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The Impact of ADHD on Adolescents' Mental Health and Social Interactions in Classroom Settings

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Abstract: *Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorders in adolescents of school age, and relates closely to difficulties in school, particularly with regard to academic, social and emotional functioning. This narrative review integrates the literature from 2005 to 2025 related to the links between symptoms of ADHD, classroom behaviours, peer and teacher relationships, and adolescent mental health. There is evidence that adolescents with ADHD tend to be less involved in classroom activities, are more likely to experience higher levels of peer rejection and teacher conflict as compared to typically developing adolescents, and that such negative classroom experiences are correlated with higher levels of emotional distress in adolescents with ADHD. Results also indicate that classroom climate (fair and consistent disciplinary practices, teacher–student respect, and a culture of seeking help) is correlated with academic, social and emotional outcomes, even for adolescent youth with high symptom severity, which suggests a potential buffering effect. Extending these trends, this review suggests a classroom-interaction approach in which symptoms of ADHD are constructed, manifested and given consequence in the context of ordinary relational processes and not in individual pathology alone. Beyond its focus on individual-level clinical intervention, the review suggests that supporting adolescents with ADHD needs to focus on classroom-level relational and institutional practices that influence the psychosocial course of ADHD students.*

Keywords: *ADHD, adolescent mental health, classroom environment, peer relationships, teacher-student interaction, school-based intervention*

1. Introduction

Attention deficit hyperactivity disorder is a neurodevelopmental disorder characterized by complex criteria of persistent inattention, hyperactivity, and impulsiveness across contexts for several years, including school [1]. Clinical relevance of the ADHD symptoms is maintained during adolescence when both the demands and expectations of school, peer relations, and adequate self-regulation intensify; thus, worldwide, ADHD emerges as a significant neurodevelopmental disorder in achieving developmental goals of school-age adolescents. Given that adolescents spend most of their waking time in school, behaviors symptomatic of ADHD are typically noted, observed, rated, and reacted to by one's teacher and peers. Furthermore, along with being a place for academic learning, school represents a highly developed social and emotional learning environment, wherein modifications in cognitive and behavioral functioning characteristic of ADHD are rarely compatible with such an environment [2].

Past studies have linked ADHD symptoms to poor academic performance, behavioral problems, and psychosocial impairment; again, only the most significant interactions among these factors occur in the more proximal context of classroom life. This knowledge prevents the behaviors displayed in class, the attitude of the peers, and the mood of the students from becoming separate independent variables rather than an inseparable part of class-behaving phenomena. Such ADHD-related behaviors, for example, interrupting, not sitting still, or not following instructions, are often perceived as a symptomatic behavioral index of defiance, laziness, or unwillingness in social situations. Therefore, it results in stigmatization and social sanctioning, whereby the difficulties linked with neurodevelopment become further embedded in social and systemic problems.

In such a case, ADHD may be considered a developmental cascade over the years through which it became apparent in behavior, teacher and peer interpretation of behavior, and further development of social interactive processes; classroom climate variables related to disciplinary structure and respect for help-seeking norms map onto and moderate such a proposed pathway toward the psychopathological

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consequences of ADHD behaviors [3].

The literature reviewed herein, therefore, addresses the association of ADHD and mental health and social interaction in the classroom among adolescents. It takes the stance that ADHD is best understood, in the classroom context, as a relational classroom-climate perspective, one that puts the individual clinical construct in relation to the everyday relations between students and teacher and the practices of schooling. This review focuses on three research questions which are stated formally in Section 3.2: What are the manifestations of ADHD symptoms as classroom behaviours and how do teachers and peers interpret them? What is the relationship between peer and teacher relationships and the mental health of adolescents with ADHD? What are the potential classroom-level strategies and school policies to reduce the negative impact of ADHD on mental health and social interactions for adolescents?

2. Literature Review

2.1 ADHD Symptoms and Classroom Behavior

ADHD symptoms of inattention, impulsivity, and reduced self-regulation are commonly associated with difficulties in working memory, inhibition, planning, and cognitive flexibility [4]. It occurs as both high visibility and low visibility in everyday school life because of the degree to which self-regulation is required within group routines [5].

For instance, behaviors related to social meaning: What teachers and peers may interpret as impulsivity in answering questions, hyperactivity due to restlessness, and a withdrawn attitude for the lack of motivation or laziness rather than a neurodevelopmental condition are understood differently. Thus, one might expect such behavior to be repeatedly corrected, renamed negatively, and reduced to the least level of participation [6]. Indeed, such research suggests that students with the most problematic behaviors do not participate as much as others with students in both informal and formal peer group participation in school activities due to poor academic performance and general failure [7].

2.2 Peer Relationships, Teacher–Student Interactions, and Mental Health

Social impairment is one of the most debilitating features of ADHD and is highly correlated with overall adjustment and the development of comorbidity. A recent review confirmed high peer rejection, lower-quality friendships, fewer high-quality reciprocal friendships, and impairments in peer-related social information processing among children and adolescents with ADHD [8]. Indeed, once an individual is rejected by peers, acceptance is such an uphill struggle that even symptom treatment does little to improve such social reputations for children with ADHD [9].

These may operate via the following mechanisms: inattention and self-regulation difficulties reduce his/her ability to maintain a variable amount of interruption during interaction, detect social cues amid continuous interaction, and respond timely and appropriately. To the degree that social information processing pathology becomes manifest in poorly encoding social cues, appropriately perceiving others' emotions, and responding to variable modes of behavior, it has thus far been evidenced in the classroom across variable components of friendship and cooperation [10].

These peer problems are particularly significant in classrooms where so much of the social life of the adolescents takes place in group work, through daily interactions, and informal reputation building. Adolescents with ADHD may appear disruptive, disreputable or socially awkward and could be less accepted in group collaborations, and they may be more vulnerable to exclusion and bullying [11]. Longitudinal studies like the Children's Attention Project suggest that positive peer interactions over time are linked to positive emotional control, while peer conflict and rejection relate to greater irritability and socioemotional problems. Classroom social structures also influence the quality of peer relationships: small group dynamics, cooperative group structures, and informal friendship groups may help or hinder social integration into a classroom for students with ADHD [12]. ADHD-related challenges may be more visible and stigmatized with classroom norms that focus on competition and public performance, and have the potential for positive peer connections to be more present with classroom norms that focus on cooperation and inclusion [13].

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2.3 Classroom Climate as a Risk or Protective Factor

In this line of evidence, the classroom climate of consistent fairness in disciplinary structure, respect in teacher-student relations, and evident possibilities for students to seek help are strongly associated with proportionally better academic, emotional, and social outcomes, even in high symptom level contexts. The classroom becomes a low-conflict area, and the feeling of membership and security among students appears safe [14].

All this is supported by intervention research [15]. In contrast, the meta-review found that school- and class-wide interventions were more promising for attention, classroom behavior, and academic functioning—that is, several or some social outcomes—although less clear or more variable for hyperactivity and impulsivity. Stand-alone social skills training is probably one type of intervention that is easily discarded if, after establishing class norms about the acceptability of such problematic behaviors, peers continue to respond predictably and negatively [16][17]. Larger teacher training and universal classroom support strategies are needed, but these are the least investigated kinds of studies to date and have earned referral about structural changes in how class behaviors problematic for ADHD are interpreted and managed. Table 1 summarises the typical features of each climate dimension and their likely impact on adolescents with ADHD.

Table 1 Classroom Climate Dimensions and Expected Effects on ADHD Outcomes.

Classroom Climate Dimension	Typical Features in Practice	Likely Impact on Adolescents with ADHD	Supporting Evidence
Disciplinary structure	Clear rules, predictable routines, consistent consequences	Lower anxiety, fewer internalising symptoms, reduced conflict	[14], [15]
Respectful teacher–student relations	Non-stigmatising language, private feedback, supportive correction	Higher self-esteem, stronger engagement, greater sense of belonging	[14], [28], [29]
Help-seeking culture	Visible support channels, trusted adults, normalised requests for help	Reduced emotion dysregulation, more adaptive coping, improved school connectedness	[14], [19]

Note. Citations indicate the empirical sources supporting each association.

3. Conceptual Framework and Research Questions

3.1 Conceptual Classroom Interaction Framework

This review adopts a conceptual classroom interaction framework in which ADHD affects adolescent mental health through both direct and indirect pathways shaped by everyday school relationships [18]. At the centre of the framework is a cascading process. ADHD symptoms such as inattention, impulsivity, and hyperactivity are expressed in classroom life through observable behaviours, including off-task conduct, interruptions, disorganisation, and difficulties responding appropriately to instructional and social demands. These behaviours are then interpreted by teachers and peers, often as signs of defiance, unreliability, or low motivation rather than as manifestations of a neurodevelopmental condition. Such interpretations influence classroom interactions, including teacher correction, peer acceptance or rejection, friendship stability, and opportunities for participation. Over time, these relational experiences contribute to mental health outcomes such as anxiety, depression, emotional dysregulation, reduced self-esteem, and burnout-like exhaustion.

The framework further assumes that the classroom is not a neutral backdrop but an active social environment that moderates the impact of ADHD-related behaviour. Classroom climate factors—such as disciplinary structure, teacher responsiveness, peer norms, and perceived support—may either interrupt or amplify negative pathways. A fair and predictable classroom environment may reduce conflict and uncertainty, whereas punitive or disrespectful settings may intensify shame, exclusion, and emotional overload [19]. The framework also recognises bidirectional influences: mental health difficulties may worsen attention, increase reactivity, and reduce social confidence, thereby reinforcing the very behavioural and relational problems that contributed to distress in the first place.

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3.2 Research Questions

This review addresses three research questions:

How do ADHD-related symptoms manifest as specific classroom behaviours in adolescents, and how are these behaviours typically interpreted by teachers and peers?

How do peer relationships and teacher–student interactions in classroom settings influence the mental health outcomes of adolescents with ADHD?

What classroom-level strategies and school policies have been shown, or are theoretically positioned, to reduce the negative impact of ADHD on adolescents' mental health and social interactions?

4. Methodology

This paper uses a systematized literature review design with a narrative synthesis approach on ADHD, classroom experiences, social relationships, and adolescent mental health. A narrative approach was selected because the topic spans developmental psychology, educational research, school mental health, and clinical studies, and because the aim is to integrate conceptual and empirical patterns rather than estimate a single pooled effect size [20]. Reporting of the search and screening procedure below follows recommendations for narrative reviews with a systematic search component, adapted from PRISMA-style reporting.

Relevant studies were identified by searching the databases: PubMed, ERIC, PsycINFO and Google Scholar with combinations of the following search terms: ADHD, adolescents, classroom behaviour, peer relationships, teacher–student relationships, school climate, emotion regulation and mental health. Only published peer-reviewed sources in the English language that were released from 2005 to 2025 were searched to include a few important foundational, classroom-observation studies that were cited in the literature and previous research and that predate the start of the window, but that are still directly relevant to the questions in this review.

Searching resulted in 1,383 articles in PubMed, 120 articles in ERIC, and 342 articles in PsycINFO. Due to not being able to set a fixed bibliographic export, and the results being sorted by relevance, the first 200 results retrieved from Google Scholar were sifted using the same relevance criteria that were used to sift the other databases.

Duplicates were removed from across databases with help from reference-management software (Zotero), leaving 1,857 unique records. Records were then screened in two stages: (1) title and abstract screening based on the inclusion/exclusion criteria below resulted in 156 records for full-text screening and (2) full-text screening based on the inclusion/exclusion criteria below resulted in 61 records meeting all inclusion criteria. From these, 33 sources were retained for the final synthesis based on conceptual relevance, methodological quality and lack of redundancy with other sources included and the rest of the screened records were checked for patterns reported in the included records without being individually cited.

Studies were included if they: (a) had a school-aged or adolescent population in a school setting; (b) were set in a mainstream classroom; (c) had quantitative or qualitative data on classroom behaviour, peer relationships, teacher–student interaction or mental health outcomes; and (d) were published in English in a peer-reviewed journal or as a peer-reviewed book chapter. Studies were rejected if they: (a) only included adults; (b) only considered neurobiological or pharmacological mechanisms with no educational or psychosocial context; (c) were unpublished theses, dissertations or grey literature; or (d) were unpublished conference proceedings.

The final body of literature included systematic reviews and meta-analyses on teacher–student relationships and school-based interventions, longitudinal studies on school climate and peer processes, quantitative studies of classroom functioning and emotional adjustment, and qualitative work examining belonging, masking, and school distress [21]. This combination enabled the review to identify both major empirical patterns and the mechanisms through which ADHD symptoms become linked to social and mental health outcomes in classrooms.

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5. Thematic Synthesis of Findings

5.1 Behaviour Patterns and Interpretive Processes

The literature indicates that classroom difficulties associated with ADHD are best understood not simply as deficits in attention or behaviour, but as patterns of action that acquire social meaning within institutional settings. Behaviours such as interrupting, appearing distracted, losing materials, struggling with transitions, or failing to complete tasks are highly visible because classroom life depends on routines, self-regulation, and collective attention. Consequently, ADHD-related behaviour is often interpreted through moral or disciplinary categories. What may originate as a difficulty in inhibition, working memory, or cognitive flexibility may be read instead as laziness, irresponsibility, or disrespect [22].

This interpretive process links neurocognitive differences to relational consequences. Teachers may respond to repeated off-task behaviour with escalating correction, while peers may view the same behaviour as evidence that a classmate is difficult to work with or socially awkward [23]. In this sense, ADHD-related behaviours function as social signals, even when they do not accurately reflect intention. Reduced participation in collaborative work or classroom discussion may then be misread as disinterest or incompetence, further restricting access to positive feedback and inclusion [24].

Over time, these processes can stabilise a negative classroom identity. Once a student is repeatedly positioned as disruptive or unreliable, later behaviour may be interpreted through that label, making it harder for adults and peers to recognise effort or improvement [25]. The reviewed evidence therefore suggests that the impact of ADHD in classrooms depends not only on behaviour itself but on the interpretive context in which behaviour is seen and judged.

5.2 Relational Pathways to Mental Health

Another important impact that classroom experience has on adolescent mental health is through peer relationships. For instance, children with ADHD are highly susceptible to peer rejection and associated instability of friendships, lower friendship quality, and peer victimization, which all contribute to the sense of non-belonging typical of this developmental window, already salient for approval [26]. Negative first impressions quickly become snowballing in the group-oriented classroom or informality of status in day-to-day contact. Rejection may be able to seclude support and socialization opportunities while it becomes internalized and reflected in loneliness, self-devaluation, and hypersensitivity to further rejection [27].

Another critical conduit is the teacher-student relationship: Less closeness and more conflict represent another school-turned-reeducation-violation-failing environment. After all, teachers control the class, correction, grading, and permission to get help and thus channel intense emotional experiences with teachers [28]. For instance, correction in front of the class, prolonged angry outbursts, or punitive exclusion evokes feelings of humiliation and alienation; respect toward expectations for students builds feelings of safety and confidence [29].

In this sense, emotion dysregulation can unfold the social imprint into concrete psychological conditions. For instance, it can be postulated that problematic irritability and frustration may have placed them across hyperactive agitation as a reaction to provoked events in class by peers' active teasing or teachers' negative attitudes toward them [30]. Thus, what is going on in school seems clear, giving rise to such emotional accumulation into frequently experienced events rather than previously isolated ones; this fact should be regarded as the emotionally charged variable in such an event.

Qualitative interpretations have derived implications for how alienation and hypervigilance against oneself operate: Other ADHD youths report avoiding objectionable features as part of self-shielding mechanisms from their classmates and peers' ridicule. The overt stress implicitly involved in this is hardly managed, hence contributing to exhaustion, a loss of self, and an illness-like experience [31]. Thus, peer rejection, conflict with teachers, and emotional dysregulation fuel a cascade-down effect of daily school demands, manifesting themselves as a series of symptoms of anxiety and depression, eventually disturbing the general well-being of adolescents with ADHD.

5.3 Classroom Climate and Intervention Logic

The review thus considers that the classroom climate may be one of the few empirically testable

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and intervention factors that can sustain or break developmental failures. Indeed, in well-managed classrooms, rules and routines take care of irritability, disruptions, and angry outbursts of out-of-control behavior, besides minimizing humiliation and other feelings of class chaos. In this case, structure reduces the ambiguity around errors; misbehavior is seldom considered a threat or a personal grievance. Respectful approaches to error reduce the shame in having made one; a visible culture of support is available to instill school advice when it is needed before things get out of control.

Intervention findings are broadly consistent with this ecological logic. School-based trials and meta-analyses suggest that classroom interventions can improve combined ADHD symptoms, inattention, academic functioning, and some aspects of behaviour and social adjustment, but effects are uneven across domains [32]. In particular, interventions often show smaller or less consistent effects for hyperactivity and impulsivity, and individualised social skills training alone may be insufficient when peer norms and classroom responses remain unchanged [33]. These patterns suggest that effective support requires not only helping the individual student but also altering the classroom ecology in which behaviour is interpreted, regulated, and socially rewarded.

6. Discussion

6.1 ADHD as a Relational Condition in Classrooms

The evidence in this review suggests that, in the classroom, ADHD is a relational condition and not just a clinical diagnosis of the individual. The neurocognitive impact of symptoms of inattention and impulsivity and the teacher and peer interpretation and response to these behaviors are factors that contribute to problems with school adjustment. This isn't an attack on the neurodevelopmental root of ADHD; it's the assumption that the consequence of the behaviors symptomatically indicative of ADHD are influenced by classroom practices, expectations, and the responses of adults and peers around the student. One behaviour, such as calling out without a hand may be punished, corrected or accepted as a peer behaviour, depending on classroom norms and relationships. When considered in this manner, difficulty with ADHD is not simply 'in' the student, but instead is an experience that unfolds in a relational pathway that depends on school and classroom contexts.

6.2 From Individual Interventions to Ecosystemic Change

The results of this review indicate that a more holistic perspective of support for adolescents with ADHD may be necessary in addition to individual symptom management, to support classroom and school-level change. Most of the traditional approaches to the treatment of ADHD (medications, individual behavioural management, and stand-alone social-skills training) are delivered at the individual student level. But, as seen in the literature reviewed, interventions at the individual level are sometimes not enough to solve the emotional and social problems that adolescents with ADHD have in the classroom. Therefore, intervention might be warranted using a multilevel and ecosystemic approach; practical strategies found within the literature reviewed are:

 Teacher-level strategies: trainer sessions beyond just awareness of ADHD that focus on classroom management strategies, including predictable routines, private instead of public correction, structured transitions, and flexible participation options.

Peer-level strategies: cooperative learning structures and classroom norms that focus on inclusion and minimise informal stigmatisation and promote peer acceptance.

 Institutional level strategies: school policies that incorporate consistency within the discipline, and make available support paths that are not stigmaizing, and minimise the need for exclusionary discipline for ADHD behaviour.

In line with this context, the data indicates that while more individual-level structure may not help adolescents with ADHD, a consistent, fair, responsive and respectful classroom and school context in response to ADHD related behaviours may prove helpful.

6.3 Limitations and Future Directions

The evidence reviewed here may be less generalizable, given the overwhelming predominance of studies from Western school systems, which ultimately produce less comparable educational provisions concerning authority, competition, and inclusion. Girls with ADHD often represent the problem of how class experiences may be differentially displayed or perceived in a male or sex-diverse sample. Indeed,

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at the state of the art, while generally longitudinal research has increased remarkably, most studies still remain cross-sectional; thus, establishing relatively firm causality in the bidirectional interplays between symptoms and reactions brought about or against the classroom through symptoms with consequent implications for mental health remains only broached tentatively.

Therefore, longitudinal trajectory research and qualitative interpretation of these experiences by adolescents themselves are discussed. Cross-cultural research is much needed regarding the functioning of these classroom mechanisms in different educational settings. Further research is required on peer-mediated social-norm-changing and class-wide interventions rather than individual student training. Conceptual clarity in masking, emotional burden, and burnout is required.

7. Conclusion

From an ADHD cascading relational framework, the literature derives how classroom experiences elicit symptoms of ADHD and store them in memory if relationships are positive or later reactivated if relationships are negative. The effects of ADHD on adolescence in school cannot be explained without considering the relative ease or difficulty of accessing these symptoms and resources in school afternoons with peers and teachers. Indeed, adverse outcomes may be indicated through relationships with peers, teachers, the burden of schoolwork, and emotion dysregulation.

Support for adolescents with ADHD will not be remedial or compensatory; it must be at the levels of class and relationship, school climate, and institutional configuration. For this to happen, schools must move beyond behavioral management to how structural equity is formed and manifests interaction and support within structural equity, lessening the burden of being a school. Thus, it must be considered class-related ADHD; hence, the concept is intervention for irreparable change in the environments linked to learning and development, not in the adolescent students themselves.

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