

# Diagnosing ADHD in Israeli Adults: The Psychometric Properties of the Adult ADHD Self Report Scale (ASRS) in Hebrew

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## ABSTRACT

This paper argues for the importance of diagnosing ADHD in adults, while acknowledging the many attendant difficulties. The paper presents results from two studies implementing the Adult ADHD Self Report Screen (ASRS) in Hebrew. The Hebrew version of the ASRS as approved by the World Health Organization is appended to this paper. The first of the two studies used a paper and pencil version of the ASRS (ASRS\_PP) and the second used a computer administered version (ASRS\_C). A subset of the participants in the two studies was given both versions. The Hebrew ASRS had excellent test-retest reliability. It had good internal consistency in both forms. Support for the validity of the Hebrew ASRS is given by the significantly higher scores of adults with ADHD versus those without, on both versions of the ASRS and on all of its subscales. The sensitivity of the raw sum of all 18 items was significantly higher than that of the 6-item screen suggested by the authors of the ASRS. The sensitivity and specificity of the ASRS in Hebrew should be further examined in future studies including clinically referred participants. The benefit of using the ASRS as part of the diagnostic process for adult ADHD is discussed.

## INTRODUCTION

Attention deficit hyperactive disorder (ADHD) is a common childhood disorder that can be found in 3-5% of school children, in most cultures as in Israel (1). It can be diagnosed if an individual has serious attention prob-

lems, serious hyperactivity and impulsivity, or both. At least some of the symptoms must appear before the age of seven to satisfy the DSM IV diagnosis (2). Many more boys than girls are affected with ADHD, and in particular the hyperactivity component of the diagnosis is more common among boys.

There is substantial genetic influence on ADHD, so that the risk for a sibling of an affected child is 15%, three times the population prevalence, and the risk for children of adults with childhood onset ADHD is 57%, twelve times the population prevalence (3, 4). These results can be interpreted to mean that ADHD that persists into adolescence and adulthood is more genetically influenced than remitting childhood ADHD (5). This odds ratio might be construed as additional motivation to diagnose ADHD in adults, as it confers substantial risk on offspring, who might profit from timely diagnosis and treatment, unlike their parent.

The diagnosis of ADHD in adults is both important and difficult. By definition, at least some of the symptoms need to be present before the age of seven, in order to diagnose the disorder (2). Clinicians to whom children are brought, and who are the first to diagnose ADHD in the child, often note that at least one of the parents who brings in the child meets criteria for ADHD or would have met criteria in childhood had there been a professional available to observe and diagnose the disorder. On the other hand, the diagnosis of ADHD requires two sources of report (such as parent and teacher) and significant functional impairment or distress. In adults who have already built their life around the undiagnosed and untreated impairment, having made life choices that reflect their limitations, this criterion is much harder to establish (4).

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In a recent epidemiological study of adult ADHD (6) a probability sample of households was ascertained in ten countries, the United States, Mexico, Colombia, Belgium, the Netherlands, France, Germany, Spain, Italy and Lebanon. All adults above 18 and under 44 years of age were interviewed by trained lay interviewers using a semi-structured interview schedule. An overall prevalence estimate of 3.4% was found. The most common comorbid conditions in descending order were substance use, mood disorders and anxiety disorders. The most common configuration was three or more co-morbid conditions. With the exception of specific phobia, the temporal order of onset was first ADHD, and then the co-morbid conditions. Substantial dysfunction was associated with ADHD in this study, affecting mobility, cognitive function, and the number of days per month when the adult with ADHD was able to function in his social and occupational capacities.

While semi-structured interviews are the golden standard for psychiatric diagnosis, they are time consuming and expensive, and are not feasible for screening large populations. Several self-assessment instruments have been suggested to bridge this gap. A partial list includes: the Connor's Adult ADHD Rating Scales (7); the Brown ADD Scale (8), and the Wender Utah Rating Scale (9). These self-assessments were originally intended for clinical use, but were also extensively used in research. They showed good screening qualities against diagnostic interviews, in clinical settings. These screening scales were based on the research into adult ADHD of the 1980s (8) and 90s (7, 9). However, as longitudinal and epidemiological information on adult ADHD accrued, it was important to devise a friendly and simple screener that incorporated this additional information. In particular, the measure of hyperactivity or impulsivity in adults needed revision, as they are the most likely to be modified over maturation.

Recently, a group of researchers in the United States in conjunction with the World Health Organization (WHO) developed a self-report scale for the screening of ADHD in adults (ASRS-v1.1; 10). The scale they propose is a short, 18-item scale which relates directly to the DSM IV TR diagnostic criteria (2). Part A of the scale is a 6-item screen, and the second part is the remaining 12 items. Gaining a score of 4 or more on Part A is a strong indication of adult ADHD (10). The ASRS can be used by a clinician, as in the WHO version appended to the current paper. It can also be used as a self-assessment (11) without loss of sensitivity or specificity.

The goals of the current study were to present the self-report ASRS-v1.1 in Hebrew, in a paper and pencil form as well as in a computer administered form, and to test its validity against clinical diagnosis in college students. The self-report rather than the clinician administered form was used. The inference behind using the self-administered form is that it will provide a conservative, lower bound estimate, of the psychometric properties of the ASRS, with the clinician administered version expected to outperform it.

## METHODS

### INSTRUMENTS

The ASRS-v1.1 was translated into Hebrew by translation back translation comparison and correction. The Hebrew translation of the ASRS-v1.1 and the scoring information are appended to this paper. The current Hebrew version of the ASRS-v1.1 has been approved by the WHO as the official Hebrew version (12, 13).

In addition, the items of the Hebrew ASRS-v1.1 were adapted for computer presentation. The order of presentation, the wording of the items, and the response categories remained the same. However, the computer presents each item separately on the computer screen. A new item appears only when the participant has responded to the previous item. Thus there were two modes of presentation of the Hebrew ASRS-v1.1 in the current study, paper and pencil (ASRS\_PP) and computer screen (ASRS\_C).

The self-report version can be used in any setting, and thus is the more generalizable. Kessler et al. found it to be no less sensitive or specific than the clinician administered version (11). However, it is reasonable to suppose that the clinician administered version will outperform it psychometrically, especially if there is an established relationship of trust between the clinician and the patient being screened.

### PROCEDURE

The research protocol was approved by the ethics committee of the Department of Behavioral Sciences at Ruppin Academic Center, and by the General Director of the college. The study goals were presented to the participants as studying cognitive and emotional function of young adults. Informed consent forms were obtained from all participants. Participants also agreed to have their file at the Learning Disorders Center reviewed by the researchers. Confidentiality was promised and ensured by entering the data without any identifying information.

The ASRS in both modes was presented after other psychological measures were presented, and was not the last scale presented in either mode. For the subset of participants who completed both the ASRS\_PP and the ASRS\_C, the order of presentation was randomized, about half (N=29) completed the ASRS\_PP first, and the other half (N=26) completed the ASRS\_C first.

**PARTICIPANTS**

All participants were college student volunteers. Most were first year volunteers, who were completing their requirement of participating in research as part of their Introduction to Psychology class. In addition, students were ascertained through the learning-disorder support center of Ruppin College, enriching the sample for individuals who had previously been clinically diagnosed with ADHD. All participants were told that the study was concerned with the cognitive and emotional function of young adults, without mention of ADHD. The ASRS\_PP was administered to 120 participants, with a mean age of 24.9, ranging from 21 to 35 years of age. Of this sample, 20 participants, or 16.7%, had a current clinical diagnosis of ADHD. The ASRS\_C was administered to 72 participants, with a mean age of 24.8, and a range of 21 to 34. Of these 23 participants, or 31.9%, had a current clinical diagnosis of ADHD. A subset of each group, 55 participants in all, completed both the ASRS\_PP and the ASRS\_C. The demographics of this subset were similar to those of the two original samples, and 8 out of 55 or 12% had previously been diagnosed with ADHD by a clinician.

**CLINICAL DIAGNOSIS OF ADHD**

The learning-disorder support center of Ruppin College has a two-tier process. The students who apply to the center come with a diagnosis of learning disorders or ADHD given by a relevant professional, a neurologist, psychiatrist, clinical psychologist, or neuropsychologist. An MA level educational psychologist (HK) conducts a file review, as well as a face-to-face interview to assess current status and current severity of symptoms. All the participants ascertained through the College support center were judged to currently meet criteria for ADHD. In addition all participants, who were volunteer college students and who were not ascertained through the learning disorder center, were asked about childhood onset conditions, including ADHD. Five participants reported that they had been diagnosed with ADHD in the past, and were interviewed by AHZ, a senior clinical psychologist, to assess their current status. The semi-structured interview developed for

the International Gilles de la Tourette Syndrome Linkage Group (14) was used for determining the diagnosis of these individuals. This interview takes into account the individual's developmental history as well as operationalizing the DSM IV TR criteria for ADHD. Four of these five individuals met criteria for current ADHD and were thus added to the "clinical diagnosis of ADHD" group.

**RESULTS**

Reliability of the Hebrew ASRS-v1.1 was tested in two ways. Test-retest reliability was assessed by calculating the Pearson correlation between the same items presented in the ASRS\_PP and the ASRS\_C, as well as the correlation of the unweighted sum of responses in the ASRS\_PP and the ASRS\_C, in the subset of participants who were administered both forms of the ASRS. The correlations are presented in Table 1, and are all highly significant. The lowest correlation is 0.60 and the highest is 0.90. Thus there is very high test-retest reliability, even though the

**Table 1:** Test -Retest Reliability; Pearson Correlation Between Written Items of the ASRS\_PP and Items Presented Singly on a Computer Screen in the ASRS\_C (N=55)

Item number	Pearson correlation
1.	0.82
2	0.67
3	0.62
4	0.60
5	0.63
6	0.80
7	0.76
8	0.81
9	0.63
10	0.77
11	0.85
12	0.77
13	0.90
14	0.80
15	0.81
16	0.71
17	0.82
18	0.77
Total score (unweighted sum of the 18 responses)	0.89

scales were presented in two quite different modes.

Reliability as a measure of internal consistency was assessed for the two scales and for the whole measures of the ASRS\_PP and the ASRS\_C by means of Cronbach's lower bound estimate of reliability, and these results are summarized in Table 2 below. All reliability estimates are between 0.79 and 0.89, i.e., the Hebrew ASRS-v1.1 is highly consistent both in the ASRS\_PP and in the ASRS\_C modes. The ASRS\_PP is slightly more reliable than the ASRS\_C.

The validity of the ASRS was assessed by comparing the scores of the participants with and without an independent clinician's diagnosis of ADHD, for the scales and the entire ASRS, for the unweighted responses as well as for symptom count, which is the number of items endorsed in the 6-item screen. For ease of reading, the results are shown in two tables: the ASRS\_PP validity is shown in Table 3a, and for the ASRS\_C in Table 3b. Group differences were tested by means of t-test. All mean scores of participants with ADHD were significantly higher than those of participants without ADHD, at the p=0.05 level, for all the ASRS variables in both versions of the test.

Comparing Table 3a and 3b demonstrates that the group differences in the ASRS\_C are larger and more significant than in the ASRS\_PP. This is due mainly to the participants with ADHD scoring higher on the ASRS\_C than in the ASRS\_PP. There are virtually no differences in the reports of the participants without ADHD in the ASRS\_PP and the ASRS\_C.

In their analysis of the diagnostic properties of the ASRS, Kessler et al. (10) found that the Part A, 6-item screen, scored dichotomously resulted in the optimal sensitivity and specificity. In the following analysis we present the properties of the Part A screen, as well as those of the complete unweighted, 18-item score. The two data sets, that of the ASRS\_PP and that of the ASRS\_C, are presented side by side in Table 4 with the resulting sensitivity and specificity values. The 6-item screen has over 70% specificity in both presentation modes, but is

**Table 2:** Scale Reliabilities for Written ASRS, and Computer Presented ASRS (N=55)

	ASRS_PP	ASRS_C
Complete scale	0.89	0.85
Nine inattention items	0.82	0.79
Nine hyperactivity and impulsivity items	0.88	0.81

low on sensitivity, 40% on the ASRS\_PP and 52% on the ASRS\_C. Since a screening test should err in the direction of high sensitivity, even if the price is lower specificity (15) the unweighted full scale outperforms the 6-item screen. In the full scale option, the sensitivity of the ASRS\_C is 73.9% and of the ASRS\_PP 62.7%; there is a price in specificity, the ASRS\_PP has a specificity of 68% while the ASRS\_C has a specificity of 62.7%.

**DISCUSSION**

The results of this study should be viewed in light of its limitations. The participants were all college students. Sampling from college students potentially restricts the severity and dysfunction of ADHD, as well as the range of co-morbid conditions prevalent in adults with ADHD (6). This range restriction of ADHD severity potentially makes it more difficult for the screening process to detect ADHD, and therefore might also be

**Table 3a:** Validity of ASRS – Scores of ASRS\_PP in Participants with and without a Clinical Diagnosis of Current ADHD

	Groups	Mean (SD)	t-value	p
Total ASRS	ADHD (N=20) No-ADHD (N=100)	52.9 (7.5) 47.7 (5.3)	-2.98	0.005
6-item screen	ADHD (N=20) No-ADHD (N=100)	3.1 (1.4) 2.1 (1.5)	-2.84	0.008
Hyperactivity	ADHD (N=20) No-ADHD (N=100)	25.0 (1.9) 22.8 (1.9)	-2.02	0.052
Inattention	ADHD (N=20) No-ADHD (N=100)	27.9 (2.3) 24.9 (1.8)	-2.68	0.012

**Table 3b:** Validity of ASRS – Scores of ASRS\_C in Participants with and without a Clinical Diagnosis of Current ADHD

	Groups	Mean (SD)	t-value	P
Total ASRS	ADHD (N=23) No-ADHD (N=49)	57.9 (8.9) 47.3 (5.3)	-4.16	0.000
6-item screen	ADHD (N=23) No-ADHD (N=49)	3.6 (1.6) 2.3 (1.6)	-3.27	0.002
Hyperactivity	ADHD (N=23) No-ADHD (N=49)	27.4 (5.3) 22.7 (2.3)	-3.35	0.001
Inattention	ADHD (N=23) No-ADHD (N=49)	30.5 (3.7) 24.6 (3.1)	-3.99	0.000

**Table 4:** Sensitivity and Specificity of the Hebrew ASRS-v1.1

	ASRS_PP		ASRS_C	
	Screen 3/4 <sup>1</sup>	Full scale 50/51 <sup>2</sup>	Screen 3/4 <sup>1</sup>	Full scale 50/51 <sup>2</sup>
Sensitivity	40%	65%	52%	73.9%
Specificity	78.4%	68%	73.5%	62.7%

<sup>1</sup> Participants with ADHD N=20, participants without ADHD N=100.

<sup>2</sup> Participants with ADHD N=23, participants without ADHD N=49.

viewed as making the psychometric assessment of the instrument more conservative.

Another limitation of sampling college students is that it restricts the range of IQ. Adults with all the symptoms of ADHD and lower IQ may have more difficulty in identifying and communicating their difficulties. This is a more serious limitation of the current sampling scheme.

In addition the version of the ASRS used in the current study was the self report. Kessler et al. (11) demonstrated for the English ASRS that the self-report performs just as well as the clinician-administered version (10). It is the belief of the current researchers that the psychometric properties of the self-report provide lower bound estimates relative to the clinician administered version. This is a reasonable empirical hypothesis which, however, needs verification in future research.

The results of the current study show that the Hebrew ASRS-v1.1 has excellent reliability in both its forms, paper and pencil and computer administration. Item reliability was extremely high, as was the scale consistency in both the ASRS\_PP and the ASRS\_C.

There is support for the validity of both the ASRS\_PP and the ASRS\_C. Participants with ADHD rated themselves higher on the ASRS\_C than on the ASRS\_PP, while there were virtually identical scores for non-ADHD participants in the two presentation modes. In the paper and pencil presentation all the items are presented on one page, so that the participants are aware of all their responses and can adjust them. Interestingly, this did not affect the responses of the participants without ADHD whose answers in both modes were indistinguishable, but it had a measurable effect on those with ADHD, who, when given the control afforded by comparison, reported their symptoms as less frequent and less severe, but in the single item presentation of the ASRS\_C scored higher. This might also explain why the ASRS\_C was slightly more sensitive than the ASRS\_PP. However, both versions showed consistent and significant discriminant

validity for the complete ASRS as for its subscales.

It should be noted that the ASRS\_C showed slightly lower reliability estimates than the ASRS\_PP. The lower reliability of computer administered tests versus the pencil and paper mode has been noted by others (16). Gamliel and Peer (16) interpreted this difference in reliability estimates as an inflation in the paper and pencil mode due to a conscious effort on the part of participants to be consistent, made possible by the simultaneous presentation of the items in the paper and pencil mode. This comparison is impossible to accomplish in the computer administration. In the current study, although reliability is lower in the ASRS\_C it is still robust, as all reliability estimates are around 0.80.

While in the English version the Part A 6-item screen with dichotomized scoring of the items provided the best specificity and sensitivity for the diagnosis of adult ADHD, this is not true for the Hebrew ASRS-v1.1 in either presentation forms. In particular the Part A screen provides low sensitivity. If there is a tradeoff between sensitivity and specificity, a screen should be set to err in the opposite direction, providing higher sensitivity and lower specificity (15). The current study supports the conclusion that the best practice of the Hebrew ASRS-v1.1 is to present the complete scale and to score it using the full range of the response categories.

As argued in the introduction, there are excellent reasons to diagnose adults with ADHD, and to do so accurately. It is hoped that the Hebrew ASRS\_v1.1 will prove a useful addition to the screening process and aid correct diagnosis. It is suggested that the Hebrew ASRS-v1.1 be adopted as a standardized and psychometrically sound measure by clinicians, testing centers in academic centers, and by researchers who wish to study adult ADHD.

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**רשימת הסימפטומים על פי סולם דיווח-עצמי של ADHD אצל מבוגרים (ASRS-vl.1)**

					שם:	תאריך היום:
לעיתים מאוד	לעיתים תכופות	לפעמים	לעיתים רחוקות	אף פעם לא	ענה על השאלות שלמטה ודרג את עצמך בכל אחד מהקריטריונים המוצגים, על-ידי שימוש בסולם המופיעה בצד השמאלי של דף זה. כאשר אתה עונה על כל שאלה, הקף את המספר בתא המתאר בצורה הטובה ביותר את האופן בו הרגשת וניהלת את עצמך בששת החודשים האחרונים. בבקשה העבר את הרשימה המלאה למטפל הבריאותי שלך, על-מנת שתדונו בכך במהלך הפגישה היום.	
חלק א'						
5	4	3	2	1	1.	באיזו תכיפות את/ה מתקשה להשלים את הפרטים הקטנים של פרויקט, מהרגע בו החלקים המאתגרים הסתיימו?
5	4	3	2	1	2.	באיזו תכיפות את/ה מתקשה ליצור סדר בדברים, כאשר את/ה מבצע/ת משימה המצריכה ארגון?
5	4	3	2	1	3.	באיזו תכיפות את/ה מתקשה בזכירת פגישות או התחייבויות?
5	4	3	2	1	4.	כאשר מוטלת עלייך משימה המצריכה חשיבה מרובה, באיזו תכיפות את/ה נמנע/ת או דוחה את התחלתה?
5	4	3	2	1	5.	באיזו תכיפות את/ה מתפתלת או מניעה בקוצר-רוח את ידייך או רגלייך, כאשר עליך לשבת במקומך למשך זמן ארוך?
5	4	3	2	1	6.	באיזו תכיפות את/ה מרגישה פעילה/ה יתר על המידה או מרגישה צורך לעשות דברים, כאילו את/ה פועלת על-ידי מנוע?
חלק ב'						
5	4	3	2	1	7.	באיזו תכיפות את/ה מבצע שגיאות הנובעות מרשלנות, כאשר עלייך לעבוד על פרויקט משעמם או מסובך?
5	4	3	2	1	8.	באיזו תכיפות את/ה מתקשה בשמירה על ריכוז, כאשר את/ה מבצע/ת עבודה משעממת או עבודה החוזרת על עצמה?
5	4	3	2	1	9.	באיזו תכיפות את/ה מתקשה להתרכז במה שאנשים אומרים לך, אפילו כאשר הם מדברים אלייך באופן ישיר?
5	4	3	2	1	10.	באיזו תכיפות את/ה מאבד/ת חפצים או מתקשה במציאתם, בעבודה או בבית?
5	4	3	2	1	11.	באיזו תכיפות דעתך מוסחת על-ידי פעילות או רעש בסביבתך?
5	4	3	2	1	12.	באיזו תכיפות את/ה קם/ה ממושך במהלך פגישה או בכל סיטואציה אחרת, בה מצופה ממך להישאר במקומך?
5	4	3	2	1	13.	באיזו תכיפות את/ה מרגישה חסר/ת-מנוחה או קצר/ת-רוח?
5	4	3	2	1	14.	באיזו תכיפות את/ה מתקשה להירגע ולהשתחרר כאשר יש לך זמן לעצמך?
5	4	3	2	1	15.	באיזו תכיפות את/ה מוצא/ת את עצמך מדבר/ת יותר מידי כאשר את/ה בסיטואציה חברתית?
5	4	3	2	1	16.	כאשר את/ה במהלך שיחה, באיזו תכיפות את/ה מוצא/ת את עצמך מסיים/ת משפטים של האנשים עימם את/ה מדבר/ת, לפני שהם מסיימים אותם בעצמם?
5	4	3	2	1	17.	באיזו תכיפות את/ה מתקשה לחכות לתורך בסיטואציות בהן נדרשת המתנה?
5	4	3	2	1	18.	באיזו תכיפות את/ה מפריעה לאחרים כאשר הם עסוקים?

הערה: בגרסה האנגלית של ארגון הבריאות העולמי נמצא כי אם בחלק א' השיב הנבדק תשובה מוצללת על לפחות 4 פריטים זוהי אינדיקציה טובה להמשך בירור ולהיתכנות של ADHD. לפי מחקר על הגרסה העברית נראה כי סכום הציונים הגולמיים על כל 18 הפריטים (חלק א וחלק ב ביחד) היא האינדיקציה הטובה ביותר להמשך בירור של ADHD, ובפרט אם הסכום הוא 51 ומעלה.

## הנחיות לרשימת סימפטומים על פי סולם דיווח עצמי של ADHD אצל מבוגרים (ASRS-vl.i)

הנוגע לשתיים עשרה השאלות. נמצא כי שש השאלות בחלק ב' הינן המנבאות הטובות ביותר של הפרעה והינן הטובות ביותר לשימוש כאמצעי-סינון. בצע סקירה של כלל רשימת הסימפטומים יחד עם הפציינט ובצע הערכה של רמת הליקוי בשילוב עם הסימפטום.

קח בחשבון את מסגרות העבודה/ בית הספר, המשפחה והחברה.

שכיחות הסימפטום בדרך-כלל קשורה עם חומרת הסימפטום, לכן, רשימת הסימפטומים יכולה גם היא לסייע בהערכת הליקויים. אם למטופליך ישנם סימפטומים תכופים, אתה עשוי להיות מעוניין בכך שהם יתארו כיצד בעיות אלה משפיעות על היכולת לעבוד, לטפל בדברים בבית, או להסתדר בחברת אנשים, כמו בן-זוגם או אחרים משמעותיים.

### היסטוריה:

הערך את נוכחות הסימפטומים הללו או סימפטומים דומים בילדות. מבוגרים בעלי ADHD צריכים שלא להיות מאובחנים רשמית (כסובלים מהפרעה) בילדותם. בהערכת ההיסטוריה של הפציינט, חפש ראיות של הופעה מוקדמת ובעיות ארוכות-טווח הקשורות בקשר או בשליטה-עצמית. ישנם סימפטומים משמעותיים אשר אמורים היו להיות נוכחים בילדות, אך לא דרושים לכך כל הסימפטומים.

השאלות בעמוד הבא מיועדות לעורר דיאלוג בין לבין הפציינטים שלך, וכן לעזור לאשר אם הם סובלים מהתסמינים של הפרעת קשב, ריכוז והיפר-אקטיביות (ADHD).

**תיאור:** רשימת הסימפטומים הינה כלי המורכב משמונה-עשר הקריטריונים של ה-DSM-IV-TR. שש מתוך שמונה-עשרה השאלות נמצאו כמנבאות הטובות ביותר של קביעות סימפטומים ב-ADHD. שש השאלות הללו הינן הבסיס למיון על-פי ה-ASRS-vl.i, והן גם חלק א' ברשימת סימפטומים. חלק ב' מרשימת הסימפטומים כולל את שתיים-עשרה השאלות הנוותרות. **הנחיות:** בקש מהפציינט להשיב על השאלות בחלקים א' ו-ב' מרשימת הסימפטומים, על-ידי הקפת המספר בתא, המייצג בצורה האמיתית ביותר את שכיחות ההתרחשות של כל אחד מהסימפטומים. רשום את הניקוד של חלק א'. במידה וארבעה סימונים או יותר מופיעים בתאים המוצללים בחלק ב' של השאלון, אז לפציינט ישנם סימפטומים עקביים מאוד של ADHD אצל מבוגרים וראויה חקירה נוספת. שכיחות התוצאות בחלק ב' תספק רמזים נוספים ותוכל לשרת כאמצעי-בדיקה נוסף לסימפטומים של הפציינט. שים לב במיוחד לסימונים המופיעים בתאים המוצללים. שאלות מסוימות הן יותר רגישות לתשובות המבוססות על תכיפות. אין תוצאה כוללת או סבירות אבחונית בכל

## ערכו של הסינון עבור מבוגרים עם ADHD:

המחקר מציע כי סימפטומים של ADHD יכולים להימשך במהלך הבגרות, עם יכולת השפעה משמעותית על יחסים, קריירה ואפילו על ביטחונם האישי של מטופליך, אשר עשויים לסבול מכך. מכיוון שלעיתים קרובות הפרעה זו אינה מובנת כהלכה, אנשים רבים הסובלים ממנה לא מקבלים טיפול הולם וכתוצאה מכך, הם עשויים לא לממש את הפוטנציאל המלא שלהם לעולם. חלק מהבעיה הינו הקושי באבחון, במיוחד אצל מבוגרים. רשימת הסימפטומים על פי סולם דיווח-עצמי של ADHD אצל מבוגרים (ASRS-vl.i), פותחה בשיתוף עם ארגון הבריאות העולמי (World Health Organization - WHO) ובשיתוף עם קבוצת-עבודה על ADHD אצל מבוגרים, אשר כללה צוות של פסיכיאטרים וחוקרים:

**Lenard Adler, MD \***

פרופסור עמית לפסיכיאטריה ונירולוגיה בית-הספר לרפואה, אוניברסיטת ניו-יורק.

**Ronald C. Kessler, PHD \***

פרופסור, המחלקה למדיניות הטיפול הבריאותי בית-הספר לרפואה, הרווארד.

**Thomas Spencer, MD \***

פרופסור עמית לפסיכיאטריה בית-הספר לרפואה, הרווארד.

כמטפל בריאותי, אתה יכול להשתמש ב-ASRS-vl.i כאמצעי-עזר לסינון הפרעת ADHD אצל פציינטים מבוגרים. הסתכלות פנימה על-ידי כלי-סינון זה, עשוי להעלות את הצורך בהסתכלות מעמיקה יותר על-ידי ראיון קליני. השאלות ב-ASRS-vl.i עוקבות אחר הקריטריונים של ה-DSM-IV ופונות להצגת הסימפטומים של ADHD אצל מבוגרים. תוכנו של השאלון גם משקף את החשיבות שנותן ה-DSM-IV לסימפטומים, לליקויים ולהיסטוריה - לאבחון מדויק ונכון.

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