

• EVIDENCE SYNTHESIS • 2025-2026

CITED

The ADHD Misinformation Crisis on Social Media

How viral content distorts a real diagnosis – and what evidence-based care actually looks like.

FOCUS

Adults aged 18–34

PERIOD

2025–2026 (with 2022–2024 foundations)

PREPARED

July 2026

SOURCES

28 peer-reviewed & institutional

THE FINDINGS AT A GLANCE

52–89%

of top ADHD TikTok videos are misleading across peer-reviewed studies

25%

of US adults suspect undiagnosed ADHD vs. ~6% true prevalence

+61.7%

rise in adult ADHD diagnoses (2018–2023), concentrated in women

25.3%

of adults prescribed stimulants report misuse

ADHD has become one of the most popular – and most distorted – health topics on social media. A converging body of peer-reviewed research now quantifies the scale of the problem with remarkable consistency: **between roughly half and nine in ten of the most-watched ADHD videos on TikTok contain misleading, inaccurate, or non-diagnostic information.** Across two platforms and a systematic review of more than 5,000 posts, the finding is stable: the content young adults are most likely to encounter about ADHD is also the content most likely to be wrong.

This is not a victimless problem. The same research links heavy consumption to inflated prevalence estimates, reduced but more *confident* knowledge, and increased treatment-seeking – including for non-evidence-based treatments. At a population level, recent years have seen a surge in adult self-diagnosis, a tripling of UK assessment demand, stimulant prescribing up nearly a quarter, and documented misuse in one in four prescribed users.

This paper quantifies the inaccuracy, maps the specific myths against the cognitive science, documents the downstream effects, and provides a practical framework for spotting misinformation.

1 • The Scale of the Problem

Why this matters for adults 18–34 – the heaviest users of short-form video and the group most affected by the recent surge in adult ADHD identification.

15.5M

US adults with a current ADHD diagnosis (6.0%), about half diagnosed in adulthood. – CDC MMWR 2024

71.5%

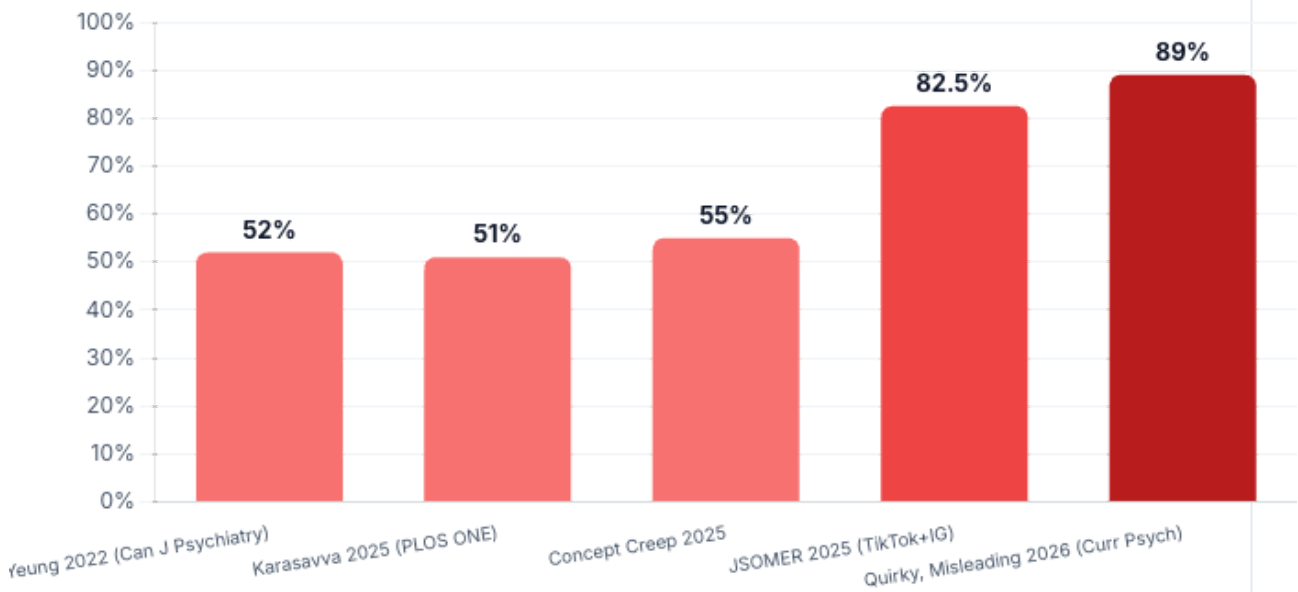
of diagnosed adults reported difficulty filling their stimulant prescription due to shortage. – CDC MMWR 2024

30×

increase in telehealth e-prescribing of stimulants, 2019 → 2023 (DEA pandemic waivers). – Trilliant Health 2025

Figure 1 • Misinformation prevalence in the most popular ADHD videos

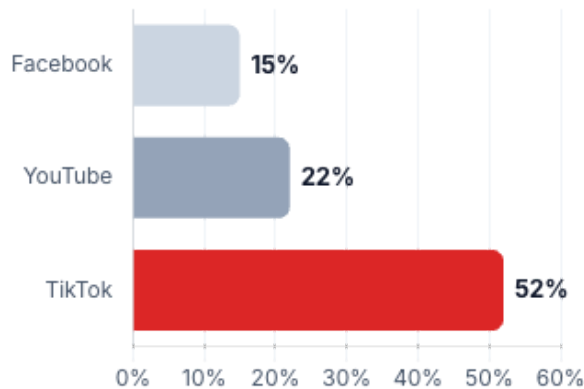
Five independent peer-reviewed content analyses coded the top #ADHD videos on TikTok (and, in one case, TikTok + Instagram). Despite different methods and coder teams, every study found a majority of content to be inaccurate or misleading.



Sources: Yeung 2022 (CJP); Karasavva 2025 (PLOS ONE); "Exploring concept creep" 2025; "My socials told me I have ADHD" 2025 (JSOMER); "Quirky, relatable, misleading" 2026 (Current Psychology). Methods differ: Yeung & Karasavva classify whole videos; the 2026 study codes individual claims at higher granularity.

Figure 2 · ADHD misinformation by platform

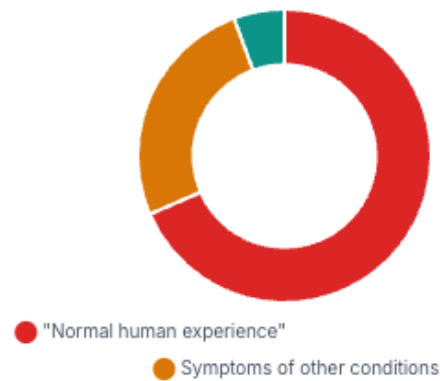
TikTok consistently carries more inaccurate ADHD content than any other major platform.



Source: UEA systematic review, 2025/26 (27 studies, 5,057 posts).

Figure 3 · What "non-core" symptom claims actually describe

When clinicians flagged a claim as not matching DSM-5, what was it really about?



Source: Karasavva et al. 2025 (PLOS ONE). "Other conditions" derived (100% – 68.5% – 5.6%).

The core mechanism

Of the symptom claims that did **not** match DSM-5 criteria, only **5.6%** referred to issues genuinely associated with ADHD by research (e.g., working-memory difficulties). The rest pointed to other conditions – or, in **68.5% of cases**, to what clinicians deemed **"normal human experience."** Relatable, universal experiences are being rebranded as diagnostic. This is the engine of the problem.

Does misinformation actually change minds? Yes — in the worst way.

The 2025 *European Child & Adolescent Psychiatry* RCT ("Misinformation mayhem") exposed 490 treatment-naïve college students to accurate, misleading, or control ADHD TikTok content. It is the clearest causal evidence of harm:

↓ Knowledge

Significantly *less* accurate ADHD knowledge afterward

↑ Confidence

But *higher* confidence in that now-wrong knowledge

↑ Treatment-seeking

Including for *non-evidence-based* treatments

Source: *European Child & Adolescent Psychiatry*, 2025 (PMC12647241).

2 · The Myths: Viral vs. Verified

Six recurring viral claims, each mapped against what peer-reviewed research – including the literature on ADHD cognition and reading – actually demonstrates.

MYTH 1 · VIRAL

"ADHD is a dopamine deficiency" / "dopamine detox"

ADHD is caused by chronically "low dopamine"; people therefore "chase dopamine" and benefit from "dopamine detoxes," supplements, or novelty protocols.

VERIFIED

Dopamine is involved — but "deficiency" is unsupported

A 2024 critical review of 40+ years of evidence found "limited evidence for a hypo-dopaminergic state *per se*." Dopamine activity is actually *higher* in some ADHD brain regions. The accurate framing is altered dopamine *function & regulation*, not a global shortage.

— Frontiers in Psychiatry, 2024

MYTH 2 · VIRAL

"People with ADHD lack object permanence"

"Out of sight, out of mind" is reframed as a failure of object permanence.

VERIFIED

Object permanence develops in infancy — adults don't lose it

The real explanation is **working-memory & attention-regulation difficulty** – tracking objects in active memory. Conflating this with an infant-stage milestone is a category error.

MYTH 3 · VIRAL

Hyperfocus is uniquely & diagnostically ADHD

"Hyperfocusing for 8 hours" is presented as a signature ADHD "superpower."

VERIFIED

Hyperfocus is trans-diagnostic & poorly defined

It appears in autism, schizophrenia, and neurotypical "flow." A foundational review notes it is "poorly defined within the literature" with "no single consensus." Not part of diagnostic criteria.

— Halmøy et al., Psychological Research (PMC7851038)

MYTH 4 · VIRAL

"Stimming" is an ADHD diagnostic sign

Fidgeting / repetitive movement videos framed as proof of ADHD.

VERIFIED

Stimming is strongly associated with autism, not an ADHD marker

ADHD fidgeting is a milder, distinct self-regulation behavior linked to *sustaining attention*, not a diagnostic marker. Blurring ASD/ADHD here misleads.

MYTH 5 · VIRAL

"Everyone has a little ADHD"

Because symptoms are universal, ADHD is framed as the far end of a normal spectrum — anyone who relates might "have it."

VERIFIED

Diagnosis requires impairment + childhood onset — ~90–95% don't have it

Traits are dimensional, but the diagnosis needs functional impairment across **2+ settings** and onset before age 12. This framing is the single biggest driver of false-positive self-diagnosis.

MYTH 6 · VIRAL

Self-diagnosis checklists = diagnosis

"5 signs you definitely have ADHD" quizzes presented as diagnostic.

VERIFIED

Screening ≠ diagnosis — false-positive rate can exceed 80%

The validated ASRS screen has positive predictive value **below ~20%** in clinical populations — most positives are false, driven by anxiety, depression, sleep loss, or trauma. Real diagnosis needs a clinical interview + collateral + rule-outs.

The irony: what real ADHD cognition research shows is rarely mentioned online

The peer-reviewed literature on how ADHD actually affects cognition – especially reading – is more specific, replicable, and useful than the viral symptom lists, yet barely features on the For You page.



Centrality deficit. ADHD readers recall fewer *important* ideas – not fewer details. A prioritization problem, not a decoding problem. (Miller 2013)

Sustained attention is king. The single strongest predictor of comprehension in adults with ADHD – above WM, vocabulary, or speed. (Friedman 2023)

Shallower processing. ADHD readers reread central ideas *more* yet recall fewer. (Lavi 2019)

Structure helps everyone. Signaling (headings, bolding) improves comprehension across 103 studies, N=12,201. (Richter 2016)

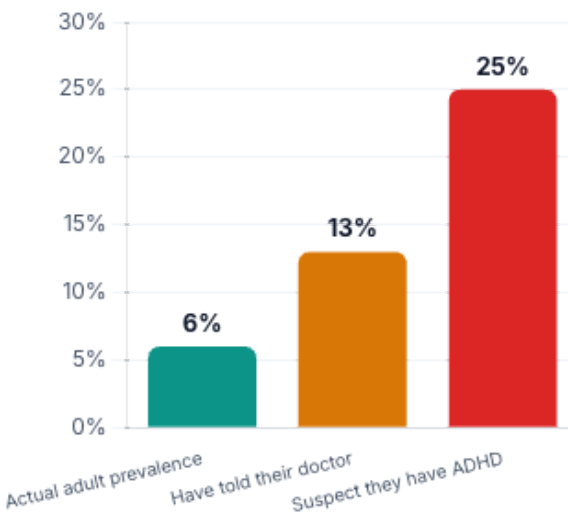
3 · The Downstream Effects

The misinformation does not stay on the screen. A measurable chain of consequences follows – in self-diagnosis, clinical services, and prescribing.

3.1 · The self-diagnosis surge

Figure 5 · The self-diagnosis gap (US adults)

A fourfold gap between suspicion and reality – and most never tell a clinician.



Sources: Ohio State Wexner survey 2024; CDC MMWR 2024.

FROM THE PLOS ONE 2025 STUDY

The more frequently students watched #ADHD TikTok content, the more they **overestimated ADHD's prevalence** and the **worse they rated their own symptoms**.

Crucially, heavy viewers could **not distinguish the most accurate videos from the least accurate** – recommending both equally.

3.2 · Pressure on clinical services

8 yrs

average NHS adult ADHD wait in many UK areas. – BBC FOI 2024

196,000

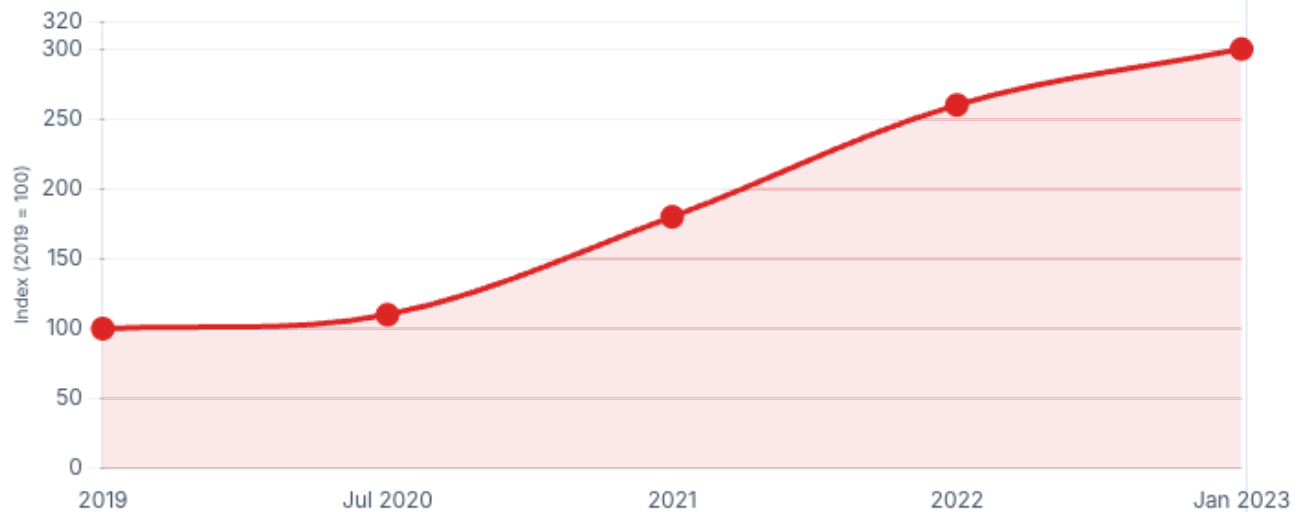
adults on UK NHS waiting lists; referrals 4× since 2019. – BBC FOI 2024

2027

year the *first* US adult ADHD clinical guidelines are due. None exist today. – APSARD/CHADD

Figure 6 · UK adult ADHD assessment demand (index, 2019 = 100)

Demand roughly tripled between mid-2020 and early 2023; female referrals now outstrip male.

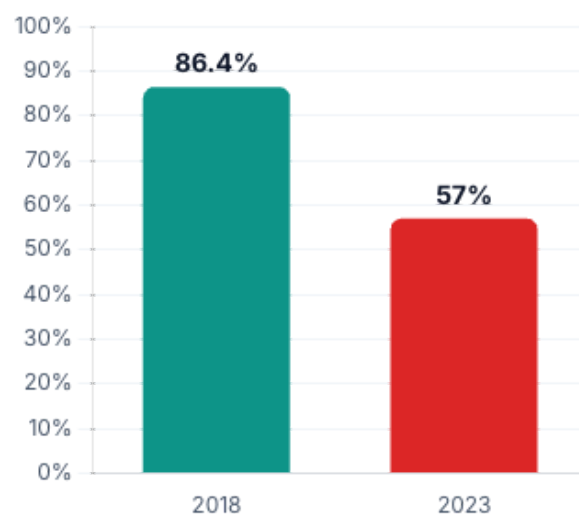


Source: *BJPsych Bulletin*, 2024 (10.1192/bjb.2024.53). Indexed trend illustrative of reported multipliers (3× demand; 4× referrals); Google searches for "ADHD" rose in parallel.

3.3 · Stimulant prescribing & misuse

Figure 7 · The diagnosis–prescription mismatch (US)

Share of stimulant recipients with a documented ADHD diagnosis in their medical claims.



Source: Trilliant Health, 2025.

Figure 8 · US ADHD medication fills (millions)

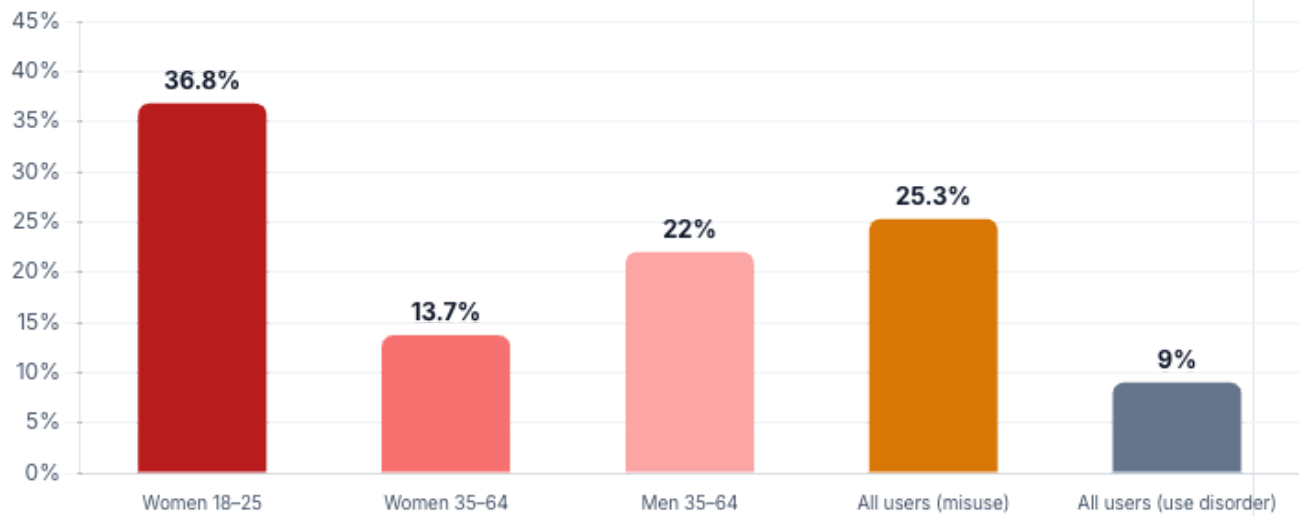
Total fills rose 23.8% in four years; nonstimulant fills grew fastest (+60.1%).



Source: Psychiatric Services, 2025 (appi.ps.20240574).

Figure 9 • Prescription stimulant misuse by group (US adults 18–64)

Among those prescribed stimulants: overall misuse, use disorder (PSUD), and misuse by sex/age subgroup. Misuse is highest among young women.



Source: *JAMA Psychiatry* 82(6):572–581, 2025. Amphetamine users carry 3.1× the misuse risk of methylphenidate users.

Important nuance

A surge in adult diagnosis is partly a *legitimate correction* of historic underdiagnosis — adult ADHD, especially in women, has been missed for decades. The problem is not that more adults are being identified; it is that identification is happening in an information environment that is majority-misinformation, with no adult clinical guidelines, uneven assessment rigor, and measurable downstream misuse. **Both underdiagnosis and misdiagnosis can be true at once.**

4 · How to Spot Misinformation

A six-check filter (adapted from CHADD & the ADD Resource Center). A claim failing two or more checks is marketing, not medicine.

1

Reject the quick fix

ADHD is lifelong, managed with medication, skills, and structure – not eliminated by a supplement or 30-day "detox." Any "cure" fails immediately.

2

Discount single studies

"New study changes everything" is almost always a misreading. Look for convergence across many studies and meta-analyses.

3

Distrust certainty

Real science is full of nuance ("involved but not definitive"). Confidence without caveats is a warning sign.

4

Follow the money

~Half of popular ADHD creators sell something (coaching, supplements, merch). A product link reframes "education" as advertising.

5

Verify credentials

Is the creator a licensed clinician with ADHD expertise, or an influencer? Personal experience is valid as experience, not as generalizable diagnosis.

6

Confirm with a clinician

No post – however relatable – replaces an assessment. A video is a prompt to seek evaluation, not a diagnosis.

What evidence-based resources actually look like

Resource	What it is	Why it's reliable
World Federation Consensus Statement	208 evidence-based conclusions	Requires studies with >2,000 participants or meta-analyses of ≥5 studies
CHADD	National resource; diagnosis criteria & provider guidance	Long-standing nonprofit aligned with DSM-5
APSARD	Developing first US adult ADHD guidelines (2027)	Clinician-led, evidence-based

Resource	What it is	Why it's reliable
DSM-5-TR criteria	The actual diagnostic standard	≥5 symptoms, ≥2 settings, impairment, onset before 12
ASRS-v1.1 (validated form)	A screening tool, properly contextualized	Good as a screen – clearly <i>not</i> a diagnosis
A qualified clinician	Evaluation: 60–90+ min interview, collateral, rule-outs	The only route to a real diagnosis

A constructive note: what actually helps

The real ADHD research points to genuinely useful, low-cost supports – many invisible in viral content:

- ▶ **Structural clarity.** Signaling important info (headings, bolding, previews) improves comprehension & cuts cognitive load – robustly, across 103 studies and 12,201 participants. Helps ADHD *and* non-ADHD readers. (Richter 2016)
- ▶ **Work within working-memory limits.** Chunking, one idea per block, reduces the comprehension penalty under cognitive load. (Kofler 2018; Casteel 1988)
- ▶ **Support sustained attention.** Shorter sections, clear structure, minimal distraction – sustained attention is the single strongest predictor of adult ADHD comprehension. (Friedman 2023)

These are mundane. Nobody makes a viral video about "use clear headings." But they are what the evidence supports – in stark contrast to dopamine detoxes and diagnostic stimming reels.

The peer-reviewed evidence is unambiguous: **the most-watched ADHD content on the world's fastest-growing video platform is majority-misinformation.** Across six independent content analyses, between roughly half and nine in ten popular ADHD videos contain inaccurate, non-diagnostic, or unsupported claims – replicated on a second platform and confirmed in a systematic review of more than 5,000 posts.

The downstream chain is measurable: inflated self-diagnosis, assessment demand tripling in the UK with eight-year waits, adult diagnoses up ~62% in the US, stimulant fills up nearly a quarter, and one-in-four misuse among those prescribed. These trends reflect a genuine collision between real historic underdiagnosis and an information environment that systematically misrepresents what ADHD is.

For adults 18–34, the practical takeaway is sharp: social media can be a valid starting point for self-reflection, but it is, by formal measurement, the worst available source of ADHD information. The path from "this resonates" to "I have ADHD" must run through clinical assessment – not the For You page.



ABOUT THIS RESEARCH

Why we commissioned this paper

This white paper was researched and written by **Optiread**, a reading tool built around the *actual* cognitive science of attention – not the symptom lists that dominate the For You page. The research that matters for reading with ADHD is unglamorous and remarkably consistent: people with ADHD recall fewer *central* ideas from text (the centrality deficit), working memory is the bottleneck, and structural cues like headings, bolding, and clear summaries measurably improve comprehension for everyone.

Optiread puts those findings to work. It front-loads the key takeaways, chunks content to fit within working-memory limits, and uses signaling to make the important ideas impossible to miss – the same evidence-based techniques this paper recommends. It's designed around ADHD reading research, but because the same formatting lowers cognitive load for anyone, it helps non-ADHD readers too (the universal-design, or “curb-cut,” effect). It is a reading-comfort tool, not a medical treatment – and it will never promise to “fix” ADHD.

Try Optiread →

optiread.app

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This white paper is an evidence synthesis, not medical advice. ADHD diagnosis and treatment decisions must be made with a qualified clinician. For corrections or updates, re-verify all statistics against the primary sources cited above. · Prepared July 2026.