

The Instrument Is Not the Identity

Every new diagnostic instrument produces the same cultural backlash. From Laennec's stethoscope to TikTok, the argument is historically consistent. The condition always existed before the instrument found it.

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I.

In 1816, René Laennec rolled a sheet of paper into a tube and pressed it against a patient's chest.

His colleagues called it ridiculous.

"He that hath ears to hear, let him use his ears and not a stick of paper," one reportedly wrote.

They were not wrong that something had changed. They were wrong about what it meant.

The stethoscope did not create heart disease. It made heart disease visible in a way it had not been before. The number of diagnoses rose. The number of patients rose. The debate about whether doctors were finding too much rose with it.

That debate has never stopped.

It just keeps finding new instruments to be about.

II.

In 1902, a British pediatrician named George Still stood before the Royal College of Physicians in London and described forty-three children he had studied at King's College Hospital.

They had serious problems with sustained attention. They were defiant, resistant to discipline, emotionally volatile. They could not learn from consequences in the way other children could. Their intellect was intact. Their behavior was not.

Still called it an abnormal defect of moral control.

He did not mean they were bad children. He meant that something in the mechanism of self-regulation was not working the way it should. He even proposed a biological basis — a neurological difference, not a character flaw.

His colleagues heard the moral language and drew the obvious conclusion.

These were difficult children from bad homes, or weak families, or insufficient discipline. The instrument Still was using — careful clinical observation across dozens of cases — was not yet trusted enough to override the simpler explanation.

But notice what happened to the children in that room.

The instrument said: something is different in how this child's attention works.

The culture heard: this child has a defective character.

The diagnosis became an identity before it became a tool. And the identity was wrong.

The children existed. The condition existed. The name was wrong, the framing was wrong, and the understanding would take another century to arrive.

But the forty-three children were real.

III.

In 1937, a physician named Charles Bradley gave a group of children at the Emma Pendleton Bradley Home in Rhode Island a drug called Benzedrine.

He was not trying to treat their behavior.

He was trying to relieve headaches caused by a diagnostic procedure.

It did not work for the headaches.

Something else happened instead. The children's behavior changed. Their attention improved. Their school performance improved. Teachers noticed. Parents noticed. Bradley noticed.

He published his findings the same year in the American Journal of Psychiatry. Thirty children. Documented improvement in fourteen of them across academic performance and behavior. Careful, methodical, published in a peer-reviewed journal.

His colleagues ignored it for nearly two decades.

Not because the findings were wrong. Because the instrument — stimulant medication improving children's cognition and behavior — did not fit the existing frame. The idea that a drug could reach into a child's attention and reorganize it was too strange, too chemical, too reductive.

There was also something else. If the condition was a character defect — a moral failing, a family problem — then a pill could not fix it. A pill that worked meant the condition was biological. And a biological condition meant the children had not been failing morally. They had been failing to receive the right instrument.

That was uncomfortable.

Bradley died in 1961. He did not live to see methylphenidate become the most prescribed drug in child psychiatry.

The children he treated in 1937 were real.

The effect was real.

The world was not ready to read it yet.

IV.

In 1980, the American Psychiatric Association published the third edition of the Diagnostic and Statistical Manual of Mental Disorders.

DSM-III was a rupture.

The previous editions had been built on psychoanalytic theory — diagnoses derived from presumed causes, internal conflicts, developmental histories. DSM-III threw that out. It replaced theory with observation. Symptoms. Duration. Frequency. Impairment. Criteria you could check against a patient sitting in front of you.

For the first time, a child's inability to sustain attention had a name with operational criteria attached to it.

ADD. Attention Deficit Disorder.

It was not a new condition. George Still had described it in 1902. Charles Bradley had treated it in 1937. Researchers had been studying it under various names — minimal brain dysfunction, hyperkinetic reaction of childhood — for decades.

What DSM-III gave it was legibility.

A doctor in Copenhagen and a doctor in Chicago could now look at the same child and apply the same criteria and reach the same conclusion.

That is not overdiagnosis.

That is what a diagnostic instrument is supposed to do.

Ritalin prescriptions in the United States stood at approximately 400,000 in 1980.

The debate about whether that number was too high began almost immediately.

V.

By 1995, Ritalin prescriptions in the United States had risen from 400,000 to 2.6 million.

The press called it the Ritalin Wars.

Congressional hearings were held. Investigative documentaries were produced. Parent groups mobilized on both sides. Academics wrote books. Lawyers filed lawsuits. The phrase "drugging our children" entered the cultural vocabulary and did not leave.

The argument against was intuitive and powerful: something had gone wrong. A condition that affected perhaps three to five percent of children was suddenly being diagnosed everywhere. The pharmaceutical industry had a financial interest in the expansion. Parents were being pressured by schools. Doctors were writing prescriptions too quickly. Normal childhood behavior was being pathologized.

These were not unreasonable concerns.

But underneath the debate was a quieter question that rarely got asked: what exactly did it mean to be a child with ADHD?

The boy in the Ritalin ad — blurred with hyperactivity in the before image, tranquil and reading on a sofa in the after — was not being described as someone using a tool. He was being described as someone being transformed. Fixed. Restored to normal.

The instrument had been turned into an identity machine. Not the diagnosis itself, but the cultural story around it. You were a problem child. Now you are a good child. The medication mediated the identity, not just the attention.

In 1997, the Council on Scientific Affairs of the American Medical Association reviewed the evidence going back to 1975 and found no widespread overdiagnosis. No systematic overprescription. What they found instead was a condition that had been underidentified for decades, finally becoming visible to a system that had recently acquired the instruments to see it.

The Journal of Pediatrics put it plainly: the prescription rate would need to significantly exceed ten percent of the school-age population before it could be interpreted as prima facie evidence of overuse.

It never came close to that.

What had changed was not the prevalence of the condition.

What had changed was the instrument.

And the cultural reaction was not to the instrument. It was to the identity the instrument implied.

VI.

In 2013, the American Psychiatric Association published DSM-5.

Among the changes: ADHD in adults was now explicitly recognized as a distinct diagnostic category. The age of onset criteria was loosened. Fewer symptoms required for adults than for children.

The reaction was predictable.

Allen Frances, the psychiatrist who had chaired the DSM-IV task force, launched a public campaign against the new edition. He called it diagnostic hyperinflation. He said it would make mental illness ubiquitous. He coined the phrase "saving normality" and wrote a book with that title.

Frances was not a fringe voice. He was the man who had built the previous version of the instrument.

And he was pointing at something real: the boundaries of the category had moved. Adults who had spent their entire lives struggling with attention, organization, emotional regulation, and sustained effort could now receive a diagnosis that had previously been reserved for hyperactive boys in elementary school.

That was not a bug.

That was a correction.

Research had been accumulating for decades showing that ADHD did not disappear at puberty. It changed shape. The hyperactivity often reduced. The attention deficit did not. The impulsivity often internalized. The impairment continued into adulthood, into relationships, into careers, into finances, into health.

Women in particular had been systematically missed. The hyperactive boy was the cultural template. The quietly inattentive woman was invisible to it. She was disorganized, forgetful, scattered, emotional — personality traits, not symptoms. She did not get referred. She did not get assessed. She did not get treated.

DSM-5 did not create these people.

It finally gave the instrument a wide enough aperture to find them.

But something else happened at the same time.

ADHD began to shift in cultural meaning. Not just a clinical category. A community. An identity. A framework for explaining a life. Online spaces formed around neurodivergence. People who had spent decades feeling broken found each other and found language for what they had been carrying.

That community was real. The relief was real. The belonging was real.

But the instrument had started to become something else alongside its clinical function.

VII.

In 2023, the ADHD Association in Denmark documented that the waiting time for an assessment had reached up to eighty-four weeks.

Almost twenty months.

In England the same year, adults in some areas were waiting an average of eight years after referral. In Surrey, the local waiting list had swelled to eleven thousand people. Across England in December 2025, up to 2.76 million people were waiting for an ADHD assessment.

In Denmark, ADHD medication use among adults more than doubled between 2020 and 2024 — from around 61,000 to 133,000 people filling prescriptions. Women now slightly outnumber men among users — a reversal of everything the previous decade had looked like. Among adult women under thirty, the number of users has more than doubled in ten years.

The debate restarted immediately.

This time the instrument was TikTok.

A study published in PLOS One in 2025 found that fewer than fifty percent of the claims made in the top one hundred ADHD videos on TikTok aligned with the Diagnostic and Statistical Manual of Mental Disorders. A separate survey found that one in four adults now believed they had ADHD. The actual prevalence is estimated at one in fifteen to one in seventeen.

The conclusion drawn by many commentators was familiar: overdiagnosis. Social contagion. People performing illness for identity. Young people who want to be special finding a label that makes them feel that way.

It is the same argument that was made about the stethoscope.

It is the same argument that was made about DSM-III.

It is the same argument that was made about Ritalin.

And it contains the same error — but also, this time, something more.

The error is not that TikTok is accurate. It is not. Fewer than half its claims hold up. The error is the conclusion drawn from the waiting lists and the rising numbers.

A system with 2.76 million people waiting for assessment is not a system that is diagnosing too many people.

It is a system that cannot keep up with the people who need assessment.

The NHS ADHD taskforce noted in 2025 that only twenty-five percent of children and fifteen percent of adults with ADHD in England were receiving pharmacological treatment. Randomized controlled trials show that seventy to ninety percent would benefit from it.

The system is not overdiagnosing.

The system is undertreating.

But the "something more" is real too.

Research published in Scientific Reports in 2025 examined adolescents with ADHD and measured how they related to their diagnosis across four dimensions: acceptance, rejection, enrichment, and engulfment.

Engulfment — the degree to which the diagnosis had become the totality of the self — was a stronger predictor of low quality of life than the severity of ADHD symptoms themselves.

Not the condition. The identification with the condition.

A second study confirmed the finding: engulfment was a significant negative predictor of executive functioning, self-management, and quality of life simultaneously.

The instrument was not the problem.

What was done with the instrument was the problem.

VIII.

My son Silas got his first pair of glasses recently.

The first thing people said was that he looked great in them.

They probably do. But glasses are not an accessory. They are an instrument. They correct something that was not working the way it should. And the compliment, however kindly meant, lands on the wrong thing.

There is a version of this that is simply social — people noticing, people being kind. But there is another version that is a trap.

Because research on children and spectacle wear documents something uncomfortable: children with glasses are significantly more likely to be victims of bullying. The primary reason children stop wearing their prescribed glasses is social pressure from peers. A meta-analysis found that overall compliance with spectacle wear among children with diagnosed refractive errors is around fifty percent.

Half the children who need glasses are not wearing them.

Not because the glasses do not work. Because the social reaction to the instrument has become a barrier to using it.

But there is also the opposite movement.

A meaningful share of the American population wears glasses with no prescription — purely as a fashion accessory. The trend began in Japan and Taiwan around 2010 and spread globally.

The instrument became fashion.

And fashion is conditional. Fashion changes. And when fashion changes, the instrument goes with it — whether or not the eye still needs correction.

This is the mechanism hiding inside the aesthetic compliment.

When we tell a child they look great in glasses, we attach the instrument to appearance. And appearance is conditional. There will be a day when Silas does not want to look great in a particular way, or when the social pressure runs the other direction, or when the comment about how fine he looks becomes the reason he leaves them on the table.

A diagnosis is the same kind of object.

When we tell someone their ADHD makes sense of their life, we are doing something useful. When we tell them their diagnosis makes them interesting, or special, or part of a community, we have attached the instrument to identity. And identity is conditional too.

The research on engulfment shows what happens next.

The instrument exists to correct something. Not to perform something.

The glasses are for seeing.

The diagnosis is for functioning.

Neither one is an aesthetic choice.

IX.

Nobody says opticians are overdiagnosing myopia.

More people wear glasses than ever before. More children are diagnosed with impaired vision at younger ages. The instruments have improved. Screening has expanded. Awareness has grown. Parents bring their children in earlier.

We do not interpret rising prescription rates for corrective lenses as evidence that opticians have lost their minds, or that children are faking poor eyesight for the social status of wearing glasses, or that pharmaceutical companies have manufactured a vision crisis for profit.

We understand that the condition existed before the instrument found it. We understand that better detection means more detection. We understand that the alternative — not finding it, not treating it, leaving children to struggle through school unable to read the board — is not a neutral outcome. It is a harm.

ADHD is not myopia. The analogy is not perfect. Psychiatric diagnosis involves more interpretation than a vision test. The boundaries of the category are genuinely contested in ways that optometry's are not. TikTok is a real problem. Misinformation is a real problem. The risk of unnecessary medication in people without the condition is a real problem.

But the structure of the argument is the same.

Every time a new instrument finds something that was previously invisible, the same debate begins. The numbers are too high. The criteria are too loose. The industry has an interest. People are seeking labels for social reasons. Normality is under threat.

George Still's colleagues said the children had defective moral character.

The 1990s press said we were drugging normal boys into compliance.

Allen Frances said DSM-5 would make mental illness ubiquitous.

The 2025 commentators say TikTok is manufacturing an ADHD epidemic.

In each case, the instrument improved.

In each case, the number of diagnoses rose.

In each case, the people being diagnosed had always existed.

They were just finally visible.

And in each case, the culture did the same thing: it turned the instrument into an identity question before it was done being a medical one.

X.

The forty-three children George Still described in 1902 are still in the room.

They are adults now, in different bodies, in different centuries, sitting on waiting lists that stretch to twenty months in Denmark and eight years in parts of England.

Some of them found a TikTok video that described their entire life in ninety seconds and felt, for the first time, that the thing they had been carrying had a name.

That is not a crisis of overdiagnosis.

That is what it looks like when an instrument finally becomes available to people who needed it decades ago.

The question is not whether the instrument exists.

The question is whether we can keep it an instrument.

The stethoscope did not create heart disease.

The glasses are for seeing.

The diagnosis is for functioning.

The instrument is not the identity.

This article was written the week my son got his first pair of glasses.

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