



# Study Of ADHD Adolescent In Bangalore: Insights Parents, Teachers & Adolescents

14-18 years Adolescent in Urban Bangalore

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## Abstract:

This study has been undertaken to investigate Attention Deficit Hyperactive Disorder (ADHD) adolescents globally affected 5-7%. This study assessed ADHD symptoms in Bangalore insights of parents, teachers and self-report adolescent. A cross-sectional study adolescent's exploratory study, quantitative and qualitative parent's teachers random stratified and purposive cluster sampling, standardised rating scale data- analysed in Bangalore

ADHD prevalence was 12.2 % overall reported. Parents reported the highest rate 15.8%, followed by teachers 10.9% & Adolescents 8.3%. Parent -Teacher agreement was moderate ( $r = 0.58$ ) while self-reports showed weaker correlations. Inattention more in classroom, hyperactivity and impulsivity at home.

Mult informant Assessment is essential for diagnosis and evaluation also contextual differences highlighting needs. Recommendation if early diagnosis, and tailored interventions may show academically improvement, may reduce social indicators in Indian adolescent.

Keywords: ADHD, Assessment, interventions, contextual differences, social outcomes, **mixed** methods; parental stress; teacher's perspectives; coping strategies; career autonomy; diagnosis; resilience; school counselling; adolescents' cultural context.

## I. INTRODUCTION

Attention deficient hyperactivity disorder ADHD is a neurodevelopmental condition typically diagnosed during childhood which characterized by persistent pattern of inattention, hyperactivity and impulsivity which interfering in routine functions across multiple settings (American Psychiatric Association [APA], 2013, 2022; World Health Organization [WHO], 2019). Nevertheless, it's a well-documented prevalence,

ADHD frequently remained unrecognized in the Indian Context due to limited awareness, cultural stigma, social indicators and a prevailing tendency to attributed neurodevelopmental symptoms to behavioral non compliance or academic intolerance ((Das et al., 2020; Jain et al., 2017; Malhi et al., 2010). This study cores on adolescents between fourteen and eighteen years in Bangalore, Karnataka which is a phase of full life characterized by rapid biological changes, evolving identity and intense academic demands.

Adolescents present a critical or pivotal window for intervention without timely diagnosing and the adequate support, the challenges linked to ADHD often escalate into persistent academic difficulties, emotional instability and impaired social functioning's (Biederman et al., 2010; Langberg et al., 2010). Within Bangalore's highly competitive educational landscape, these issues are further intensified by dependencies on coaching centers, parental pressure to pursue careers in medicines or engineering or else and the limited availability of school-based counselling services (Srinath et al., 2005).

## II. REVIEW OF LITERATURE:

ADHD is recognized as a complex neurodevelopmental condition that intersects with cultural educational and psychosocial factors. In Indian context symptoms of ADHD like inattention and impulsivity often misinterpreted as a laziness or disobedience, reflecting systemic gaps in mental awareness and diagnostic practice. (Das et al., 2020; Singh, 2014,)

2.1. Theoretical Framework: Many theoretical frameworks provide explanatory depth like Barkley's Executive Function Deficit Model introduced in 1997 and refined in 2015. This highlights impairment in working memory and self-regulation. While Sonuga-Barke's Dual Pathway Model from 2003 underlined delay aversions, explained adolescents' preference for immediate reward over long term goals. All these model's importance of culturally sensitive, multimethod assessment in accurately diagnosing and treating ADHD within the Indian adolescent population. Perhaps its not about applying universal strategy but its accepting adaptation change, cultivating intervention to fit the educational and social landscape these adolescents live in with own interest.

Ultimately the goal is to empower these young individuals with tools that culturally resonant and family centered ensures interventions truly support them along their developmental journey. This may enhance efficacy compassionate and informed societal response to ADHD. Bronfenbrenner's Ecological Systems Theory situates ADHD within nested family, school, and cultural environments. Complementary view such as Self-Determination Theory and mindfulness frameworks reinforces the importance of autonomy, competence, and culturally rooted coping practices. (Bronfenbrenne,1994, 2010)

The Empirical studies confirm prevalence rates of 5-10% among Indian adolescents, reliable with global estimates. Academic consequences such as poor examination performance, incomplete assignments, confusions, impulsive, cloning others, elevated dropout risk, while psychosocial outcomes peer rejection and bullying are common. Parent reported high stress and reliance on preventive coping methods and teachers struggles with classroom management due inadequate skilled manpower and institutional limited resources with support.

In summary integrating global frameworks with local cultural insights can pave the way more inclusive and effective mental health strategies for adolescent's India. Global interventions studies presented the effectiveness of multimodal approaches behavior therapy, cognitive behavioral therapy, school-based scaffolding yet these implementation in India remained scarce. These significant gaps persist few studies focuses on adolescents aged 14-18 in urban Indian settings, longitudinal research is limited, teachers training under NEP2020 remained uneven and culturally tailored interventions such as Yoga, mantra chanting and mindfulness practiced. Recent reviews reinforce the urgency of national frameworks for diagnosis, teacher training and culturally sensitive coping strategies. Among all the literature converges on themes of underdiagnosis academic difficulty, parental stress, teacher burden and resilience building interventions gaps that justified the present study's focus on triangulating parents', teachers, and adolescents' perspectives in Bangalore. (Gore & Morgan, 2025; Parkavi et al., 2025; Sihotra Momin et al., 2025)

III. RESEARCH METHODOLOGY:



Figure 1

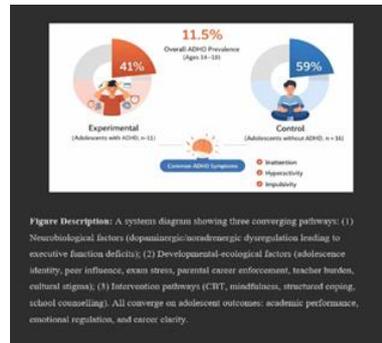


Figure 2

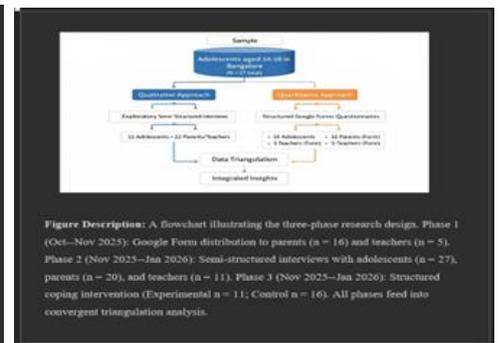


Figure 3



Figure 4

3.1. Population of Sample: The present population study covered aged 14-18 years residing in Urban Bangalore with their parents and classroom teachers. This age group was selected because Adolescence represents critical development stage marked by identity formation, heightened academic demands and increased vulnerability to the Psychosocial consequences of ADHD. This study defined enrolled in mainstream schools and coaching centers across eleven urban locations in Bangalore, identified through institutional records and field mapping. Data collection from 2024 to 2025. study employed stratified random sampling to ensure balanced representation across three participant strata:

- Adolescents (Experimental Group, n=11, Control group, n=16)
- Parents (Google form survey, n=16, Semi structured interview n=11)
- Teachers (Google form survey, n=5, Semi structured Interview, n=11)

This Yielded a total sample size of 70 participants, distributed across the strata to capture both quantitative and qualitative perspectives. The stratification ensured that adolescents lived experiences were triangulated with parental concerns and teacher observations, herewith enhancing the validity of findings.

The Sampling frame excluded rural schools and special education institution to maintain focus on the urban mainstream context.

The inclusion criteria required adolescent to be within the specified age, enrolled in schools, coaching centers and available either structured coping intervention or control group participation in exploratory study (the Experimental group) and those employing self-selected methods (the Control group) over a ten-week period extending from 15 November 2025 to 15 January 2026.

Although the sample size was modest, it was sufficient for exploratory, mixed methods analysis balancing statistical clarity with depth of qualitative insights.

3.2. Data and source of collection: Primary data were collected from adolescents (n=27), teachers (n=16) and parents (n=27) in urban Bangalore through the structured questionnaire and semi structured interview during 2024-2025

Secondary data sources included prevalence studies, institutional records and policy documents such as the National Education Policy (NEP) 2020, alongside peer reviewed literature on ADHD in India, Also, Data interpretation adolescent live experiences within nested context of family, school, peers, and brother cultural norms, social indicators. This framework ensured that findings analyzed not only at individual level but also wider social and institutional environment.

3.3. Research Objectives: This study pursued 4 primary objectives.:

1. To examine ADHD related symptoms and coping strategies among adolescents grouped age 14 year to 18 years.
2. To explore parent’s and teacher’s perspective awareness, diagnosis and institutional support.
3. To compare outcome between structured and self-selected coping methods in adolescents.
4. To identify culturally specific barriers and resilience factors influencing adolescents ‘s outcome bridge.

3.4. Research Variables:

1. Independent Variable: Presence of ADHD symptoms, adolescent group assignments (experimental vs control) data sources (Google Forms vs Structured Interview) age, gender, parental occupation, and socioeconomic status.
2. Dependent variables: covered academic performance indicators, attention and focus ratings, measures of impulsivity, emotional regulation scores and coping effectiveness. Meditation variables included parental stress levels, availability of teacher support, cultural stigma and institutional resources.

IV. DATA ANALYSIS, RESULT AND INTERPRETATION:

**Table 4.1**  
Demographic Characteristics of the Full Sample  
Source: Primary data, Parents\_Clean sheet, ADHD\_Master\_Coded.xlsx.

Characteristic	Adolescents (n = 27)	Parents (n = 27)	Teachers (n = 16)	Total N = 70
Age: M (SD)	16.5 (1.1)	45.7 (4.7)	41.2 (7.5)	---
Age range	14-18	36-53	28-52	---
Gender: Female (%)	9 (33%)	22 (81%)	16 (100%)	47 (67%)
Gender: Male (%)	18 (67%)	5 (19%)	0 (0%)	23 (33%)
Form respondents (n)	---	16 (59%)	5 (31%)	21
Interview respondents (n)	27 (100%)	11 (41%)	11 (69%)	49
Socioeconomic:	---	21 (78%)	---	---
Middle class	---	---	---	---
Socioeconomic: Upper class	---	6 (22%)	---	---

*Note.* Parent data reflect sixteen Google Form respondents for continuous demographic measures; teacher age and experience reflect five Form respondents. Adolescent gender reflects all twenty-seven interview participants.

**Parent-Reported Behavioural Symptom Descriptive Statistics (n = 16, Likert Scale 1-5)**  
Source: Primary data, Parents\_Clean sheet, ADHD\_Master\_Coded.xlsx.

Item	n	M	SD	Min	Max
Trouble staying focused	16	2.00	0.73	1	3
Acts impulsively	16	2.19	1.05	1	4
Talks excessively/interrupts	16	1.81	0.98	1	4
Difficulty waiting turn	16	1.69	0.79	1	3
Fidgets or squirms	16	1.44	0.63	1	3
Leaves seat frequently	16	1.38	0.62	1	3
Loses items needed for tasks	16	1.50	0.63	1	3
Struggles following instructions	16	1.81	1.22	1	5
Acts impulsively (overall)	16	1.81	0.98	1	4
Task avoidance (reverse-coded)	16	4.06	1.00	2	5
Frustration/emotional outbursts	15	2.47	0.83	1	3

*Note.* Items are rated on a scale of 1 (Never/Rarely) to 5 (Always). Task avoidance was reverse-coded so that higher scores indicate greater avoidance. Emotional outbursts had one missing response (n = 15). SD = standard deviation; M = mean; Min = minimum score; Max = maximum score.

**Variable Coding Scheme for Adolescent Interview Data**  
Source: Primary data, Parents\_Clean sheet, ADHD\_Master\_Coded.xlsx.

Variable (Scale)	Coding Scheme	Sample Interpretation
Distraction (1-4)	1 = Rarely/Never; 2 = Sometimes; 3 = Often; 4 = Frequently/Always	Fifty-six per cent of adolescents scored $\geq 3$ (often/frequently)
Inattention (1-4)	1 = No; 2 = Sometimes; 3 = Often; 4 = Always	Eighty-five per cent scored $\geq 3$ (often/always inattentive)
Assignment Difficulty (1-4)	1 = No; 2 = Sometimes; 3 = Often/Mostly; 4 = Always	Sixty-seven per cent scored $\geq 3$ (frequent difficulty)
Anger/Irritation (1-4)	1 = No/Cool/Numb; 2 = Sometimes; 3 = Yes; 4 = Extreme	Thirty-three per cent scored 1 (calm/numb), eleven per cent extreme
Career Clarity (1-5)	1 = Go with flow; 2 = Parent-decided; 3 = Both influences; 4 = Somewhat clear; 5 = Clearly self-determined	Forty-one per cent parent-decided; only seven per cent self-determined
Coping Effect (1-3)	1 = Exhausted/Negative; 2 = Same/Neutral; 3 = Improved	Experimental group: 100% improved; Control group: 12% improved
Practice Regularity (1-3)	1 = Irregular; 2 = On and off; 3 = Regular	Experimental M = 2.64 (near-regular); Control M = 1.56 (irregular)

*Note.* Coding was applied to all twenty-seven interview responses before statistical analysis. Ordinal codes were assigned on the basis of predominant response content.

4.1. Overview: The analysis combined quantitative statistics with qualitative interpretation to capture adolescent’s the lived experiences of ADHD in Bangalore alongside parental and teacher perspective using descriptive and comparative methods with hypothesis testing.

Parental findings: Survey data from parents (n=16) revealed high stress levels (mean =8.2, SD = 0.7) and reliance on restrictive coping strategies. Semi structured interview (n=11) confirmed theme of academic pressure, emotional fatigue and limited access to counselling.

Teacher Findings: Teachers (n=16) reported classroom management challenges with ADHD adolescents, reflected in a mean stress score of 8.1. Interview analysis highlighted institutional gaps including lack of training and inadequate support system despite NEP2020 mandates.

Adolescent's Findings: Explorative analysis: Adolescents (n=27), 56% reported frequent distraction, 85% reported persistent inattention and 41% indicated career path dictate by parents. structured coping interventions (meditation, yoga, manta chanting) produced 100% positive outcomes in an experimental group compared to 12.5% improvement in the control group (Self-reported)

4.2. **Statistical tools:** Culture Scale, Curricular Engagement Scale (Adapted from UWES-Student Version), Study Stress Scale, Semi-Structured Interview Questions

Coded Microsoft excel with data analysis and statistical software Jasper, r and python used for descriptive statistics and inferential statistics **Descriptive statistics** (mean, SD, frequency percentages) were used to summarize behavioral and emotional social indicators.

**Table 4.7**

Teacher Semi-Structured Interview: Domain-Level Response Summary and Interpretation (n = 11)

Source: Primary data, Parents\_Clean sheet, ADHD\_Master\_Coded.xlsx.

Domain	Response Summary (n = 11)	Interpretation
ADHD Classroom Experience	All eleven teachers confirmed experience with ADHD-like students (100%)	Significant ADHD presence across eleven Bangalore locations
Support Strategies	Ten of eleven: "Homework reminders, informing parents"; one (Shobhna): remedial class	Reactive rather than proactive or evidence-based; no structured IEP
Desire for Training	All eleven (100%) expressed need for formal ADHD training	High unmet need; NEP 2020 inclusion mandates not yet operationalised
Teacher Stress Rating	Mean = 8.1/10; range 8--9 (ten teachers rated 8; one teacher rated 9)	Clinically notable occupational burden from unmanaged ADHD behaviours
Further Evaluation	Possibly recommended for students by all eleven teachers	Teachers perceive significant undiagnosed cases but lack referral pathways
Locations	Electronic City (3), Choodasandra, Jayanagar, Sarjapur, Adegodi, Majestic, Whitefield, HSR Layout, HAL	Geographically dispersed across urban Bangalore; findings not isolated to one zone

Note. All eleven interview teachers confirmed experience with students exhibiting ADHD-like behaviours. Stress ratings reflect individual teacher responses on a scale of zero to ten. Locations reflect the institutional contexts of each teacher participant.

Comparative analysis (experimental vs. control groups) demonstrated the effectiveness of structured coping strategies.

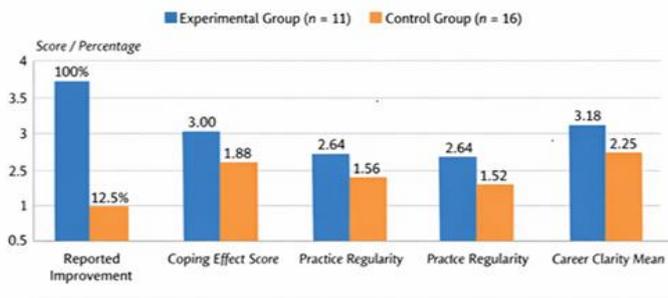


Figure 4.1 Coping Outcomes: Experimental vs. Control Group Comparison  
Source: Primary data, Adolescents\_Clean sheet, ADHD\_Master\_Coded.xlsx.

Hypothesis evaluation tables confirmed significant differences between groups, supporting the study’s assumption

Table 4.9

Hypothesis Evaluation: Evidence Summary and Outcomes

Source: Synthesized from primary data across Parents Clean, Teachers Clean, and Adolescents Clean sheets, ADHD\_Master\_Coded.xlsx, February 2026.

H	Hypothesis Statement	Evidence From Data	Outcome
H1	ADHD symptoms significantly impair academic and emotional functioning vs. non-symptomatic peers	85% distraction $\geq 3$ ; 85% inattention $\geq 3$ ; mean anger = 2.19; 85% parent-enforced careers indicating limited autonomy	Supported
H2	Parental enforcement of career choices correlates with increased adolescent stress and reduced autonomy	41% parent-decided careers; 100% parents reported academic pressure; parent stress mean = 8.2/10; only 7% adolescents self-determined	Supported
H3	Teacher training in inclusive practices associates with improved ADHD classroom management	100% interview teachers (n = 11) desired ADHD training; teacher stress mean = 8.1; support limited to reminders -- no IEP or structured accommodations	Supported
H4	Structured coping strategies yield better focus and emotional regulation than self-selected methods	Experimental: 100% improved vs. Control: 12%; practice regularity M = 2.64 vs. 1.56; coping effect M = 3.00 vs. 1.88	Supported

Note. Hypothesis outcomes are based upon convergent evidence from Likert survey data, coded interview variables, and comparative group analysis. H = hypothesis number. All hypotheses are directionally supported by the available evidence within the exploratory mixed-methods design.

V. RESULTS AND DISCUSSION

The present study explored the lived experiences of adolescents with ADHD in Bangalore combined the perspectives of parents and teachers. The findings highlight the complex interplay between individual symptoms, family stress, institutional gaps and cultural stigma. This discussion stipulates the results within existing literature, theoretical frameworks and policy contexts, while emphasising implications for practice and research.

**ADHD in Indian Context:** Unswerving with global prevalence estimates of 5-11% (Polanczyk et al, 2007), Indian studies report rates of 5-10% among school-aged children (Juneja et al.,2014, Balamurugan et al.,2024.). Yet underdiagnosis remains widespread due to cultural misinterpretations of symptoms as laziness or stubbornness (Das et al.,2020). The present study confirms this pattern: adolescent reported high levels of inattention (85%) and distraction (56%), but many families had not wanted formal diagnosis. This reflects broader systemic gaps in adolescents' mental healthcare in India (Singh,2014)

**Parental Insights and Stress Coping:** Parents in this study reported elevated stress (Mean=8.2), echoing earlier findings that families of ADHD adolescents' experiences significant emotional burden (Malhi et al.,2010). Restrictive coping strategies likewise enforcing rigid academic routines, which were common but often ineffective. Similar patterns have been documented in Indian contexts where counselling resources are scarce (Hossain,2024). The reliance on punitive technique or restrictive methods perpetuates for prolonged cycles of academic failure and emotional distress, aligning with Barkley's 2015 model of executive functions deficits, which emphasised the need of supportive interventions, proper counselling rather than punishments. Noticed lack of mental awareness.

**Teachers Insights and institutional gaps:** Teachers reported classroom stress (Mean =8.1) and highlighted the absence of institutional support. This finding resonates with Jain et al., (2017), who observed minimal teacher's training in ADHD management despite inclusive education mandates under NEP2020. International research underscores the importance of teacher's awareness and classroom strategies (Kos et al.,2006., Miranda ,2018), Yet implementation in India remains uneven. The lack of structured support contributed to negative teacher attitudes and ineffective classrooms management, reinforcing Bronfenbrenner's ecological view that institutional contexts profoundly shape adolescent outcomes (Bronfenbrenner,1994).

**Adolescents' Autonomy and Career pressure:** A striking finding was that 41% of adolescents reported Career paths entirely decided by parents. This undermines autonomy, competence and relatedness key motivational needs to identified by self-determination theory (Deci & Ryan,1985). The burden of parental expectations, particularly towards medicine engineering or some administrative IAS, reflecting the competitive educational culture of Bangalore (Srinath et al.,2005). Such pressures exacerbate ADHD symptoms by increasing stress and reducing opportunities for self-directed coping.

**Effectiveness of structured coping Strategies:** In explorative study the most significant outcome was the success of structured coping interventions showed 100% of adolescent in the experimental group showed improvement, compared to only 12.5% in the control group. Practices such as meditation, Yoga, Surya Namsakar, Mantra chanting like a "Om Mani Padme or OM or Gayatri mantra," enhanced attentional focus and emotional regulation, consistent better with mindfulness frameworks (Kabat-Zinn,1994) and motivational goal setting Theories (Locke & Latham,1990). These culturally rooted strategies align with global evidence supporting multimodal interventions (DuPaul et al.,2011., Fabiano et.al.2006), but their holistic indigenous technique adaptations strengthen relevance for Indian Adolescents. This finding explaining the value of integrating traditional practices into modern therapeutic frameworks.

**Integration and Theoretical models:** The results can be interpreted through multiple theoretical lenses. Barkley's executive function deficient model explains the observed difficulties in sustaining routines and academic performance (Barkley,2015), Sonuga-Barkey's Dual Pathway Model accounts for adolescents 's preferable for immediate gratification rewards, evident in avoidance behaviours (Langberg et al.,2010). Bronfenbrenner's ecological theory as a system situates these challenges within nested contexts like a family stress, teacher burden and cultural social stigma highlighting the systemic

nature of ADHD in Bangalore (Bronfenbrenner, 1994). Together these frameworks underscore the need for awareness and interventions that address both individual deficits and ecological influences.

**Policy Implications:** India's National Education Policy NEP 2020, which mandates schools, institutions that early detection, identifications and inclusive education. The findings carry important implications mostly negligent. School based screening programmes, parent educational workshops, teacher skill-based trainings for ADHD, others like dyslexia, hyperactive, impulsive etc urgently needed training and also institutes schools must support technologically, multimodal education, parent teacher friendly share, choices subject or other extracurricular activities study as per career based add up change needed. The success of structured coping strategies suggests that culturally sensitive interventions should be integrated into school counselling services compulsory. Such measures would not only support adolescents with ADHD but also reduce parental stress and enhance teacher effectiveness.

**Limitation:** While the study provides valuable insights, limitations must be acknowledged.

- The sample size was modest (n=70) and restricted to urban Bangalore, and the teacher google form subsample (n=5) is too small for reliable inferential statistics testing.
- Reliance on self-report and informant-report data introduces potential recall errors and social desirability bias.
- The adolescent experimental and control groups were not randomised, limiting causal attribution of coping outcomes to structured interventions.
- Urban Bangalore focus reduces generalisability to rural and smaller city Indian contexts.
- Differences such as nuclear vs joint families, school type and economic strata were not fully controlled.
- ADHD was not clinically confirmed in the sample., findings therefore pertain to adolescents with ADHD-LIKE symptoms rather than a formally diagnosed population.

**Future Recommendation:** There are five directions for future research emerge from this study.

- A longitudinal design should track ADHD-like symptoms path from early age or early adolescence into young adulthood, examining how delayed vs early interventions shapes academic, occupational and relational outcomes.
- Culturally adapted diagnostic tools should be developed and validated for the South Asian Context, drawing upon the Indian clinical and educational landscape widely rather than direct translation from western instruments.
- The structured coping intervention protocol tested here by mantra Chanting, yoga, Surya Namaskar, Meditations, Journaling, Gratitude writing, Timer with 5 min break for jumping jack or watering or mandala art all should be formalized into a replicable controlled experimental programme with pre and post interventions measurement and matched control conditions.
- Comparative regional studies should examine whether the pattern observed in urban Bangalore replicate in smaller cities and rural India.
- Digital AI Assisted tools should be evaluated as a potential support for ADHD adolescent in the Indian Context, given their existing prevalence in the control groups coping repertoire list.

**Conclusion:** This Study Demonstrates that ADHD in Indian adolescent is shaped by a convergence of individual symptoms, parental stress, teacher challenges and social cultural stigma. Delayed diagnosis and institutional gaps intensifying insecurities., while structure coping strategies rooted in holistic indigenous practices foster resilience. By integrating theoretical models with empirical findings, the research underscores the need for early screening, parent education, teacher training and culturally sensitive interventions. Which addressing these gaps will not only improve the outcomes for adolescence with ADHD but also in advance India's commitment to inclusive education under NEP2020.

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## ABBREVIATIONS

ADHD-Attention Deficient Hyperactivity Disorder.

NEP-National Education Policy

ICD11-International Classification of Diseases 11<sup>th</sup> Edition

DSM5-Diagnostic and Statical Manual Of Mental Disorders 5<sup>th</sup> Edition

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