ADHD symptoms predict lower adaptation to the COVID-19 outbreak: financial decline, low adherence to preventive measures, psychological distress, and illness-related negative perceptions

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Abstract

Objective. The COVID-19 outbreak created numerous multidimensional stressors, to which people show different levels of vulnerability. The current paper examines whether ADHD symptoms are associated with poorer adaptation.

Method. 2055 adults participated in an online survey after the first quarantine in Israel.

Participants completed scales probing adaptation indicators: financial status, adherence to preventive measures, mental health, and COVID-19 related perceptions. Background measures, including the level of ADHD symptoms, were collected.

Results. Adaptation indicators negatively correlated with the level of ADHD symptoms.

Financial decline explained a small portion of the link between ADHD and decreased mental health; background risk-taking, anti-social, and pro-social behavior partially explained the link between ADHD and non-adherence to preventive measures; COVID-19 related perceptions also partially explained the same link.

Conclusion. The current study suggests that people with ADHD are more vulnerable to the challenges created by the COVID-19 pandemic and therefore deserve special attention and care.

Keywords: ADHD, COVID-19; Health; Well-Being; Pandemic

The novel coronavirus 2019 (COVID-19) pandemic is a public health and global economy breakdown affecting every facet of society. At the individual level, the pandemic has created a myriad of long-term and multidimensional psychosocial stressors such as lockdown and social distancing, unemployment, as well as decreased family and social support that are important for financial security and emotion regulation (Gruber et al., 2020). As a result, deleterious effects on physical and mental health and life satisfaction are likely. International organizations advocate for integration of mental health and psychosocial support into the COVID-19 response (Moreno et al., 2020).

Different people will respond to the challenges of the pandemic by various behaviors and perceptions, thus demonstrating variable degree of adaptation. Vulnerable people might be at increased risk and are expected to show lower levels of adaptation. Indeed, a recent study demonstrated substantial increases in distress during the emergence of the COVID-19 crisis. Importantly, those with pre-existing mental health conditions were more likely to show a rise in distress (Daly & Robinson, 2020).

Attention deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition characterized by inattention, hyperactivity, and impulsivity leading to functional impairment (American Psychiatric Association, 2013). ADHD is one of the earliest reliable predictors of long term poor health outcomes, including various psychiatric and physical disorders, smoking and substance use, risky behavior, and accidental injury (Nigg, 2013). Being a risk factor for multiple adverse outcomes, ADHD might confer increased vulnerability to significant life transitions and challenges such as recently presented by the COVID-19 pandemic.

Tremendous changes in life are not uncommon. An onset of a health condition, transition to college life, grief after a loss of a beloved person, etc., all demand adaptation of psycho-behavioral

functions. Adaptability, the capacity to constructively adapt to new or changing situations, relates to behavioral, cognitive and emotional regulation (Martin, Nejad, Colmar, & Liem, 2012). Individuals who are deficient in regulatory functions might show vulnerability to higher stress in times of change. The literature has long documented lower regulatory skills in ADHD (Barkley, 1997) showing more difficulties to manage increased stress levels (Hirvikoski et al., 2011; Lackschewitz, Hüther, & Kröner-Herwig, 2008). In the face of stressful episodes, individuals with ADHD more frequently use maladaptive coping strategies such as escape-avoidance, confrontational, and unplanned problem-solving (Hampel, Manhal, Roos, & Desman, 2008; Oster, Ramklint, Meyer, & Isaksson, 2019; Young, 2005). Individuals with ADHD reported greater stress in transition to college, demonstrating unhealthy coping skills and lower adaptability (Martin, & Burns, 2014). In transition to military service in countries like Korea, Singapore and the US, individuals with ADHD experience higher emotional distress, more alcohol and caffeine use, and reduced quality of life (Cipollone et al., 2020; Noh, Lee, & Bahn, 2018). Finally, the high prevalence of ADHD among patients with post-traumatic stress disorder (PTSD) suggests that ADHD is a vulnerability factor for developing PTSD following an exposure to stress (Adler, Kunz, Chua, Rotrosen, & Resnick, 2004).

In line with the suggestion that ADHD is a vulnerability factor to adaptation, the present study aimed to examine the links between ADHD and adaptation indicators during the COVID-19 outbreak. Specifically, the links between ADHD symptoms and financial decline, adherence to preventive measures, psychological distress and life satisfaction, as well as to COVID-19 related perceptions, were examined.

Methods

Data from a study that aimed to detect risk factors for non-adherence to preventive measures was re-analyzed for the purpose of the current research. The methods of the study have been described extensively in the manuscript summarizing the primary findings of the study (Pollak, Shoham, Dayan, Gabrieli Seri, & Berger, *MedRxiv*). Below are only methods that were used for the current paper, briefly described.

The study was approved by the ethics committee of the Seymour Fox School of Education at the Hebrew University of Jerusalem. From May 13 to 23, 2020, a sample of 2055 online panel respondents was recruited (<https://www.panel4all.co.il>) representing the variety of the adult Israeli population.

Outcome measures

For the current study, the main outcome variables were financial decline, low adherence to preventive measures, psychological distress, and illness-related perceptions. Financial decline was measured by a five-point question concerning the level of decrease in income since the onset of the outbreak (1 = no decrease at all, 5 = a sharp decrease). In addition, Participants reported their pre-outbreak and current percent of position. A difference score was computed and categorized into a binary variable (0 = no decrease, 1 = decrease). Low adherence to preventive measures was probed by a 13-item questionnaire. Participants rated the extent of which they adhered to each of 13 preventive measures that were released by the Israeli Ministry of Health at the corresponding period (focusing on social distancing, personal hygiene practicing, facemask wearing) on a five-point Likert scale (1 = not at all, 5 = strictly). Psychological distress was measured by the Kessler Screening Scale (K6) probing current non-specific psychiatric symptoms (Kessler et al., 2002). Life satisfaction was probed by two questions concerning the current level of happiness and satisfaction from life. COVID-19-related perception measures

included the perceived risk of COVID-19, the perceived efficacy of the preventive measures, the perceived costs of adherence to preventive measures, and the perceived norms regarding adherence to preventive measures (see Pollak et al. *MedRxiv* for detailed description of the measures).

The independent variable, level of ADHD symptoms, was measured by the Hebrew version of the Adult ADHD Self-Report Scale for measuring the level of ADHD symptoms (Kessler et al., 2005).

Other background measures consisted of sociodemographic, behavioral, and personality characteristics. Sociodemographic measures included age, gender, marital status, having children, religiousness, education, place of living (urban versus rural), background migration, and pre-outbreak level of income. In addition, participants reported whether they were confirmed COVID-19 cases. Behavioral and personality measures included a short form of the Adult Risk-Taking Inventory (ARTI) (Shoham, Sonuga-Barke, Yaniv, & Pollak, 2019, 2020), past anti-social behavior scale (adapted from Cho, Martin, Conger, & Widaman, 2010), and the pro-social subscale of the young adult Strengths and Difficulties Questionnaire (Brann, Lethbridge, & Mildred, 2018).

Statistical analysis

Descriptive statistics included medians and ranges of the continuous variables and frequency and percentage of categorical variables. Spearman correlations were used to measure the links between the ASRS score and the different adaptation indicator. Linear regression analyses were used to covariate for demographic variables (gender, age, religiousness, marital status) and for examining the specific contributions of ADHD symptoms clusters (inattention,

hyperactivity/impulsivity) to the prediction of the continuous outcome measures. The direct and indirect effects of ADHD symptoms on the outcome measures through financial decline, behavioral characteristics, and COVID-19-related perceptions were calculated using the multiple mediation approach and the SPSS macro (PROCESS, Model 6) provided by Hayes (2017). The significance of the indirect effects was tested via a commonly performed bootstrap analysis (bias-corrected and accelerated, 5000 samples), which allows for greater statistical power in multiple mediator analyses. All analyses were conducted using SPSS 25.0, including an SPSS macro designed for assessing multiple mediation models (Preacher & Hayes, 2008).

Results

Descriptive statistics

Table 1 present the sociodemographic, clinical, and behavioral characteristics and COVID-19 perceptions of the sample.

Table 1: Demographic and clinical characteristics

Categorical variables	n	%
Gender		
<i>Females</i>	1128	55.4%
<i>Males</i>	909	44.6%
Religiosity		
<i>Non-religious</i>	1501	73.7%
<i>Religious</i>	535	26.3%

Marital status

Not married 740 36.2%

Married 1302 63.8%

Having children

No children 582 31.7%

Children 1253 68.3%

Higher education

No 983 48.3%

Yes 1054 51.7%

Pre-outbreak level of income

Much more than average 78 3.8%

More than average 292 14.3%

Average 611 30.0%

Less more than average 498 24.4%

Much less than average 561 27.5%

Decrease in percent of position

No 1231 62.8%

Yes 729 37.2%

Continuous variables

Mdn (25%-75%)

Age

37.0 (27.00-52.00)

Decline in income (1-5 scale)

2.00 (1.00-4.00)

Adherence to preventive measures (1-5 scale)

4.15 (3.62-4.62)

Mental health measures

Life satisfaction	3.00	(2.00-3.00)
Psychological Distress (K6)	1.83	(1.50-2.50)

Behavioral and personality

ARTI	1.57	(1.29-2.00)
Antisocial	1.13	(1.07-1.33)
Prosocial	2.80	(2.40-3.00)

COVID-19-related perception measures

Efficacy	4.00	(3.40-4.50)
Norm	4.00	(3.25-4.50)
Cost	2.71	(2.14-3.43)
Risk	3.00	(2.64-3.45)

ADHD symptoms – mean ASRS score (1-5 scale)

Total	2.17	(1.78-2.56)
Inattention	2.22	(1.78-2.67)
Hyperactivity	2.11	(1.67-2.56)

Note: ADHD = attention deficit/hyperactive disorder, Antisocial = past anti-social behavior, ARTI = a short form of the Adult Risk-Taking Inventory, ASRS = the Hebrew version of the Adult ADHD Self-Report Scale, Cost = the perceived costs of adherence to preventive measures, Efficacy = the perceived efficacy of the preventive measures, Norm = the perceived norms regarding adherence to preventive measures, Prosocial = pro-social subscale of the young adult Strengths and Difficulties Questionnaire (SDQ), Psychological Distress (K6) = Kessler Screening Scale for Psychological Distress, Risk = perceived risk of COVID-19.

Table 2 presents the correlations between level of ADHD symptoms and each of the adaption indicators. ADHD symptoms correlated with all outcome variables. A set of regression analyses included all demographic variables in the first block and the inattention and hyperactivity/impulsivity subscales scores of ASRS in the second block. The second block remained a significant predictor of all outcome variables above and beyond the demographic variables. Inattention symptoms predicted decrease in income above and beyond hyperactivity symptoms, but not vice versa. Hyperactivity/impulsivity symptoms predicted increase in perceived risk and decrease in perceived efficacy above and beyond inattention symptoms, but not vice versa. Both inattention and hyperactivity predicted mental health outcome (K6 and life satisfaction scores), adherence to preventive measures, and perceived norms and costs of adherence to preventive measures above and beyond each other (see Table S1-2 in the Supplementary Materials).

Table 2: Spearman's rho correlations between ADHD symptoms and outcome variables

		ADHD symptoms			Finance		Mental health measures		Behavioral and personality		COVID-19-related perception measures				Adherence to preventive measures	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
<u>ADHD symptoms</u>																
1	Mean ASRS	-														
2	Inattention	.913**	-													
3	Hyperactivity	.912**	.679**	-												
<u>Finance</u>																
4	Decrease in income	.135**	.127**	.120**	-											
5	Decrease in percent of position	.110**	.107**	.094**	.608**	-										
<u>Mental health measures</u>																
6	Psychological Distress (K6)	.535**	.468**	.519**	.214**	.154**	-									
7	Life satisfaction	-.309**	-.299**	-.274**	-.160**	-.125**	-.569**	-								
<u>Behavioral and personality</u>																
8	Prosocial	-.098**	-.095**	-.082**	.015	.008	-.102**	-.201**	-							
9	Antisocial	.315**	.309**	.276**	-.004	.028	.142**	.118**	.132**	-						
10	ARTI	.347**	.302**	.332**	.094**	.074**	.223**	.113**	.066**	.477**	-					
<u>COVID-19-related perception measures</u>																
11	Risk	.101**	.084**	.108**	.073**	.010	.180**	.117**	-.029	-.128**	-.100**	-				
12	Efficacy	-.203**	-.190**	-.184**	-.039	-.031	-.162**	-.156**	-.166**	-.215**	-.216**	.362**	-			
13	Cost	.279**	.245**	.269**	.289**	.240**	.345**	.253**	.063**	.088**	.155**	.247**	-.099**	-		
14	Norm	-.212**	-.206**	-.188**	.002	.001	-.185**	-.119**	-.194**	-.163**	-.199**	.135**	.453**	-.074**	-	
15	<u>Adherence to preventive measures</u>	-.226**	-.227**	-.193**	.035	.010	-.121**	-.105**	-.164**	-.324**	-.306**	.315**	.420**	-.067**	.347**	-

Note: ADHD = attention deficit/hyperactive disorder, ARTI = a short form of the Adult Risk-Taking Inventory, ASRS = the Hebrew version of the Adult ADHD Self-Report

Scale, Cost = the perceived costs of adherence to preventive measures, Decrease in income = decrease in income since the onset of the outbreak, Decrease in percent of position =

pre-outbreak level of income, Efficacy = the perceived efficacy of the preventive measures, Norm = the perceived norms regarding adherence to preventive measures, Psychological Distress K6 = Kessler Screening Scale for Psychological Distress, Risk = perceived risk of COVID-19,

In an additional set of analyses, indirect pathways between ADHD symptoms and different outcome variable were examined (see Table 3). The first two mediation models examined whether the link between ADHD symptoms and decrease in income explains the increase in psychological distress and decrease in life satisfaction. The first model demonstrated a small but significant indirect pathway between the ASRS and K6 scores through the level of decrease in income. In a similar vein, the second model revealed a small but significant indirect pathway between the ASRS and life satisfaction scores through the level of decrease in income. The next models examined indirect pathways between ADHD symptoms and lower adherence to preventive measures. The third model revealed significant indirect pathways between the ASRS and lower adherence to preventive measures through increased risk-taking behavior and antisocial behavior and decreased prosocial behavior. The fourth model revealed significant indirect pathways between the ASRS and lower adherence to preventive measures through increased perceived non-adherence norms to the preventive measures and increased perceived cost of the preventive measures. Also, a significant indirect pathway through decreased perceived efficacy of the preventive measures was found. On the other hand, an indirect pathway through increased perceived risk of the COVID-19 illness diminished the negative link between ADHD and adherence. Interestingly, adding K6 as a covariate to the model reduced the indirect pathway through the perceived risk (see Table 3).

Table 3: Mediation coefficients and confidence intervals (CIs)

Dependent Variable	Model R ²	Indirect effect:				Direct effect
K6	31.33	Decrease in income				
		0.015				0.469
		95% CI [0.007, 0.024]				95% CI [0.428, 0.509]
Life satisfaction	16.09	Decrease in income				
		-0.013				-0.301
		95% CI [-0.06, -0.022]				95% CI [-0.257, -0.346]
Adherence to preventive measures	16.74	Behavioral and personality				
		ARTI	Antisocial	Prosocial		
		-0.036	-0.057	-0.007		-0.088
		95% CI [-0.054, -0.021]	95% CI [-0.075, -0.038]	95% CI [-0.014, -0.001]		95% CI [-0.134, -0.041]
Adherence to preventive measures	29.34	COVID-19-related perception measures				
		Norm	Cost	Risk	Efficacy	
		-0.030	-0.017	0.035	-0.037	-0.140
		95% CI [-0.045, -0.018]	95% CI [-0.031, -0.004]	95% CI [0.021, 0.050]	95% CI [-0.053, -0.022]	95% CI [-0.184, -0.096]
Adherence to preventive measures	29.34	COVID-19-related perception measures with Psychological Distress (K6) covariated				
		Norm	Cost	Risk	Efficacy	
		-0.026	-0.010	0.014	-0.031	-0.141
		95% CI [-0.041, -0.014]	95% CI [-0.019, -0.002]	95% CI [-0.000, 0.029]	95% CI [-0.048, -0.015]	95% CI [-0.189, -0.093]

Final mediation path analysis predicting adherence to preventive measures. The values shown are the standardized regression coefficients of the indirect and direct effects (taking into account other mediators) of ADHD symptoms upon adherence to preventive measures. In bold are the variables that were significant (the respective 95% bias-corrected confidence intervals did not contain zero in bootstrap analyses). The covariates of age, gender, marital status, child, religious, higher education and income are not shown in the table for the sake of brevity.

Discussion

The current paper examined the link between ADHD symptoms and adaptation indicators to the COVID-19 pandemic in several domains. It was found that higher levels of ADHD symptoms predicted lower economic outcome, mental health indices, and adherence to preventive measures. In addition, ADHD symptoms correlated with higher perceived risk of COVID-19 but also with perceptions that encourage non-adherence to preventive measures.

ADHD symptoms predict financial decline

Level of ADHD symptoms correlated with a decrease in percent of position and in income. Furthermore, this correlation explained a small but significant proportion of the variance in the link between ADHD and psychological distress. Inattention rather than hyperactivity/impulsivity symptoms predicted financial decline, in line with a study reporting that persisting high levels of ADHD inattention symptoms in adulthood predicted occupational outcome (Fredriksen et al., 2014; Gjervan, Torgersen, Nordahl, & Rasmussen, 2012). Interestingly, economic decline correlated with COVID-19 related perceptions, such that participants who experienced greater financial problems perceived the illness as more severe and the preventive measures as more costly and less effective.

ADHD symptoms predict lower adherence to preventive measures

Level of ADHD symptoms correlated with lower level of adherence to preventive measures. Non-adherence to preventive measures reflects risk-taking behavior as it increases the likelihood of infection. Indeed, ADHD was found to be a risk factor for COVID-19 infection (Merzon et al., 2020). Also, as the preventive measures were mandatory in Israel at the time of the study, non-adherence may also be considered as anti-social behavior. Importantly, both risk-taking and anti-

social behavior are closely related to ADHD (Pollak, Dekkers, Shoham, & Huizenga, 2019; Retz et al., 2020). Accordingly, the link between ADHD and non-adherence was partially explained by high levels of risk-taking and anti-social behavior.

Non-adherence to preventive measures correlated with illness-related perceptions, namely, with lower perceived severity of the illness, lower perceived efficacy of and lower perceived norms of adhering to the preventive measures, and higher perceived cost of adherence. In our sample, level of ADHD symptoms correlated with lower perceived efficacy and norms and with higher perceived cost of adherence to the preventive measures, explaining part of the link between ADHD and non-adherence. On the other hand, levels of ADHD symptoms also correlated with higher perceived illness severity, tempering the tendency toward non-adherence. Interestingly, the link between ADHD and perceived illness severity was fully nullified by controlling for psychological distress, suggesting a common source for ADHD-related increase in perceived illness severity and psychological distress.

ADHD symptoms predict higher psychological distress

Level of ADHD symptoms also predicted higher psychological distress and lower life satisfaction. Notably, these links are not unique to the COVID-19 outbreak era (APA, 2013). Therefore, the findings may indicate that during the period of the study people with high levels of ADHD symptoms were more likely to experience distress, but not necessarily that these people experienced more distress than they had experienced before the outbreak. Importantly, part of the link between ADHD and psychological distress was accounted for by financial decline, suggesting that at least some of the negative consequences of the pandemic aggravated pre-outbreak levels of distress of people with high levels of ADHD symptoms.

The study has limitations. ADHD was dimensionally defined and did not focus on a comparison between people who meet the DSM-5 criteria of ADHD. All measures were based on self-report and not on objective observations. Data collection took place at relatively early stages of the pandemic and might not be fully generalizable to later stages.

Clinical implications

The COVID-19 outbreak's deleterious effects on the individual's financial security and health are well recognized, and international organizations advocate for integration of mental health and psychosocial support into the COVID-19 response (Moreno et al., 2020). The current study suggests that people with ADHD are even more vulnerable to the challenges created by the COVID-19 pandemic and therefore deserve special attention and care. Specifically, vocational, and mental counseling is important, as well as fostering healthy lifestyle that includes optimal adherence to preventive measures.

The documented vulnerability among people with ADHD to the challenges of the COVID-19 pandemic is a matter of concern since it leads them to undesirable consequences. This study highlights the difficulty of people with ADHD to adopt a new lifestyle of preventive measures and offers new insights into this tendency. In treating people with ADHD who show adaptation problems, clinicians should attend to the ways their patients view the positive outcomes of non-adherence and the perceived low efficacy of the adherence, rather than how they assess the potential risks of the illness. Therapeutic discourse could thus focus on the benefits attained from non-adherence, in attempt to help patients develop more adaptive decision-making skills.

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Supplementary Materials:

Table S1. Prediction of Financial Decline, Adherence to Preventive Measures, Psychological Distress, Life Satisfaction, and COVID-19 Related Perceptions by Demographics and ADHD Symptoms

Predictor	Financial Decline				Adherence to Preventive Measures				Psychological Distress				Life Satisfaction			
	ΔR^2	<i>B</i>	95% <i>CI</i>	β	ΔR^2	<i>B</i>	95% <i>CI</i>	β	ΔR^2	<i>B</i>	95% <i>CI</i>	β	ΔR^2	<i>B</i>	95% <i>CI</i>	β
Block 1	.034*				.050*				.070*				.055*			
Age		-.012	-.017 - -.006	-.117		.008	.006 - .011	.171		-.009	-.012 - -.006	-.173		-.004	-.007 - -.001	-.082
Gender		.031	-.118 - .184	.010		.153	.082 - .224	.103		.176	.101 - .254	.110		-.084	-.154 - -.014	-.059
Marital Status		.046	-.150 - .241	.014		.072	-.016 - .162	.046		.007	-.094 - .107	.004		.180	.094 - .268	.120
Having Children		.092	-.140 - .320	.029		.031	-.067 - .129	.020		-.078	-.209 - .051	-.046		.071	-.029 - .171	.047
Religious		-.156	-.315 - -.003	-.046		.013	-.063 - .093	.008		-.140	-.221 - -.052	-.077		.214	.139 - .287	.133
Higher Education		-.107	-.255 - .041	-.035		-.002	-.072 - .070	-.001		.019	-.055 - .094	.012		.002	-.065 - .071	.002
Income		-.157	-.223 - -.092	-.120		-.031	-.064 - .000	-.049		-.052	-.088 - -.016	-.075		.040	.010 - .071	.066
Block 2	.012*				.035*				.229*				.096*			
Age		-.010	-.016 - -.005	-.100		.007	.004 - .010	.141		-.005	-.008 - -.002	-.093		-.006	-.009 - -.004	-.132
Gender		.024	-.129 - .177	.008		.159	.087 - .228	.107		.145	.079 - .211	.090		-.076	-.144 - -.008	-.053
Marital Status		.055	-.140 - .248	.017		.063	-.023 - .150	.041		.032	-.056 - .119	.019		.168	.086 - .247	.112
Having Children		.105	-.125 - .326	.032		.022	-.075 - .122	.014		-.049	-.158 - .052	-.029		.054	-.041 - .150	.036
Religious		-.158	-.316 - -.006	-.046		.014	-.062 - .094	.008		-.143	-.215 - -.067	-.079		.215	.143 - .286	.134
Higher Education		-.114	-.261 - .031	-.038		.006	-.065 - .078	.004		.007	-.059 - .074	.004		.015	-.049 - .081	.011
Income		-.151	-.217 - -.085	-.116		-.037	-.069 - -.005	-.057		-.041	-.073 - -.009	-.059		.032	.003 - .061	.051
Inattention		.183	.018 - .349	.079		-.153	-.225 - -.082	-.136		.205	.127 - .283	.168		-.242	-.313 - -.170	-.224
Hyperactivity		.091	-.074 - .252	.039		-.078	-.151 - -.004	-.069		.440	.359 - .520	.358		-.127	-.201 - -.052	-.117

Predictor	Perceived Risk				Perceived Norms				Perceived Efficacy				Perceived Cost			
	ΔR^2	<i>B</i>	95% <i>CI</i>	β	ΔR^2	<i>B</i>	95% <i>CI</i>	β	ΔR^2	<i>B</i>	95% <i>CI</i>	β	ΔR^2	<i>B</i>	95% <i>CI</i>	β
Block 1	.049*				.042*				.040*				.020*			
Age		.005	.003 - .007	.117		.008	.005 - .011	.153		.009	.006 - .012	.154		-.007	-.010 - -.003	-.107
Gender		.140	.079 - .199	.112		.128	.050 - .209	.078		.105	.024 - .183	.062		-.034	-.122 - .051	-.018
Marital Status		.097	.020 - .174	.074		.008	-.088 - .103	.005		.058	-.049 - .166	.032		-.008	-.133 - .117	-.004
Having Children		.013	-.075 - .105	.010		.012	-.103 - .131	.007		.020	-.101 - .149	.011		.003	-.137 - .150	.002
Religious		-.116	-.183 - -.051	-.083		.190	.104 - .277	.102		.103	.011 - .191	.054		-.035	-.131 - .064	-.017
Higher Education		-.019	-.076 - .039	-.016		-.105	-.187 - -.025	-.064		-.128	-.207 - -.044	-.076		.135	.042 - .227	.074
Income		-.054	-.081 - -.026	-.100		-.005	-.045 - .032	.007-		-.018	-.056 - .019	-.025		-.040	-.083 - .001	-.050
Block 2	.019*				.035*				.026*				.077*			
Age		.006	.003 - .008	.140		.007	.004 - .010	.123		.007	.004 - .010	.128		-.004	-.007 - .000	-.062
Gender		.134	.074 - .193	.108		.135	.058 - .214	.082		.114	.035 - .189	.067		-.053	-.139 - .029	-.029
Marital Status		.103	.027 - .178	.078		-.001	-.096 - .092	.000		.049	-.054 - .153	.027		.010	-.107 - .131	.005
Having Children		.021	-.069 - .114	.016		-.001	-.113 - .117	.000		.009	-.112 - .134	.005		.025	-.108 - .168	.013
Religious		-.117	-.183 - -.054	-.084		.192	.107 - .276	.103		.105	.014 - .195	.055		-.039	-.133 - .055	-.019
Higher Education		-.023	-.079 - .035	-.018		-.098	-.177 - -.020	-.059		-.122	-.201 - -.040	-.073		.126	.039 - .213	.069
Income		-.051	-.079 - -.024	-.095		-.011	-.049 - .025	-.015		-.023	-.060 - .014	-.031		-.033	-.074 - .008	-.041
Inattention		.057	-.011 - .121	.060		-.159	-.247 - -.072	-.126		-.092	-.189 - .003	-.072		.142	.050 - .237	.101
Hyperactivity		.090	.021 - .156	.094		-.101	-.190 - -.014	-.080		-.137	-.235 - -.037	-.106		.287	.192 - .382	.203

Note: ADHD = attention deficit/hyperactive disorder, ASRS = the Hebrew version of the Adult ADHD Self-Report Scale, Cost = the perceived costs of adherence to preventive measures, Decrease in income = decrease in income since the onset of the outbreak, Efficacy = the perceived efficacy of the preventive measures, Norm = the perceived norms regarding adherence to preventive measures, Psychological Distress = Kessler Screening Scale for Psychological Distress (K6) score. Risk = perceived risk of COVID-19, * p < .001.