THE ROMANTIC RELATIONSHIPS OF ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts

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2013

Abstract

The present study compared the romantic relationships of adolescents with and without Attention-Deficit/Hyperactivity Disorder (ADHD) with regard to romantic involvement, partner identity, relationship content, and relationship quality. A community sample of 58 participants (30 ADHD, 28 Comparison), ages 13-18, completed a standardized battery of questionnaires. Adolescents with ADHD reported having more romantic partners than their typically developing (TD) peers. Females with ADHD were found to have shorter romantic relationships than TD adolescents while males with ADHD reported their age of first intercourse to be nearly two years sooner than TD peers. Irrespective of gender, adolescents with ADHD had nearly double the number of lifetime sexual partners. When choosing a romantic partner, adolescents with ADHD placed less importance on aspects of their partner’s academic and social competence than TD adolescents. However, the romantic relationships of adolescents with and without ADHD did not differ on levels of aggression and relationship quality.
Acknowledgements

Foremost, I would like to thank my loving and devoted wife, Laura Arlabosse-Stewart, for urging me to chase my dream even when it seemed unattainable. Thank you to my family, Batia Tarrab, Luis Rokeach and Gaby Rokeach, for inspiring me to aim higher and persevere in spite of my missteps. I would like to express my sincere gratitude to my supervisor, Judy Wiener, for her ongoing support, guidance, and taking a chance on me when others would not. Thank you to my lab mates, Vicky Timmermanis, Daniella Biondic, Ashley Brunsek, Jill Haydicky, Angela Varma, Clarisa Markel, Gladiola Musabelliu, Heidi Pokroy, and Gwyneth Hodgins, for your encouragement, advice, and making our lab such an enjoyable environment to work in. Thank you to Katreena Scott, for your thorough reading of my thesis, constructive comments, and detailed suggestions on how best to improve it. Finally, thank you to all the participants who took the time out of their busy schedules to make this research possible.
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1. Introduction

The overall purpose of the present study is to explore the romantic relationships of adolescents with Attention-Deficit Hyperactivity/Disorder (ADHD). Romantic relationships are a hallmark of adolescence (Collins et al., 2009). By late adolescence, more than 70% of teens have been involved in at least one romantic relationship (Carver et al., 2004; Furman, Low, & Ho, 2009) and rely primarily on their romantic partner, rather than their peer group, for support (Kuttler & La Greca, 2004). Romance is also at the forefront of adolescents’ minds; 34% of girls and 25% of boys attribute their strong emotions to romantic relationships (Wilson-Shockley, 1995) and spend between five and eight hours each week thinking about actual or potential romantic partners (Richards, Crowe, Larson, & Swarr, 1998). These proportions are considerably larger than those attributed to school, peers, and family (Brown, 1999). Yet, until recently, adolescent romance had not garnered much interest from the scientific community.

Currently, empirical studies of romantic relationships in adolescence are burgeoning. No longer are these relationships erroneously viewed as trivial and ephemeral. Instead, they are increasingly regarded as a significant factor in adolescent development and subsequent adult functioning (Furman & Shaffer, 2003; Giordano et al., 2006). Healthy romantic relationships may buffer negative outcomes and are associated with several positive aspects of development, including forming a personal identity, promoting harmonious relationships with peers, adjusting to changes in family relationships, shaping positive romantic relationships in adulthood, and lowered levels of adult psychopathology (e.g., Furman & Collins, 2008; Wolfe et al., 2006). Poor-quality romantic relationships, however, have been linked with alcohol and drug use, exposure to violence in relationships, increases in externalizing and internalizing symptomatology, academic underachievement, and an inadequate rubric for adult relationships
(Zimmer-Gembeck et al., 2004; Woodward et al., 2002). While the last decade has seen a marked increase in the number of studies examining the romantic relationships of typically developing (TD) adolescents, less is known about the nature of romantic relationships in adolescents with various psychopathologies such as ADHD.

Although ADHD is conceptualized as a neurobiological disorder (Kieling, Gonclaves, Tannock, & Castellanos, 2008), it is diagnosed on the basis of significantly impairing and age-inappropriate behavioural symptoms of inattention and/or hyperactivity/impulsivity (American Psychiatric Association [APA], 2000). Approximately 5% of school-aged children have ADHD (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007; Willcutt, 2012) and it represents one of the most common referrals for mental health and paediatric services (Barkley et al., 2004). Moreover, ADHD predicts a highly dispersed pattern of impairment across behavioral, affective, academic, social, and family domains (e.g., Hoza, 2007; Jensen, Hinshaw, & Kraemer, 2001; Johnston & Mash, 2001; Pliszka, 2000). While ADHD was once considered a disorder of childhood, longitudinal research indicates that its symptoms and negative effects often persist well into adolescence and adulthood (Biederman, Petty, Evans, Small, & Faraone, 2010). The arrival of adolescence brings about new domains of potential impairment for individuals with ADHD, such as risky driving (Fischer, Barkley, Smallish, & Fletcher, 2007), substance use (Lee et al., 2011), risky sexual behaviour (Flory et al., 2006; Barkley, Murphy, & Fischer, 2010), and potentially, poor-quality romantic relationships.

It is well documented that, when compared to other youth, the presence of ADHD in childhood and adolescence is associated with disturbances in family functioning, peer rejection, and lower quality friendships (e.g., Bagwell et al., 2001; Johnston et al., 2001; Wehmeier et al., 2010). Moreover, an ever-growing body of research now illustrates that adolescent experiences
with parents and peers are important precursors of romantic relationship quality in young adulthood (Collins & Van Dulmen, 2006; Connolly, et al., 2000; Seiffge-Krenke, 2003). Individuals with ADHD tend be forgetful, disorganized, distracted, and fail to meet their responsibilities. In addition, they may be more impulsive, explosive, and more likely to have verbal and physical outbursts than their TD peers (Barkley, 2006). It is therefore not unreasonable to expect that such characteristics and behaviours may detrimentally impact their romantic relationships. Surprisingly, the link between romantic relationships and individuals with ADHD has received little empirical attention to date and even less is known about the romantic relationships of adolescents with ADHD.

In part, the study of romantic relationships in adolescence has been hindered by a number of methodological challenges, including operational definitions, obtaining representative samples, and identifying the relevant dimensions of variation in romantic relationships (Collins et al., 2009). To facilitate a more standardized assessment of romantic relationships and its correlates of current and/or long-term individual functioning, Collins (2003) has identified four features that characterize romantic relationships in adolescence: romantic involvement, partner identity, relationship content, and relationship quality. The present study entails a comparison of adolescents with and without ADHD on each of these features.

1.1. Romantic Involvement

Romantic involvement refers to whether or not a person dates, the frequency and regularity of their dating, and the duration of their relationships (Collins, 2003; Collins et al., 2009). The timing of the initiation of dating is important because early dating is closely associated with early sexual initiation (Cooksey et al., 2002), which in turn is correlated with risky sexual behaviour (RSB), depression, violence, academic underachievement, and substance
use (Crockett, Bingham, Chopak, & Vicar, 1996; Jessor, Costa, Jessor, & Donovan, 1983). Not surprisingly, the frequency of romantic relationships steadily increases as a function of age, with 25% of 12-year-olds, 50% of 15-year-olds, and more than 70% of 18-year-olds reporting having experienced a romantic relationship in the previous 18 months (Carver et al., 2003). Similarly, romantic relationships become more stable as adolescents develop. 14-year-olds report that their relationships only last from a few weeks to four months, while the relationships of 16-year-olds last on average six months, and more than one year for 18-year-olds. Although boys and girls typically report similar frequencies of romantic relationships (Connolly & McIsaac, 2011), girls tend to have relationships of greater duration (Carver et al., 2003; Shulman & Sharf, 2000).

There is some evidence that the romantic involvement of adults with ADHD differs from typically functioning adults. Although the validity of DSM-IV subtypes of ADHD as discrete subgroups with long-term stability are currently a point of contention (Wilcutt et al., 2012), Canu and Carlson (2003) found that college students with the inattentive subtype (ADHD-I) achieved dating milestones later and had a lower number of steady dating relationships, than both college students with the combined subtype (ADHD-C) and healthy college students. Similarly, Babinski et al (2011) reported that when compared to typically functioning peers, girls diagnosed with ADHD in childhood experienced fewer romantic relationships in late adolescence and young adulthood.

1.2 Partner Identity

Partner identity refers to the characteristics of the partner with whom the adolescent has had a romantic experience (Collins 2003; Collins et al, 2009). While overly-stereotyped portrayals of the characteristics that males and females find important in relationships is commonplace, the reality is that little is known about the relative significance that adolescents
place on various attributes when selecting a romantic partner. The extent to which partner characteristics are important to the development of each member of the adolescent couple is also unclear (Furman & Simon 2008). Like adults, adolescents report that their ideal partners are intelligent, interpersonally skillful, and physically attractive (Regan, 2003). Moreover, romantic partners often share similar demographic (e.g., ethnicity, socio-economic status), social (e.g., popularity, attractiveness) and psychological characteristics (e.g., depressive symptoms) (Carver et al., 2003; Simon et al., 2008). This “selective partnering” as it is coined, is also evident in patterns of psychological and physical aggression in young at-risk couples (Capaldi & Crosby, 1997). To date, no published studies have examined the characteristics that individuals with ADHD view as important when selecting their romantic partner.

1.3 Relationship Content

Content refers to shared activities of relationship partners (Collins 2003; Collins et al., 2009). Evidently, adolescents in romantic relationships engage in patterns of interaction that differ from interactions with parents or peers. Two aspects of relationship content that have garnered considerable attention are sexual behaviour and aggression between partners.

Although many adolescent couples are in healthy and supportive relationships, physical aggression occurs in a sizeable proportion of adolescent romantic relationships. Estimates vary widely across samples (e.g., national versus regional surveys) and assessment methods (one-time retrospective versus cumulative), but roughly 10%-48% of adolescents experience physical aggression and 25%-50% endure psychological aggression in their dating relationships (Halpern et al., 2001; Jouriles et al., 2005). In spite of already elevated proportions of abuse in the romantic relationships of typically functioning individuals, young adults with ADHD have been found to resort to more frequent negative conflict resolution patterns (Canu et al., 2007; Overbey
et al., 2011) and to be more verbally aggressive and violent (Wymbs et al., 2012) than romantic partners without ADHD.

Recent investigations reveal no gender differences in prevalence rates of perpetrators of aggression (Capaldi et al., 2007, Halpern et al., 2001). However, gender differences exist on variables related to sexual behaviour. The average age of first intercourse is 16 for boys and 17 for girls (Diamond & Savin-Williams, 2009). Males are also somewhat more likely than females to report higher numbers of sexual partners and frequency of casual sex (Petersen & Hyde, 2010). On the other hand, adolescent females are more likely to believe that sexual behaviour should occur within the context of a romantic relationship (Diamond & Savin-Williams, 2009) and, as a result, may experience more shame if sexual activity occurs outside of a relationship (Grello et al., 2003).

Existing research on the sexual behaviour of individuals with ADHD focuses on young adults and exposes some alarming tendencies. When compared to age-matched peers, young adults with ADHD are at an increased risk for unwanted pregnancies, sexually transmitted infections (STIs), earlier initiation of sexual activity, and a greater frequency of casual sex and sexual partners (Barkley et al., 2010; Flory et al., 2006; Huggins, Rooney, & Chronis-Tuscano, 2012; White et al., 2012; Winters et al., 2008). Such RSB has been linked to sexual victimization in both the general population (Fargo, 2009) and in adolescents with ADHD (White & Buehler, 2012). Other studies, however, have found no significant associations between ADHD symptomatology and RSB when co-occurring conduct disorder (CD) is taken into account (Monuteaux, Faraone, Gross, & Biederman, 2007; Ramrakha et al., 2007). Mixed results also exist with respect to antisocial sexual activities (e.g., forced sex) among adults diagnosed with ADHD in childhood. Mandell (1999) and Theriault and Homberg (2001) found ADHD
symptomatology and CD to be small but significant predictors of both physical and sexual aggression, however, Barkley et al (2004) did not find any such association. Although these inconsistent findings appear puzzling, they most likely reflect methodological variability across studies, such as differing sample characteristics (e.g., gender, population-based vs. clinic-referred) and assessment methods (e.g., structured interviews, self-report) and it is evident that more research is needed to explain these discrepant results.

1.4 Relationship Quality

Relationship quality encompasses the degree that partners manifest affection and nurturance to create generally beneficial experiences (Collins 2003; Collins et al., 2009). Evidence suggests that the skills necessary for establishing and maintaining friendships in childhood serve as the building blocks for establishing high-quality romantic relationships later in life (Collins et al., 1997). By the same token, the quality of peer and family relationships early in life significantly predicts the quality of ensuing romantic relationships (Collins et al., 2006, Roisman et al., 2009). Low-quality relationships are marked by irritation, controlling behaviour, antagonism, high levels of discord, and an imbalance between conflict and support (Galliher et al., 2004). High quality relationships, however, are associated with a high level of commitment, feeling appreciated, good communication, and being attracted to the partner (Levesque, 1993). Interestingly, while interactions with romantic partners involve more conflict than with friends and less responsiveness and communication than with mothers, adolescents perceive themselves as receiving more support from their partner (Furman & Shomaker, 2008).

To date, the quality of romantic relationships of individuals with ADHD has only been studied in adults. Spouses of adults with ADHD, who themselves are not diagnosed with ADHD, report feeling resentful and overwhelmed due to inadequate emotional support and an unequal
distribution of household tasks pertaining to planning, organizing, financial decisions, and maintaining family harmony (Robin & Payson, 2002; Weiss, Weiss & Trokenberg-Hechtman, 1999). Thus, it is not surprising that, when compared to controls, ADHD status is associated with lower relationship satisfaction and a higher incidence of divorce (Biederman et al., 1993; Murphy & Barkley, 1996).

1.5 Rationale and Purpose of the Current Study

Collectively, the findings described above paint a bleak picture of romantic relationships in individuals with ADHD, with most of the existing research involving adult current or retrospective report. Adolescence, however, represents a period of flexible change and somewhat of a blank slate for individuals who have yet to experience a romantic relationship. In theory, maladaptive romantic relationships should only occur after a series of repeated deviations from normative relationships that invariably steer an individual towards a path that is disturbed (Sroufe, 1997). Hence, it is evident that an additional emphasis should be placed on the exploration of adolescent relationships, as they represent the foundation for romantic relationships throughout the lifespan (Collins & Sroufe, 1999).

The major purpose of present pilot study was to compare the romantic relationships of adolescents with and without ADHD on the following four relationship features: 1) romantic involvement, 2) partner identity, 3) relationship content, and 4) relationship quality. With regard to romantic involvement, based on previous studies (Babinski et al., 2011; Canu & Carlson, 2003), it was expected that adolescents with ADHD would commence dating later and have fewer and shorter-lasting relationships than their TD peers. In spite of this, it was anticipated that adolescents with ADHD would engage in sexual activity at a younger age and with more partners than teens without ADHD. In terms of partner identity, given the absence of previous
research, no predictions were made with regard to the characteristics that adolescents with ADHD would value in a romantic partner. However, because youth with ADHD frequently associate with deviant peer groups (Barkley, 2006), it was expected that they would be more likely to date negatively influential partners and place less importance on more redeemable qualities than adolescents without ADHD. Based on previous research on adults with ADHD (e.g., Barkley et al., 2010; Canu et al., 2007; Flory et al., 2006; Overbey et al., 2011; Wymbs et al., 2012), differences between adolescents with and without ADHD were anticipated on measures of relationship content and quality. When in relationships, it was predicted that adolescents with ADHD would report higher levels of dissatisfaction, conflict, and aggressive behaviours (verbal, relational, sexual, physical), and lower levels of affection and nurturance than TD adolescents. Lastly, it was also expected that adolescents with ADHD would report higher levels of risky sexual behaviour (e.g., unprotected sex, unwanted pregnancies, promiscuity, intercourse while using drugs or alcohol, and sexually transmitted infections) than TD adolescents.

2. Method

2.1 Participants

A community sample of 60 participants with ADHD (37% female (n= 22); mean age = 15.32, SD= 1.56) and 50 TD peers (52% female (n= 26); mean age = 15.54, SD = 1.73) were recruited by distributing flyers to a select number of schools in the Greater Toronto Area, children’s mental health centres, family doctors, advertisements in newspapers, and phoning research participants from previous studies who had consented to be contacted regarding future studies. All participants were in grades 7 through 12 with average intellectual ability (IQ ≥ 85) as assessed by the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999).
Eligibility criteria for the ADHD sample included; 1) a previous diagnosis of ADHD based on DSM-IV criteria; and 2) at least one clinically significant score (T ≥ 70) on the DSM-IV ADHD scales of the parent form of the Conners-3rd Edition (Conners, 2008); or 3) at least one borderline range score (T = 65-69) on the DSM-IV ADHD scales of the parent form of the Conners, and at least one score on the same scales by another informant (self-report or teacher) in the borderline or clinical range (T ≥ 65). TD adolescents required scores on the Conners parent scales within the average range (T ≤ 60). While adolescents with co-occurring learning disabilities, conduct disorder, oppositional defiant disorder, anxiety, or depression were included in the sample, participants with Pervasive Developmental Disorders, Psychotic Disorders, Bipolar Disorder, Obsessive-Compulsive Disorder and Tourette’s Syndrome were excluded.

Accordingly, one TD and five ADHD participants were excluded from the analyses because their IQ and/or T-scores did not meet their respective eligibility criteria. This left a sample of 104 participants, of whom 55 were classified as ADHD (35% female (n= 19); mean age = 15.31, SD = 1.55) and 49 as a TD comparison group (53% female (n = 26); mean age = 15.57, SD = 1.73) (see Figure 1). Approximately two thirds of adolescents with ADHD (n = 37) regularly took stimulant medication (e.g., Adderall, Concerta, Ritalin), but participants were asked to refrain from taking medication on the day of testing. Significantly more adolescents with ADHD (77%) had one or more comorbid diagnoses (i.e., learning disability, anxiety, depression, oppositional defiant disorder), compared to only 5 (10%) of their TD peers, $\chi^2 (1, N =104) = 37.70, p < .001$.

In accordance with the research aims of this study, the sample was further partitioned to only include participants with previous romantic relationship experience. Nearly identical proportions of participants with and without ADHD, $\chi^2 (1, N = 102) = 0.01, p = .93$, experienced
a romantic relationship in their lifetime. This final subsample comprised 58 participants, of whom 30 were classified as ADHD (40% female, \(n = 12\); mean age = 15.71, SD = 1.49) and 28 as TD comparison adolescents (57% female, \(n = 16\); mean age = 16.0 SD = 1.68) (see Figure 1). Amongst this subsample, 17 (57%) adolescents with ADHD regularly took stimulant medication. Significantly more adolescents with ADHD (81%) had one or more comorbid diagnoses compared to 3 (10%) of their TD peers, \(\chi^2 (1, N = 58) = 23.59, p < .001\).

As shown in Table 1, t-tests revealed no significant group differences on age, IQ, or years of parental education for the entire sample \((N = 104)\) or subsample \((n = 58)\) of participants with previous romantic relationship experience. Furthermore, Chi-Square tests revealed no significant groups differences on gender, \(\chi^2 (1, N = 104) = 3.62, p = 0.06\), parental marital status, \(\chi^2 (1, N = 104) = .43, p = 0.51\), or language spoken at home, \(\chi^2 (1, N = 104) = .15, p = 0.69\) for the entire sample, and no significant groups differences on gender, \(\chi^2 (1, N = 58) = 2.00, p = 0.16\), parental marital status, \(\chi^2 (1, N = 58) = .01, p = 0.94\), or language spoken at home, \(\chi^2 (1, N = 58) = 1.22, p = 0.27\) for the subsample of adolescents with romantic relationship experience. However, as expected, participants with ADHD had significantly higher scores on variables measuring current manifestation of inattentive and hyperactive/impulsive symptoms (parent, teacher, and self-reports) for both the entire sample and the subsample of adolescents with a history of romantic relationships. On the other hand, ratings of conduct problems were mixed. Parents of adolescents with ADHD rated their children as having significantly more conduct problems across the whole sample and the subsample of adolescents with romantic relationship experience. In contrast, teacher and self reports indicated no differences in conduct problems for the subsample of participants with romantic experience (see Table 1).

### 2.2 Measures
Sample Definition and Description

2.2.1 Conners Rating Scale- Third Edition

The *Conners Rating Scale-3rd Edition* (Conners, 2008) Parent, Teacher, and youth Self-Report long-forms were used to confirm current manifestation of ADHD symptoms. The Conners is a well-validated standardized measure consisting of 99-115 items on a 4-point Likert scale from 0 (Not at all/Seldom, Never) to 3 (Very Much True/Very Often, Very Frequent). Internal consistency coefficients are high, .90 or above for Parent and Teacher scales, and .85 or above for self-report scales (Conner, 2008). For most subscales, test-retest reliability ranges from .82 to .98 (Parents), .83 to .90 (Teacher) and .71 to .83 (Self-Report) (Conner, 2008).

2.2.2 Wechsler Abbreviated Scale of Intelligence

Cognitive ability was assessed using the *Wechsler Abbreviated Scale of Intelligence (WASI)*; Wechsler, 1999, an individually administered, brief test of intelligence. This abbreviated IQ scale demonstrates solid psychometric properties with high internal consistency (.93), test-retest reliability (ranging from .88 to .93), and concurrent and construct validity (Wechsler, 1999).

**Romantic Relationships:**

Only the subsample of 58 participants with a history of romantic relationships completed all measures pertaining to romantic relationships. In addition, all 104 participants completed the *Important Characteristics in a Romantic Partner (ICRP)* rating scale (described below) because the ICRP does not require that adolescents have previous romantic relationship experience to answer the questions. To minimize discomfort, all measures related to romantic relationships, other than the ICRP, were branched such that answering “no” to questions pertaining to previous
involvement in romantic relationships and intercourse precluded participants from answering more in-depth questions.

2.2.3 Health and Sexual Behaviours Questionnaire

The Health and Sexual Behaviours Questionnaire (HSBQ; Flory et al., 2006) (See Appendix B) was used to obtain a history of participants’ romantic involvement and assess their engagement in potentially risky sexual behaviour. Items included questions pertaining to age of first sexual experience and intercourse, promiscuity, frequency of casual sex, use of reliable contraception and sexually transmitted infections (STI) prevention methods, and unwanted pregnancies. Most items were dichotomized to be consistent with cut-offs for risky sexual behaviour used in other studies (Flory et al., 2006, Grunbaum et al., 2004).

2.2.4 Networks of Relationships Inventory-Behavioural Systems Version

The Networks of Relationships Inventory-Behavioural Systems Version (NRI-BSV; Furman & Buhrmester, 2009) is based on an integration of attachment theory and Sullivanian theory. It assesses how frequently different relationships (e.g., mother, father, romantic partner, same-sex friend) are used to “fulfill the functions of three behavioural systems: attachment, caregiving, and affiliation” (Furman & Buhrmester, 2009). It is a 24-item survey, with three items per scale, rated on a five-point scale from 1 (little or none) to 5 (the most). It assesses five support features (Provides Secure Base, Seeks Secure Base, Provides Safe Haven, Seeks Safe Haven, Companionship) and three negative interactions (Conflict, Antagonism, Criticism). Two second order factors are computed by averaging the five support and three negative interactions scales. For the purposes of this study, only responses pertaining to the participants’ romantic partner were explored. The NRI-BSV has strong internal consistency relating to romantic partners with alphas ranging from .75 to .92.
2.2.5 Conflict in Adolescent Dating Relationships Inventory

The Conflict in Adolescent Dating Relationships Inventory (CADRI; Wolfe et al., 2001) is a 35-item self-report scale assessing abusive behaviour among adolescent dating partners on five primary factors (Sexual Abuse, Threatening Behaviour, Verbal or Emotional Abuse, Relational Abuse, and Physical Abuse). An Overall Abuse factor is generated by summing all 25 items pertaining to abuse (range 25 to 100), whereas a Restricted Abuse factor is derived by summing all items from the Threatening Behaviour, Verbal or Emotional Abuse, and Physical Abuse factors (range 18-72). The remaining ten items on the CADRI assess conflict resolution within the couple. The CADRI is scored on a scale of 1 to 4 (from “Never” to “Often”) with higher scores indicating greater levels of abuse. The CADRI has fair internal consistency with alphas in the mid .80s for Verbal, Physical, and Overall abuse, and .51 to .66 for the remaining scales. With the exception of Sexual Abuse (.28), the remaining scales of the CADRI have acceptable test-retest reliability ranging from .58 to .72.

2.2.6 Important Characteristics in a Romantic Partner

The Important Characteristics in a Romantic Partner rating scale (ICRP; Royer, Keller, & Heidrich, 2009) (See Appendix C) was used to assess the relative importance attributed to desirable features in a potential romantic partner. The ICRP lists 22 partner characteristics including physical, social, and risk characteristics that participants rate on a scale of 1 (very important) to 3 (not at all important). Internal consistency for the ICRP overall is strong at .84 (Royer et al., 2009). Internal consistencies of individual subscales were explored for this study and are also high (.73 to .83).

2.3 Procedure
Institutional ethic’s board approval was obtained from the University of Toronto (protocol reference #25468) and all participants and their parents provided informed written consent prior to the start of the study. During an initial phone screening, parents of participants provided demographic information about their child and family, completed the Conners-Parent long form, and consented to having their child’s teacher fill out the Conners-Teacher long form (See Appendix A). On the day of testing, researchers assisted participants in completing an individually administered battery of standardized tests and self-report measures. Researchers were graduate students in school and clinical child psychology with considerable training in psychological testing. Participants were given the choice of receiving $30 as compensation for their time (approximately 4 hours) and travel expenses incurred, or receiving a volunteer service certificate documenting time spent participating in the study. Additionally, participants were provided with an educational report detailing their cognitive, academic, and socio-emotional functioning.

3. Statistical Analyses

Statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 20. Descriptive statistics were calculated for the demographic characteristics (e.g., age, gender, IQ, parental marital status, parental education, language spoken at home) of the ADHD and comparison groups separately. Data points of variables with standard deviations larger than 3 were adjusted using the winsorizing method. Statistical assumptions checking for homogeneity of variance and normality of the outcome variables were met. If t-tests revealed gender differences on outcome variables, gender and group status were included as fixed factors in subsequent 2 x 2 ANOVAs. Partial $\eta^2$ values were computed to ascertain effect size and determine clinically meaningful differences. According to Vacha-Haase and Thompson (2004),
\( \eta^2 \geq 0.01 \) constitutes a small effect, \( \eta^2 > 0.09 \) corresponds to a medium effect, and \( \eta^2 > 0.25 \) represents a large effect. In order to minimize the possibility of type I error, overarching scales were first examined, and only when significant differences existed were the results of item-level differences reported. However, given the absence of previous research regarding the characteristics that individuals with ADHD value when selecting a romantic partner, individual attributes of the ICRP were also explored.

The first objective of the study was to evaluate group-level differences in the romantic involvement of participants with a history of romantic relationships. Dependent variables included: age of first romantic relationship, number of romantic and sexual partners, length of longest relationship, and age of first sexual experience and intercourse. The second objective of the study was to compare the relative importance that adolescents with and without ADHD placed on various attributes (e.g., smart, honest, attractive, funny) when selecting a romantic partner. All 104 participants were included in the analyses. Dependent variables included four overarching categories of partner characteristics: Personal Qualities, Physical Attractiveness, Does Not Smoke/Drink, and Prestige factors. The third objective was to explore the shared activities of adolescents with and without ADHD within the context of their romantic relationships. Dependent variables included level of engagement in risky sexual behaviour and the frequency of abusive behaviours perpetrated or incurred. Both groups were also compared on the frequency of more positive, conflict resolution, response patterns. The final objective of the study was to compare the degree to which adolescents with and without ADHD manifest and receive intimacy, affection, and nurturance within their romantic relationships.

4. Results

4.1 History of Romantic Involvement
As shown in Table 2, for the subsample of adolescents with a history of romantic relationships, adolescents with ADHD reported having more romantic partners than their TD counterparts, $F(1,53) = 5.18, p = 0.03, \eta^2 = .09$. Males reported beginning dating at a younger age than females, $F(1,53) = 3.79, p = 0.05, \eta^2 = .07$; there was no group main effect nor group x gender interaction effect on age of onset of dating. Females with ADHD had shorter romantic relationships than their TD counterparts, whereas males with and without ADHD reported equally short relationships across groups, $F(1,53) = 5.53, p = 0.02, \eta^2 = .10$. A significant interaction effect also indicated that males with ADHD reported a younger age of first intercourse than their TD male counterparts, while females with and without ADHD reported their first intercourse to occur at approximately the same age, $F(1,17) = 4.41, p = 0.05, \eta^2 = .21$. The strength of this relationship, as assessed by $\eta^2$, was moderate to strong.

4.2 Partner Identity

A significant gender difference was found for the overall category of Personal Qualities on the ICRP (see Table 4), whereby male participants placed less importance on individual characteristics such as good hygiene, $F(1,100)= 7.46, p = 0.01, \eta^2 = .07$, and being interesting, $F(1,100)= 5.45, p = 0.02, \eta^2 = .05$. While no significant group differences existed on overarching partner characteristics, group differences emerged at the individual item-level. Adolescents with ADHD viewed attributes such as being smart, $F(1,100)= 4.18, p = 0.04, \eta^2 = .04$, and being a leader, $F(1,100) = 4.54, p = 0.04, \eta^2 = .04$, as less important than their TD peers.

4.3 Relationship Content and Quality

As reported on the HSBQ, when compared to their TD peers, adolescents with ADHD were significantly more likely to have had multiple sex partners in their lifetime (defined as four or more), and to have had casual sex within the past year (Table 4). While adolescent with and
without ADHD did not differ in terms of other high risk sexual behaviour, both adolescent groups showed alarming rates for the frequency of intercourse while under the influence of drugs/alcohol, and irregular use of a combination of reliable contraception and sexually transmitted infection (STI) prevention methods.

Adolescents with and without ADHD did not differ on the Overall Abuse factor of the CADRI (Sexual Abuse, Threatening Behaviour, Verbal or Emotional Abuse, Relational Abuse, and Physical Abuse), assessing abuse perpetrated by the participant, $F(1,41) = 1.59, p = 0.22, \eta^2 = .04$, or incurred by the participant, $F(1,41) = .03, p = 0.86, \eta^2 = .00$. Nor they did differ on the frequency of more adaptive, conflict resolution, patterns of behaviour, $F(1,41) = .05, p = 0.82, \eta^2 = .00$.

Similarly, adolescents with and without ADHD did not differ on the Social Support $F(1,40) = .16, p = 0.69, \eta^2 = .00$, or Negative Interactions (Conflict, Antagonism, Criticism), $F(1,40) = 1.14, p = 0.29, \eta^2 = .03$, factors of the NRI-BSV.

5. Discussion

The current exploratory study set out to compare the romantic relationships of adolescents with and without ADHD on four features of romantic relationships: romantic involvement, partner identity, relationship content, and relationship quality. Preliminary findings suggest that the presence of ADHD symptomatology is associated with differences on key features of romantic relationships. Adolescents with ADHD were found to have significantly more romantic partners than their TD peers, and in particular, female adolescents with ADHD were found to have shorter romantic relationships than their TD counterparts. In addition, males with ADHD reported their age of first intercourse to be nearly two years prior to males without ADHD, and adolescents with ADHD, irrespective of gender, had nearly double the number of
lifetime sexual partners than TD adolescents. However, in the current study, adolescents with and without ADHD did not differ on measures assessing the quality of their romantic relationships or the levels of aggression perpetrated or incurred. When choosing a romantic partner, adolescents with and without ADHD did not differ on the level of importance placed on overarching categories of partner characteristics. Further exploration at the individual item-level revealed that adolescents with ADHD placed less importance on intelligence and leadership.

5.1 Romantic Involvement

Nearly identical proportions of males and females with and without ADHD reported experiencing a romantic relationship in their lifetime. Contrary to predictions, and findings from Babinski and colleagues (2011), adolescents with ADHD had significantly more romantic partners than their TD peers, and did not differ on their age of entry into romantic relationships. While unexpected, these findings are not altogether surprising. Canu and Carlson (2003) found that college-students with ADHD-I reported reaching dating milestones at a later age than healthy controls and participants with ADHD-C. However, ADHD-C was associated with a similar age of entry into romantic relationships when compared to controls. The present sample, as rated by parents, scored on average above the 99th percentile on variables measuring current manifestation of both inattentive and hyperactive/impulsive symptoms. However, because diagnostic interviewing was not done in the current study, ADHD subtypes were not delineated. Furthermore, whereas Babinski et al (2011) found individuals with ADHD to have a significantly lower number of romantic partners than healthy controls, their sample was comprised solely of college females. In the current study, while participants with ADHD had significantly more romantic partners than their TD peers, discrepancies appear to be mostly driven by male adolescents with ADHD. As predicted, differences also emerged on the variable duration of
romantic relationships. Interestingly, this interaction effect was primarily the result of females with ADHD having shorter romantic relationships than their TD counterparts, while males with and without ADHD reported relationships of similar lengths. These results suggest that the deficits in social skills, excessive negative behavior, and poor social information processing present in girls with ADHD (Crick & Dodge, 2000; Hoza et al., 2000; Wheeler et al., 1994), may not only affect the stability of the friendships they form (Bagwell et al., 2001; Blachman & Hinshaw, 2002), but also their romantic relationships.

A moderate to strong interaction effect was also found for ADHD status and gender, on the variable age of intercourse, with ADHD males reporting their first intercourse to be nearly two years sooner than their TD counterparts. Accordingly, when compared to typically functioning peers, adolescents with ADHD had nearly double the number of lifetime sexual partners. These findings have important implications because sexual precociousness and exposure to multiple sex partners early in adolescence, is associated with HIV infections (Overby & Kegles, 1994) and a host of other negative outcomes including depression, academic underachievement, substance use, and further RSB (Jessor, Costa, Jessor, & Donovan, 1983; Crockett, Bingham, Chopak, & Vicar, 1996).

5.2 Partner Identity

Overall, participants across both groups rated most attributes related to Personal Qualities and Physical Attractiveness as important, and placed less emphasis on Prestige. However, a significant gender difference was found for the overall category of Personal Qualities, with males placing less importance than females on individual characteristics such as good hygiene and being interesting. No differences existed on overarching partner characteristics as a function of ADHD status, but an exploratory analysis revealed differences at an individual item-level.
Specifically, adolescents with ADHD viewed being *smart* and being a *leader*, as less important than their TD peers.

Children tend to prefer and associate with peers who are similar to themselves in social status and behavior (Schneider, Wiener, & Murphy, 1994). Specifically, less-accepted children like other less-accepted children, and disruptive youngsters associate with other troublesome peers (Nangle, Erdley, & Gold, 1996). Similar findings exist in studies of romantic relationships, with “selective partnering” evident in young at-risk couples (Capaldi & Crosby, 1997). Indeed, ADHD children prefer to associate with other ADHD children more than do typically developing children (Hinshaw & Melnick, 1995). Because ADHD is consistently linked to academic difficulties, social deficits, and behavioural problems, it is not surprising that adolescents with ADHD place less value on characteristics related to social and academic competence when selecting their romantic partner. Nevertheless, these findings must be interpreted with caution as no group or interaction effects existed on overarching partner characteristics, and group differences only emerged when further exploring individual attributes.

### 5.3 Relationship Content

Like other studies examining the sexual behaviour of young adults with ADHD (Barkley et al., 2010; Flory et al., 2006; Huggins, Rooney, Chronis-Tuscano, 2012; White et al., 2012; Winters, Botzet, Fahnhorst, Baumel, & Lee, 2008), the present study replicates certain findings related to RSB with an adolescent population. When compared to their TD peers, adolescents with ADHD were significantly more likely to have had multiple sex partners in their lifetime (defined as four or more) and to have had casual sex within the past 12 months. Despite the sample’s young age, these high proportions of promiscuity are disconcerting, and a risk factor for subsequent internalizing and externalizing psychopathology.
Unlike findings from previous research (Barkley et al., 2010; Flory et al., 2006), in the current study, participants with ADHD were not more likely than their TD peers to have contracted an STI or become unintentionally pregnant. Discrepant results may be partially explained by the small sample size and younger age of the current sample relative to other studies. More specifically, adolescents may have thus far been fortunate enough to escape further ramifications of their RSB, in spite of their irregular use of a combination of reliable contraception and STI prevention methods. Alternatively participants may have been concerned about the confidentiality of their responses, or reluctant to divulge potentially embarrassing information, thereby decreasing their endorsement of socially undesirable items.

While the ADHD group and their TD peers did not differ on other items assessing RSB, both groups showed startling rates for the frequency of intercourse while under the influence of drugs/alcohol, and infrequent use of a combination of reliable contraception and STI prevention methods. In addition to the numerous risk factors of unprotected sex mentioned above, alcohol and drug use prior to sex is associated with further lapses in judgement, disinhibition of sexual behaviours, and an increased likelihood of additional RSB (Cooper et al., 2002; Staton et al., 1999).

Contrary to expectations and studies assessing relationship aggression and conflict resolution (Canu & Carlson, 2007; Overbey et al., 2011; White & Buehler, 2012, Wymbs et al., 2012), adolescents with and without ADHD did not differ on any variables assessing abuse perpetrated or incurred. Nor they did differ on the frequency of more adaptive, reconciliatory, patterns of behaviour. These results are somewhat perplexing, but may be partially explained by the relatively low ratings of conduct problems in the sample of adolescents with ADHD. Although there were significant group differences in parental appraisal of conduct problems, the
mean score of the ADHD sample still fell within the average range. Furthermore, no group
difference emerged according to teacher and self-reports of conduct problems. Conduct disorder
and its successor antisocial personality disorder (ASP) are invariably linked with intimate partner
violence (Schumacher, 2001). The moderately low scores of adolescents in this sample may
therefore be mitigating the levels of relationship aggression found in other studies. Alternatively,
it is also possible that participants with ADHD were reluctant to disclose abusive and potentially
self-incriminating behaviour.

5.4 Relationship Quality

Lastly, adolescents with and without ADHD did not differ on measures of relationship
quality, as assessed by levels of social support and negative interactions. While ADHD status in
adulthood is associated with lower relationship satisfaction and a higher incidence of divorce
(Biederman et al., 1993; Murphy & Barkley, 1996), and non-ADHD spouses report feelings of
resentment and dissatisfaction due to inadequate emotional support and an unequal distribution
of household responsibilities (Weiss et al., 1999), it is possible that the expectations and level of
support implied in adolescent relationships are not as demanding as in adulthood. Furthermore,
countless studies and comprehensive reviews (e.g., Owens et al., 2007, Hoza et al., 2004)
describe how individuals with ADHD tend to underreport the presence of problems and
overestimate their own competence in social domains. While participants in this study report
being satisfied with the quality of their relationship, a limitation of this study was that no
information was acquired from participants’ respective partners to corroborate the data and/or
obtain their point of view.

5.5 Limitations and Future Directions
These preliminary results, while interesting, should be considered in light of several important caveats. As in all studies, the generalizability of the findings is constrained by sample characteristics. The small sample size greatly decreased the power of this study, and a larger sample is needed to validate the findings. While group differences emerged on a number of outcome variables, the small sample prevented further exploration of factors potentially moderating the relationship between ADHD status and various outcome variables. Future studies should examine the role of the distal context (e.g., culture, ethnicity, SES), the immediate context (e.g., family structure, family relations, parental monitoring, peer groups) and child characteristics (comorbidity, self-esteem, attachment, achievement) in explaining the association between ADHD and the features of romantic relationships. Conversely, it would be equally interesting to examine how romantic relationships can positively or negatively impact other developmental outcomes, including educational attainment, family and peer functioning, substance use, and externalizing and internalizing symptomatology.

Another limitation of this study was its reliance on self-report to assess relationship content and quality. Although the use of self-report is commonplace in the study of adolescent behaviour, it is susceptible to response bias (Kazdin, 1998; Wolfe et al., 2001). Eakin et al (2004) suggests that in ADHD couples, partners often have conflicting views regarding their relationship. Adolescents with ADHD have a propensity to inflate self-appraisals and downplay problematic behaviour. Accordingly, obtaining corroboration from romantic partners would lend more credibility to the findings and help minimize scepticism related to a positive illusory bias (PIB).

Additionally, some of the findings may have been limited by certain aspects of the measures themselves. The Important Characteristics in a Romantic Partner rating scale
exclusively consisted of “sought-after” characteristics. While group and gender differences emerged on individual features, participants across both groups found most of the characteristics listed in the ICRP to be desirable. Perhaps it would have been more pertinent to examine the value placed on potentially unfavourable characteristics as well (e.g., disloyal, impatient, irresponsible). It is also possible that examining attributes in the form of a checklist did not elicit the priorities of the participants when selecting a partner. It might therefore be helpful to limit participants to a specific number of characteristics, ask them to rank the characteristics in order of importance, or to ask an open-ended question such as “What are the characteristics that you value in a romantic partner”? Furthermore, the exploration of item-level attributes on the ICRP increased the probability of type I errors. Therefore, further research is needed to validate the findings.

5.6 Clinical Implications

The findings regarding romantic involvement, partner identity, and sexual behaviour in the current study have important implications for the parents, educators, and clinicians who work with adolescents with ADHD. Unfortunately, only a minority of adolescents with ADHD, about one in eight, receive care for their disorder (Jensen et al., 1999). Most are treated with stimulant medication (Smith et al., 2000) and few receive some form of psychosocial or educational intervention. Given the poor outcomes associated with risky sexual behaviour, relationship instability, and negative partner characteristics, it is imperative that any comprehensive assessment of adolescents with ADHD include queries into the nature of their romantic relationships. In turn, information obtained may help clinicians devise specific and individualized strategies to help adolescents prevent and/or cope with romantic relationship difficulties. At a more universal level, results from this study, although preliminary, may help
inform sex education programs seeking to reduce unsafe sexual behaviour in this at-risk population.

Given the unique contributions of this multi-faceted study, it would appear that the strengths of the current investigation outweigh its limitations. This investigation explored several aspects, rather than just one facet, of romantic relationships in individuals with ADHD. Moreover, the sample, albeit small, was comprised of both males and females, thereby increasing the generalizability of the study. In addition, the sample, comprised of adolescents, represents an understudied population in the ADHD literature. As a corollary, the young age of the sample limited the need for participants to retrospectively recall their relationship history, thus limiting the confounding and biased effects of recall.
References


Figure 1 *Breakdown of sample into groups of analysis.*

**Total Sample**
- \( N = 104 \)
  - male: 57% (\( n = 59 \))
  - female: 43% (\( n = 45 \))

**ADHD**
- \( n = 55 \)
  - male: 65% (\( n = 36 \))
  - female: 35% (\( n = 19 \))

**Comparison**
- \( n = 49 \)
  - male: 47% (\( n = 23 \))
  - female: 53% (\( n = 26 \))

1. Romantic Relationship (RR)
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<td>Comparison</td>
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<td>M (SD)</td>
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<td>50.75 (9.13)</td>
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*p ≤ .05, **p ≤ .01, ***p ≤ .001
Table 2

Romantic Involvement of Adolescents with and without ADHD by Gender

<table>
<thead>
<tr>
<th>Variable</th>
<th>ADHD Male</th>
<th>ADHD Female</th>
<th>COMPARISON Male</th>
<th>COMPARISON Female</th>
<th>GROUP</th>
<th>GENDER</th>
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<td>2.09(1.38)</td>
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<td>11</td>
<td>13.55 (1.37)</td>
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<tr>
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<td>5.82 (5.42)</td>
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<td>1.60(.55)</td>
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*p < .05.
Table 3

Importance Ratings of Partner Characteristics in Adolescents with and without ADHD by Gender

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<td>1.77 (.57)</td>
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<td>No Smoking/ Drinking</td>
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*\(p < 0.05\).
Table 4

Risky Sexual Behaviour Among Adolescents with and without ADHD

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<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
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<td>1st sexual partner Casual</td>
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<td>5/11</td>
<td>46</td>
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<tr>
<td>Casual sex (past year)</td>
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<td>Multiple sex partners lifetime</td>
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<td>0</td>
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<td>5/11</td>
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<td>Infrequent use of reliable B/C + STI prevention</td>
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</table>

*p < .05.

1Multiple is defined as 4 or more partners. 2Defined as some of the time, half of the time, most of the time. 3Infrequent is defined as less than almost always. 4Reliable methods of birth control plus STI prevention defined as use of condom + birth control.
Appendices

Appendix A: Parent Consent letter, Parent Consent form, Adolescent Assent Form, and Adolescent Consent Form

PARENT CONSENT LETTER

Dear:

My name is Dr. Judith Wiener, and I am a professor at the Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). Together with my colleague (Dr. Maria Rogers), and my graduate students, I am doing a research project on teenagers with Attention-Deficit Hyperactivity Disorder (ADHD). We are writing to ask you if you would give permission for your son/daughter to take part in this research. For this, we need the participation of teenagers who have been diagnosed with ADHD and teenagers who do not have ADHD. We are asking you and your son/daughter to take part in this research because we believe that your feelings and opinions and theirs are valuable information that can help adolescents with ADHD achieve in school and have healthy relationships with parents and peers.

Purpose of the Research
We want to learn more about the peer and family relationships of adolescents with ADHD. So far, there is very little research on this. We believe that knowing more about the peer and family relations of teens with ADHD is important because it will help us develop strategies for teens to help themselves get along with parents and friends, and suggest strategies for parents, teachers, and other professionals to help the teens. This research has been funded by the Social Sciences and Humanities Research Council.

Description of the Research
If your son/daughter takes part in this research study, the testing session will take about 3 to 4 hours. The session will take place in a quiet room at OISE/University of Toronto. During the session, a research assistant will ask your son/daughter to answer some questions about him/herself, such as the first name of his/her friends, how often he/she spends time with them, and whether he/she has been bullied or bullies others. Other questionnaires will also ask him/her whether or not they have ever been involved in a romantic relationship. If yes, the questionnaire will continue to ask for some details of his/her relationship, such as conflicts or arguments in their relationship, intercourse, birth control, and characteristics they find important in a romantic partner. Lastly, the research assistant will also ask him/her about arguments he/she sometimes has with his/her parents and his/her beliefs about why they happen. You will be asked to fill out a questionnaire about this as well. We will also ask you and your son/daughter about your involvement in his/her education. In addition, the research assistant will ask your son/daughter to listen to some descriptions of social problems that teens often have and ask him/her how he/she would solve them. Sometimes the research assistant asks him/her questions and writes down the answer. Other times, your son/daughter fills out a questionnaire by checking off or circling a number. He/she can read the questionnaires him/herself or ask the research assistant to read them to him/her. He/she will also do some short reading, writing, and math, vocabulary, and problem-solving activities. We will give him/her breaks, including a lunch break if it is lunchtime. We will also send questionnaires to you...
and your son/daughter’s teacher to fill out and send back to us. The questionnaires will take the teacher about a half hour to fill out. Your questionnaires will likely take about an hour and a half to complete.

Benefits
The main benefit of this study is that it will help us learn more about peer and family relationships of adolescents with ADHD. We want to listen to what your son/daughter and you say and think, and then use that information to help teens with ADHD. A second benefit is that your son/daughter would learn a bit about how research in psychology is done.

Another benefit from this study is that your son/daughter’s answers to the questions from the reading, writing, and math activities and some of the questionnaires that he/she and you and the teacher fill out will let us know what his/her strengths are and what areas require support. About three months after he/she take part in the study and we receive all of the questionnaires back from you and the teacher, we will mail a report to you and your son/daughter about his/her behaviours and his/her skills in reading, writing, and math, and list some strategies that might help him/her achieve in school and behave appropriately at home, in school, and with friends. Although this is not a complete psychoeducational assessment, the report is often useful for developing an individual educational plan (IEP) in high school and for obtaining accommodations in postsecondary institutions.

Potential Harms and Withdrawal
There are no harms associated with taking part in the study. The only thing that might happen is that your son/daughter may feel a little uncomfortable talking about him/herself and how he/she feels about some things. If he/she feels that he/she doesn’t want to answer some of the questions, he/she can tell the research assistant, and talk about it. He/she may also say that he/she wants to stop, skip a question, or that he/she needs a break and wants to continue some other time. Also, if he/she says that he/she will take part in the study and then changes his/her mind that is okay. He/she can decide at any time to stop taking part in the study. The same applies to you – you can withdraw from the study at any time. The only consequence is that if you do not complete the questionnaires, we will not have the information needed to write the report on your son/daughter’s skills described above.

Confidentiality
All of the data will be confidential – it will only be accessed by Dr. Wiener and her research assistants. No information that reveals your identity or that of your son/daughter will be released without consent unless required by law. The information that we collect from you, your son/daughter, and his/her teacher will be analyzed and stored in locked files in a locked office. The questionnaires will not have your name or that of your son/daughter on them. All of the data will be kept at OISE/UT in locked files for 5 years after we publish an article in a journal or book on the research. The report that we write about your son/daughter and the test protocols on which this report is based will be kept for 10 years after his/her 18th birthday. A number code will be used in place of the names. We would need your permission and signed consent if you want to send these scores to another professional.

The results of the questionnaires and activities described above will be used for research purposes only. We will analyze the information, talk about it at conferences, and write about it so that youth, parents, teachers, and other professionals such as doctors and psychologists can learn from what we have found. Because we are working with many teenagers on this project, people hearing our presentations or reading what we write will not know which teenager said what. When we do this, or when we publish our research in academic journals/books, we will only present group information. We will not tell anyone your son/daughter’s or your name or give any information that could help people know who you are.

We will not be able to provide you with your responses on some of the questionnaires and interviews because they were developed for the purpose of the research. We will not tell your son/daughter the specific answers that you gave to the questions, but, as discussed above, we will write a report about how your son/daughter did and mail it to him/her and you.
The only time that we would have to tell somebody something you or your son/daughter said is if he/she or you say that he/she would do serious harm to him/herself or someone else, or someone is seriously harming him/her or you (for example: abuse, that they are dating someone much older or younger than them, or that you or your child are having suicidal ideations). In that case, as required by law, we would have to make sure he/she gets help by contacting and informing appropriate mental health, child protection, or law enforcement professionals of the clear and imminent danger only. Otherwise, everything he/she, you or the teacher say or write is kept confidential (e.g. information pertaining to your child’s sexual behaviour would not be shared with you or other parties).

Compensation
Participation in research is voluntary for both you and your son/daughter. If you and your son/daughter do decide to take part in the study, he/she can choose between getting $30.00 for his/her participation or (for teenagers in high school) the time he/she spends taking part in the study can be counted towards his/her community service hours; we will give him/her a certificate.

Access to Results
We will write a summary of the results of the study when we are finished and put it on our website. We will send you the link when it is ready. You and your son/daughter can read this.

You may contact Dr. Judith Wiener, __________________ (graduate student) or ______________ (lab manager) with any questions you may have about the study. We will try to answer all of these questions.

Sincerely,

__________________________
Ph.D. Student
(416) 978-0933

__________________________
Lab Manager
(416) 978-0933

__________________________
Judith Wiener, Ph. D
Professor
School and Clinical Child Psychology(416) 978-0935

Department of Human Development and Applied Psychology
Ontario Institute for Studies in Education of the University of Toronto (OISE/UT)
Toronto, Ontario M5S 1V6
PARENT CONSENT FORM

“I acknowledge that the research procedures described above have been explained to me and that any questions that I have asked have been answered to my satisfaction. As well, the potential harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I know that I may ask now, or in the future, any questions that I have about the study. I have been assured that no information will be released or printed that would disclose my identity without my permission, unless required by law. I understand that I will receive a copy of this signed consent. I understand that participation is voluntary and I can withdraw at any time.”

I hereby consent to take part in this research.

___________________________________
Name of Parent/Guardian

___________________________________
Signature

___________________________________
Date

___________________________________
Name of person who obtained consent

___________________________________
Signature

The person who may be contacted about this research is:

___________________________________
who may be contacted at:

(416) 978-0933

“I agree to be contacted in the future regarding other studies being conducted by the ADHD Laboratory at OISE/UT.”

___________________________________
Signature

“I agree that the information collected about my son/daughter in this study can be used for future data analysis provided that all identifying is removed and that he/she cannot be identified.”

___________________________________
Signature
ADOLESCENT CONSENT LETTER

Dear:

My name is Dr. Judith Wiener, and I am a professor at the Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). My colleague (Dr. Maria Rogers), together with our graduate students are doing a research project on teenagers with Attention-Deficit Hyperactivity Disorder (ADHD). We are writing to ask you if you would like to take part in this research. For this, we need the participation of teenagers who have been diagnosed with ADHD and teenagers who do not have ADHD. We are asking you to take part in this research because we believe that your feelings and opinions and those of your parents are valuable information that can help adolescents with ADHD achieve in school and have healthy relationships with parents and peers.

Purpose of the Research

We want to learn more about the peer and family relationships of adolescents with ADHD. So far, there is very little research on this. We believe that knowing more about the peer and family relations of teens with ADHD is important because it will help us develop strategies for teens to help themselves get along with parents and friends, and suggest strategies for parents, teachers, and other professionals to help the teens. This research has been funded by the Social Sciences and Humanities Research Council.

Description of the Research

If you take part in this research study, the testing session will take about 3 to 4 hours. The session will take place in a quiet room at OISE/University of Toronto. During the session, a research assistant will ask you to answer some questions about yourself, such as the first name of your friends, how often you spend time with them, and whether you have been bullied or bully others. Other questionnaires will also ask you whether or not you have ever been involved in a romantic relationship. If yes, the questionnaire will continue to ask about some details of your relationship, such as conflicts or arguments in your relationship, intercourse, birth control, and characteristics you find important in a romantic partner. Lastly, the research assistant will also ask you about arguments you sometimes have with your parents and your beliefs about why they happen. Your parents will also fill out a questionnaire about this. We will also ask you and your parents about how your parents are involved with your education. In addition, the research assistant will ask you to listen to some descriptions of social problems that teens often have and ask you how you would solve them. Sometimes the research assistant asks you questions and writes down the answer. Other times, you fill out a questionnaire by checking off or circling a number. You can read the questionnaires yourself or ask the research assistant to read them to you. You will also do some short reading, writing, math, vocabulary, and problem-solving activities. We will give you breaks, including a lunch break if it is lunchtime. We will also send questionnaires to your parents and teachers to fill out and send back to us. The questionnaires will take the teacher about a half hour to fill out. The questionnaires for your parents will likely take about an hour and a half to complete.

Benefits

The main benefit of this study is that it will help us learn more about adolescents with ADHD. We want to listen to what you say and think, and then use that information to help other teens with ADHD. A second benefit is that you would learn a bit about how research in psychology is done.
Another benefit about this study is that your answers to the questions from the reading, writing, and math activities and some of the questionnaires will let us know what your strengths are and what areas you need to work on. About three months after you take part in the study and we receive all of the questionnaires back from your parents and teacher, we will mail a report to you and your parents about your behaviors and your skills in reading, writing, and math, and list some strategies that might help you achieve in school and behave appropriately at home, in school, and with friends. Although this is not a complete psychoeducational assessment, the report is often useful for developing an individual educational plan (IEP) in high school and for obtaining accommodations in postsecondary institutions.

Potential Harms and Withdrawal
There are no harms associated with taking part in the study. The only thing that might happen is that you may feel a little uncomfortable talking about yourself and how you feel about some things. If you feel that you don't want to answer some of the questions, you can tell the research assistant, and talk about it. You may also say that you want to stop, skip a question, or that you need a break and want to continue some other time. Also, if you say that you will take part in the study and then change your mind, that is okay. You can decide at any time to stop taking part in the study. The only consequence is that we would not have the information we need to write the report that we described above.

Confidentiality
Everything you tell the research assistant in the session will stay between you, the research assistant, and Dr. Wiener. No information that reveals your identity will be released without consent unless required by law. The information that we collect from you, your parents, and teacher will be analyzed and stored in locked files in a locked office. The questionnaires will not have your name on them. A number code will be used in place of your name. The data will be kept at OISE/UT in locked files for 5 years after we publish an article in a journal or book on the research. The report we write about you and the test protocols we use to write it will remain in the locked files for 10 years after your 18th birthday. We would need your permission and signed consent and the consent of your parents if you are under 16 if you want to send these scores or your report to another professional, your school, or postsecondary institution.

The results of the questionnaires and activities described above will be used for research purposes only. We will analyze the information, talk about it at conferences, and write about it, so that parents, teachers, and other professionals such as doctors and psychologists can learn from what we have found. Because we are working with many teenagers on this project, people hearing our presentations or reading what we write will not know which teenager said what. When we do this, or when we publish our research in academic journals/books, we will only present group information. We will not tell anyone your name or give any information that could help them know who you are.

We will not be able to provide you with your responses on some of the questionnaires and interviews, because they were developed for the purpose of the research. We will not tell your parents the specific answers that you gave to the questions, but we will write a report about how you did and mail it to you and them.

The only time that we would have to tell somebody something you have said is if you tell us that you will do serious harm to yourself or someone else, or someone is seriously harming you (for example if you reveal abuse, that you are dating someone much older or younger than you, or are having suicidal ideations). In that case, as required by law, we would have to make sure you get help by contacting and informing appropriate mental health, child protection, or law enforcement professionals of the clear and imminent danger only. Otherwise, everything else you say is kept confidential (e.g. information pertaining to sexual behaviour would not be shared with your parents or other parties).

Compensation
Participation in research is voluntary – you can decide. If you and your parents decide to take part in the study, you can choose between getting $30.00 for your participation or (for teenagers in high school) the time you spend taking part in the study can be counted towards your community service hours; we will give you a certificate.
Access to Results
We will write a summary of the results of the study when we are finished and put it on our website. We will send you the link when it is ready. You and your parents can read this.

You may contact Dr. Judith Wiener, __________________ (graduate student) or ______________ (lab manager) with any questions you may have about the study. We will try to answer all of these questions.

Sincerely,

______________________
Ph.D. Student
416-978-0933

______________________
Lab Manager
416-978-0933

__________________________________
Judith Wiener, Ph. D
Professor
School and Clinical Child Psychology
(416) 978-0935

Department of Human Development and Applied Psychology
Ontario Institute for Studies in Education of the University of Toronto (OISE/UT)
Toronto, Ontario M5S 1V6
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I hereby consent to take part in this research.

___________________________________
Name of Teenager

___________________________________
Signature

___________________________________
Date

___________________________________
Name of person who obtained consent

___________________________________
Signature

The person who may be contacted about this research is:
___________________________________
who may be contacted at:
(416) 978-0933

“I agree to be contacted in the future regarding other studies being conducted by the ADHD Laboratory at OISE/UT.”

___________________________________
Signature

“I agree that the information collected about me in this study can be used for future data analysis provided that all identifying is removed and that I cannot be identified.”

___________________________________
Signature
Appendix B: Health and Sexual Behaviours Questionnaire (HSBQ)

1. Have you ever been involved in a romantic relationship?
   1. No
   2. Yes

   3a. If yes, how many romantic relationships have you had? _____ Number
   3b. If yes, what is the length of your longest romantic relationship? _____ years, __ months

2. How often in the past year did you go out on a date with someone?

<table>
<thead>
<tr>
<th>Never</th>
<th>1 Time</th>
<th>2 Times</th>
<th>3-5 Times</th>
<th>6-10 Times</th>
<th>11-20 Times</th>
<th>20 Times or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

3. Are you dating someone fairly regularly or going steady now? No Yes

   3a. If yes, is the person you are dating the only partner you are seeing now? No Yes

4. Have you ever had sexual relations (more than kissing, but not intercourse)? No Yes

5. How old were you when you had your first sexual experience with a partner (more than kissing, but not intercourse)? __________ years

6. Have you ever had sexual intercourse? No Yes If NO, check here (___)

7. How old were you the FIRST TIME you had sexual intercourse? __________ years

8. What was your relationship to the first person with whom you had sexual intercourse?
   1. Engaged
   2. Going steady
   3. Dating casually
   4. Friend
   5. Knew each other a little
   6. 1-night stand
   7. Other ______

9. How many DIFFERENT partners have you ever had sexual intercourse with in your life?

<table>
<thead>
<tr>
<th>None</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>More than 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

10. How many times did you have sexual intercourse in the PAST YEAR?

<table>
<thead>
<tr>
<th>Never</th>
<th>1 Time</th>
<th>2 Times</th>
<th>3-5 Times</th>
<th>6-10 Times</th>
<th>11-20 Times</th>
<th>20 Times or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

11. When you had sex in the past year, how often was each type of birth control or disease prevention method used (answer for all types used)?

<table>
<thead>
<tr>
<th>Birth Control Pills</th>
<th>Almost always</th>
<th>Most of the time</th>
<th>About half the time</th>
<th>Some of the time</th>
<th>Hardly ever</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

   | Condoms            | 1             | 2                | 3                   | 4                | 5           | 6     |
12. When you had sex in the past year, who USUALLY made the decision about whether or not to use birth control?
   1. I Did
   2. My Partner Did
   3. We Both Did

13. How often in the past year have you had sex while under the influence of alcohol or drugs?

<table>
<thead>
<tr>
<th>Almost always</th>
<th>Most of the time</th>
<th>About half the time</th>
<th>Some of the time</th>
<th>Hardly ever</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

14. If you are female, how many times have you been pregnant? Never _____# of Times
    N/A

15. If you are male, how many times have you made a girl pregnant? Never _____# of Times
    N/A

16. How often in the past year have you had sex with someone you did not know or someone you just met?

<table>
<thead>
<tr>
<th>Never</th>
<th>1 Time</th>
<th>2 Times</th>
<th>3-5 Times</th>
<th>6-10 Times</th>
<th>More Than 10 Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

17. How often in your life have you had a sexually transmitted disease or venereal disease? Never _____# of times
Appendix C: Important Characteristics in a Romantic Partner (ICRP)

Imagine you are writing a “want ad” to find a boyfriend or girlfriend. What would you want the person to be like? Here is a list of characteristics you might want your ideal boyfriend or girlfriend to have. Please circle the answer that matches your idea about the importance of each characteristic in a boyfriend or girlfriend.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Important at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Athletic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good hygiene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talkative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fun</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funny</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interesting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attractive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Popular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not drink alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not smoke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leader</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rich</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involved in things outside of school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the right thing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix D: Supplemental Tables

Abusive Behaviour in Adolescents with and without ADHD

<table>
<thead>
<tr>
<th>CADRI SCALE</th>
<th>ADHD</th>
<th>Comparison</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M(SD)</td>
<td>n</td>
<td>M(SD)</td>
<td>F</td>
</tr>
<tr>
<td><strong>PARTICIPANT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Abuse</td>
<td>23</td>
<td>30.94 (5.95)</td>
<td>20</td>
<td>33.52 (7.45)</td>
<td>1.59</td>
</tr>
<tr>
<td>Restricted Abuse*</td>
<td>23</td>
<td>23.70 (5.69)</td>
<td>20</td>
<td>25.97 (7.19)</td>
<td>1.33</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>23</td>
<td>4.25 (.70)</td>
<td>20</td>
<td>4.40 (.82)</td>
<td>.44</td>
</tr>
<tr>
<td>Threatening Behaviour</td>
<td>23</td>
<td>4.26 (.62)</td>
<td>20</td>
<td>4.40 (.94)</td>
<td>.34</td>
</tr>
<tr>
<td>Verbal &amp; Emotional Abuse</td>
<td>23</td>
<td>15.04 (4.42)</td>
<td>20</td>
<td>16.80 (5.94)</td>
<td>1.23</td>
</tr>
<tr>
<td>Relational Abuse</td>
<td>23</td>
<td>3.00 (.00)</td>
<td>20</td>
<td>3.00 (.00)</td>
<td>b</td>
</tr>
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*Restricted Abuse refers to (Physical, Verbal Emotional, Threatening Behaviour)

*Cannot be computed because standard deviations of both groups are 0.

Note: Higher Scores denotes higher frequency
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<th>NRI-BSV SCALE</th>
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1. Little or none. 2. Somewhat 3. Very Much. 4. Extremely Much 5. The most.