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Preterm birth risk in pregnant women diagnosed with ADHD: A literature review

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ABSTRACT

Background: The medical community now acknowledges ADHD as a condition that affects women during their reproductive years. The presence of ADHD during pregnancy increases the chances of adverse perinatal outcomes, especially preterm birth (PTB), but this correlation needs further investigation in clinical practice. **Methods:** The review gathers findings from seven major studies which include population-based cohorts and meta-analyses performed in Sweden, the United States and Australia. The studies underwent analysis to determine ADHD diagnostic criteria, population characteristics, risk statistics (e.g. adjusted odds ratios) and both spontaneous and medically indicated PTB differentiation. **Results:** The prevalence of ADHD among pregnant women has experienced a substantial increase according to U.S. data, which shows a 39.4% rise during five years. Most ADHD patients were younger women who also had co-occurring conditions. The available research demonstrates that ADHD leads to a moderate increase in preterm birth risk. The risk of PTB persisted even after controlling for stimulant medication use, which suggests that ADHD-related behavioral, biological and psychosocial factors play a more significant role. The available data indicate that PTB occurs more frequently in both spontaneous and medically induced cases. **Conclusion:** Maternal ADHD is an important and under-recognized risk factor for preterm birth. In the prenatal care should be included both early psychiatric assistance and proper interventions to reduce associated risks. Future research needs to establish the causal pathways of ADHD while differentiating between its subtypes and assessing treatment effects during pregnancy to develop safer and more effective perinatal care.

Keywords: ADHD, pregnancy, preterm birth, maternal health, obstetric outcomes

1. INTRODUCTION

The diagnostic classification systems ICD-10 and DSM-5 (American Psychiatric Association, 2013) define attention-deficit/hyperactivity disorder (ADHD) as a neurodevelopmental disorder that presents inattention and hyperactivity-impulsivity domains. The disorder consists of symptoms that include attention

deficit, impulsivity as well as disorganization and hyperactivity, which shows individual and temporal variations (Barkley et al., 2015; Franke et al., 2018).

The disorder that primarily affects children at rates between 3% to 7% (Thomas et al., 2015) happen to persist across adulthood, affecting an estimated 4.4% of general adults' population. Research indicates that ADHD impacts females less often than males (3.2% vs. 5.4%) (Kessler et al., 2006; Biederman et al., 2010) although symptoms persist in 75% of women throughout their adult years (Owens et al., 2017). The medical field has significant concerns regarding how ADHD diagnosis affects pregnant women, because both recognition of the disorder and pharmacological treatment usage among female population continue to grow.

Women with ADHD experience unique healthcare obstacles when they become pregnant. People with ADHD commonly experience co-occurring psychiatric conditions alongside behavioral factors like substance use and non-adherent medical care (Song et al., 2025; Poulton et al., 2022). These factors potentially increase prenatal management difficulties while creating additional risks of adverse obstetric outcomes. Preterm birth, defined as any delivery before 37 completed weeks of gestation, remains the main reason for neonatal death and serious diseases worldwide (World Health Organization, 2019). ADHD influences multiple factors, such as medical, behavioral, and psychosocial, which may contribute to preterm delivery (Khandre et al., 2022).

The association between maternal ADHD and preterm birth outcomes was examined in population-based studies. The Swedish cohort study showed that women with ADHD had a considerably higher chance of PTB than the ones without ADHD (7.3% versus 5.8%) even after adjusting for BMI, psychiatric comorbidities and substance use disorder (Hesselman et al., 2020). The study revealed an elevated risk for both spontaneous and medically indicated very preterm births (<32 weeks) among women with ADHD.

The Healthcare Cost and Utilization Project analyzed nine million births in the U.S. and discovered that women who took ADHD medications had an increased possibility for obstetric complications such as hypertensive disorders of pregnancy and chorioamnionitis, which further may contribute to premature birth (Amikam et al., 2024). Study results showed that the risk of preterm delivery among women with ADHD and the hyperactive subtype was significantly higher as compared with those who had mainly inattentive type ADD (Amikam et al., 2025).

Safety of ADHD medication in pregnancy is an ongoing dilemma. Multiple studies have covered the concern and found no statistical risk for congenital malformation or miscarriage while taking methylphenidate and atomoxetine (Di Giacomo et al., 2024). The research indicates that preterm birth risks among ADHD patients stem from the disorder itself and its behavioral and psychosocial factors instead of medication use.

As the number of pregnant women with ADHD rises, it is imperative for an early investigation of the relationship to ensure that preterm birth has no profound negative impact. The aim of this review was to assess the scant evidence on preterm birth risks for ADHD individuals and to examine potential mechanisms, and the implications on clinical care.

2. REVIEW METHODS

Search Strategy and Study Selection

The review of the literature investigated the link between maternal ADHD and preterm birth risks. The research used PubMed and Google Scholar databases to find relevant information through keywords including 'ADHD', 'preterm birth', 'Attention deficit hyperactivity disorder', 'pregnancy outcomes', 'maternal ADHD', 'premature birth', 'pregnancy complications', 'obstetric outcomes', 'preterm birth risk' and 'ADHD medication'. The authors performed a manual review of peer-reviewed articles to select the studies for this research. The final evaluation incorporated seven original studies from 2018 to 2025 that examined different geographical locations (Sweden, the United States, Australia) and used different research approaches (cohort studies, cross-sectional analyses and meta-analyses) (figure 1).

Inclusion Criteria

We included the studies if they:

- Investigated pregnant women diagnosed with ADHD using clinical criteria, administrative diagnostic codes (ICD-9 or ICD-10), or medication prescription records;
- Reported outcomes related to preterm birth or closely associated maternal complications (e.g., hypertensive disorders, infections, small-for-gestational-age infants);
- Were population-based or included large representative cohorts;
- Were published in peer-reviewed journals in English.

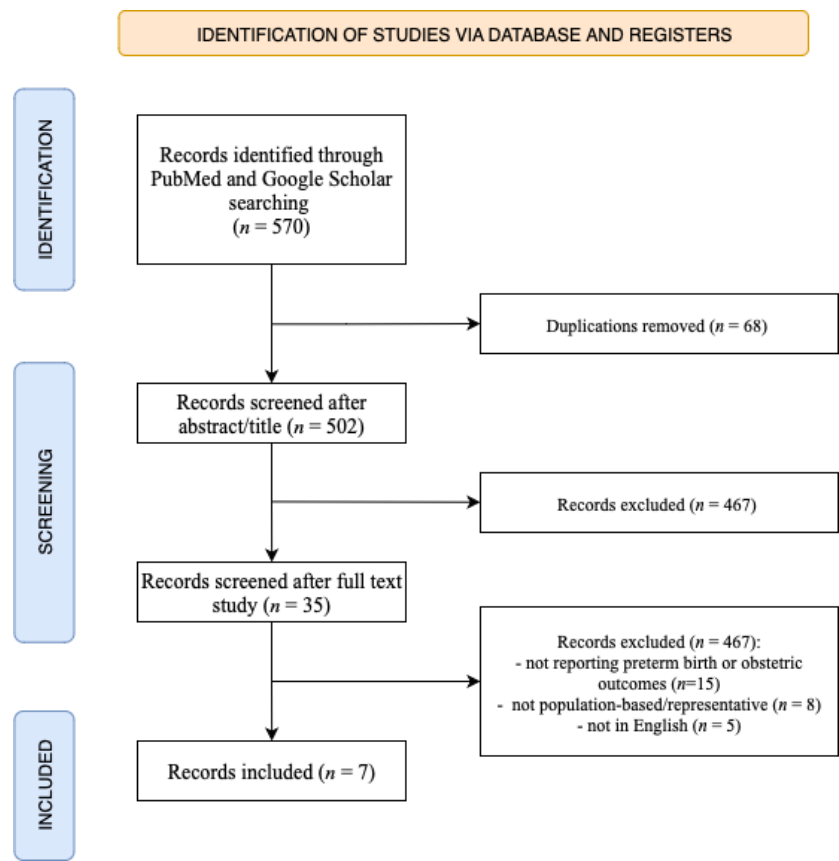


Fig 1. PRISMA flowchart

Data Extraction and Synthesis

Data was extracted on the following parameters:

- Study design, population size, and country of origin;
- Method of ADHD diagnosis (e.g., ICD codes, prescription data);
- Sample size of ADHD pregnancies;
- Preterm birth outcome measures (e.g., crude rates, adjusted odds ratios);
- Classification of preterm birth (spontaneous vs. medically indicated, when available);
- Comorbidities and behavioral risk factors associated with ADHD;
- Information regarding ADHD medication use and related outcomes.

Quality Assessment

The quality assessment of each study included its methodological strength, examined through the evaluation of sample size, confounder adjustment, clarity of ADHD diagnosis criteria, and risk estimate reporting. The included studies analyzed large datasets while controlling for essential maternal and demographic variables resulting in moderate to high evidence quality.

3. RESULTS & DISCUSSION

Epidemiology of ADHD in Pregnant Women

Prevalence of ADHD Among Pregnant Women

Research indicates that the occurrence of Attention-Deficit/Hyperactivity Disorder (ADHD) in pregnant women has steadily risen over the last several decades. The growing diagnosis of adult ADHD with increased awareness about existence of ADHD across all stages of life explains this trend. The Healthcare Cost and Utilization Project’s National Inpatient Sample (HCUP-NIS) study by Song et al., (2025) showed a 39.4% increase in ADHD cases among delivering women in the United States from 2016 to 2020, leading to 16.5 to 23.0

per 10,000 hospital deliveries. The Australian research by Poulton et al., (2018) demonstrated increasing stimulant use for ADHD treatment among women of childbearing age, including rising prescription rates during pregnancy and the surrounding period.

The upward trend demonstrates enhanced public understanding about adult ADHD diagnosis alongside changing social views toward ADHD in women since diagnostic standards and clinical suspicion have changed throughout time. The rising numbers demonstrate how untreated or undiagnosed childhood ADHD cases develop into adulthood and create new challenges during childbearing years.

Characteristics of the ADHD Population

Pregnant women who receive an ADHD diagnosis show unique traits in their clinical presentation along with their sociodemographic background. According to the U.S. national cohort study, women with ADHD showed statistical differences from the general population. They were more likely to be at a younger age, have a white racial background, the occurrence of asthma, and various substance use disorders, including tobacco and alcohol abuse (Song et al., 2025). The group showed a higher prevalence of psychiatric comorbidities like depression and anxiety disorders, which made both diagnosis and care delivery more complex (Walsh et al., 2022). Women diagnosed with ADHD usually face greater challenges in their social lives, along with economic difficulties. The Australian research indicated that women with ADHD achieved lower educational levels while also demonstrating lower participation in prenatal healthcare visits than women without ADHD (Poulton et al., 2018). The presence of the risk factors mentioned above indicates that this obstetric population requires multidisciplinary care as the present healthcare system happens to underserve their needs.

ADHD Diagnosis Criteria and Study Comparison

The research studies employed different methods to establish and detect ADHD. Hesselman et al., (2020) used National Prescribed Drug Register prescription data to develop clinical ADHD diagnosis in their Swedish register-based cohort study. The researchers considered women who received prescriptions for ADHD stimulant or non-stimulant medications between 2005 and 2014 as having active ADHD. The method detects patients who receive medical treatment but fails to identify people who have not received a diagnosis or treatment.

The U.S.-based studies employed administrative diagnostic codes (ICD-9-CM or ICD-10-CM) from hospital discharge records within the HCUP-NIS dataset (Amikam et al., 2024; Amikam et al., 2025; Song et al., 2025). The method provides extensive population reach but may experience variability with coding errors and inconsistent documentation practices. Song et al., (2025) performed their research in women with ADHD and without any comorbidity besides relatively common psychiatric disorders, to avoid potential confounding variables. However, Amikam et al., (2024) included female ADHD cases, irrespective of their comorbid conditions to improve the generalizability of the results.

The study by Amikam et al., (2025), who presented a novel tool to differentiate between attention-deficit disorder (ADD) vs. hyperactive-impulsive ADHD. Researchers found that women with the hyperactive-impulsive subtype of ADHD were at greater risk for preterm birth as well as adverse outcomes, such as preterm birth, as opposed to women with inattentive symptoms. The analysis demonstrates how different symptoms of ADHD need evaluation when determining obstetric risks. For better understanding, we extracted the data into Table 1.

Table 1. ADHD Diagnosis Definition Across Studies

Study (Author, Year)	ADHD Diagnosis Definition	Data Source/ Methodology	Notes
Hesselman et al., 2020	At least one ADHD medication prescription (stimulant or non-stimulant)	Swedish National Prescribed Drug Register	Only treated ADHD cases, may miss untreated
Amikam et al., 2024	ICD-9/10-CM diagnosis codes for ADHD	HCUP-NIS, U.S. inpatient database	Broad population sample, psychiatric exclusions
Amikam et al., 2025	ICD-9/10-CM codes; ADHD vs. ADD subtypes separated	HCUP-NIS, U.S. inpatient database	Subtype analysis offers detailed comparison
Poulton et al., 2018	Stimulant prescription history	Australian population-based cohort; pharmacy data	Focused on stimulant use, including historical exposure
Walsh et al., 2022	ICD coding for ADHD in inpatient	U.S. nationwide matched	Matched analysis increases

	datasets	inpatient cohort	comparability
<i>Song et al., 2025</i>	ICD-10-CM code F90 in hospital records	HCUP-NIS, national dataset 2016–2020	Excluded other mental health diagnoses
<i>Di Giacomo et al., 2024</i>	Meta-analysis; diagnostic coding or clinical reports across studies	Multiple international databases; systematic review	Includes both medicated and unmedicated ADHD

Association Between ADHD and Preterm Birth

Summary of Findings and Risk Estimates

Multiple research studies confirm that pregnant women who have ADHD face a greater chance of preterm birth (PTB). A survey of 377,381 nulliparous women in Sweden found that women with ADHD delivered preterm babies at a rate of 7.3 percent compared to 5.8 percent for women without ADHD. The research by Hesselman et al., (2020) reveal that PTB risk for pregnant women with ADHD stayed elevated at 1.17 (95% CI: 1.05–1.30) after controlling for maternal age BMI smoking and psychiatric conditions.

The U.S. nationwide analysis conducted by Amikam et al., (2024) studied over 9 million births to find increased preterm birth rates among women who had ADHD. The population shows increased risk for PTB through its higher rates of hypertensive disorders of pregnancy (aOR 1.36), chorioamnionitis (aOR 1.34) and small-for-gestational-age neonates (aOR 1.30). However, these conditions were not the primary study endpoints.

The obstetric outcomes study conducted by Amikam et al., (2025) compared women with ADHD to those with ADD and demonstrated that women with ADHD were at higher risk of having a preterm birth (aOR 1.19; 95% CI: 1.01–1.39). This study supports the theory that both hyperactive and impulsive behaviors could produce behavioral and physiological elements which increase the risk of preterm birth (Table 2).

Table 2. Association Between Maternal ADHD and Preterm Birth

Study (Author, Year)	Sample Size (ADHD Pregnancies)	Preterm Birth Risk Measure	Risk Estimate (95% CI)	Notes on Preterm Birth Type
<i>Hesselman et al., 2020</i>	6 327	Adjusted Odds Ratio (aOR)	1.17 (1.05–1.30)	Both spontaneous and medically indicated
<i>Amikam et al., 2024</i>	10 031	aOR (indirect indicators)	HDP: 1.36; Chorioamnionitis: 1.34	Indirect PTB via maternal complications
<i>Amikam et al., 2025</i>	11 404	aOR	1.19 (1.01–1.39)	Direct ADHD–PTB association vs. ADD
<i>Poulton et al., 2018</i>	5 131	Odds Ratio (OR)	1.2 (PTB); 1.2 (pre-eclampsia)	Historical stimulant exposure relevant
<i>Walsh et al., 2022</i>	~42 916 (matched)	Descriptive comparison	OR range 1.2–1.8 (various outcomes)	PTB not directly isolated; elevated obstetric risk
<i>Song et al., 2025</i>	33 415	Prevalence comparison	Modest increase (no OR reported)	Modest increase in early and late PTB
<i>Di Giacomo et al., 2024</i>	Varied across included studies	Meta-analytic summary	No significant PTB increase from meds	Focus on medication exposure, not ADHD alone

Spontaneous vs. Medically Indicated Preterm Labor

In the Swedish study by Hesselman et al., (2020) the division into subtypes was made. The results showed that women with ADHD had an increased risk for both spontaneous and medically indicated preterm labor. Medically indicated PTB appears to contribute substantially to the increased risk because pregnant women often develop gestational hypertension and pre-eclampsia and infections (Amikam et al., 2024; Amikam et al., 2025).

Spontaneous PTB tends to result from lifestyle and psychosocial factors, but medically indicated PTB emerges from maternal medical issues. Future research should try to identify these distinct categories for developing specific prevention methods.

Potential Mechanisms Linking ADHD and Preterm Birth

Behavioral, Biological, and Social Risk Factors

The relationship between ADHD and PTB is likely multifactorial. The leading behavioral factors play a significant role among the multiple factors that contribute to this connection. Research by Walsh et al., (2022) and Song et al., (2025) shows that women with ADHD are more likely to experience preterm birth because of their smoking habits, tendency to consume alcohol and substances, poor dietary choices, and sporadic prenatal medical appointments. The main ADHD symptoms, including impulsivity, inattention, and executive dysfunction, worsen these behavioral patterns.

Psychiatric comorbidities also play a role. The frequent occurrence of depressive and anxiety disorders among women with ADHD has been found to increase their risk of obstetric complications independently of other factors. Research by Walsh et al., (2022) demonstrates that inadequate stress management, disturbed sleep, along with insufficient social support may create additional risks.

The biological symptoms of ADHD include HPA axis dysregulation as well as systemic inflammation and immune response disturbances. Research shows that the physiological changes linked to ADHD increase the chances of preterm birth complications that demand premature delivery (Amikam et al., 2025). The study indicates that people with hyperactive-impulsive subtype have an elevated risk of complications because of their behavioral and physiological reactions.

ADHD patients experience higher rates of social health determinants that include limited healthcare access, together with educational disadvantage and lower income status. The presence of these factors reduces the possibility of early prenatal care, delays the detection of complications while making it challenging to follow medical guidelines.

Influence of ADHD Medication

There exists an ongoing debate about the safety of stimulant medications for pregnant women. The current scientific evidence indicates that ADHD pharmacotherapy does not raise the chances of preterm birth. According to Poulton et al., the increased rates of adverse outcomes in women who stopped taking stimulants before conception suggested ADHD as the most important risk factor.

Another study investigated the effects of the first line ADHD medication on pregnancy. Patients taking methylphenidate and atomoxetine appeared not to have higher risk of miscarriage, congenital abnormalities or other severe adverse effects in comparison to non-medicated ADHD patients and controls (Di Giacomo et al., 2024). The results of this study suggest that pharmacological intervention, when needed, is safer and contributes to the improvement of self-regulation in pregnant women, along with better health status during pregnancy.

Clinical Implications

Monitoring and Personalized Care

The continued association between ADHD and adverse pregnancy outcomes suggests it would be reasonable for providers to screen and follow pregnant women with ADHD actively. Healthcare workers can better prevent and manage risks if they can identify ADHD early through review of medical records or symptom identification.

The management of this population requires personalized interdisciplinary care because ADHD symptoms interact with comorbid conditions and obstetric risk factors in complex ways. The integration of psychiatric services within prenatal care facilities enables healthcare providers to deliver prompt behavioral interventions and support services.

Opportunities for Intervention and Prevention

The potential interventions for this population include prenatal counseling, enhanced along with behavioral therapy and structured care pathways that should focus on time management, medication adherence and stress reduction. The frequency of prenatal visits combined with specific support for high-risk behaviors through smoking cessation programs and nutritional counseling should decrease complications.

Women with controlled ADHD symptoms should continue their medication treatment because the advantages typically outweigh the potential risks. The decision-making process requires a collaborative approach between both healthcare providers and patients, to perform individualized risk-benefit assessments based on symptom severity, treatment history and personal values.

Gaps in Knowledge and Future Research Directions

The research shows promising results, yet multiple significant gaps persist. Most of the current research uses observational methods, which prevent scientists from establishing cause-and-effect relationships. Randomized controlled trials represent an ethical challenge, but they could determine the effects of structured intervention initiatives.

One limitation of the present work is that we have no distinction between PTB cases occurring spontaneously or after a medical intervention, which makes it difficult to isolate important mechanisms. For the future, it will be necessary to differentiate between spontaneous or medically indicated PTB outcomes. Research has not established the long-term neurodevelopmental results of children born to mothers with ADHD while also studying how maternal symptom control and pregnancy medication use affect these outcomes.

The research lacks data about how different ADHD subtypes, symptom intensities, and diagnosis durations affect outcomes. Research on how these factors affect outcomes would enable better risk assessment and treatment approaches.

The rates of diagnosis, treatment access, and clinical outcomes differ between countries because of their unique cultural backgrounds and healthcare systems. Research that compares international healthcare practices would reveal optimal treatment methods to enhance patient care throughout different healthcare environments.

4. CONCLUSION

The review presents accumulating evidence showing that maternal ADHD increases preterm birth risk through both spontaneous and medically necessary labor. The risks are caused by multiple factors, including behavioral elements, biological components, and social determinants, instead of pharmacological treatment as the leading cause. The research demonstrates an urgent requirement for identifying ADHD in pregnant women at an early stage through integrated care systems that implement proactive intervention methods.

The increasing number of women with ADHD who are planning to become mothers requires obstetric care systems to develop specific strategies for their unique needs. Obstetric care should identify ADHD as a significant risk factor for pregnant women, while multidisciplinary prenatal care that includes psychiatric and behavioral support can help prevent associated complications. Multidisciplinary prenatal care, which includes psychiatric and behavioral counseling, may help prevent complications related to use. The current evidence reflects robust associations, but forthcoming studies should clarify causation, the role of specific ADHD subtypes, and the safety and efficacy of treating ADHD during pregnancy. The advancement of maternal and newborn health relies on closing these knowledge gaps.

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Author contributions

All authors contributed significantly to the preparation of this manuscript. Olga Samsel conceived and designed the review topic and supervised the project. Kamil Nieczaj, Julia Sztubińska, Marta Tortyna, Marta Marciniak conducted the literature search and data extraction. Authors Paula Szarek, Julia Urbańska, Natalia Sioch performed critical analysis and interpretation of the collected data. Authors Kamil Nieczaj and Maciej Trzciński contributed to the writing of the manuscript draft. Author Danuta Borowska coordinated the final editing and formatting of the manuscript. All authors reviewed and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

Informed consent

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Ethical approval

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Conflict of interest

The authors declare that they have no conflicts of interests, competing financial interests or personal relationships that could have influenced the work reported in this paper.

Data and materials availability

All data associated with this study will be available based on the reasonable request to corresponding author.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington (DC): American Psychiatric Publishing; 2013;50–90.
2. Amikam U, Badeghiesh A, Baghlaf H, Brown R, Dahan MH. Comparing obstetrical outcomes between attention deficit hyperactivity disorder and attention deficit disorder: a population-based study. *J Clin Med* 2025;14(12):4142. doi:10.3390/jcm14124142.
3. Amikam U, Badeghiesh A, Baghlaf H, Brown R, Dahan MH. The association between attention deficit hyperactivity disorder and pregnancy, delivery and neonatal outcomes: an evaluation of a population database. *BMC Pregnancy Childbirth* 2024;24:364. doi:10.1186/s12884-024-06561-5.
4. Barkley RA, editor. Attention-deficit hyperactivity disorder: a handbook for diagnosis and treatment. 4th ed. New York: Guilford Press; 2015;45–78.
5. Biederman J, Petty CR, Monuteaux MC, Fried R, Byrne D, Mirto T, Spencer T, Wilens TE, Faraone SV. Adult psychiatric outcomes of girls with attention-deficit/hyperactivity disorder: 11-year follow-up in a longitudinal case-control study. *Am J Psychiatry* 2010;167(4):409–417. doi:10.1176/appi.ajp.2009.09050736.
6. Di Giacomo E, Confalonieri V, Tofani F, Clerici M. Methylphenidate and atomoxetine in pregnancy and possible adverse fetal outcomes: a systematic review and meta-analysis. *JAMA Netw Open* 2024;7:e2443648. doi:10.1001/jama.networkopen.2024.43648.
7. Franke B, Michelini G, Asherson P, Banaschewski T, Bilbow A, Buitelaar JK, Cormand B, Faraone SV, Ginsberg Y, Haavik J, Kuntsi J, Larsson H, Lesch K-P, Ramos-Quiroga JA, Réthelyi JM, Ribasès M, Reif A. Live fast, die young? A review on the developmental trajectories of ADHD across the lifespan. *Eur Neuropsychopharmacol* 2018;28(10):1059–1088. doi:10.1016/j.euroneuro.2018.08.001.
8. Hesselman S, Wikman A, Skoglund C, Kopp Kallner H, Skalkidou A, Sundström-Poromaa I, Wikström A-K. Association of maternal attention deficit hyperactivity disorder and preterm birth: a cohort study. *BJOG* 2020;127(12):1480–1487. doi:10.1111/1471-0528.16310.
9. Kessler RC, Adler L, Barkley R, Biederman J, Conners CK, Demler O, Faraone SV, Greenhill LL, Howes MJ, Secnik K, Spencer T, Üstün TB, Walters EE, Zaslavsky AM. The prevalence and correlates of adult ADHD in the United States: results from the National Comorbidity Survey Replication. *Am J Psychiatry* 2006;163(4):716–723. doi:10.1176/ajp.2006.163.4.716.
10. Khandre V, Potdar J, Keerti A. Preterm birth: an overview. *Cureus* 2022;14(12):e33006. doi:10.7759/cureus.33006.
11. Owens EB, Zalecki C, Gillette P, Hinshaw SP. Girls with childhood ADHD as adults: cross-domain outcomes by diagnostic persistence. *J Consult Clin Psychol* 2017;85(7):723–736. doi:10.1037/ccp0000217.
12. Poulton AS, Armstrong B, Nanan R. Perinatal outcomes of women diagnosed with attention-deficit/hyperactivity disorder: an Australian population-based cohort study. *CNS Drugs* 2018;32(7):643–651. doi:10.1007/s40263-018-0505-9.
13. Song BB, Agle ZW, Anderson ZS, Schulman AD, Lackey CL, Reeves DP, Clay H, Ross EL, Smethers AD. Trends, characteristics, and outcomes of pregnancy in women with attention-deficit/hyperactivity disorder: a nationwide analysis. *Eur J Obstet Gynecol Reprod Biol* 2025;306:226–232. doi:10.1016/j.ejogrb.2025.01.034.
14. Thomas R, Sanders S, Doust J, Beller E, Glasziou P. Prevalence of attention-deficit/hyperactivity disorder: a systematic review and meta-analysis. *Pediatrics* 2015;135(4):e994–e1001. doi:10.1542/peds.2014-3482.
15. Walsh CJ, Rosenberg SL, Hale EW. Obstetric complications in mothers with ADHD. *Front Reprod Health* 2022;4:1040824. doi:10.3389/frph.2022.1040824.
16. World Health Organization. International statistical classification of diseases and related health problems. 10th revision (ICD-10): Version 2019. Geneva: WHO; 2019.