



ADHD in Context: A Qualitative Exploration of Diagnostic Frameworks, Lived Experiences, and Cultural Influences in India

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<http://dx.doi.org/10.47814/ijssrr.v9i8.3432>

ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD) is a common neuro-developmental disorder, affecting around 7.1 % children in India, but its diagnosis and recognition is largely influenced by cultural, structural and gendered contexts that are not fully captured by the standardised and westernised diagnostic tools like DSM-5. The study investigated the applicability of the criteria for ADHD diagnosis as presented in DSM-5 in the Indian sociocultural context with the viewpoints of clinical psychologists as well as those of adolescents diagnosed with ADHD. A qualitative research design was used and included conducting semi-structured online interviews with five psychologists (aged 25–29 years, and with one to four and a half years of clinical experience) and four adolescents (aged 16–19 years) from India. Interviews were audio recorded and analysed using an inductive and semantic thematic analysis method. The psychologist interviews yielded thirteen themes and the adolescent interviews yielded twelve themes. Four main convergence points were present in both groups: that emotional dysregulation is a clinically significant but unrecognized feature of ADHD; that masking and delayed diagnosis, especially among girls, is common; that there is pervasive stigma and mislabelling of ADHD symptoms as behavioural or moral problems; and the school system is both a venue of diagnosis and a primary locus of impairment. The DSM-5 also was found to be very westernized and psychologists suggested the need for an Indian specific clinical interview protocol, while the adolescents focused on the emotional, social and identity aspects of life with ADHD. The results overall reflect the need for a culturally responsive, gender-sensitive, strengths-based approach to assessment and intervention for ADHD in India.

Keywords: ADHD; DSM-5; Diagnostic Assessment; Adolescents; Cultural Validity; India

1. INTRODUCTION

1.1 Understanding ADHD as a Neurodevelopmental Disorder

Children and young people who find it difficult to sit still, complete their tasks or restrain themselves from doing things impulsively do not simply have problems with behaviour. Many of these

challenges are a true neurodevelopmental disorder for a large portion of them. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) details the definition of attention-deficit/hyperactivity disorder (ADHD) as a persistent pattern of inattention and/or hyperactivity-impulsivity that causes a significant impairment in functioning or development and that occurs across multiple settings, not just one (American Psychiatric Association, 2013). The International Classification of Diseases (11th Revision; ICD-11) is an updated version of the ICD-10, which is the classification system used for hyperkinetic disorders. ICD-11 takes a similar path, collapsing older classifications of hyperkinetic disorders into a classification of ADHD that uses the core dimensions of inattention and hyperactivity-impulsivity across the lifespan (World Health Organization, 2018). In both frameworks, attentional problems and hyperactivity are viewed as core symptoms of the disorder, which is predicted to be cross-situational and developmentally atypical. These essential signs are typically classified into separate behaviour domains. Inattention includes problems with sustaining attention, distractibility, disorganisation, inability to finish tasks, forgetfulness. Hyperactivity is a developmentally inappropriate motor restlessness such as fidgeting, leaving a seat, and having excessive talking. Impulsivity is defined as the tendency to act without thought, interrupt others and not taking turns. Symptoms that are considered clinically significant are not just that they occur at all, but that they interfere with academic, social, and occupational functioning beyond the usual individual variation (American Psychiatric Association, 2013).

However, ADHD is not so easily defined. It is a very heterogeneous developmental disorder and not a singular behavioral disorder; the clinical profile, neurocognitive function and the neurobiological mechanisms vary significantly from case to case across its various etiologies (Luo et al., 2019). These findings are supported by large genome-wide studies: ADHD is a highly heritable disorder with multiple quantitative risk loci (no single gene) and recent studies have identified 27 significant risk loci associated with neurodevelopmental pathways (Demontis et al., 2023). This is highlighted again by longitudinal data from the Multimodal Treatment Study of ADHD, which indicate that many individuals will have periods of remission and periods of recurrence—not a uniform and predictable pattern (Sibley et al., 2022). The neuroimaging picture is also similar: there are group-level differences in structure within a number of subcortical regions, but no one diagnostic neural signature has been identified, and the clinical value of neuroimaging in the diagnosis of ADHD is very limited (Hoogman et al., 2017; Pereira-Sanchez & Castellanos, 2021).

The impact of ADHD extends beyond the classroom. Impulsivity, lack of sustained attention, lack of inhibition and lack of planning not only hinders academic learning and task completion, but also affects interpersonal relationships, causing peer conflict and social friction due to poor regulation of behavior. Irritability, mood instability and emotional reactivity have been identified as a clinically significant component of ADHD (Shaw et al., 2014) and are important factors in impairment throughout the life course. This is supported by wider outcome research, which links ADHD to educational and work problems, lower quality of life, mental health comorbidities, risk-taking and relationship issues into adulthood and beyond (French et al., 2024). Thus, any comprehension of ADHD must consider more than just attention, it must also consider the developmental, emotional and adaptive outcomes.

1.2 ADHD in Global and Indian Contexts

ADHD is a global public health problem. A meta-analysis of the estimated prevalence of this worldwide in children and adolescents was 8% with a higher rate of prevalence in male children and adolescents than female children and adolescents (Ayano et al., 2023). This range is generally consistent with the prevalence in India, ranging from 1.3% to 28.9% with a pooled national estimate of 7.1% (Joseph & Devu, 2019). This diversity suggests diversity in the methodology of local research, given the difference in region, sample, screening tools, and diagnostic criteria, but not necessarily a uniform profile within the country (Joseph & Devu, 2019).

But while prevalence is similar, recognition is not. The problem in India is that ADHD is not easily identifiable because cultural and educational factors influence the perception of inattention, hyperactivity or impulsivity, in the first place. Studies suggest that ADHD is sometimes culturally understood and interpreted as a school-based issue, and that parents may view child psychiatric services as highly stigmatizing and may choose to instead make accommodations for their children in school rather than undergoing clinical treatment (David, 2013). Parents and environmental factors are often blamed for ADHD and many teachers believe that it arises from the way parents raise their children and the environment, rather than from a child's underlying neurodevelopmental processes (David, 2013). Parental explanatory models are crucial determinants of seeking help within families and can be a primary reason for the foreclosure of other traditional or pedagogical avenues at which families resort before turning to psychiatric conceptualizations (Wilcox et al., 2007). The results as a whole indicate that the diagnosis of ADHD goes through a process of filtering through lay concepts such as moral, familial and pedagogical.

These interpretive issues are related in meaningful ways to social stigma. Families might well reject psychiatric pathways because taking such action involves social risks such as distancing or loss of familial status (David, 2013). This is indicative of other systemic vulnerabilities – official the Ministry of Health and Family Welfare suggest that 70% to 92% of people with mental disorders in India do not get appropriate treatment, with low awareness, social stigma and a lack of trained professionals being cited as primary factors in this institutional treatment gap (Press Information Bureau, 2025). This gap refers to mental disorders in general, but is particularly pertinent to ADHD. Identification of a neurodevelopmental disorder is often a fragile process, as parents, teachers, school counselors and clinicians must all identify it, and each layer depends on the other for its success (David, 2013; Press Information Bureau, 2025).

These gender expectations add to the confusion in diagnosing. Research shows that inattention and/or hyperactivity or impulsivity are less likely to be obvious in girls and women with ADHD, and that girls and women with the disorder are more likely to present with internalizing symptoms (anxiety/fear or mood disorders) that mask or delay the identification of underlying executive dysfunction (Young et al., 2020).

Within the Indian context, girls' presentations of ADHD may be less obvious because there are deep cultural norms within this population for females to obey, be quiet and focused in their studies and to be emotionally restrained, making it easier to dismiss their executive functioning difficulties as just anxiety or shyness or not doing hard enough (David, 2013; Young et al., 2020). These are aggravated by structural and systemic constraints in the diagnostic process. While there are national-level initiatives in place, including the National Mental Health Programme, and integration of basic screening services at the AWCs under Ayushman Bharat, availability of specialised pediatric services is still highly limited and rationed. India's ratio of psychiatrists to population is around 0.75 / 100,000, which is very low compared to the recommended ratio of 1 psychiatrist for every 100,000 people (Press Information Bureau, 2025), the acute workforce shortages directly impact the ability to access assessment and care on time and in an equitable way. However, there are culturally responsive tools for the identification of ADHD, e.g., INCLEN Diagnostic Tool for ADHD (INDT-ADHD) which was tested for children in India aged 6–9 years (Mukherjee et al., 2014). However, the availability of localized tools does not resolve more general operational challenges, such as professional availability, regional economic differences and lack of validated tools targeting the adolescent population 10–19 years (Gore & Morgan, 2025).

These perceptions are profoundly influenced by socio-economic stratification and system of education design. In many schools, children are expected to hold their concentration, follow a strict routine, and achieve success in school; their problems are seen as dilemmas of behaviour, attention, or family dysfunction (David, 2013). Socioeconomic disadvantage exacerbates these tendencies by denying disadvantaged families access to private specialist evaluation and early intervention at just the right time when it could make a difference in long-term outcomes. They face further challenges when their educational system is focused on behavior conformity and does not recognize any variation in

neurodevelopment, further reinforcing the idea that the child's problem is intrinsic, and not one between the child and the environment (David, 2013; Gore & Morgan, 2025).

1.3 Lived Experience of ADHD: Emerging Evidence and Gaps

For a young person with ADHD, life is far more than just a day of symptoms involving attention. Of 30 studies in 11 countries, a qualitative evidence synthesis revealed significant effects on young people's education, peer interactions, self-identity, health care experiences, and daily functioning (Tierney et al., 2026). Typically, this manifests in long-standing difficulties maintaining attention, organizing work, managing time, and keeping up with strict academic demands in the classroom, leading to negative feedback from teachers, academic disengagement, and a lack of self-efficacy (Wiener & Daniels, 2016). Self-regulation problems are at the heart of the participants' accounts of their daily lives, including their self-regulation of cognition and behaviour as well as their extreme problems with emotional self-regulation. All these issues lead to chronic stress, physical and mental fatigue, social conflicts, and ongoing and internalized self-criticism (Zetterqvist et al., 2025). Socially, adolescents who have ADHD frequently report enduring experiences of stigma, peer rejection, and feelings of loneliness, indicating a general sense of being different, a stigma that can cause deep shame and social isolation (Beristain & Wiener, 2020; Tierney et al., 2026).

But the deficitist storyline is complicated by qualitative research, too. The adolescents' experience is not consistently negative; rather, there are positive aspects as well, such as greater creativity, physical and mental vigour, the ability to engage intensely in tasks that are personally meaningful, and a quality of divergent thinking that is conducive to novel problem-solving (Tierney et al., 2026; Zetterqvist et al., 2025). These self-reported strengths are not insignificant and it is essential that they be recognized for a balanced approach to neurodiversity, as opposed to solely pathology-based models.

The next important lacuna is not in the developmental area of ADHD as a clinical general type of disorder, but in the area of qualitative studies that focus on Indian adolescent's own experiences and narratives of ADHD within the specific socio-cultural contexts in which they live their lives. Some local work is underway to map the baseline terrain such as a qualitative pilot study, which explored the contemporary landscape of diagnosis and management of ADHD among urban Indians, identifying structural barriers in psychiatric clinics (Basu & Banerjee, 2021). The existing literature, however, largely focuses on quantitative symptom counts or parent/reporter reports, thereby neglecting a critical research area on the relationship between the subjective experience of adolescents and localised family dynamics, over-ambitious educational systems and narrow public health resources. Most importantly, there is no qualitative data that delves into these stories on adolescents from underserved communities or among NGO-supported populations. This youth are at a "double disadvantage" of experiencing a neurodevelopmental variance that is not widely understood and of being at a lower socioeconomic status, which does not have the financial capital to investigate themselves. This gap leaves us with a very limited understanding of ADHD as it applies to the lived reality of executive dysfunction, which is deeply impacted by systemic deprivation and cultural norms around filial duties and economic productivity (Basu & Banerjee, 2021; Gore & Morgan, 2025).

1.4 The Diagnostic Perspective: Clinical Frameworks and Limitations

Although frameworks are crucial to establishing eligibility for services and organizing medical management for ADHD, they can be conceptually and practically limited. Philosophically and psychopathologically, the critical issue with the "harmful dysfunction" model is the assumption that there is a biological cause for the disorder when boundaries for diagnosis are defined in terms of behavioral symptom checklists and global impairment ratings, leaving the area of statistical variation, contextual challenge or socially inconvenient behavior uncovered (Wakefield, 1992, 2016). With ADHD, this is a very real concern. The broad behavioral criteria of the DSM-5 leave the diagnosis open to overdiagnosis,

particularly when standardized clinical parameters are applied without consideration of developmental variation, age-positioning in the classroom, and changing social norms, as researchers have pointed out when investigating clinical parameter boundaries (Epstein & Loren, 2013; Kazda et al., 2021; Thomas et al., 2013). The DSM-5 framework is also being criticized for omitting structures. Although dysfunctional emotions (or emotional dysregulation) are frequently reported in the literature and are likely to contribute to a significant proportion of impairments in ADHD, this factor has not been formally recognised in the core diagnostic criteria of the DSM-5 (Shaw et al., 2014).

Leaving out is especially problematic when trying to apply the framework to a population that deviates from the hyperactive schoolboy type. This encompasses socioeconomically at-risk children and adolescents who may have chronic environmental stressors and/or trauma that can worsen or mimic executive dysfunction, girls who may have internalized symptoms, and those with other overlapped psychiatric disorders that can mask or mimic the presentation of executive dysfunction (Thomas et al., 2013; Wakefield, 2016; Young et al., 2020). The obstacles encountered in real-world clinical work render the criteria in the DSM-5 as an objective, tidy checklist much less frequently than is often assumed. They should be understood in conjunction with extensive developmental and contextually impaired history-taking data, comorbid presentations and collateral information from several observers, which heavily depends on subjective judgment, clinical intuition and situational heuristics. All this diagnostic indeterminacy is exacerbated in the Indian context because of less availability of standardized multi informant rating scales, inconsistent application of clinical guidelines in the rural-urban divide, and educational pressures that influence the perception of symptoms by the parents and educators, and the high prevalence of mental health stigma, which makes it difficult to consistently apply the western normed criteria. The standardized diagnostic framework, however, was not created with the aim of addressing the complex social, linguistic, and economic realities of the Indian psychiatric landscape (Gore & Morgan, 2025).

2. METHODOLOGY

2.1 Aim

The aim of this study is to critically examine the applicability of the ADHD diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or the International Classification of Diseases, Tenth Revision (ICD- 10) within the cultural context of India. The study explores whether standardized diagnostic frameworks developed primarily in Western contexts adequately reflects the experiences and perceptions of ADHD in Indian settings.

2.2 Research Questions

RQ1: How do psychologists perceive the applicability of DSM-5 ADHD diagnostic criteria within the Indian cultural context?

RQ2: How do adolescents diagnosed with ADHD in India describe their experiences of ADHD symptoms, diagnosis, and everyday functioning?

RQ3: What cultural, social, and institutional factors do psychologists and adolescents identify as influencing the recognition and diagnosis of ADHD in India?

2.3 Participants

The study included two groups of participants: psychologists and adolescents diagnosed with ADHD. Psychologists were selected to provide professional insight into diagnostic practices and the use of DSM-5 criteria. Adolescents diagnosed with ADHD were included to provide first-hand perspectives

on their experiences with symptoms, diagnosis, and daily challenges. Participants varied in age and gender, making up a heterogeneous sample befitting the nature of the research. The study included two respondent groups: psychologists and individuals with lived experience of ADHD. The psychologist respondents were aged between 25 and 29 years and had approximately 1 to 4.5 years of clinical experience. The lived-experience/student respondents ranged from approximately 16 to 19 years, based on the available demographic data.

2.4 Research design

The primary data used in this research involved interviews with psychologists and ADHD diagnosed adolescents. Interviews with psychologists focus on the interpretation and application of standard diagnostic criteria in the cultural context of India. Interviews with adolescents diagnosed with ADHD gives insight into how adolescents perceive their diagnosis and symptoms, as well as how it impacts their life.

The study takes a qualitative approach to the lived experiences of adolescents with ADHD and the psychologists' view of the disease along with its diagnosis and treatment. This approach allows for the collection of richer and in-depth data which provides a more comprehensive understanding of the condition, its diagnosis, and the influence of cultural context on how ADHD symptoms are recognized, interpreted, and managed.

Thematic analysis was used to interpret the data. Systematic coding was adopted to analyse participants' responses into themes. After collating the themes, examined them for any patterns, similarities, and insights pertaining to shared experiences on ADHD diagnosis and way some behaviours were interpreted, as well as possible limitations of applying a standardized Western diagnostic framework within the sociocultural context of India.

2.5 Data collection procedure

Online video-call interviews were conducted via Zoom and audio-recorded to ensure accuracy. The recordings were then transcribed into text manually and analysed using thematic analysis. All participants were based in India.

2.6 Data Analysis procedure

The interview transcripts were analysed using thematic analysis following the six-phase framework proposed by Virginia Braun and Victoria Clarke (2006). This approach was selected because it allows for the systematic identification, organisation, and interpretation of patterns of meaning across qualitative data while remaining flexible to participants' lived experiences.

The analysis followed an inductive and primarily semantic approach. Rather than beginning with pre-established categories derived from DSM-5 criteria or existing ADHD theories, codes and themes were generated directly from participants' narratives. This allowed culturally specific experiences and underrepresented aspects of ADHD, such as masking, emotional dysregulation, stigma, and identity-related experiences, to emerge organically from the data.

The analysis proceeded through six stages:

1. Familiarisation with the data through repeated reading of transcripts and listening to recordings.
2. Initial coding of meaningful segments related to diagnosis, symptoms, school experiences, emotional functioning, stigma, and cultural perceptions.
3. Grouping related codes into broader candidate themes.

4. Reviewing and refining themes to ensure internal consistency and conceptual distinction.
5. Defining and naming themes based on shared meaning across participant accounts.
6. Selecting representative verbatim quotations to illustrate each theme.

The themes were refined iteratively throughout the analytic process to ensure they accurately reflected both recurring patterns and meaningful divergences within the data. Particular attention was paid to preserving participant voice and contextual nuance.

Reflexivity was maintained throughout the analysis process. The researcher remained aware that personal assumptions, familiarity with ADHD literature, and expectations regarding cultural limitations of DSM-5 criteria could influence interpretation. To minimise interpretive bias, themes were continuously reviewed against the original transcripts to ensure they remained grounded in participant narratives rather than researcher assumptions.

Given the exploratory and small-scale nature of the study, formal intercoder reliability testing was not conducted. Instead, credibility was strengthened through repeated transcript review, careful code comparison, and consistent alignment between participant quotations and thematic interpretations.

Data collection continued until thematic repetition became evident across interviews, particularly regarding emotional dysregulation, stigma, masking, delayed diagnosis, and academic struggles. While full theoretical saturation cannot be claimed due to the modest sample size, sufficient thematic recurrence was observed to support meaningful qualitative interpretation.

2.7 Ethical Considerations

Informed consent was obtained from all participants before the interviews, and participation was entirely voluntary. Permission to audio-record the interviews was also requested from each participant. They were assured that their responses would remain strictly confidential and that any demographic information collected would be kept anonymous. Participants were also given the option to decline voice recording if they preferred. Additionally, they were informed that if at any point during the interview they felt uncomfortable or did not wish to answer a particular question, they were free to skip the question or withdraw from the study entirely. These precautions aided in establishing the participant's autonomy, privacy and well-being.

3. FINDINGS OF THE STUDY

Theme	Codes	Description of Theme
Academic Struggles and Effort-Outcome Discrepancy	Academic difficulty; Failing science; Grace marks; High effort–low reward; Draining study process; Hatred toward academics; difficulty sustaining information in classes; timed task difficulty; time pressuring; careless errors; academic stress; masking	The respondent experiences persistent academic struggles despite high effort. She describes repeated failure in science despite studying extensively, leading to emotional distress and mental exhaustion. There is a strong perceived mismatch between effort invested and academic outcomes.
Emotional Dysregulation and Medication Effects	Mood swings; Irritability; Anger; Emotional overwhelm; Medication side effects; Emotional management; Emotional reactivity; Impulsivity; Medication benefits ; rejection sensitivity	ADHD symptoms and medication contribute to emotional volatility. She reports increased irritability and mood swings, especially when starting medication. Emotional regulation is described as challenging but consciously managed.
Focus Variability and Hyperfocus	Easily distracted; Fidgeting; Off-topic speech; Difficulty sustaining attention; Hyperfocus when interested; Interest-based attention; zoning out; time blindness; selective focus	The respondent describes classic ADHD attentional patterns: distractibility, difficulty focusing on uninteresting tasks, and strong hyperfocus on areas of personal interest (e.g., reading Percy Jackson). Attention is described as interest-dependent.
Diagnosis Experience and Clinical Process	Lengthy testing; Frustration during assessment; Lack of transparency (mother hid report); Annoyance; Preteen confusion; Diagnostic uncertainty (depression.R2) ; misdiagnosis considerations,Lengthy diagnostic process;Retrospective childhood evaluation; delayed diagnosing due to masking (3) ; Misattribution to anxiety; Limitations of current diagnostic tools, Need for adolescent-specific diagnostic scales	The diagnostic process was experienced as long and frustrating. The respondent felt irritated by testing procedures and lacked full understanding due to parental gatekeeping of the report, contributing to confusion and resentment.

Academic Accommodations and Isolation	Extra exam hour; Separate exam room; Writer provision; Feeling disconnected; Out-of-place during exams	While accommodations (extra time, separate room) are provided, they produce social isolation. The respondent feels disconnected from peers during exams, highlighting the social cost of institutional support structures.
Stigma, Rumors, and Peer Discrimination	Rumor spreading; Being called “deranged”; Fear-based reactions; ADHD used in arguments; Academic invalidation; Social unpredictability; medication stigma , family based stigma, workplace invalidation, ADHD used to invalidate struggles ; minimisation ; academic and gender stereotype	The respondent reports recurrent stigma from peers. ADHD is weaponized against her in arguments and academic discussions. Rumors and mislabeling create emotional hurt and uncertainty in social interactions.
Parental and Teacher Responses	Teacher awareness; Gentle support; Father emotionally distant; Mother emotionally affected but supportive; Financial support for medication; parental minimisation; lack of willingness to acknowledge; Supportive parental response; Supportive school environment	Teachers were supportive and initiated diagnosis. The father showed limited emotional engagement, mainly financial support. The mother demonstrated emotional concern and encouragement, indicating differentiated parental responses.
Social Identity and Polarized Reactions	“People either love me or hate me”; Personality influence; Strong presence; Social intensity	ADHD is perceived as shaping her personality and social dynamics. She experiences polarized peer reactions, suggesting heightened social intensity linked to ADHD traits.
Strengths Associated with ADHD	Passion; Hyperfocus; Multiple hobbies; Energy; Talkativeness; Expressiveness	Despite challenges, the respondent identifies positive aspects such as creativity, passion, hyperfocus, and high energy. ADHD is framed partly as contributing to strong engagement and personality depth.

Self-Perception and Internal Impact	Mental exhaustion; Hurt from failure; Fear of disclosure; Disheartenment; Self-awareness; Awareness as coping tool, feeling less alone; Frustration with system expectations	The psychological impact of ADHD includes internalized hurt, mental fatigue, and caution in disclosure due to anticipated stigma. However, strong self-awareness is evident in how she articulates her experiences.
Lack of Awareness in Society	Poor public understanding; Misconceptions; Need for education; Fear-based stereotypes, Need for early evaluation awareness; medical dismissal ; Gendered misunderstanding	The respondent emphasizes insufficient awareness in India regarding ADHD. She highlights misconceptions, labeling, and the need for better education to reduce stigma and discrimination.
Home vs School Functioning	Difficulty initiating study or tasks; Emotion regulation challenges; Enjoyment of hobbies; Social irritation with classmates; Preference for breaks/home Subject specific ease , easier engagement in interest based activities, difficulty with chores; system inflexibility (school context) ; chores difficulty	Daily functioning varies by context. Academic initiation is difficult at home. At school, certain subjects are easier (painting), but peer dynamics are frustrating. Home is associated with hobbies and relief from academic pressure.

Thematic analysis of the adolescent interviews yielded 12 themes across four respondents. To aid interpretation, each theme is reported alongside the number of respondents among whom it was identified. Themes identified across all four respondents are considered dominant findings; those identified across three respondents reflect a broadly shared pattern. Themes emerging from only two respondents represent limited patterns, while those drawn from a single respondent are treated as exploratory observations. Given the small and non-representative nature of the sample, the latter two categories should be interpreted with caution.

The first theme, **Academic Struggles and Effort-Outcome Discrepancy**, had 12 codes and was identified across three respondents, reflecting a broadly shared pattern. Respondents described a consistent mismatch between effort invested and outcomes achieved, with masking causing struggles to go unrecognised and timed assessments identified as particularly disabling. Respondent 1 noted *"I used to study science day and night... I passed by three grace marks. It is just hurtful because you put in so much time just to fail,"* while Respondent 3 observed that decent grades meant her symptoms went unquestioned for a long time.

The second theme, **Emotional Dysregulation and Medication Effects**, had 10 codes and was identified across three respondents, reflecting a broadly shared pattern. Respondents described mood swings, disproportionate anger, and rejection sensitivity as among the most disruptive aspects of ADHD, with medication offering benefits but introducing its own emotional side effects. Respondent 2 noted that rejection sensitivity appeared particularly pronounced in females with ADHD.

The third theme, **Focus Variability and Hyperfocus**, had 9 codes and was identified across all four respondents, making it a dominant theme. Respondents described attention as interest-dependent rather than effort-dependent, with time blindness and attentional drift also prominent. Respondent 4 illustrated this clearly: *"if I am cleaning my room and I see a book, I will just start reading that book... I realise I have not done the main thing I was supposed to do."*

The fourth theme, **Diagnosis Experience and Clinical Process**, had 12 codes and was identified across all four respondents, making it a dominant theme. The diagnostic process was described as lengthy, frustrating, and frequently delayed by masking or misattribution to anxiety. Respondent 4 noted that dismissal by academic counsellors meant he did not receive a diagnosis *"until I had my own money while I was working."*

The fifth theme, **Academic Accommodations and Isolation**, had 5 codes and was identified across two respondents, representing a limited pattern to be interpreted with caution. While accommodations such as extra time were practically helpful, both respondents described them as producing social disconnection. Respondent 1 noted that sitting in a separate exam room made her feel *"really separate"* from her own classroom.

The sixth theme, **Stigma, Rumours, and Peer Discrimination**, had 11 codes and was identified across three respondents, reflecting a broadly shared pattern. Respondents described stigma as multi-directional, with ADHD weaponised in conflicts and symptoms reattributed to attitude or choice. Respondent 3 noted that others framed her difficulties as an *"attitude issue"* rather than a neurological difference.

The seventh theme, **Parental and Teacher Responses**, had 8 codes and was identified across all four respondents, making it a dominant theme. Teachers were generally more willing to acknowledge ADHD and offer support, while parental responses ranged from acceptance to active minimisation. Respondent 4 has not disclosed his diagnosis to his parents at all, given their wariness toward psychiatric medication.

The eighth theme, **Social Identity and Polarised Reactions**, had 4 codes and was identified by one respondent only, and should therefore be treated as an exploratory observation. Respondent 1 described a pattern in which people *"either really love me or they hate me,"* attributing this to ADHD's influence on her personality, and expressed acceptance of this dynamic.

The ninth theme, **Strengths Associated with ADHD**, had 6 codes and was identified across three respondents, reflecting a broadly shared pattern. Respondents described hyperfocus, energy, and creativity as genuine strengths rather than merely compensatory traits. Respondent 4 noted that his associative thinking directly supports his career as a writer.

The tenth theme, **Self-Perception and Internal Impact**, had 7 codes and was identified across all four respondents, making it a dominant theme. Respondents described significant psychological toll including mental exhaustion and internalised hurt from repeated failure, with self-awareness functioning as an active coping tool. Respondent 4 reflected that being labelled lazy throughout school caused lasting identity damage.

The eleventh theme, **Lack of Awareness in Society**, had 7 codes and was identified across three respondents, reflecting a broadly shared pattern. Respondents described poor public understanding of ADHD in India, with a particularly significant gendered dimension: the cultural image of ADHD as affecting hyperactive boys actively delayed recognition in girls. Respondent 3 noted that despite being unable to sit still, *"because I was a girl, it was not seen in that light."*

The twelfth and final theme, **Home vs School Functioning**, had 11 codes and was identified across all four respondents, making it a dominant theme. Respondents consistently described school's rigid structure and timed assessments as systematically disabling, while home environments allowed for easier engagement through interest-based activities. Respondent 3 captured this plainly: "*there is no flexibility in terms of what I want to study, when I want to study.*"

Table 2 shows the thematic analysis of responses from psychologists

Theme	Codes	Description of Theme
DSM-5 as Preliminary but Incomplete Framework	Starting point; Preliminary checker; Standardised structure; Useful for differential diagnosis; Centralised guideline	DSM-5 is viewed as a foundational diagnostic tool that provides structure and legitimacy, but not sufficient as a standalone framework for ADHD diagnosis in India.
Over-Westernisation & Cultural Gap in DSM-5	Westernised framework; White culture bias; Lacks Indian context; Needs cultural adaptation; Missing socio-cultural lens; Native representation lacking	Clinicians perceive DSM-5 as culturally narrow and insufficiently adapted to Indian socio-cultural realities. There is a call for region-specific or culturally sensitive adaptations.
Missing Symptom Domains in DSM-5	Emotional dysregulation not core; Masking not included; Time blindness; Digital overstimulation; Overlapping symptoms underrepresented	DSM-5 fails to fully capture emotional intensity, masking (especially in girls), modern digital influences, and time-related dysfunction in ADHD presentations.
Emotional Dysregulation as Central Feature	Rejection sensitivity; Intense frustration; Sensory overload; Deep emotional responses; Feeling misunderstood	Emotional dysregulation is widely observed clinically as a core aspect of ADHD, despite not being formally listed as a primary DSM-5 criterion.

Cultural Stigma and Mislabeling	“Naughty child”; Parenting failure; Will grow out of it; Taboo around mental health; Underreporting symptoms	ADHD symptoms are often dismissed as behavioural problems or poor parenting in Indian contexts, leading to delayed diagnosis and stigma.
Socioeconomic Barriers to Diagnosis & Treatment	Limited access to therapy; Government hospital burden; Cost barriers; Late diagnosis; Educational inequality	Socioeconomic background affects early detection, acceptance, and treatment access, with lower-income families facing systemic barriers.
Academic System as Diagnostic Catalyst	School referrals; Complaint-driven diagnosis; Performance pressure; Mandated assessments	Schools frequently initiate ADHD evaluations, often due to academic or behavioural concerns, influencing how and when diagnosis occurs.
Gendered Presentation of ADHD	Boys hyperactive; Girls internalise; Masking; Overthinking; Behaviour normalised in boys; Misdiagnosis in girls	ADHD manifests differently across genders. Boys show externalised symptoms, while girls often mask or internalise symptoms, leading to underdiagnosis.
Physiological & Holistic Considerations	Hormonal imbalance; Sleep disturbance; Substance use; Rule out medical causes; Body-based restlessness	ADHD symptoms may overlap with physiological or lifestyle factors. Holistic assessment beyond behavioural checklists is necessary.

Differential Diagnosis & Comorbidity Complexity	Autism overlap; Anxiety overlap; Learning disability confusion; Residual depression; Misdiagnosis risk	Clinicians emphasise the importance of differential diagnosis, noting symptom overlap between ADHD and other disorders such as autism, anxiety, and learning disabilities.
Strength-Based Reframing of ADHD	Hyperfocus; Creativity; Pattern recognition; High energy; Social dynamism; Rapid learning	Clinicians intentionally highlight strengths in ADHD, reframing traits such as hyperfocus and creativity as assets rather than deficits.
Diagnosis as Identity Validation	Restored confidence; Self-understanding; Empowerment; Makes sense of self	Receiving a diagnosis can validate experiences, reduce self-blame, and improve self-concept among adolescents.
Need for Reform in Diagnostic Criteria	Include masking; Include emotional dysregulation; Add socio-cultural lens; Reduce rigid time duration; Add digital exposure; Gender differentiation; Indian clinical interview protocol	Clinicians suggest reforms to make ADHD criteria more culturally inclusive, gender-sensitive, and reflective of lived experiences in India.

Thematic analysis was used to analyse the results of the psychologist interviews. Overall, 13 themes emerged including 68 codes. Each theme is presented along with its corresponding code, the number of people who provided the code, and verbatim excerpts of the interviews to illustrate data supporting the theme. For ease of interpretation, each theme is reported with the percentage of the sample who identified it. Themes that occurred in all five respondents are treated as dominant findings, those that occurred in four respondents as broadly shared patterns, those that occurred in three respondents as moderate patterns, those that occurred in two respondents as limited patterns and those that occurred in one respondent as exploratory observations and should be interpreted with caution because of the limited and non-representative nature of the sample.

The first theme, **DSM-5 as a Preliminary but Incomplete Framework**, had 5 codes and was identified across all five respondents, making it a dominant theme. Respondents acknowledged the DSM-5 as a useful starting point that provides structure to the diagnostic process, but were unanimous that it cannot function as a standalone tool and must be supplemented with clinical judgement and culturally grounded observation. Respondent 2 described it as "*definitely like an ideal starting point,*" while Respondent 4 noted that "*beyond that, it's missing things.*"

The second theme, **Over-Westernisation and Cultural Gap in DSM-5**, had 6 codes and was identified across four respondents, reflecting a broadly shared pattern. Respondents described the DSM-5 as culturally narrow and insufficiently adapted to Indian socio-cultural realities, designed primarily for a white Western population. Respondent 3 noted that *"if you don't take into account the cultural context of things, then a large group of people just gets disregarded."*

The third theme, **Missing Symptom Domains in DSM-5**, had 5 codes and was identified across four respondents, reflecting a broadly shared pattern. Clinicians described encountering clinically significant presentations involving time blindness, excessive screen exposure, and masking that receive no formal recognition in the DSM-5. Respondent 4 noted that *"time blindness is a real thing,"* while Respondent 1 highlighted digital overstimulation as a contributing factor absent from current criteria.

The fourth theme, **Emotional Dysregulation as a Central Feature**, had 5 codes and was identified across four respondents, reflecting a broadly shared pattern. Despite its absence from DSM-5 criteria, emotional dysregulation was described as a clinically observable core feature of ADHD, frequently contributing more to daily dysfunction than formally recognised symptoms. Respondent 5 noted it is *"one of the basic things that we see for people who are struggling with ADHD."*

The fifth theme, **Cultural Stigma and Mislabelling**, had 5 codes and was identified across four respondents, reflecting a broadly shared pattern. ADHD symptoms in India were described as frequently misattributed to poor parenting or deliberate misbehaviour, with profound consequences for children's self-concept and help-seeking behaviour. Respondent 3 noted that being repeatedly told *"you're just naughty"* leads children to internalise the belief that they are *"good for nothing."*

The sixth theme, **Socioeconomic Barriers to Diagnosis and Treatment**, had 5 codes and was identified across two respondents, representing a limited pattern to be interpreted with caution. Respondents described how low socioeconomic status creates a cascading effect — first limiting education, which in turn prevents recognition of ADHD, with the cost of private therapy and inaccessibility of government services compounding the delay. Respondent 3 noted that *"going to a psychologist is like a massive, massive taboo"* and that accessible options remain unaffordable for many.

The seventh theme, **Academic System as Diagnostic Catalyst**, had 4 codes and was identified most directly across two respondents, with indirect reference from two others, representing a limited pattern. Schools were described as a primary initiator of ADHD evaluations through complaint-driven referrals tied to classroom behaviour and academic performance. Respondents held mixed views, cautioning against over-referral while acknowledging that school-initiated referrals are rarely inaccurate.

The eighth theme, **Gendered Presentation of ADHD**, had 6 codes and was identified across three respondents, reflecting a moderate pattern. Boys' hyperactivity was described as normalised within Indian cultural expectations, while girls tend to internalise or mask symptoms, leading to systematic underdiagnosis in female adolescents. Respondent 2 noted that girls are expected to be *"quiet or more reserved,"* meaning even genuine symptoms can be overlooked or misattributed.

The ninth theme, **Physiological and Holistic Considerations**, had 5 codes and was identified primarily by one respondent, with partial overlap from Respondent 1, and should therefore be treated as an exploratory observation. Respondent 4 described prioritising blood tests, sleep routines, and hormonal regulation as first clinical steps before attributing symptoms to ADHD, arguing that many presentations may have treatable physiological causes.

The tenth theme, **Differential Diagnosis and Comorbidity Complexity**, had 5 codes and was identified across all five respondents, making it a dominant theme. Clinicians highlighted significant symptom overlap between ADHD and conditions such as autism, anxiety, learning disabilities, and

depression, with the DSM-5's categorical structure seen as insufficiently fine-grained to reliably distinguish between them. Respondent 5 noted the importance of identifying the source of each symptom, as emotional dysregulation *"can exist in multiple disorders, not just ADHD."*

The eleventh theme, **Strength-Based Reframing of ADHD**, had 6 codes and was identified across four respondents, reflecting a broadly shared pattern. Respondents described an intentional clinical practice of identifying strengths such as hyperfocus, creativity, and pattern recognition, while noting that no formal diagnostic framework — including the DSM-5 — acknowledges these positive dimensions. Respondent 4 observed that diagnostic criteria *"shouldn't be focussing on symptoms as just negative traits."*

The twelfth theme, **Diagnosis as Identity Validation**, had 4 codes and was identified most strongly by one respondent, with implicit presence in two others, and should therefore be treated as an exploratory observation. Respondents described diagnosis as a moment of identity repair for adolescents who had internalised years of mislabelling, with Respondent 3 noting that it *"reinstalls their confidence"* and helps young people *"make a lot more sense out of who they are."*

The thirteenth and final theme, **Need for Reform in Diagnostic Criteria**, had 7 codes and was identified across four respondents, reflecting a broadly shared pattern. Respondents called for diagnostic reform to include masking, emotional dysregulation, gendered presentations, and a socio-cultural lens, with a recurring suggestion for an India-specific clinical interview protocol. Respondent 5 noted that *"it is very possible for us to have a protocol... that can help us include all these cultural aspects."*

4. DISCUSSION

The results of the present study reveal that there is a high degree of thematic similarity between the responses of psychologists and the responses of the adolescents, indicating that ADHD in Indian adolescents is a multi-faceted experience beyond the basic symptoms of inattention, hyperactivity, and impulsivity as described in the DSM-5. Emotional dysregulation was one of the more salient themes of overlap. Emotional dysregulation was identified as a clinically significant and overlooked characteristic of ADHD by psychologists, and adolescents reported experiencing mood swings, anger, emotional overwhelm, rejection sensitivity, and challenges with emotional reactions. Emotional symptoms are an intrinsic part of ADHD, as Shaw et al. (2014) found, they are common throughout the life course of ADHD and are a major source of impairment. Van Stralen (2016) also reported that emotional dysregulation is now known to be a component of ADHD in children, with an internal emotional state of sadness and an external emotional response of anger and aggression. Combined, the information from both the psychologists and the adolescents indicates that the current diagnostic system underestimates the emotional component of ADHD and that emotional instability is one of the most debilitating aspects of ADHD in adolescents.

A second area of convergence was related to masking and delayed diagnosis. Psychologists said that ADHD is often undiagnosed in teens, and especially in girls, they might hide their symptoms or have good grades to cover up their problems. Adolescents also explained how good grades or superficial coping mechanisms made it difficult for parents to see how much they were struggling. This trend was confirmed by Quinn and Madhoo (2014) who found that presentations of ADHD in women and girls are qualitatively different and less conspicuous, which may lead to underdiagnosis. Young et al. (2020) found that there were several barriers to diagnosis for this group such as symptom differences, gender bias, comorbidities, and compensatory strategies, all of which could lead to a female ADHD patient not being referred to a pathway. The results indicate the extent to which the diagnostic recognition of disruptive behaviour is dependent on the visibility of that behaviour and the importance of paying more attention to inattentive and internalising presentations.

The present study also shows that stigma and mislabelling are a major obstacle to the recognition of ADHD for both groups. According to psychologists, ADHD is often blamed by adults in India as being due to laziness, naughtiness, negligent parenting or intentional misbehaviour. Adolescents then reported experiencing the following: being labeled as abnormal; a diagnosis being used against them in interpersonal relationships; and an over-exaggeration of problems. Müller et al. (2012) identified stigma against ADHD as a negative factor that can impact treatment adherence, treatment efficacy, symptom severity, life satisfaction and psychological well-being. This finding is consistent with the results of the study conducted by Ghanizadeh et al. (2006), who found that 53.1% of teachers in India believed ADHD was due to overindulgence of children by their parents, which suggests that it is not seen as a neurodevelopmental disorder but rather a moral or behavioral issue. Importantly, the results indicate that stigma is not only a post-diagnostic phenomenon, but can also influence the initial clinical diagnosis of symptoms as significant.

The school environment also proved to be a major factor. Schools have become the main source of referrals for evaluation of ADHD, psychologists said. Adolescents, however, indicated that they had the most functional impairment in school because of problems with time pressure, rigid assessment formats, a persistent discrepancy between effort and academic outcome, and social isolation due to accommodations like separate examination rooms. Malhi et al. (2008) point out the importance of making observations in the school setting, as well as the fact that there is a high degree of agreement between parent and teacher reports which adds to the diagnostic accuracy. In a systematic review, Lovett and Nelson (2021) reported that although academic accommodations for students with ADHD are frequently used, the effectiveness of these accommodations is inconsistent and the evidence base is limited. The present study exemplifies this ambivalence: adolescents recognized that accommodations (e.g., extended time) were practically helpful, but at the same time, they noted that they created a sense of social separation. Schools are seen as a place of self-identification and as a source of discomfort for young people with ADHD.

Another point of convergence was the lack of diagnostic recognition in the case of gender differences. Psychologists pointed out that boys with hyperactive behaviour are more likely to be told that they are being "mischievous" while girls are more likely to internalise their symptoms, mask difficulties, or be given a wrong diagnosis. Adolescents, especially girls, described the lack of recognition of ADHD in female presentations as a persistent problem, as ADHD is still thought of as a disorder of hyperactive boys. Mowlem et al. (2019) reported higher rates of ADHD symptoms among males and suggested that the sex differences in symptom expression and adult perceptual biases could explain the discrepancies in diagnosis. Slobodin and Davidovitch (2019) also pointed out that the inattentive and internalising behaviours of girls with ADHD are less disruptive in the classroom and less likely to lead to referral. The overall results suggest that the symptom severity is not the only factor involved in the diagnostic identification but also the gendered behavioural expectations.

In addition to these convergences, the present study found several differences in the psychological and adolescent accounts of their experience with ADHD. The clinical and diagnostic viewpoints were used by psychologists and the systemic viewpoints were used by adolescents, with the emotional and everyday impact being the primary focus. Psychologists critically responded to the DSM-5, stating that it is a helpful but incomplete diagnostic system and that clinical judgment, contextual observation, differential diagnosis, and revision of current criteria are important. Adolescents, on the other hand, did not use the DSM-5 as a framework; instead, they described the diagnostic process as being lengthy, confusing, and often inaccurate. This distinction corresponds with the perspective of Wolraich et al. (2019). Hinshaw et al. (2015) emphasize that diagnosing ADHD cannot rely solely on self-report or symptom checklists; instead, it demands a holistic approach integrating clinical insight, functional impairment data, and history from collateral informants. Similarly, Andersson Frondelius et al. (2019) discovered that school-based support is felt to be helpful when students feel understood and trust in the

support, but it fails to meet their needs and is therefore disappointing. The current study builds on these findings by emphasizing that schools have very different functions for clinicians and for adolescents: For the psychologist, schools are a vital diagnostic entry point; for the adolescent, the school is often the place where ADHD is most visible, most stressful, and most socially relevant.

It also found that the process of conceptualizing barriers to recognition differed across the groups. Psychologists found that structural and systemic barriers such as socioeconomic inequalities, limited psychological services, cost of private psychological care, burden of public psychological services, cultural stigma and lack of public awareness were all present. Adolescents, by contrast, reported interpersonal and affective obstacles such as rumors among peers, family disconfirmation, fear of disclosure, stigma related to medication and invalidation within interpersonal and school environments. However, structural determinants do not only affect the presentation of ADHD; sociodemographic factors also add significant inequities to the diagnosis and treatment of ADHD, shown by Morgan and Hu (2023). Stigma, awareness, service provision, choice of parents and person centred care are also cited as barriers and facilitators to accessing ADHD services as per McKenna et al. (2024). These findings together indicate that psychologists are more sensitive to systemic challenges, and adolescents are more likely to describe the lived, interpersonal impact of the same systemic issues.

There were also differences regarding treatment and symptom interpretations. The clinical significance of excluding other co-occurring or overlapping conditions, such as anxiety, autism spectrum disorders, specific learning differences, depression, sleep disorder, hormonal disorders and other physiological factors before making a diagnosis was emphasised by psychologists. Adolescents were less interested in differential diagnosis and more interested in the effects of treatment, both positive and negative, such as agitation, mood disturbance, low mood and emotional problems. Research in clinical literature has shown that there is a considerable overlap between symptoms and comorbidity in the diagnostic process (Barkley, 2015). As reported in this study, stimulant medication may enhance concentration and daily functioning in young people, but also carries risks of unwanted physical and emotional side effects (Singh 2010). The results indicate that clinical issues of diagnosis and planning of treatment are most important but that adolescents' focus is on the lived experience of ADHD and its management.

To recap, the differences between the two groups are an added enhancement to the current study. Psychologists voice diagnostic constraints, referral chains, and the complexity of the clinical terrain and adolescents express their experience of the systems, in a way that is confused, stigmatised, pressured in school, exhausting emotionally, and problematic in terms of identity. The difference between the two is not a weakening of the findings rather it adds to them, and gives a more comprehensive view of the diagnostic picture of ADHD in Indian adolescents.

5. CONCLUSION

This study aimed to explore the understanding, diagnosis and lived experience of ADHD in the unique sociocultural context of India through a comparative analysis of perspectives of clinical psychologists and adolescents with a diagnosis of ADHD. The results provide a more detailed and complex understanding of the findings than currently available diagnostic tools.

The four areas of convergence were identified in both groups. Firstly, emotional dysregulation has been consistently shown to be a clinically important and functionally impairing symptom of ADHD that is extensively reported in the empirical literature (Shaw et al., 2014; van Stralen, 2016) but not formally part of the DSM-5 diagnostic criteria. Second, masking and delayed diagnosis were both more common, with several girls having only a surface-level ability to present with academic skills but lacking executive skills, consistent with evidence that female presentations of ADHD tend to be less obviously

noticeable and thus are systematically underdiagnosed (Quinn & Madhoo, 2014; Young et al., 2020). Third, stigma and mislabelling was seen as widespread barriers to recognition: ADHD symptoms in India are often attributed to lack of motivation, insufficient care and attention to the child, or active misbehaviour, instead of viewed as signs of a neurodevelopmental difference (Müller et al., 2012). Fourth, the school system had a contradictory and, at times, paradoxical role in terms of the initiation of referrals and at the same time creating some of the most disabling and stigmatising experiences adolescents identified (Malhi et al., 2008; Lovett & Nelson, 2021).

In parallel to these convergences, some significant differences in framing were found. Psychologists working with ADHD from a diagnostic perspective — critiquing the cultural validity of the DSM-5, differential diagnosis, and the importance of and need for structural reform such as developing an India-specific clinical interview protocol. Adolescents, on the other hand, described ADHD in terms of its emotional and social impact: fatigue, stigma, isolation, school failure, and a slow, sometimes painful journey of self-discovery. The differences are not contrasting, but complementary, as they are the different perspectives that young people and clinicians experience when dealing with the same condition. This difference between a structurally-oriented clinical account and a relationally-oriented lived account, in itself, is clinically meaningful, and aligns with the broader research evidence that systemic barriers and interpersonal lived experiences of ADHD do not operate in isolation (McKenna et al., 2024; Morgan & Hu, 2023).

Two findings are important to highlight for their novelty and policy implications. First, the psychologists' near unanimous attack on the DSM-5, as overly Western and less culturally appropriate for India to use, is a kind of institutional self-critique: the framework is perceived to be failing not only patients but also the practitioners tasked with applying it. This discovery provides qualitative support for the argument to develop culturally relevant assessment instruments and regionally validated procedures (Gore & Morgan, 2025; Nallur, 2025). Second, adolescents did not characterize ADHD-related characteristics (hyperfocus, creativity, social intensity, associative thinking) as incidental compensations, but as true and important dimensions of identity. This aligns with growing research which has linked strength-based, identity affirming psycho-education strategies with improved self-understanding and resilience among adolescents with ADHD (Frick et al., 2025), and highlights the limitations of deficit-based diagnostic frameworks.

The results collectively suggest a more inclusive, culturally informed framework of assessment and intervention for ADHD in India which explicitly accounts for emotional dysregulation, masking, gender expression, and the role of family, school, and socioeconomic factors. India is home to one of the largest and culturally the most diverse populations in the world, however, there are very few qualitative, experience-centred studies on ADHD in the Indian context (Mishra et al., 2025). The present study directly tackles this gap. It does not just reflect the patterns found in the western literature but represents a genuine reflection of the socio-cultural norms in India which are characterized by the exam culture, stigma associated with family and community, gender expectations with respect to behavior and the structural inaccessibility in private psychiatric services for a large percentage of the population. These are not secondary or incidental issues which can be solved after diagnosis, they are part of the manner in which ADHD can be diagnosed, named and lived in India.

5.1 Limitations of the study

The present research has certain limitations that need to be acknowledged. Future researchers can work on bridging this gap and improving the scope of the literature:

- i) Five psychologists and four adolescents participated in the study. This is in line with the qualitative methodology, which gives greater emphasis on depth of knowledge than breadth, but due to the small sample size, findings cannot be generalized for all the clinical, cultural and geographical context of India.
- ii) Some of the professionals (psychologists and psychotherapists) were no longer actively working in the clinical field. They had shifted to other jobs which makes their interview more retrospective than an ongoing viewpoint.
- iii) The adolescent sample had a disproportionate number of males and females. The three females and one male adolescent participants offered important perspectives on gendered ADHD experience, and the male adolescent perspective was under-represented. This imbalance should be taken into account when interpreting findings related to the experience of adolescents.
- iv) The sample comprised all participants from urban or semi-urban, with access to private mental health services. The study, however, does not provide a view of the experiences of people with ADHD in rural areas or those with lower levels of socioeconomic status, or in communities where ADHD has not been formally named or recognised, which would be of particular interest, as these represent the areas where a key theme identified was socioeconomic and geographic barriers to diagnosis.
- v) Although parents, teachers and school counselors also indicated that they play a key role in recognizing, referring and socializing ADHD, they were not included in the study. Exclusion reduces the ecological validity of their findings.

5.2 Future Recommendation

1. A clinical interview protocol specific to India for ADHD needs to be designed and validated. There were several psychologist respondents who specifically pointed out that the DSM-5 and ICD-10 were not suitable for the social, family and educational context of clinical practice in India. A protocol should then explicitly include emotional dysregulation, masking, gendered presentations, time blindness, and digital overstimulation that can be clinically observed in the Indian context but have not been included in existing protocols (Nallur, 2025; Gore & Morgan, 2025).
2. There is a critical need for gender-specific research in ADHD in the Indian context. According to the present study, delayed diagnosis and masking were more common among females adolescents, and coupled with the cultural expectations of girls' behavioural conformity. More research is needed to investigate the effect of gendered norms in the household and school environment on the identification, naming and referral to assessment of ADHD presentations (Kooij et al., 2025; Young et al., 2020).
3. Qualitative and mixed method studies exploring the experiences of ADHD in India in urban, semi-urban and rural settings should be encouraged in future research. Presently, the Indian ADHD literature is dominated by quantitative prevalence studies, with very little documentation of lived experience (Mishra et al, 2025). Studies following adolescents from the time of first recognition to diagnosis and into early adulthood that involved a qualitative analysis of the process would be especially helpful.
4. A culturally adapted and structured teacher training program for ADHD needs to be designed and assessed. The two groups of participants recognized schools as being both a place of diagnosis and a place of stigmatizing experiences. It is important that training covers gendered symptoms, social impact of accommodations, and identifies the difference between 'neurodevelopmental need' and 'deliberate misbehaviour' (Lasisi et al., 2017; Gore & Morgan, 2025).

5. Strength-based and identity affirming models of ADHD psychoeducation need to be explored and assessed in India. In this study, the adolescents reported that they saw ADHD-related characteristics as real and positive facets of their identities, but most existing diagnoses and psychoeducation focus on deficits. Frick et al. (2025) discovered that adolescents who come to an affirming story about their diagnosis exhibit higher levels of resilience and self-understanding.
6. Parents, teachers and school counsellors should be added in the future as independent participant groups. These figures have been recognized as important in the diagnosis and treatment of ADHD by both psychologists and adolescents, but they have not been studied from either of these viewpoints in this current study. A multi-stakeholder design would give a more ecologically valid understanding of the way in which the understanding and management of ADHD is understood in the systems around Indian adolescents (McKenna et al., 2024;).
7. Studies should be expanded to the rural and less well-to-do community of India. The study was restricted to those people who could avail private care and thus results of the present study are not representative of the majority of the population in India. Future studies should be designed to specifically sample from government schools, rural health centres, and community settings to capture the full spectrum of ADHD in India (Gore & Morgan, 2025; Mishra et al., 2025).

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