From Early to Fewer Births: ADHD and Family Formation

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Abstract

Background

Attention-deficit/hyperactivity disorder (ADHD) is common, yet its implications for fertility remain unclear. Because ADHD is linked to difficulties in relationships, it may influence both the likelihood and timing of entry into parenthood.

Methods

We used Finnish population register data on 759,430 individuals born in 1982–1993. ADHD was identified based on diagnoses and prescription records. The outcome was the first birth by age, analysed using discrete-time event history models estimated separately for women and men. Stepwise models adjusted for age and cohort, education, and partnership status, and interaction analyses assessed whether having a partner with ADHD influenced fertility outcomes.

Results

ADHD was negatively associated with the likelihood of having a first child in models adjusted for age and birth year, with similar effects for men and women. Including education explained part of the negative association for women. In the fully adjusted model, which also accounted for partnership variables, the association reversed: individuals with ADHD had almost 10% higher odds of having a first child compared to those without ADHD. Having a partner with ADHD was negatively associated with the likelihood of a first birth, while childbearing was lowest among individuals without a co-residential partner. Predicted cumulative probabilities showed that individuals with ADHD entered parenthood earlier, but by the end of the follow-up, their overall likelihood of having a first child was lower.

Conclusion

ADHD is linked to earlier but ultimately less frequent entry into parenthood. Much of this disadvantage is explained by educational and partnership differences. Once partnership status is taken into account, individuals with ADHD are slightly more likely to become parents, underscoring the central role of relationship formation in shaping fertility patterns among people with ADHD.

Introduction

Neurodevelopmental disorders, including attention-deficit/hyperactivity disorder (ADHD), have become increasingly prevalent in recent decades, yet their implications for fertility outcomes remain poorly understood. Most prior research on ADHD has focused on treatment and life satisfaction (Ostinelli et al., 2025; Turk et al., 2023), links with criminality (Carlander et al., 2024), labour market attachment (Christiansen et al., 2021; Chen et al., 2023), and educational attainment (French et al., 2024). ADHD is also associated with poorer outcomes in both physical and mental health (French et al., 2024). Currently, it is among the most common neurobehavioral conditions, affecting an estimated 5–10% of school-aged children and 2–5% of adults (Ornoy & Kore, 2021). In our Finnish total population register-based sample, 2.1% of men and 1.7% of women born between 1982 and 1993 had an ADHD diagnosis by age 27–38 (measured in 2020).

Although ADHD has been linked to various aspects of social functioning, its relationship to childbearing remains unexplored. Individuals with ADHD often experience greater difficulties in peer and social relationships, with some studies suggesting stronger impairments among women (Ros & Graziana, 2018; Kok et al., 2016). Previous studies have examined ADHD in romantic relationships, documenting lower relationship satisfaction, more frequent conflict, and higher risks of separation among individuals with ADHD compared to those without (Huynh-Hohnbaum & Benowitz, 2023; Wymbs et al., 2021; Katzman et al., 2017; Klein et al., 2012; Michielsen et al., 2013). Couples where one partner has ADHD are also more likely to have more stress and depression (Ghahramanzadeh et al., 2021). Core ADHD-related challenges—such as difficulties with executive functioning, attention, and impulse control—can lead to forgetfulness and disorganisation, which often

strain partnerships and increase the risk of separation (Hankin, 2001; Robin & Payson, 2002). Such relationship instability may, in turn, reduce opportunities for planned childbearing and contribute to childlessness or smaller family sizes.

Gender differences in ADHD may also shape fertility patterns. ADHD is more commonly diagnosed in males, particularly in adulthood, yet symptom presentation diverges by gender. Boys more often display hyperactivity, impulsivity, and externalizing behaviours, while girls tend to show internalizing symptoms such as anxiety and depression, and academic underachievement (Antoniou et al., 2021). Girls with ADHD have more often risk behaviour such as smoking and teenage pregnancy than their peers (Meinzer et al., 2020; Mikkelsen et al., 2017). This suggests that ADHD may not only influence whether individuals have children but also the timing of childbearing. Evidence from sibling comparison studies indicates that associations between parental ADHD and early parenthood are partly explained by shared genetic and socioeconomic factors (Mikkelsen et al., 2017).

In this study, we extend previous research by examining how ADHD is related to three central fertility outcomes among young adults: (1) the likelihood of having a first child, and (2) the age at first birth. We further assess the role of partnership status and partner's ADHD diagnosis in shaping these associations.

Methods

Data

We use Finnish total population register data for cohorts born between 1982 and 1993 (371,563 women; 387,867 men). The sample is restricted to individuals born in Finland, as for these persons we were able to achieve complete linkage of education, healthcare, and

sociodemographic data throughout the study period. Statistics Finland's Board of Statistical Ethics (TK/2182/07.03.00/2024) and THL’s research license number for medical data is THL/3141/6.02.00/2022) have approved the use of the register data underlying this study. All methods were carried out in accordance with relevant guidelines and regulations. When participants are not contacted, informed consent is not required for register-based studies in Finland.

The main explanatory variable is ADHD, and it is measured using both diagnostic information (ICD-10 codes) from specialised health care registers and data on prescription medication purchases (ATC codes). The ADHD diagnostic information (ICD-10 codes, F90) is derived from the specialised health care registers and the medication information (ATC-codes, N06B) from the prescription register of Social Insurance Institution of Finland. All psychotropic medication is prescribed by clinical doctors, and all persons residing in Finland are entitled to reimbursement for medication expenses by the Social Insurance Institution of Finland, thus increasing the validity of our measure. The partner’s disorders are measured in the same way as the index person’s disorders. In the analysis, ADHD is treated as a time-invariant variable because by nature it is present from birth even though diagnoses come later.

The outcome variables are whether an individual has a first birth and age at first birth. The first birth is measured by having the first child during a given year, coded as a time-varying dummy variable. The age at first birth varies from 16 to 39.

The control variables are year of birth, age, number of partners, own education, and current partnership status. Year of birth is a categorical variable and varies from 1982 to 1993. Age is

a categorical variable and has values from 18 to 39. Own highest education was categorised into basic, secondary (including vocational and general tracks), and tertiary education (including those with a bachelor's degree or higher). Number of partners was the highest partner order at each observation point. For current partnership status, 1 refers to having a partner without ADHD, 2 refers to not having a partner, and 3 refers to having a partner with ADHD. Partnerships are defined as co-residential partnerships, combining both marriages and cohabitations.

Method

We estimated discrete-time (logit) event-history models of first birth using person-year data with age as the time scale. ADHD was measured and treated as time-invariant. We predict the time-varying binary variable ‘birth of a first child’ in time t by mental health disorder status in year t-1. We use similar lagging of covariates for all time-varying variables. To let the association between ADHD and the yearly probability of first birth change with age, we used a cubic spline in age with knots at 23 and 30 (covering ages 18–23, 24–30, and 31–38). The baseline hazard was fully flexible via single-year age indicators. To avoid collinearity with these indicators, we interacted ADHD only with the spline terms and did not include the spline main effects.

All other covariates were entered as fully time-varying. Standard errors were clustered at the individual level. We assessed the importance of the age-varying ADHD effect with a joint test of the ADHD×spline terms and summarized results using age-specific marginal effects and model-implied cumulative probabilities by age.

There are separate stepwise models where we first control only for age and year of birth (M1), then for education (M2), and in the last model additionally for current partnership status and number of partners (M3). This helps us to evaluate the role of partnerships in the association between ADHD and fertility outcomes. We also examined the possible effects of the accumulation of ADHD within couples, by including an interaction term between own ADHD and partner's ADHD status on each outcome variable.

Results

The descriptive results are reported at the end of the observation period, i.e., in 2020, when individuals were aged 27 to 38. Young adults with ADHD were less likely to have children, had lower levels of education, and were less often in partnerships (Table 1). ADHD was associated with a roughly 10 percent higher prevalence of childlessness among both men and women, and with an age at first birth approximately two years younger compared to individuals without ADHD.

Table 1. Descriptive statistics by mental health disorder status and gender at the end of the observation period.

		Women (%)		Men (%)	
		No ADHD	ADHD	No ADHD	ADHD
Child		57	50	44	36
Highest education					
	Basic	6	17	11	25
	Secondary	43	56	55	58
	Tertiary	51	27	34	17

Partnership				
Partner, no				
ADHD	64	39	55	34
No partner	35	57	44	64
P with ADHD	1	3	1	2
	Mean (SD)			
			Mean (SD)	
Number of partners	1.0 (1.0)	0.8 (1.1)	0.8 (0.9)	0.6 (0.9)
Age at first birth	26.7 (4.5)	24.3 (4.5)	27.9 (4.3)	26.4 (4.4)
Number of children	1.2 (1.3)	1.0 (1.3)	0.8 (1.2)	0.7 (1.2)

Note: Min/Max for number of partners is 0 and 9 in all categories. Age at first birth varies from 16 to 39, and number of children from 0 to 9. Age is treated as a categorical variable in the models.

Using discrete time event history models, we found that ADHD was negatively associated with the likelihood of having a first child, with similar effects for men and women in models adjusted for age and birth year (Table 2, Model 1, first birth). Adding education explained part of the negative association for women (Model 2). In the fully adjusted model that also included partnership variables, ADHD was positively related to the likelihood of having a first child (Model 3). In this model, the odds of having a child were almost 10% higher for individuals with ADHD compared to those without ADHD. In addition, having a partner with ADHD was negatively associated with the likelihood of a first birth compared to having a partner without ADHD. The likelihood of having a child was lowest among those without a co-residential partner.

Table 2. ADHD and first birth. Discrete time event history model.

	Men			Women		
	M1	M2	M3	M1	M2	M3
ADHD	0.900*** [0.873,0.928]	0.921*** [0.893,0.950]	1.089*** [1.059,1.120]	0.918*** [0.895,0.942]	0.941*** [0.917,0.966]	1.071*** [1.044,1.098]
Age	X	X	X	X	X	X
Year of birth	X	X	X	X	X	X
Education (ref. Basic)		X	X		X	X
secondary		0.895*** [0.884,0.905]	0.739*** [0.731,0.747]		0.700*** [0.692,0.708]	0.645*** [0.637,0.652]
tertiary		1.230*** [1.215,1.246]	0.877*** [0.867,0.888]		1.107*** [1.094,1.119]	0.948*** [0.937,0.959]
Current partnership status (ref. P without ADHD)						
No P			0.066*** [0.065,0.068]			0.127*** [0.125,0.130]
P with ADHD			0.871*** [0.837,0.907]			0.936*** [0.909,0.965]
Number of partners			1.056*** [1.048,1.063]			1.126*** [1.119,1.132]
N (person-years)	5,906,504	5,906,504	5,906,504	5,627,317	5,627,317	5,627,317

To illustrate the timing and magnitude of the associations, Figure 1 presents the predicted cumulative probability of having a first birth by ADHD status, estimated stepwise across three models. Model 1 controls for year of birth and age, Model 2 additionally includes education, and Model 3 further adjusts for current partnership status and the number of partners.

In the top panels (cumulative probability curves), individuals with ADHD tend to enter parenthood earlier than those without ADHD. Their cumulative curves rise more steeply in the early twenties, showing a higher probability of early first births. However, from the mid-

twenties onward the increase slows down, and by the end of the follow-up the cumulative probability of having a first child is lower among individuals with ADHD. Among men (Figure 1a), the gap between ADHD and non-ADHD groups widens from the late twenties, whereas among women (Figure 1c) the divergence appears slightly earlier.

The bottom panels (Figures 1b and 1d) display these differences directly (ADHD – No ADHD) and demonstrate how the stepwise modelling affects the estimated gap. In the age- and cohort-adjusted models, individuals with ADHD appear slightly more likely to have early first births, but once education and especially partnership status are included, the gap narrows and reverses. The fully adjusted model indicates that from the mid-twenties onward, individuals with ADHD become progressively less likely to have a first child. Together, the results show that ADHD is linked to earlier but ultimately less frequent entry into parenthood, and that much of the disadvantage emerges once differences in education and partnership formation are taken into account.

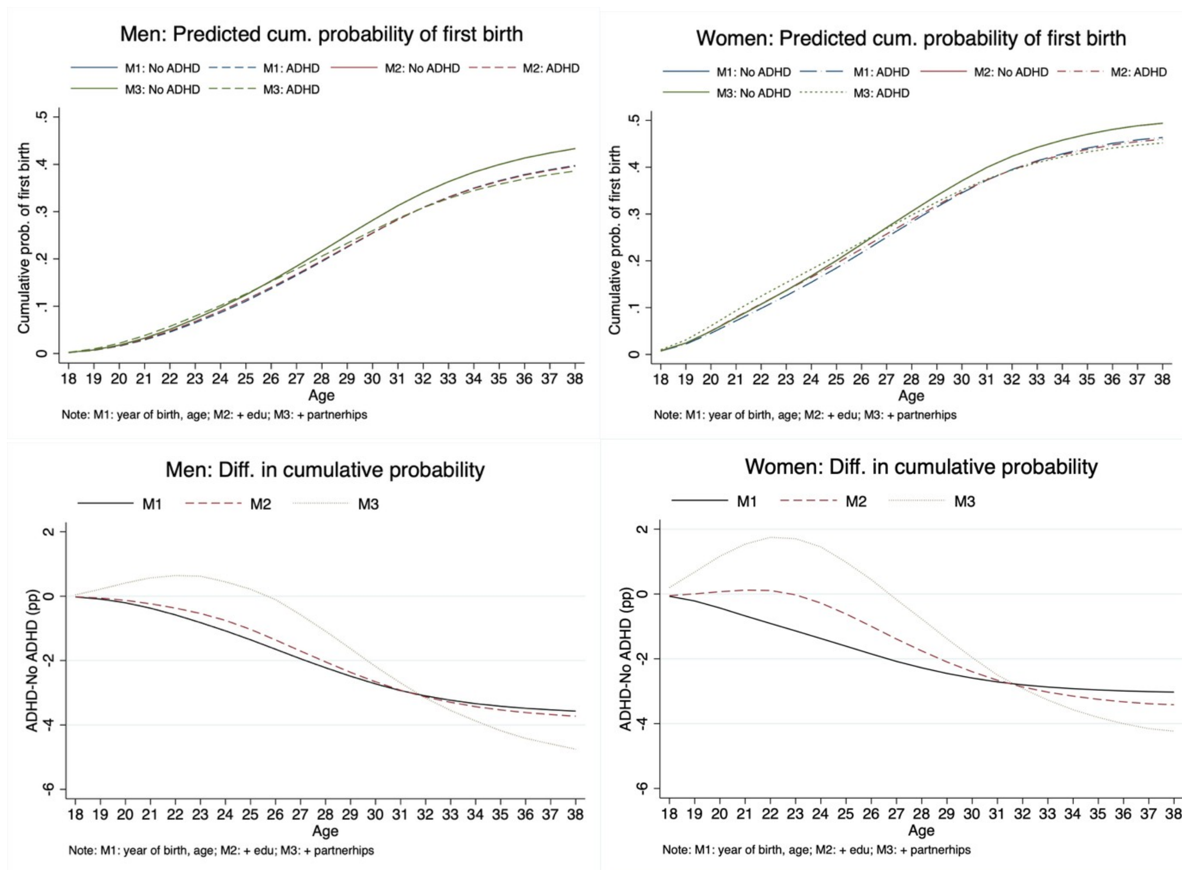

Figure 1. Predicted cumulative probability of having a first birth by age and ADHD status (top) and difference in the cumulative probability of first birth between individuals with and without ADHD (ADHD – No ADHD, in percentage points) (bottom). Estimates are based on discrete-time event history models. M1: age and birth year, M2: M1+education, M3: M2+ current partnership status and number of partners.

Interaction analysis on the accumulation of ADHD within couples

We examined whether the accumulation of ADHD within couples is associated with the likelihood of having a first child (Figure 2). Interaction analyses were conducted between individuals' ADHD status and their partnership status and partner's ADHD status. We found no clear evidence of accumulation effects. However, individuals with ADHD without a co-residential partner had a slightly higher likelihood of having a first child compared to those without ADHD who are partnered, with a stronger association for women.

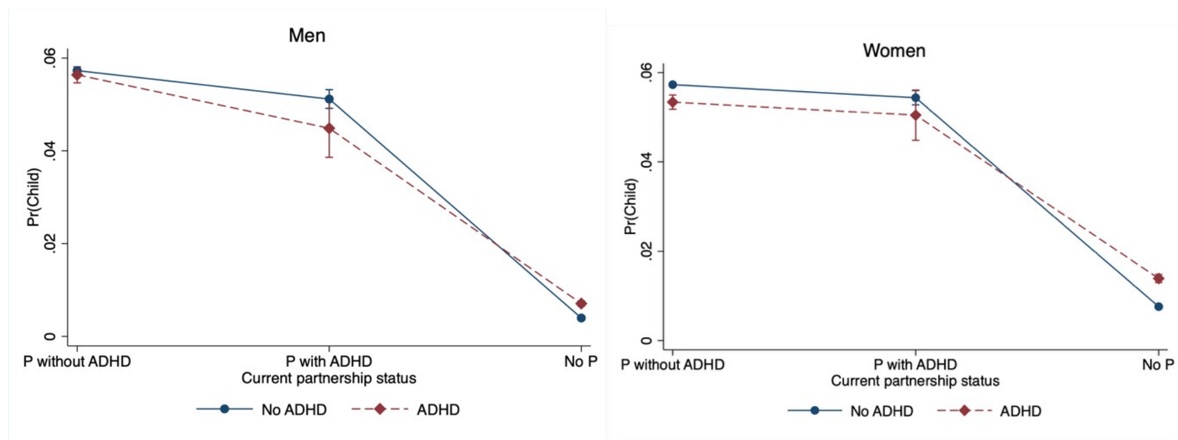

Figure 2. Interaction between own ADHD and partnership status on the first birth (discrete time event history model).

Robustness analysis

We also examined the association between ADHD and the number of children. In models adjusted for age and birth year, ADHD was negatively related to the number of children (Table A1, Model 1). Adding education strengthened the negative association (Model 2). However, in the fully adjusted model that also accounted for partnerships, ADHD was associated with a higher number of children for men, while for women the inclusion of partnership variables fully explained the negative association (Model 3). In the interaction model, we found little evidence of accumulation. Individuals with ADHD outside co-residential partnerships showed a slightly higher number of children which is similar finding compared to likelihood of having a first child (Figure A1).

We also conducted a robustness analysis by examining whether the results remained similar when ADHD was measured for all individuals by age 27. The results were largely unchanged, with only a slight strengthening of the association (Appendix, Table A2 and Figure A2).

Discussion

This study examined how ADHD is associated with fertility outcomes among young adults using Finnish total population register data. The results show that individuals with ADHD are less likely to have children overall and tend to become parents at a younger age than their peers without ADHD. Stepwise analyses revealed that this association is largely explained by partnership dynamics. In models controlling only for age and birth cohort, ADHD was negatively associated with first births, but when education and especially partnership status were added, the association weakened and even reversed. In the fully adjusted model, individuals with ADHD were slightly more likely to have a first child than those without ADHD. These findings suggest that lower fertility among individuals with ADHD primarily reflects reduced rates of partnership formation rather than lower fertility within partnerships.

The stepwise models also highlighted differences in the timing of childbearing. Individuals with ADHD were more likely to enter parenthood early but ultimately remained less likely to have a first child by their late thirties. This pattern indicates accelerated family formation among those with ADHD, followed by a slowdown and lower overall fertility. Once partnership characteristics were included, these differences diminished, suggesting that early parenthood and lower cumulative fertility are both strongly linked to partnership patterns. This finding aligns with research linking ADHD to impulsivity and an increased likelihood of teenage pregnancy (Meinzer et al., 2020; Mikkelsen et al., 2017).

Consistent with previous studies showing that ADHD is associated with interpersonal difficulties and relationship instability (Wymbs et al., 2021; Katzman et al., 2017), the results demonstrate that individuals with ADHD are less often in partnerships and therefore less likely to have children. Importantly, having ADHD does not appear to reduce fertility among those who are in partnerships; rather, lower partnership rates among those with ADHD explain most of the fertility disadvantage. This underscores the role of social and relational factors as key mechanisms connecting ADHD to fertility outcomes.

Interaction analyses provided little evidence that having both partners with ADHD would substantially reduce fertility. Individuals with ADHD outside co-residential partnerships were slightly more likely to have a child than non-ADHD individuals in similar situations. These results mirror findings from previous studies on mood and addiction-related disorders (Kailaheimo-Lönnqvist et al., 2025), suggesting that complex social and behavioural pathways may underlie fertility patterns among those with ADHD.

Robustness analyses confirmed the stability of these findings. Restricting ADHD measurement to diagnoses made by age 27 produced nearly identical results, with only a slightly stronger association. Using the number of children as an alternative outcome yielded similar conclusions: the negative association between ADHD and fertility observed in simpler models was largely explained or reversed once partnership variables were included. Together, these analyses strengthen the conclusion that partnership formation and stability are key mediators of the relationship between ADHD and fertility.

The strengths of this study include the use of comprehensive nationwide register data, objective measurement of ADHD based on diagnoses and medication records, and the ability to link individual and partner characteristics. Nonetheless, several limitations should be acknowledged. ADHD is likely underdiagnosed, especially among women. While partnership status and number of partners were included, information on partnership quality or informal relationships such as living-apart-together unions was not available. Moreover, the analyses covered fertility outcomes only up to ages 27–38, and thus did not capture completed fertility. Future research should examine whether the associations observed here persist across the full reproductive life course once these cohorts reach older ages.

Overall, this study highlights partnership formation as a central mechanism through which ADHD influences fertility. Supporting stable relationships and reproductive health among individuals with ADHD may help reduce fertility disparities. Understanding these dynamics is particularly relevant in light of the rising prevalence of ADHD and its intergenerational transmission.

Funding and acknowledgements

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Appendix

Table A1. ADHD and the number of children. Poisson.

	Men			Women		
	M1	M2	M3	M1	M2	M3
ADHD	-0.141***	-0.148***	0.059***	-0.097***	-0.165***	-0.016
	(0.014)	(0.014)	(0.014)	(0.012)	(0.012)	(0.012)
Age	X	X	X	X	X	X
Year of birth	X	X	X	X	X	X
Education (ref. basic)						
secondary		0.057***	-0.161***		-0.114***	-0.277***
		(0.006)	(0.006)		(0.006)	(0.006)
tertiary		-0.036***	-0.386***		-0.357***	-0.589***
		(0.006)	(0.006)		(0.006)	(0.006)
Current partnership status (ref. P without ADHD)						
No P			-1.391***			-0.874***
			(0.005)			(0.004)
P with ADHD			-0.227***			-0.076***
			(0.021)			(0.016)
Constant	-0.265***	-0.284***	0.363***	171.825***	177.258***	166.937***
	(0.013)	(0.014)	(0.014)	(2.291)	(2.291)	(2.294)
N	375776	375776	375776	357103	357103	357103

Note: The outcome variable, number of children, includes values from 0 to 9, with 0 indicating childlessness.

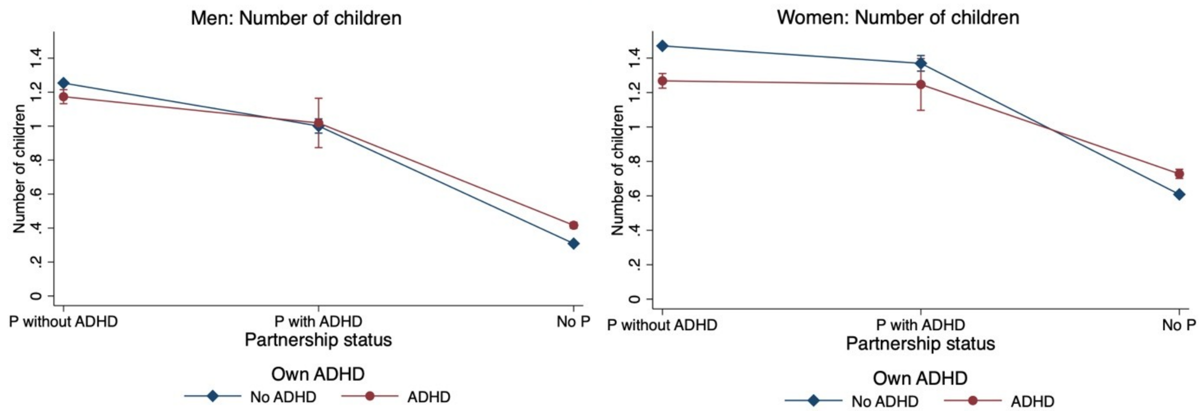

Figure A1. Interaction between own ADHD and partnership status on the number of children (Poisson regression).

Table A2. ADHD and the first birth. ADHD measured by the age of 27. Discrete time event history model.

	Men			Women		
	M1	M2	M3	M1	M2	M3
ADHD	0.854*** [0.811,0.900]	0.872*** [0.828,0.918]	1.130*** [1.078,1.185]	0.833*** [0.790,0.878]	0.842*** [0.798,0.887]	1.043 [0.991,1.099]
Age	X	X	X	X	X	X
Year of birth	X	X	X	X	X	X
Education (ref. Basic)		X	X		X	X
secondary		0.895*** [0.884,0.905]	0.738*** [0.730,0.746]		0.699*** [0.692,0.707]	0.644*** [0.637,0.651]
tertiary		1.231*** [1.215,1.247]	0.877*** [0.866,0.887]		1.107*** [1.094,1.119]	0.947*** [0.936,0.958]
Current partnership status (ref. P without ADHD)						
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P with ADHD			0.874*** [0.839,0.909]			0.940*** [0.912,0.968]
Number of partners			1.056*** [1.048,1.063]			1.126*** [1.119,1.133]

N (person-years)	5,906,504	5,906,504	5,906,504	5,627,317	5,627,317	5,627,317

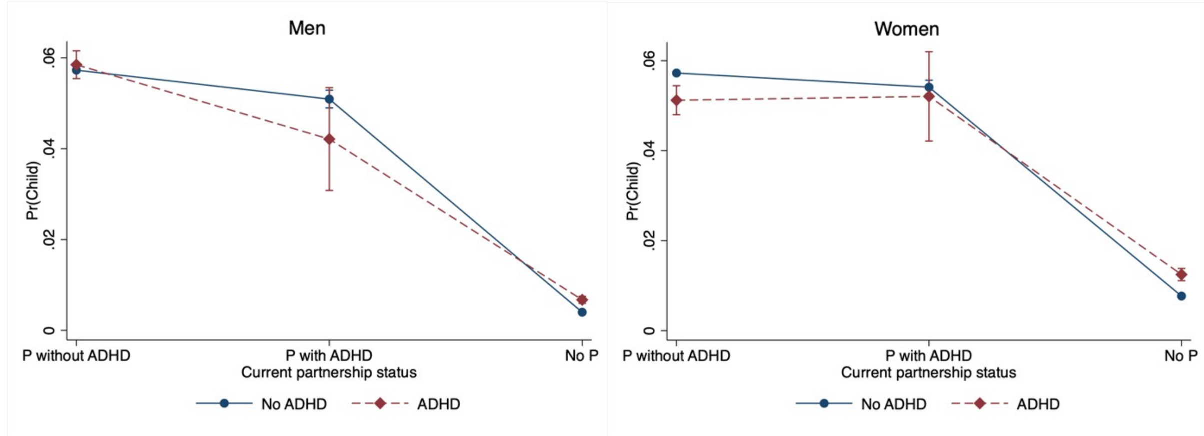

Figure A2. Interaction between own ADHD and partnership status on the first birth (discrete time event history model). ADHD measured by the age of 27.