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Evaluating the Clinical Validity of ADHD Portrayals on TikTok

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To my Nannan Sue, thank you for always being there for me throughout my life. Without your kindness, I would have been lost in the dark. I will always cherish the main lesson you taught me, and no, I'm not talking about not swearing! - "*it's a beautiful day.*"

Finally, I dedicate this to my nieces and nephews: we are not bound by circumstance, only by our expectations of ourselves. Monique, Tyreece, Nafiah, Kason, Romey, Laila, Marcus, River, Myles, and Jaide – I love you all dearly.

Abstract

Public interest in Attention-Deficit/Hyperactivity Disorder (ADHD) has grown significantly, driven in part by social media platforms such as TikTok. However, increased visibility has not necessarily translated into accurate public understanding. This study examined the clinical accuracy and representational fidelity of ADHD-related TikTok content. A quantitative content analysis of 83 videos tagged with ADHD-related hashtags assessed the presence of DSM-5-TR symptoms and overall diagnostic accuracy. A custom DSM Accuracy Scale (DAS) was developed to evaluate clinical validity. While 84% of videos referenced DSM symptoms, only 7.14% met the threshold for diagnostic accuracy. Inattention symptoms were disproportionately represented, accounting for 67.6% of total symptom mentions. Video duration and the frequency of inattention symptoms significantly predicted DAS scores. These findings suggest that although TikTok increases ADHD visibility, it often presents partial and clinically inaccurate portrayals, raising concerns about misinformation and its influence on self-diagnosis and public understanding.

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1. Literature Review

1.1 Clinical Evolution of ADHD

There have been historical descriptions of children exhibiting symptoms of inattention, hyperactivity, and impulsivity, dating as far back as the 18th century, notably by Alexander Crichton (1798) and later by George Frederic Still in 1902 (Palmer & Finger, 2001). Clinical observations in the 1940s initially attributed these symptoms primarily to subtle brain damage or neurological impairments. However, without structural evidence of brain damage, alternative explanations were explored (Erk, 1995). Chess (1960) proposed that hyperactivity should be viewed primarily as a behavioural syndrome rather than purely as a consequence of brain injury or neurological impairment. Douglas (1972) expanded the focus beyond hyperactivity alone, highlighting deficits in sustained attention, impulse control, and self-regulation. Subsequently, Eisenberg (1966) provided empirical evidence demonstrating the efficacy of stimulant medications in reducing hyperactive behaviours. Around the same period, reliable standardised assessment tools, such as the Conners Rating Scales (Conners, 1973), were developed to provide objective and validated criteria for clinical diagnosis and research. Together, this body of work laid the conceptual foundation for the symptomatology of Attention-Deficit Hyperactivity Disorder (ADHD), helping to validate it as an observable, treatable, and clinically meaningful condition.

These clinical and psychometric advances informed the development of formal diagnostic classification systems. The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), progressively incorporated these evolving conceptualisations of attention and hyperactivity. DSM-II introduced the diagnosis of Hyperkinetic Reaction of Childhood, though it provided minimal criteria and retained a tenuous link to neurological dysfunction (APA, 1968). A more rigorous and behaviourally defined framework emerged with DSM-III, which introduced Attention Deficit Disorder (ADD) with or without hyperactivity (APA, 1980). Subsequent editions—DSM-III-R, DSM-IV, and DSM-IV-TR, refined symptom clusters and subtype classifications in response to empirical findings (APA, 1987; APA, 1994; APA, 2000). Notably, DSM-5 extended the age-of-onset criterion from 7 to 12 years and reduced the symptom threshold for individuals aged 17 and older, thereby increasing diagnostic sensitivity across the lifespan (APA, 2013).

The current DSM-5-TR provides the formal criteria used in clinical practice today. ADHD is classified as a neurodevelopmental disorder. Diagnostic thresholds require the presence of at least six symptoms from inattention and/or hyperactivity-impulsivity, with onset before the age of 12 and evidence of impairment in at least two contexts (e.g., home, school, or work) (APA, 2022). This standardised framework supports diagnostic consistency across practitioners and settings and facilitates targeted intervention. However, the revisions throughout the DSM have contributed, in part, to rising prevalence rates and reflect a broader trend toward recognizing ADHD as a heterogeneous, developmentally dynamic disorder, an approach that some critics argue undermines the disorder's legitimacy (Li et al., 2023).

1.2 Clinical and Conceptual Debates

1.2.1 Diagnostic Concerns

Changes in the diagnostic criteria and clinical definitions have intensified scrutiny of the disorder. Central to the debate is whether ADHD constitutes a legitimate neurodevelopmental disorder or pathologizes typical childhood behaviour. Questions of diagnostic validity and reliability persist, as criteria depend on behavioural observations that are inherently subjective and shaped by cultural, situational, and developmental contexts (Chan et al., 2022). However, cross-national studies show consistent ADHD prevalence under standardised criteria, supporting its validity as a clinical diagnosis (Faraone et al., 2003). Nevertheless, concerns about misdiagnosis remain, with variability in clinician judgment, symptom expression, and diagnostic frameworks contributing to false positives, especially where symptoms overlap with other developmental or environmental factors (Gordon et al., 2006; Merten et al., 2017). Some argue that these cases reflect misdiagnosed underlying conditions, such as vigilance disorders, learning difficulties, or mood disorders (Weinberg & Brumback, 1992). Distinguishing ADHD from other disorders with overlapping behavioural profiles remains a significant clinical challenge.

A growing criticism suggests that ADHD may instead reflect normative developmental variations rather than pathological impairments, raising concerns about the potential for overdiagnosis in children who are simply less developmentally mature than their peers (Furman, 2002; Merten et al., 2017). Research has highlighted children who are the youngest in their school year are significantly more likely to be diagnosed with ADHD (Ford-Jones, 2015; Schwandt & Wuppermann, 2016). This “relative age effect” suggests that some diagnoses may reflect developmentally typical immaturity rather than a neurodevelopmental disorder.

1.2.2 Evidence and Controversies

Clinical psychology integrates neurobiological explanations of ADHD, citing consistent neuroimaging findings of widespread brain volume reductions. For instance, individuals with ADHD often show smaller cerebral and cerebellar volumes, associated with impairments in executive function, motor coordination, and emotional regulation (Castellanos, 2002; Mackie et al., 2007). Further, reductions in grey and white matter suggest disruptions in both cognitive control and neural connectivity (Jacobson et al., 2018; Van Ewijk et al., 2012). Some studies report lateralised brain volume reductions in individuals with ADHD, with hemispheric asymmetries potentially contributing to difficulties in attention, verbal processing, and executive function observed in certain symptom profiles (Mostofsky et al., 2002).

While widely reported, these structural differences are complicated by methodological limitations, including predominantly male samples and reliance on cross-sectional designs, which do not account for developmental changes over time (Mostofsky et al., 2002; Van Ewijk et al., 2012). This makes it difficult to distinguish between fixed neurological abnormalities and developmental delays. Children with ADHD may follow a slower but ultimately typical neurodevelopmental trajectory, with apparent deficits reflecting a temporary lag in maturation (Furman, 2002; Merten et al., 2017; Mostofsky et al., 2002). Some research suggests individuals with ADHD may gradually catch up in brain development, and that stimulant medication may mediate structural differences, factors often unreported or uncontrolled in neuroimaging studies (Nakao et al., 2011). Recent longitudinal neuroimaging studies, such as Shaw et al. (2018), have begun addressing these developmental concerns by tracking brain maturation over time. Their findings suggest ADHD-related differences in cerebellar white matter reflect a delayed, not fixed, trajectory. Nonetheless, the results are preliminary and highlight the complexity of ADHD's neurobiological development, especially when such evidence is used to support its clinical validity.

Genetic research supports the neurobiological basis of ADHD. Twin and family studies show high heritability, and dopamine-related genes such as *DRD4* and *DAT1* have been implicated, suggesting that neurochemical factors may play a role in the disorder's expression (Curatolo et al., 2010). However, the search for definitive "ADHD genes" has been largely inconclusive, with most findings showing only modest, inconsistently replicated associations. This suggests that ADHD is highly polygenic and shaped by complex gene–environment interactions (Gizer et al., 2009; Thapar et al., 2013). For example, children from low socioeconomic backgrounds are two times more likely to be diagnosed with ADHD, partly due to factors such as maternal education and single-parent status (Banerjee et al., 2007). Symptoms have also been linked to toxin exposure, foetal alcohol, and maltreatment, although, children in disadvantaged environments often face both environmental and genetic risks, complicating causal interpretation (Russell et al., 2015).

Neurobiological and genetic research supports ADHD's validity as a clinical diagnosis, yet concerns persist about overdiagnosis, subjective assessment, and the pathologisation of normative behaviours (Chan et al., 2022; Merten et al., 2017). Although methodological and interpretative limitations must be acknowledged, they do not invalidate neurobiological findings. The issue lies not in the presence of neuroanatomical variation, but in assumptions about its clinical relevance, especially amid debates over diagnostic validity and the medicalisation of behavioural diversity. The disorder's heterogeneity, both in symptom presentation and in its neurobiological correlates, suggests that ADHD cannot be fully understood through a singular lens. These ongoing scientific and clinical debates highlight the complexity of ADHD, but they are also prone to misrepresentation in public discourse, where oversimplification fosters widespread misunderstanding.

1.3 The Shifting Landscape of ADHD Knowledge and Authority

1.3.1 Medical Gatekeeping in the Pre-Digital Era

Before the digital age, medical information was largely confined to textbooks, academic journals, and institutional libraries, with limited public access. Peer-reviewed articles were costly without University affiliations, and clinical guidelines were rarely publicly available (Groen, 2006; Lorkowski & Pokorski, 2022). Even when accessible, the use of jargon made interpretation challenging for lay audiences (Ryba et al., 2021). As a result, medical knowledge was largely inaccessible to non-experts and deemed best interpreted through professional judgment. This positioned medical professionals and researchers as the primary 'gatekeepers' of medical literacy, with authority rooted in both clinical expertise and institutional control over education, research, and dissemination of knowledge (Clausen & Freidson, 1971; Garrido et al., 2010; Loudon et al., 1974).

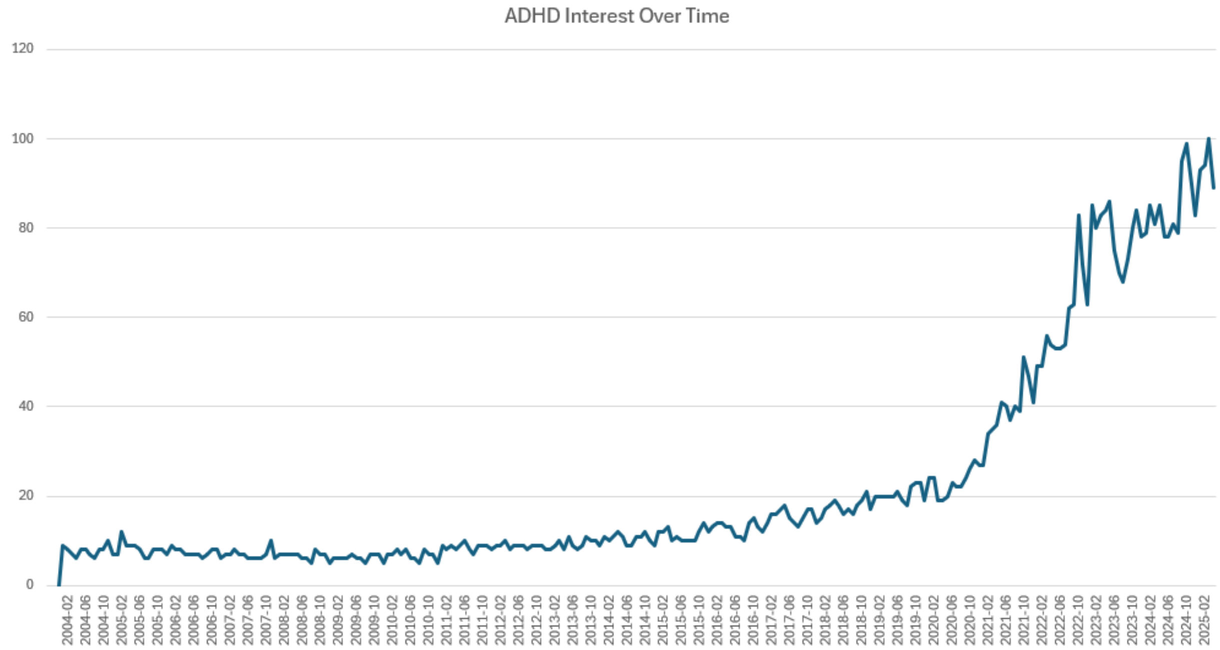
While professional control ensured medical accuracy, it limited accessibility and patient autonomy. With few credible alternatives, patients relied on healthcare providers for both diagnosis and understanding of their conditions (Haug, 1988). Such dependence made it difficult for patients to judge whether the guidance they received reflected current medical research, particularly relevant to ADHD, where evolving evidence continually reshapes diagnostic criteria and treatment (Lange et al., 2010). As a result, non-stereotypical presentations were often overlooked, evident in diagnostic discrepancies among females due to referral bias (Young et al., 2020), and in the systemic underdiagnosis of Black and Latino children, shaped by cultural and institutional barriers (Coker et al., 2016).

1.3.2 The Democratisation of Medical Knowledge

The rise of the internet disrupted traditional medical authority, removing long-standing barriers and increasing information liquidity (Meskó et al., 2017). Medical literacy became more democratised, as individuals began accessing, interpreting, and sharing health information beyond clinical settings. Online campaigns like *ADHD Awareness Month* sought to educate the public, raise visibility, and challenge misconceptions (CHADD, 2025), contributing to higher Google Trends search activity (Zhao et al., 2021) and growing public interest (see Figure 1). This heightened awareness parallels a 72% relative increase in ADHD diagnoses among children, rising from 6.1% to 10.47% between 1997 and 2022 (Abdelour et al., 2020; Li et al., 2023).

Figure 1

'ADHD' Google Search Trends From 2004 - Present



Note. Numbers represent search interest relative to the highest point on the chart for that given time

Declining professional gatekeeping and vulnerabilities in modern information systems have enabled the spread of unverified, and sometimes harmful, health information, particularly around ADHD where public understanding remains fragmented (Godfrey et al., 2020; Southwell et al., 2019). Platforms such as PubMed, health forums, and online communities increasingly allow laypeople to self-diagnose without clinical oversight (Charland, 2004; Giles & Newbold, 2010; Nettleton et al., 2005). Parents and caregivers are especially influenced, often searching for their child's symptoms such as "child's anger", "hyperactivity", or "lack of concentration", and being directed to ADHD-related websites (Bringer et al., 2025). Consequently, online health information has overtaken healthcare professionals as the primary source of ADHD understanding (Bussing et al., 2012).

1.3.3 ADHD and the Wellness Economy

The expansion of online ADHD discourse has been accompanied by the commercialisation of the condition. This emerging 'wellness economy' includes ADHD life coaching, cognitive-enhancing supplements, and paid online diagnostic quizzes (Bergey, 2024; Sarris et al., 2011; Verma & Sinha, 2024). Financial incentives encourage overidentification with ADHD traits and risk exploiting individuals seeking support or experiencing health anxiety, while shifting focus from clinical care to alternative private-sector models (Giles & Newbold, 2010; Young et al., 2021). Such dynamics introduce bias, with claims often exaggerated to drive sales or user engagement (Campanini, 2023). The dissemination of unsupported advice further undermines public understanding of ADHD and its treatment (Lui et al., 2025). Moreover, access to information has again become restricted behind paywalls, without any guarantee of medical accuracy, as shown by the poor concordance between online ADHD resources and established clinical standards (Giles & Newbold, 2010; King et al., 2021).

Greater access to medical information has empowered self-guided health-seeking but also blurred the line between credible guidance and misinformation. This risks reinforcing stigma, trivialising ADHD, and undermining trust in legitimate interventions (Charland, 2004; Mueller et al., 2012). While such services may meet needs unmet by long clinical wait times, they often conflate advocacy with commercial interests (Takeda, 2019). As online spaces shape public understanding, balancing accessibility and accuracy remains essential.

1.4 ADHD and TikTok: A New Paradigm

1.4.1 TikTok's Role in Shaping ADHD Discourse

As online health-seeking expanded, social media became a central hub for ADHD discourse, offering not only information but also emotional support, advice, and reassurance. Online communities replicated traditional support systems and became as influential as family and friends in shaping behaviours and health decisions (Frey et al., 2021; Moon et al., 2019).

Among these platforms, TikTok has been particularly influential in shaping public perceptions of ADHD. With 1.14 billion users globally and over 11 billion views on the #adhd hashtag (Statista, 2025), its attention-oriented design offers a strategic advantage in disseminating health content (Lupton, 2020; MacKinnon et al., 2021). However, algorithmic curation creates echo chambers that reinforce beliefs, and TikTok's focus on trends, virality, and aesthetics promotes ADHD content that encourages self-diagnosis (Milton et al., 2023; Siles et al., 2022).

Content creators have driven the discourse, leveraging rising awareness by sharing symptom-focused and experiential content (Verma & Sinha, 2024). To boost engagement and credibility, they follow co-produced norms shaped by audience expectations and TikTok's algorithm, crafting content that is relatable, humorous, and intimate (Holroyd, 2025). This environment may incentivise generalised portrayals of ADHD, blurring the line between awareness and sensationalism (Karasavva et al., 2025; Siles et al., 2022). In one study, 64% of respondents had heard of ADHD, but only 33% could accurately describe its symptoms, and 13% doubted its legitimacy as a real disorder (McLeod et al., 2007), suggesting that increased awareness doesn't always lead to accurate understanding.

1.4.2 Platform Design, Cognitive Effects, and Self Diagnosis

Recent studies indicate that TikTok can shape how users move from casual engagement to self-identification and diagnosis. Often encountering ADHD content incidentally through algorithmic suggestions, users may be prompted to reflect on and recognize ADHD traits (Eagle & Ringland, 2023). Gilmore et al. (2022) found that TikTok frequently acts as a diagnostic catalyst, encouraging users to interpret longstanding challenges through an ADHD framework. Similarly, Lovelace (2024) reports a measurable link between engagement with ADHD-related content and the likelihood of pursuing clinical evaluation. These findings indicate that TikTok's influence extends beyond awareness, actively shaping diagnostic trajectories.

A growing concern is that TikTok's algorithm and addictive design may not just mimic but also contribute to ADHD-like symptoms, particularly in attention and impulse control. Research links its fast-paced, high-stimulation content to reduced attentional control, making it harder to focus on sustained tasks or remain still (Firth et al., 2019; Kuss & Griffiths, 2017). These behavioural effects closely align with core ADHD symptomatology (APA, 2022). Moreover, time spent on TikTok has been positively correlated with elevated hyperactivity symptoms in the absence of childhood-onset presentation (Lovelace, 2024).

These platform-induced cognitive changes may lead individuals to misattribute transient attentional difficulties to enduring, trait-based neurodevelopmental disorders, particularly in digital environments where mental health content is algorithmically reinforced based on user engagement (Holroyd, 2025; Siles et al., 2022). Engagement with ADHD-related material further amplifies perceived symptom alignment through self-reinforcing feedback loops (Karasavva et al., 2025). This process fosters confirmation bias, as individuals selectively attend to information that supports self-diagnosis while disregarding contradictory evidence (Suzuki & Yamamoto, 2021). Consequently, the interplay between digital media use and ADHD self-identification warrants critical scrutiny within contemporary diagnostic discourse. However, research in this area remains relatively new and predominantly correlational; thus, causation cannot yet be directly attributed to TikTok use.

While TikTok may encourage self-identification, this does not imply that users engaging with such content lack ADHD. TikTok's short, stimulating format has been associated with dopamine spikes and aligns with shorter attention spans (Nadeem & Sabir, 2022). Combined with algorithmic reinforcement, it creates a self-perpetuating cycle of engagement. For individuals with ADHD who have reduced dopamine levels and attentional difficulties, these features may make the platform particularly appealing (Volkow et al., 2009; Hussain & Griffiths, 2019; Siles et al., 2022). Nevertheless, rising ADHD identification has strained diagnostic services, with some NHS regions reporting wait times of up to 5–10 years (Takeda, 2019; Young et al., 2021). This unmet demand has accelerated the growth of private ADHD services via right-to-choose pathways (UK Government, 2012), contributing to a two-tiered system in which GPs often hesitate to continue prescriptions from unverified or private providers, disrupting care for diagnosed individuals (Smith et al., 2023).

While TikTok has increased public recognition of ADHD and may encourage health-seeking behaviours, it also raises concerns around self-diagnosis, symptom misattribution, and added pressure on clinical services. Accordingly, the accuracy of ADHD-related content on the platform warrants critical investigation.

1.5 The Accuracy of TikTok Content and Research

1.5.1 TikTok Content Accuracy

Research on the accuracy of ADHD-related content on TikTok remains limited, with only three peer-reviewed studies identified in this literature review. The first, by Yeung et al. (2022), analysed the top 100 most-viewed videos under the #adhd hashtag, categorising them as *useful*, *misleading*, or *personal experiences*. Using a systematic sampling method and referencing the Canadian ADHD Practice Guidelines (CADDRA) and the American Academy of Pediatrics (AAP) ADHD Practice Guidelines. Videos were deemed *useful* if they contained scientifically accurate information on any aspect of ADHD (e.g., symptoms, diagnosis, treatment), and *misleading* if they included unsupported claims (e.g., unproven treatments). They found 52% of videos to be misleading, primarily due to the misattribution of general psychiatric symptoms to ADHD, while 27% were personal experiences and 21% were considered useful.

The second study, by Verma and Sinha (2024), conducted a content analysis of the top 50 TikTok videos promoting self-diagnosis under the #adhdtest hashtag. Only videos referencing ADHD diagnosis or assessment were included. The content was categorised as *useful* or *misleading* based on whether it contained at least 4 of the 6 items from the Adult ADHD Self-Report Scale (ASRS). By this criterion, 92% of videos were classified as misleading.

Finally, Karasavva et al. (2025) analysed the 100 most-viewed TikTok videos under the #adhd hashtag, focusing on symptom and treatment claims. Two licensed clinical psychologists independently assessed each symptom claim against DSM-5 criteria, finding 51.3% inaccurate. Inaccurate claims most often reflected normal experiences (68.5%), transdiagnostic symptoms (42%), or other disorders (18.2%). Among accurate claims, inattention was most common (71.3%), followed by hyperactivity (27.2%) and impulsivity (16.2%). Attempts to assess severity and impairment were excluded due to poor inter-rater reliability. The average psychoeducational rating was 1.78/5, reflecting low educational value and concerns about misinformation.

All three studies found high levels of misinformation in ADHD-related TikTok content, largely from misattributing general symptoms to ADHD. Accurate content was scarce, lacked clinical nuance, and offered low educational value. These findings highlight TikTok’s frequent misrepresentation of ADHD, raising concerns about misinformation and its impact on public understanding and self-diagnosis.

1.5.2 TikTok Research Accuracy

Despite consistent findings, all three studies face methodological issues, notably sampling bias from focusing solely on the “top” most-viewed videos. Karasavva et al. (2025) and Yeung et al. (2022) both analysed content under the #adhd hashtag, suggesting potential overlap in their samples. Verma and Sinha (2024) used #adhdtest, but similar limitations apply. Focusing on top-performing videos may over-represent individual creators or viral trends, limiting the generalizability of findings (Hurwitz et al., 2016).

Concerns remain about the potentially inconsistent methods used to classify TikTok content as 'accurate' or 'misinformation'. Yeung et al. (2022) cited CADDRA and AAP guidelines but failed to explain how these informed classifications or how mixed-content videos were assessed, reducing transparency and replicability. Verma and Sinha (2024) used the ASRS, which does not fully reflect DSM-5 criteria (APA, 2022); requiring videos to match 4 out of 6 items may unfairly penalise short-form content not intended to be comprehensive or equivalent to a formal screener. Karasavva et al. (2025) used clinical psychologists to assess alignment with DSM-5 ADHD symptoms at the claim level, improving precision. However, they excluded symptom severity and functional impairment due to low inter-rater reliability, limiting the clinical validity of their accuracy ratings. This may explain the gap between nearly half of claims rated as accurate and the low average psychoeducational score (1.78), suggesting that accuracy alone does not ensure educational value. Although the only study to examine symptom distribution, Karasavva et al. (2025) did not report specific symptoms, and their sampling may reflect which profiles drew the most views rather than representing the full spectrum of ADHD content on TikTok.

1.6 The Current Study

This study reduces sampling bias and enhances generalisability by analysing ADHD-related TikTok's from unique creators instead of only top-performing or viral content. Prior studies have focused on content accuracy or individual claims, often neglecting broader symptom representation and how well TikTok reflects ADHD as a clinical condition. Inconsistent definitions of 'accuracy' and 'misinformation' underscore the need for a standardised, context-specific framework to assess short-form mental health content.

To address these gaps, this study applies DSM-5-TR criteria (APA, 2022) to assess the diagnostic validity of ADHD symptom portrayals on TikTok, examine symptom distribution, and identify factors predicting diagnostic accuracy. Based on prior literature, it is anticipated that inattention symptoms will be most frequently represented (Karasavva et al., 2025). Specific symptoms, "*Difficulty sustaining attention*", "*Frequently leaves seat when sitting is expected*", and "*Hyperactivity*" may appear more often, as TikTok's association with them likely drives discussion and inclusion under ADHD-related content (Firth et al., 2019; Holroyd, 2025; Kuss & Griffiths, 2017; Lovelace, 2024). Finally, consistent with previous findings (Karasavva et al., 2025; Yeung et al., 2022; Verma & Sinha, 2024), most videos are expected to fail to meet the DSM-5-TR threshold for diagnostic accuracy.

1.6.1 Hypotheses

H1: Inattention symptoms will be significantly more frequently represented than hyperactivity/impulsivity symptoms.

H2: The individual symptoms *"Difficulty sustaining attention," "Frequently leaves seat when sitting is expected,"* and *"Hyperactivity"* will be the most frequently mentioned.

H3: A majority of TikTok videos that reference ADHD symptoms will not meet the minimum threshold for diagnostic accuracy.

1.6.2 Research Questions

RQ1: Does TikTok content holistically and accurately represent ADHD?

RQ2: What content features predict higher diagnostic accuracy in ADHD-related TikTok videos?

2. Method

2.1 Design

This study employed a quantitative content analysis to systematically quantify and interpret TikTok video content, chosen for its suitability in categorising and analysing media. (Krippendorff, 2019). The research was non-experimental, observational, and cross-sectional, analysing a representative sample of TikTok videos. A primarily deductive coding approach was used, guided by DSM-5-TR criteria, which were chosen over alternatives like the ICD due to its widespread use, detailed diagnostic criteria, and alignment with ICD guidelines (APA, 2022; Gomez et al., 2023). Inductive coding was also incorporated to allow new categories to emerge and be integrated during analysis.

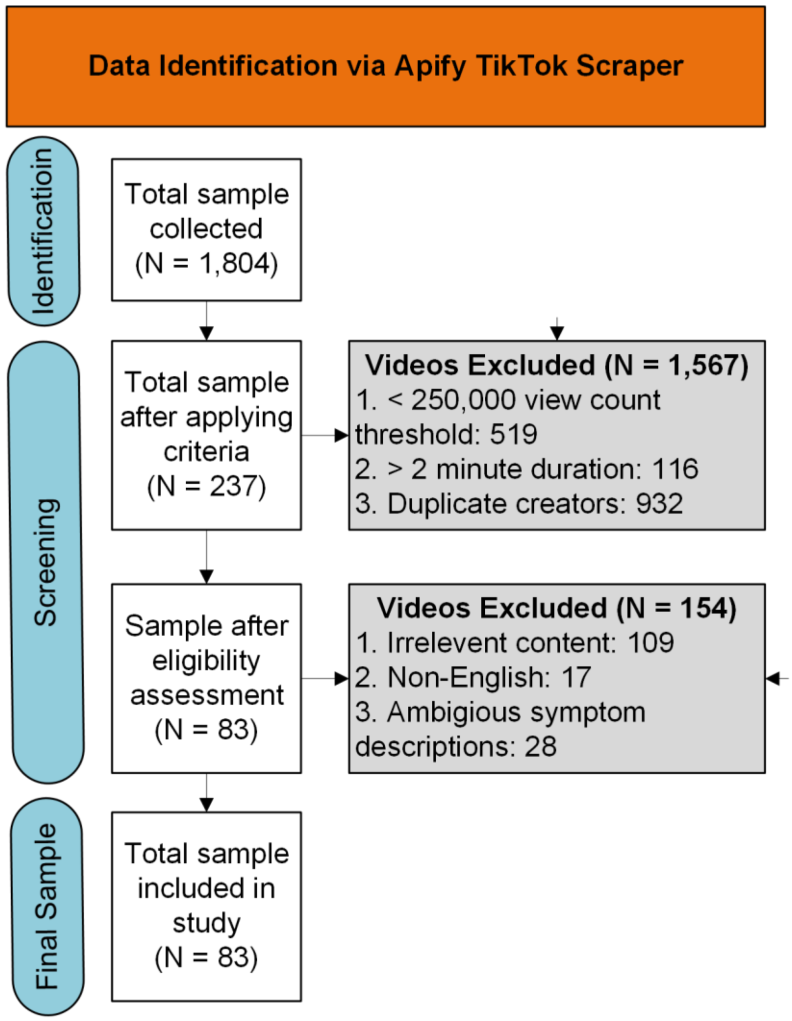
2.2 Data collection

The sample was generated using the Apify TikTok Scraper (Clockworks, 2025) on the 19th of February 2025, targeting the hashtags #adhdsymptoms, #adhdawareness, and #adhddiagnosis, which yielded a total of 1,804 videos for initial review (see Appendix A). Because the dataset comprised publicly accessible TikTok videos, participant consent was not required. However, efforts were made to maintain user anonymity and represent content respectfully in the analysis.

Purposive sampling was employed to obtain a representative sample of TikTok content, using a predefined set of inclusion and exclusion criteria (Figure 2), which is consistent with other studies of a similar nature (Karasavva et al., 2025; Yeung et al., 2022).

Figure 2

Applied Inclusion and Exclusion Criteria



The initial sample was drawn from the #adhd hashtag, but much of the content was irrelevant to the research question(s). The sampling strategy was revised to better align with the study's focus on ADHD symptomatology. Nonetheless, some relevant content may have been excluded due to user variability in hashtag use.

A view count threshold of 250,000 was chosen to ensure a diverse mix of professional and personal content, as higher thresholds risked excluding educational videos that typically receive lower engagement on TikTok (Ramjee & Hasan, 2024). Additionally, a maximum video duration of two minutes was set to align with TikTok's short-form content norms while still providing sufficient data for analysis.

To prevent over-representation, only the most-viewed video per creator was retained. While some studies focus on the top 100 most-viewed videos (Karasavva et al., 2025; Yeung et al., 2022), this can overrepresent viral trends rather than consistent content patterns. Additionally, creators often repost or slightly modify content to boost engagement, resulting in redundancy (Hurwitz et al., 2016). Limiting to one video per creator helped ensure diverse perspectives and reduce duplication. This filter yielded 237 unique videos.

Two independent researchers (psychology undergraduates) manually assessed the remaining videos for relevance. Exclusions were made for lacking reference to ADHD symptomatology, being non-English, or presenting symptoms too ambiguously for coding. This process resulted in a final dataset of 83 unique TikTok videos (see Appendix A).

Although the final sample of 83 videos fell slightly short of the original target of 100, prior adjustments to inclusion criteria (e.g., video duration, view threshold) had already been made to expand the sample. Further revisions would have required including content unrepresentative of TikTok's short-form or popular formats. As 83 remained methodologically sound and close to the target, it was deemed sufficient for analysis.

2.3 Materials

Data were extracted from TikTok using the Apify TikTok Scraper (Clockworks, 2025), resulting in an Excel spreadsheet containing metadata for each video (see Appendix A). Relevant fields included the video URL, duration, engagement metrics (likes, comments, saves, views), hashtags, creator handle and bio, and caption text. These data informed the application of inclusion and exclusion criteria and supported manual coding.

A structured coding framework was developed in Excel (see Appendix B). ADHD-focused creators were identified by reviewing each creator's username and bio for relevant references (e.g., ADHD, neurodivergent). Videos were classified as either educational (e.g., raising awareness, encouraging diagnosis) or non-educational (e.g., personal experiences, point-of-view content). Based on DSM-5-TR criteria (APA, 2022), references to symptom impairment, persistence, severity, pervasiveness, or onset were coded. Each of the nine inattention and nine hyperactivity/impulsivity symptoms was individually coded when mentioned. Any behaviour presented as specific to ADHD but not recognised by the DSM-5-TR was coded under the 'Non-DSM Symptom' category. Inter-rater reliability between two independent coders was assessed using JASP (version 0.19.3). Subsequent data analysis was conducted using Jamovi (version 2.6.26).

2.3.1 DSM Accuracy Scale

A custom DSM Accuracy Scale (DAS) was developed to assess whether TikTok videos included diagnostically significant criteria for ADHD based on DSM-5-TR guidelines. The scale included five criteria: *Impairment*, *Severity*, *Persistence*, *Pervasiveness*, and *Onset*. It should be noted that impairment was added to the coding framework after the initial coding phase and was, therefore, not included in the interrater reliability assessment. Each of these core criteria was assigned a weight to prioritise diagnostically significant features while still recognising the value of supporting contextual indicators. Each video was then scored based on their presence of diagnostic criteria identified during the coding phase.

Impairment was weighted most heavily, reflecting its central role in determining clinical significance and functional disruption (APA, 2022). Similarly, *Severity*, which captures the extent of symptom-related dysfunction and is often underrepresented in TikTok content (Barkley et al., 2004; Karasavva et al., 2025), and *Persistence*, which establishes the chronic nature of symptoms beyond occasional occurrences, were also considered core criteria within the accuracy framework. These three features are essential for distinguishing normative behaviours from clinically significant ADHD symptoms, thereby reducing the risk of false-positive identification (Gathje et al., 2008; Gordon et al., 2006).

Pervasiveness and *Onset* serve as supporting features; they add value when present but are not sufficient on their own. *Onset* can be difficult to confirm, as adults often struggle to recall early symptom history (Simon & VonKorff, 1995), while *Pervasiveness* is typically inferred rather than explicitly stated due to the brevity of TikTok content (Woods et al., 2023). The final scoring framework emphasises *Impairment* as the most critical factor, while also requiring a combination of core clinical features and developmental or contextual support to meet the diagnostic accuracy threshold (see Table 1).

Table 1

DSM Accuracy Scale Weights

Feature	Weight
Core Criteria	
Impairment	4.5
Severity	3.0
Persistence	3.0
Supporting Indicators	
Pervasiveness	1.5
Onset	1.5

Note. Accuracy Score Calculation: (Impairment * 4.5) + (Severity * 3) + (Persistence * 3) + (Pervasiveness * 1.5) + (Onset * 1.5)

A total DAS score of 6.0 or higher was established as the minimum threshold for acceptable diagnostic accuracy. Scoring combinations were determined based on their contextual relevance and alignment with DSM-5-TR standards. For example, a video referencing two core criteria, such as *Impairment* and *Persistence*, demonstrates sufficient diagnostic depth: *"For extended periods, I have difficulty sustaining attention, preventing me from completing tasks."* In contrast, statements reflecting only supporting indicators, such as *"I cannot sustain attention in school and social interactions,"* lack specificity and could be attributed to a range of other conditions. A combination of *Impairment* and a supporting indicator like *Onset*, *"Since childhood, I have difficulty sustaining attention, preventing me from completing tasks effectively",* offers slightly more depth and helps rule out certain alternative explanations, but only narrowly meets the threshold. Videos that include either *Severity* or *Persistence* paired with a supporting indicator, such as *"I have had difficulty sustaining attention for extended periods since childhood,"* fall just below the threshold. While such statements provide some contextual richness, they are not sufficient to reflect a clinically accurate portrayal of ADHD. The DSM requires differential diagnosis, and similar concentration issues are commonly observed in other conditions, such as anxiety and learning disorders (APA, 2022). For this reason, *Impairment* is weighted most heavily in the DAS, as it captures the consistent, measurable, and cross-situational disruption in functioning that distinguishes ADHD from non-clinical or alternative presentations.

2.4 Procedure

The collected video data was reviewed in full by two independent researchers. An initial set of ten videos was randomly selected to calibrate and refine the coding technique collaboratively. Any initial disagreements between coders were resolved through discussion, and no third-party adjudicator was required. Following this, each researcher independently reviewed and coded all 83 videos using the coding framework outlined in the Materials section and detailed in Appendix B.

Interrater reliability was assessed using two methods. Cohen's Kappa was calculated for nominal data, indicating substantial but not absolute agreement between the two raters, $\kappa = .69$, 95% CI [.63, .74]. For ratio data, the intraclass correlation coefficient (ICC) was calculated using a two-way mixed-effects model, single measures, and absolute agreement.

This analysis indicated moderate reliability, ICC = .72, 95% CI [.64, .81]. Upon closer inspection, disagreements were frequently associated with coding errors and inconsistent interpretations of the DSM-5-TR criteria (see Appendix C). Consequently, it was determined that a higher level of interrater agreement was necessary to ensure the accuracy and consistency of subsequent coding.

To improve interrater reliability, the two researchers collaboratively re-coded all videos. This process involved watching each video together and discussing coding decisions to ensure consistent and accurate application of the coding scheme (see Appendix D). Interrater reliability was re-assessed following this process. For nominal data, Cohen's kappa indicated almost perfect agreement, $\kappa = .95$, 95% CI [.93, .98]. For ratio data, the ICC indicated excellent reliability, ICC = .96, 95% CI [.93, .996]. The data were thus deemed appropriate for analysis.

2.5 Ethics

This study was conducted in accordance with Sheffield Hallam University's ethical guidelines, with all necessary ethical considerations addressed prior to data collection. Ethical approval was granted through a UREC-3 application on 13/01/2025 (see Appendix E). The researcher also completed relevant Epigeum training (see Appendix F). Data were collected on 19/02/2025 and securely stored on an allocated network drive to maintain confidentiality and prevent unauthorised access.

As this study did not involve direct interaction with participants, informed consent was not required. The research used publicly available TikTok content and adhered to ethical research practices to ensure responsible use, minimising potential harm or distress to individuals or communities. This approach aligned with the British Psychological Society's (BPS) guidelines for internet-mediated research (BPS, 2021).

To maintain academic integrity, data analysis and findings were reported honestly and transparently. An objective approach with a clearly defined rationale was applied to the coding criteria, and inter-rater reliability was used to ensure consistency and reduce subjectivity. Findings were contextualised within relevant clinical guidelines to enhance accuracy and applicability, helping to prevent the dissemination of misinformation (BPS, 2021).

3. Results

3.1 Descriptive Statistics

All 83 TikTok videos were successfully coded (see Appendix G) and analysed using Jamovi (version 2.6.26). Video metrics, such as duration, likes, comments, saves, shares, and views, violated parametric assumptions and deviated from normality, as indicated by histograms, boxplots, and skewness statistics (see Appendix H). One video had saving and sharing disabled and was therefore excluded from the total video metrics, as it constituted an outlier. The range, median (*Mdn*), and interquartile range (*IQR*) for the video metrics are presented in Table 2.

Table 2

Video Metrics Descriptive Statistics

	Range	***Median (IQR)***	***Skewness***	***Std. error skewness***
Duration (seconds)	6 - 119	25 (30.5)	1.29	.29
Likes	5,827 - 5,500,000	181,500 (382,100)	4.05	.29
Comments	56 - 35,500	1,860 (3,861)	2.93	.29
Saves	583 - 351,900	20,900 (44,457)	3.04	.29
Shares	490 - 359,100	17,800 (38,120)	3.39	.29
Views	254,500 - 38,300,000	2,600,000 (3,720,000)	3.59	.29

Of the 83 videos analysed, 18 (21.7%) used the hashtag #adhdawareness, 15 (18.1%) used #adhddiagnosis, and 50 (60.2%) used #adhdsymptoms. In total, 51 videos (61.4%) were made by ADHD-focused creators, and 45 (54.2%) were classified as educational (e.g., raising awareness, informing diagnosis).

3.2 DSM Symptom Inclusion

3.2.1 Symptom Distribution

Each of the 83 videos in the dataset was coded for the presence or absence of all nine symptoms of inattention (IN) and all nine symptoms of hyperactivity/impulsivity (HI) in line with DSM-5-TR criteria (APA, 2022).

Multiple analyses were conducted to investigate the ADHD symptom inclusion and distribution. Initially, to assess if TikTok content included DSM-referenced symptoms at an expected equal distribution, a chi-squared goodness-of-fit test was deemed appropriate to examine the distribution of a single categorical variable (Pearson, 1900). The results showed a significant deviation, $\chi^2(1, N = 83) = 39.10$, $p < .001$, with a large effect size $\varphi = .69$. This indicates that TikTok content was significantly more likely to include DSM-related symptoms than to exclude them (see Table 3).

Table 3

Observed and Expected Frequencies of Videos Including DSM-Referenced Symptoms

Content-Type	Observed (Proportion)	Expected (Proportion)
DSM Absent	13 (16%)	41.5 (50%)
DSM Inclusion	70 (84%)	41.5 (50%)

Note. Expected values assume an equal distribution of inclusion and exclusion.

To assess the distribution of IN versus HI symptoms, McNemar's test was used for paired binary data, as it is appropriate for comparing two related proportions (McNemar, 1947). The test revealed a significant difference in the proportion of videos reporting IN versus HI symptoms, $\chi^2(1, N = 70) = 14.10, p < .001$. The log odds ratio was also significant (log OR = –1.21, $p < .001$), corresponding to an OR ratio of 0.30. This indicates that among videos reporting only one symptom type, the odds of reporting IN symptoms were approximately 3.34 times higher than the odds of reporting HI symptoms. Specifically, 59 videos (71.08%) featured IN symptoms, compared to 33 (39.76%) featuring HI symptoms (see Table 4)

Table 4

Contingency Table of IN and HI Symptom Presence in TikTok Content

	HI Absent	HI Present	Row Total
IN Absent		11	11
IN Present	37	22	59
Column Total	37	33	70

Note. Only videos reporting at least one symptom type (IN or HI) were included

3.2.2 Symptom Frequency

For deeper analysis, a Chi-square goodness-of-fit test was appropriate to assess whether the observed frequencies of IN and HI symptoms deviated from an expected equal distribution, as the data were categorical (Pearson, 1900). The analysis revealed a significant deviation from an equal distribution, $\chi^2(1, N = 188) = 23.17, p < .001$, Cohen's $w = 0.35$, indicating a medium effect size, suggesting IN symptoms were mentioned significantly more frequently than HI symptoms (see Table 5).

Table 5

Observed and Expected Frequencies of IN and HI Symptoms

	Observed (Proportion)	Expected (Proportion)
IN Symptom Mentions	127 (67.6%)	94 (50%)
HI Symptoms Mentions	61 (32.4%)	94 (50%)

Note. Expected values assume an equal distribution between symptom mentions.

Building on this, a Chi-square goodness-of-fit test was used to assess the distribution of all 18 symptoms collectively, as this test is suitable for categorical variables (Pearson, 1900). The test revealed a significant deviation from equal distribution, $\chi^2(17, N = 188) = 88.45, p < .001$, Cramér's $V = 0.17$, indicating a medium effect size. This suggests a substantial variation in the frequency of symptoms, with some symptoms being notably more prevalent than others. The frequency table for IN and HI symptoms can be found in Table 6 and visual distribution can be seen in Figure 3.

Table 6

Observed and Expected Frequencies of All ADHD Symptoms

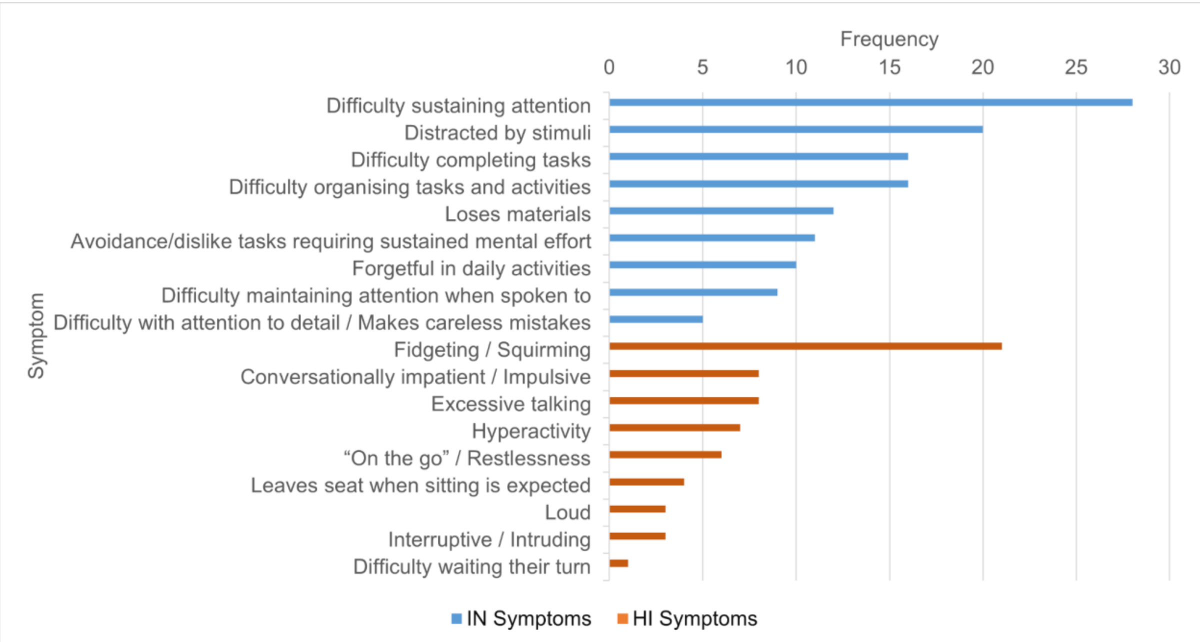
Symptom	Observed (Proportion)	Expected (Proportion)
Inattention Symptoms	127 (67.6%)	93.96 (50%)
Difficulty sustaining attention	28 (14.9%)	10.44 (5.6%)
Distracted by stimuli	20 (10.6%)	10.44 (5.6%)
Difficulty completing tasks	16 (8.5%)	10.44 (5.6%)
Difficulty organising tasks and activities	16 (8.5%)	10.44 (5.6%)
Loses materials	12 (6.4%)	10.44 (5.6%)
Avoidance/dislike tasks requiring sustained mental effort	11 (5.9%)	10.44 (5.6%)
Forgetful in daily activities	10 (5.3%)	10.44 (5.6%)
Difficulty maintaining attention when spoken to	9 (4.8%)	10.44 (5.6%)

Difficulty with attention to detail / Makes careless mistakes	5 (2.7%)	10.44 (5.6%)
Hyperactivity/Impulsivity Symptoms	61 (32.4%)	93.96 (50%)
Fidgeting / Squirming	21 (11.2%)	10.44 (5.6%)
Conversationally impatient /Impulsive	8 (4.3%)	10.44 (5.6%)
Excessive talking	8 (4.3%)	10.44 (5.6%)
Hyperactivity	7 (3.7%)	10.44 (5.6%)
"On the go" / Restlessness	6 (3.2%)	10.44 (5.6%)
Leaves seat when sitting is expected	4 (2.1%)	10.44 (5.6%)
Loud	3 (1.6%)	10.44 (5.6%)
Interruptive / Intruding	3 (1.6%)	10.44 (5.6%)
Difficulty waiting their turn	1 (0.5%)	10.44 (5.6%)
Total	188 (100%)	188 (100%)

Note. Symptom descriptions are abbreviated from DSM-5-TR criteria. Expected values reflect an equal distribution across the 18 symptoms.

Figure 3

Frequencies of ADHD Symptom Mentions in TikTok Videos



Note. IN = Inattention, HI = Hyperactivity / Impulsivity

3.3 ADHD Content Accuracy

3.3.1 Accuracy Assessment

The DSM Accuracy Scale (DAS), described in Methods 4.3, revealed deviations from normality, as indicated by histograms, boxplots and descriptive statistics (see Appendix I). Box plots indicated four possible outliers, and the computed Z-scores, using ±3.29 as the cut-off (Tabachnick & Fidell, 2006), confirmed one of them ($z = 4.86$). Further, skewness statistic shows that the data is not normally distributed (skewness = 2.49, $SE = 0.29$), and a Shapiro-Wilk test indicated a significant violation of the normality assumption for DAS scores, $W = 0.634$, $p < .001$. Although Z-scores confirmed one outlier, this was retained as they represented valid scores consistent with the DAS framework. These results indicate that the data are non-parametric; therefore, non-parametric tests were used for the subsequent analysis.

To investigate whether content that included DSM-referenced symptoms ($N = 70$) met the DAS threshold (6.0), a one-sample Wilcoxon signed-rank test was employed, as this is suitable for one sample, non-parametric, paired data (Wilcoxon, 1945). The results showed that DAS scores were significantly lower than the test value, $W = 81.0$, $p < .005$, $r = -.93$, indicating a large negative effect. Of the 70 videos that included DSM-referenced content, only 5 (7.14%) met the DAS threshold. These findings suggest that the content generally did not meet the standard for adequate DSM accuracy.

3.3.2 Accuracy Prediction

Further analysis was conducted to explore which factors predicted DAS scores. To investigate this, multiple linear regression (MLR) was employed to examine whether video metrics (e.g., likes, views, shares, comments, saves, and duration), content characteristics (ADHD-focused status, educational classification), and symptom types (IN and HI counts, non-DSM mentions) predicted DAS scores. This method was appropriate, as the outcome variable was continuous and the analysis aimed to determine the unique contribution of each predictor to content accuracy (Cohen et al., 2013).

Prior to analysis, the assumptions of linearity, homoscedasticity, normality of residuals, and absence of multicollinearity were assessed to ensure the suitability of the MLR model. Multicollinearity concerns were present, as variance inflation factor (VIF) values for several individual engagement metrics exceeded 10 (see Appendix J). To address this, a composite Engagement Score was created by dividing the sum of likes, comments, shares, and saves, by the number of views. This transformation standardised engagement across the content of varying popularity and reduced redundancy among predictors.

The new Engagement Score (Mdn = 0.09, IQR = 0.07) was tested for normality and demonstrated mild deviations, as indicated by a Shapiro–Wilk test, W = 0.96, $p = .015$, and a skewness value of 0.60 (SE = 0.29). However, the histogram revealed a minor skew, and boxplots showed no outliers (see Appendix K). The resulting composite variable was used in place of individual metrics in the final regression model.

Assumption checks for the revised model indicated no issues with multicollinearity, as all VIF values were below 3 (see Appendix L). Visual inspection of the residuals versus fitted values plots, including those for individual predictors, suggested a roughly random distribution, indicating that the assumptions of linearity and homoscedasticity were generally met (see Appendix M). While mild outliers were present, the residuals appeared symmetrically distributed, with no evidence of funnelling or curvature. A Shapiro–Wilk test of the regression residuals indicated a deviation from normality ($W = .89$, $p < .001$); however, visual inspection of the Q–Q plot (see Appendix L) suggested the residuals were approximately normally distributed. Given the robustness of multiple regression to mild violations of normality and the fact that all other key assumptions were met, the model was deemed appropriate for interpretation (Cohen et al., 2013).

A multiple linear regression was conducted to examine predictors of DAS scores. The final model was statistically significant, $F(7, 61) = 3.07$, $p = .008$, and accounted for 18% of the variance in scores (*adjusted* $R^2 = .18$), indicating a medium effect size $f^2 = .22$ (Cohen, 1988). Full model fit statistics are provided in Appendix N, and regression coefficients and significance levels are presented in Table 7 and Appendix N.

Table 7

Multiple Linear Regression Predicting DAS Scores

Predictor	B	SE	t	p	β (Standardized)
Intercept	.42	1.16	.36	.720	
Duration	.03	.01	2.51	.015*	.31
Inattention Count	.46	.19	2.37	.021*	.27
Hyperactivity / Impulsivity Count	-.32	.25	-1.30	.198	-.16
ADHD-Focused Account	.09	.57	.16	.870	.04
Educational Video	.21	.58	.35	.726	.08
Non-DSM Symptoms Mentioned	-40	.62	-.64	.524	-.16

Engagement Score	-5.39	5.83	-.93	.358	-.12

Note. $^*p < .05$

Video duration was a significant positive predictor of DAS scores, $B = 0.03$, $SE = 0.01$, $t(61) = 2.51$, $p = .015$, with a medium effect size ($\beta = .31$). Inattention symptom count was also a significant positive predictor, $B = 0.46$, $SE = 0.19$, $t(61) = 2.37$, $p = .021$, also reflecting a medium effect size ($\beta = .27$). These results suggest that longer videos and those referencing more inattention symptoms tended to receive higher DAS scores. Other variables were not significant predictors of DSM accuracy (ps > .05).

3.4 Sensitivity Power Analysis

A G*Power sensitivity power analysis (Faul et al., 2009) was conducted post hoc, as the obtained sample size ($N = 83$) was slightly below the target ($N = 100$). The analysis estimated the minimum detectable effect sizes with 80% power ($\alpha = .05$) for all statistical tests. For the chi-square goodness-of-fit tests, power was sufficient to detect effect sizes of $w = .31$ ($N = 83$, $df = 1$), $w = .21$ ($N = 188$, $df = 1$), and $w = .33$ ($N = 188$, $df = 17$). For McNemar's test ($N = 70$), the design was sensitive to discordant proportions of $p_{12} = .53$ and $p_{21} = .24$, corresponding to an odds ratio of 2.24. The one-sample Wilcoxon signed-rank test (N = 70) was sensitive to an effect size of d = .35. Finally, the multiple linear regression model (N = 70, 7 predictors) was adequately powered to detect an effect size of $f^2 = .23$ ($R^2 \approx .19$). Overall, the tests were adequately powered to detect the effect sizes observed.

4. Discussion

4.1 Main Findings

4.1.1 Holistic Investigation

This study examined the representation and clinical accuracy of ADHD-related TikTok content using DSM-5-TR criteria. While 84% of videos referenced at least one DSM-recognised symptom, this alone did not ensure clinical accuracy. No formal hypothesis predicted this outcome due to limited prior research, and the presence of symptoms does *not* guarantee accurate representation.

To assess whether TikTok content holistically reflected the symptom profile of ADHD, the distribution of inattention (IN) and hyperactivity/impulsivity (HI) symptoms was examined. IN symptoms were 3.34 times more likely to be mentioned than HI symptoms, with 67.6% of all symptom mentions reflecting IN and only 32.4% reflecting HI. These findings support H1, which predicted IN symptoms would be significantly more frequently represented. This is consistent with prior research reporting similar representational disparities (Karasavva et al., 2025).

The distribution of individual symptoms was also highly uneven, reflecting a selective portrayal of ADHD on TikTok. Among IN symptoms, "*Difficulty sustaining attention*" was the most frequently mentioned, appearing in 28 videos (14.9%), while "*Difficulty with attention to detail*" was among the least (5 videos; 2.7%). For HI symptoms, "*Fidgeting*" was most common (21 videos; 11.2%), whereas "*Difficulty waiting their turn*" appeared in only one video (0.5%). These findings offer partial support for H2. Although "*Difficulty* *sustaining attention*" was the most frequently mentioned symptom as predicted, the other hypothesised symptoms, "*Frequently leaves seat*" and "*Hyperactivity*", were referenced far less often, appearing in only 4 (2.1%) and 7 (3.7%) videos, respectively. This disparity suggests that creators tend to emphasise certain symptoms over others.

One possible explanation is the public's limited understanding of ADHD, which may contribute to the disproportionate focus on specific symptoms over others (McLeod et al., 2007). This may reflect either a lack of awareness among content creators about the full range of ADHD symptoms or a deliberate effort to highlight those symptoms most relatable or misunderstood by the public. Additionally, symptom emphasis may be influenced by user experience (i.e., the symptoms most often self-identified or debilitating) or algorithmic dynamics, where content that highlights specific traits garners more engagement (Siles et al., 2022; Verma & Sinha, 2024).

While previous research has suggested an association between TikTok use and ADHD-like symptoms (Firth et al., 2019; Kuss & Griffiths, 2017; Lovelace, 2024), these findings are correlational and do not establish causality. Even if a causal link existed, it would not necessarily explain which symptoms are most frequently discussed. It is plausible that certain symptoms resonate more with viewers or perform better algorithmically, making them more prominent. However, such interpretations remain speculative, as the motivations behind content creators' choices are not directly measured. Therefore, it is reasonable that H2 was only partially supported, as specific symptoms may be more relatable or performative, leading to their disproportionate representation in TikTok content.

4.1.2 Accuracy Investigation

Accuracy was measured using the DSM Accuracy Scale, which comprises weighted variables essential to diagnosis. Of the 70 videos that included DSM-referenced symptoms, 65 (92.86%) were considered inaccurate. This finding is consistent with previous research, though some variation exists across studies: Verma and Sinha (2024) reported 46 out of 50 videos (92%) as inaccurate, closely aligning with the current results. Yeung et al. (2022), however, found a lower inaccuracy rate, with 52 out of 100 videos (52%) deemed inaccurate. Karasavva et al. (2025) evaluated individual claims rather than full videos and found that 51.3% of claims were inaccurate. Although, they did not report the total number of claims assessed, only that videos (N = 98) included an average of 2.99 claims each, making direct comparisons more difficult. Despite these methodological differences, the consistent pattern across studies suggests that ADHD-related TikTok content frequently lacks clinical accuracy. This supports H3, which predicted that TikTok videos would fail to accurately portray ADHD according to DSM criteria.

Exploratory analysis was conducted to better understand what predicts higher accuracy (RQ2). Specifically, the analysis examined whether video duration, engagement metrics, the number of symptom types mentioned, the presence of non-DSM symptoms, the educational framing of the video, or whether the creator was an ADHD-focused account influenced diagnostic accuracy. The results indicated that specific content characteristics, such as video length and the number of IN symptoms referenced, were meaningful predictors of diagnostic accuracy. The influence of video length is intuitive, as longer videos allow for more detailed symptom explanations. Interestingly, the predictive value of IN symptoms may suggest that these are better understood by the public, which could help explain the relative underrepresentation of HI symptoms. However, the overall model explained only a moderate portion of the variance (18%), suggesting that easily observable features account for accuracy only in part. It is likely that other unmeasured variables, such as creator intent (Campanini, 2023), clinical expertise (Godfrey et al., 2020; Southwell et al., 2019), or algorithmic factors (Milton et al., 2023), play a substantial role. These findings highlight the partial utility of surface-level video characteristics in predicting diagnostic accuracy while underscoring the complexity and variability of ADHD content on TikTok.

4.1.3 Accurate Representation

These findings contribute to answering RQ1: *Does TikTok content holistically and accurately represent ADHD?* A holistic investigation revealed that ADHD is not discussed equally on TikTok, with IN consistently overshadowing HI in both the number of videos referencing each category and the frequency of individual symptom mentions. Additionally, there were substantial discrepancies in how often specific symptoms were mentioned. Accuracy analysis showed that, even when TikTok content included DSM-referenced symptoms, the portrayal was rarely accurate according to clinical standards. Taken together, these findings suggest that TikTok does not represent ADHD either holistically or accurately.

This pattern may be attributed, in part, to widespread public misunderstanding of ADHD. Although public interest in the condition has increased significantly (Zhao et al., 2021), accurate understanding has not advanced simultaneously (McLeod et al., 2007). While TikTok content may not align with current DSM-5-TR criteria, it may still reflect the lived experiences of individuals with ADHD. Given the DSM’s evolving conceptualisation of the disorder (Lange et al., 2010), it is plausible that some portrayals may resonate with future diagnostic frameworks, even if they fall short of current clinical standards. Nevertheless, TikTok frequently encourages self-identification and pursuit of diagnosis (Gilmore et al., 2022; Lovelace, 2024), which, when driven by content that lacks clinical accuracy, may contribute to inappropriate self-referrals. This can exacerbate existing pressures on diagnostic services, which are already overburdened (Smith et al., 2023). These findings highlight the need for further investigation into the accuracy of ADHD-related content and its broader implications for public health and clinical practice.

4.2 Implications

These findings have real-world implications. TikTok’s short-form content can foster oversimplified views of ADHD, leading to misguided self-diagnosis based on a few relatable but insufficient traits. While personal experience videos may reduce stigma, their lack of clinical nuance risks trivialising the condition. The study highlights a need for improved digital literacy and targeted psychoeducation, especially around underrepresented DSM symptoms like “Difficulty waiting their turn”.

Enhancing public understanding of ADHD’s full symptom profile can help individuals better assess whether their experiences reflect the disorder or something else. This is a more practical solution than expecting diagnostic nuance from TikTok content and could reduce unnecessary self-referrals, easing pressure on clinical services. These insights should guide healthcare professionals, educators, and content creators to deliver accessible, accurate, and informed ADHD psychoeducation that raises awareness while maintaining clinical integrity.

4.3 Limitations

Due to time constraints, diagnostic accuracy was assessed at the video level rather than the claim level, potentially inflating accuracy scores. Longer videos could reference multiple symptoms but depict only one accurately and still meet the DAS threshold. However, the consistently low accuracy scores suggest this limitation had limited impact on overall findings.

Concerns also arise regarding coding reliability. Both coders were psychology students without formal clinical training, and coding relied on subjective interpretation of DSM criteria. Additionally, the DAS was developed by the researcher and lacks validation from clinical experts. Its most heavily weighted component (*impairment*) was introduced post hoc and was not included in inter-rater reliability testing, further limiting the scale's construct validity. Nevertheless, the DAS was grounded in relevant literature, and the remaining components demonstrated high inter-rater reliability.

Finally, violations of parametric assumptions may have reduced the robustness of the multiple linear regression analysis; future research should consider alternative approaches, such as generalised linear models or ordinal regression.

4.4 Future Directions

Future research should examine which ADHD symptoms generate the most engagement on TikTok and whether engagement metrics predict symptom frequency. This could clarify whether certain symptoms are discussed more often due to platform-driven feedback loops or other influencing factors. Additionally, while research increasingly focuses on content accuracy, little is known about how users interpret this content. It remains unclear whether viewers recognise omissions, such as symptom severity, or take such content at face value. Investigating whether users expect clinical accuracy or implicitly understand the platform's limitations is a critical next step.

5. Conclusion

This study sought to examine whether TikTok content claiming to depict ADHD symptomatology accurately reflects the diagnostic criteria outlined in the DSM-5-TR. Through a quantitative content analysis of 83 publicly available TikTok videos, findings suggest that ADHD-related content on the platform frequently lacks clinical accuracy and offers only a partial portrayal of the disorder.

The methodological framework employed addressed limitations observed in prior studies, including ambiguous symptom definitions and sampling bias, by utilising a structured coding scheme grounded in established diagnostic standards. While the results were largely consistent with existing literature and supported the initial hypotheses, the use of a novel 'DSM Accuracy Scale' introduced potential concerns regarding construct validity, warranting further refinement and empirical validation. Nevertheless, the study contributes a more systematic and nuanced account of ADHD symptom portrayal on TikTok, extending the current understanding of how digital media may influence public conceptions of the disorder. These insights highlight the need for more clinically informed and responsible psychoeducational content online.

Future research should explore how underrepresented symptoms are perceived by viewers and assess the broader impact of ADHD-related content on users' diagnostic understanding, self-identification, and health-seeking behaviours within digital ecosystems.

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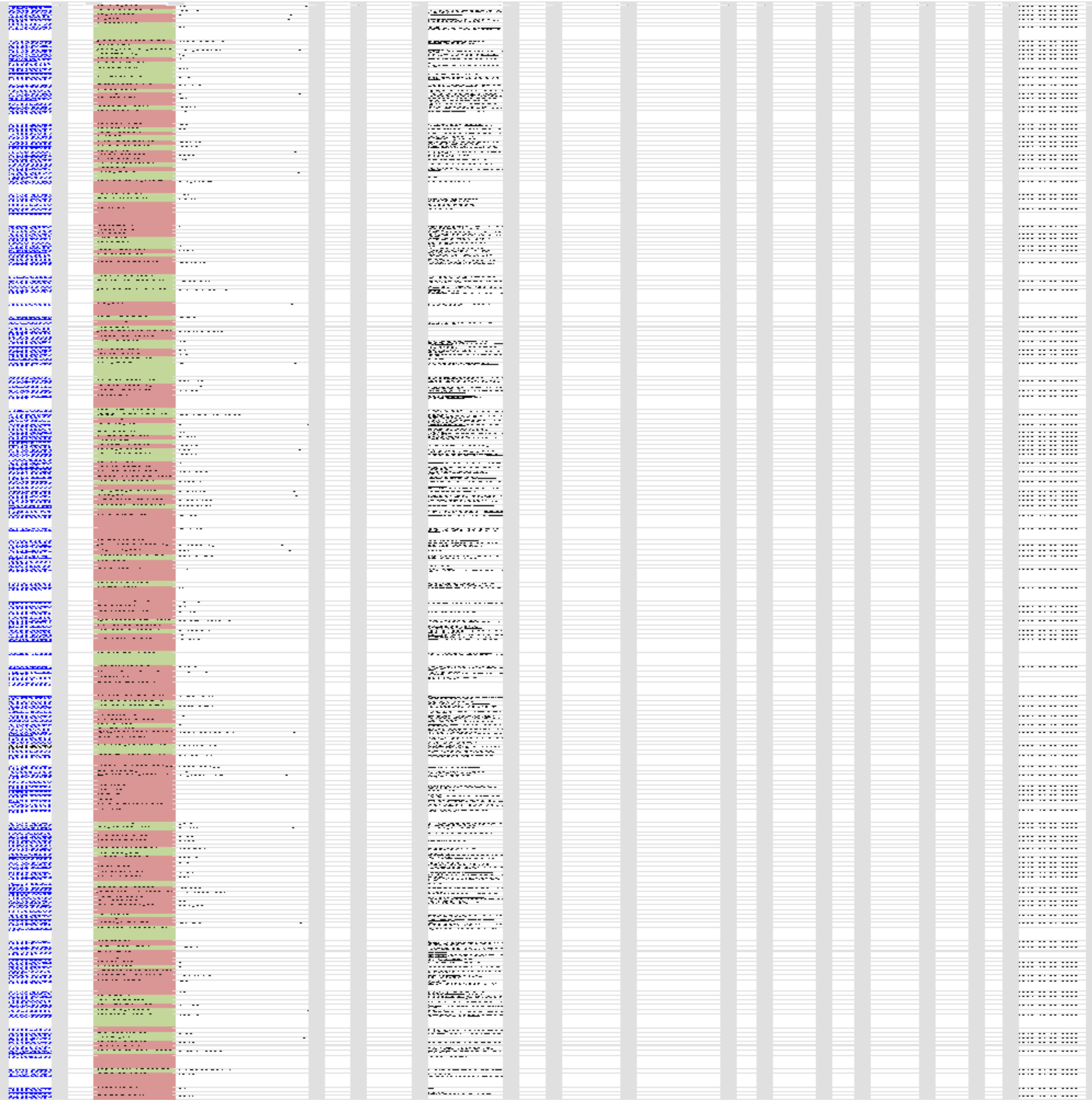
7. Appendices

Appendix A: Raw Data Collection

Filtered Data File



List of TikTok's Used in Content Analysis

1. https://www.tiktok.com/@tarah.and.barry/video/7231141360399551770
2. https://www.tiktok.com/@greapaxcherri/video/7304995602432085255
3. https://www.tiktok.com/@chantelleef/video/7154417771869162757
4. https://www.tiktok.com/@jaccokmn/video/7448214753102662934
5. https://www.tiktok.com/@adhd_chatter_podcast/video/7364699496871120160
6. https://www.tiktok.com/@cobywatts_/video/6983979354845940993
7. https://www.tiktok.com/@olivialutfallah/video/7345919753778629893

8. https://www.tiktok.com/@jacobmhoff/video/7341261254973230382
9. https://www.tiktok.com/@parkerstevensbiz/video/7219711646770482437
10. https://www.tiktok.com/@drjimcostello/video/7365259340611145002
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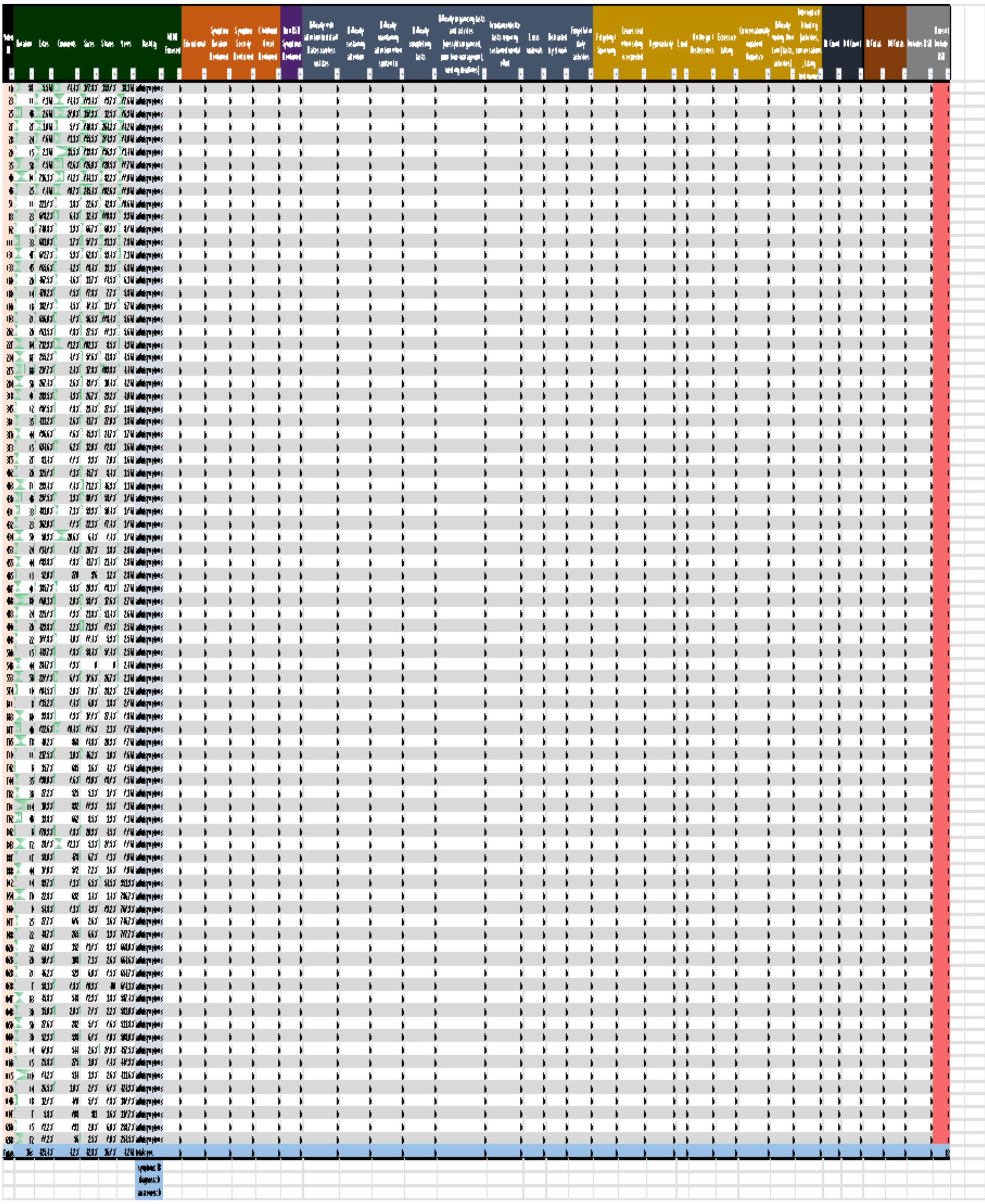
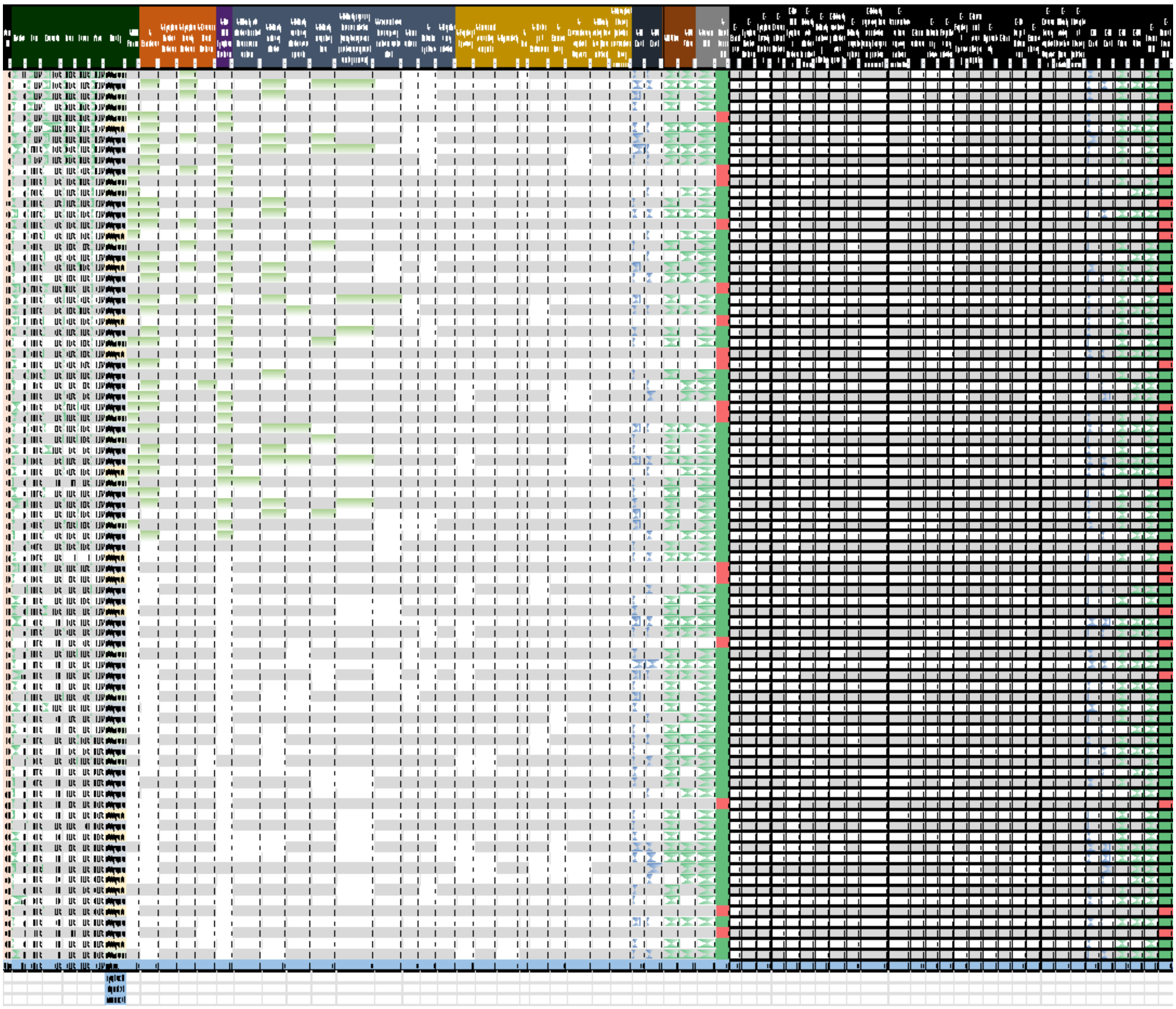
83. ***https://www.tiktok.com/@neozoom.io/video/715323306497076486***

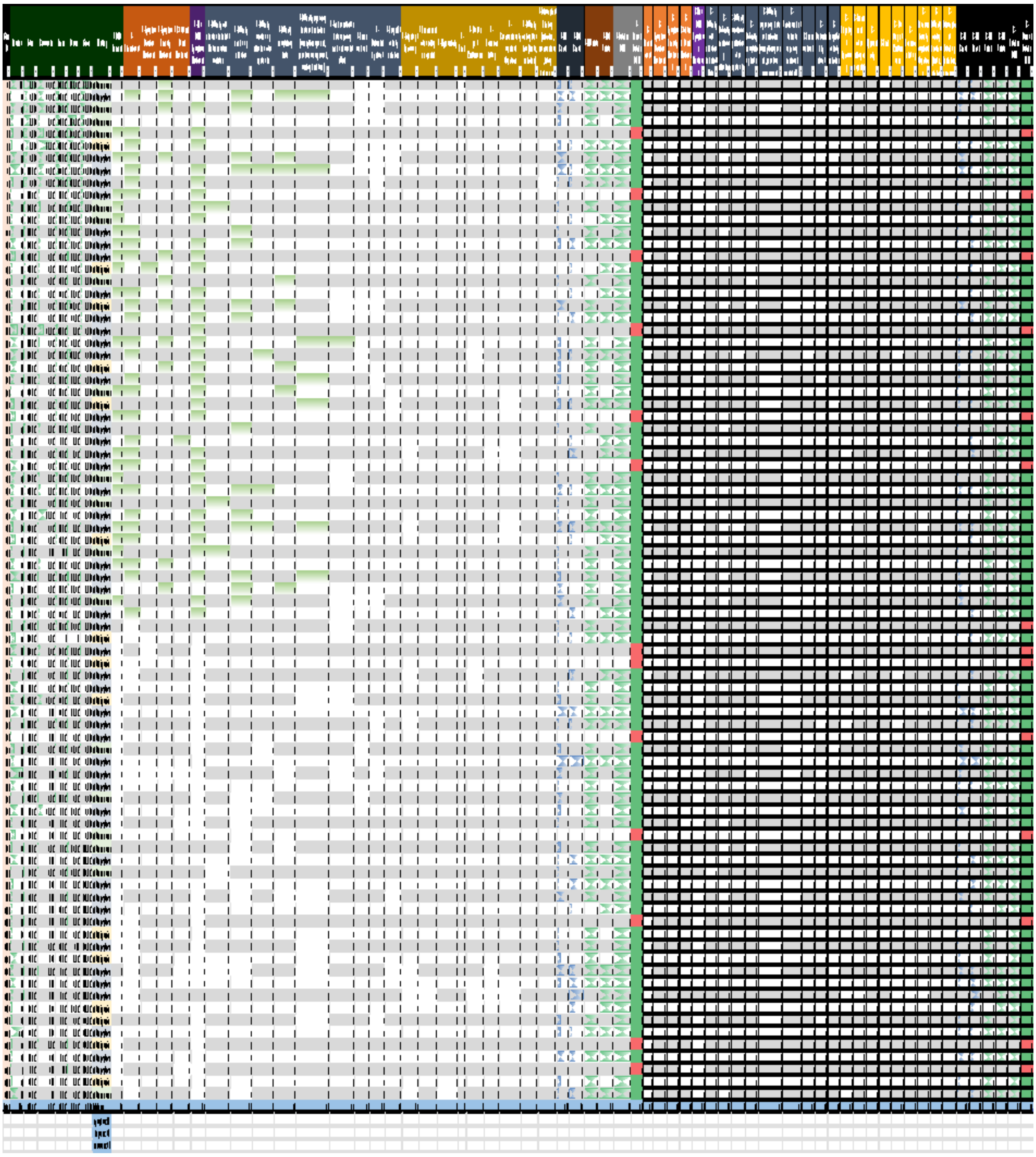
Appendix B: Coding Framework



Appendix C: Initial Merged Coding



Appendix D: Final Merged Coding



Appendix E: UREC-3 Application

Sheffield Hallam University

UREC 3 Application for Research Ethics Approval FOR Higher Risk Social science type studies WITH HUMAN PARTICIPANTS UNDERTAKEN BY STUDENTS ON TAUGHT COURSES

This form is designed to help students and their supervisors to complete an ethical scrutiny of proposed research. The University Research Ethics Policy (https://www.shu.ac.uk/research/excellence/ethics-and-integrity/policies) should be consulted before completing the form. The initial questions are there to check that completion of the UREC3 is appropriate for this study. The final responsibility for ensuring that ethical research practices are followed rests with the supervisor for student research.

Note that students and staff are responsible for making suitable arrangements to ensure compliance with the General Data Protection Act (GDPR). This involves informing participants about the legal basis for the research, including a link to the University research data privacy statement and providing details of who to complain to if participants have issues about how their data was handled or how they were treated (full details in module handbooks). In addition, the act requires data to be kept securely and the identity of participants to be anonymized. They are also responsible for following SHU guidelines about data encryption and research data management. Guidance can be found on the SHU Ethics Website https://www.shu.ac.uk/research/excellence/ethics-and-integrity

Please note that it is mandatory for all students to only store data on their allotted networked drive space and not on individual hard drives or memory sticks etc.

The present form also enables the University and College to keep a record confirming that research conducted has been subjected to ethical scrutiny.

The form must be completed by the student and the supervisor and independently reviewed by a second reviewer or module leader (additional guidance can be obtained from your College Research Ethics Chair). In all cases, it should be counter-signed and kept as a record showing that ethical scrutiny has occurred. Some courses may require additional scrutiny. Students should retain a copy for inclusion in their research projects, and a copy should be uploaded to the relevant module Blackboard site.

Please note that it may be necessary to conduct a health and safety risk assessment for the proposed research. Further information can be obtained from the University's Health and Safety Website

Checklist Questions to ensure that External Approval for the research is not required

Question	*Yes/No*
Does the research involve? • *Patients recruited because of their past or present use of the NHS*	*No*
• *Relatives/carers of patients recruited because of their past or present use of the NHS*	*No*
• *Access to data, organs, or other bodily material of past or present NHS patients*	*No*
• *Foetal material and IVF involving NHS patients*	*No*
• *The recently dead in NHS premises*	*No*
• *Prisoners or others within the criminal justice system recruited for health-related research*	*No*
• *Police, court officials, prisoners, or others within the criminal justice system*	*No*
• *Participants who are unable to provide informed consent due to their incapacity even if the project is not health related*	*No*
• *Is this an NHS research project, service evaluation or audit?* *For NHS definitions please see the following website* *http://www.hra.nhs.uk/documents/2013/09/defining-research.pdf*	*No*

If you have answered YES to any of the above questions, then you MUST consult with your supervisor to obtain research ethics from the appropriate institution outside the university. This could be from the NHS or Her Majesty's Prison and Probation Service (HMPPS) under their independent Research Governance schemes. Further information is provided below.
https://www.myresearchproject.org.uk/

SECTION A: Research Protocol

1. Student Name: Archie-Lee Thomas Irving

College: Sheffield Hallam University

Department: Psychology

Email address: Archie-Lee.T.Irving@student.shu.ac.uk

2. Title of research: Exploring ADHD Symptomology on TikTok: A Content Analysis
3. Supervisor: Sue Jamison-Powell
Supervisor's email address: s.jamison-powell@shu.ac.uk

4. Proposed duration of project

Start date: 01/11/2024 ***End Date: 01/05/2025***

5. Location of research if outside SHU:

6. Background to the study and scientific rationale (500-750 words approx.)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as defined by the DSM-5. The diagnostic criteria assess these qualities, including inattention, hyperactivity, and impulsivity (American Psychiatric Association, 2013). The global prevalence of ADHD is estimated to be around 5% in children and 3-4% in adults (NHS, 2024). However, there has been a recent spike in self-referrals for ADHD diagnoses, with Google Trends showing a significant increase in ADHD-related searches (Abdelnour et al., 2022). This rise may reflect increased awareness and discourse surrounding ADHD, such as ADHD Awareness Month and the impact of social media in educating the public on ADHD.

In recent years, social media platforms have become increasingly popular spaces for sharing personal experiences, including discussions about mental health and neurodevelopmental disorders. This online sharing has proven beneficial, allowing individuals to find community with others who have shared experiences, which may help reduce the isolation sometimes associated with mental health conditions (Sweet et al., 2019; Keir et al., 2021; Kožuh et al., 2016). TikTok, in particular, has emerged as a significant platform for this purpose, with over 3.6 million posts under the #ADHD tag. It offers a space for individuals to educate others and raise awareness about the challenges faced by those with ADHD.

However, this representation is not always positive. While some content can be informative, other posts may perpetuate stereotypes and misunderstandings about the disorder. This is a growing concern, as misconceptions about disorders like ADHD can significantly impact those diagnosed and are challenging to correct once established. For example, misinformation surrounding vaccines and autism or stereotypes about empathy in autistic individuals persist despite substantial evidence debunking these claims (Fletcher-Watson & Bird, 2019; Gerber & Offit, 2009). Furthermore, adolescents may not feel confident discerning accurate information from misinformation on social media (Lupton, 2020). Although ADHD content online can raise awareness, it may diverge from DSM-5 diagnostic criteria and instead focus on superficial, non-diagnostic traits. This discrepancy between clinical and online symptomatology risks fostering stereotypes and may encourage individuals to identify with ADHD based on generalised personality traits rather than clinically significant symptoms (Yeung et al., 2022).

The increasing prevalence of ADHD discussions on social media could partly explain the rise in self-referrals for ADHD diagnoses. The Retreat Clinics (2023) reported an increase from an average of 60 self-referrals per month to 153 per month, highlighting the need to examine how ADHD is portrayed on social media and whether these portrayals align with established clinical guidelines like those presented in the DSM-5. Evaluating the impact of such content can help ensure that social media portrayals of ADHD are accurate and align with established diagnostic criteria, preventing misinterpretation and promoting mental health literacy.

As social media usage continues to grow, so does its influence on public perceptions of mental health and neurodevelopmental conditions. Research is needed to determine whether social media accurately represents these conditions according to established diagnostic criteria, particularly for ADHD. While previous studies have explored the general benefits and risks of social media for mental health awareness, fewer have focused specifically on ADHD and the broader implications of its portrayal on platforms like TikTok. This study aims to analyze ADHD-related TikTok content and compare the symptoms discussed in these posts with the DSM-5 diagnostic criteria. The findings may illuminate the ways ADHD is represented on social media and promote a more accurate and informed public understanding of the condition.

References:

Abdelnour, E., Jansen, M. O., & Gold, J. A. (2022). ADHD diagnostic trends: Increased recognition or overdiagnosis? PubMed, 119(5), 467–473. https://pubmed.ncbi.nlm.nih.gov/36337990

Association, A. P. (2015). DSM-5 Classification. American Psychiatric Publishing.
Fletcher-Watson, S., & Bird, G. (2019). Autism and empathy: What are the real links? Autism, 24(1), 3–6. https://doi.org/10.1177/1362361319883506
Gerber, J. S., & Offit, P. A. (2009). Vaccines and Autism: A tale of shifting hypotheses. Clinical Infectious Diseases, 48(4), 456–461. https://doi.org/10.1086/596476
Keir, A., Bamat, N., Hennebry, B., King, B., Patel, R., Wright, C., Scrivens, A., ElKhateeb, O., Mitra, S., & Roland, D. (2021). Building a community of practice through social media using the hashtag #neoEBM. PLoS ONE, 16(5), e0252472. https://doi.org/10.1371/journal.pone.0252472
Kožuh, I., Hintermair, M., & Debevc, M. (2016). Community building among deaf and hard of hearing people by using written language on social networking sites. Computers in Human Behavior, 65, 295–307. https://doi.org/10.1016/j.chb.2016.08.035
Lupton, D. (2020). Young People's Use of Digital Health Technologies in the Global North: Narrative review. Journal of Medical Internet Research, 23(1), e18286. https://doi.org/10.2196/18286
NHS. (2024, March). Attention deficit hyperactivity disorder (ADHD) Programme update. NHS England. Retrieved October 28, 2024, from https://www.england.nhs.uk/long-read/attention-deficit-hyperactivity-disorder-adhd-programme-update/
Sweet, K. S., LeBlanc, J. K., Stough, L. M., & Sweany, N. W. (2019). Community building and knowledge sharing by individuals with disabilities using social media. Journal of Computer Assisted Learning, 36(1), 1–11. https://doi.org/10.1111/jcal.12377
The Retreat Clinics. (2023, October). Important changes to how we receive Autism and ADHD referrals. Retrieved October 28, 2024, from https://theretreatclinics.org.uk/important-changes-to-how-we-receive-autism-and-adhd-referrals/
Yeung, A., Ng, E., & Abi-Jaoude, E. (2022). TikTok and Attention-Deficit/Hyperactivity Disorder: A Cross-Sectional Study of Social Media Content Quality. The Canadian Journal of Psychiatry, 67(12), 899–906. https://doi.org/10.1177/07067437221082854

7. Main research questions

To what extent do TikTok videos that claim to represent ADHD symptoms align with clinical diagnostic criteria as outlined in the DSM-5?

8. Summary of study design, procedures, types of data collection, and proposed data analysis.

Study Design:
This quantitative content analysis study examines TikTok videos representing ADHD symptoms to assess their alignment with the clinical diagnostic criteria outlined in the DSM-5. Quantitative data will be collected in the form of frequency counts for ADHD symptoms (e.g., inattentive, hyperactive, and impulsive behaviours) and additional video metrics such as likes, shares, comments, and views. Data will be organised into a structured dataset for subsequent analysis. To achieve this, the following data collection and analysis procedures will be implemented:
Data Collection Procedures:

1. ***Video Selection:***
   TikTok videos will be identified using the Apify TikTok Scraper tool by searching for posts tagged with #ADHD and related hashtags. Inclusion and exclusion criteria will be applied to refine the sample of videos for analysis.
2. ***Coding:***
   Each video will be systematically coded for the presence or absence of ADHD symptoms based on DSM-5 criteria. Categories will include inattentive symptoms, hyperactivity, and impulsivity symptoms, as well as other behavioural markers. In addition, each video will be coded for metrics such as likes, shares, comments, views, symptom severity, and tone.

Data Analysis Procedure:
The primary analysis will include:

- ***A chi-square test, suitable for comparing categorical data, will assess the alignment of observed ADHD symptom frequencies in TikTok videos with expected distributions derived from DSM-5 criteria.***
- ***Descriptive statistics will be used to analyse trends such as symptom prevalence, video format, and tone. These analyses will help identify statistically significant differences between the portrayal of ADHD symptoms on TikTok and established clinical criteria.***

SECTION B: Ethics Proforma

1. Describe the arrangements for recruiting, selecting/sampling potential participants. This should clearly indicate if participants with a particular health condition or healthy volunteers are being recruited, the inclusion and exclusion criteria, the sample sizes with power calculations if appropriate. You must include copies of any advertisements for participants or letters/emails to individuals or organisations inviting participation.

Recruitment and Sampling Method:
Data will be sampled from TikTok posts using the Apify TikTok Scraper tool. Videos will be identified through searching the #ADHD hashtag on TikTok and selected based on specific inclusion and exclusion criteria:
Inclusion Criteria:

- ***Language: Videos must be in English.***
- ***Tagging: Videos must include #ADHD or related hashtags.***

- ***Search Visibility: Videos must appear in searches for ADHD-related tags.***
- ***Content Focus: Videos must explicitly reference ADHD experiences, symptoms, or behaviours.***
- ***Popularity Threshold: Videos must have a minimum of 1 million views.***
- ***Video Length: Short-form videos of less than 3 minutes.***
- ***Original Content: The video must be original TikTok content where ADHD is the primary focus.***

Exclusion Criteria:

- ***Language: Non-English-speaking videos.***
- ***Irrelevant Content: Videos that do not explicitly address ADHD (e.g., unrelated comedy skits, general mental health content without ADHD focus).***
- ***Advertisement/Promotions: Videos solely promoting products, services, or unrelated media.***
- ***Duplicate Videos: Reposts or duplicates of the same content.***
- ***View Count: Videos with fewer than 1 million views.***
- ***Overly Long Videos: Videos exceeding 3 minutes.***
- ***Non-Video Formats: Slideshows, image compilations, or content sourced from external media such as documentaries.***

Sample Size:

The target sample size is 50 TikTok videos. This sample size ensures sufficient data for meaningful analysis while remaining manageable within the scope of this study. Power calculations are not applicable, given the nature of the analysis.

Coding Framework:

- ***DSM-5 Criteria: Symptoms will be categorised based on DSM-5 diagnostic criteria for ADHD.***
- ***Symptom Analysis: Inattentive symptoms, hyperactivity, and impulsive symptoms, as well as other behavioural markers, will be coded.***
- ***Coding Variables:***
    - ***Video Metrics: Duration, likes, shares, comments, views, account type (personal, professional, or organisational).***
    - ***Symptoms: Categorized into inattentive, hyperactive, and impulsive, or other non-ADHD behaviours.***
    - ***Explicit Mentions: Specific references to DSM-5 symptoms or umbrella terms.***
    - ***Symptom Severity: Measured by symptom duration and perceived impact as described in the content.***
    - ***Behavioural Context: Differentiating ADHD-related behaviours from unrelated habits (e.g., non-ADHD behaviours like "I pick my nose").***
    - ***Tone/Intent: Categorized into humour, educational content (e.g., informing vs self-diagnosis), and community-building narratives.***

Recruitment Materials:

Recruitment materials, such as advertisements or invitations, are not applicable as the study involves publicly available TikTok content.

2. What is the potential for participants to benefit from participation in the research?

Not applicable, as this study does not involve direct interaction with participants and utilises publicly available data.

3. Describe any possible negative consequences of participation in the research along with the ways in which these consequences will be limited. This includes the use of participants time, or any discomfort both physical and psychological.

No direct risks are anticipated. Indirectly, potential risks involve reinforcing stereotypes or misinformation about ADHD. To mitigate this, findings will be contextualised within clinical guidelines and ethical academic dissemination.

4. Describe the arrangements for obtaining participants' consent. This should include copies of the participant information sheet and the consent forms that participants will receive. If children or vulnerable people are to be participants in the study details of the arrangements for obtaining consent from those acting in loco parentis or as advocates should also be provided.

Note: Vulnerable people include children and young people, people with learning disabilities, people who may be limited by age or sickness, pregnancy, people researched because of a condition they have, etc. See full definition on ethics website in the document Code of Practice for Researchers Working with Vulnerable Populations (under the Supplementary University Polices and Good Research Practice Guidance)

Consent is not applicable as the study utilises publicly available data on TikTok in line with platform terms of use.

5. Describe how participants will be made aware of their right to withdraw from the research. This should also include information about participants' right to withhold information and a reasonable time span for withdrawal should be specified.

Participants' right to withdraw is not applicable as no direct engagement with participants occurs, and only publicly available content is analysed.

6. If your project requires that you work with vulnerable participants, please describe how you will implement safeguarding procedures during data collection.

Note: Vulnerable people include children and young people, people with learning disabilities, people who may be limited by age or sickness, pregnancy, people researched because of a condition they have, etc. See full definition on ethics website in the document Code of Practice for Researchers Working with Vulnerable Populations (under the Supplementary University Polices and Good Research Practice Guidance)

Not applicable.

7. If Disclosure and Barring Service (DBS) checks are required, please supply details

Not applicable.

8. Describe the arrangements for debriefing the participants. This should include copies of the information that participants will receive where appropriate.

Not applicable.

9. Describe the arrangements for ensuring participant confidentiality. This should include details of:

- ***how data will be stored to ensure compliance with data protection legislation (GDPR)***
- ***how results will be presented***
- ***exceptional circumstances where confidentiality may not be preserved***
- ***how and when confidential data will be disposed of***

Data will be anonymised and stored on the secure F drive on the university servers in compliance with GDPR. The analysis or reporting will not include TikTok usernames or personal identifiers.

10. Are there any conflicts of interest in you undertaking this research? (E.g., are you undertaking research on work colleagues or in an organisation where you are a consultant?) Please supply details of how this will be addressed.

Not applicable.

11. What are the expected outcomes, impacts and benefits of the research?

The expected outcome of this research is to enhance understanding of ADHD portrayals on social media, with a focus on TikTok, by analysing whether the symptoms discussed align with established clinical standards, such as those in the DSM-5. By clarifying the distinction between clinically significant symptoms and generalized personality traits, this study aims to improve public understanding of ADHD. This increased awareness will be particularly beneficial for adolescents and young adults, who may be more vulnerable to misinformation on social media.

In addition, the findings could promote more accurate portrayals of ADHD symptoms online, which may reduce the prevalence of inaccurate self-diagnoses and, consequently, the number of self-referrals for ADHD assessment. Ultimately, this could lead to shorter waiting lists for individuals genuinely in need of a professional diagnosis, allowing for more timely and effective mental health care.

12. Please give details of any plans for dissemination of the results of the research.

Findings will be included in the dissertation submitted for academic evaluation and may be shared in academic or public forums to promote understanding of ADHD representations online.

SECTION C

HEALTH AND SAFETY RISK ASSESSMENT FOR THE RESEARCHER

1. ***Do you have a health and safety risk analysis for the procedures to be used? (Discuss this with your supervisor)***

☐ ***Yes***
☐ ***No***

(If YES the completed Health and Safety Project Safety Plan for Procedures should be attached). You can find here a [Blank/Sample Risk Assessment Form]

0. ***Will the data be collected fully online (no face-to-face contact with participants)?***

☐ ***Yes (See the safety guidance for online research and go to question 8b).***

0. ***Will the proposed data collection take place on campus?***

☐ ***Yes (Please answer questions 5 to 8)***
☐ ***No (Please complete all questions and consult with your supervisor or HoD for current guidance and permission for face-to-face research outside the university)***

0. ***Where will the data collection take place?***
   (Tick as many as apply if data collection will take place in multiple venues)

	Location	***Please specify***
☐	***Researcher's Residence***	
☐	***Participant's Residence***	
☐	***Education Establishment***	
☐	***Other e.g. business/voluntary organisation, public venue***	
☐	***Outside UK***	

0. ***If face-to-face contact with participants is required for your study, please confirm that you will comply with any government requirements related to Covid-19 and social distancing or other limitations on contact. Please consult the following link:*** ***https://www.shu.ac.uk/covid-19-student-guidance***

Yes, I have read, and I will comply ☐

No face-to-face contact will be required for this study ☐

0. ***How will you travel to and from the data collection venue?***

☐ ***On foot*** ☐ ***By car*** ☐ ***Public Transport***
☐ ***Other (Please specify)***

Please outline how you will ensure your personal safety when travelling to and from the data collection venue.

☐

0. ***How will you ensure your own personal safety whilst at the research venue?***

☐

0. ***Are there any potential risks to your health and wellbeing associated with either (a) the venue where the research will take place and/or (b) the research topic itself?***

☐ ***None that I am aware of***

☐

☐

0. ***If you are carrying out research off-campus, you must ensure that each time you go out to collect data you ensure that someone you trust knows where you are going (without breaching the confidentiality of your participants), how you are getting there (preferably including your travel route), when you expect to get back, and what to do should you not return at the specified time.***

Please outline here the procedure you propose using to do this.

☐

Adherence to SHU policy and procedures

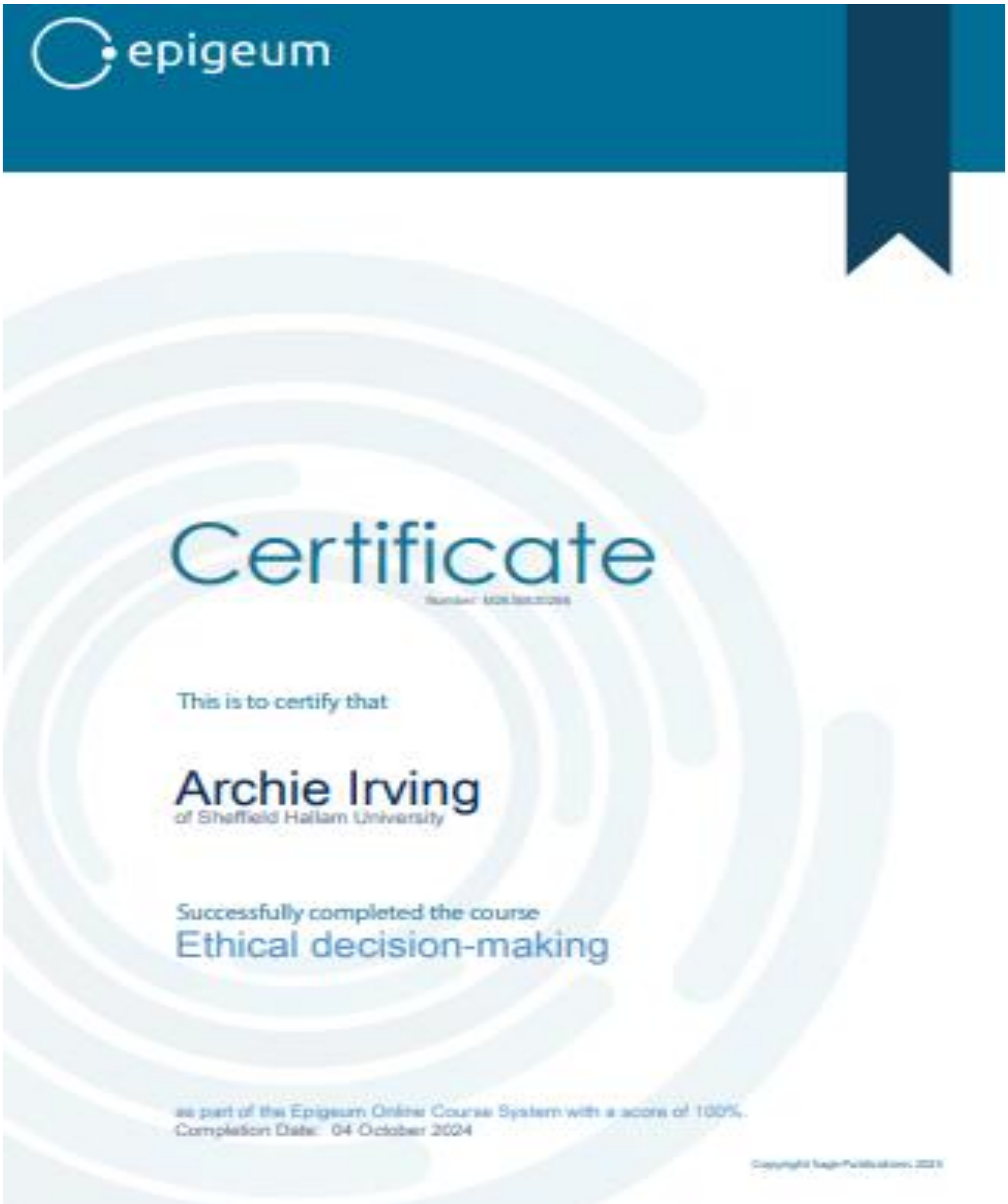
<table>
<tr><td colspan="2">Ethics sign-off</td></tr>
<tr><td colspan="2">Personal statement</td></tr>
<tr><td colspan="2">I can confirm that:
• I have read the Sheffield Hallam University Research Ethics Policy and Procedures
• I agree to abide by its principles.</td></tr>
<tr><td colspan="2">Student</td></tr>
<tr><td>Name: Archie-Lee Thomas Irving</td><td>Date:28/10/2024</td></tr>
<tr><td colspan="2">Signature: A. Irving</td></tr>
<tr><td colspan="2">Supervisor or another person giving ethical sign-off</td></tr>
<tr><td colspan="2">I can confirm that completion of this form has not identified the need for ethical approval by the TPREC/CREC or an NHS, Social Care or other external REC. The research will not commence until any approvals required under Sections 4 & 5 have been received and any necessary health and safety measures are in place.</td></tr>
<tr><td>Name:</td><td>Date:</td></tr>
<tr><td colspan="2">Signature:</td></tr>
</table>

Ethics sign-off	
Additional Signature if required by course leader:	
Name:	*Date:*
Signature:	

Please ensure that you have attached all relevant documents. Your supervisor must approve them before you start data collection:

Documents	*Yes*	*No*	*N/A*
Research proposal if prepared previously	☐	☐	☐
Any recruitment materials (e.g., posters, letters, emails, etc.)	☐	☐	☐
Participant information sheet	☐	☐	☐
Participant consent form	☐	☐	☐
Details of measures to be used (e.g., questionnaires, etc.)	☐	☐	☐
Outline interview schedule / focus group schedule	☐	☐	☐
Debriefing materials	☐	☐	☐
Health and Safety Risk Assessment Form	☐	☐	☐

Appendix F: Epigeum Certificate


epigeum

Certificate

This is to certify that

Archie Irving
of Sheffield Hallam University

Successfully completed the course
Ethical decision-making

as part of the Epigeum Online Course System with a score of 100%.
Completion Date: 04 October 2024

epigeum

Certificate

Number: [illegible]

This is to certify that

Archie Irving

of Sheffield Hallam University

Successfully completed the course

Working with human participants

as part of the Epigeum Online Course System with a score of 100%.

Completion Date: 04 October 2024


epigeum

Certificate

This is to certify that

Archie Irving

of Sheffield Hallam University

Successfully completed the course

Underpinning values for ethical research

as part of the Epigeum Online Course System with a score of 100%.

Completion Date: 04 October 2024

epigeum

Certificate

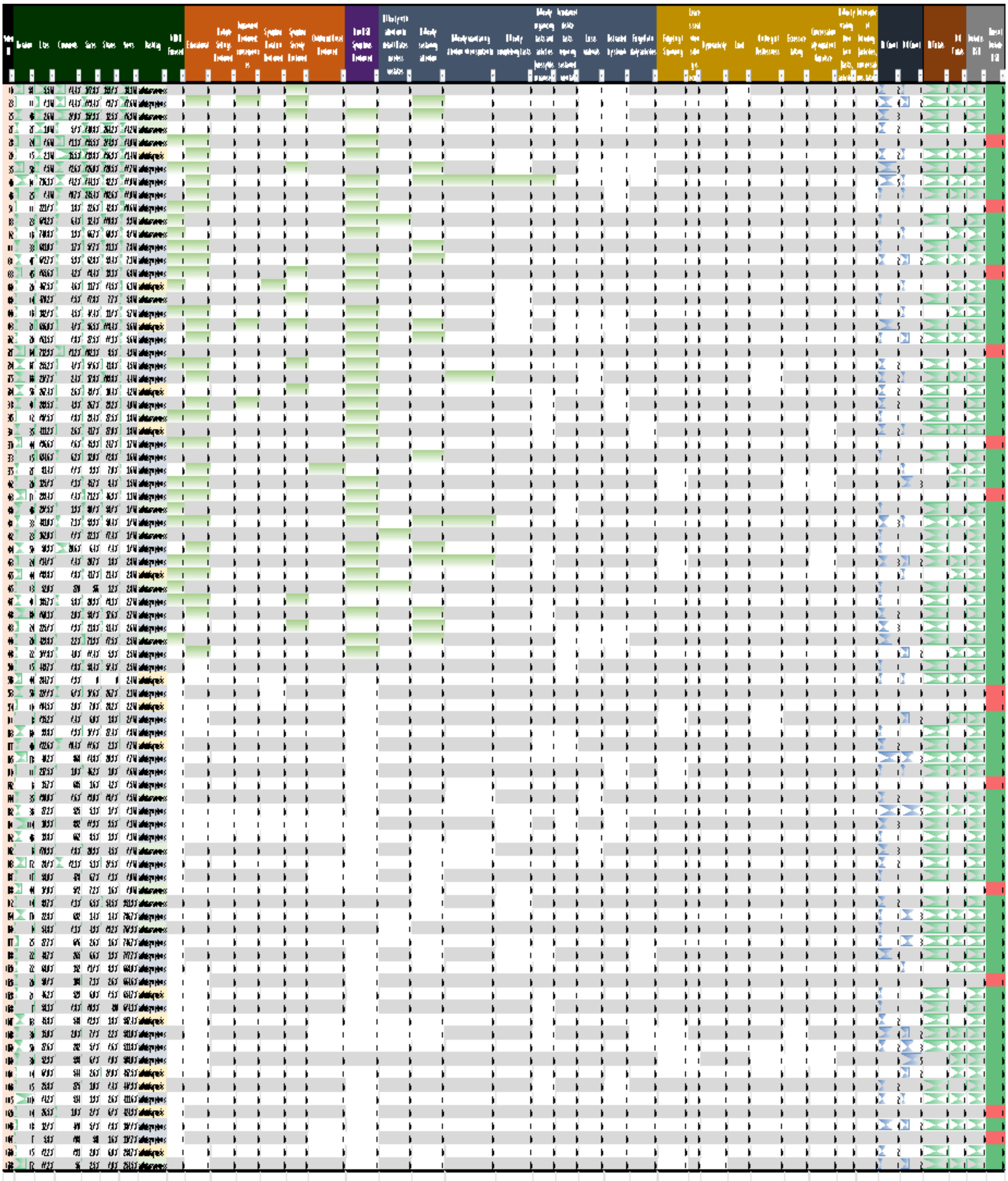
This is to certify that

Archie Irving
of Sheffield Hallam University

Successfully completed the course
Understanding research ethics approval

as part of the Epigeum Online Course System with a score of 80%
Completion Date: 04 October 2024

Appendix G: Coded Data



Appendix H: Content Descriptive Statistics

Table H1

Content Video Descriptives

	Duration	Likes	Comments	Saves	Shares	Views
N	83	83	83	82	82	83
Missing	0	0	0	1	1	0
Mean	35.5	425408	4166	43307	36517	4.22e+6
Std. error mean	2.73	86992	636	7047	6528	605168
Median	25	181500	1860	20900	17800	2600000
Standard deviation	24.9	792537	5795	63810	59114	5.51e+6
IQR	30.5	382100	3861	44457	38120	3.72e+6
Range	113	5494173	35444	351317	358610	38045500
Minimum	6	5827	56	583	490	254500
Maximum	119	5500000	35500	351900	359100	38300000
Skewness	1.20	4.19	2.87	3.02	3.31	3.50
Std. error skewness	0.264	0.264	0.264	0.266	0.266	0.264
Kurtosis	1.26	21.7	10.6	10.5	13.2	17.5
Std. error kurtosis	0.523	0.523	0.523	0.526	0.526	0.523
Shapiro-Wilk W	0.885	0.513	0.660	0.632	0.602	0.646
Shapiro-Wilk p	<.001	<.001	<.001	<.001	<.001	<.001

Figure H1

Duration Parametric Visuals

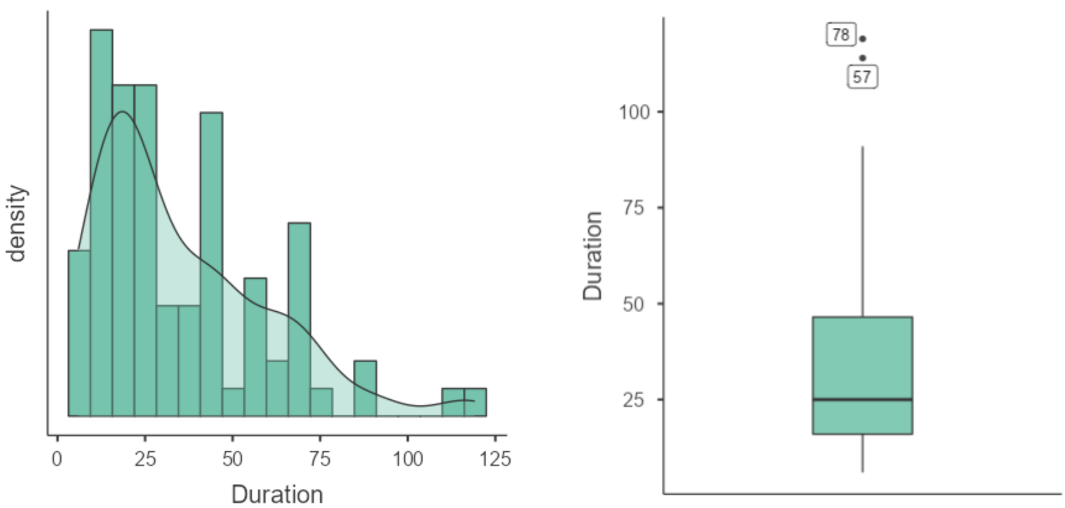


Figure H2

Likes Parametric Visuals

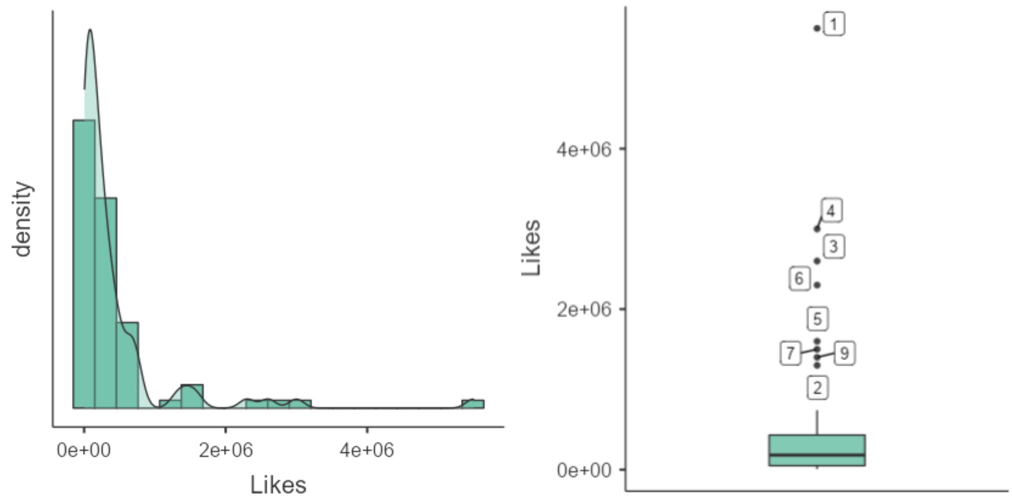


Figure H3

Comments Parametric Visuals

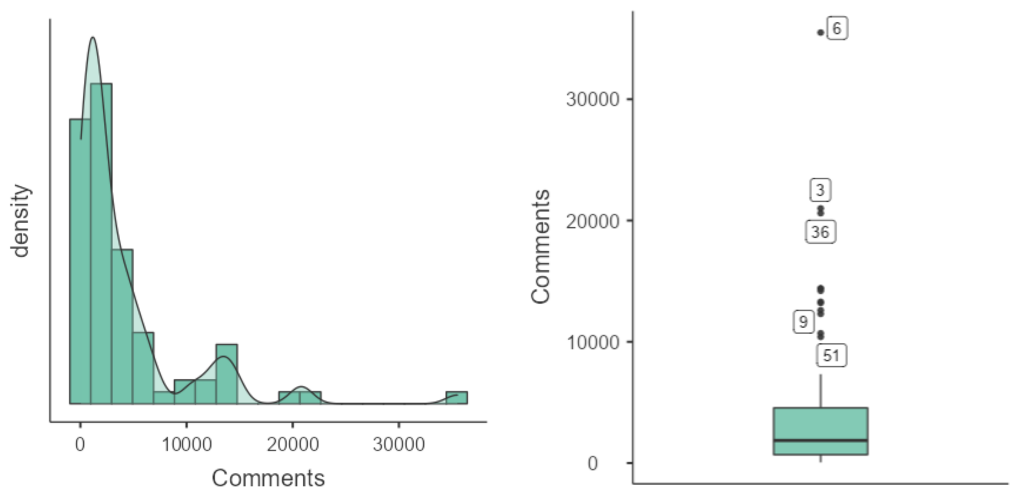


Figure H4

Saves Parametric Visuals

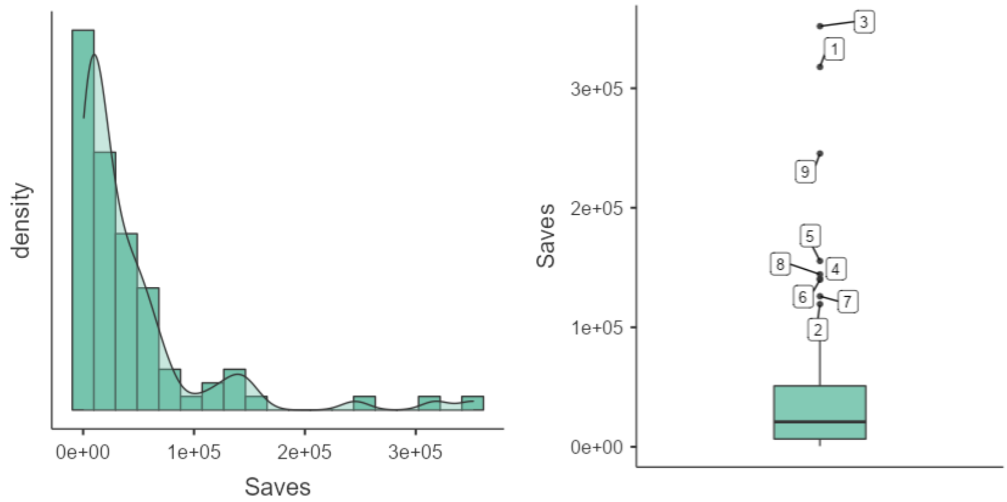


Figure H5

Shares Parametric Visuals

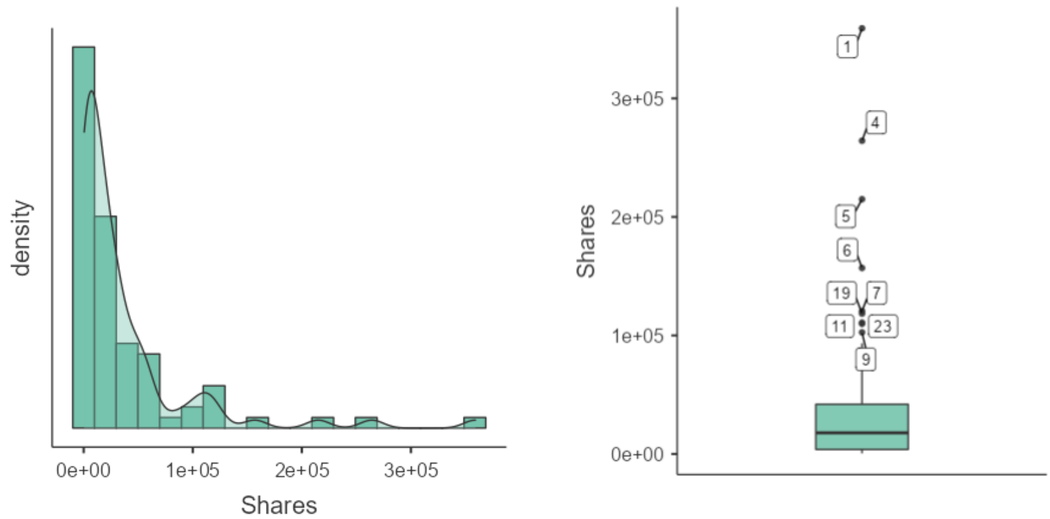
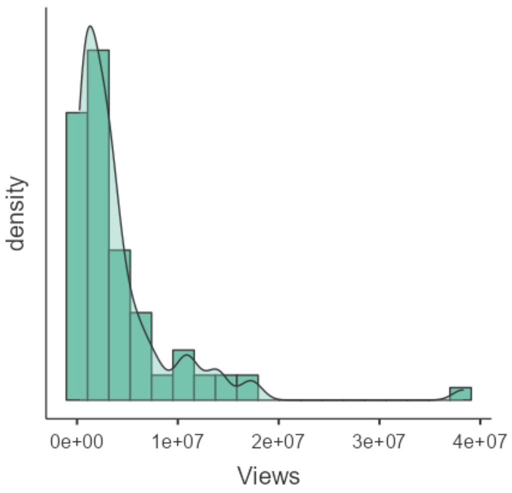
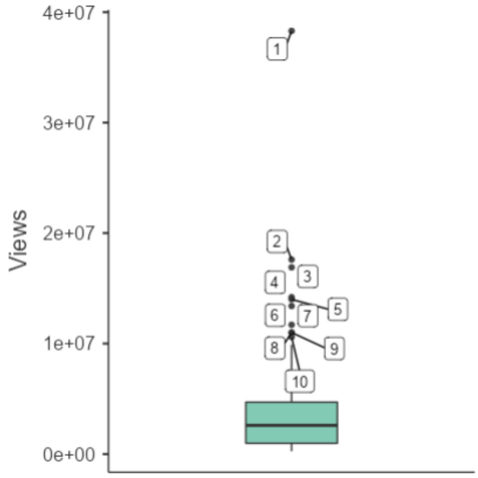


Figure H6

Views Parametric Visuals


density
0e+00
1e+07
2e+07
3e+07
4e+07
Views


4e+07
3e+07
2e+07
1e+07
0e+00
Views
1
2
3
4
5
6
7
8
9
10

Appendix I: DSM Accuracy Scale Parametric Assessment

Figure I1

DSM Accuracy Scale Parametric Visuals

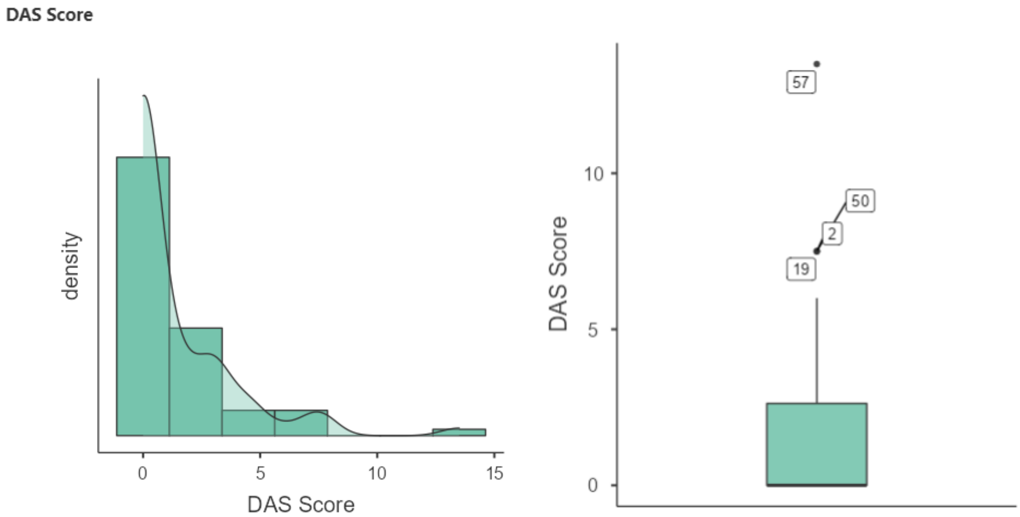


Table I1
DAS Descriptive Statistics

	DAS Score
N	*70*
Missing	*0*
Mean	*1.41*
Std. error mean	*0.297*
Median	*0.00*
Standard deviation	*2.49*
IQR	*2.63*
Range	*13.5*
Minimum	*0.00*
Maximum	*13.5*
Skewness	*2.49*
Std. error skewness	*0.287*
Kurtosis	*7.80*
Std. error kurtosis	*0.566*
Shapiro-Wilk W	*0.634*
Shapiro-Wilk p	*<.001*

Appendix J: Multiple Linear Regression Variance Inflation Factor

Table J1

Collinearity Statistics for Multiple Linear Regression Model

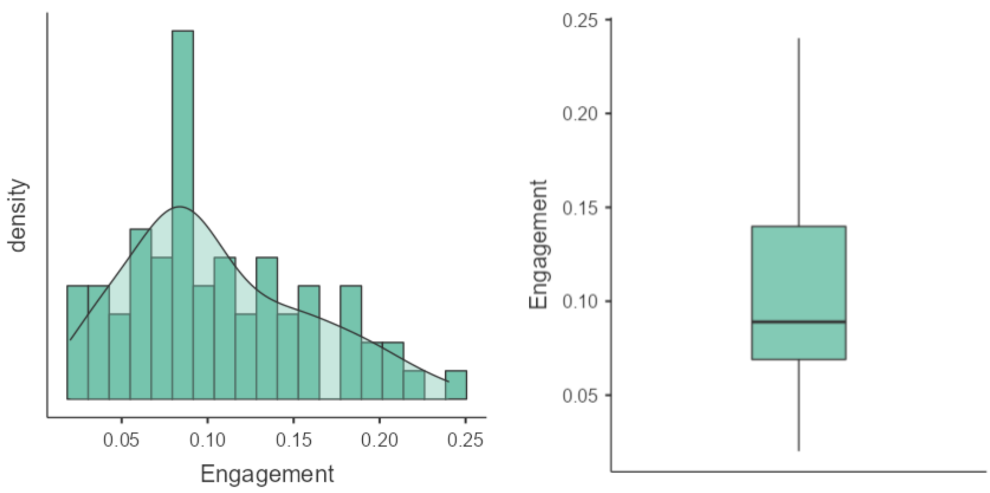
	VIF	*Tolerance*
Duration	***1.19***	***0.8413***
Likes	***19.51***	***0.0513***
Comments	***2.04***	***0.4904***
Saves	***5.74***	***0.1743***
Shares	***5.33***	***0.1875***
Views	***10.33***	***0.0968***
ADHD Focused	***1.20***	***0.8318***
Educational	***1.34***	***0.7477***
Non DSM Symptoms Mentioned	***1.29***	***0.7727***
INCount	***1.16***	***0.8609***
HICount	***1.26***	***0.7947***

Appendix K: Descriptive Statistics for Engagement Metric

Table K1
Engagement Descriptive Statistics

	Engagement
N	***69***
Missing	***1***
Mean	***0.106***
Std. error mean	***0.00639***
Median	***0.0890***
Standard deviation	***0.0530***
Variance	***0.00281***
IQR	***0.0709***
Range	***0.220***
Minimum	***0.0201***
Maximum	***0.240***
Skewness	***0.596***
Std. error skewness	***0.289***
Kurtosis	***-0.346***
Std. error kurtosis	***0.570***
Shapiro-Wilk W	***0.955***
Shapiro-Wilk p	***0.015***

Figure K1
Engagement Parametric Visuals



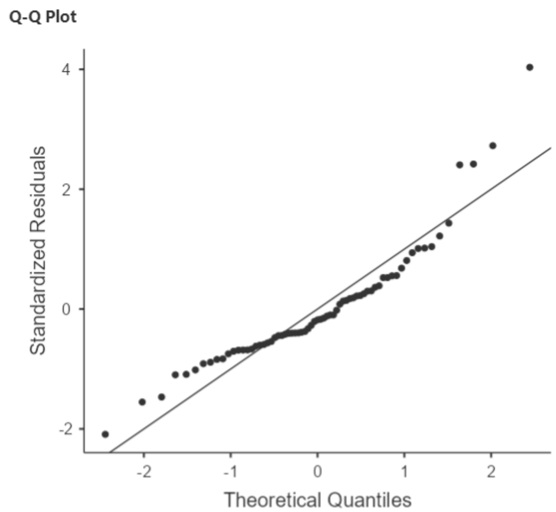
Appendix L: Assumption Checks of Multiple Linear Regression Model

Table L1

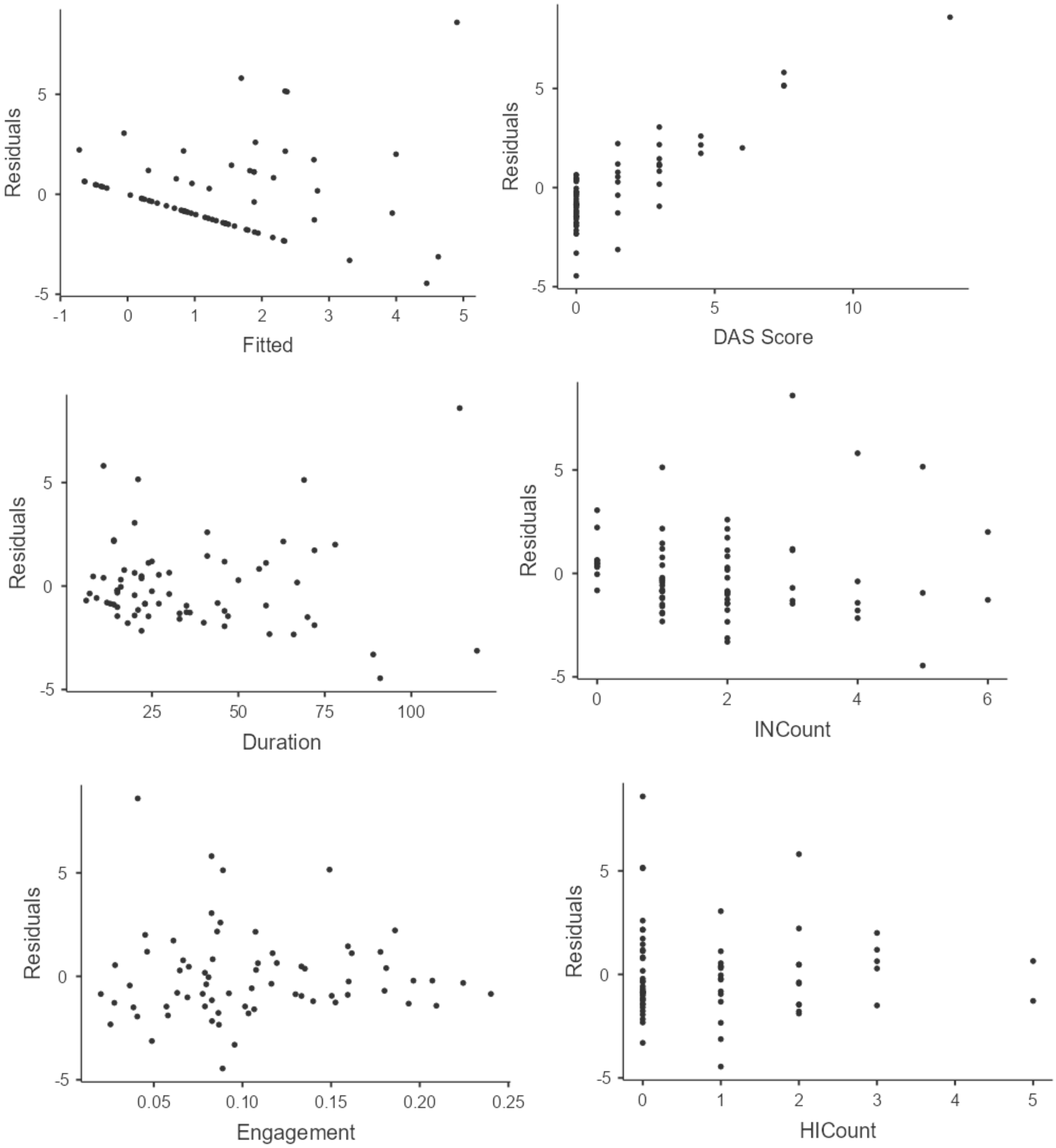
Collinearity Statistics

	VIF	*Tolerance*
Duration	***1.27***	***0.790***
ADHD Focused	***1.09***	***0.915***
Educational	***1.16***	***0.865***
Non DSM Symptoms Mentioned	***1.11***	***0.905***
INCount	***1.11***	***0.902***
HICount	***1.20***	***0.837***
Engagement	***1.29***	***0.778***

Figure L1
Visual Multicollinearity Checks



Appendix M: Residuals Versus Fitted Values Plots



Appendix N: Linear Regression Model Tables

Table N1

Model Fit Measures

						Overall Model Test			
Model	*R*	*R²*	*Adjusted R²*	*AIC*	*BIC*	*F*	*df1*	*df2*	*p*
1	*0.511*	*0.261*	*0.176*	*317*	*337*	*3.07*	*7*	*61*	*0.008*

Table N2

Model Coefficients - DAS Score

						95% Confidence Interval	
Predictor	*Estimate*	*SE*	*t*	*p*	*Stand. Estimate*	*Lower*	*Upper*
Intercept [a]	*0.4166*	*1.1563*	*0.360*	*0.720*			
Duration	*0.0301*	*0.0120*	*2.512*	*0.015*	*0.3111*	*0.0634*	*0.5589*
ADHD Focused:							
1 – 0	*0.0937*	*0.5709*	*0.164*	*0.870*	*0.0378*	*-0.4230*	*0.4986*
Educational:							
1 – 0	*0.2051*	*0.5827*	*0.352*	*0.726*	*0.0828*	*-0.3875*	*0.5531*
Non DSM Symptoms Mentioned:							
1 – 0	*-0.3962*	*0.6186*	*-0.640*	*0.524*	*-0.1599*	*-0.6592*	*0.3394*
INCount	*0.4583*	*0.1934*	*2.369*	*0.021*	*0.2747*	*0.0428*	*0.5065*
HICount	*-0.3236*	*0.2486*	*-1.302*	*0.198*	*-0.1567*	*-0.3974*	*0.0840*
Engagement	*-5.3937*	*5.8293*	*-0.925*	*0.358*	*-0.1155*	*-0.3651*	*0.1341*

[a] Represents reference level