The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 13, Issue 2, April- June, 2025
DIP: 18.01.102.20251302, DOI: 10.25215/1302.102
https://www.ijip.in

Review Paper

A Systematic Review of Misdiagnosis Among Children Who Are Diagnosed with ADHD

Drishti Srivastava[1]*

ABSTRACT

Attention deficit hyperactivity disorder (ADHD) is one of the most commonly diagnosed disorders in children. The prevalence of ADHD is roughly 5.29% worldwide, although it varies by study and geography, with OECD countries having rates as high as 8–12%. Due to the social and financial consequences, a proper diagnosis is essential. Misdiagnosis of ADHD in children is a significant concern within the mental health field. This literature review examines the prevalence, consequences, and underlying causes of ADHD misdiagnosis among children. By analyzing existing research and diagnostic criteria, and modifications made in diagnostic criteria this study delves into the complexities of differentiating ADHD from other conditions with overlapping symptoms. Moreover, the potential ramifications of incorrect diagnoses on children's development, education, and overall well-being are explored. The review also identifies factors contributing to misdiagnosis, such as clinician bias, diagnostic criteria limitations, and comorbid conditions. Finally, based on expert input, potential recommendations for improving diagnostic accuracy and minimizing misdiagnosis are presented.

Keywords: *Misdiagnosis, ADHD*

Attention deficit hyperactivity disorder (ADHD) is a behavioral disorder with symptoms of hyperactivity, impulsivity, and inattention.

- Hyperactivity means a person may seem to move about constantly, including in situations when it is not appropriate, or excessively fidgets, taps, or talks.
- Impulsivity means a person may act without thinking or have difficulty with self-control. Impulsivity could also include a desire for immediate rewards or the inability to delay gratification.
- Inattention means a person may have difficulty staying on task, sustaining focus, and staying organized, and these problems are not due to defiance or lack of comprehension.

"ADHD is known as Hyperkinetic Disorder by the World Health Organization (WHO), and over a person's lifetime, the symptoms and impact of the condition may vary considerably."

[1]Student, Department of Psychology, Mount Carmel College, Autonomous
*Corresponding Author

Received: April 18, 2025; Revision Received: April 30, 2025; Accepted: May 03, 2025

ADHD is not a new condition and has been called different names throughout history. It was labeled as 'minimal brain dysfunction' in the 1930s and has ever since changed names to ADD and ADHD, respectively. Its prevalence has increased over time, with a seeming spike in the 1950s as school became more standardized for children.

According to DSM-5-TRTM Prevalence of Population surveys suggest that ADHD occurs worldwide in about 7.2% of children; however, cross-national prevalence ranges widely, from 0.1% to 10.2% of children and adolescents. Prevalence is higher in special populations such as foster children or correctional settings. In a cross-national meta-analysis, ADHD occurred in 2.5% of adults.

Diagnostic Criteria for ADHD according to DSM-5-TRTM

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

a) Often fails to give close attention to details or makes careless mistakes in schoolwork, etc.
b) Often has difficulty sustaining attention in tasks or play activities.
c) Often does not seem to listen when spoken to directly.
d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.
e) Often has difficulty organizing tasks and activities.
f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.
g) Often loses things necessary for tasks or activities.
h) Is often easily distracted by extraneous stimuli.
i) Is often forgetful in daily activities.

2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

a) Often fidgets with or taps hands or feet or squirms in seat.
b) Often leaves seat in situations when remaining seated is expected.
c) Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
d) Often unable to play or engage in leisure activities quietly.
e) Is often “on the go,” acting as if “driven by a motor”.
f) Often talks excessively.
g) Often blurts out an answer before a question has been completed.

h) Often has difficulty waiting his or her turn.
i) Often interrupts or intrudes on others.

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication, or withdrawal).

Diagnostic Criteria for ADHD according to ICD-11

An ongoing pattern of hyperactivity-impulsivity and/or inattention that lasts for at least six months, usually starting in early to mid-childhood, is what is known as attention deficit hyperactivity disorder (ADHD). This behavior impedes academic, professional, or social functioning and is noticeably above typical age and intellectual ability variance.

Distractibility, difficulties maintaining focus, and organization issues are all aspects of inattention. Overindulgence in movement and trouble staying motionless in controlled environments are examples of hyperactivity. Acting impulsively means not thinking through the possible outcomes or risks. A diagnosis can only be made if these symptoms are seen in multiple contexts.

- **6A05.0 Attention deficit hyperactivity disorder, predominantly inattentive presentation**
- **6A05.1 Attention deficit hyperactivity disorder, predominantly hyperactive-impulsive presentation**
- **6A05.2 Attention deficit hyperactivity disorder, combined presentation**
- **6A05.Y Attention deficit hyperactivity disorder, other specified presentation**
- **6A05.Z Attention deficit hyperactivity disorder, presentation unspecified**

Diagnostic Method

Following an ADHD diagnosis, a comprehensive evaluation is conducted to determine the presence of coexisting conditions. If identified, these conditions are addressed prior to initiating ADHD treatment. Upon resolution or management of coexisting conditions, a reassessment of ADHD symptoms is performed. If ADHD symptoms persist, a treatment plan incorporating behavior management strategies and, if necessary, medication, is implemented. The effectiveness of the treatment is monitored, and adjustments are made as needed based on symptom improvement.

Behavior Assessment

Since it incorporates feedback from parents and teachers, the **Vanderbilt ADHD scale** is frequently used with children. Although a physical examination is not very helpful in diagnosing ADHD, it can help rule out other medical illnesses including thyroid problems.

Test-retest reliability results for the **ACTeRS-2 rating scale**, conducted by Alaine A. Benson of Eastern Illinois University, show that three of the four subscales that comprise the behavior rating scale exhibit moderate to high correlations between administrations. It was found that the test-retest reliability for attention, hyperactivity, and social skills was sufficient. Nevertheless, the Oppositional subscale values fell short of meeting the necessary degree of correlation significance to demonstrate test-retest reliability. Additionally, the substantial positive correlation (.81) between the Social Skills and Attention measures—which suggests that there is about 65% shared variance—makes it difficult to evaluate the two separately.

The Attention Deficit Disorder Evaluation Scale - Fourth Edition (ADDES-4) was created in 2013 by Tamara J. Arthaud, Ph.D., and Stephen B. McCarney, Ed.D., to assess and diagnose ADHD in children and youth using data from primary observers of a student's behavior, such as teachers, psychologists, and medical professionals. The ADDES-4 integrates knowledge from recent research in the fields of education, neurology, and psychology. It also includes methods for diagnosing and identifying behavior disorders, learning disabilities, and ADHD. Based on current characteristics of ADHD, it includes subscales for inattention and hyperactivity-impulsivity. The scale's findings are in line with the criteria that educators, psychiatrists, and pediatricians use to diagnose ADHD in kids and teenagers.

The research and application of the **Child Behaviour Checklist** (CBCL; Achenbach, 2001) are well-established. The current CBCL is similar to its earlier versions, with the addition of DSM-oriented scales and some adjustments to items and response structure. The CBCL is part of a larger assessment system that includes classroom observation measures, self-reporting (YSR), and teacher ratings (TRF). The latest CBCL version (Achenbach & Rescorla, 2001) offers two distinct forms: one for children aged 1.5–5 and another for children aged 6–18.

One of the most widely used instruments for assessing behavioral and emotional functioning is the **Conners Rating Scale** (Conners, 1997, 2008). The Conners Scales, which are widely used in clinical practice and research, are designed to evaluate behaviors that are frequently linked to the diagnosis of ADHD. They are available in parent, teacher, and self-report versions.

The Quantified Behaviour examination is a computerized neuropsychological examination that uses a continuous performance test (CPT) to evaluate the three main symptoms of ADHD in children aged 6 to 12 and in subjects aged 12 and up. These tests have the tremendous advantage of measuring head movements using a motion tracking system in addition to providing estimates of participant performance (e.g., omission and commission mistakes).

MISDIAGNOSIS

Schiff and colleagues (2009, p. 1882) defined diagnostic error as "any mistake or failure in the diagnostic process leading to a misdiagnosis, a missed diagnosis, or a delayed diagnosis." and divided the diagnostic process into seven stages:

(1) Access And Presentation
(2) History Taking/Collection
(3) The Physical Exam
(4) Testing

(5) Assessment
(6) Referral
(7) Follow-Up

Any point along the diagnostic procedure might result in a diagnostic error, and the repercussions for the patient can range from little harm to serious harm. Not all errors will lead to a missed, delayed, or incorrect diagnosis. Schiff and colleagues believe diagnosis to be an intermediate outcome of the diagnostic process, and any resulting adverse patient harm would be regarded as actual patient outcomes. This model is related to Donabedian's structure-process-outcome concept. (Schiff and Leape, 2012; Schiff et al., 2005, 2009).

METHODOLOGY

To study misdiagnosis among children who are diagnosed with ADHD , this study used a research design that was mainly based on the literature. A thorough analysis of pertinent books, reports, and scholarly articles was done in order to compile the body of information already in existence and pinpoint research needs. In addition to the literature analysis, individuals participated in a small-scale exploratory interview to provide preliminary qualitative data. The results of the interviews should be regarded cautiously, though, because of the small sample size. They are mainly intended to guide future study topics.

REVIEW OF LITERATURE

Polly Ford-Jones' research Misdiagnosis of Attention Deficit Hyperactivity Disorder: 'Normal Behavior' and Relative Maturity from May 2015, using the Review of Literature Method revealed that, despite its poorly understood causes and contentious diagnosis, ADHD is one of the most commonly diagnosed disorder in children.

Children with ADHD face challenges in school and are at a higher risk for drug use, car accidents, and other mental health issues. Overdiagnosis and unnecessary medication, which can have adverse effects, are significant concerns. The variation in ADHD diagnosis within a six-day birth range suggests that non-biological factors influence diagnosis. Diagnosing ADHD in preschoolers is particularly problematic, as behaviors such as impulsivity and inattention are often typical for that age group.

Sex, behavior, and diagnosis

According to "Is ADHD diagnosed in accordance with diagnostic criteria? Overdiagnosis and influence of client gender on diagnosis" A study done by the **American Psychology Association** in 2011 goal was to address open-ended issues with the diagnosis of ADHD, such as potential overdiagnosis and gender discrepancies. Studies reveal that boys receive ADHD diagnoses at a rate higher than the overall male-to-female ratio (3:1), ranging from 6 to 9 to 1. It was proposed that rather than rigorously following DSM-IV and ICD-10 criteria, therapists may overdiagnose ADHD by basing their diagnosis on a prototype concept.

Polly Ford-Jones' research highlights the significant influence of social institutions and beliefs on defining 'normal' behavior across ages and genders, impacting children's education, health, and societal costs. With teachers conducting over half of ADHD tests, accurate diagnosis in schools is crucial to address the heightened risk of academic issues. The educational system must accommodate different maturity levels and carefully interpret children's behavior. Overdiagnosis is a concern, especially in preschoolers, as unnecessary medication can have serious adverse effects and uncertain long-term consequences.

Solutions proffered by the study Knowledge-translation techniques include educating parents about behavioral and developmental differences in their children, training educators to manage these variations, and reminding professionals conducting ADHD evaluations to avoid prescribing unnecessary stimulants. Longer clinician examinations, lasting two to three hours, may ensure more accurate long-term predictions and appropriate stimulant use for preschool diagnoses.

In a 2016 study "The Youngest Get the Pill: ADHD Misdiagnosis in Germany, its regional correlates and international comparison" conducted by Hannes, Schwandt; Amelie, Wuppermann, using a Comparison of ADHD Prevalence Rates across Data Sources, the authors discussed that Children in wealthy countries are frequently diagnosed with ADHD, but reasons are still up for debate. The research from the United States, Canada, and parts of Europe highlights a concerning trend: younger students starting school are disproportionately diagnosed with ADHD compared to older peers, suggesting potential misdiagnosis due to their relative immaturity. This issue is explored further using extensive health insurance data from Germany, where similar age-related misdiagnoses of ADHD are observed. These findings echo global patterns where regions with higher misdiagnosis rates also tend to report higher overall ADHD prevalence. The study underscores the significant roles of teachers and parents in identifying and managing ADHD-related behavioral issues, emphasizing the need for more nuanced diagnostic approaches and consideration of socioenvironmental factors in healthcare and education systems.

Expanding on this research, it addresses how medication is commonly used to manage symptoms, concerns persist regarding its long-term effects on development and brain function. The study also discusses the impact of relative age on ADHD prevalence, pointing out spikes in diagnosis rates around school enrollment cut-off dates, which may indicate misdiagnoses rather than genuine health differences.

Overall, the study's findings align with global trends suggesting that misdiagnosis significantly contributes to the high prevalence of ADHD. It calls for improved diagnostic strategies and a deeper understanding of socio-environmental influences on ADHD diagnoses in school-age children.

Another Review of the Literature "Why the Diagnosis of Attention Deficit Hyperactivity Disorder Matters" by Alaa M. Hamed, Aaron J. Kauer, and Hanna E. Stevens will help us understand about challenges that affect the diagnosis of the patient.

For kids to realize their full potential at home and at school, the American Academy of Paediatrics and related organizations advise screening for and diagnosing ADHD as early as preschool. Guidelines take into account the child's internal variables, but outside circumstances can have a big impact on diagnosis. These include the child's traits, school-related variables, medical system components, and parental participation. These diverse factors influence the diagnosis and timing of ADHD treatment.

Parental Role: Parents are essential in helping their children identify behavioral problems and get the care they need. Their decision-making about medical advice and treatment is greatly influenced by their belief that ADHD is a neurobehavioral illness that needs to be managed medically. Parents may be discouraged from seeking treatment, though, for a variety of reasons, including diet, school difficulties, personal tolerance levels, psychosocial stressors, and the misconception that inattentive ADHD is less severe. The timing of an

ADHD diagnosis is influenced by various economic circumstances, including income and health insurance type because specialized care can be expensive. Misinformation, particularly from social media, stressful parenting, and life interruptions can all cause delays in diagnosis and treatment. Perceptions of behavioral standards and clinical examinations are influenced by cultural and ethnic backgrounds. While mistrust can impede the diagnostic process, effective communication and trust between parents and teachers are essential for the early detection of ADHD. In addition to the fact that parents of children with ADHD are more likely to have the disorder themselves, parents without an ADHD diagnosis may face greater family conflicts and damaged relationships with their children.

Health Care Provider: Early diagnosis and identification of ADHD depend on access to medical professionals and research. Subjectivity in symptom evaluation, doubts over the validity of the diagnosis, and conflicting definitions in diagnostic manuals (DSM-IV-TR, DSM-5, and ICD) are some of the issues associated with diagnosis. According to a study on more effectively scheduled care for individuals diagnosed with ADHD, only 57% of patients did not have comorbidity assessments, and only 5% had standardized diagnostic documentation. The acceptance of diagnoses by physicians and families may rise with the use of standardized assessment instruments.

Educator Role: Teachers' evaluations of children's behavior are crucial in clinical assessments of ADHD, though these can be biased. Educators need training and support to accurately identify and manage ADHD in children, as they often spend significant time with students and are usually the first to notice issues. Schools' perspectives on ADHD and their early intervention programs greatly influence children and parents

Children's Role: A child's diagnosis of ADHD is influenced by several factors, including symptom intensity, gender, age, race, and socioeconomic background. Because their externalizing symptoms are more obvious in boys, especially in the hyperactive/impulsive or mixed forms, boys are diagnosed with ADHD more often. Comorbid conditions such as anxiety, depression, conduct and oppositional defiant disorders, learning and developmental difficulties, and other neurodevelopmental disorders are also assessed as part of comprehensive testing for ADHD. The existence and severity of comorbidities can help with a more accurate diagnosis of ADHD, even when somatic, physical, or syndromic traits can disguise symptoms of the disorder. Girls who have Turner syndrome (XO), for example, are more likely to have ADHD, which may confirm or contradict the diagnosis.

In another research study, "Misdiagnosis and Dual Diagnosis of Gifted Children" Authors: James T. Webb, Edward R. Amend, Nadia E. Webb, Jean Goerss, Paul Beljan, F. Richard Olenchak discussed that An excessive number of talented kids are receiving incorrect diagnoses for Attention Deficit Hyperactivity Disorder (ADHD). The intensity, sensitivity, impatience, and high motor activity of a brilliant youngster can readily be confused with ADHD symptoms. While some gifted children undoubtedly have ADHD and are therefore dual diagnosed with giftedness and ADHD, most gifted children, in my opinion, are not. Few medical professionals pay enough attention to the DSM-IV (1994) description of ADHD, which states "…inconsistent with developmental level…."

In comparison to other children, the gifted child's developmental stage is distinct (asynchronous), so medical professionals should inquire as to whether the child exhibits inattentiveness or impulsive behaviors exclusively in certain contexts (e.g., at school but not at home; at church but not at scouts, etc.). The youngster probably does not have ADHD if

the problematic behaviors are situational only. To make matters more complicated, based on clinical observations, approximately three percent of exceptionally talented youngsters have a functional borderline hypoglycemia syndrome. It has been postulated by Silverman (1993) that a similar proportion may also experience allergies of different kinds. In these circumstances, physical reactions might mirror symptoms of ADHD due to their severity and sensitivity. The type of food consumed, the time of day, the amount of time since the last meal, and exposure to other environmental factors can all affect how ADHD-like the symptoms are in certain situations.

From the previous research paper discussed Why the Diagnosis of Attention Deficit Hyperactivity Disorder Matters, we can get a good overview of the consequences of untreated ADHD, in many different domains of functioning.

Academic Achievement
Stimulant treatment for ADHD in children leads to academic gains in adolescence compared to those untreated.

Family/Relationship
Untreated hyperactivity in ADHD can result in long-term social issues, poor listening skills, frustration, family conflict, decreased intimate relationships, low self-esteem, and potential intimate partner violence (IPV).

Substance/Alcohol Abuse
ADHD is strongly linked to substance/alcohol abuse. Even mild symptoms can increase the risk, and untreated ADHD can lead to earlier substance abuse and higher rates of comorbid disorders, criminal convictions, and suicide attempts.

Financial/Employment
Untreated ADHD often causes financial and employment problems, including job instability, lower income, more sick days, reduced work quality, and economic burden due to medical services.

Criminal
Untreated ADHD increases the likelihood of criminal behavior, imprisonment, speeding, traffic violations, and motor vehicle accidents.

Input from frontline personnel on the underlying factors and potential resolutions for the increasing challenge
In a recent interview with experts on ADHD diagnosis, several professionals shared their insights on how to avoid misdiagnosis in children. **Dr. Manoj Bhagat,** an MBBS and MD physician, emphasized the importance of thorough testing, asking as many questions as possible, and conducting comprehensive examinations and other medical tests. **Saanjana Shailendra**, a former clinical psychiatrist now working in HR, highlighted that parental hesitation due to dilemmas, worries, and taboos often delays the diagnosis, increasing the risk of misdiagnosis. Saanjana Shailendra suggested interacting with parents, family, and teachers to ensure a proper diagnosis.

Dr. Sowmya Puttraraja, a consultant psychologist, advised against relying solely on assessments, recommending observation of the child in different contexts and over different periods, as well as monitoring the child's nutrition intake and sleeping patterns. **Ms Priya**

Kurian, an assistant professor in the psychology department, attributed the rise in misdiagnosis to over-familiarity with ADHD, leading to self-diagnosis and pressure for formal diagnosis. Ms. Priya Kurian recommended enforcing standardized assessments conducted by licensed professionals and recertifying diagnoses through additional evaluations.

Bhavya Naidu, a senior child psychologist and behavioral analyst specializing in neurodivergence pointed out that misdiagnosis can result from symptom overlap with other disorders, developmental variability, cultural factors, misinformation, or bias. Bhavya Naidu suggested seeking second opinions, conducting comprehensive evaluations, reviewing the child's history and social context, and educating both patients and families. **Geenaa Thaploo**, another psychologist, noted that a limited understanding of ADHD, particularly in females, contributes to misdiagnosis. Geenaa Thaploo also mentioned cultural myths and parental misconceptions, which led to delayed medical consultations. To address these issues, Geenaa Thaploo proposed initial management of overlapping symptoms before diagnosing ADHD, training teachers, fostering better relationships between schools and psychiatric hospitals, revisiting diagnoses after initial visits, increasing testing areas, and focusing on understanding symptoms rather than just the disease itself.

RESULT

The research study reveals that ADHD diagnosis is influenced by a range of factors beyond biological ones, including socioeconomic status, environmental conditions, and educational institutions. The study highlights the crucial role of parents, teachers, and the trust between these parties and the children. It also identifies the various factors contributing to misdiagnosis and the long-term harmful effects, including the adverse impacts of medications given due to misdiagnosis.

The study suggests several measures to improve diagnosis accuracy: comprehensive testing and examinations, involving parents, family, and teachers in the diagnostic process, avoiding sole reliance on assessments, and observing children in various contexts while monitoring their nutrition and sleep. It recommends standardized assessments by licensed professionals, recertification of diagnoses, and educating patients and families. Additionally, managing overlapping symptoms first, training teachers, fostering better school-hospital relationships, and revisiting diagnoses are emphasized as effective strategies.

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Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Drishti, S. (2025). A Systematic Review of Misdiagnosis Among Children Who Are Diagnosed with ADHD. *International Journal of Indian Psychology*, *13*(2), 1136-1146. DIP:18.01.102.20251302, DOI:10.25215/1302.102