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THE RISE OF ADULT ADHD DIAGNOSIS: AWARENESS OR OVERDIAGNOSIS

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ABSTRACT

Background. In the early 2020s, the global ADHD landscape shifted radically, marked by surging public interest, social media discourse, and rising diagnosis rates. The review investigates whether it reflects enhanced clinical awareness or a trend toward overdiagnosis. Comparing diagnostic trajectories, the study addresses the issue of overdiagnosis in certain populations and persistent underdiagnosis in others, followed by age and gender influence prevalence rates.

Aim. The study aims to analyze epidemiological trends in ADHD diagnosis among children and adults, assesses overdiagnosis and underdiagnosis, and identify challenges in the diagnostic process along with factors influencing current diagnostic trends.

Material and methods. A literature review was conducted using PubMed, Frontiers, and Google Scholar. The analysis was grounded in DSM-5 criteria, Conners 3, and DIVA-5 questionnaires. NICE guidelines were incorporated to evaluate methodological rigor and temporal demands required for valid clinical assessments.

Results. Data indicate an increase in ADHD diagnoses from 6.1% in 1997 to 10.2% in 2016. Longitudinal analysis reveals an escalation linked to the COVID-19 pandemic. Pre-pandemic, adult diagnoses averaged 8.8 per 100,000 population monthly. During 2020–2021, this rose to 19.2/100,000 (a 4.9% month-over-month increase). Post-pandemic reached an average of 34.8/100,000.

Conclusions. Despite the noticeable increase in diagnostic rates reported in clinical settings, there remains a lack of solid epidemiological evidence demonstrating a rise in the prevalence of ADHD within the general population within the last decade. Currently, the data does not support a rise in ADHD prevalence, rather it reflects shifts in awareness, diagnostic practices, and health-care seeking behaviors.

KEYWORDS

ADHD, Overdiagnosis, Awareness, DSM-5, Diagnostic Trends

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1. Introduction

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental condition characterized by persistent patterns of inattention and/or hyperactive-impulsive behavior that interfere with functioning or development. The disorder involves difficulties in sustaining focus, regulating activity levels, and controlling impulses, with symptoms appearing in childhood and often continuing into adulthood. Diagnosis requires that these behaviors occur across multiple settings and lead to clinically significant impairment in social, academic, or occupational functioning. As interest in the recently characterized condition of ADHD continues to grow, understanding actual epidemiological trends can provide significant value to recipients of social media content about this neurodevelopmental disorder. Furthermore, it may foster a more critical approach to self-diagnosis as well as encourage individuals to seek professional help during the diagnostic process.

2. Material and methods

2.1 Data collection and analysis

A comprehensive literature review was conducted using databases including PubMed, Frontiers, and Google Scholar. The analysis was grounded in DSM-5 criteria, Conners 3 and DIVA-5 questionnaire. Furthermore, NICE guidelines were incorporated to evaluate the methodological rigor and temporal demands required for valid clinical assessments. The studies included in this paper were selected based on their publication dates; the analysis drew on studies published between 2018 and 2026, as well as a single older study indicating a trend in the diagnosis of neurodevelopmental disorders over recent years.

3. Research results

3.1 Diagnostic Criteria and Conceptual Evaluation

The diagnosis of ADHD is not based solely on an examination conducted by a mental health professional, but requires a broader perspective and the use of tools such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria. The interview conducted with the patient contains information about their daily functioning in the present, but also requires reference to their behavior in early childhood. Therefore, it is often useful to conduct a social history interview with the patient's relatives, who, with the benefit of hindsight, are able to provide important information about the course of the disorder and the development process of an individual.

DSM-5 distinguishes three presentations of ADHD: predominantly inattentive presentation (ADHD-I), predominantly hyperactive-impulsive presentation (ADHD-HI), combined presentation (ADHD-C) and includes severity specifiers from mild to severe. Furthermore, ADHD symptoms may change, which affects the variability of a patient's ADHD presentation. For children, at least six symptoms from one or both domains are required; for individuals aged 17 and older, five symptoms suffice. Several symptoms must have been present before age 12, occur in two or more settings (e.g., home, school, work), and cannot be better explained by another mental disorder.

Table 1. DSM-5 questionnaire.

Inattention Symptoms					
1	Fails to give attention to details or makes careless mistakes in schoolwork, work, or during other activities (e.g. overlooks or misses details, work is inaccurate).	Not at all	Just a little	Often	Very often
2	Has difficulty sustaining attention to tasks or play activities (e.g., has difficulty remaining focused during lectures; conversations; or lengthy reading).	Not at all	Just a little	Often	Very often
3	Does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).	Not at all	Just a little	Often	Very often
4	Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g. starts tasks but quickly loses focus and is easily sidetracked).	Not at all	Just a little	Often	Very often
5	Difficulty organizing tasks and activities (e.g., difficulty with sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).	Not at all	Just a little	Often	Very often
6	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework, preparing reports, completing forms, reviewing lengthy papers).	Not at all	Just a little	Often	Very often
7	Loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).	Not at all	Just a little	Often	Very often
8	Is easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).	Not at all	Just a little	Often	Very often
9	Is forgetful in daily activities (e.g. doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).	Not at all	Just a little	Often	Very often
Hyperactive Symptoms					
10	Fidgets with or taps hands or feet or squirms in seat.	Not at all	Just a little	Often	Very often
11	Leaves seat in situations in which it is inappropriate (NOTE: in adolescents or adults may be limited to feelings of restlessness).	Not at all	Just a little	Often	Very often
12	Unable to play or engage in leisure activities quietly.	Not at all	Just a little	Often	Very often
13	Has difficulty playing or engaging in leisure activities quietly.	Not at all	Just a little	Often	Very often
14	Is "on the go", acts as if "driven by a motor" (e.g. is unable or uncomfortable being still for extended time in restaurants, meetings; may be seen as restless or difficult to keep up with).	Not at all	Just a little	Often	Very often
15	Talks excessively.	Not at all	Just a little	Often	Very often
Impulsive Symptoms					
16	Blurts out an answer before question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).	Not at all	Just a little	Often	Very often
17	Has difficulty waiting his or her turn (e.g., while waiting in line).	Not at all	Just a little	Often	Very often
18	Interrupts or intrudes (e.g. butts into conversations, games, or activities; using other people's things without asking permission; may intrude into or take over what others are doing).	Not at all	Just a little	Often	Very often

Note. Adopted from *DSM-5 Adult ADHD Checklist*, by Compass Psychology, 2021 (<https://compasspsy.co.uk/wp-content/uploads/2021/01/DSM-5-Adult-ADHD-Checklist-Jan-2021-1.pdf>). Access date: 01.02.2026.

3.2 Epidemiological Trends in Adult ADHD Diagnosis

One of the most accessible sources of information for the general population are Internet search engines as well as Large Language Model (LLM) chatbots enabling convenient and discreet access to information on topics of interest, thereby eliminating immediate need for direct contact with a mental health specialist.

An extensive database offers information on the etiology, symptoms, diagnosis, treatment, and prognosis of many diseases. Statistical data from the Google search engine was analyzed for a 10-year period between November 1, 2015, and November 1, 2025. A significant increase in interest in ADHD has been observed.

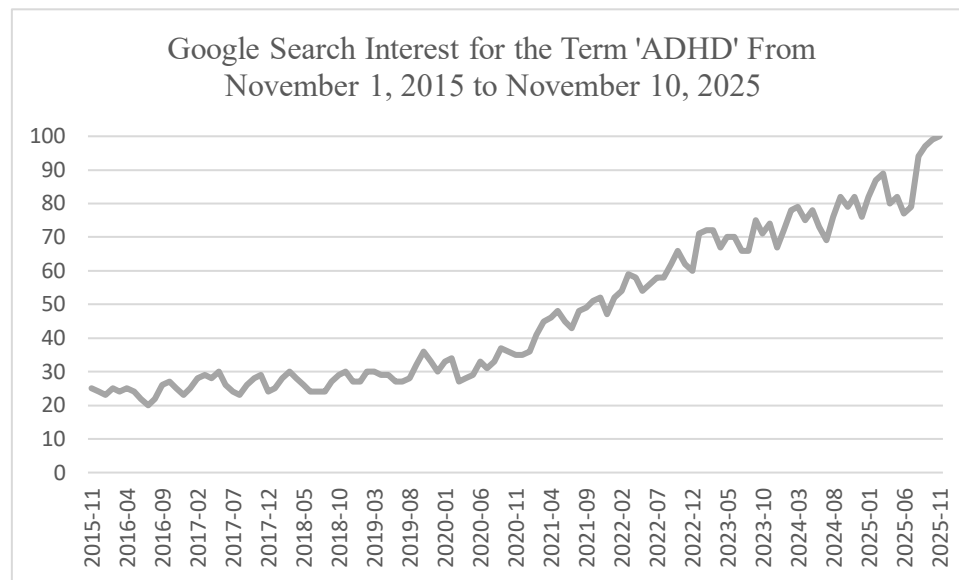


Fig. 1. Google Search Interest for the Term 'ADHD' From November 1, 2015 to November 10, 2025.

Source: Data from Google Trends, 2026 (<https://trends.google.com/trends/explore?date=2015-11-01%202025-11-01&q=adhd>). Access date: 03.02.2026.

An international survey conducted among more than 180,000 children and adolescents indicates a significant increase in ADHD diagnoses between 1997 and 2016. The data shows that the frequency of ADHD diagnoses increased from 6.1% in 1997 to 10.2% in 2016 [1]. A study conducted by Hu K., et al. between 2013 and 2023 indicates a change in the trend of ADHD adults' diagnoses when comparing the period before, during, and after the Covid-19 pandemic. In the pre-pandemic phase, the average monthly frequency of adults newly diagnosed was 8.8 cases per 100,000 population per month. In 2020-2021, this number increased up to 19.2 cases per 100,000 per month, with an accompanying 4.9% month-over-month increase in diagnoses. In the post-pandemic phase, this rate increased significantly to an average of 34.8 newly diagnosed cases of ADHD per 100,000 population [2].

Data from a meta-analysis published in 2025 show that the global prevalence of ADHD is estimated at 7.2% [3]. In the child population, the prevalence of ADHD ranges from 5.9% to 14%, whereas among adults, it is estimated to range from 0.2% to 2.8% [4]. A meta-analysis published in 2023 by N. Salari et al. shows that the prevalence of ADHD in children aged 3–12 years is approximately 7.6%, whereas in teenagers aged 12–18 years, the prevalence decreases to 5.6%. Furthermore, studies indicate differences in the prevalence of ADHD subtypes depending on the age group of children. In children under 12 years of age, the prevalence of predominantly inattentive presentation (ADHD-I), predominantly hyperactive-impulsive presentation (ADHD-HI), and combined presentation (ADHD-C) was almost equal. In adolescents, the predominant subtype of ADHD was ADHD-I [5].

Epidemiological data indicate a difference in the diagnosis of ADHD depending on gender. In boys, the incidence of ADHD diagnosis is three times higher than in girls, whereas in adults, the ratio of ADHD diagnosis in women to men is close to 1:1 [6].

Table 2. Most common age of ADHD diagnosis.

Population	Most common age of diagnosis	Source
Girls	10-14 years old	Pediatrics 2024; Danish Cohort 2024 [7]
Boys	7-10 years old	Pediatrics 2024; Danish Cohort 2024 [7]
Adults	25-40 years old	Frontiers in Psychology (2025) [8]

Source: Adapted from "ADHD: A developmental perspective," by A. Thapar, 2024, *Nature Reviews Psychology*, 3, p. 155 (<https://doi.org/10.1038/s44159-024-00280-w>); and from "Cognitive behavioral therapy for ADHD: Long-term outcomes," by S. Müller et al., 2025, *Frontiers in Psychology*, 16, Article 1466088 (<https://doi.org/10.3389/fpsyg.2025.1466088>).

A study by U. Klefsjo et al. indicates a difference in the main reason for seeking diagnosis of ADHD in boys and girls. For boys, the main issue was behavioral problems, whereas for girls, emotional symptoms predominated. In addition to the difference in the reason for seeking psychiatric help, there is also a difference in the age of the first referral to a mental health specialist depending on gender. The guardians of boys sought help earlier (average age of boys 11.4 years) than the guardians of girls (average age of girls 12.7 years). Furthermore, the number of visits also differed depending on biological sex, which may have had an impact on the age of ADHD diagnosis, which was on average 1.6 years later in girls than in boys [9].

3.3 Factors Contributing to the Increase in Adult ADHD Diagnoses

Over the past decade, the number of adults receiving a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) has risen substantially across many regions of the world. However, various studies show an uneven distribution of ADHD diagnosis rates depending on the region of the world. This trend reflects not only a genuine increase in clinical recognition but also broader, cultural, social, technological shifts that have reshaped perception of ADHD symptoms, reported and evaluated. Several interrelated variables appear to contribute to this surge.

Share of population with attention deficit/hyperactivity disorder, 2019

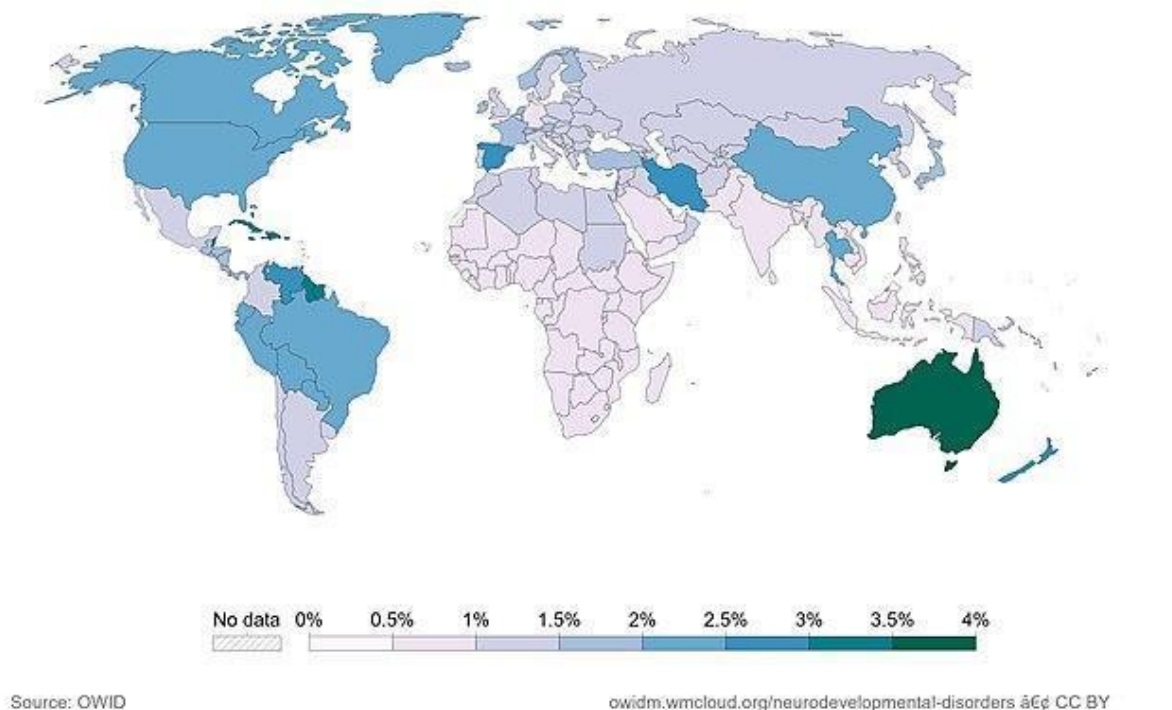


Fig. 2. Share of population with attention deficit/hyperactive disorder, 2019.

Source: From Share of the population with attention-deficit/hyperactivity disorder, 2019, by Our World in Data, 2019 (<https://commons.wikimedia.org/wiki/File:Share-of-population-with-adhd.jpg>). Access date: 10.02.2026.

One of the most influential drivers is the growing awareness of ADHD as a lifespan neurodevelopmental condition. Historically, ADHD was conceptualized primarily as a childhood disorder, leading to the assumption that symptoms diminished or disappeared in adulthood. Advances in longitudinal research have challenged this view, demonstrating that a significant proportion of individuals continue to experience impairing symptoms well into adult life. As a result, clinicians, researchers, and the general public have become more attuned to the manifestations of ADHD beyond childhood, increasing the likelihood that adults seek professional assessment. Updates in diagnostic manuals, including the DSM-5 and DSM-5-TR, have clarified symptom presentations in adults and lowered the threshold for adult diagnosis by reducing the required number of symptoms. These changes have made it easier for clinicians to identify ADHD in individuals whose symptoms may have been overlooked under earlier, more restrictive criteria. However, some patients during adolescence develop the ability to mask ADHD symptoms. A study conducted with adult respondents with an average age of 29.20 years who had been diagnosed with ADHD indicates that 91.60% of the patients who participated in the study mask the symptoms of their diagnosed ADHD in social situations, and some also do so when alone. The largest percentage of patients cited the desire to be liked as well as to avoid unpleasant experiences as the reason for masking ADHD symptoms [10].

The rise of digital health technologies has played a significant role. Telemedicine, online screening tools, and remote psychiatric as well as psychological consultations have increased access to diagnostic services, particularly for adults who previously faced barriers such as stigma, limited availability of specialists, or geographic constraints. The COVID-19 pandemic accelerated the introduction of these technologies, leading to a surge in mental-health evaluations, including assessments for ADHD.

Sociocultural factors further contribute to the increase. Public discourse on neurodiversity, amplified by social media and advocacy groups, has normalized conversations about attention, executive functioning, and mental health. This visibility has encouraged many adults to re-evaluate long-standing difficulties that may align with ADHD. Additionally, contemporary work environments, which often demand sustained attention, multitasking, and rapid information processing, may exacerbate symptoms in individuals with undiagnosed ADHD, prompting them to seek clinical evaluation. Improved recognition of comorbid conditions has led to more frequent identification of ADHD in adults. Disorders such as anxiety, depression, and substance-use disorders may often mask or complicate ADHD symptoms.

As clinicians adopt more comprehensive assessment practices, underlying ADHD is increasingly detected in individuals initially seeking help for other mental-health concerns. This distribution reflects both the historical conceptualization of ADHD as a neurodevelopmental disorder and the fact that many diagnostic criteria rely on evidence of symptom onset during early life.

3.4 Overdiagnosis vs. Underdiagnosis: A Critical Analysis

The global increase in interest in ADHD is a potential source of problems with overdiagnosis and underdiagnosis. Furthermore, it is important to note that ADHD occurs as a spectrum of severity and occurrence of symptoms. What is more, some of the symptoms that form the basis for the ADHD diagnosis are not unique to this neurodevelopmental disorder. Some of the symptoms also occur in autism spectrum disorder (ASD), specific learning disorders (dyslexia, dyscalculia, dysgraphia), anxiety disorders, depression, bipolar disorder, personality disorders, sleep disorders, and even in non-psychiatric conditions such as thyroid diseases, epilepsy, vitamin deficiencies, and diabetes. Making an accurate diagnosis of ADHD is even more challenging when the patient has previously been diagnosed with another disorder that affects executive functions such as response inhibition, attention control, memory, attention functions, sensory and motor functions, language and communication functions, and circadian rhythm functions. This stems from the observation that specific symptoms may be concealed within the symptomatology of a comorbid neurodevelopmental disorder. Research indicates an increasing likelihood of co-occurrence of other mental health disorders in patients diagnosed with ADHD. Depression may emerge simultaneously in 18.6% to 53.3% of patients diagnosed with ADHD. In the case of anxiety disorders, the co-occurrence of ADHD is estimated at 25% to 60% of patients with ADHD. According to Xinyu U. et al., up to 70% of ADHD adult patients may have other mental health disorders [11]. This data not only influences the diagnosis of ADHD, but also the treatment process and its effectiveness.

The issue of overdiagnosis and underdiagnosis of individuals with ADHD has many common causes. The creation of universal diagnostic criteria for diseases and neurodevelopmental disorders creates room for diagnostic errors. The DSM-5 criteria for ADHD were published in 2013, and an updated version known as DSM-5-TR was published in 2022. With advancing knowledge in the field of psychiatry and psychology, the diagnostic process for many mental health conditions may be modified, which is strongly linked to the need for continuous updating of medical knowledge by health workers involved in the diagnostic process of ADHD. Another possible cause of ADHD overdiagnosis is the influence of social media and our immediate environment. Content published online related to this neurodevelopmental disorder may present a distorted image of ADHD and subconsciously influence recipients who try to relate to their favorite online creator. The patient's relatives play a crucial role in the diagnostic process. However, strong emotions and a lack of knowledge about mental health can lead to a biased perception of certain patient symptoms and their evolution over time. Although recognition of adult ADHD has increased, adult diagnoses often represent either the persistence of childhood ADHD into later life or the delayed identification of symptoms that were previously overlooked.

3.5 Diagnostic Challenges in Adults

Despite the fact that ADHD does not only affect children, it is most commonly diagnosed in school-aged children. This is strongly linked to the sudden increase in responsibilities and demands placed on them by caregivers and teachers. Symptoms such as hyperactivity and impulsivity increase, leading to the need to seek help from mental health professionals. Specialists can be particularly helpful in distinguishing between problems related to a possible diagnosis of ADHD and normal child development and behaviors associated with specific stages of adolescence. In early childhood, observing the patient's interactions with peers, for example during play, can be an important factor in encouraging caregivers to further investigate the causes of behavioral problems. Behaviors noticeable in patients with ADHD include difficulty following the rules of games, sharing toys, quickly abandoning activities, trouble engaging in pretend play that requires planning, sequencing, or role consistency, using toys in ways that are overly rough, fast, or chaotic, sometimes leading to breakage, difficulty calming down after high-energy play, not noticing when peers are annoyed or want space and sensitivity to rejection, sometimes perceiving neutral behavior as negative.

DIVA-5 is a questionnaire commonly used in the diagnostic process of ADHD, particularly in adult patients. It consists of three parts: Symptoms of attention-deficit, Symptoms of hyperactivity-impulsivity, and Impairment on account of the symptoms. The classification is based on the widely used DSM-5 criteria. It allows the assessment of the symptoms occurring in childhood as well as in adulthood. The process of completing the questionnaire accurately may be hindered by a distorted perception of the past, a sense of injustice in childhood assessments, or the biased transmission of memories to the patient by relatives who accompanied the patient during adolescence. An analysis conducted by I. Studart et al. shows that in nearly 300 randomized controlled studies, only 35% of ADHD diagnoses in adult patients were made by certified psychologists or psychiatrists [12]. These data may contribute to an unreliable diagnostic process and lead to both overdiagnosis and underdiagnosis of patients. The occurrence of ADHD in adults may indicate a different presentation of symptoms and affect areas of life that are less developed in children, such as functioning in relationships.

Conners 3 is a classification based on DSM-5 guidelines used to diagnose ADHD in patients aged 6 to 18. It can be completed by a caregiver, teacher, or independently by a child aged 8 and above [13]. Unlike the DIVA-5 classification, it refers to ADHD symptoms that may appear during school age and concerns areas of life such as interpersonal relationships, knowledge acquisition, assessment of concentration abilities, perception of one's own abilities and behaviors. The use of different classifications depending on age, and thus the stage of the patient's development, can simplify the initial diagnostic process and focus on the most important problems that may accompany the patients.

Although ADHD is most commonly diagnosed in early school age, the symptoms associated with this neurodevelopmental disorder do not usually occur with constant severity. Research by M. H. Sibley et al. based on follow-up after baseline ranging from 2 to 16 years indicates that in less than 11% of participants diagnosed with ADHD, symptoms persisted constantly. Almost 64% of participants showed fluctuation of ADHD symptoms over time, which consisted of remission and recurrence. During the study, 9.1% of patients experienced remission of ADHD, indicating that the symptoms of this neurodevelopmental disorder persist in the vast majority of those tested in adulthood [14]. Due to the fluctuation of symptoms in the course of ADHD,

making a correct diagnosis can be problematic, as assessing a patient during remission of symptoms may lead to underdiagnosis of some patients who will experience a relapse.

In 2018, the National Institute for Health and Care Excellence (NICE) published guidelines on the ADHD diagnostic process. The guidelines aim to ensure consistency in the diagnosis of ADHD across countries and serve as a helpful tool for patients, their families, and mental health professionals alike. Primary care practitioners should not make an initial diagnosis of ADHD or prescribe treatment, but should focus on assessing the severity of the problems and how symptoms affect the patient's daily life and their environment. The guidelines suggest an initial observation period of up to 10 weeks for individuals suspected of presenting ADHD. If the symptoms constitute severe impairment, the patient should be referred to a secondary care specialist, who, in the case of children, may be a pediatrician, psychiatrist, or a specialist in the ADHD diagnostic process, who will conduct a further evaluation. The specialist should conduct a thorough assessment, which will include a complete history of the patient's mental health, developmental history, and psychosocial assessment [15]. The final diagnosis should not be based solely on the results of questionnaires such as the DIVA - for adult patients, or the Conners 3 - for children. The multi-stage nature of the diagnostic process significantly extends the time required to reach a diagnosis, while also helping to reduce the likelihood of underdiagnosis or overdiagnosis. This process takes anywhere from a few weeks to several months, and in the case of a diagnosis for children, it may involve an initial visit by the caregivers, followed by a visit with the child and their caregivers, observation, reports on the patient's functioning at school or preschool, a discussion of test results, and, in the case of visits to a psychologist, a referral to a psychiatrist to establish an official diagnosis and determine a treatment plan. In a study conducted by M. Bonati et al., the waiting time from the initial referral to the diagnosis of ADHD ranged from 66 to 375 days, with a median of 177 days [16].

4. Discussion

4.1 Clinical and Social Implications

A survey conducted in 2024-2025, completed by over 1,400 respondents on the perception of ADHD in society, highlights the issue of stigmatization of this neurodevelopmental disorder. Among the respondents, 61.5% had a confirmed diagnosis of ADHD, 25.3% were in the process of diagnosis, and the remaining respondents did not have a diagnosis of ADHD. 76% of respondents experienced a negative perception of their ADHD diagnosis in three areas of life: at work, in public settings, and in interpersonal relationships. Furthermore, the study points to the significant issue of waiting time for an ADHD diagnosis, which most respondents estimated to be 1-2 years [17]. According to the statistical data on the waiting time for the ADHD diagnosis, this may also affect the level of persistence required to obtain a final diagnosis. As long as difficulty maintaining attention and completing tasks are concerned to be some of the challenges associated with ADHD, a subset of patients may decide to discontinue the diagnostic process.

4.2 Post-diagnosis Treatment Uptake and Adherence in ADHD

A study published in 2020 by B. Libutzki et al., which examined a German population of patients with a confirmed diagnosis of ADHD at an average age of 35, addresses the issue of continued treatment following the diagnostic process. The study indicates that 32% of participants received initial medication within one year of their ADHD diagnosis and highlights low adherence to medical recommendations among patients. Within 4 years of diagnosis, the percentage of all diagnosed patients receiving a prescription dropped to 13%, whereas among patients who received their first prescription for treatment within the first year of diagnosis, 41% continued to use pharmacological treatment. In the first year following diagnosis, a total of 62% of patients undergo at least one session of psychotherapy. The percentage of patients undergoing such treatment declined in the years following diagnosis. In the second year, the data show that the percentage demonstrated a decrease to 43%, to 38% in the following year, and to 35% in subsequent years [18]. These findings emphasize that a diagnosis does not necessitate medication in all clinical cases, and that treatment outcomes are heavily moderated by the patient's long-term compliance with the established protocol. Furthermore, the motivation for initiating the diagnostic process may stem not solely from the intention to obtain appropriate treatment, but also from an inner motivation to obtain an ADHD diagnosis.

4.3 Social Media Content Concerning ADHD

A study by A. Yeung published in 2022 focuses on evaluating the top 100 most-viewed ADHD-related videos published in 2021 on one of the most popular social media platforms in recent years - TikTok. The inclusion criteria for a video in the study were that it addressed at least one of three topics: a personal experience of living with a diagnosed ADHD, ADHD management, or ADHD diagnosis or symptoms. A group of specialists in the field of psychiatry then independently evaluated each video for the accuracy of the information presented, and the videos were subsequently assessed using the Patient Education Materials Assessment Tool for Audiovisual Materials (PEMAT-A/V) as well as the Journal of the American Medical Association (JAMA). Scientific data indicate that only 21% of the analyzed content is considered useful, 27% is described as personal experience, and more than half of the videos, approximately 52%, were rated as misleading [19]. The younger segment of the audience is particularly vulnerable to misleading content, as they tend to view information presented in videos on platforms such as TikTok and Instagram with less critical scrutiny. However, there is a lack of clear, well-established empirical evidence regarding the impact of such content on ADHD self-diagnosis.

A study published in 2025 examining the impact of misinformation about ADHD on TikTok users states that, compared to a control group, users' confidence in their knowledge considering ADHD increased as the factual accuracy of the information decreased. Furthermore, exposure to misinformation about ADHD led to an increase in treatment-seeking behaviors among users [20]. The authors of the study point to a link with the Dunning-Kruger effect, which states that those with the least competence are, paradoxically, the most likely to hold an exaggerated view of their capabilities [21]. In the context of the cited study on the impact of misinformation about ADHD, increased consumption of content published on TikTok does not lead to an actual increase in knowledge about this neurodevelopmental disorder. The rise in misinformation concerning ADHD and the growing confidence among recipients of misleading information may not only affect the tendency to seek support from professionals specialized in neurodevelopmental disorders, but may also lead to an increase in self-diagnosis behaviors, that do not accurately reflect the symptoms experienced by the content recipient, who attributes them to ADHD, as opposed to a comprehensive psychiatric evaluation leading to a reliable diagnosis.

4.4 Future Directions

Due to the growing interest in ADHD among the general public, significant changes can be expected in the diagnosis of ADHD using Artificial Intelligence-based tools. The recipients of data about a potential patient may be a smartphone, sensor, watch, or online platforms that monitor certain aspects of user daily behavior. Another aspect that can aid in the diagnostic process is genetic and biological data collected and analyzed by AI, which can indicate the risk of ADHD based on genetic variations [22]. Blood and urine tests may be useful in the diagnostic process. Scientific studies suggest a link between metabolites such as altered amino acids and kynurenine present in samples and the occurrence of ADHD among adults and children. Furthermore, dysregulation of neurotransmitters such as serotonin and dopamine and a link between oxidative stress and ADHD have been observed [23].

Functional magnetic resonance imaging (fMRI) has emerged as a valuable, non-invasive tool for examining neural activity patterns associated with ADHD. Growing evidence indicates that resting-state fMRI (rs-fMRI) can capture alterations in large-scale functional networks that may support more precise diagnostic approaches for neurodevelopmental conditions, including ADHD. Recent reviews highlight a broader trend in which fMRI-derived features, combined with machine learning and deep learning techniques, are increasingly applied to identify a range of neurological and psychiatric disorders [24]. Research is also ongoing into the use of eye tracking and electroencephalography during the diagnostic process. Research indicates inconsistency in the assessment of children on the Child Behavior Checklist (CBCL) between the assessment of parents and the assessment of teachers working with the children being assessed [25]. This may be due to differences in the behavior of the subject depending on the environment and the presence of peers. Due to the lack of consistency in assessment using tests such as the CBCL, it may be important to use imaging tests such as fMRI or methods based on electroencephalography. However, the high cost of discussed tests, as well as their limited prevalence and availability, restricts their use in the routine diagnostic process for ADHD, and may further extend an already convoluted and time-intensive diagnostic pathway.

5. Conclusions

The growing public and clinical attention devoted to adult Attention-Deficit/Hyperactivity Disorder has stimulated an important debate regarding whether the observed rise in diagnoses reflects a genuine epidemiological change or rather an improved recognition of a previously underdiagnosed neurodevelopmental condition. The findings discussed in this study suggest that, despite the noticeable increase in diagnostic rates reported in clinical settings, there remains a lack of solid epidemiological evidence demonstrating a rise in the prevalence of ADHD within the general population within the last decade. Currently, the data does not support a rise in ADHD prevalence, rather it reflects shifts in awareness, diagnostic practices, and health-care seeking behaviors. As the quantity of content published on social media platforms regarding Attention-Deficit/Hyperactivity Disorder continues to grow, along with the expanding audience for such content, a concerning phenomenon has emerged: an overconfidence in self-diagnosing psychiatric disorders among individuals who, in some cases, possess inaccurate knowledge about ADHD. Substantial increase in the number of scientific publications, clinical guidelines, and public discussions addressing ADHD as a lifelong condition is observed. Increased awareness may enable individuals who previously remained undiagnosed to seek assessment and support. However, the expansion of research and public discourse may also contribute to diagnostic inflation if clinical criteria are interpreted inconsistently or applied without sufficient differential assessment.

A major challenge in the diagnostic process arises from the high prevalence of psychiatric comorbidities associated with ADHD. Disorders such as anxiety disorders, depressive disorders, substance use disorders, and certain personality disorders frequently co-occur with ADHD and may present with partially overlapping symptom profiles. These comorbid conditions can mask core ADHD symptoms or mimic attentional and executive dysfunction. The overlapping nature of these symptom clusters highlights the necessity of comprehensive clinical evaluation and longitudinal assessment. ADHD continues to be diagnosed predominantly during childhood and adolescence, with developmental-age diagnoses substantially outnumbering those made in adulthood. The complexity introduced by psychiatric comorbidities further underscores the need for cautious and methodologically rigorous diagnostic procedures. Future research should prioritize large-scale longitudinal studies and standardized diagnostic frameworks to clarify true prevalence patterns and to ensure that increased recognition does not inadvertently lead to overdiagnosis. Ultimately, a balanced approach that combines improved awareness with careful clinical evaluation is essential for accurately identifying individuals who may benefit from appropriate treatment and support.

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