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Attention-Deficit/Hyperactivity Disorder in children and adolescents: comorbidity and developmental implications

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Abstract. Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most prevalent neurodevelopmental disorders, typically emerging in early childhood and persisting into adolescence and adulthood. Characterized by inattention, hyperactivity, and impulsivity, ADHD manifests in three primary types: predominantly inattentive, predominantly hyperactive-impulsive, and combined. Its etiology is multifactorial, encompassing genetic, neurobiological, environmental, and psychosocial factors. ADHD frequently co-occurs with comorbid conditions, including learning disabilities, anxiety, depression, behavioral disorders, and emotional dysregulation, which exacerbate functional impairments and social difficulties. Developmental trajectories reveal persistent cognitive deficits, especially in executive functions, contributing to academic underachievement, peer rejection, low self-esteem, and increased risk of maladaptive behaviors. Evidence-based interventions, including pharmacological treatment, behavioral strategies, special education services, and mindfulness programs, can enhance emotional regulation, self-esteem, and adaptive functioning. Understanding ADHD's complex presentation, comorbidities, and psychosocial impact is essential for effective assessment, intervention, and support across childhood, adolescence, and adulthood.
Keywords: Attention Deficit Hyperactivity Disorder (ADHD), comorbidity, stress, anxiety, depression

Contextualization and analysis

ADHD constitutes one of the most common neurodevelopmental disorders, whose primary symptoms generally appear before the age of 7, with an average onset between three and four years old, and persist over time and across different settings(Barkley et al., 1990; Faraone et al., 2006).ADHD is a common neurodevelopmental disorder of childhood associated with the maturation of the central nervous system and consistently manifests with specific cognitive dysfunctions. Specifically, in the DSM-IV, the three core symptoms of ADHD are listed as inattention, hyperactivity, and impulsivity (Wilmshurst, 2011). According to the American Psychiatric Association (2013), ADHD, characterized by excessive hyperactivity, impulsivity, and persistent attention difficulties in multiple settings, is a chronic mental health disorder and one of the most frequently diagnosed disorders in childhood, affecting students in the school environment. These core symptoms interact in complex ways, influencing behavior, emotional regulation, and overall development. In school settings, ADHD frequently affects students' ability to engage with the curriculum, manage tasks, and maintain relationships with peers and teachers. Although the presentation of ADHD can vary widely among individuals, its impact on cognitive, emotional, and social functioning underscores the importance of early identification, understanding, and support.These challenges can contribute to frustration, low self-esteem, and strained relationships, emphasizing the need for targeted support strategies in school and home settings. Early recognition and intervention are therefore essential in helping children with ADHD develop coping mechanisms, improve focus, and participate more effectively in academic and social activities.Beyond the classroom, ADHD affects broader aspects of daily life, including personal organization, time management, and goal-directed behavior. The disorder's impact on executive functioning—such as planning, prioritizing, and regulating behavior—can persist into adolescence and adulthood, highlighting its long-term significance. While the severity and combination of symptoms can vary widely among individuals, ADHD represents a complex interaction between neurological development, cognitive function, and environmental demands. Understanding these dynamics is critical not only for effective management but also for fostering an environment where

children with ADHD can thrive and reach their full potential.

Types of ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning or development. According to the DSM-IV (Papaeliou, Maniadaki, &Kakouros, 2015), ADHD manifests in three primary forms: predominantly inattentive, predominantly hyperactive-impulsive, and combined type.

The predominantly inattentive type is characterized by difficulties in sustaining attention, organizing tasks, and completing assignments. Children and adolescents with this presentation are often easily distracted, forgetful in daily activities, and may appear daydreamy or disengaged. They frequently struggle to follow instructions, manage time, and maintain order in schoolwork or personal tasks. This type is commonly associated with academic challenges and may impact social interactions, as peers and teachers may perceive these children as inattentive or disinterested.

The predominantly hyperactive-impulsive type, on the other hand, is characterized by excessive motor activity and impulsive behaviors. Children with this presentation often fidget, talk excessively, interrupt others, and find it difficult to remain seated or wait their turn. They may act without considering the consequences of their actions, engage in risk-taking behaviors, and exhibit challenges in controlling impulses. While these children may excel in activities requiring movement, their hyperactivity and impulsivity can create conflicts in structured academic or social environments.

The combined type includes significant symptoms of both inattention and hyperactivity-impulsivity. Children and adolescents with this form experience difficulties sustaining attention, completing tasks, and organizing their work, while also displaying high levels of restlessness, impulsivity, and emotional dysregulation. This type often has the greatest impact on academic, social, and emotional functioning, and is frequently associated with comorbid conditions such as learning disabilities, anxiety, depression, and behavioral disorders (Fiorentzi& Antoniou, 2023; Galitskaya et al., 2025).

Across development, ADHD symptoms may evolve. Hyperactivity tends to decrease with age, while inattention and executive function deficits often persist into adolescence and adulthood (Barkley, 2006). Inattentive symptoms are more closely linked to academic difficulties and internalizing problems, whereas hyperactive-impulsive symptoms are associated with behavioral conflicts and risk-taking. The combined type, encompassing both sets of symptoms, often presents the most significant challenges and higher risk for co-occurring psychiatric disorders (Biederman et al., 1996; Bussing & Mehta, 2013).

Etiopathogenesis of ADHD

ADHD is distinguished by its heterogeneous nature, as the clinical presentation of individuals is complex and variable. Specifically, according to Castellanos & Tannock (2002), Durston et al. (2009), and Nigg & Casey (2005), genetic, environmental, and neuropsychological factors are linked to the disorder's pathogenesis (Papaeliou, Maniadaki, &Kakouros, 2015):

ADHD is usually hereditary, although the precise genetic correlations have not yet been identified. Research from Greece and abroad indicates that approximately 7–12% of children referred to child psychiatry guidance and mental health centers show symptoms related to ADHD. According to a recent meta-analysis of 102 studies with a total sample of 171,756 children worldwide, the global prevalence of ADHD was 5.2% (Theodoritsi et al., 2018). It has been found that children with parents who have ADHD have over a 50% chance of inheriting it. If one child in a family is diagnosed with ADHD, the remaining siblings, current or future, have over a 30% chance.

The genetic basis of the disorder is the main cause of its occurrence. In addition, developmental, environmental, and psychological factors may further contribute and exacerbate the condition (Drigas &Driga, 2019). Twin studies by Sherman et al. (1997) suggest that 75% of ADHD cases are attributable to genetic factors (Wilmshurst, 2011). According to Kalantzi-Azizi & Zafeiropoulou (2010), ADHD is caused by general dysfunctions in neurotransmitter systems (noradrenaline, serotonin) and the functioning of the frontal lobe. Environmental factors, such as maternal smoking, alcohol consumption, and psychopathology (depression) during pregnancy, significantly contribute to ADHD manifestation. First, maternal nutrition is crucial for the fetus. Specifically, smoking and alcohol consumption during pregnancy pose risks for fetal brain development. Premature birth has also been associated with neurological and cognitive risks, while low birth weight correlates with ADHD. Socioeconomic factors and excessive video game use also contribute to the likelihood of symptom development. Ostberg &Hagekull (2000) assert that certain child characteristics increase the stress experienced in raising children with ADHD, such as antisocial behavior and aggression, which worsen parental stress.

Kalantzi-Azizi & Zafeiropoulou (2010) also identify environmental risk factors including low family socioeconomic status, inconsistency in boundaries, excessive strictness, overprotection, parental aggression, and parental conflicts. Furthermore,Willcutt et al. (2005) report that individuals with ADHD show dysfunction in cognitive and neuropsychological mechanisms (executive functions) such as inhibitory control, working memory, emotional self-regulation, and time perception.

Studies with infants at high risk for ADHD due to family history found early detectable signs even in the neonatal period. A study of 158 male neonates, whose fathers met ADHD diagnostic criteria, assessed infants with the Neonatal Behavioral Assessment Scale (Auerbach et al., 2005), finding reduced neurodevelopmental maturity compared to controls. Another study of 78 infants aged 8–12 months, whose mothers met ADHD criteria, observed shorter attention span and increased motor activity compared to controls (Ninowski, 2010).

ADHD symptoms can be identified in children aged 2–6 years. Preschoolers with ADHD show difficulties in social skills, adaptive behavior, and pre-academic skill acquisition (DuPaul et al., 2001; Lahey et al., 1998). They also display similar executive function difficulties as older children, including working memory, organizational skills, and inhibitory control (Sonuga-Barke et al., 2005).

School age is the most studied developmental period for ADHD. Children with ADHD often display noisy, sometimes disruptive and provocative behavior at school and home. Frequent temper outbursts, noncompliance with rules, and inadequate response to adult instructions are core behaviors in school-aged children with ADHD (Papaeliou, Maniadaki, &Kakouros, 2015). Concentration duration in children with ADHD is shorter than peers (Kofler et al., 2007).

Schoolwork is often disorganized, messy, incomplete, and marked by "careless errors" (Lougy& Rosenthal, 2002). Poor organizational skills also manifest in personal spaces. In the family context, avoidance of study, easy frustration, and the need for constant support lead to conflicts, school avoidance, and accumulation of learning gaps (Cunningham, 2007). Children with ADHD often perform below their intellectual potential in all academic areas (80%), with one-third having Specific Learning Disorders (Loe & Feldman, 2007; DuPaul & Volpe, 2009). Social interaction with peers is also challenging, with rejection rates of 52–82% (Hoza et al., 2005).

Adolescents with ADHD experience rapid biopsychosocial changes and increased demands in both school and social domains. The transition to adolescence is characterized by independence from parents, more time outside the home, reduced parental influence, and increased peer influence (Wehmeier et al., 2010). These factors interact negatively with reduced self-control and low self-esteem, making adolescents with ADHD more vulnerable to risk behaviors (Edbom et al., 2006).

In general, attention deficit is a persistent feature, while impulsivity causes the greatest difficulties. Hyperactivity symptoms typically decrease, replaced by restlessness and anxiety (Wehmeier et al., 2010). Persistent hyperactivity increases the likelihood of Conduct Disorder. Low self-esteem and high peer acceptance needs make adolescents with ADHD more susceptible to deviant behavior, school dropout, substance abuse, and law violations.

Girls with ADHD typically do not exhibit hyperactivity but show higher inattention, low self-esteem, poor academic performance, anxiety, depressive disorders, and higher risk of early pregnancy or smoking (Antoniou et al., 2021). Boys more often display hyperactivity, impulsivity, and delinquent behavior, with more pronounced ADHD manifestation. Delays in brain development areas often lead to anxiety, aggression, or dysfunctional behaviors. Inattention symptoms are more common in girls and are linked to fewer disruptive behaviors than hyperactive-impulsive boys, causing girls with ADHD to remain often undiagnosed. Adolescence adds challenges, including low self-esteem, social pressures, parental/teacher expectations, and sexual concerns.

In adulthood, 30–60% of individuals still meet ADHD criteria (Faraone et al., 2000; Weiss & Murray, 2003). ADHD in adults often co-occurs (90%) with anxiety, mood disorders, substance use disorder, and antisocial personality disorder (Nutt et al., 2007). Adults with ADHD exhibit unstable professional and interpersonal behavior and are more prone to traffic violations and accidents (Papaeliou, Maniadaki, &Kakouros, 2015).

Comorbidity and ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is a multifactorial condition influenced by genetic, environmental, and neuropsychological factors, with symptom severity and intensity varying across individuals. Beyond its core manifestations, children with ADHD frequently experience secondary symptoms such as anxiety, stress, low self-esteem, academic underachievement, and diverse behavioral challenges. Anxiety disorders and ADHD are among the most prevalent childhood disorders, co-occurring in approximately 25% of cases. Furthermore, sleep disturbances, both in quality and duration, are reported in 56% of children with ADHD, compared to 23% of typically developing peers. Overall, ADHD is associated with decreased quality of life, childhood obesity, and elevated parental stress (Theodoritsi et al., 2018; Zografou, Drigas, & Antoniou, 2025).

Characterized by cognitive dysfunctions and developmentally inappropriate or excessive behaviors (Barkley, 2006), ADHD frequently coexists with Learning Disabilities (LD), with comorbidity estimates ranging from 20% to 60% (Maynard & McCaffrey, 1999; Willcutt et al., 2007). Although ADHD and LD are generally recognized as distinct disorders, research suggests that a shared deficit in executive functions (EF) may account for the substantial overlap (Seidman et al., 2001; Willcutt et al., 2005; Fiorentzi& Antoniou, 2023; Galitskaya et al., 2025). According to Bussing and Mehta (2013), ADHD is a neurodevelopmental disorder, while Dunne and Moore (2011) conceptualize it as both a behavioral and emotional disorder. Kendall (2016) emphasizes that comorbidity with additional disorders is the rule rather than the exception.

Executive functions encompass the cognitive processes that regulate goal-directed behavior, including goal setting, behavioral organization, response inhibition, cognitive flexibility, working memory, attention, emotional regulation, and progress monitoring (Denckla, 2007; Fernandez Duque et al., 2000; Fiorentzi& Antoniou, 2023). Students with ADHD and LD commonly exhibit deficits in one or more of these domains (Lazar & Frank, 1998). Difficulties in social functioning and peer relationships have also been documented (Bagwell et al., 2001; Wiener et al., 1993; Wiener & Schneider, 2002). Adolescents with ADHD and LD are at increased risk for psychiatric comorbidities such as anxiety, depression, and substance use (Beitchman et al., 2001; Elia et al., 2008; Jarrett & Ollendick, 2008; Treuting & Hinshaw, 2001).

ADHD is also associated with behavioral disorders, including Oppositional Defiant Disorder and Conduct Disorder, anxiety disorders, and learning difficulties (Wenar&Kerig, 2000). Research further identifies comorbidity with mood disorders, including depression and bipolar disorder (Kalantzi-Azizi & Zafeiropoulou, 2010). Emotional dysregulation is prevalent in ADHD, with major depressive disorder affecting 12–50% of children and adolescents (Angold et al., 1999). Depressive disorders often emerge several years after ADHD onset, influenced by long-term psychosocial stressors such as family dynamics, peer relationships, and academic failure (Kovacs et al., 1994; Biederman et al., 1995; Daviss, 2008).

Adolescence, marked by profound biological and psychological changes, sees the persistence of ADHD symptoms in approximately 85% of affected students (Biederman et al., 1996). While overt hyperactivity may diminish, adolescents frequently display immaturity, distractibility, impulsivity, and internal restlessness. Depression incidence rises during adolescence, increasing from 2% in childhood to 4–7% (Costello et al., 2002; Wilmshurst, 2011). Typical depressive manifestations include psychomotor retardation, hypersomnia, and, in severe cases, hallucinations, with most adolescents exhibiting melancholic features (Wilmshurst, 2011). Approximately 3% of adolescents experience major depression, a severe and enduring psychological disorder (Cicchetti & Toth, 1998; Grunbaum et al., 2001; Galambos et al., 2004; Feldman, 2011).

Adolescents with depression often exhibit irritability and nervousness, contributing to interpersonal tension. Psychological distress is frequently expressed somatically, including headaches and abdominal pain, while low self-esteem fosters harsh self-criticism and declining academic performance, exacerbating depressive

symptomatology. School phobia represents a critical marker of depressive risk, while conduct disorders may manifest as aggression, violence, or substance misuse. Gender differences are evident, with adolescent girls exhibiting higher depression rates and a tendency toward internalizing stress, whereas boys often display externalizing behaviors such as aggression or substance use (Hankin & Abramson, 2001; Winstead & Sanchez, 2005; Feldman, 2011).

ADHD significantly impacts developmental trajectories, increasing vulnerability to maladaptive behaviors during adolescence and adulthood (Cantwell et al., 1996). Low self-esteem is a critical mediator of depression and substance use among adolescents with ADHD (Emery & Laumann-Billings, 1993). Self-image formation begins by age eight and profoundly influences interpersonal relationships, academic performance, and behavioral regulation (Harter, 1982; Zimmerman & Mattia, 1997; Bussing et al., 2000).

Therapeutic interventions, including special education services and pharmacological treatment, can enhance self-esteem, reduce maladaptive behaviors, and improve emotional regulation. Stimulant medications have been associated with increased self-acceptance and self-control (Swanson et al., 1993; Frankel & Myatt, 1996; Bussing et al., 2000). Mindfulness-based interventions and mobile applications have also shown promise in managing stress and anxiety in children with ADHD (Zografou, Drigas, & Antoniou, 2025). Deficits in inhibitory control further influence self-regulation and emotional processing (Barkley, 2006; Wehmeier et al., 2010).

Children with ADHD may overestimate their abilities, a phenomenon termed ***illusory bias*** (Hoza et al., 2002), often attributing success to luck rather than effort (Owens & Hoza, 2003; Wiener et al., 2012). Medication is frequently credited with behavioral improvements by both children and adolescents (Johnston & Leung, 2001; Ohan & Johnston, 1999). ADHD-related behaviors can disrupt family balance, affect educators, and provoke peer irritation, contributing to social stigma (Greene et al., 1995; Wiener et al., 1988). Stigma, defined as undesirable deviations in physical, characterological, or behavioral traits, negatively impacts self-esteem and social interactions (Rusch et al., 2005; Hinshaw, 2005).

Parents frequently report stigma-related concerns, including fears of labeling, rejection, or social isolation (DosReis et al., 2003). Teachers' attitudes and competence significantly influence student outcomes, with positive engagement improving educational success and negative responses reinforcing maladaptive behaviors and low self-esteem (Atkinson et al., 1997; Rizzo &Vispoel, 1991; Bell et al., 2010; Kendall, 2010; Sherman et al., 2008). Neurobiological mechanisms, such as dopaminergic dysfunction, and environmental stressors, including trauma and adverse family relationships, further contribute to comorbid depression in ADHD (Schmidt & Peterman, 2009; Birmaher et al., 1996; Zalsman& Brent, 2006; Beck & Young, 1985; Randolph & Dykman, 1998; Ostrander & Herman, 2006; Spencer, 2000; Daviss, 2008).

Emotions and Self-Esteem of Students with ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is among the most prevalent neurodevelopmental disorders in childhood and adolescence. Its symptomatology constitutes a persistent risk factor that continues to affect functional outcomes into adolescence (Barkley, 1998; Wilmshurst, 2011).

Adolescents with ADHD experience significant physical and psychological changes and face challenges in academic, social, and emotional domains (Edbom et al., 2006; Kruenger& Kendall, 2001). Combined with reduced self-control and low self-esteem, these challenges increase vulnerability to comorbid conditions, particularly mood disorders such as depression (Papaeliou, Maniadaki, &Kakouros, 2015; Zografou, Drigas, & Antoniou, 2025).

Social isolation and stigmatization are common experiences for adolescents with ADHD. Difficulties managing cognitive and social challenges, together with high expectations from significant others, negatively impact self-esteem, heighten stress, and perpetuate maladaptive behaviors both within and beyond the educational environment. Evidence-based behavioral interventions, including positive reinforcement, ignoring inappropriate behavior, and the establishment of clear rules and instructions, are effective in reducing disruptive behaviors (Taylor et al., 1984; Kalantzi-Azizi & Zafeiropoulou, 2011). Structured programs, such as peer-assisted learning, can further support skill acquisition and social integration.Teachers' knowledge, attitudes, and competence are crucial determinants of student outcomes. Educators with higher professional training and positive perceptions of ADHD demonstrate more effective classroom management and foster improved self-esteem and behavioral outcomes in students. Conversely, negative or unrealistic expectations may trigger self-fulfilling prophecies, undermining students' academic and social development (Bell et al., 2010; Sherman et al., 2008).

According to Kendall (2016), although ADHD is a childhood disorder, it can persist into adolescence and adulthood, with symptoms continuing throughout an individual's life. The symptoms of ADHD can significantly affect a person in many areas of life and are associated with academic failure. The consequences of academic failure for an individual with ADHD, and the subsequent professional failure in adulthood, are widely discussed in the literature. Individuals with ADHD may face difficulties in keeping up with and being consistent in their school obligations and assignments. Polanczyk et al. (2007) report that at least one child with ADHD is present in every classroom, representing 5.3% of children and adolescents. According to Kos et al. (2006), behaviors associated with ADHD are notable in classrooms because school settings require children with ADHD to behave in ways that conflict with the symptoms of the disorder. The majority of children with ADHD face learning difficulties, with estimates suggesting that the percentage of children with learning difficulties exceeds 50%-60%. Learning and socio-emotional difficulties can lead children with ADHD to repeat a grade or even drop out of school at rates of 25%-30%. In a study with a Greek population, it was found that 56% of the sample had repeated at least one grade (Kalantzi-Azizi & Zafeiropoulou, 2011).

Due to symptoms of inattention, hyperactivity, and impulsivity, students with ADHD may exhibit behavioral disturbances in the classroom, which can pose challenges for a teacher (Kapalka, 2005; Mautone et al., 2011; Ohan et al., 2011). Ohan et al. (2008) report that children with ADHD occupy teachers' time, often distract other children, and cause disturbances in the classroom. Children with ADHD often consider themselves socially competent; however, in reality, they adopt inappropriate and ineffective communication strategies and struggle to accurately assess their behavioral and social adequacy. Furthermore, overestimation of their social skills has been associated with the emergence of externalizing behavioral problems and, more generally, with lower levels of psychosocial functioning. Children with developmental

disorders face greater difficulties in interpersonal relationships and experience higher rates of social exclusion, as well as more incidents of verbal and physical aggression compared to their peers without disorders. Given that the psychosocial profile of students with ADHD often includes and is accompanied by the above characteristics and deficits, these students are considered a high-risk group for involvement in bullying. Research shows that students with ADHD are more frequently involved in bullying compared to their typically developing peers and are more likely to assume the role of perpetrator, victim, or even dual involvement. Social changes can cause anxiety during the transition to secondary school. Peer relationships change during this period, causing fears regarding the loss of old friends, the formation of new friendships, and the possibility of bullying. Based on previous research, neurodiverse students are more likely to experience bullying during their school life compared to neurotypical peers, which can have significant effects on mental health (Polydoros et al., 2025).

Individuals with ADHD may face difficulties in completing schoolwork, being able to focus on specific tasks, and are easily distracted. They may have problems with memory and task planning, possess poor organizational skills, and struggle with following subsequent teacher instructions. Educators often hold negative perceptions of students with ADHD regarding academic achievement, which can affect the educational outcomes of the individual. The behavior of children with ADHD challenges parents, who often experience frustration and disappointment. As a result, they struggle to manage their children effectively and are forced to remain in a constant state of vigilance, either to prevent potential injuries or to help them complete their school assignments (Kalantzi-Azizi & Zafeiropoulou, 2011). Poznanski and Mokros (2018) find that ADHD has been associated with negative relationships with family members, peers, and teachers, higher levels of substance use, and school dropout.

Conclusion

Attention-Deficit/Hyperactivity Disorder (ADHD) is a complex neurodevelopmental disorder with early onset and persistent symptoms that affect multiple domains of functioning across the lifespan. The disorder manifests in three primary types—inattentive, hyperactive-impulsive, and combined—each presenting distinct challenges in attention, behavior, and emotional regulation. ADHD's etiology is multifactorial, involving genetic, neurobiological, environmental, and psychosocial factors, which interact to influence symptom severity and developmental outcomes. Comorbidities, including learning disabilities, anxiety, depression, and behavioral disorders, are common and further exacerbate academic, social, and emotional difficulties. Children and adolescents with ADHD often experience low self-esteem, social stigma, and maladaptive coping, highlighting the importance of early identification and comprehensive intervention. Evidence-based approaches, including pharmacological treatment, behavioral strategies, special education services, and mindfulness-based interventions, have demonstrated efficacy in improving executive function, emotional regulation, self-esteem, and overall quality of life. Effective management requires collaboration among families, educators, and mental health professionals, emphasizing individualized support tailored to each child's needs. A holistic understanding of ADHD and its impact across developmental stages is essential for optimizing outcomes and promoting adaptive functioning in affected individuals.

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