



# Il trattamento dell'ADHD nell'adulto: focus sulle comorbidità



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# ADHD and other psychiatric disorders

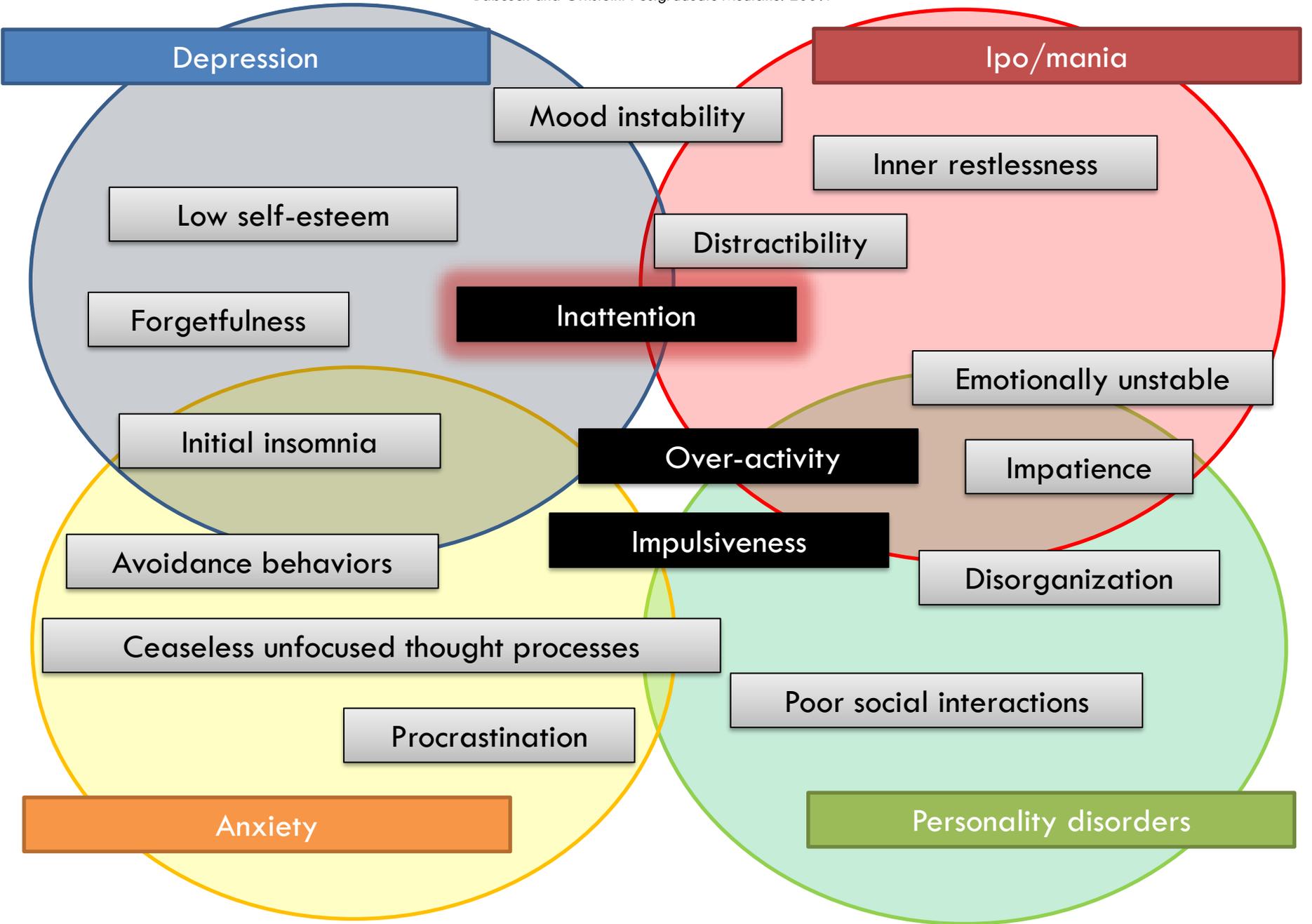
- 1. Overlap**
- 2. Differential diagnosis**
- 3. Comorbidity**

# ADHD and other psychiatric disorders

**1. Overlap**

**2. Differential diagnosis**

**3. Comorbidity**



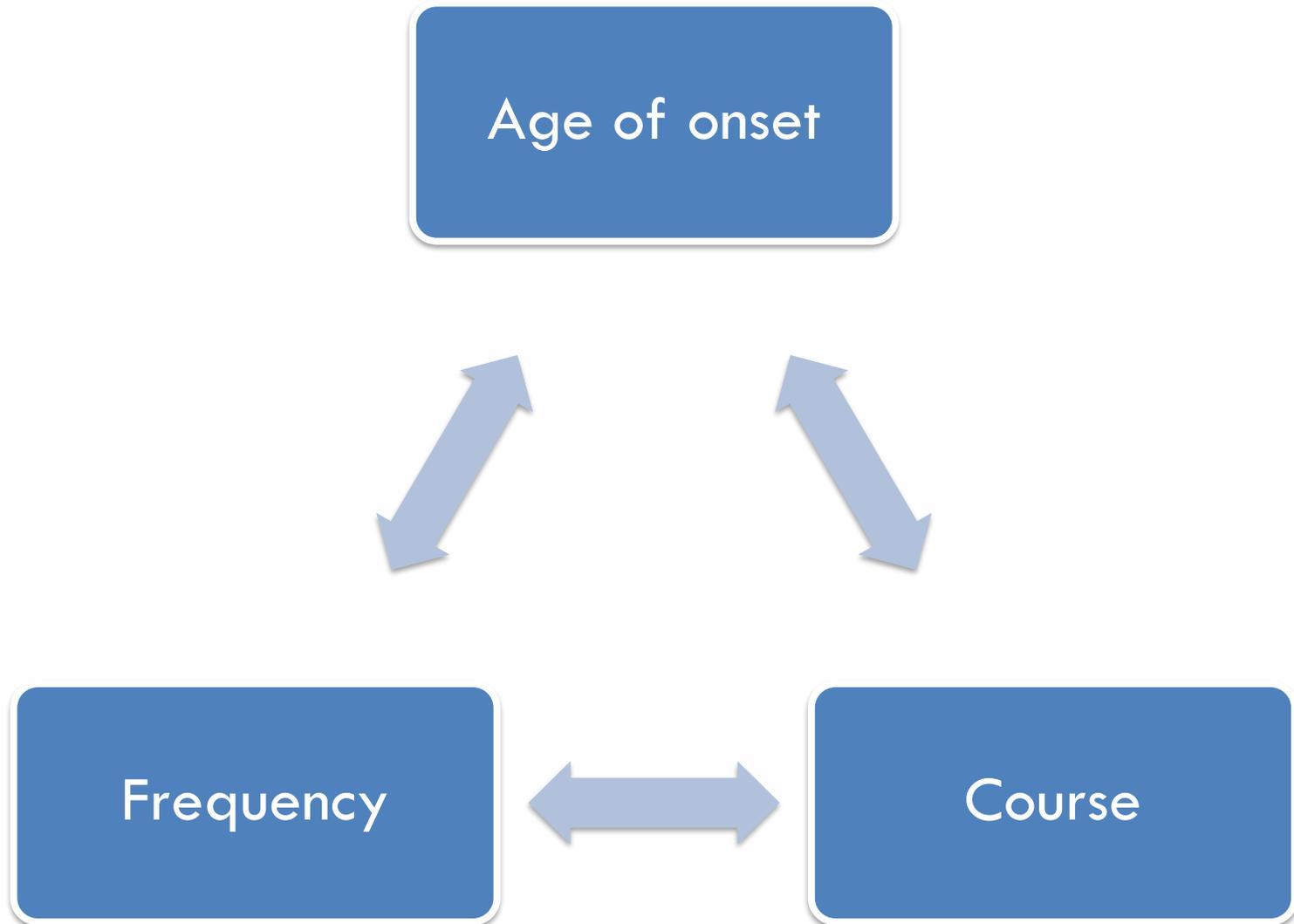
# ADHD and other psychiatric disorders

1. Overlap

**2. Differential diagnosis**

3. Comorbidity

# ADHD and psychiatric/addictive disorders, differential diagnosis



# ADHD Mood Swing – Differential Diagnosis (DDx)

Age of onset (Childhood)  
DDX Juvenile-Onset Bipolar disorder

≠ Personality Disorders



Frequency (4.5/day)  
DDx Personality disorders

≠ Bipolar Disorders

Course (Chronic)  
DDx Personality disorders

≠ Bipolar Disorders  
Cyclothimia

# ADHD and other psychiatric disorders

1. Overlap

2. Differential diagnosis

**3. Comorbidity**

# Comorbidity in adult ADHD

**Table 2.8** Occurrence of comorbid disorders in ADHD

	Clinical study of adults	Epidemiological study of adults	Clinical study of children
Some comorbidity	75 %	66 %	66 %
Average number of comorbid disorders per patient	3	Chances of ADHD increased 8.3 times with three comorbid disorders	–
Depressive disorder	25–66 % (60 % of which displayed a seasonal pattern)	31 %	20–25 %
Bipolar disorder	10 % (mostly type II)	Chances of bipolar disorder increased 6.2 times in ADHD	20 %
Anxiety disorder	25–63 %	51 %	15–25 %
Addiction	25–55 %	14 %	10–25 %
Smoking	40 %	Each ADHD symptom contributes to an earlier onset of smoking and to more smoking	20–30 %
Sleeping disorder (predominantly delayed sleep phase disorder)	80 %	–	73 %
Behavioral or personality disorder	6–25 % cluster B	–	45–50 % ODD or CD
Eating disorder (predominantly bulimia)	9 %	–	4 %
Autistic spectrum disorder	–	–	22 %
Tic disorder	11 %	–	50 %

*References:* Amons et al. (2006); Biederman et al. (1991, 1993, 2002, 2005a ; Brown (2000); Elia et al. (2008); Gau et al. (2007); Kessler (2007); Knell and Comings (1993); Kollins et al. (2005); Kooij (2006); Kooij et al. (2001a, 2004, 2008); Ronald et al. (2008); Spencer et al. (2000); Van Ameringen (2008); Van der Heijden et al. (2005); Van Dijk et al. (2011, 2012); Van Veen et al. (2010); Weiss et al. (1985); Wilens (2004) ; Wilens et al. (1994)

**Prevalence of ADHD in comorbid disorder is round 20%**

**1 out of 5 psychiatric/addicted patients could also have ADHD**

**The average number of comorbid disorders in ADHD is 3**

## The descriptive epidemiology of DSM-IV Adult ADHD in the World Health Organization World Mental Health Surveys

John Fayyad<sup>1</sup> · Nancy A. Sampson<sup>2</sup> · Irving Hwang<sup>2</sup> · Tomasz Adamowski<sup>3</sup> · Sergio Aguilar-Gaxiola<sup>4</sup> · Ali Al-Hamzawi<sup>5</sup> · Laura H. S. G. Andrade<sup>6</sup> · Guilherme Borges<sup>7</sup> · Giovanni de Girolamo<sup>8</sup> · Silvia Florescu<sup>9</sup> · Oye Gureje<sup>10</sup> · Josep Maria Haro<sup>11</sup> · Chiyi Hu<sup>12,13</sup> · Elie G. Karam<sup>1,14,15</sup> · Sing Lee<sup>16</sup> · Fernando Navarro-Mateu<sup>17</sup> · Siobhan O'Neill<sup>18</sup> · Beth-Ellen Pennell<sup>19</sup> · Marina Piazza<sup>20,21</sup> · José Posada-Villa<sup>22</sup> · Margreet ten Have<sup>23</sup> · Yolanda Torres<sup>24</sup> · Miguel Xavier<sup>25</sup> · Alan M. Zaslavsky<sup>2</sup> · Ronald C. Kessler<sup>2</sup> · on behalf of the WHO World Mental Health Survey Collaborators

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**Abstract** We previously reported on the cross-national epidemiology of ADHD from the first 10 countries in the WHO World Mental Health (WMH) Surveys. The current report expands those previous findings to the 20 nationally or regionally representative WMH surveys that have now collected data on adult ADHD. The Composite International Diagnostic Interview (CIDI) was administered to

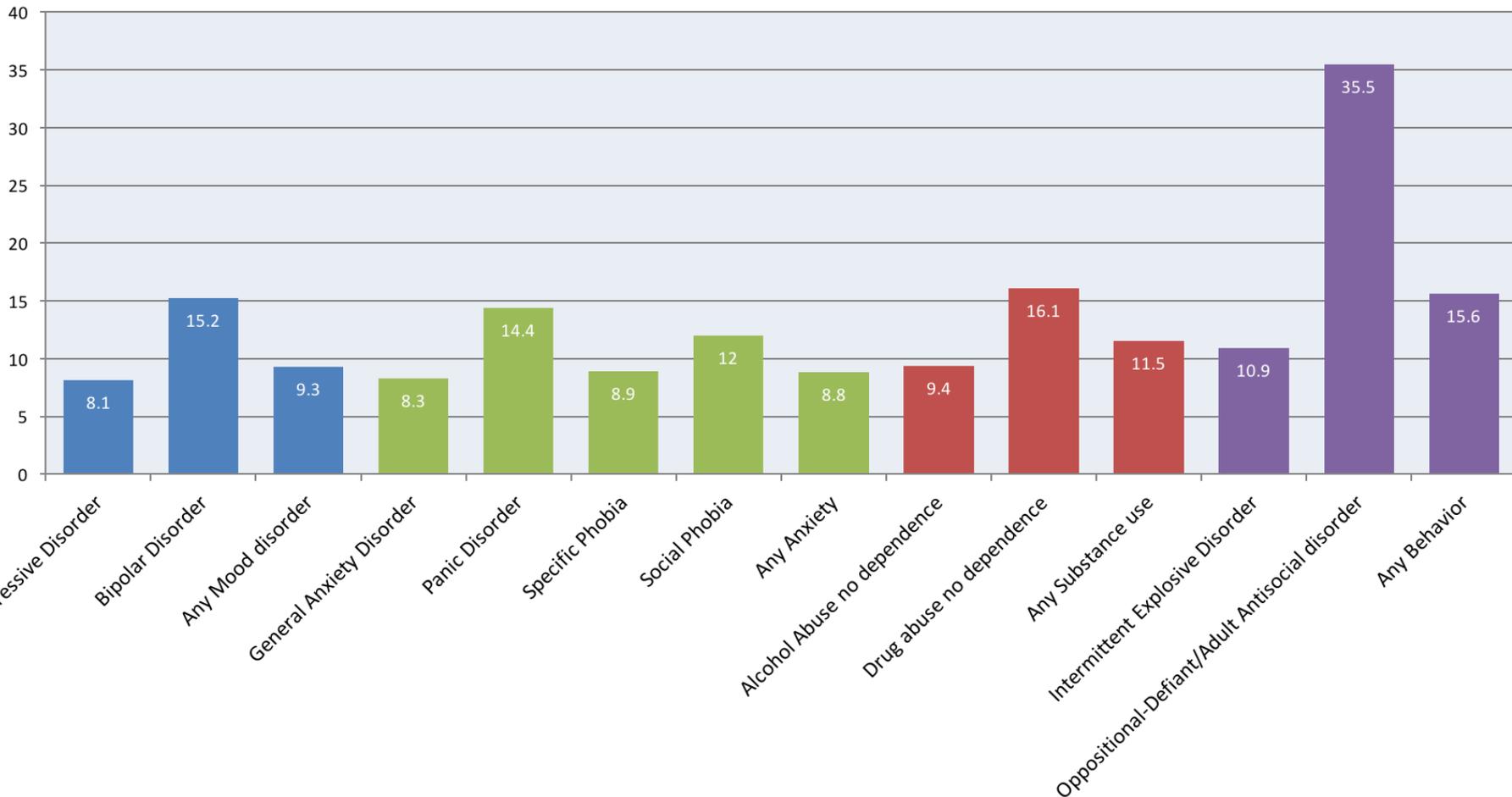
26,744 respondents in these surveys in high-, upper-middle-, and low-/lower-middle-income countries (68.5% mean response rate). Current DSM-IV/CIDI adult ADHD prevalence averaged 2.8% across surveys and was higher in high (3.6%)- and upper-middle (3.0%)- than low-/lower-middle (1.4%)-income countries. Conditional prevalence of current ADHD averaged 57.0% among childhood cases and 41.1% among childhood subthreshold cases. Adult ADHD was significantly related to being male, previously married, and low education. Adult ADHD was highly

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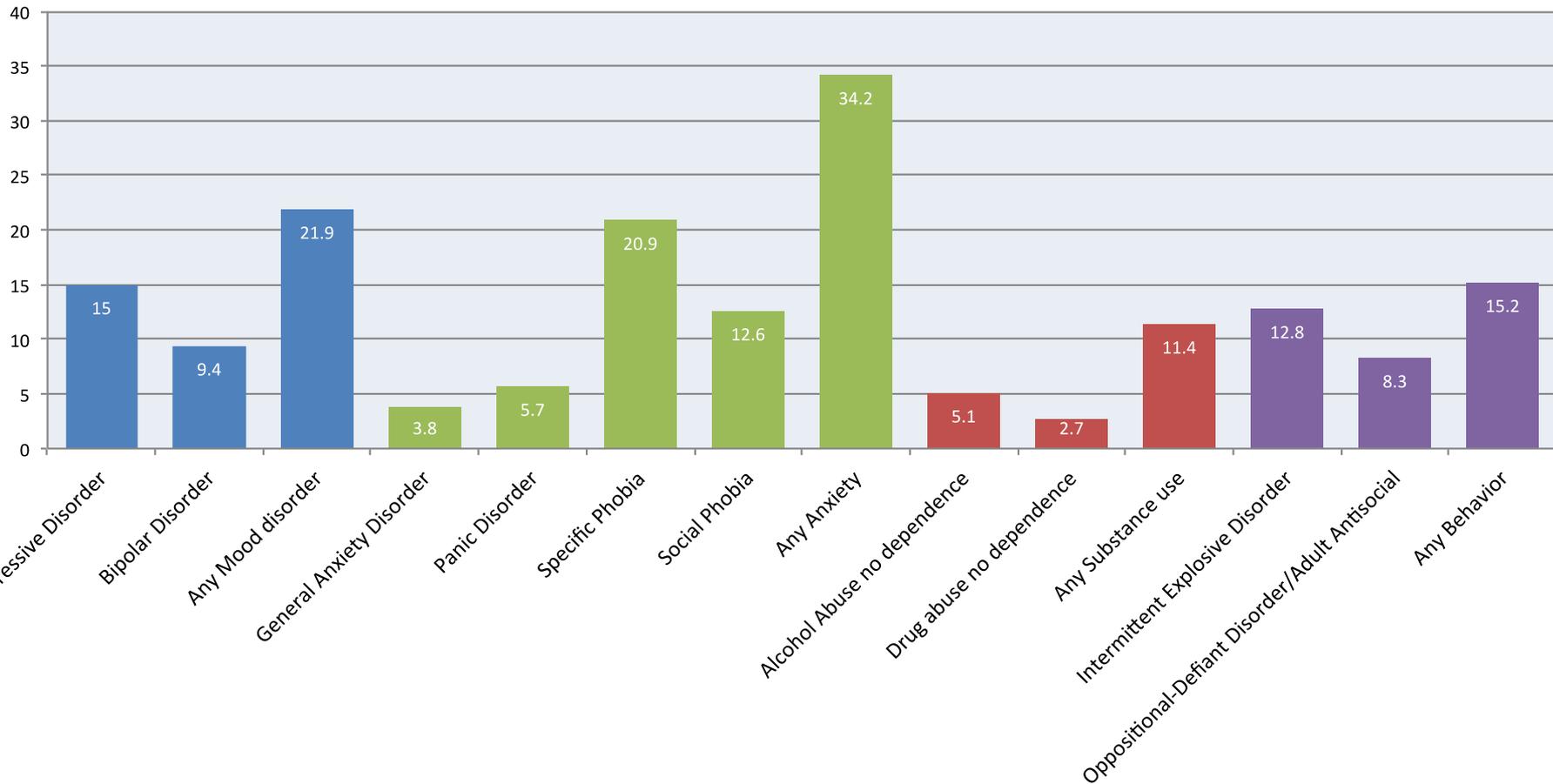
# Co-occurrence and comorbidity

ADHD in other psychiatric disorders



# Co-occurrence and comorbidity

Other psychiatric disorders in ADHD



# ADHD and Bipolar Disorder

10% of adult ADHD



Bipolar Disorder  
(of these 88% are BP II)

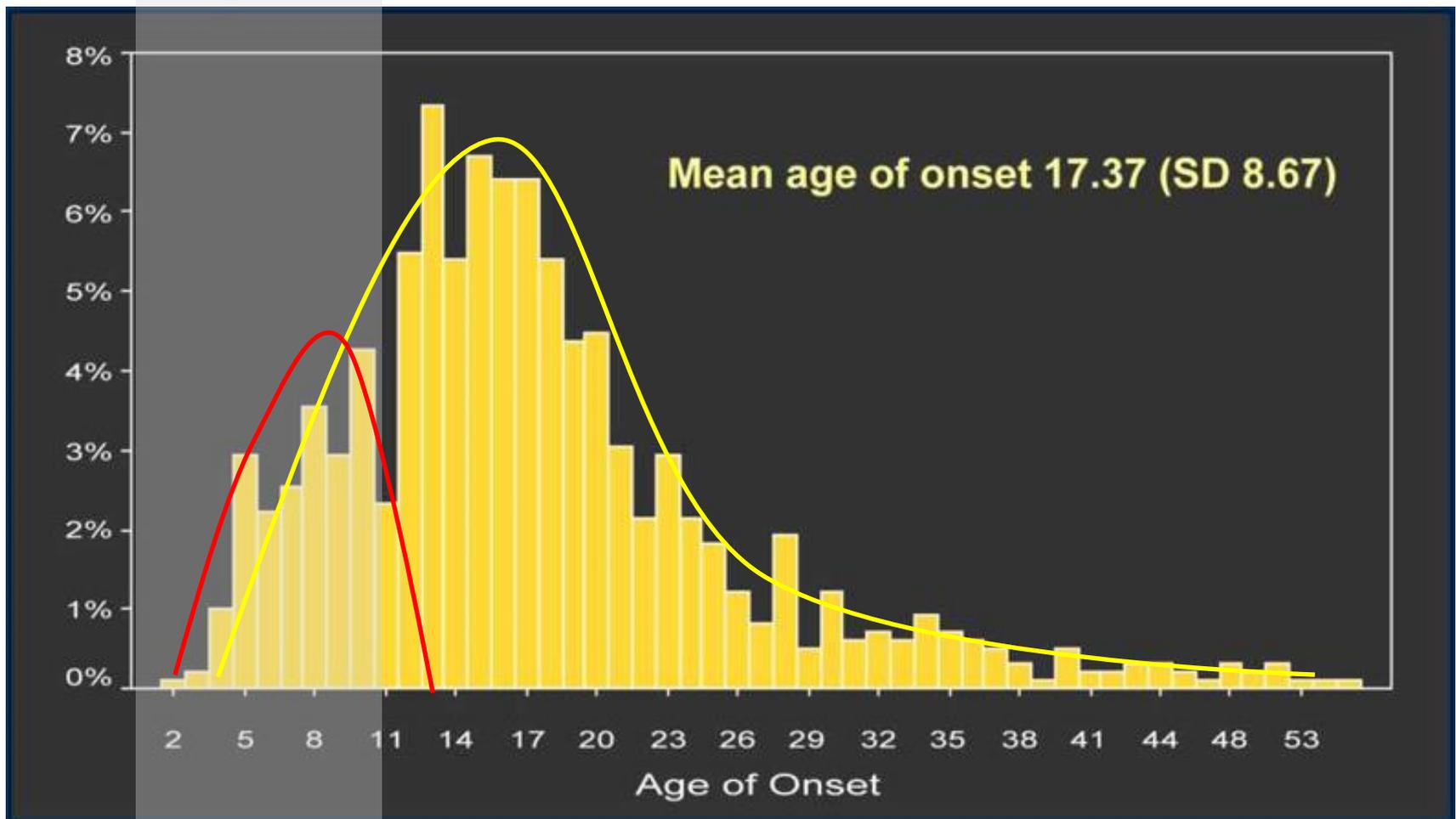
ADHD have a 6.2 times risk of



Bipolar Disorder

When you have a bipolar patient difficult to treat, with complex problems and chronic course, think also about ADHD.  
Comorbid bipolar disorders tend to be more severe.

# Age of onset of BD



# ADHD and Juvenile-Onset Bipolar Disorder (JOBBD)

- 15% of BD
- a more severe type of bipolar disorder (Singh et al., 2006)
- a stronger genetic load (Faraone et al., 2003; Masi et al., 2006)
- Comorbidity with ADHD > 85%, Oppositional Defiant Disorder (ODD) or with Conduct Disorder (CD)

# Characteristics and profiles of bipolar I patients according to age-at-onset: Findings from an admixture analysis

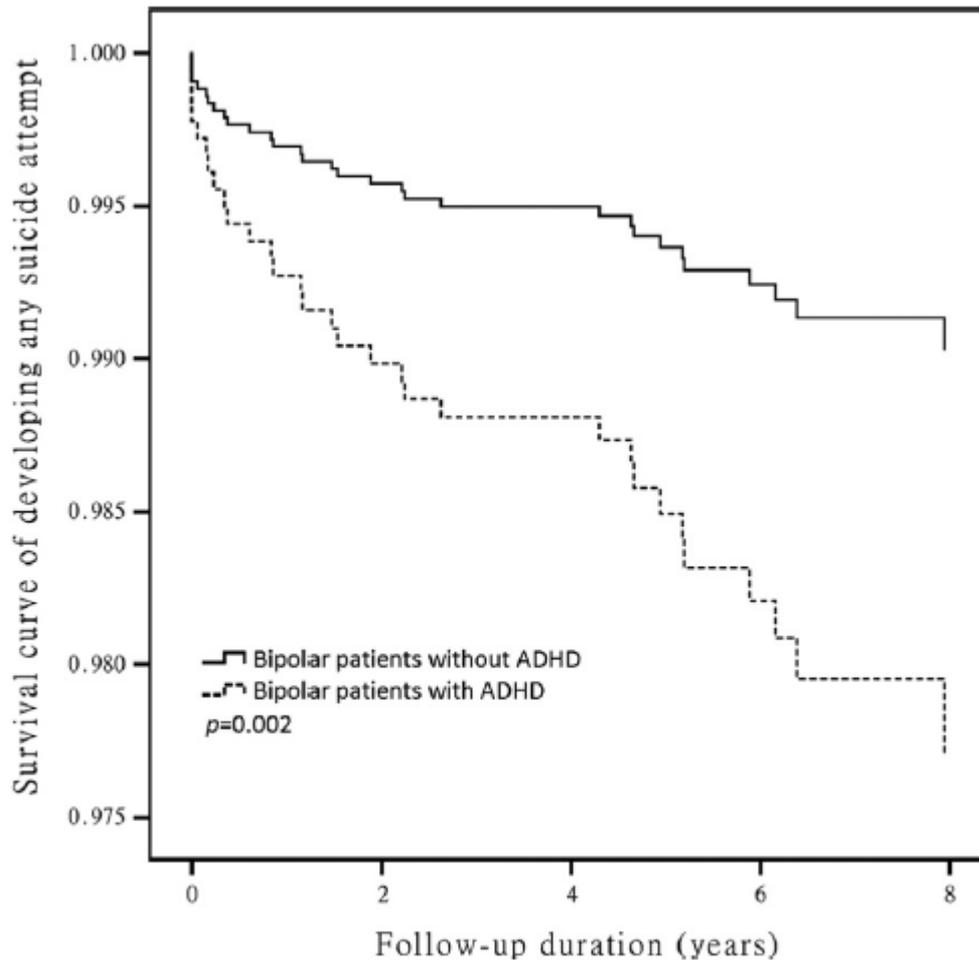
## Early onset:

- severe mania with psychotic features
- subcontinuous course of illness
- more comorbidities
  - SUD
  - Panic Disorder

- more suicide attempts

**GREATER  
SEVERITY**

# Comorbidity of ADHD and suicide attempts among adolescents and young adults with bipolar disorder: A nationwide longitudinal study



**ADHD was an independent risk factor for suicide attempts in BD**

**n= 500 pts  
(15 to 24 years old)**

Fig. 1. Survival curve of developing any suicide attempt among adolescents and young adults with bipolar disorder with or without ADHD.

# Drug treatment for attention-deficit/hyperactivity disorder and suicidal behaviour: register based study

Table 4| Sensitivity analyses for association between use of attention-deficit/hyperactivity disorder drugs and rate of suicide related events

Analysis	Population level*			Within patient level†		
	No of patients	No of suicide related events	Hazard ratio (95% CI)	No of patients	No of suicide related events	Hazard ratio (95% CI)
Treatment ended 30 days after last prescription	37 936	7019	1.39 (1.27 to 1.53)	21 125	4599	0.96 (0.86 to 1.08)
Treatment status defined by 3 month cut-off	37 936	7019	1.40 (1.26 to 1.56)	22 883	4718	0.90 (0.80 to 1.01)
Stimulant users	16 460	3322	1.02 (0.90 to 1.16)	14 757	3191	0.81 (0.70 to 0.94)
Non-stimulant/mixed users	6992	1493	1.49 (1.27 to 1.76)	6417	1424	0.96 (0.77 to 1.20)
Stimulant treatment periods v non-treatment periods	—	—	1.45 (1.22 to 1.73)	—	—	0.93 (0.72 to 1.20)
Non-stimulant treatment period v non-treatment periods	—	—	1.48 (1.17 to 1.88)	—	—	0.96 (0.72 to 1.30)
Younger cohort born during 1982-96 (baseline age 10-24 years)	26 639	4214	1.17 (1.05 to 1.31)	14 548	2699	0.92 (0.79 to 1.07)
Older cohort born during 1960-81 (baseline age 25-46 years)	11 297	2805	1.39 (1.20 to 1.61)	6626	1916	0.82 (0.68 to 0.99)
Patients without comorbid conditions	22 555	946	1.24 (1.03 to 1.48)	11 873	587	1.08 (0.69 to 1.70)
Patients with lifetime depressive disorder	9233	4208	1.28 (1.13 to 1.43)	5584	2796	0.78 (0.68 to 0.91)
After adjustment for use of antidepressants	—	—	1.14 (1.02 to 1.29)	—	—	0.77 (0.66 to 0.89)

\*Adjusted for sex and categorical age.

†Adjusted for categorical age, previous number of treatment switches, and previous number of suicide attempts.

# ADHD and Suicide

Bushe and Savill *Child and Adolescent Psychiatry and Mental Health* 2013, 7:19  
<http://www.capmh.com/content/7/1/19>



CHILD & ADOLESCENT  
PSYCHIATRY & MENTAL HEALTH

## RESEARCH

## Open Access

### Suicide related events and attention deficit hyperactivity disorder treatments in children and adolescents: a meta-analysis of atomoxetine and methylphenidate comparator clinical trials

Chris J Bushe\* and Nicola C Savill

#### Abstract

**Background:** Attention Deficit Hyperactivity Disorder (ADHD) is becoming an increasingly commonly diagnosed and treated childhood illness. Untreated ADHD is recognised as an independent risk factor for suicide-related events and deliberate self-harm and is reported more commonly in these populations. With the treatment of ADHD it is thus crucial to understand further any associations between pharmacological treatments and suicide-related events. Specific data for suicide-related events with stimulants have not been publically reported. Suicidal tendencies are, however, a contraindication to the treatment of patients with methylphenidate. Clinicians and patients may be helped by a meta-analytic comparison of suicide-related events in comparative randomised double-blind atomoxetine and methylphenidate clinical trials.

**Methods:** Suicide-related events retrospectively mapped to the suicide-related event assessment instrument recommended by the FDA, the Columbia Classification Algorithm for Suicide Assessment (C-CASA), were evaluated in five double-blind placebo controlled comparative studies of atomoxetine and methylphenidate ( $n = 1024$ ) of 6 to 9 weeks duration. The Mantel-Haenszel risk ratio and Mantel-Haenszel incidence differences have been calculated.

**Results:** In total there were 5 suicide-related events, atomoxetine (ATX) 3/559 and methylphenidate (MPH) 2/465. There were no suicide attempts nor completed suicides. Meta-analysis finds no difference of a difference in risk between ATX and MPH with a Mantel-Haenszel risk ratio of 0.52 (95% CI; 0.06, 4.54).

**Conclusion:** In the only reported meta-analysis of comparative suicide-related events between atomoxetine and methylphenidate, no significant evidence of a difference in risk has been found. These data may be informative to clinicians and patients when developing clinical guidelines.

**Keywords:** ADHD, Suicide-related events, Summary of product characteristics, Systematic review, Atomoxetine, Methylphenidate

No different risk of  
suicide-related events  
between  
atomoxetine and  
methylphenidate  
(Bushe and Savill,  
2013)

# ADHD and Suicide

- No evidence for a positive association between the use of drug treatments for ADHD and the risk of concomitant suicidal behaviour among patients with ADHD
- A potential **protective effect of drugs for ADHD** on suicidal behaviour, particularly for stimulant drugs was found
- Despite the black box warning on atomoxetine related suicidal ideation, **no evidence existed for an increased rate of suicide related events associated with the use of atomoxetine**

# ADHD and Substance Use Disorder

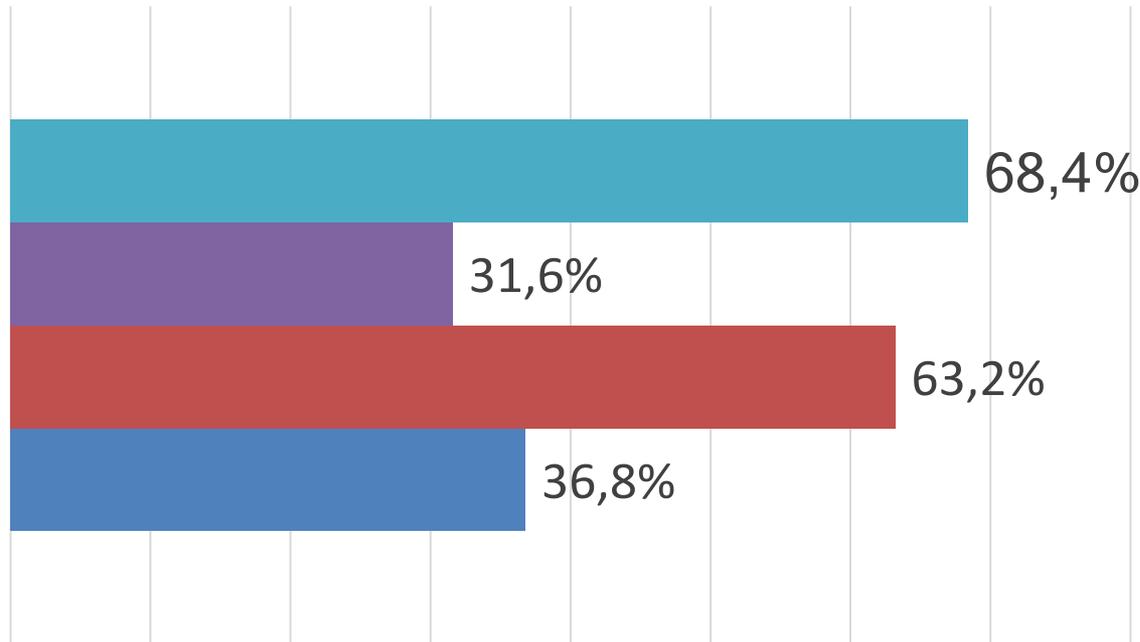
The risk of substance abuse, especially cannabis and alcohol, is strongly increased ADHD

Adult ADHD start to abuse **earlier**  
**Self-medication**

Substance use **worsens the course** of ADHD

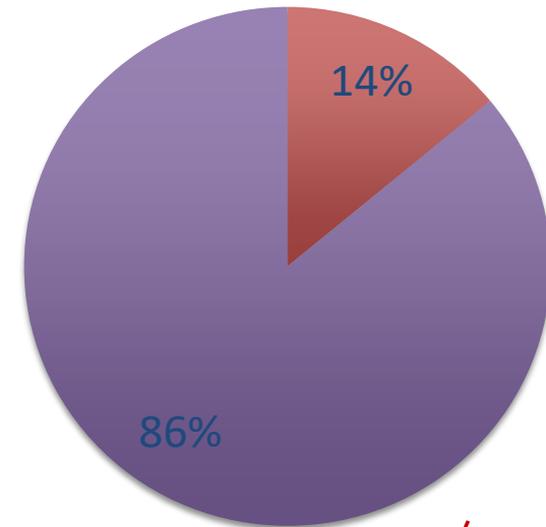
Substance Use Disorders **could imitate** ADHD symptoms

# ADHD e cocaina: pattern di utilizzo



■ Uso in compagnia    ■ Uso in solitaria  
■ Effetto euforizzante    ■ Effetto calmante

15.4% (n=19) Cocaine Use Disorder



(p = 0,005)

■ Effetto calmante E uso in compagnia  
■ Effetto calmante E uso in solitaria

# ADHD therapy: induction or reduction of SUD?

**Table 3.** Substance Use Disorder Outcomes in Treated Versus Untreated Childhood ADHD

Authors	Design	n	Outcome	Results
Wilens, Faraone, Biederman, and Gunawardene (2003)	Data from six prospective and retrospective studies used in a meta-analysis	1,034	Subsequent SUD	Stimulant therapy in childhood associated with reduction in SUD risk
Faraone, Biederman, Wilens, and Adamson (2007)	Naturalistic design; adult participants grouped into no treatment, past pharmacologic treatment, and current and past pharmacologic treatment	206	DSM-IV (SCID); drug use screening inventory (DUSI)	Pharmacotherapy did not cause subsequent SUDs; did not provide protective effect either
Biederman (2008)	10-year naturalistic follow-up study evaluating male Caucasian children with ADHD	112	Subsequent SUD	No statistically significant associations between stimulant treatment and alcohol, drug, or nicotine use disorders
Huss, Poustka, Lehmkuhl, and Lehmkuhl (2008)	Multisite retrospective nonrandomized longitudinal study with ADHD children (diagnosis at 9.2 years of age; reassessment for SUD-N at 21.9 years of age) looking at MPH treated children and drug naïve children	215	Nicotine	MPH did not induce nicotine use disorders and may in fact delay onset for continuous nicotine consumption in ADHD patients

However Long-acting stimulant or atomoxetine are recommended (Upadhyaya, 2008)

# Treatment of ADHD with comorbidity

European Psychiatry 56 (2019) 14–34



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Contents lists available at ScienceDirect

European Psychiatry

journal homepage: <http://www.europsy-journal.com>



Original article

## Updated European Consensus Statement on diagnosis and treatment of adult ADHD



J.J.S. Kooij<sup>a,b,\*</sup>, D. Bijlenga<sup>a</sup>, L. Salerno<sup>9</sup>, R. Jaeschke<sup>1</sup>, I. Bitter<sup>l</sup>, J. Balázs<sup>c</sup>, J. Thome<sup>s</sup>, G. Dom<sup>x</sup>, S. Kasper<sup>d</sup>, C. Nunes Filipe<sup>7</sup>, S. Stes<sup>e</sup>, P. Mohr<sup>w</sup>, S. Leppämäki<sup>f</sup>, M. Casas<sup>g</sup>, J. Bobes<sup>o</sup>, J.M. McCarthy<sup>h</sup>, V. Richarte<sup>i</sup>, A. Kjems Philipsen<sup>j</sup>, A. Pehlivanidis<sup>8</sup>, A. Niemela<sup>k</sup>, B. Styr<sup>l</sup>, B. Semerci<sup>10</sup>, B. Bolea-Alamanac<sup>m</sup>, D. Edvinsson<sup>n</sup>, D. Baeyens<sup>o</sup>, D. Wynchank<sup>a</sup>, E. Sobanski<sup>l</sup>, A. Philipsen<sup>p</sup>, F. McNicholas<sup>4</sup>, H. Caci<sup>m</sup>, I. Mihailescu<sup>q</sup>, I. Manor<sup>3</sup>, I. Dobrescu<sup>r</sup>, T. Saito<sup>h</sup>, J. Krause<sup>5</sup>, J. Fayyad<sup>s</sup>, J.A. Ramos-Quiroga<sup>n</sup>, K. Foeken<sup>t</sup>, F. Rad<sup>u</sup>, M. Adamou<sup>v</sup>, M. Ohlmeier<sup>6</sup>, M. Fitzgerald<sup>w</sup>, M. Gill<sup>q</sup>, M. Lensing<sup>u</sup>, N. Motavalli Mukaddes<sup>x</sup>, P. Brudkiewicz<sup>y</sup>, P. Gustafsson<sup>11</sup>, P. Tani<sup>z</sup>, P. Oswald<sup>12</sup>, P.J. Carpentier<sup>a</sup>, P. De Rossi<sup>y</sup>, R. Delorme<sup>b</sup>, S. Markovska Simoska<sup>c</sup>, S. Pallanti<sup>d</sup>, S. Young<sup>e</sup>, S. Bejerot<sup>v</sup>, T. Lehtonen<sup>f</sup>, J. Kustow<sup>g</sup>, U. Müller-Sedgwick<sup>k</sup>, T. Hirvikoski<sup>z</sup>, V. Pironti<sup>2</sup>, Y. Ginsberg<sup>t</sup>, Z. Félegyházy<sup>l</sup>, M.P. Garcia-Portilla<sup>r</sup>, P. Asherson<sup>p</sup>

# Treatment of ADHD with comorbidity

*“Before treatment starts, all comorbidities must be established so that the best order of treatment can be determined together with the patient.*

*In general, the **most severe disorder is prioritized.***

- *For instance, psychosis, bipolar disorder, substance abuse, severe depression and severe anxiety are usually **treated first.***

# Treatment of Bipolar Disorders in adult ADHD

La monoterapia con metilfenidato in pazienti bipolari aumenta il rischio di episodio maniacale (HR = 6.7).

Il metilfenidato in trattamento combinato con stabilizzatore dell'umore riduce il rischio di avere episodi maniacali (HR = 0.6)

Viktorin et al. 2016

**La problematica dell'aumentato rischio di episodi maniacali è di fatto ancora dibattuta**, in assenza di evidenze chiare e incontrovertibili. Allo stesso modo, sono segnalati da alcuni studi i benefici della terapia stimolante negli episodi depressivi.

(Katzman et al., 2017)

Incontrovertibili, invece, sono i dati sull'azzeramento del rischio suicidario dovuto alla comorbilità ADHD con il trattamento con metilfenidato.

(Chen et al. 2014)

**PRIMA CURARE E STABILIZZARE IL DISTURBO BIPOLARE**

# Treatment of ADHD with comorbidity

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*In general, the **most severe disorder is prioritized.***

- *For instance, psychosis, bipolar disorder, substance abuse, severe depression and severe anxiety are usually **treated first.***
- ***Milder** mood or anxiety disorders, and emotional instability, may respond to treatment of ADHD and can be treated at the same time as ADHD.*
- *Drug and alcohol abuse should be stabilized but can be treated at the same time as ADHD.”*

# Treatment of anxiety disorders in adult ADHD

## Clinical Case Discussion

### Treatment of Comorbid Adult Attention-deficit/ Hyperactivity Disorder and Generalized Anxiety Disorder: 2 Case Reports

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#### Case presentation:

FRANCESCO OLIVA, MD  
CLAUDIO CAREZANA, MD  
GABRIELE NIBBIO, MD  
STEFANO BRAMANTE, MD  
ALBERTO PORTIGLIATTI POMERI, MD  
GIUSEPPE MAINA, MD

Attention-deficit/hyperactivity disorder (ADHD) is often comorbid with anxiety disorders such as generalized anxiety disorder, but the best approach to treat this comorbidity in adults has yet to be determined, as current evidence on which disorder should be treated first is poor and conflicting. In this report, we present 1 case in which we treated adult ADHD first and 1 case in which we treated generalized anxiety disorder before prescribing any medication for ADHD. More studies are required on this topic, but our results suggest that treating anxiety disorders until a clear reduction of anxiety symptoms is observed, or at least taking a combined treatment approach, is more appropriate than treating adult ADHD alone and waiting for a reduction in anxiety symptoms as a secondary effect. (*Journal of Psychiatric Practice* 2018;24:292–298)

*medication treatments, concluding that the best result is obtained by medicating both disorders in tandem, or even perhaps starting by treating the anxiety, because stimulants could worsen anxiety at the outset. We could propose using psychotherapy as well for the anxiety and self-esteem issues from which these two men suffered, but the point is the same, that specifically addressing this comorbid cluster of symptoms, even if conceptualized as the secondary emotional consequence of delayed diagnosis of ADHD, is key to achieving a good outcome.*

*David A. Kahn, MD  
Clinical Case Editor*

#### CASE PRESENTATION

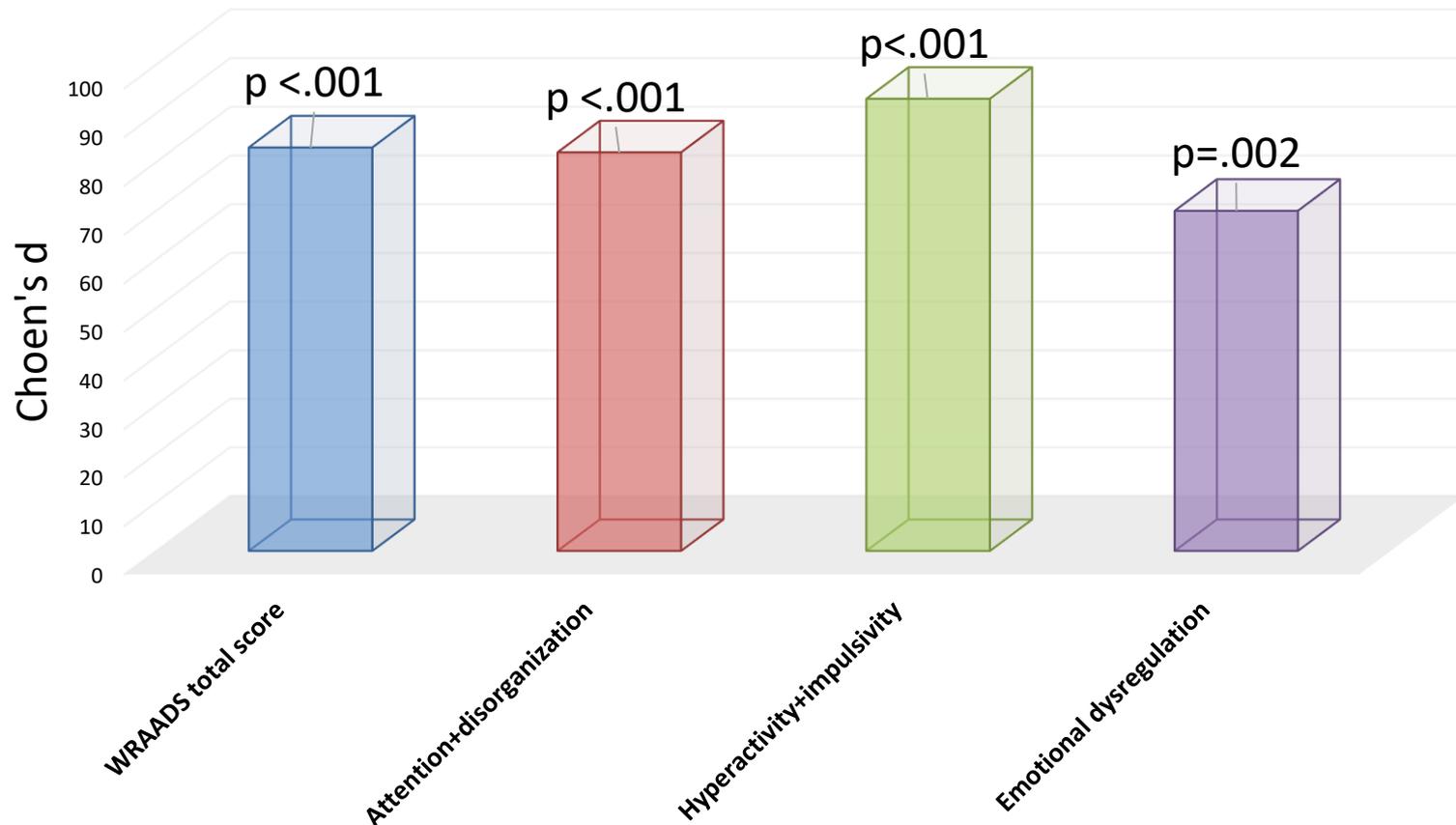
##### Background

Metilfenidato/amfetamine + SSRI/SNRI è efficace nel ridurre i sintomi ansiosi

Gabriel et al, 2010; Biederman et al., 2012

# Emotional dysregulation co-varies with adhd symptoms during treatment response

Outcomes for adhd clinical scale as a function of treatment (methylphenidate or placebo)



# Treatment of ADHD with comorbidity

*“Before treatment starts, all comorbidities must be established so that the best order of treatment can be determined together with the patient.*

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## Drug and Alcohol Dependence

journal homepage: [www.elsevier.com/locate/drugalcdep](http://www.elsevier.com/locate/drugalcdep)

Full length article

### How treatment improvement in ADHD and cocaine dependence are related to one another: A secondary analysis



Frances R. Levin<sup>a,b,\*</sup>, C. Jean Choi<sup>e</sup>, Martina Pavlicova<sup>c</sup>, John J. Mariani<sup>a,b</sup>, Amy Mahony<sup>a</sup>, Daniel J. Brooks<sup>a</sup>, Edward V. Nunes<sup>a,b</sup>, John Grabowski<sup>d</sup>

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<sup>e</sup> New York State Psychiatric Institute, Division of Biostatistics, 1051 Riverside Drive, New York, NY 10032, USA

Treatment dell'ADHD sembrerebbe essere efficace (24/%) nel portare ad astinenza da **cocaina** previo miglioramento dei sintomi ADHD.

Psychiatry Research 251 (2017) 197–203

Contents lists available at [ScienceDirect](#)

## Psychiatry Research

journal homepage: [www.elsevier.com/locate/psychres](http://www.elsevier.com/locate/psychres)

Review article

### N-acetylcysteine for treating cocaine addiction – A systematic review



Marco Antonio Nocito Echevarria<sup>\*</sup>, Tassio Andrade Reis, Giuliano Ruffo Capatti, Victor Siciliano Soares, Dartiu Xavier da Silveira, Thiago Marques Fidalgo

Addiction Unit (PROAD), Department of Psychiatry, Federal University of São Paulo, Avenida Professor Ascendino Reis, 763 – Vila Clementino, São Paulo, SP CEP 04027-040. Brazil

## Trattamento della comorbidità come trattamento personalizzato dell'ADHD dell'adulto

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tide

# MCMI-III Personality Disorders, Traits, and Profiles in Adult ADHD Outpatients

Journal of Attention Disorders  
1–10

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Francesco Oliva<sup>1</sup> , Chiara Mangiapane<sup>1</sup>, Gabriele Nibbio<sup>2</sup>,  
Alberto Portigliatti Pomeri<sup>1</sup>, and Giuseppe Maina<sup>1</sup>

### Abstract

**Objective:** To assess prevalence of personality traits and disorders according to Millon's evolution-based model and to identify the most representative personality profiles among adult ADHD outpatients. **Method:** Personality traits and disorders were evaluated using the Millon Clinical Multiaxial Inventory–III (MCMI-III) and an exploratory factor analysis (EFA) in a consecutive sample of adult ADHD outpatients ( $N = 70$ ) diagnosed by the Adult ADHD Self-Report Scale–version 1.1 (ASRS-v1.1) and the Diagnostic Interview for ADHD in Adults (DIVA 2.0). **Results:** More than half of our sample (57.1%) showed at least one personality disorder (PD). The most prevalent PDs were paranoid, schizotypal and negativistic (18.6% for all three PDs), depressive (17.1%), and sadistic (11.4%). No patient had a borderline PD. The EFA identified three personality profiles (“sadistic-antisocial-negativistic,” “masochistic-depressive-dependent-avoidant,” and “antihistrionic-schizoid”). **Conclusion:** High prevalence of PDs among adult ADHD patients was confirmed. The personality profiles seemed to reflect the persistence of ADHD and related childhood comorbidities in adulthood. (*J of Att. Dis XXXX; XX(X) XX-XX*)

# RISULTATI: prevalenza disturbi e tratti di personalità

Disturbi di personalità	<p><b>Negativistico:</b> cinico, scettico e dubbioso; risentito, permaloso, resistente a corrispondere aspettative altrui, procrastinante; alterna posizioni conflittuali nel rapporto con gli altri (dalla contrita dipendenza all'ostile indipendenza); umore irritabile, impulsivo con precipitosi sfoghi di rabbia</p>	<p>ADHD + Disturbo Oppositivo Provocatorio</p>
	<p><b>Depressivo:</b> autocritici, pessimistici e disperati</p>	<p>Deficit Autostima</p>
	<p><b>Antisociale:</b> non conforme alle norme sociali, impulsivo; <b>Sadico:</b> competitivo, non consapevole dell'impatto della propria distruttività (Callosi)</p>	<p>ADHD + Disturbo della condotta</p>
Gravi	<p><b>Paranoide</b> → conferisce disadattativa inflessibilità al profilo personologico (i.e., sadico-antisociale) <b>Schizotipico</b> → conferisce disadattativo distacco/isolamento al profilo personologico (i.e., schizoide ed evitante)</p>	<p>Pervasiva impossibilità adattativa</p>

# RISULTATI: Explanatory Factor Analysis

MCMI-III scale	Factor		
	1	2	3
Schizoid	0.027	-0.062	<b>0.716</b>
Avoidant	0.023	<b>0.606</b>	0.591
Depressive	0.332	<b>0.631</b>	0.186
Dependent	0.257	<b>0.642</b>	0.257
Histrionic	-0.154	-0.272	<b>-0.853</b>
Narcissistic	0.342	-0.311	-0.540
Antisocial	<b>0.743</b>	0.098	-0.046
Sadistic	<b>0.863</b>	0.273	0.034
Compulsive	-0.540	-0.238	-0.097
Negativistic	<b>0.702</b>	0.480	0.010
Masochistic	0.305	<b>0.700</b>	0.068
Schizotypal	0.321	0.429	0.454
Borderline	0.493	0.488	0.039
Paranoid	0.545	0.533	0.188

## Fattore 1

Sadico  
Antisociale  
Negativistico

## Fattore 2

Masochistico  
Depressivo  
Dipendente  
Evitante

## Fattore 3

Antistrionico  
Schizoide

Extraction method: Principal Axis Factoring

Rotation method: Varimax with Kaiser Normalization, Rotation converged in 5 iterations

