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.

When conducting a diagnostic workup for ADHD, Dr. Kaplan recommends a comprehensive psychiatric interview with expanded focus on:

- Present illness–academic and work status, areas of impairment, and the presence of significant symptoms of substance abuse, or affective or anxiety disorder
- Past History–the presence of ADHD childhood symptoms (corroborated with relatives when possible)
- Medical History–current medications, history of head trauma or other neurological conditions, presence of endocrinology problems

Appropriate rating scales include the Conners' Adult ADHD Rating Scale (CAARS), the Brown ADD Rating Scale (BAADS), and the Adult ADHD Self Report Scale v1.1 (ASRS-v1.1) for current symptoms and the Wender Utah Rating Scale (WURS) for retrospective childhood symptoms [Brown T ed. Comorbidities Handbook for ADHD Complications in Children and Adults. Washington DC, American Psychiatric Press. 2009]. It is expected that the criteria for ADHD will be revised to be more appropriate for the adult population in DSM-V.

The mainstay of treatment for ADHD is either long- or short-acting stimulants. There are currently 6 medications that are approved (5 stimulants; 1 nonstimulant). Adjunctive psychotherapy can also be associated with improved outcomes.

The Treatment of Alzheimer's Disease: Comparing Guidelines

IIt is projected that there will be 8.7 million patients with dementia who live in the United States by 2030 [Guttman R et al. *Arch Fam Med* 1999]. Cognitive decline that is associated with mild to moderate Alzheimer Disease (as measured by MMSE score) progresses an average of 2 to 4 points per year if left untreated [Becker JT et al. *Arch Neurol* 1988]. Alzheimer Disease (AD) is a complex, debilitating disease, and due to conflicting guidelines, there is confusion among practitioners regarding the best treatment practices for a patient who suffers from AD. Thus far, AD treatment is limited to symptomatic therapy, but prevention and disease-modifying therapy are the ultimate goals.

Methodologies for generating a consensus and evaluating evidence are evolving. Gary W. Small, MD, David Geffen School of Medicine, University of California, Los Angeles, CA, compared the American Association for Geriatric Psychiatry (AAGP) and American Psychiatric Association (APA) recommendations. Both models emphasize nonpharmacological and pharmacological therapies, but while the AAGP concentrates on AD, the APA has a wider focus that includes a recommendation coding system that is based on clinical evidence (I=substantial confidence, II=moderate confidence, and III=recommendation is based on individual circumstances with a lower level of confidence). The American Academy of Neurology (AAN) guidelines, presented by Martin R. Farlow, MD, Indiana University School of Medicine, Indianapolis, IN, use a coding system that is similar to the APA, but the recommendations are categorized by class (I=AAN Standard recommendation based on 1 or more randomized clinical trials with a high level of certainty, II=AAN Guideline recommendation based on well-designed observational trials with a moderate degree of certainty, and III=AAN Practice Option recommendation based on expert opinion and/or case reports, so clinical utility is uncertain).

William Maurice Redden, MD, St. Louis University School of Medicine, St. Louis, MO, discussed the clinical pharmacology of approved AD therapies that are related to the Alzheimer's Disease Management Council (ADMC) consensus and the National Institute for Health and Clinical Excellence (NICE). There are currently 4 cholinesterase inhibitors that are approved by the Food and Drug Administration (FDA) for the treatment of mild to moderate AD: tacrine, donepezil, galantamine, and rivastigmine. The APA guidelines state that 30% to 40% of patients with mild to moderate AD may have modest benefits with cholinesterase inhibitor therapy, and it should also be considered for patients with dementia that is associated with Parkinson Disease (APA Coding Level I). Additionally, memantine and donepezil have been FDA-approved for the treatment of moderate to severe AD. The AAN guidelines do not address the use of cholinesterase inhibitors or memantine in AD patients. Prof. Farlow attributes this discrepancy to the fact that the AAN guidelines are 8 years old and are in need of revision.

Charles A. Cefalu, MD, MS, Professor and Chief, Section of Geriatric Medicine, Louisiana State University Health Sciences Center and School of Medicine at New Orleans, New Orleans, LA, presented the American College of Physicians (ACP)/American Academy of Family Physicians (AAFP) 2007 guidelines for the pharmacological management of patients with AD. The guidelines suggest that the initiation of cholinesterase inhibitor or memantine therapy should be based on individualized assessment after careful consideration of tolerability, adverse effect profiles, ease of use, and cost. The level of confidence that is associated with this ACP/AAFP recommendation is weak, based on insufficient evidence that compares the effectiveness