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Perinatal experience of women with attention deficit hyperactivity disorder (ADHD)[1]

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Abstract: *Background*: Attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental disorder with considerable individual variability. Population-based studies put its prevalence at 1% to 5% of the population. Due to the different presentation of symptoms, women with ADHD are less likely to receive adequate help. They face more difficulties in the perinatal period than neurotypical women. Pregnant women with ADHD are more likely to experience family difficulties, including conflicts with their partner or lack of support from relatives, as well as a variety of obstetric complications, such as the need for delivery by cesarean section, pregnancy-induced hypertension or anaemia. A small number of scientific papers focus on their individual experience of pregnancy and childbirth. *Method*: the study was conducted by means of semi-structured individual interviews. Ten women with a formal diagnosis of ADHD, whose last delivery was between 2019 and 2024, participated in the study. Participants were selected by purposive sampling from women willing to participate in the study. Data were analysed and coded according to reflective thematic analysis methodology. *Results*: When analysing the content of the interviews, 3 leading themes were identified: 1. *ADHD in the perinatal period* (Attention Deficit Disorder, Hyperactivity and impulsivity, Atypical sensory processing), 2. *In relationships with others*, and 3. *Consequences of perinatal experiences*, together with subthemes that were relevant to the women interviewed. *Conclusions*: The perinatal experiences of women with ADHD were significantly influenced by the symptoms of the disorder. Focusing on the individual needs of pregnant and birthing women and taking into account the difficulties arising from attention deficit hyperactivity disorder can significantly improve the perinatal experience of these women. Care during labour should take into account the particular sensory sensitivity to the hospital environment described in the study and avoid immobilising parturients. Lack of support from medical staff and family can result in long-term negative consequences. Changes are needed in the management of care for pregnant and birthing women with ADHD, as research has shown that some women, due to traumatic birth experiences, declared abandonment of further procreative plans.

Keywords: ADHD, childbirth, perinatal experiences, pregnancy

Introduction

According to the ICD-11 classification, attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental disorder that occurs in early childhood. The components that make up ADHD show considerable individual variability. For this reason, the disorder has been divided into subtypes, depending on the predominant symptoms, and a mixed subtype. Features associated with attention deficit disorder include difficulty focusing on tasks that do not provide immediate reward, being easily distracted by external stimuli. These individuals also have difficulty organising tasks and forget to complete planned activities. The hyperactive subtype may be characterised by excessive busyness, making it impossible to complete tasks in complete stillness. Such individuals often speak their thoughts without thinking, or interrupt their interlocutors. It is also typical to impulsively take actions under the influence of external stimuli, without thinking about the possible consequences. People with ADHD perceive their environment differently and may not follow established social norms. Although the severity of symptoms shows variability, depending on the current environment and its demands, they must,

1 Article in Polish language: https://stowarzyszeniefidesetratio.pl/fer/63P_Anio.pdf

by definition, negatively affect daily functioning. At the same time, individuals with ADHD, may not be aware of the existence of the disorder until adulthood, when the demands of the environment begin to exceed the individual's compensatory capacity (*Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders*, 2024, Elliott et al., 2024). It is noticeably more common in females, as they are less likely to present with typical ADHD symptoms such as hyperactivity or conflictuality. They are most likely to present with the mixed or attention deficit disorder subtype. However, due to social and cultural expectations different from those directed at men, women are able to compensate for their symptoms relatively well. Difficulties in daily functioning are most often noticed during periods of major life changes such as starting a family or entering the workforce. Although most traits present themselves differently according to gender, one of the few equally prevalent traits in men and women is a propensity to abuse psychoactive substances or alcohol (Young et al., 2020).

Depending on the diagnostic criteria adopted, the study methodology or the population studied, the prevalence of ADHD is estimated to be between 1.6 % and 5 %. However, these values may be underestimated due to diagnostic difficulties in adults, particularly in women (Popit et al., 2024). In the United States, approximately 4% of parturients had a diagnosis of ADHD one year before, or up to one year after birth. The number of such diagnoses increased by 290% between 2008 and 2020 (Hall et al., 2024).

The perinatal period defines a distinctive constellation of experiences, encompassing both physiological and mental health dimensions, which can be profoundly influenced by an individual's neurodivergent characteristics. This period is distinguished by significant hormonal changes, particularly in relation to estrogen and progesterone levels. Estrogen can increase dopamine and serotonin concentrations, and its stably increased concentration during pregnancy can have a significant impact on attentional abilities, impulsive behaviour and emotional regulation. At the same time, sudden hormonal changes during childbirth may cause a sudden increase in ADHD symptoms (Elliott et al., 2024, Osianlis et al., 2025).

Consequently, women with ADHD in the perinatal period often experience increased emotional, physical and social challenges, leading to a higher risk of psychiatric disorders (Bang Madsen et al., 2024). In a study conducted on a relatively large group of women from seven different countries, a correlation was found between the severity of ADHD symptoms and reduced support from both family and friends. This may make it more difficult to cope with the already increased number of stressful situations that are associated with pregnancy (Murray et al., 2022). Research suggests that women with ADHD may be particularly sensitive to a sharp drop in estrogen and progesterone levels, potentially increasing the risk and severity of postpartum depression. Neuroatypical women report greater difficulty in coping with external stimuli during pregnancy, which is mainly manifested by increased sensory sensitivity (Elliott et al, 2024; Kamath et al, 2020; Panagiotidi et al, 2018). Women diagnosed with ADHD are more likely to have problems related to being underweight or overweight, as well as alcohol, tobacco and substance abuse, which can result in harmful obstetric and perinatal consequences (Skoglund et al., 2019). It has also been shown that pregnant women with ADHD were more likely to have pregnancy-induced hypertension, anaemia, heart or kidney disease. Complications were also not uncommon during labour, including preterm labour, postpartum haemorrhage and the need to terminate labour by caesarean section. Newborns, on the other hand, were more likely to require prolonged stays in the neonatal unit, which may be related to the higher prevalence of low birth weight and associated complications among them. An increased incidence of congenital anomalies was also noted among neonates, which may also have predisposed them to prolonged hospitalisation (Amikam et al, 2024; Poulton et al, 2018; Walsh et al, 2022).

Despite growing public awareness of neurodevelopmental disorders, people with ADHD still face numerous barriers in their interactions with health care professionals. Only a small percentage of patients receive adequate support and tailored therapeutic approaches (Ramos-Quiroga et al., 2013). They often receive recommendations that are not adapted to their individual needs and limitations (Ward et

al., 2024). This can, in the long term, lead to feelings of abandonment and misunderstanding by health professionals (Matheson et al., 2013). In the perinatal period, these factors lead to significant communication difficulties and ignoring the needs of pregnant and birthing women, which can ultimately result in a negative birth experience (Elliott et al., 2024).

Despite the extensive literature on the influence of maternal factors on the possibility of ADHD in the offspring, much less attention has been paid to the wellbeing of pregnant and birthing women with ADHD. In a literature review published in November 2024 on the perinatal experiences of neurodiverse individuals, only one of the eleven studies cited was related to ADHD; the others referred only to the autism spectrum. Seventy-three families participated in the study, including only 17 mothers with ADHD (Elliott et al., 2024). This shows how underrepresented the group of women with ADHD is in work covering the perinatal period. Additionally, in most existing studies, mental status is assessed with standardised questionnaires such as the Adult ADHD Quality of Life (AAQoL), which, due to their generic nature, do not provide the opportunity for deeper insight into the experiences of these women (Gjervan & Nordahl, 2010). This indicates an urgent need to look at the individual stories of women with ADHD. Analysing these experiences can contribute to a better understanding of their perspectives and to tailor the management of health professionals to their individual needs. Despite emerging studies on neurodiverse women in the perinatal period, there is also a lack of studies that take into account the Polish cultural context.

The aim of this study is to analyse the perinatal experience of women with ADHD and to investigate the impact of neurodiversity on the subjective experience of pregnancy, childbirth and postpartum time.

1. Materials and methods

Participants were selected using a purposive sampling method from women who volunteered to participate in the study. They were members of thematic groups targeting people with ADHD on a social networking site. Women with a formal diagnosis of ADHD whose last delivery was between 2019 and 2024 were included in the study. Women with concomitant other neurodevelopmental disorders were excluded from participation. The study ultimately included 10 women aged 28-42 years. Only one of them was over 40 years old. Two of the participants were in informal relationships, the rest were married. Three of the respondents were first-borns, for most of the others it was the second birth.

The study was conducted by means of semi-structured individual interviews conducted remotely with the help of ICT software allowing real-time interview with video transmission. Each woman was interviewed once. Prior to the interview, participants gave their consent to participate in the study. At the beginning of each interview, women gave their consent to be recorded.

The interview began with general open-ended questions "Tell me about your pregnancy.", "Tell me about your birth." and then depending on the answers, more specific questions were asked in order to fulfil the objectives of the study, for example "How was your pregnancy, how did you feel when you were pregnant?", "What treatment by loved ones or medical staff was supportive to you?". The women interviewed had the opportunity to express their feelings and experiences fully freely. The interviews lasted on average about one hour.

The interviews were recorded and then manually transcribed in MS-Word editor by the first author of the study. Data were analysed and coded according to the methodology of reflective thematic analysis according to Braun and Clarke (2022). Codes were grouped into concepts, which were categorised by identifying relationships between them. The categories created in this process, as well as the connections found between them, allowed the main themes to emerge. After revisiting the material from each interview, sub-themes and corresponding quotations were listed.

Reflexivity was used as a means of quality control, and detailed documentation of all stages of the study, coding several times, and consulting the wording and meaning of codes and themes emerging from the data with other members of the research team or researchers not involved in the study.

2. Results

In the process of analysing the content of the collected interviews, 3 leading themes were identified: *ADHD in the perinatal period*, *In relationships with others*, and *Consequences of perinatal experiences*. Within the first theme, subthemes emerged: Attention Deficit Disorder, Hyperactivity and Impulsivity, Atypical Sensory Processing, and within the second: Relationships with relatives, Communication and cooperation with medical staff.

2.1. ADHD in the perinatal period

In narratives about pregnancy and childbirth, women referred to the impact of the various components of the hyperactivity disorder on their experiencing and experiencing the perinatal period. Some of those interviewed described an increase in ADHD symptoms during this period, which caused considerable discomfort and hindered functioning. At the same time, some of the traits and behaviours characteristic of women with attention deficit hyperactivity disorder were described by women as a resource.

2.1.1. Attention deficit disorder

The procrastination tendency present in the women interviewed had an impact on their behaviour in the perinatal period. They had difficulties maintaining attention and focus, starting activities and completing tasks on time. Despite their approaching due date, the women were not prepared for their stay in hospital, and even though labour had started, they were able to procrastinate going to the medical facility. One participant declared that she had laboratory tests done during the beginning of contraction activity, although she should have done this much earlier. Other women postponed getting the necessary things ready for the hospital until they were forced to do so by the onset of labour.

> 'I didn't believe I was actually in labour and I made breakfast, did the dishes and didn't want to get myself together for the hospital, despite my husband's urging. He was angry with me and told me to pack up and go. I had my bag unpacked because I didn't believe so much that it was going to happen anymore.' (participant 2)

In contrast, some women declared different patterns of behaviour. They described an excessive focus and involvement in relation to the course and management of the pregnancy, preparation for the upcoming birth or lactation. They also reported a need for intensive knowledge concerning the perinatal period.

> 'I had hyper focus on this pregnancy, I had all the tests done as on time as no one, I had two pregnancy cards, one on the National Health Service, one privately, I had all the tests done twice.' (participant 6)

> 'And I got into hyperfocus and a whirlwind of reading books about childbirth. From the beginning of my pregnancy I read, I read probably all the popular literature available about pregnancy and childbirth. And the same with childcare, I tried to learn everything about it.' (participant 4)

2.1.2. Hyperactivity and impulsivity

The women interviewed described making ill-considered decisions and impulsive actions during the perinatal period, some of which were associated with negative consequences. A recurring motive was to travel during pregnancy at the due date, despite the risks involved. Hypervigilance in respondents' opinions influenced hospitalisation behaviour. Women were discharging themselves from hospitals at their own request, and the need to stay on the move made the immobilisation required during KTG recording or the delivery itself difficult to bear. Despite being aware of the possible consequences, the women surveyed tried to avoid immobilisation by all means.

> 'When I was a baby I was just naughty because I couldn't sit still. In pregnancy pathology I was a naughty patient.' (participant 6)

> 'And also they didn't let me move at all, that's something, that's the nail in the coffin (...) I wasn't able to lie down. So they couldn't do the CTG properly, so I had to keep lying down, so I was lying down, it was hard.' (participant 1)

Some participants described the difficulty in accepting a change of plans during the perinatal period triggered by circumstances beyond their control.

> '(...) when I got up on the morning of Christmas Eve I got a text message that my appointment was cancelled. And I said to my partner that no matter what I wasn't going to go on any Christmas until I went for that ultrasound. So we found a doctor at the other end of town and we went there.' (participant 6)

2.1.3. Atypical sensory processing

All of the women interviewed frequently remarked on the inadequacy of the hospital environment to meet their needs, which affected their feelings and behaviour. Abnormalities in the processing of external stimuli made the experience of childbirth additionally difficult.

> 'The same walking around in wet flip-flops after a shower. The feeling of sticking to that foil on the birthing chair, the felt and plastic. And the fact that you're all wet and sweaty and still sticking to it (...) It was horrible. The light was on, so I had my eyes closed for practically the whole birth.' (participant 2)

> 'I have hypersensitivity to light, overhead light especially, I hate it. And there was an overhead light on all the time and it was very bothersome. I also have auditory hypersensitivity. And in the hospital the children were crying all the time, I practically didn't sleep, I thought I was going mad.' (participant 5)

Some women specifically highlighted the psychological discomfort that medical activities requiring tissue disruption caused them. The potential risk of reliving such an event again may even have influenced the decision to choose the type of birth.

> 'It was literally written in the birth plan that I was tactilely hypersensitive, that I couldn't stand the needles because they caused me psychological pain and I could feel it in every movement. I remember her exasperation and great wonder why I was so scared of needles as I had three c- sections. But I have just survived three c-sections and I don't want another one. If I wasn't so scared of needles, I could have had another caesarean.' (participant 7)

Women with ADHD declared that discomfort can cause them to experience events that are completely physiological in childbirth. A particularly sensitive sense of touch meant that the birth experience included additional sensations that were unpleasant for them.

> 'They put the baby on my chest and I was so irritable, I didn't want to cuddle that baby. It was so wet, slimy, I felt bad too. (...) I already wanted it to be clean, dry, wrapped in something, or even naked, but clean. Because I know it's mine, I know it's from me and it's not something bad, what it's wearing, but it made me feel so disgusted, uncomfortable and unpleasant very much.' (participant 3)

> 'I, after giving birth, I felt terribly dirty afterwards, I felt awful. It irritated me incredibly, this feeling of sweating, of dirt. (...) I spent a lot of time in the shower, I didn't want to get out from under it. I found it soothing, the fact that the water was running and that I could wash off the sweat on a regular basis.' (participant 3)

Discomfort was also associated with breastfeeding. This forced women to make difficult decisions and look for alternatives.

> 'When I pumped for him, I didn't do it with a breast pump, I did it manually and everyone was shocked too. I hated the breast pump, the touch of it, the sound of it, a nightmare. (...) And that's also mainly why I weaned them, because of the sensory sensations. Even though I didn't want to finish, I wanted it to finish on its own, I did it because it made me so tired.' (participant 2)

The women interviewed declared that they often tried to calm down after giving birth with things that usually brought them comfort. They then chose relaxing pastimes like watching a favourite TV series, or eating food that they associated with the carefree nature of childhood.

> 'And I felt so empowered to eat those Michals (name of candy) and I would just have those Michals in a drawer stashed away and eat them like that. It was like some sort of trance state, like under the influence of drugs I would say. I love Michaleks, they are my favourite sweets, maybe sentimental, because my dad is very fond of Michaleks and I always snacked on them from him.' (participant 4)

> 'She cooked me a soup like she used to cook for me when I was little, there is 12 years difference between us, so she used to cook me when I was a little girl such a soup.' (participant 1)

Some participants described food selectivity resulting from sensory difficulties during the perinatal period. Women who perceived such difficulties in themselves emphasised that they found a diet that did not take into account individual food exclusions burdensome during their hospital stay.

> 'I have a certain food selectivity. If the smell of something doesn't suit me, I'm not able to eat it because I throw up. I took a big stock of food of my own to the hospital to have.' (participant 5)

> 'I am proud of myself when I eat a vegetable in a sandwich. (...) I don't like the texture of many either. If someone adds a fresh tomato or a pickled cucumber, the whole dish is such that it would be abstract to eat it. (...) I don't have such a thing that I can eat food even though I don't like it. If it doesn't taste good to me, I will vomit sooner than eat it.' (participant 4)

2.2. In relationships with others

A large space in the women's interviews was occupied by relationships both in relation to relatives, especially the partner and also people from the medical staff.

2.2.1. Relationships with relatives

The women interviewed described experiencing difficulties in family relationships during their pregnancy. This included both the relationship with the partner and with older children. At the same time, the origins of the conflicts were varied, although all related to the disorder described.

> 'Everything was taking me out of balance and I wasn't able to stop, as usual, this gets worse in pregnancy. I was very sensitive to touch and sounds. (...) It made me nervous when my children were next to me, when they wanted to hold my hand. Normally that's fine, but in pregnancy it's not. If the children are playing loudly, or squealing, arguing, I normally go into the other room and manage, but in pregnancy if I can hear it even from another room, I find it hard to bear.' (participant 7)

> 'In pregnancy, especially in those first 4 months we argued terribly and I also liked to have everything on a knife edge like that.' (participant 9)

At the time of the birth itself, women's expectations of their partners varied. For some of them, the instrumental support they received and the mere accompaniment of the birth was sufficient. For others, however, the insufficient emotional involvement of the men was a problem.

> 'I in childbirth preferred to be more alone, I don't like touch. So my husband gave me water, but he didn't take such a direct part, because I don't need it that much either. But it is very important for me to have his presence and for him to switch the music.' (participant 1)

> 'He, when he came to this delivery room, was also such a technical support. He followed the midwife's instructions 'Here, you hold your wife's leg' and took care of my hydration during labour. (...) Maybe I would have needed him to be more present, with his emotions rather than his body, but he was in his own way.' (participant 4)

2.2.2. Communication and cooperation with medical staff

Some of the respondents were aware of their difficulties in interpersonal contacts. The women interviewed paid particular attention to the role of communication in the therapeutic relationship with medical staff during childbirth. According to the majority of respondents, it could dramatically change their perinatal feelings. Even difficult experiences, when staff were able to respond to the needs of the parturient in a way that was appropriate for her, were mentioned as positive. However, in many cases communication and cooperation with staff was unsatisfactory. The parturients often perceived the messages addressed to them as incomprehensible or too vague. They declared that they would have needed clear instructions during childbirth.

> 'I was prepared for the birth but I needed someone to tell me at that moment how to behave and I didn't know that and I felt very bad about it and I was completely alone. (...) I didn't know what was going on.' (participant 1)

> 'And I didn't know what to do and I felt like I was doing everything wrong. The midwife was making me feel guilty because I didn't know at all how I was supposed to push, what I was supposed to do, how it was supposed to look. (...) And she was telling me that here the head is already coming out, you can already see, and you won't push and you'll strangle your baby. See what you're doing.(...) the way this midwife conducted this action, it was a nightmare. (participant 3)

Another problem often highlighted was the lack of a sense of subjectivity. Women felt that they were treated in a patronising and objectifying way, which projected onto their feelings about the birth and their willingness to cooperate with the staff.

'There was no cooperation with the midwife, I remember her back at the desk more than her face or her voice.' (participant 7)

'And that's how I felt like an intruder there. (...) I felt patronised.(...) I found it hard to talk to them.(...) I would like the doctors to take me seriously, as a partner, that what I say is important to them, how I feel. And that they didn't treat me like another cow to give birth to that they got, but no woman. That's how I imagined it. I felt like I was just another woman on a conveyor belt and I'm supposed to go give birth in this room and see ya. The factory has to work like that and we go with the next woman to give birth.' (participant 5)

When staff gave parturients a sense of agency and competence to make decisions, their cooperation was better and more effective. Parturients who received instructions that were clear to them followed them and described the birth experience as more positive, even when there were medical complications.

'During labour, the midwife encouraged me to change position, but very gently and explaining what it was about so that I agreed. The fact that she was explaining why was important to me. She asked my consent and encouraged me and this made me feel involved in the process and not treated down. (...) I was empowered and that was the biggest difference in all of this. In that first birth they left such a mother totally crushed, I felt so inadequate, up to no good. Not knowing at all what had happened, totally without the strength for what was ahead of me. And in the second one, I felt that I could do it, that I had the power inside me to take care of this child, that I could cope with everything. (participant 2)

'I wasn't traumatised by my causality in the first birth. I could come out of it traumatised, but by me agreeing to everything I didn't have trauma. I was able to say 'no'. And it was this doctor who emphasised 'it is your decision. I am telling you that there could be hypoxia. But it is your decision whether you agree to it. I am waiting to do it, if you say no, I will not do it'.' (participant 1)

3. Consequences of perinatal experiences

The difficult experiences of pregnancy and childbirth cited above had long-term consequences in the form of psychological problems in some of the women interviewed.

'After my first birth I had suspected postnatal depression (...) The therapist at the time suggested to me that I might have PTSD after that birth and that kind of treatment by the midwife. I have flashbacks of that birth. For example, I could see the tower of the church from my window and whenever I see that tower walking around the city, I am reminded of those scenes.' (participant 2)

'I didn't have a diagnosis of postnatal depression after any birth, but I think there were indications for it. Maybe if I had had more time, or my partner had been more sensitive to my needs, it would have been done. I felt that I was alone, that no one understood me (...) Lack of support and lack of understanding from my partner and in-laws, lack of interest, lack of willingness to help' (participant 3)

Two of the female participants in the study declared that they had to change their procreation plans as a result of the traumatic perinatal experience.

> 'And I wanted to say that this is one of the most important reasons that I don't plan to have a second child. Because I'm scared of this birth and how these women in labour are looked after, that you don't know what you're going to end up with. I really wanted to have a lot of children-four or three. And definitely two. And now I don't want to have another child. (...) And it was so bad that I still can't get over it. It is a tragedy simply.' (participant 5)

> 'During this later therapy I also worked on the topic of pregnancy and childbirth. And after that I decided that my daughter was my first and only child, because the whole thing cost so much nerves that I wouldn't want to go through it a second time. I would consciously rather not decide to have a second child.' (participant 6)

4. Discussion

The study focused on the individual pregnancy and childbirth experiences of 10 women with a formal diagnosis of ADHD. The interviews identified several main elements that significantly influenced the experience of pregnancy and the perinatal period of women diagnosed with attention deficit hyperactivity disorder. Most of the women paid a lot of attention to the difficulties resulting from ADHD. One of the most notable was sensory overreactivity, the severity of which is typical of this period (Elliott et al., 2024). In some cases, this led to significant discomfort during pregnancy, during hospitalisation and an aversion to medical interventions, regardless of their benefits. Also during childbirth, there were strong negative feelings related to external stimuli, which are less frequently reported by neurotypicals. At the same time, none of the women reported experiencing perinatal complications such as pre-eclampsia, postpartum haemorrhage, or preterm birth, despite these being more common in pregnant women with ADHD (Poulton et al., 2018; Walsh et al., 2022).

Some of the women reported difficulties in adhering to a healthy diet during pregnancy, which were mainly related to sensory disturbances. During their hospital stay, the enforced diet caused them additional discomfort. This is consistent with findings from other studies indicating poor eating habits in women with ADHD (Jones et al., 2018). It has also been shown that individuals with ADHD have a different chemosensory profile (characteristics of the body's response to chemical stimuli), which may be one reason for the women's reported difficulties during the study period (Stankovic et al., 2021).

The literature describes the occurrence of additional difficulties resulting in less support from loved ones and more family conflict. Women with ADHD also felt isolated from loved ones and found it more difficult to spend satisfying time with their families Baker et al., 2022; Murray et al., 2022). Similar situations were reported by some of the women in our study, who indicated more frequent arguments with relatives and disappointment caused by their partners' failure to meet their expectations. At the same time, other participants in our study did not report such difficulties and were satisfied with the role their relatives played during the birth. Despite the respondents reporting an increase in challenges related to daily functioning and difficulties in family relationships, only one of them mentioned complications on professional grounds, which is not in line with the results of other studies indicating a higher prevalence of such problems during the period described (Eddy et al., 2019).

During pregnancy, existing problems with planning or attention deficit disorder in women with ADHD may be exacerbated, negatively affecting their appropriate use of medical care (Scoten et al., 2024). Several of the women we interviewed reported such difficulties, mainly related to the

period of childbirth and going to hospital. Women with ADHD often have co-occurring anxiety and emotional disorders. Due to the unpredictable nature of the course of pregnancy and women's concerns about their ability to cope with the changes ahead, they may experience an increase in symptoms of these disorders (Young et al., 2020). At the same time, several of the women we interviewed noted an

excessive focus on pregnancy, which may also be due to the need to control the uncontrollable experience that is pregnancy and childbirth. In the literature, attention in women with ADHD has so far only been described in the context of attention deficit, so excessive focus on a specific topic, referred to as hyperfocus, is an area that needs further investigation.

In our study, women were much more likely to note difficulties arising from hyperfocus, which caused considerable discomfort during pregnancy check-ups and hospital stays. Immobilisation, even of relatively short duration, was difficult for them to bear and they strenuously tried to avoid it. In an article published by Young et al. motor hyperactivity is more often associated with men with ADHD, resulting in such difficulties occurring in women being ignored (Young et al., 2020).

Several of the women interviewed also described situations involving health risk activities during the last trimester of pregnancy. Although these actions appeared to be well planned, they may nevertheless have resulted in risks to the health and life of the baby and themselves. This impression of well-considered decisions may be due to better masking of symptoms and adaptation to social demands in women (Young et al., 2020).

In a study by Matheson et al, people with ADHD described a lack of understanding of their problems and difficulties in communicating with medical staff, among whom stereotypes attributed to women with ADHD persist (Matheson et al, 2013). Such attitudes often lead to the stigmatisation of people with ADHD and their avoidance of interaction with healthcare professionals (Lebowitz, 2016). The lack of cooperation with midwives and doctors, experienced by some of the women we interviewed, may have been partly related to this. They also sensed a lack of respect and a lack of willingness to cooperate on the part of health care staff, which had a very negative impact on their perception of childbirth. This is an issue described by neuroatypical people in other studies as well (Elliott et al., 2024).

The quality of collaboration with the midwife during labour was a frequently raised theme. Women who were given a sense of agency and understanding had significantly better recollections of their births compared to women who lacked this. Such an important role of empowerment by staff may be due to the frequent lack of a sense of control over life events in women with ADHD (Attoe & Climie, 2023). Research shows that both women and physicians perceive difficulties in providing care to people with ADHD, at the same time as both groups see that improving communication and adapting medical facilities to their specific requirements can significantly increase the quality of their care and improve their feelings about interactions with health care (Ward et al., 2024). Similar statements were expressed by female participants in this study. They appreciated situations where staff were able to adapt the way they communicated and the hospital environment to their needs.

Several women interviewed described experiencing psychological problems in the postnatal period and later in life. Several of them experienced postpartum depression, which they link to negative experiences during childbirth. According to a cohort study by Johnson et al. depressive symptoms were more prevalent in women with ADHD both 3 months postpartum and more than a year postpartum (Johnson et al., 2025). ADHD is also independently associated with the occurrence of greater family difficulties in the postpartum period (Joseph, Khetarpal, Wilson, Molina, 2022).

Some women described their perinatal experience as very traumatising, which forced them to abandon further procreative plans for fear of repeating such an experience.

Conclusions

The perinatal experiences of women with ADHD were significantly influenced by symptoms of the disorder such as hypersensitivity to a variety of stimuli and hyperactivity. Women receiving perinatal care reported a lack of understanding of their needs by medical staff and difficulties in communicating effectively with them. However, where staff took into account the personal preferences of the parturients, they described their births as more satisfactory. While some of the participants' statements may represent

women's universal needs for subjectivity and agency, they also manifested co-occurring communication challenges specific to ADHD. Lack of support from medical staff and family can result in long-term negative consequences, mainly of a psychological nature. Our study showing difficulties in the perinatal period in women with ADHD points to the need for changes in the management of their care. In two cases, these experiences led women to abandon further procreative plans. One possible change is the introduction of training of medical staff to take into account the limitations of Attention Deficit Hyperactivity Disorder and to individualise care for pregnant and parturient women. Perinatal care should take into account the special sensory sensitivity to the hospital environment described in the study and avoid immobilising women.

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