whose correlations with depression vary between 0.42 and 0.65 (3). It is not surprising that this factor was found to be the strongest predictor of psychopathology in the study by Dr. Grabe and colleagues. The authors should have included in the linear regression analysis a dimensional measure of depression, or they should have measured with a hierarchical regression analysis the additional part of the variance of psychopathology explained by alexithymic features beyond the variance accounted for by depression, as was done by Luminet and colleagues (4). These procedures would have strengthened their results and would have allowed a comparison with previous published studies that have shown that alexithymia is truly associated with higher levels of psychopathology and acts as a negative predictor of outcome beyond the influence of depression (5).

These limitations aside, we agree with Dr. Grabe and colleagues on the relevance of the alexithymia construct in mental disorders and on the need for developing specific psychotherapeutic techniques to improve affect identification and differentiation for emotionally dysregulated subjects.

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Dr. Grabe and Colleagues Reply

TO THE EDITOR: We want to reply to the important comments of Dr. Speranza et al., who suggest including a dimensional measurement of depression as an additional independent variable in regression analyses predicting the psychopathological dimensions of the SCL-90-R. They argue that the "difficulties identifying feelings" subscale of the Toronto Alexithymia Scale and the ratings of depression have especially been shown to be correlated with each other alexithymic features and psychopathology." First, because alexithymia is conceptualized as a personality construct demonstrating a high relative stability (Luminet et al., 2001), our intention was to assess the association between alexithymia and psychopathology, with adjustment for personality dimensions (the Temperament and Character Inventory) that have been shown to explain up to 45% of the variance in alexithymia (1). Second, our data show that depression (beta= 0.32) is not only associated with alexithymia but also with a broad range of psychopathologic dimensions, including anxiety (beta=0.41) and somatization (beta=0.44). Thus, anxiety or somatization could also act "as a strong mediator between alexithymia and psychopathology." Third, one has to decide a priori whether actual psychopathology is the dependent variable or a confounder within the model.

Ignoring these three statements, we followed the statistical recommendation of Dr. Speranza et al. Unfortunately, we do not have dimensional information on depression other than the depression subscale of the SCL-90-R. Given the high internal consistency of the SCL-90-R, each subscale, e.g., depression, entered as a confounder will show major statistical effects on the dependent variable, which is also an SCL-90-R subscale in our model. Thus, when we entered depression, the three Toronto Alexithymia Scale factors, the Temperament and Character Inventory, age, and gender as independent variables and the SCL-90-R global severity index (without items assessing depression) as an dependent variable into a hierarchical linear regression model, SCL-90-R depression resulted in R^2=0.785 and difficulties identifying feelings added an additional R^2_{chg}=0.030 (F_{chg}=41.3, p<0.001) to the variance. However, it is important to consider that the correlation (Pearson) between SCL-90-R global severity index (without depression) and the depression subscale was r=0.89! Thus, the adjustment of a statistical model for, e.g., depression is more reasonable if the confounder variable is not as highly correlated with the dependent variable. This was done by Luminet et al. (2001) in predicting posttreatment scores for alexithymia with pretreatment scores of alexithymia with adjustment for scores for depression or by Grabe et al. (1) when they predicted alexithymia with Temperament and Character Inventory dimensions with adjustment for the SCL-90-R global severity index.

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Refining the Personality Disorder Diagnosis

TO THE EDITOR: The article by Jonathan Shedler, Ph.D., and Drew Westen, Ph.D. (1), provides an excellent overview of the need to refine personality disorder diagnostic criteria. We would like to add some additional data about the complex diagnostic relationships between borderline and histrionic personality disorders in clinical practice.

Andalusia is the most highly populated region in Spain (7,606,848 inhabitants) (2). The health care network in Andalusia, which serves the region's entire population, comprises 17 psychiatric units for acutely ill patients in general hospitals.

As part of a wider study, we have been working with the Minimum Basic Data Set at Discharge From Hospitals (3), a system of hospital record-keeping that records all patient discharges taking place at Andalusian hospitals.

It has been fully operational and reliable since 1995, and we have processed data up until 2002: 81,466 admissions in psychiatric units were recorded, with 12,919 receiving a diagnosis of personality disorder at discharge. The yearly total of borderline personality disorder diagnoses as a percentage of the total number of personality disorder diagnoses was as follows: 10.03% (1995), 10.27% (1996), 13.83% (1997), 16.22% (1998), 21.41% (1999), 17.18% (2000), 17.67% (2001), and 17.56% (2002). On the other hand, histrionic personality disorder accounted for the following percentages of all personality disorders: 25.75% (1995), 29.46% (1996), 16.98% (1997), 20.52% (1998), 16.78% (1999), 17.88% (2000), 17.96% (2001), and 19.17% (2002). The percentage of borderline personality disorder increased significantly over the first part of the period under study, whereas the percentage of histrionic personality disorder decreased over the same time period until the final years of the study when both percentages stabilized (the graphic representation of these percentages is nearly symmetrical around the x axis).

The sum of borderline personality disorder diagnoses plus histrionic personality disorder as a percentage of the total number of personality disorder diagnoses changed little over time: 35.78% (1995), 39.72% (1996), 30.80% (1997), 36.74% (1998), 38.18% (1999), 35.06% (2000), 35.06% (2001), and 36.72% (2002). Therefore, it is not at all unreasonable to think that a situation of "diagnostic transfer" has taken place over this period of time, moving from histrionic to borderline personality disorder.

One of the keys to this finding was provided by the results of Blashfield and Intoccia's brief report (4): the amount of literature on borderline personality disorder has experienced striking growth since the 1980s (after DSM-III), whereas the literature on histrionic personality disorder has declined since the mid-1970s. This situation has consequently influenced the practice of clinicians, including those in European countries.

New elements and conclusions can also be drawn from the excellent study by Drs. Shedler and Westen (1): On one hand, as the authors interpreted the data, clinicians may not have clearly differentiated conceptions of the two personality disorders, leading them to be confused because of their high level of comorbidity, or, on the other hand, current diagnostic classifications should perhaps not maintain their current distinction between borderline and histrionic personality disorder.

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Comment on Hoarding

TO THE EDITOR: The intriguing report by Sanjaya Saxena, M.D., et al. on hoarding (1) prompts me to write concerning what I believe is a significant defect in DSM-IV-TR regarding persons who primarily present with hoarding.

My own experience with hoarders is based on having performed close to 800 guardianship evaluations over the last 15 years. Guardianship evaluations are generally performed as home visits. The high prevalence of hoarding in this group is notable.

Dr. Saxena et al. included hoarders within obsessive-compulsive disorder (OCD). Our diagnostic manual defines compulsions as "repetitive behaviors" and gives examples that all have an active motoric or cognitive component. The actions or mental acts "reduce anxiety." Hoarding, I believe, usually arises from inaction. The only anxiety I have observed is when hoarders are threatened by forced clearing. The problem is not so much that these people collect. The problem is that they are unable to discard.

Hoarding in DSM-IV-TR appears only in the description of obsessive-compulsive personality disorder. The "differential diagnosis" for obsessive-compulsive personality disorder does state that OCD should be diagnosed when hoarding is "extreme." Thus, "extreme" hoarding is OCD, and less than "extreme" hoarding is obsessive-compulsive personality disorder. The clinician is further frustrated by being referred to the OCD section but finds the DSM-IV-TR section on OCD totally silent in respect to hoarding. Although DSM-IV-TR accommodates a dual diagnosis of OCD and obsessive-compulsive personality disorder, it clearly discourages diagnosing both conditions: "the clinical manifestations of these disorders are quite different" (p. 462).

One of the significant findings by Dr. Saxena et al. is that there is an anatomic locus for the syndrome of hoarding. This certainly should lead us to conclude that the one place hoarding does not belong is among "personality disorders." Hoarding needs to be explicitly embraced under OCD. To do this, the basic definitions of OCD may need to be modified.

An alternative suggestion is to regard hoarding syndromes as independent of OCD and as part of a new grouping of diagnostic entities titled "disorders of executive function."

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Dr. Saxena Replies

TO THE EDITOR: My associates and I thank Dr. Amdur for his comments on our recent publication. His letter raises several important issues regarding the diagnostic classification of the compulsive hoarding syndrome.

We agree with Dr. Amdur's contention that compulsive hoarding should be removed from the diagnostic criteria for obsessive-compulsive personality disorder. Only 15%–45% of hoarders meet criteria for obsessive-compulsive personality disorder (1, 2). No correlation was found between hoarding