individuals to conceal their diagnoses to avoid negative repercussions.

Future Aspirations and Institutional Interaction

Looking ahead, the participant plans to seek increased institutional support, particularly within academic settings, to enhance their educational outcomes. Their readiness to engage with private psychiatric services further exemplifies a proactive approach to managing their condition, despite initial reservations concerning institutional labels.

Participant 1: "In the future, I want to get more help, as much as possible. 'Why not?'"

This proactive stance resonates with Foucault's notion of biopower, where individuals navigate institutional systems to optimise their health and well-being, despite the constraints and opportunities these systems present.

The participant's experiences highlight the complex interplay between institutional behaviour and individual identity formation concerning mental health. While institutions like universities and healthcare providers can offer essential support structures, the stigma associated with mental health diagnoses often complicates these interactions. Foucault's concepts of biopower and governmentality provide a valuable framework for understanding these dynamics, underscoring the need for institutions to adopt more inclusive and supportive practices to genuinely benefit individuals with mental health conditions.

Discussion

This discussion seeks to elucidate the nuanced insights derived from semi-structured interviews, which offer a rich tapestry of subjective experiences and theoretical frameworks that illuminate these narratives. Central to this discussion is the Subjectivity and Learning dimension, which underscores the deeply personal nature of mental health experiences and the intricate ways in which individuals internalise and respond to their diagnoses.

By examining the subjective experiences and narratives of individuals, we can attain a more comprehensive understanding of the profound impact that clinical labels exert on their identities and lives. The semi-structured interviews serve as an essential methodological tool, enabling participants to articulate their experiences and perspectives in their own words. This methodological approach not only enriches our understanding of mental health but also fosters a deeper appreciation for the diversity of human experiences and the unique strategies individuals employ to navigate and interpret their diagnoses.

The theoretical frameworks employed in this study provide a critical lens through which the data can be analysed. These frameworks facilitate the contextualization of personal narratives within broader social, political, and ethical dimensions, revealing that mental health diagnoses are not merely medical categorizations but are imbued with significant societal implications. The interplay between personal narratives and theoretical insights underscores the importance of considering the socio-political context in which mental health diagnoses are made and experienced. Such an approach allows for a holistic understanding of mental health that transcends the confines of clinical practice, integrating the societal structures and power dynamics that shape and are shaped by these diagnoses.

Connecting personal narratives to broader theoretical constructs permits a multifaceted examination of the implications of mental health diagnoses. This approach highlights the importance of understanding mental health not only through the lens of clinical practice but also in relation to the societal structures and power dynamics that influence and are influenced by these diagnoses. Through this comprehensive analysis, we gain a deeper appreciation of the complex and diverse ways in which individuals navigate their mental health journeys, ultimately contributing to a more nuanced and empathetic understanding of mental health in society.

The Text and Sign dimension serves as a pivotal analytical tool for decoding the language embedded within mental health narratives. Through thematic analysis of interview transcripts, researchers unveil the underlying codes and linguistic constructs that shape individuals' experiences. By exploring both visible and non-visible signs within the interviews, the study transcends conventional diagnostic labels, offering a holistic portrayal of the emotional, social, and personal dimensions of mental health. This analytical approach reveals the deep-seated meanings and interpretations that individuals attach to their diagnoses and the language they use to describe their mental health experiences.

Drawing upon Foucault's theoretical framework, the discussion delves into the power dynamics and discursive practices that underpin mental health diagnoses. By interrogating the role of institutions in shaping individual subjectivities and perpetuating societal norms, researchers illuminate the complexities of navigating mental health within institutional contexts. Foucault's emphasis on resistance and agency further elucidates participants' efforts to reclaim autonomy over their identities and challenge dominant psychiatric discourses. This theoretical lens provides a critical perspective on the intersection of personal agency and institutional power in the realm of mental health.

Thematic analysis reveals the emotional, social, and institutional dimensions of mental health experiences, offering a comprehensive exploration of participants' narratives. From the emotional impact of diagnoses to societal attitudes towards mental health labels, the analysis underscores the intricate interplay between personal experiences and broader societal constructs. Integrating Foucault's concepts enriches the analysis by providing theoretical insights into the power dynamics and discursive formations that shape mental health discourses. This integration allows for a deeper understanding of the ways in which societal power structures influence individual experiences of mental health.

Employing qualitative research methodologies has facilitated a nuanced exploration of mental health diagnoses. By engaging with specific theoretical frameworks, participants' subjective experiences, and linguistic constructs, the study contributes to a deeper understanding of how young adults navigate their mental health within societal contexts. Through meticulous attention to methodology and analysis, researchers illuminate the complexities inherent in mental health experiences, advocating for empathy, awareness, and support within society. This comprehensive approach underscores the importance of considering the broader social and political contexts in which mental health diagnoses occur, ultimately contributing to a more informed and compassionate societal response to mental health issues.

Limitations

While semi-structured interviews and the utilisation of a qualitative research approach offer a nuanced assessment of individuals' experiences, they are not without limitations. These methodologies afford a comprehensive exploration of subjective perspectives, yet their application necessitates an acknowledgment of inherent constraints.

Firstly, participant bias may have impacted the content of the interviews. Given that this project delves into a very personal and sensitive subject, participants may not have been fully transparent about their experiences with receiving a mental diagnosis, and the impact it has had on various aspects of their lives. Furthermore, it is imperative to acknowledge that participants might have selectively disclosed information during the interviews, guided by social desirability and perceptions of what is acceptable or expected by the researchers. This phenomenon underscores the complexity of participant bias, wherein individuals may consciously or unconsciously present themselves in a favourable light or filter their responses based on social norms and expectations. Additionally, the retrospective nature of recalling events and experiences from earlier stages of their lives introduces the potential for memory distortion or inaccuracies, further complicating the reliability and validity of the data obtained. Thus, it becomes essential for researchers to critically evaluate and triangulate the information gathered from interviews with other sources or methodologies to mitigate the impact of participant bias and enhance the trustworthiness of the findings. Moreover, selective memory may have also played a role in what the participants expressed during the interviews. For instance, participants may have only been able to recall events that were negative, despite also having had many positive experiences with being diagnosed. With memory serving as a possible hindrance, this may have limited the level of comprehensiveness and detail that went into their answers. For instance, participants may have only mentioned events that they have vague memories of, and so their narratives of those events lack detail and full clarity. This in turn affects the quality and depth of the analysis of that statement. Another issue which needs to be taken into account is that the interviews are conducted in another language than their native language, which may have made it more difficult for participants to express themselves.

Another limitation of the study is the fact that it is difficult to generalise the results due to the small participant pool. This makes it difficult to extrapolate what was claimed in the interviews and inductively argue that the participants' individual experiences are representative of other's experiences with those same mental diagnoses. This limit in the representativeness of the sample can be attributed to the sample's lack of diversity in cultural backgrounds and the limited amount of mental diagnoses we worked with. The participants' experiences may therefore not be representative of the broader population of people with mental diagnoses.

Researcher bias may also be a concern when conducting qualitative research such as this. It must be accounted for that many of the researchers who underwent this study have themselves been diagnosed with mental disorders, which may serve as a bias when conducting research within this field. The researchers' personal beliefs, experiences and cultural backgrounds may have framed the direction that was taken with the semistructured interviews and how certain questions were chosen to be framed. This in turn may have framed the answers given by participants in a way that aligns more with the biases of the researchers. The potential for researcher bias to impact the analysis is important to consider, given that the researchers' subjective viewpoints or prior encounters with mental diagnoses may have shaped the selection and interpretation of interview content. On the other hand, the biases that come with the researchers having been diagnosed may have also facilitated greater nuance to the analysis, as it can allow for unique insights and an enhanced ability to recognise themes which may have otherwise been overlooked.

Another limitation that may have affected the quality of the research is the lack of control of variables when conducting the interviews. The interviews were conducted in different settings at different times, which may have affected other factors such as the mood of the participants at that time and in turn, the answers they gave. This variety of settings that the interviews were conducted in may partly account for the variation in responses given.

Conclusion

Conclusively, the process of receiving a mental health diagnosis is personal and subjective, shaped by the unique perspectives and of each individual participant.

Firstly, our findings convey critical themes revolving around the perception and communication of mental health labels in contemporary society. One significant concern is the overuse of terms like "depression," which portrays the theme of trivialisation. Casual usage dilutes the seriousness and specificity of mental health conditions. This trivialisation causes a lack of empathy from those who have not experienced mental health issues, causing an empathy gap that affects interpersonal relationships and societal attitudes.
There was also a clear frustration with the misuse of mental health labels specifically on social media, which points to the broader societal issue of how these platforms can generate misconceptions of mental health conditions. This reflects the need for greater media literacy and responsible portrayal of mental health to eliminate harmful stereotypes and create a more accurate discourse.

Furthermore, participants' narratives show the emotional impact of navigating life with a mental health condition. They highlighted the need for greater empathy and understanding from institutions and society. There is a clear need for supportive networks, whether through professional coaching or community connections because they provide validation and a sense of belonging in a world often marked by stigma and misunderstanding.

In addition, the thoughts of the participants about their relationships and decisions related to sharing information convey the important role of institutions such as universities and healthcare providers. There is still a critical need for more inclusive practices and greater awareness of the intricacies surrounding mental health.

Foucault's insights into power dynamics and knowledge production offer a way of understanding the institutional and societal forces at play in the diagnosis and management of mental health conditions. Through creating more informed discourse, society can work towards reducing stigma and generating a supportive environment for individuals living with mental health diagnoses.

Overall, our research highlights the transformative potential of empathy, education, and community in changing societal attitudes towards mental health. Through collective efforts to promote understanding and inclusivity, individuals can become stronger at navigating their mental health journeys with resilience.

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Appendix

1: Interview: 23 year old female ADHD

- Individual: “Can you tell me about your journey with your mental health diagnosis? How has it affected you and how you see yourself?"

Before I got my ADHD I was always wondering why I couldn't do things probably. Nothing was fully accomplished or it took me a long time. Now I have many tools to manage it and now I want to finish something. When I was a child I always doubted myself. Why I couldn't finish stuff, such as homework. I still have noise in my head but it has helped me to know that I have ADHD. I would hyperfocus on why I couldn't get it done. I'm getting better at doing things and I will go into autopilot mode but it can also stress me. Sometimes if I take a walk, I can completely forget it afterwards. I was completely on autopilot.

If I have a plan to clean my room and then I go on autopilot mode again and then I forget things. It's like it isn't me that is doing the things. So, if I do things, like eating, I'm like "I didn't do the things' '. Getting the diagnosis had a positive effect on me and it gave me more understanding of myself. I wish that people would have told me that maybe it had something. But it gave me some insight and I was like "now I get it". I see myself kind of different after getting the diagnosis. Before me and other people would joke about it but now I would never do that now.

I see the diagnosis as a taboo and I am afraid of how people see me. Everything makes more sense. The tools are helping me but it has also been hard getting the diagnosis. Now I recognise the things I do. I have my own voice in my head and if I hear music I focus on the lyrics and it makes me calm. My ADHD can stop when I am with people and if I'm listening to something interesting.

My friends have received the fact that I have a diagnosis in a good way.

- In what ways has the acknowledgment of a mental health diagnosis influenced your feelings of self-worth and confidence?

My self-worth has stayed a bit the same but I am still confused. Maybe a bit worse but still, it has only helped me getting the diagnosis. All the tools I've gotten have helped me a lot. I have been researching it and reading books about it. I am more aware of the fact that there is a "them" and an "I". "How can no one ever tell me about this".

- Can you provide examples of moments where being identified with a mental health diagnosis has either empowered or challenged your agency to make decisions and assert control over your own life?

I have done so many different things. Travelling, courses, schools, etc. I wished that I would be better at decision-making. I need to buy a new coffee table but I can't do it, there are too many opportunities. It gets overwhelming so I end up not buying it. Someone has to make the decision for me.

- University:

I'm interested in how different people are and I have recently realised that it isn't cruel to ask questions about people's private life. People are so different.
I also want a master's degree but I don't know where. "One day at a time". I am very glad for the university and course. I realised that it helps me to have the structure that the university gives me.

- Societal: “From your perspective, how does society's perception of individuals labelled with a specific mental health condition affect you? Have you faced any stereotypes or discrimination because of this label?"

I am afraid of how people see me and maybe think I'm stupid. I motivate myself to do stuff. The way society sees people with ADHD is changing. Before the diagnosis it was mostly men who had it but now there is more focus on women. I try to focus on my hyperfocus as a positive ability. I remember specific details like dates and time. On this exact day I know what I did last year on this date. I don't really allow myself to think of how society sees me.

People in my community could be telling me "ADHD person". Before I saw it as a good thing but now I see it as a negative thing.

I haven't faced any stereotypes because of the label and for many people they think it makes sense. I've never been aggressive or anything but I just had a hard time focusing. I wish that there would be more focus on women having ADHD.

- Institutional: “Within institutions such as healthcare providers or school, how has being to be labelled with a mental health condition influenced the support you've received? Can you recall times when this label has been helpful or limiting in accessing resources or understanding?"

It is so new so I haven't experienced anything with institutions. I wished that my primary school and high school would have more focus on it. I have a coach that guides me and gives me insight to which tools I can use to manage it.

My opinion on mental health diagnosis is very neutral.

Because I don't have the diagnosis I haven't experienced missing out on anything. I will always blame myself down on my ADHD and how I do things. "What is wrong with me?"
I wouldn't be able to have a job where I sit down, it scares me.

Most people talk about it in a good way and I don't have a problem with people being honest. More and more people are being diagnosed, so it gets more normal now.

I have received a lot of support from professionals. My coach is pretty spiritual and he starts talking about how people behave which I really like. I don't like when people ask me "Is there something you want to talk about today?" He gives me some answers to my problems.

- Plans for the future

In the future I want to get more help, as much as possible. "Why not?" I would like to get a better outcome. I would like to get more time for the exams and therefore I'm going to talk to the university. I am getting private psychiatrist hospitals which I pay for. I've been there five times now and know that I already think it's been too long. They don't want to give me a wrong diagnosis and the wrong help. Maybe you have to get the diagnosis but you can get that in the private hospital.

2: Interview with a 25 year old male studying medicinal chemistry at Copenhagen University.

Diagnosis: Depression (with panic attacks).

Can you tell me about your journey with diagnosis?

I got a diagnosis two years ago, so i havent had it as long as other people that I know. I guess where it affects me the most is in terms of school, because sometimes it's hard for me to focus, I zone out, and I am not fully present.

Does your school know about your diagnosis?

No. There are no advantages in telling people. I don't feel the need to get extra time on exams for example.

Getting the diagnosis, did that make you feel a certain way?

I don’t know. I was neutral about it. It didn't affect me either negatively or positive, and it didn't give me clarity. I guess the term depression has been so widely used that the word kind of lost its meaning.

What do you mean?

I guess it's not something I've thought about a lot in my life, it was just suddenly there, and then I got told this is what it is, “depression”, which makes sense, but not because I understood more about myself.

I would definitely say it has affected me though in terms of my personal life. Especially with my parents. I feel like it was hard at the start to know what was going on and to tell them properly . I didn’t know how to explain it. This sometimes led to discomfort or awkwardness.

Why did it matter to explain it properly?

I guess I feared they would misunderstand me. That they wouldn't see it as a big deal. I was worried they would be like “well why don't you just do this or that?. I feared they would neglect it. They are from a different time, where mental health issues were looked at differently. But even my brother I felt wouldnt understand it, who isn't that much older than me. I tried to tell them at the start about my diagnosis, but they didn’t understand the severity of it. I guess the diagnosis label doesn't mean the same to them as it does to me.

So for you it's hard with the label in terms of people not properly understanding?

I just think some people don't take it seriously in society. But that also makes sense, because if people haven't experienced it for themselves, then how can they know what you mean?

Is there a change you wish to see in society?

People could read up on it and try to understand it. But for me, I feel the best thing for my diagnosis is to talk to someone who has been through it themselves or can understand.

What was nice about talking to people who have been through it?

It created a deeper connection to them I guess, a sense of belonging, and a feeling of ‘being normal’.

Have you ever felt bad about yourself? Because of the label?

No. I haven't thought of it as a “label”. All the terms in relation to mental health, adhd, ocd etc, is more a way of defining how you are as a person.

Do you think it defines how you are as a person?

A part of me, yes. I don't identify myself completely with the label, because it is such a broad term, and you can’t put yourself in a box. But it still somehow tells you something about yourself.

Can you elaborate?

My experiences with depression or anxiety have influenced my thoughts and emotions to some extent. They've shaped the way I navigate the world and interact with others. So, in that sense, the label reflects a part of my lived experience and adds to my self-understanding. But I am more than any single label or diagnosis for example my interests, values, relationships, and life experiences. I don't think we should let any label define us entirely, since we are always evolving and growing and identity is more fluid than a single label.

Is it a good feeling to learn something about yourself?

Yes. It makes you understand yourself more as an individual. In that way, it gives some sort of clarity. The label also connects me to others in society, which can be a powerful thing. It reminds me that I am not alone and that others feel this way too.

What do you think about the terms people use regarding mental health?

I really dislike when people say things like “Argh I am so depressed” or “This gives me OCD”, “The weather is bipolar” and so on, because the mental health label loses its proper meaning and makes it feel less serious than it is. In some way, it feels degrading almost, not to sound weird.. I just think the words have become overused, which causes them to diminish in their meaning. I also think people use the label to sound special or unique sometimes, for example on tik tok and so on. In my experience, I really dislike it. Mental diagnosis shouldn't be something that is ‘cool’ or ‘edgy’ when some people genuinely really struggle with it.

Can you elaborate?

I just think there's still a tendency to oversimplify mental health conditions, especially when they're used casually or inaccurately in everyday language.

Are mental health labels good or bad then?

It can be both. I don’t think you can put people in boxes, since everyone has a different experience. Like you cannot say, “This is how you are and that's that”.

Why not?

It can be too general sometimes and it is not that simple. I think people are more intricate than a label, and are all intrinsically different.

So labels don't represent the full human experience?

While labels like "depression" or "anxiety" can say certain things about our mental and emotional states, they don’t capture the whole story of our lived experiences. I think It's important to remember that a label doesn't define completely who we are as individuals.

How would you like to see society deal with mental health labels in the future?

I suppose we need to move away from using mental health terms as catchy and funny phrases. Instead, we should try to have more nuanced and empathetic conversations that recognize the complexity of individual experiences. In general I think it's about understanding, acceptance, and support rather than reducing mental health issues to pure labels. That sounded negative, I do of course recognise the importance of mental health labels, I just think they are thrown around too easily in society.

3: Adhd interview transcribed - female 21 years old

Can you tell me about your journey with the diagnosis?
I figured out I had ADHD quite late, I was around 16 years old. Before this I always thought it was very frustrating to feel all these different emotions that it seemed like people around me didn't feel. Everyone around me did good in school but I never really managed, I felt stupid and actually useless sometimes. While everyone else paid attention in class, for me it was a struggle to understand anything at all. In second year of highschool I was diagnosed with adhd and I felt relieved. It felt like it made sense why school perhaps was a bit harder for me than other people.

I started medication after getting the diagnosis. I tried different ones a while but never really felt like anything worked that well, I felt like I lost parts of me while being medicated so at the end it wasn't worth it for me.

Something I feel really strongly about are all my different emotions. The strong emotions one might get from adhd have both positive and negative sides to it. When I'm happy, I'm so happy and grateful and nothing can ruin my mood or my day. However when I'm sad, everything seems so dark and terrible. I can fall far down before I feel like I can pick myself up again, this can last hours and it can last days.

What was positive for me about being diagnosed:
I got a lot more understanding of why I am the way I am, and why I react the way I do. This made it easier for me to work on myself.

Other people have more understanding as well. I have many good friends around me who understand me well, and who take it into consideration that I might have a different range of emotions and feelings than they have.

People such as teachers always deemed me as lazy and stupid, when in reality I just didn’t know what to do or where to begin, being diagnosed helped my own and others' understanding of me in general, which made life a lot easier.

Would you say being diagnosed was a good thing for you?
My life became a lot easier after being diagnosed, so I would definitely say it was a good thing for me. At the end of the day adhd is a big part of who I am and it makes me who I am, and I wouldn’t trade that for anything. I like my strong feelings as it is who I am. Being diagnosed has only improved the quality of my life because now it makes sense when I react differently from people around me or when I don’t understand certain things.

Also, making decisions in my future is easier now because now I know that things like school and studies maybe aren't for me and I can try other things that I know will be a better fit for me.

What do you think about the terms people use regarding mental health?
I don't think we should just throw terms out there and misuse them, but when they are used properly and in settings they are meant for I think it can be very helpful and enlightening. It might make people understand you more.