≥4 psychotropic medications. African-Americans were significantly (p=0.020) less likely to be discharged with ≥4 psychotropic medications (3.0% vs 19.4% for all other races; OR 0.1; 95% CI, 0.01 to 1.0).

"The patients most at risk for not receiving guideline-based treatment in this study," said Dr. Ehret, "were women and patients with psychotic features or borderline personality disorder."

The overall results of this study were mixed when compared with other studies that examined concordance with guideline-based therapy, in that the rate of compliance was higher than that seen by Lim and colleagues [Lim PZ et al. *Bipolar Disord* 2001] but less than what was reported from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BP) trial [Dennehy EB et al. *Psychopharmacol Bull* 2007]. This may be attributed to differences in study design as well as the population that was studied.

Personality Disorder: Toward DSM-V

A significant change to DSM-V that is being considered is the use of a dimensional, instead of a categorical, approach to the diagnosis of mental disorders. The research agenda for personality disorders in DSM-V can be considered a test case for such a change. Andrew E. Skodol, MD, University of Arizona College of Medicine, Tucson, AZ, and Chair of the DSM-V Personality Disorders Work Group, provided a glimpse into the group's current thinking.

In considering dimensional approaches to psychiatric illnesses, personality disorder was identified as a good starting point, because it is an area in which both researchers and clinicians have been most dissatisfied with the current categorical approach to diagnosis. The Personality and Personality Disorders Work Group is currently working on a 5-part model that includes an overall rating of personality functioning, prototypes that describe the major personality disorder types, a system to address the traits that are associated with the prototypes, generic criteria for personality disorder, and measures of adaptive functioning [Skodol AE & Bender DS. *Am J Psychiatry* 2009].

The key adaptive capacities that are not functioning properly in individuals with personality disorders occur in the domains of the self and of interpersonal relationships. The Work Group has proposed that each of these areas might be represented by 3 subdomains. With issues that involve the self, the first is *identity integration*, which includes regulation of self-states, boundary delineation, sense of time and personal history, and self-other differentiation. The second involves the concept of *integrity of the self* —having basic esteem regulation, self-respect, agency, and realistic self-appraisal, etc. *Self directedness*, or the ability to find meaning in life and having purpose, constitutes the third subdomain. *Empathy* (the ability to accurately model another person's thoughts and emotions, identify with other people's experience, pay attention to a range of other perspectives, and understand the issues of social causality) is the first subdomain within the interpersonal area. *Intimacy*—the depth and duration of connection with others and tolerance and desire for closeness—and the *complexity and integration of representations of others* form the other 2.

The following levels of self and interpersonal functioning have been proposed, each level defined by pertinent attributes that are associated with the 5 subdomains: no impairment (ie, healthy personality functioning), and mild, moderate, serious, and severe impairment. The group is currently working on whether, how, and at what point to set a cutoff for a level of impairment in personality functioning that is consistent with a personality disorder. One of the interesting questions that the group is currently debating is whether personality disorder can be defined only in terms of pathology of the self or whether it is necessary to combine the self and the interpersonal. Determining a patient's level of self and interpersonal functioning would be the first step in assessing the presence and severity of personality psychopathology.

To more specifically characterize an individual's personality, 6 domains, representing a total of 33 personality traits on which to base prototypes, are being evaluated:

- Emotionality (eg, emotional lability, anxiousness, suspiciousness, dependency, attachment insecurity, self-harm, and pessimism)
- Introversion (eg, social withdrawal, anhedonia, reservedness, detachment, and intimacy avoidance)
- Antagonism (eg, callousness, narcissism, hostility, aggression, oppositionality, deceitfulness, manipulativeness, and conduct disorder problems)
- Disinhibition (eg, impulsivity, distractibility, reckless sensation seeking, and irresponsibility)
- Compulsivity (eg, perfectionism, indecisiveness, perseveration, rigidity, and orderliness)
- Peculiarity (eg, unusual perceptions, unusual beliefs, eccentricity, and cognitive dysregulation)

The final number of traits will likely be reduced either by elimination or combination after secondary analysis and field trials have been completed. A simple definition will

be developed for each trait (eg, emotional lability might be described as "prone to unbidden mood fluctuations," "emotions are easily aroused and intense," "unstable emotional experiences," "frequent mood changes," and "incapacitated by extremity of emotions"). The group is also currently working on a rating scale so that patients could be described on a 4- or 5-point scale, depending on how applicable the trait was to their usual personality.

The current expectation is that there will be a more limited number of diagnostic types than the 10 that are currently listed in the DSM-IV. The Work Group is considering several narrative-type descriptions that capture a number of styles that are currently represented by the DSM-IV categories. Dr. Skodol noted that this does not mean that all DSM-IV (and other) types can not be diagnosed; it just means that they will be diagnosed on the basis of the level of personality functioning, the generic criteria, and some combination of traits. Each prototype will have a clinical description, as well as a criteria type system to describe the level of impairment in self-structure and interpersonal functioning that is represented, the domain and particular traits that are elevated in each prototype, and in what combination and to what extreme the traits are present.

Finally, the group intends to provide guidance on how to combine these various new elements in a systematic way that would be most clinically feasible and useful.

Within the personality work group alone, there are currently 20 ongoing literature reviews that are representing the validity of each of the 10 existing personality disorders, a proposed tripartite model, the definition of personality disorder, the clinical utility of different dimensional models, concepts and measures of functioning, criteria for change, gender and personality disorder, culture and personality disorder, levels of personality functioning, dimensionalizing existing personality disorder constructs, and the resilient personality. Secondary data analyses are being performed, and field trials will be conducted.

DSM-V is still at least 3 years away, with much work still to be done.

ADHD FAQs: Practical Answers for the Office-Based Practitioner

Adult ADHD: Prevalence, Identification, Treatment

Although once considered a childhood disorder that would remit in adolescence, we now know that there is a 70% persistence of attention deficit hyperactivity disorder (ADHD) into adulthood [Barkley RA et al. *J Abnormal Psychiatry* 2002]. Gabriel Kaplan, MD, Hoboken University Medical Center, Hoboken, NJ, provided guidance on how to identify and treat adult ADHD.

Some of the most comprehensive data on adult ADHD came from the results of the National Comorbidity Survey Replication (NCS-R) [Kessler RC et al. *Am J Psychiatry* 2006], a nationally representative household survey that used a lay-administered diagnostic interview to assess a wide range of DSM-IV disorders. The NCS-R included a screen for adult ADHD in a probability subsample of 3199 subjects aged 18 to 44 years. A subset of 154 subjects also completed structured interviews (ie, the Adult DHD Clinical Diagnostic Scale v1.2, based on ADHD-DSM-IV strict criteria and the WHO-Composite International Diagnostic Interview). The results of this study showed an estimated prevalence of current adult ADHD of 4.4%. There was a high level of comorbidity (mood disorder 38.3%, anxiety disorder 47.1%, substance abuse 15.2%) and significantly elevated odds of disability in all dimensions of basic and instrumental functioning, as assessed by the WHO Disability Assessment. Only 10.9% of the respondents had received ADHD treatment in the previous 12 months. Other studies have shown a similar pattern of impairment [Murphy K & Barkley RA. *Compr Psychiatry* 1996; Biederman J et al. *J Clin Psychiatry* 2006; Barkley RA et al. ADHD in Adults: What the Science Says. New York, NY: Guilford Press. 2008].

A diagnosis of ADHD can be complicated by the presence of psychiatric and medical conditions that are known to mimic ADHD [Searight HR et al. *Am Fam Physician* 2000; Stern MA. *CNS Spectr* 2008 13(Suppl 15)]. It is also important to note that the pattern of ADHD symptoms changes over time. While hyperactivity, impulsivity, and inattention are the cardinal symptoms of ADHD, over time adult patients present with less overt hyperactivity and impulsivity, although inattention remains the most persistent aspect of the ADHD triad [Biederman et al. *Am J Psychiatry* 2000; Adler L, Cohen J. *Psychiatr Clin North Am* 2004] (Table 1).

Table 1. Developmental Evolution of ADHD Symptoms in Adults.

Symptom	Child	Adult
Inattention	Easily distracted	• Poor time management • Working long hours but inefficiently
Hyperactivity	Fidgety	• Difficult cooperating in family • Changing jobs frequently
Impulsivity	Difficulty awaiting turn	• Saying wrong thing at wrong time • Driving violations

Adler L & Cohen J. *Psychiatr Clin North Am* 2004.