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."

Reference

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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