

ORIGINAL RESEARCH

Retrospective analysis of emotional distress and personality in social media-referred adults seeking ADHD assessment in India

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Introduction: Social media has become a growing source of mental health information about Attention Deficit Hyperactivity Disorder (ADHD). While social media can increase awareness, it may also lead to misinterpretation of symptoms and increase the help-seeking behavior among adult individuals who self-diagnose with ADHD. This study aimed to understand and examine the emotional distress and personality traits among adults who self-referred for ADHD diagnostic assessment following social media exposure.

Methods: A retrospective observational study was conducted using de-identified data of 85 adults who had sought ADHD assessments in the outpatient clinic in Chennai, India. Data of individuals who had responded to self-report assessments, including the Adult ADHD Self-Report Scale (ASRS), ADHD Rating Scale-IV (ADHD RS-IV), Wender Utah Rating Scale (WURS), Depression Anxiety and Stress Scales (DASS), and the International Personality Disorder Examination (IPDE), were included.

Results: High levels of emotional distress were observed in many individuals reporting severe to extremely severe depression, anxiety, and stress. The retrospective childhood ADHD symptoms scored by WURS were significantly associated with current stress, suggesting that current stress might be related to how individuals report past symptoms. The ADHD screening tools were linked to higher anxiety and stress, highlighting how different screening tools may capture emotional and behavioral patterns differently. A predominance of cluster C personality traits was seen in the individuals, which may shape how adults approach ADHD-related help-seeking behavior.

Conclusion: The findings suggest that considering the growing trend in social media-driven self-diagnosis of ADHD among adults, many individuals who self-refer suspecting ADHD following social media exposure experience mood disturbances and cluster C personality traits. These results highlight the importance of a comprehensive clinical diagnosis and evaluation in the case of ADHD assessments and not using only screening tools to differentiate ADHD from overlapping emotional and personality-related difficulties.

Keywords: social media, attention deficit disorder with hyperactivity/diagnosis, diagnostic self-evaluation, psychological distress, personality disorders, help-seeking behavior

Introduction

Social media has emerged as a powerful tool for disseminating mental health information that strongly

influences people, with online interest rising in Attention Deficit Hyperactivity Disorder (ADHD) to understand struggles with focus, restlessness, or impulsivity (1). ADHD, a heterogeneous neurodevelopmental disorder characterized

by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning (2). While traditionally associated with childhood, ADHD is now increasingly recognized as a condition that can persist into adulthood, affecting approximately 6.76% of the adult population worldwide (3). Adult ADHD is referred to when it is identified in individuals aged 18 years and above and not diagnosed as a child. In adulthood, ADHD symptom presentation often evolves; for example, hyperactivity manifests as restlessness rather than overt hyperactivity, and the disorder is frequently accompanied by comorbid conditions such as obesity, insomnia, mood disorders, and personality disorders (4, 5). Despite its prevalence, the diagnosis of adult ADHD remains challenging (6) and underdiagnosed regardless of its impact on academic, occupational, and social functioning (7).

Over the last few years, particularly following the COVID-19 pandemic, there has been an increase in online interest in ADHD (1). Platforms such as Instagram, YouTube, TikTok, Reddit, and Discord often provide first-hand experiences, support, and validation for individuals who identify with neurodivergent traits (6, 8). Although the increased visibility can help reduce stigma, raise awareness, and encourage help-seeking behavior, it is also accompanied by risks. The growing popularity of self-diagnosis and the reliance on brief screening tools can result in misdiagnosis (9), particularly among individuals experiencing depression, anxiety, and stress. The subjective reports of ADHD symptoms tend to be significantly co-occurring with emotional distress, increasing the risk of false positive indications (10, 11). Among individuals who self-diagnose ADHD via online sources, schizoid, impulsive, borderline, anxious, and dependent personality traits are more prevalent, which may lead to introspection, emotional distress, and exploration, leading them to resonate with ADHD-related information online (12). These personality traits are commonly evaluated on a cluster framework, which categorizes traits into three groups: Cluster A (odd/eccentric)—paranoid, schizoid; Cluster B (dramatic/emotional/erratic)—dissocial, impulsive, borderline, and histrionic; and Cluster C (anxious/fearful)—anankastic and anxious (2, 13).

In India, where mental health literacy and access to care are limited (14), and awareness is still evolving, these platforms have played a crucial role in raising awareness regarding various mental health conditions. The trend in social media platforms has also led to an increase in self-diagnosis, with many individuals opting for self-assessment rather than seeking professional evaluation (6). For those who do seek professional help, the diagnostic process in India is complicated by several factors (15, 16). One major obstacle is the limited availability of comprehensive childhood records, which are often confined to academic performance and provide little insight into the behavioral patterns that could inform an ADHD diagnosis. Additionally, the stigma surrounding mental health in Indian society

frequently deters individuals from involving family members in the diagnostic process (17). This reliance on self-reported symptoms may result in an incomplete or skewed understanding of the individual's condition. These issues are further complicated by systemic challenges such as the lack of specific guidelines in India for diagnosing adult ADHD and the shortage of available trained and qualified mental health professionals, with a 97% deficit of clinical psychologists against standard requirements (1.5 per 100,000 people), which heightens the risk of psychological concerns going untreated or being misattributed to other complaints (18). Given these challenges, there is a pressing need to understand the landscape of adult ADHD diagnosis in India.

The study aims to examine the emotional distress and personality trait profiles among adults who seek ADHD diagnostic assessment following exposure to ADHD-related social media content. Additionally, the study explores the association between ADHD symptom severity, as measured across multiple screening scales, gender, and emotional distress within this population.

Methodology

This study employed a retrospective observational study with the deidentified clinical data of individuals who had visited the outpatient psychology clinic between July 2022 and January 2025 in Chennai, India. Informed consent was obtained from all individuals included in this study at the time of their clinical visit for the use of their deidentified data for research purposes. The data used was de-identified at source. The study was reviewed by the Institutional Ethics Committee (IEC) at the Women's Christian College on January 23, 2025, and was deemed exempt from full ethical review (WCC/IEC/2024:186).

The inclusion criteria required participants to have approached the psychologist for diagnostic assessment specifically after being exposed to ADHD-related information on social media to check whether they have ADHD or not. To systematically assess participants, a social media measurement questionnaire was utilized. Individuals were categorized as social media referred only if they responded "yes" to all five criteria. These criteria required that the participant self-referred based on relatable social media content, belonged to ADHD-themed groups, followed at least one ADHD-focused account, discovered the clinic or therapist via social platforms, and actively searched social media for information regarding ADHD symptoms.

Additionally, all the participants had to be 18 years or older, of Indian nationality, and have completed all the assessments required for the study. Individuals with any prior psychiatric diagnosis and incomplete or missing data were excluded from the study.

Measures

The Adult ADHD Self-Report Scale (ASRS-v1.1) (19) symptom checklist measures the ADHD symptoms using an 18-item scale based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (2). The scale is divided into two parts, with part A consisting of 6 items predictive of ADHD, when four or more responses fall within the shaded boxes, which includes “sometimes,” “often,” or “very often” for items 1–3, and “often,” or “very often” for items 4–6 and serves as the screener, while part B consists of 12 additional items for further symptom assessment. Each item of the scale is rated on a five-point Likert scale ranging from never to very often, based on the past 6 months.

The Adult ADHD Rating Scale-IV (ADHD RS-IV) (20) with adult prompts was used to measure the severity of ADHD symptoms according to DSM-IV. The ADHD RS-IV scale includes 18 items assessing inattention and hyperactivity; each item is rated on a four-point Likert scale from none, mild, moderate, and severe. The adult prompts serve as clinical probes to get detailed responses and assess functional impairment. The highest score for the prompt for each point has to be scored, with a higher score reflecting greater symptom severity.

Wender Utah Rating Scale (WURS) (21), a self-report scale used to identify individuals who may have experienced ADHD symptoms in childhood. The scale has 25 items and is rated on a four-point Likert scale from not at all to very much, with a total score ranging from 0 to 100. A cut-off score of 46 or above is suggestive of the presence of ADHD symptoms in childhood.

The Depression Anxiety and Stress Scale-42 (DASS-42) (22) is a self-report instrument comprising 42 items that assess three distinct negative emotional states: Depression, Anxiety, and Stress. The items were rated on a four-point Likert scale, ranging from did not apply to me at all to applied to me very much or most of the time, reflecting the extent to which each statement applied over the past week. Scores are summed for each subscale, with higher scores indicating greater severity of symptoms. The severity classifications for the Depression subscale are Normal (0–9), Mild (10–13), Moderate (14–20), Severe (21–27), and Extremely Severe (28 and above). For Anxiety: Normal (0–7), Mild (8–9), Moderate (10–14), Severe (15–19), and Extremely Severe (20 and above). For Stress: Normal (0–14), Mild (15–18), Moderate (19–25), Severe (26–33), and Extremely Severe (34 and above).

The International Personality Disorder Examination (IPDE) Screening Questionnaire (23), developed along with the World Health Organization, was used to assess personality traits. This self-report tool evaluates nine personality domains: paranoid, schizoid, dissocial, impulsive, borderline, histrionic, anankastic, anxious, and dependent. Participants had to respond to items in a True/False format, with scores calculated for each domain separately. A score

of four or more in a given domain indicates the presence of clinically significant personality traits. While the IPDE screening version does not provide a clinical diagnosis, it is a widely used and validated instrument for identifying personality traits in both research and clinical practice.

Data analysis

The statistical analysis was conducted using Jamovi (Version 2.7.24) (24). Descriptive analysis was done to summarize the demographic characteristics. Mood disturbance severity levels and personality traits were summarized using frequencies and percentages. One-way Analysis of Variance (ANOVA) tests were done to assess the relationship between ADHD symptoms and severity (as measured by the ASRS and ADHD RS-IV) and mood disturbance. Post-hoc analyses were done for those with significant results in ANOVA. Chi-square tests of independence were done to assess the association between the childhood symptoms (as measured by WURS) and the mood disturbance, and Fisher's exact test was done for those with low expected counts.

Results

A total of 85 individuals' data, who had approached the psychologist based on information on social media to check if they had ADHD, were included in the study, out of which 52.9% (n = 45) were female and 47.1% (n = 40) were male. The overall mean(SD) age was 26.4(5.70), with the mean(SD) age of females being 26.6(5.51) and males being 26.1(5.97).

The severity distribution of depression, anxiety, and stress on the DASS scale is presented in **Table 1**. The depression severity levels showed that 24.7% of participants were in the normal range, with no depressive symptoms; however, 29.4% of participants experienced extremely severe depression levels. Similarly, anxiety levels showed that 28.2% of participants were within the normal range, and 27.1% of participants experienced extremely severe anxiety. The distribution of stress severity levels showed that 20.0% of participants were in the normal range. However, 24.7% experienced moderate stress, 23.5% severe stress, and 21.2% extremely severe stress.

Table 2 presents that chi-square analysis revealed no significant differences between the genders in the three DASS subscales. There was no statistically significant variation between gender for depression, $\chi^2(4,85) = 7.97$, $p = 0.093$; anxiety, $\chi^2(4,85) = 1.96$, $p = 0.743$; and stress, $\chi^2(4,85) = 1.20$, $p = 0.878$.

Table 3 represents the distribution of individuals on depression, anxiety, and stress as measured on the DASS scale based on the WURS scores, that is, no symptoms in childhood and symptoms in childhood.

TABLE 1 | Severity distribution of social media-referred individuals on the DASS scale.

	Normal	Mild	Moderate	Severe	Extremely severe
Depression (n[%])	21(24.7%)	5(5.9%)	15(17.6%)	19(22.4%)	25(29.4%)
Anxiety (n[%])	24(28.2%)	6(7.1%)	17(20.0%)	15(17.6%)	23(27.1%)
Stress (n[%])	17(20.0%)	9(10.6%)	21(24.7%)	20(23.5%)	18(21.2%)

Note: N = 85, DASS: Depression Anxiety and Stress Scale.

TABLE 2 | Gender difference in DASS subscales.

	χ^2	df	p
Depression	7.97	4	0.093
Anxiety	1.96	4	0.743
Stress	1.20	4	0.878

Note: DASS: Depression Anxiety and Stress Scale; χ^2 = chi-square test of independence.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Depression

Individuals who do not report ADHD symptoms in childhood according to the WURS predominantly reported normal and moderate (both 9.4%) levels of depression, followed by extremely severe (7.1%) and severe (5.9%) levels, as seen in [Table 3](#). In contrast, there is a shift towards higher severity of depressive symptoms for those who reported ADHD symptoms from childhood: extremely severe (22.4%), severe (16.5%), and normal (15.3%).

Anxiety

From [Table 3](#), we can see that individuals without childhood ADHD symptoms predominantly fall into the normal category (12.9%), followed by moderate (8.2%), extremely severe (5.9%), and severe (5.9%) levels of anxiety. For individuals with childhood ADHD symptoms, extremely severe anxiety was most prevalent (21.2%), followed by moderate and severe anxiety (both 11.8%). A significant portion (15.3%) reported normal anxiety levels.

Stress

In individuals with childhood symptoms, stress was markedly higher when compared to the other domains. [Table 3](#) shows that the individuals with the presence of childhood ADHD symptoms have extremely severe (20%), severe (15.3%), and moderate (16.5%) levels of stress. And those who do not have any childhood ADHD symptoms were distributed between normal (11.8%) and moderate and severe (both 7.9%) levels of stress.

Normality of the data was assessed using the Shapiro–Wilk test. ASRS scores were found to be normally distributed ($p > 0.05$), whereas the ADHD-RS scores violated the assumption of normality ($p < 0.05$). Therefore, an independent sample t-test was used to examine gender differences in ASRS scores, and for ADHD-RS, a Mann–Whitney U test was conducted. [Table 4](#) shows the results of an independent sample t-test examining gender differences in ADHD symptoms measured by ASRS. The analysis revealed no significant difference between males and females, $t(83) = -1.42$, $p = 0.159$. Similarly, [Table 4](#) shows the results of the Mann–Whitney U test examining the gender differences in ADHD symptom severity as measured by ADHD RS-IV. The result indicated no significant gender difference, $U = 710$, $p = 0.095$.

A chi-square test was done to examine differences in WURS scores between the genders. The results shown in [Table 5](#) indicate that there is no significant association between gender and WURS scores, $\chi^2(1,85) = 0.0262$, $p = 0.871$.

[Table 6](#) represents the results of a one-way ANOVA that examined the differences in ASRS scores across depression, anxiety, and stress severity levels. Assumptions of normality

TABLE 3 | Severity distribution on the DASS scale based on WURS classification.

	ADHD symptoms	Normal	Mild	Moderate	Severe	Extremely severe
Depression	No symptoms in childhood (n[%])	8(9.4)	2(2.4)	8(9.4)	5(5.9)	6(7.1)
	Symptoms in childhood (n[%])	13(15.3)	3(3.5)	7(8.2)	14(16.5)	19(22.4)
Anxiety	No symptoms in childhood (n[%])	11(12.9)	1(1.2)	7(8.2)	5(5.9)	5(5.9)
	Symptoms in childhood (n[%])	13(15.3)	5(5.9)	10(11.8)	10(11.8)	18(21.2)
Stress	No symptoms in childhood (n[%])	10(11.8)	4(4.7)	7(8.2)	7(8.2)	1(1.2)
	Symptoms in childhood (n[%])	7(8.2)	5(5.9)	14(16.5)	13(15.3)	17(20)

Note: DASS: Depression Anxiety and Stress Scale; WURS: Wender Utah Rating Scale. No symptoms in childhood: total $n = 56$ (66% of sample). Symptoms in childhood: total $n = 29$ (34% of sample).

TABLE 4 | Mean difference in ASRS and ADHD RS across gender.

		Statistic	df	p	Mean difference	SE difference
ASRS	Student's t	-1.42	83.0	0.159	-0.978	0.688
ADHD RS	Mann-Whitney U	710		0.095	-3.00	

Note: ASRS: Adult ADHD Self-Report Scale; ADHD RS-IV: Adult ADHD Rating Scale-IV.

*p < 0.05, **p < 0.01, ***p < 0.001.

and homogeneity of variance were met. Results indicated that there were no significant differences in ASRS scores across depression levels, $F(4, 80) = 0.168$, $p = 0.954$. However, a significant difference was found across anxiety levels, $F(4, 80) = 3.31$, $p = 0.017$ (refer to [Table 6](#)). A Tukey's post-hoc analysis for comparison between ASRS scores across anxiety levels was reported in [Table 7](#). The results indicated that individuals in an extremely severe range of anxiety had significantly higher ASRS scores compared to those in the normal range (mean difference = -2.76 , $p = 0.020$); refer [Table 7](#). Similarly, there was a significant difference in ASRS scores across stress levels, $F(4, 80) = 3.14$, $p = 0.019$. Tukey post-hoc analysis for ASRS scores across stress levels was shown in [Table 8](#); the results showed that individuals with an extremely severe stress range had significantly higher ASRS scores when compared to those in the normal range of stress level (mean difference = -3.46 , $p = 0.010$).

A one-way ANOVA was conducted to examine differences in ADHD RS scores across levels of depression, anxiety, and stress. The assumption of homogeneity of variance was met. Although normality was violated for depression and anxiety, ANOVA was considered robust due to the large sample size ($N=85$). There were no significant differences in

ADHD RS-IV across depression levels, $F(4, 80) = 0.202$, $p = 0.937$, and anxiety levels, $F(4, 80) = 1.62$, $p = 0.177$. There was a significant difference found across stress levels, $F(4, 80) = 2.53$, $p = 0.047$. Although a significant difference was observed across stress levels, Tukey post-hoc analysis did not show any significant pairwise differences between the levels (at $p > 0.05$).

[Table 9](#) represents the results of chi-square tests of independence conducted to examine the association between WURS scores and depression, anxiety, and stress. The results showed no significant association between WURS scores and depression levels, $\chi^2(4,85) = 4.34$, $p = 0.362$, and anxiety levels, $\chi^2(4,85) = 4.23$, $p = 0.376$. However, a statistically significant association was found between WURS scores and stress levels, $\chi^2(4,85) = 11.6$, $p = 0.021$.

[Figure 1](#) displays the distribution of personality traits for individuals referred through social media. As seen from the table, the anxious personality trait was the most present, with 65.9%, followed closely by the Anankastic trait (63.5%), which are both cluster C traits. Additionally, schizoid personality traits were observed in 55.3% of the sample. Dependent (31.8%), Impulsive (29.4%), and Borderline (25.9%) were also common in the sample. The least present trait is Dissocial, identified in 7.1% of the sample.

Chi-square analysis was conducted to examine the gender differences in personality disorder traits. The results are represented in [Table 10](#), showing no statistical significance across any traits.

[Table 11](#) shows the distribution and combinations of personality trait clusters among the individuals. It has to be noted here that these categories are not mutually exclusive. Cluster C has the largest count with 70 individuals out of the 85 individuals, followed by cluster A with 52 individuals and cluster B with 47 individuals. In [Table 11](#), the combination of clusters is represented with 47 individuals having traits from clusters A and C, 42 individuals having traits from clusters B and C, and 30 individuals having traits from clusters A and B. Out of the 85 individuals, 29 of them had a combination of all three clusters. This could indicate that the presence of pathological personality traits, especially the cluster C (anankastic, anxious, dependent) traits, made people more likely to reach out for diagnostic assessment based on the information they are exposed to on social media.

TABLE 5 | Difference in WURS across gender.

	Total	Female	Male	χ^2	df	p
WURS	56	30	26	0.0262	1	0.871

Note: WURS: Wender Utah Rating Scale; χ^2 = chi-square test of independence.

*p < 0.05, **p < 0.01, ***p < 0.001.

TABLE 6 | Differences in ASRS and ADHD RS across DASS domains.

		F	df1	df2	p
ASRS	Depression	0.168	4	80	0.954
	Anxiety	3.31	4	80	0.017*
	Stress	3.14	4	80	0.019*
ADHD RS-IV	Depression	0.202	4	80	0.937
	Anxiety	1.62	4	80	0.177
	Stress	2.53	4	80	0.047*

Note: One-way Analysis of Variance (ANOVA) was used; DASS: Depression Anxiety and Stress Scale; ASRS: Adult ADHD Self-Report Scale; ADHD RS-IV: Adult ADHD Rating Scale-IV.

*p < 0.05, **p < 0.01, ***p < 0.001.

TABLE 7 | Post-hoc comparison for ASRS scores across anxiety severity levels.

		Normal	Mild	Moderate	Severe	Extremely severe
Normal	Mean difference	-	0.875	-0.8870	-0.458	-2.76*
	p-value	-	0.969	0.893	0.991	0.020
Mild	Mean difference		-	-1.745	-1.333	-3.64
	p-value		-	0.742	0.891	0.075
Moderate	Mean difference			-	0.412	-1.89
	p-value			-	0.995	0.296
Severe	Mean difference				-	-2.30
	p-value				-	0.156
Extremely severe	Mean difference					-
	p-value					-

Note: Post-hoc Tukey's HSD test was used; ASRS: Adult ADHD Self-Report Scale.

*p < 0.05, **p < 0.01, ***p < 0.001.

TABLE 8 | Post-hoc comparison for ASRS scores across stress severity levels.

		Normal	Mild	Moderate	Severe	Extremely severe
Normal	Mean difference	-	-0.850	-2.15	-1.794	-3.46*
	p-value	-	0.960	2.00	0.385	0.010
Mild	Mean difference		-	-1.30	-0.944	-2.61
	p-value		-	0.818	0.937	0.226
Moderate	Mean difference			-	0.357	-1.31
	p-value			-	0.996	0.665
Severe	Mean difference				-	-1.67
	p-value				-	0.445
Extremely severe	Mean difference					-
	p-value					-

Note: Post-hoc Tukey's HSD test was used; ASRS: Adult ADHD Self-Report Scale.

*p < 0.05, **p < 0.01, ***p < 0.001.

Discussion

The findings from the present study highlight the complex interplay between self-perceived ADHD symptoms, mood disturbances, and personality factors in help-seeking behaviors, including seeking an ADHD diagnosis by adults influenced by social media content. The sample demographic of 85 participants had a near-equal gender distribution and a mean age of 26.4 years. They are developmentally likely to be exposed to life's transitions in career, personal lives, and academics and are heavily engaged

with social media content, so they may be more vulnerable to self-identifying with ADHD symptoms driven by social media-influenced awareness. In the current study sample, gender did not significantly influence self-reported ADHD symptoms on either the ASRS or the ADHD RS-IV, and also the WURS scores.

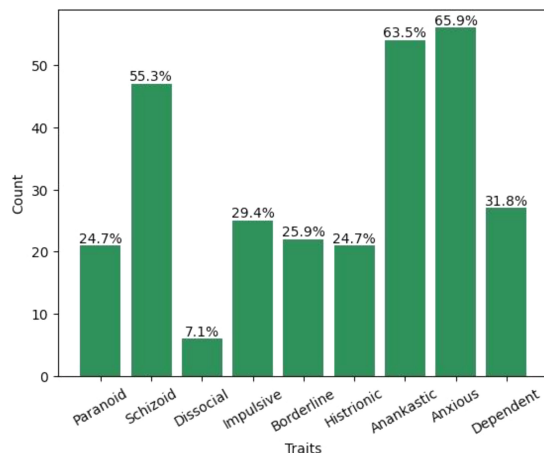
The sample revealed high levels of emotional distress, as evidenced by elevated scores on the Depression Anxiety Stress Scale, alongside varying ADHD symptom severity and prominent personality traits. A notable proportion of participants reported severe to extremely severe levels of depression (51.8%), anxiety (44.7%), and stress (50.6%),

TABLE 9 | Chi-square tests of independence between WURS scores and depression, anxiety, and stress.

	χ^2	df	p
Depression	4.34	4	0.362
Anxiety	4.23	4	0.376
Stress	11.6	4	0.021*

Note: N = 85; χ^2 = chi-square test of independence.

*p < 0.05, **p < 0.01, ***p < 0.001.

**FIGURE 1** | Distribution of personality traits.**TABLE 10** | Gender differences in personality traits.

	Count	Females	Males	χ^2	df	p
Paranoid	21	12	9	0.198	1	0.657
Schizoid	47	23	24	0.677	1	0.411
Dissocial ^a	6	2	4			0.414
Impulsive	25	14	11	0.133	1	0.715
Borderline	22	12	10	0.0307	1	0.861
Histrionic	21	10	11	0.317	1	0.573
Anankastic	54	29	25	0.0346	1	0.853
Anxious	56	27	29	1.47	1	0.225
Dependent	27	15	12	0.109	1	0.742

Note: N = 85. ^aFisher's Exact test was used for dissocial personality trait due to low expected counts.

*p < 0.05, **p < 0.01, ***p < 0.001.

far exceeding general population norms described in the Indian National Mental Health Survey (2015–2016) (25), where the estimated prevalence of depression was 1 in 20 people. A study from Chennai estimated the prevalence of depression in the region to be 15.1% and was higher in females, but in our study, there was no significant difference between the genders (26). We hypothesise that this aligns with prior research indicating that individuals self-identifying with mental health conditions via social media often experience comorbid mood disorders, potentially

TABLE 11 | Frequency across personality clusters and combinations.

Cluster	Count
A	52
B	47
C	70
A + B	30
B + C	42
A + C	47
A + B + C	29

Note: N = 85.

due to the amplification of symptom awareness through algorithmic content exposure (27).

When stratified by self-reported childhood ADHD symptoms on the WURS, participants who reported childhood symptoms exhibited heightened severity in depression, anxiety, and stress, particularly in extreme categories (e.g., 22.4% extremely severe depression vs. 7.1% in those without childhood symptoms). This pattern underscores the longitudinal impact of ADHD on adult psychopathology, consistent with a longitudinal twin study that has reported showing that those with ADHD (with or without a childhood ADHD diagnosis) showed comparable persistent mood disorders into adulthood (28). It is also hypothesised that effortful recall of childhood memories in distressed states might also be inflating the WURS scores.

The significant association between WURS scores and stress ($\chi^2 = 11.6$, $p = 0.021$) but not depression or anxiety suggests that retrospective recall of childhood symptoms may be particularly biased by current stress levels, as proposed in cognitive models of autobiographical memory in distressed states (29). The Adult ADHD Self-Report Scale (ASRS) as well as the ADHD RS-IV revealed significant links with anxiety and stress. However, the post-hoc analyses showed no pairwise significance for ADHD RS-IV. This highlights potential discrepancies in screening tool sensitivity for comorbid conditions. This supports recommendations for using multiple measures in ADHD evaluations, including collecting informant reports, emphasizing impairment, and cautiously interpreting retrospective reports, especially in self-referred populations, as young adults with ADHD tended to underreport current symptoms and those without ADHD overreported current symptoms (30). The ADHD screening tools that are freely accessible online may capture broader emotional overlays, and hence, self-diagnosis or using only this screening tool as a diagnostic scale is not recommended, especially when stress has been exacerbated by social media exposure.

The high prevalence of cluster C personality traits within our sample—anxious (65.9%), anankastic (63.5%), and dependent (31.8%), suggests that avoidant and obsessive-compulsive tendencies may drive social media-influenced diagnosis and help-seeking behaviors. This is in line with

research linking ADHD to cluster C comorbidities, where anxiety-related traits exacerbate symptom perception and online information-seeking (31). It is hypothesized based on our sample that cluster C dominance ($n = 70$), often in combination with clusters A and B (e.g., $n = 47$ in A + C; $n = 29$ in A + B + C), can make individuals misattribute traits like impulsivity or schizoid detachment to ADHD, as these are commonly highlighted in social media content.

The results from the current study have implications for clinical practice, emphasizing the need for comprehensive assessments beyond self-report screening tools in social media-referred cases to differentiate true ADHD from mood or personality-driven psychopathology, which may mimic ADHD symptoms in young adults. Social media platforms and content creators should incorporate disclaimers or links to professional resources to mitigate over-identification risks among these vulnerable populations instead of being driven by algorithmic click baits.

Limitations of the current study include the relatively small sample size and the use of data from a single outpatient clinic in Chennai, which may limit the generalizability. Additionally, the retrospective nature of the study has limited our study with respect to the type of social media content (informational vs. anecdotal; videos vs. podcasts vs. information sharing via blogs) the individuals were exposed to. Future research should employ larger multi-centric samples and longitudinal designs and compare social media-referred groups with clinician-referred controls to elucidate mechanisms of social media-driven awareness about ADHD on help and diagnosis seekers.

In conclusion, this study illustrates that younger adults seeking ADHD assessments via social media often present with significant comorbid distress and cluster C traits, without marked gender differences, underscoring the importance of nuanced, comprehensive diagnostic approaches in the digital age.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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