

Life With a Partner with ADHD: The Moderating Role of Intimacy

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Abstract Adult attention deficit and hyperactivity disorder (ADHD) manifests itself through a variety of symptoms, some of which affect not only occupational and recreational activities but also intimate relationships. Previous findings have focused on the effects of adult ADHD on intimacy and relationships from the ADHD diagnosed person's point of view. However, spouses of people with ADHD are a neglected population with regard to the effects that ADHD has on their romantic relationships. Our aim was to assess the effects of being married to a spouse with ADHD on marital relationships, and the moderating role of intimacy. We compared healthy spouses of people with ADHD to healthy spouses of healthy adults ($M = 38.23$, $SD = 4.78$) in their degree of self-reported intimacy and marital satisfaction. Our findings indicate that spouses of individuals with ADHD report significantly lower intimacy and lower marital satisfaction compared to spouses of individuals without ADHD. Moreover, our findings indicate that spousal reports about their degree of intimacy mediate the relationships between their spouses' ADHD and their marital satisfaction. Results are discussed in relation to the broad implications that adult ADHD has for romantic intimacy. Our research addresses healthy partners married to a spouse with ADHD, suggesting that living with a partner with ADHD behaviors is challenging. ADHD symptoms negatively affect various qualities in the person experiencing them, but of equal

importance is the damage occurring to his or her spouse. Implications for future research and recommendations for clinical work are suggested.

Keywords ADHD · Attention deficit and hyperactivity disorder · Intimacy · Marital satisfaction · Adult ADHD

Introduction

Until recently, attention deficit/hyperactivity disorder (ADHD) was considered an affliction affecting children and adolescents. However, recent studies have documented the prolonged effects of ADHD throughout adulthood, expressed in various aspects of life (Biederman et al. 2012). ADHD is the most common neuro-behavioral disorder in childhood, affecting 5% of school children, and is more common among boys than girls (American Psychiatric Association [APA] 2013; Willcutt 2012). ADHD is a genetically based disorder often assessed during childhood and is related to lower levels of the neurotransmitter dopamine in the brain (e.g., Cook et al. 1995; Qin et al. 2016). Its symptoms manifest themselves in three major areas: inattention, hyperactivity and impulsivity (Bilkey et al. 2014). Long-term follow-up studies of children with ADHD report that the disorder persists in adults (Biederman et al. 2012; Wender et al. 2001). Despite these reports, there is still a debate about the prevalence of adult ADHD, mainly because of the differences in symptom manifestation from childhood to adulthood and differences in the characteristics of the samples and measurements in various studies (Sibley et al. 2012). A recent review noted that a variety of emotional and care needs are neglected when studying

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adolescents with ADHD and their transition to adulthood (Treuer et al. 2016).

Various symptoms of hyperactivity decline in adulthood, but impulsivity and deficits related to executive functioning typically become more pronounced, because the demands for self-control increase with age (Resnick 2005). Executive functioning is an umbrella term used to describe a variety of cognitive processes, including planning, working memory, attention, inhibition, self-monitoring, self-regulation, and initiation, carried out by the prefrontal areas of the frontal lobes (Goldstein et al. 2014). Barkley (2011) defined executive functioning as a “self-directed set of actions intended to alter a delayed outcome” (p. 11). He emphasized the importance of self-regulation, a term encompassing the working memory, management of emotions, problem solving, and analysis and synthesis needed to accomplish new behavioral goals.

Many adults are diagnosed for the first time during adulthood, often following their children’s diagnosis with ADHD. Thus, impaired functioning because of ADHD symptoms and appropriate treatment options are often unfamiliar to them, leading to a poor quality of life (Koemans et al. 2015). About 4% of adults are estimated to have ADHD symptoms (Polanczyk et al. 2014), which often include procrastination, disorganization and forgetfulness, even while engaging in activities they enjoy. Hyperactivity is most likely experienced as tension and restlessness (Resnick 2005), sleep disturbances and time management difficulties (Bilkey et al. 2014). Impulsivity may lead to unpleasant situations such as driving wildly, unprotected sex that can lead to unwanted pregnancies, verbal outbursts that impede communication, economic splurges leading to overspending or interpersonal impulsivity expressed in angry outbursts and impatience. Concomitant outcomes may include the inability to deal with stress, affective lability and the avoidance of deadlines (Resnick 2005). As a result of their executive deficits, adults with ADHD may find it hard to hold onto a job, because they have difficulty with routine tasks and have poor organizational skills with regard to both time and money (Wolf and Wasserstein 2001).

ADHD may also be reflected in social and family relationships. According to Barkley (2010), a very specific impairment in executive functioning may be responsible for a set of interpersonal difficulties, causing impaired inhibition and emotional self-regulation. The need for stimulation often results in arguing over unimportant matters as a way of providing physical and emotional excitement. Unfortunately, the need for stimulation serves both the ADHD partner’s hypersensitive nature and the non-ADHD partner’s need for control—a risky combination that may result in a breakdown in communication or serious conflict (Betchen 2003). Under-stimulation may also lead to self-stimulation by seeking conflict and provoking others (Robbins 2005).

Therefore, interpersonal confrontations are often brief and intense (Resnick 2005). Inattentiveness may result in listening to only parts of the conversation with significant others. Distraction and forgetfulness may also impair the feeling of being important to one’s partner. Impulsivity may result in interrupting conversations, impulsive decision-making or impulsive spending (Robbins 2005). Distractibility, impulsivity, sensitivity, over-reactivity, a focus on oneself and overall poor self-regulation can interfere with learning to read and interpreting social cues accurately, a crucial component of developing social skills (Robbins 2005). Indeed, studies have established that higher levels of ADHD symptomology in college students are related to increased social impairment but not to satisfaction with romantic relationships (Saccetti and Lefler 2014). Children and adolescents with ADHD are less liked and more rejected by their peers, due to multiple factors including their disruptive behavior, which others interpret as self-centered, intrusive, domineering and hostile (Zambo 2008). A recent study using social network analysis among elementary school children found that a higher degree of ADHD symptomology is correlated with poorer relationships with peers and an increased likelihood of the youngsters being regarded as outsiders among their classmates (Kim et al. 2015). Students are more hesitant to initiate social relationships with ADHD classmates, and women are less likely to engage in casual or steady dating with male ADHD partners (Canu et al. 2008).

The home environment has a two-fold relationship with the functioning of adults with ADHD. On one hand, the noise and chaos typical of the family environment can be over-stimulating for adults with ADHD, who need an orderly and clutter-free environment in order to function properly. On the other hand, the tendency of ADHD adults to take on too many activities and not manage their time properly can intensify an already stressful environment by creating problems of time management, lateness and the lack of time left to recuperate from life’s daily stresses (Robbins 2005). Executive deficits may also result in organizational and memory problems, evident in piles of unfinished laundry, lost keys, missed events and unpaid bills, and boredom during routine chores such as washing dishes or paying bills (Bilkey et al. 2014), contributing to conflicts with spouses (Robbins 2005). All of these outcomes may impair the sense of intimacy in close relationships. Halverstadt (1998) pointed out that the outcomes of ADHD may cause concerns about being a significant person to one’s spouse. Feeling unimportant and neglected because of unattended chores may contradict the need to “know that we are significant enough to each other that our wants, needs and desires are being heard” (p. 106).

Intimacy is a crucial component of healthy romantic relationships. Sternberg (1997) defined intimacy as one of

the three components that create love. Pedersen (2004) extended this definition, stating that intimacy is a profound element in emotional alliances, expressed in the desire to be one with another, enjoy his or her presence, share the difficulties of life and provide mutual support. The quality of a couple's intimacy is a major contributor to overall marital satisfaction throughout the lifespan of the relationship (Greeff and Malherbe 2001). Betchen (2003) underscored the many ADHD symptoms that interfere with intimacy between couples. They may have trouble sitting still while their partners speak and may also have difficulty refraining from verbally interrupting their partners or keeping their hands off them.

Years of criticism and rejection from parents, teachers and peers may lead to low self-esteem, which also contributes to the development of relationship deficits (Robbins 2005). A history of rejection by peers and partners may result in a fear of intimate relationships and criticism, because they do not want to be hurt (Marton et al. 2015). Studies conducted in the US and China demonstrated that the greater the number of symptoms of ADHD, the greater the fear of intimacy. Specifically, those with more symptoms of ADHD reported more concerns about intimacy when reflecting on past relationships, suggesting that difficulties in past interpersonal relationships may lead people to develop fears about future relationships. Fear of intimacy was strongly related to symptoms of inattention, which were also related to a reduced belief in intimacy (Marsh et al. 2015).

Difficulties in maintaining relationships may lead to divorce, and multiple marriages are not uncommon among adults with ADHD (Wasserstein 2005). Canu and Carlson (2007) reported less satisfaction with their relationships among individuals with inattentive type ADHD and their partners. In a university sample, subclinical inattentive symptoms of ADHD were associated with lower levels of romantic satisfaction. Interestingly, those symptoms were also associated with maladaptive self-talk in their intimate relationships, such as telling themselves they were stupid or a failure (Overbey et al. 2011). Novotni and Petersen (1999) also noted that disrupted relationships in adults with ADHD result in part from misattributions related to ADHD symptoms. For example, being late because of the inability to manage time is attributed to a lack of caring and selfishness. A study assessing co-parenting relationships indicated that whereas mothers' ADHD symptoms were not related to the functioning of the couple, fathers' ADHD symptoms were associated with their negative attributions of their wives' behavior (Williamson and Johnston 2013).

Halverstadt (1998) noted that because the ADHD partner craves stimulation, he or she will gravitate toward three types of partners: someone who is stimulating, someone with whom they can "co-stimulate" or someone who can

tolerate their stimulation-seeking behavior while providing the stability in the relationship, which seems to be the most pervasive case. The ADHD partner may then perceive the non-ADHD partner as too rigid, demanding, controlling, and critically parental, and the non-ADHD partner often comes to see the ADHD partner as contrary and rebellious. The more the non-ADHD partner complains, the more distant, resentful or oppositional the ADHD partner may become, and vice versa. Some adults with ADHD develop co-dependent relationships, wherein they become overly submissive to a controlling and highly organized partner. Therefore, mutual resentment and misunderstanding of the underlying forces frequently occur (Wasserstein 2005). ADHD also affects sexual activity, with couples reporting sex with an ADHD-impulsive partner as too rough, fast-paced and painful, with a tendency to skip foreplay and proceed directly to intercourse. ADHD hypersensitivity may also cause intimate behaviors such as caressing to be perceived as unpleasant, and the tendency to become bored may easily lead to affairs and risky sexual behaviors (Betchen 2003).

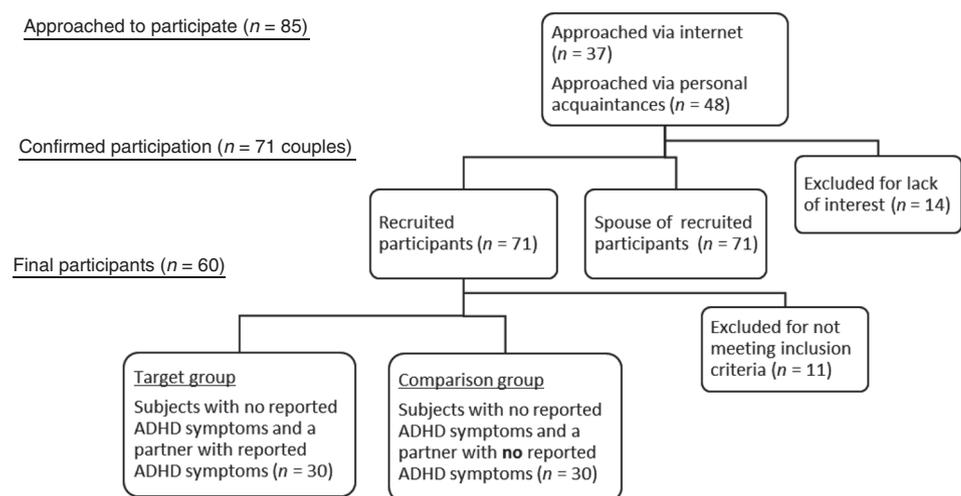
The aim of the current study is to investigate the quality of the relationships of participants whose spouses have ADHD symptoms. Based on the research noted above, we hypothesized that the spouses of those individuals with ADHD would report lower levels of marital satisfaction and intimacy than the spouses of those without ADHD. We also hypothesized that intimacy would mediate the relation between the spouse's ADHD and marital satisfaction.

Method

Participants

Sixty Israelis volunteered to participate in the study, 28 males and 32 females, aged 30–53 years ($M = 38.23$, $SD = 4.788$). All of the participants were heterosexual, married and parents to at least one child. With regard to education, 23.3% of the participants had a high school education, and 76.6% held an academic degree. None of the participants had ADHD, a fact we established through their scores on Conner's Adult ADHD Assessment Questionnaire (CAARS). Based on the responses to this questionnaire, we also determined that 30 of the participants were married to a partner with self-reported ADHD symptoms. Of these partners, 11 had also been previously diagnosed by a neurologist, thus validating this assessment. There were no differences in the CAARS scores between those who had been diagnosed by a neurologist and those who had not. Nine of the partners were taking pharmacological treatments for ADHD on a regular basis. The rest of the sample (30 participants) consisted of individuals who were married

Fig. 1 Sampling and flow chart of participants through the experiment



to a partner who did not report ADHD symptoms on the questionnaire. Men and women were equally distributed between the groups (56.7% women in the group married to a partner with ADHD, 50% women in the control group, n.s.).

Procedure

Initially, 85 participants were approached to participate in the study. The criteria for inclusion were that they be heterosexual, married and had children. We solicited potential participants through advertisements online and on social networks such as Facebook (43.5% of participants) and through a snowball method of recruitment (56.5% of participants). Seventy-one participants agreed to participate in the study (83.5% response rate). The researchers then met with all of them and their spouses individually (overall 142 participants). After signing an informed consent form, all of the participants and their spouses completed the CAARS questionnaire individually. Participants and their spouses who both reported having ADHD symptoms were excluded from the study. Of the remaining 60 original participants and their spouses (overall 120 participants), those who did not have ADHD symptoms but whose partners did report ADHD symptoms were considered the target group. Those who did not report having ADHD symptoms nor did their spouses were considered the comparison group, whereas the original participants targeted were considered our reference group. Sampling and flow of participants through the experiment is detailed in Fig. 1. We then asked all of the 60 original participants to answer the questions on the Marital Adjustment Scale, an intimacy questionnaire and a demographic questionnaire using paper and pencil. Upon completing the questionnaires, the participants were debriefed.

Measures

CAARS-conner's adult ADHD assessment questionnaire

(Erhardt et al. 1999). In order to determine whether the participants and their spouses had ADHD symptoms, we used the DSM-IV-based questionnaire following the Israeli Ministry of Health's instructions for adult ADHD diagnosis. Their responses to the questions were made on a Likert scale ranging from 0 to 3. The alpha coefficients in the original validation ranged from .86 to .92. The overall diagnostic efficiency rate was 85% (rate of accurately diagnosing ADHD). Unfortunately, the alpha values for the current CAARS sample were not available. Sample items include: "Do you find it difficult to pay attention to details?" and "Are you distracted easily?" We adapted the cutoff score to the DSM-V diagnosis, namely, at least five symptoms of inattention and/or at least five symptoms of impulsivity/hyperactivity. To this questionnaire we added the questions: "Did you ever go through a formal diagnosis for ADHD?" and "Are you using any pharmacological treatments for ADHD and if so, in what dosage?"

MAT-marital adjustment scale (shortened version)

In order to assess marital satisfaction, the participants were asked to complete a questionnaire developed by Locke and Wallace (1959, reassessed for psychometric properties in Jiang et al. 2013). The questionnaire included 15 items, in 9 of which the participants ranked their agreement with the statements on a Likert scale ranging from 5 to 15 points. For the remaining six items, the participants answered three questions, each scored differently. The total score could range from 2 to 158. The alpha for internal consistency was .90, and in this study, it was .80. Higher scores indicated greater satisfaction. A sample item is: "If you had to live

Table 1 Significant univariate effects for the ADHD and comparison groups in their MAT and intimacy scores

Measure	Group	<i>M</i>	<i>SD</i>	<i>F</i> (1,58)	<i>p</i>	<i>SE</i>	95% CI
MAT score	ADHD	91.4	23.2	35.9	<.001	3.83	[83.8, 99.1]
	comparison	123.8	18.4				[116.2, 131.5]
Intimacy score	ADHD	169.1	20.3	29.8	<.001	3.08	[162.9, 175.2]
	comparison	192.8	12.4				[186.6, 199.0]

Note. CI confidence interval

your life over from the beginning, would you be married to the same spouse, married to another person or not married at all?"

Intimacy questionnaire

Participants were asked to indicate the degree to which they agreed with the 36 items on Sharabany's (1994) questionnaire on a Likert scale ranging from 1 to 6. We totaled the points for each participant, which could range from 36 to 216. The internal consistency was .86. Sample items include: "I tell her if I did something others wouldn't like" and "I know how she feels about things without her telling me."

Demographic questionnaire

Participants were also asked to provide us with details about their age, education, marital status, children, and occupation.

Data Analyses

The preliminary analysis consisted of hierarchical regressions to identify the associations among the research measures and a MANOVA to examine the differences between the participants married to a partner with self-reported ADHD compared to those married to a partner without ADHD symptoms. Based on previous findings indicating that the degree of intimacy may be linked to marital satisfaction, a mediation model was tested using Preacher and Hayes' (2008) bootstrapping method with 5000 resamples with replacement. Bootstrapping was used instead of Sobel testing or the Baron and Kenny (1986) mediation technique, because it provides a more reliable estimate of indirect effects, does not assume normality, and evaluates total, direct, and indirect effects (Preacher and Hayes 2008). Bootstrapping also has higher power and better Type I error controls than other mediation analyses. It tests the intervening variables' indirect effect on the entire model and does not require the interpretation of each path. Instead, we determined significance by examining the 95% confidence interval produced by the bootstrapping mediation analyses. In order for the mediation model to attain significance, the

confidence interval must not include zero. This approach has two advantages over alternative methods of testing mediation. First, multiple mediating variables can be assessed simultaneously. Second, bootstrapping methods can generate confidence intervals for estimates of the product of the a and b model coefficients for the indirect or mediated effects.

Results

Initially, a MANOVA was used to compare the target group (partner with self-reported ADHD) and comparison group (partner without ADHD symptoms) with regard to two dependent variables, namely, their MAT score and their intimacy score. The multivariate result was significant, $F(2, 57) = 20.07$, $p < .001$; Wilk's $\Lambda = .59$, partial $\eta^2 = .41$, indicating a difference between the target group and comparison group in their MAT and intimacy scores. The univariate F tests showed there was a significant difference between the target group and comparison group for MAT, $F(1, 58) = 35.88$, $p < .001$, partial $\eta^2 = .38$, and intimacy, $F(1, 58) = 29.75$, $p < .001$, partial $\eta^2 = .34$. As expected, the target group reported lower levels of MAT and intimacy in their relationships than the comparison group. Table 1 presents the significant univariate effects for the target and comparison groups with regard to their MAT and intimacy scores ($N = 60$).

To assess the relation between the spouse's self-reported ADHD and marital satisfaction, a hierarchical regression was conducted with ADHD diagnosis, gender, age and pharmacological treatment as dummy variables, and marital satisfaction as the dependent variable. As Table 1 illustrates, in the first step only the spouses' self-reported ADHD significantly predicted their spouses' marital satisfaction (adjusted $R^2 = .29$, $p < .001$, $\beta = .57$). In the second step we added intimacy as a predictor. This step better predicted marital satisfaction, with adjusted $R^2 = .59$, $p < .001$, and ADHD ($\beta = .25$, $p = .01$), and intimacy ($\beta = .65$, $p < .001$) both significantly predicting marital satisfaction. A between-groups comparison of the demographic variables of the target and comparison groups indicated no significant differences in age, $t(58) = -.48$, $p = \text{n.s.}$, educational

level, $U = 420, p = \text{n.s.}$, or gender prevalence, $X^2(1) = .27, p = \text{n.s.}$

In order to examine whether ADHD's effect on the MAT and intimacy scores differed according to gender, a second MANOVA test was assessed, with gender as an additional independent variable. This two-way MANOVA testing indicated a significant main effect for ADHD, $F(2, 55) = 21.43, p < .001$; Wilk's $\Lambda = .56$, partial $\eta^2 = .44$, replicating the significant results of the first MANOVA, as well as a significant interaction between ADHD and gender, $F(2, 55) = 3.62, p < .05$; Wilk's $\Lambda = .88$, partial $\eta^2 = .12$. The effect of gender alone was not significant. The univariate F tests of the interaction effect on each of the dependent variables separately indicated a significant effect for intimacy, $F(1, 56) = 7.28, p < .01$, partial $\eta^2 = .12$ but not for the MAT score, $F(1, 56) = 3.21, p = .08$, partial $\eta^2 = .05$. Figure 2 illustrates the significant interaction effect for intimacy in detail ($N = 60$). A between-groups comparison showed that ADHD has a stronger effect on women's intimacy than on that of men. For women, an ADHD diagnosis led to lower intimacy ratings than in the comparison group, $F(1, 30) = 34.96, p < .001$. For men, a similar but less dramatic effect was evident, $F(1, 26) = 4.44, p = .045$.

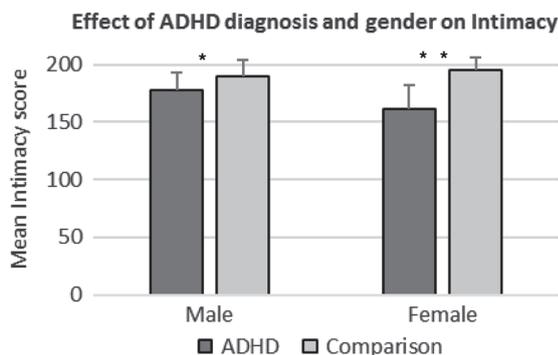


Fig. 2 Interaction effect on intimacy score as a function of group (ADHD or comparison) and gender. * $p < .05$; ** $p < .01$

To determine whether intimacy accounted for the relation between the spouse's ADHD and marital satisfaction, a mediation analysis was performed using the bootstrapping method with bias-corrected confidence estimates (MacKinnon et al. 2004; Preacher and Hayes 2004). We obtained a 95% confidence interval of the indirect effects with 5000 bootstrap resamples (Preacher and Hayes 2004).

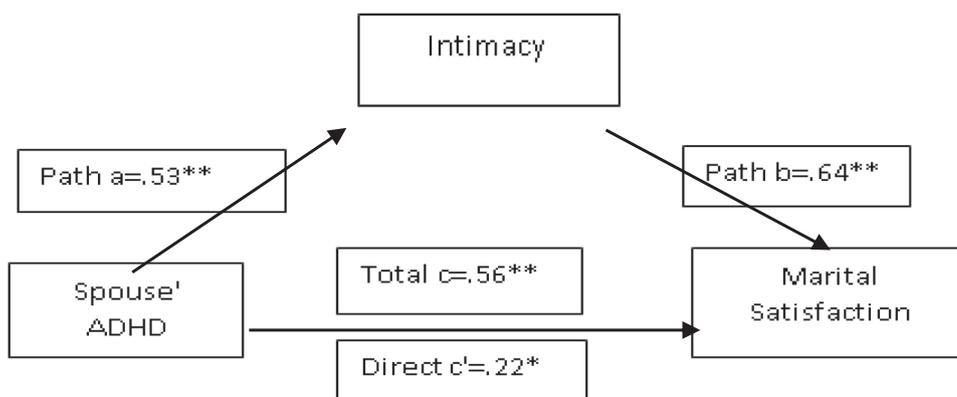
We determined that ADHD symptoms were negatively associated with the degree of intimacy with one's spouse ($B = 21.56, t = 4.74, SE = 4.55, p < .001$). In addition, ADHD symptoms were negatively related to the spouse's marital satisfaction ($B = 11.70, t = 2.28, SE = 5.14, p < .05$). As illustrated in Fig. 3, we also established that the degree of intimacy had a significant mediating effect on the relation between ADHD symptoms and the spouse's marital satisfaction (indirect effect = 17/66, $SE = 5.26, 95\% \text{ CI} = [\text{LLCI} = 8.20, \text{ULCI} = 28.45]$).

Discussion

This study assessed the quality of life of people living with a partner with self-reported ADHD. As hypothesized, both marital satisfaction and intimacy were independently related to self-reported ADHD in one's spouse, indicated by reduced levels of intimacy and less marital satisfaction. These results confirm previous findings documenting the far-reaching effects that ADHD has on adults in their romantic relationships (Halverstadt 1998; Robbins 2005). However, we also established that the degree of intimacy between the spouses mediated the relation between self-reported ADHD and the spouse's marital satisfaction, indicating that the couple's degree of intimacy could mediate the negative effects of the ADHD symptoms, leading to more (or less) satisfaction with the marriage.

Previous findings have focused on the effects of adult ADHD on intimacy and relationships from the ADHD diagnosed person's point of view, demonstrating their negative effects on these areas compared to adults without

Fig. 3 Indirect effect of spouses' ADHD on marital satisfaction through intimacy (beta scores)



ADHD (e.g., Resnick 2005). However, very few studies have dealt with the spouses without ADHD. This research addresses this neglected group, suggesting that living with a partner with ADHD behaviors is challenging. Many adults with ADHD have never been diagnosed, so they have not received confirmation of or information about the effects of their symptoms on their quality of life or been offered appropriate treatment.

Interestingly, this study's results indicated that a spouse's ADHD has a stronger effect on the feelings of intimacy among women. Women married to a spouse with ADHD symptoms scored lower on intimacy ratings than women married to a spouse without ADHD. In contrast, for men this difference was more moderate. This finding is in line with other studies indicating that various medical and psychiatric diagnoses in the family affect women more strongly than men. Examples include intellectual disabilities (Olsson and Hwang 2001, 2002; Singer 2006), congestive heart failure (Rohrbaugh et al. 2002), severe physical disabilities (Trute et al. 2012) and cancer (Northouse et al. 2000).

Betchen (2003) defined intimacy as "an ongoing process involving two mates who have achieved a healthy degree of differentiation (emotional autonomy) from their respective families of origin, which, in turn, contributes to their abilities to be in touch with their feelings and to express these feelings freely, clearly, and rationally without fear of or actual consequence from the partner" (p. 104). Marital satisfaction in itself is considered one of the most important predictors of divorce and the stability of a marriage over time (e.g., Gottman and Levenson 2000). It is related to various intrapersonal variables such as physical functioning and health problems (Gharibi et al. 2016), stress management (Zarch et al. 2014), cognitive appraisals of marriage (Boerner et al. 2014) and integrative self-knowledge (Ghorbani et al. 2015), as well as to interpersonal variables such as interpersonal problems (Ghorbani et al. 2015), parent-child interactions (Bernier et al. 2014) and predictions of divorce (Gottman and Levenson 2000). Therefore, both intimacy and marital satisfaction are crucial factors in determining the quality of a relationship and of life, and have mutual effects. Thus, the reduction in intimacy related to a partner's ADHD symptoms can significantly impair both partners' quality of life, leading to a reduction in marital satisfaction.

Focusing on the non-ADHD partner married to a spouse with self-reported ADHD captures the generalizability of this effect. ADHD symptoms negatively affect various qualities in the person experiencing them, but of equal importance is the damage occurring to his or her spouse. This study targeted a neglected group—spouses of adults with ADHD symptoms. Despite its important findings, it has a few limitations. First, given that the study aimed at exploring a new direction, sample size was relatively small.

Future studies should examine a larger sample of spouses. Furthermore, in accordance with previous studies, we assessed ADHD through self-report questionnaires without collecting childhood histories (for a review, see Sibley et al. 2012). Even though some of the current self-reports were partially validated with neurological examinations, future studies should conduct a thorough evaluation that includes further neurological diagnosis.

Future research should also examine both spouses—with and without ADHD—to establish the complicated marital patterns related to this unique couple. Another limitation is that we used only one measurement at one point in time. Future studies should perform follow up examinations in order to determine causal effects and stability vs. changes in the levels of satisfaction. Unfortunately, data was not obtained regarding the number and age of the participants' children, so we could not explore the effect of their number and age along with an ADHD diagnosis on the parents' marital relationships. Future studies may address these questions as well. Finally, we used self-report questionnaires. Interviews with couples and individuals, along with naturalistic observations, can also improve our understanding of people's marital quality of life.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interests.

Ethical approval All procedures performed in the study involving human participants were in accordance with the ethical standards of the institutional committee and with the 1964 Helsinki declaration and its later amendments.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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