Hoarding Disorder: A Literature Review

Timothy W. Burton

Southern Adventist University

Introduction

Hoarding disorder (HD) was considered a new distinct mental health disorder to the *Diagnostic and Statistical Manual of Mental Health Disorders* (*DSM-5*) (American Psychiatric Association (APA) (2013) when it was reclassified and included in the new fifth edition. It was previously considered a variant of Obsessive Compulsive Disorder (OCD) but is now under the OCD and Related Disorders section of the *DSM-5*. Prior to this it was known as little more than an urban legend that gained popularity after being portrayed in popular television shows such as *Buried Alive* and *Hoarders*, and as popular interest grew, so too did the attention of the psychiatric community (Abrams, 2012). The purpose of this paper is to review the literature about this new addition to the *DSM-5*, focusing particularly on the interventions that are used to treat it.

Statement of the Problem

Definition

Hoarding disorder has been identified as a chronic psychiatric condition (Ayers, Iqbal, & Strickland, 2014). The American Psychiatric Association (APA, 2013) defines it as the difficulty of discarding or parting with possessions, regardless of their value, and the distress and impairment to functioning that this excessive saving behavior causes. Left untreated, the severity of the symptoms of HD are likely to increase with each passing decade (Kress, Stargell, Zoldan, & Paylo, 2016).

Prevalence and Comorbidity

The prevalence of hoarding as a separate disorder from OCD is still limited, but estimates place it in the 2- 5% range of the population (Williams & Viscusi, 2016, Kress,

et al., 2016). One study found that it is almost three times more prevalent in older adults age 55-94 than in younger adults age 33- 44, but other studies have not found associations between age and hoarding severity (Ayers, et al., 2014, Kress, et al., 2016). Ayers, Bratiotis, Saxena, and Wetherell (2012) wrote of another study that found that 25% of elderly community-dwelling day care residents and 15% of nursing home residents displayed symptoms of hoarding. More recent studies have found that the initial onset of HD usually occurs in childhood (Kress, et al., 2016) with symptoms beginning around the age of ten (Williams & Viscusi, 2016). One study in particular found that 80% of its participants reported their HD symptoms began in childhood (Grisham, Frost, Steketee, Kim & Hood, 2006). Williams and Viscusi (2016) report that indications are that the prevalence of hoarding is considerably greater in the general public than what is seen in treatment facilities due to hoarders being less likely to seek treatment. Hoarders often get treatment more because of pressures exerted by their families or professionals rather than any personal desire that they have to change (Pollock, Kellett, & Totterdell, 2014). Even though there has been progress in the clinical recognition of HD in the *DSM-5,* it is notoriously difficult to treat due to resistance, low motivation to change, and hoarders tending to deny the severity of their problem (Pollock, et al., 2014).

According to the *DSM-5*, about 75% of people with HD have a comorbid mood or anxiety disorder, with depression being the most common in up to half of the cases (APA, 2013). Some also have social anxiety disorder and generalized anxiety disorder, and 20% have symptoms that meet the diagnostic criteria for OCD (APA, 2013). It is sometimes comorbid with Attention Deficit Hyperactivity Disorder (ADHD), especially

with inattentive symptoms rather than hyperactivity (Kress, et al., 2016). In addition, older adults with HD were more likely to have more medical conditions when compared to their non-psychiatric peers (Ayers, et al., 2014).

Symptoms

Hoarders may have a fear of losing items that they feel will be needed later, and they have an exaggerated belief about the importance of their material possessions. People with HD do not usually discriminate among the items they collect, and more than half of them hoard both inanimate (such as newspapers) and animate (animals) objects (Kress, et al., 2016). Additional symptoms include an excessive emotional attachment to their possessions, difficulty in making decisions and in categorization/organization, perfectionism, and a tendency to engage in both procrastination and in behavioral avoidance (Williams & Viscusi, 2016). Other symptoms are excessive shopping and collecting and a marked inability to discard items (Kress, et al., 2016). A lack of material resources in childhood does not appear to be related to the later development of HD, but some hoarders are motivated by past traumatic experiences, such as living in poverty, and this should be assessed as it may play a role in HD behavior (Kress, et al., 2016). Unlike individuals with OCD, hoarders have fewer intrusive thoughts about their possessions and less urge to perform rituals (Williams & Viscusi, 2016). Their distress only becomes a prominent symptom when they are faced with the possibility of *losing* their possessions. These symptoms may continue throughout the lifetime of someone with HD (Kress, et al., 2016)

Risks

Social workers need to be aware of the many risks that come with hoarding disorder. Living spaces can become so cluttered that it hinders activities for which the rooms were designed. The excessive clutter often results in difficulties in social and occupational functioning (Williams & Viscusi, 2016). There is a greater risk for poor sanitation, falling, inability to eat in the home, infestations of rats and insects, fires, mold growth, and blocked access for first responders in cases of emergency (Kress, et al., 2016, Williams & Viscusi, 2016). People with HD are more likely to live alone and experience financial problems due to employment difficulties (Rees, Valentine, & Anderson, 2018). Older adults who hoard are also at an increased risk for medication misplacement, which could be harmful to their health (Kress, et al., 2016). Another study found that health issues such as diabetes, sleep apnea, stroke, hematological problems, and cardiovascular problems were more prevalent in people with HD; and this was thought to be due to self neglect and lower frequency of visits to doctors (Kress, et al., 2016, Ayers, et al., 2014). Children of hoarders have been found to be at risk for self-esteem difficulties and social isolation due to a reluctance to form friendships and invite people to their homes (Rees, et al., 2018). All of these risks contribute to the problems of hoarding disorder.

Problem Exploration

Predictors

A recent study explored the predictive factors of hoarding disorder (Kyrios, Mogan, Moulding, Frost, Yap, & Fassnacht, 2017). They found that early developmental factors such as recollections of lower warmth in one's family, higher saving cognitions, a

need to keep possessions in view, attachment influences, early traumatic events, and greater fears about decision-making were consistent predictors of hoarding severity. These predictors may lead to compensatory emotional attachment to objects for people with HD. Kyrios, et al. (2017) hypothesize that "strong attachment to possessions might be derived from an early compromised developmental environment and emotionally driven processes that trigger compensatory strategies designed to defend the individual from uncertainty and threat".

Assessment and Diagnosis

***DSM-5*.** The first set of criteria for professionals, including social workers, to reference for hoarding as a specific disorder is given in the *DSM-5* (APA, 2013). The official diagnostic criteria for hoarding disorder includes: (a) a persistent difficulty discarding items that may or may not have value, (b) the desire to save items in order for the individual to avoid negative feelings associated with discarding them, (c) the significant accumulation of possessions that clutter active living areas, (d) the hoarding causes clinically significant distress or impairment in areas of functioning, (e) it is not attributable to another medical condition, and (f) the hoarding is not better explained by the symptoms of another mental disorder. Furthermore, specifiers can be used to describe the person's level of insight into their behavior, including *with good or fair insight, with poor insight,* and *with absent insight/delusional beliefs* (APA, 2013). If the difficulty in discarding possessions is accompanied by excessive acquisition of items, professionals can also use the specifier *with excessive acquisition.*

Assessment tools. The majority of the tools used to assess for HD have come about since the disorder was added to the *DSM-5* in 2013. These include the Structured

Interview for Hoarding Disorder (SIHD); the Saving Inventory-Revised (SI-R), which is a 26-item self-report to assess the severity of the symptoms; the Hoarding Rating Scale (HRS) that assesses a person's level of difficulty with acquiring objects, discarding, and clutter, along with their level of distress and impairment; the Clutter Image Rating Scale (CIR), which is a pictorial scale of the three main rooms in a home (kitchen, bedroom, and living room) that assesses the extent of clutter that is associated with hoarding; and the Activities of Daily Living in Hoarding Scale (ADL-H) to assess the degree in which hoarding impairs daily life (Williams & Viscusi, 2016, Kress, et al., 2016). Social workers should approach the assessment of hoarding disorder with a multifaceted outlook- utilizing self-reporting, interviews, behavioral tasks that are assigned to clients, and reports from secondhand parties such as family, friends, and other health professionals that are gotten after client consent has been given (Kress, et al., 2016). Once a thorough assessment for HD has been made and diagnosed, social workers can begin to use interventions to treat the disorder.

Interventions

Cognitive behavior therapy (CBT). The gold standard treatment for hoarding disorder is cognitive behavior therapy. Before 2013, cognitive behavior therapy for individuals with OCD was used to also treat hoarders, but this was found to be ineffective for those who have HD. Several studies exploring this problem found that hoarders often had higher dropout rates, poorer outcomes, and minimal clinical gains when compared to people with OCD who did not have hoarding behaviors (Kress, et al., 2016, Williams & Viscusi, 2016). As a result, a new form of CBT was developed to treat HD that focuses on reducing three symptoms specific to hoarding: (1) disorganization, (2) difficulty

discarding items, and (3) excessive acquisition. This includes the training of skills to reinforce and enhance problem solving, decision-making, and organization; the use of direct or imagined exposure to distressing stimuli; and the cognitive restricting of the individual's hoarding-related beliefs (Kress, et al., 2016, Grisham & Baldwin 2015). Hoarding specific CBT interventions are usually longer in duration that CBT to treat OCD (Williams & Viscusi, 2016).

One study found that patients made generally good initial gains following a CBT intervention for hoarding, but they made little improvement 3- 12 months after the CBT treatment ended (Muroff, Steketee, Frost, & Tolin, 2014). When a CBT approach is used, it is enhanced when home visits and motivational interviewing techniques are integrated with the intervention (Williams & Viscusi, 2016). Through home visits, social workers can help enhance and maintain the client's motivation, provide help with organizing and discarding, and assist in applying the skills learned in CBT at home (Kress, et al., 2016). Motivational interviewing techniques can help to address poor homework compliance, limited insight, and the reluctance that people with HD have to continue treatment.

CBT interventions are typically delivered over 26 weekly sessions of 60 to 90 minutes each, with additional home visits. This individualized treatment can be expensive and resource intensive and may preclude some people from seeking treatment (Moulding, Nedeljkovic, Kyrios, Osborne, & Mogan, 2017). Group treatments can have benefits of decreasing stigma, shame, and social isolation and have been found to be as effective as individual CBT (Moulding, et al., 2017). A short-term group CBT treatment of 12 weeks for HD was studied as a more cost-effective alternative, and this research

found that it was effective at reducing hoarding symptoms in a community cohort (Moulding, et al., 2017).

In a study on using CBT with older adults with HD, the elderly participants reported that the cognitive strategies and tools were too abstract and were difficult to link to their hoarding problems (Ayers, et al., 2012). These same patients stated that the direct exposure exercises, the home visits, and the therapeutic relationship itself were the most helpful aspects of their treatment (Ayers, et al., 2012). The results of another study of using CBT for hoarders found that the best results from the treatment were in the issue of difficulty discarding, and that greater number of home visits was associated with greater improvement in this area (Tolin, Frost, Steketee, & Muroff, 2015). However, their follow-up data indicates that once the CBT treatment was discontinued, that the clutter began to increase again.

Family-based approaches. Clinical case studies have shown that family-based treatment approaches may be particularly helpful in cases of children and adolescents with hoarding disorder (Ale, Arnold, Whiteside, & Storch, 2014). Ale et al. (2014) found that the HD behavior in children was often reinforced by their parents' reactions, so they used an altered CBT approach that included parental psychoeducation to train the parents how to adaptively react to their children's behaviors. Children of adult hoarders have reported conflicts with their parents regarding hoarding issues and have expressed fears that they too might develop hoarding behaviors (Rees, et al., 2018).

Multidisciplinary community-based approaches. Since hoarding disorder can impair a wide variety of people other than the individual themselves, the use of community resources may be needed as an intervention (Kress, et al., 2016). The public

health risks of hoarding can also affect neighbors in the community in addition to the person's family members. Professional organizing services that help with home clean-out may enhance treatment outcomes (Bratiotis, Steketee, Davidow, Samuels, Tolin, & Frost, 2013). Using a multidisciplinary approach, agencies may find it helpful to train teams of non-counselors to assist with these organizing and cleaning tasks or offer training to family members in order to enhance the intervention (Kress, et al., 2016).

Pharmacotherapy. According to the Mayo Clinic (n.d.), there are currently no medications approved by the FDA to treat hoarding disorder. However there is some evidence that the symptoms of hoarding can improve with the use of some pharmacological interventions (Kress, et al., 2016). Venlafaxine and Paxil have both been found to be effective in improving hoarding symptoms when used to treat the comorbid issues of depression and anxiety (Kress, et al., 2016, Grisham & Baldwin, 2015). Serotonin-noradrenaline reuptake inhibitor (SNRI) therapy has been found to improve the symptoms of HD comparable to the results found in CBT (Grisham & Baldwin, 2015). However compliance with taking medications may be particularly challenging for people with HD due to their cluttered homes that often lead to medication mismanagement (Ayers, et al., 2014, Grisham & Baldwin, 2015, Kress, et al., 2016,).

Intervention challenges. A survey study of mental health professionals, including social workers, found that working with clients with hoarding disorder can lead to high levels of frustration (Tolin, et al., 2015). When compared with non-hoarding clients, clients with HD had poorer levels of insight and awareness about their problem, had difficulty making changes, were less likely to follow through on treatment recommendations, and engaged in significant therapy-interfering behaviors during the

course of the intervention (Kress, et al., 2016). Social workers should have realistic expectations for interventions with clients with HD. On the treatment frontier, empirical evidence suggests that there is new hope for this notoriously difficult-to-treat disorder, particularly with CBT designed for HD combined with pharmacology therapies (SNRIs) (Grisham & Baldwin, 2015).

Theoretical Perspectives

Reducing Insomnia

With insomnia linked to numerous depressive and anxiety-related conditions, researchers have hypothesized if there is a relationship between insomnia and hoarding (Raines, Portero, Unruh, Short, & Schmidt, 2015). They considered the possibilities of clutter contributing to sleep difficulties and hoarding preventing individuals from accessing basic furniture. This was based on the theory that hoarders often are forced to complete activities of daily living, such as sleeping, in one small space and that the symptoms of insomnia would be associated with increased hoarding severity (Raines, et al., 2015). The results of this study indicated that insomnia was associated with increased hoarding severity and specifically with the facets of excessive acquiring and difficulty in discarding but not with the issue of clutter. Given that sleep problems can affect a person's decision-making skills, they theorized that the symptoms of insomnia may be one factor that contributes to excessive acquiring and difficulties in discarding items that are prevalent in HD.

Attachment Theory

A hoarder's emotional reactivity and perceived inability to tolerate distress can be understood through attachment theory. When primary caregivers are unable to respond

to an infant's needs and emotional states, an insecure attachment can develop which can lead to interpersonal trauma in early childhood. This trauma can then develop into anxious or avoidant attachment styles. Based on attachment theory, excessive emotional attachment to objects can develop from insecure attachment styles as a way to calm oneself and to compensate for the absence of secure relationships with people (Crone, Kwok, Chau, & Norberg, 2019).

Object Interconnectedness

One of the core defining features of hoarding disorder is the excessive attachment to possessions. A recent study explored their hypothesis of HD being a relational disorder in which the connection between a person and their possessions becomes pathological (Dozier, Taylor, Castriotta, Mayes, & Ayers, 2017). Previous studies have indicated that hoarding symptoms are predictive of emotional attachments to new objects, but this study measured the *interpersonal closeness* between an individual and their objects. Using a new self-reported measure, the Relationship between Self and Items (RSI), they found that the HD participants scored higher on the RSI than the control group did (Dozier, et al., 2017). This investigation suggests that the way in which a hoarder conceptualizes themselves in relation to their possessions changes as a result of exposure based treatment for HD.

Emotional Regulation

With many of the studies of hoarding disorder treatments showing that the symptoms of HD still tend to be closer to clinical levels even after treatment, a group of researchers last year looked at the role of emotion regulation and theorized that these constructs are also important within hoarding and its treatment (Taylor, Theiler,

Nedeljkovic, & Moulding, 2018). Emotion regulation (ER) is defined as the ability to monitor, evaluate, and modulate emotions in the context of goal-related behavior (Gratz & Roemer, 2004). These researchers found several themes that support emotion regulation difficulties in HD, including problems with identifying and describing feelings, unhelpful attitudes toward the emotional experience, the use of avoidance-based strategies, and a perceived lack of effective emotion regulation strategies (Taylor, et al., 2018). In addition, their study found that emotional factors appear to be implicated in the onset and/or the exacerbation of HD, and the aspects of acquiring behavior and emotional attachments to possessions appeared to be utilized by the clients as a form of ER (Taylor, et al., 2018). The findings also have implications for treatment of HD using psychoeducation and acceptance-based interventions.

Prominent Theoretical Model of Hoarding

Theoretical models for hoarding have changed throughout the years. Historically Sigmund Freud theorized that hoarding was part of an anal triad based on orderliness, miserliness, and obstinacy and was the result of a failure in the progression of psychosexual stages. Later Fromm theorized that hoarders acquire possessions as a way of relating to the world around them (Grisham & Barlow, 2005). Current conceptualizations of HD are based on a cognitive-behavioral theory. Grisham and Baldwin (2015) outline the prominent theoretical model of hoarding disorder to explain the core manifestations of acquiring, clutter, and difficulty discarding. According to this cognitive-behavioral theory, HD develops as a result of conditioned emotional responses associated with certain beliefs and thoughts about possessions (Grisham & Baldwin, 2015). In order to avoid the anxiety associated with decision-making and discarding,

individuals with HD fail to discard possessions. At the same time, hoarders experience the positive emotions that are associated with acquiring and saving possessions. This suggests that hoarding behavior serves to both avoid distress and bring comfort through simultaneous positive and negative reinforcement (Grisham & Baldwin, 2015).

Conclusion and Position

With new recognition and the re-classification of hoarding disorder as a distinct disorder in the *DSM-5,* research on HD and its treatment modalities has recently surged, as interest in this disorder has increased in recent years. While a new type of CBT that is hoarding specific has improved upon previous interventions that used CBT for OCD, it has not reached the degree of benefit achieved by evidence-based treatments for OCD. Research has found that the best interventions for HD use a combination of CBT, medication, motivational interviewing, and home visits, while also utilizing family and community-based approaches.

The literature is limited in that there are no known studies on HD based on gender, race, or ethnicity. The results of studies on the efficacy of CBT and medications are mixed and merit further study. The fact that the majority of HD patients continue to score in the clinical range at the post-treatment stage, underscores the need for more research on treatments.

Social workers need to have the appropriate knowledge and skills to accurately assess, diagnose, and intervene with clients who have HD. With this being a newer disorder with more recent research into assessments and treatments and one that affects more people than previously thought, it is important to keep up with the latest findings. I think this is especially true for those who work with the elderly, who have higher rates of

HD diagnosis. Finally, social workers must realize that treatment gains for individuals with HD often occur slowly and will require significant dedication and work from the clients.

References

Abrams, L. (August 10, 2012). Hoarders: From a tv spectacle to a newly defined psychiatric condition. *The Atlantic.* Retrieved from https://www.theatlantic.com/health/archive/2012/08/hoarders

Ale, C., Arnold, E., Whiteside, S., & Storch, E. (2014). Family-based behavioral treatment of pediatric compulsive hoarding: A case example. *Clinical Case Studies, 13,* 9-21. doi: 10.1177/1534650113504487

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington DC: American Psychiatric Publishing.

Ayers, C., Bratiotis, C., Saxena, S., & Wetherell, J. (2012). Therapist and patient perspectives on cognitive-behavioral therapy for older adults with hoarding disorder: A collective case study. *Aging & Mental Health, 16*(7), 915-921. doi: 10.1080/13607863.2012.678480

Ayers, C., Iqbal, Y., & Strickland, K. (2014). Medical conditions in geriatric hoarding disorder patients. *Aging & Mental Health, 18*(2), 148-151. doi: 10.1080/13607863.2013.814105

Bratiotis, C., Steketee, G., Davidow, J., Samuels, J., Tolin, D., & Frost, R. (2013). Use of services by people who hoard objects. *Best Practices in Mental Health, 9,* 39-51. Retrieved from http://essential.metapress.com/content/b17142030120626/

Crone, C., Kwok, C., Chau, V., & Norberg, M. (2019). Applying attachment theory to indecisiveness in hoarding disorder. *Psychiatric Research, 273,* 318-324. doi: 10.1016/j.psychres.2019.01.005

Dozier, M., Taylor, C., Castriotta, N., Mayes, T., & Ayers, C. (2017). A preliminary investigation of the measurement of object interconnectedness in hoarding disorder. *Cognitive Theoretical Research, 41,* 799-805. doi: 10.1007/s10608-017-9845-x

Gratz, K., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41-54. doi: 10.1023/b:joba.0000007455.08539.94

Grisham, J. & Barlow, D. (2005). Compulsive hoarding: Current research and theory. *Journal of Psychopathology & Behavioral Assessment, 27*(1), 45-54. doi: 10:1007/s10862-005-3265-z

Grisham, J., Frost, R., Steketee, G., Kim, H., & Hood, S. (2006). Age of onset of compulsive hoarding. *Journal of Anxiety Disorders, 20,* 675-686. doi: 10:1016/j.janx-dis.2005.07.004

Grisham, J., & Baldwin, P. (2015). Neuropsychological and neurophysiological insights into hoarding disorder. *Neuropsychiatric Disease & Treatment, 3*(1), 951-962. doi: 10.21/47/NDT.562084

Kress, V., Stargell, N., Zoldan, C., & Paylo, M. (2016). Hoarding disorder: Diagnosis, assessment, and treatment. *Journal of Counseling & Development, 94*(1), 83-90. doi: 10.1002/jcad.12064

Kyrios, M., Mogan, C., Moulding, R., Frost, R., Yap, K., & Fassnacht, D. (2017). The cognitive-behavioural model of hoarding disorder: Evidence from clinical and

non-clinical cohorts. *Clinical Psychology & Psychotherapy, 25*(2), 311-321. doi: 10.1002/cpp.2164

Mayo Clinic. (n.d.). Hoarding disorder. Retrieved April 23, 2019 from https://www.mayoclinic.org/diseases-conditions/hoarding-disorder/diagnosis-treatment/drc-20356062

Moulding, R., Nedeljkovic, M., Kyrios, M., Osborne, D., & Mogan, C. (2017). Short-term cognitive-behavioural group treatment for hoarding disorder: A naturalistic treatment outcome study. *Clinical Psychology & Psychotherapy, 24*(1), 235-244. doi: 10.1002/cpp2001

Muroff, J., Steketee, G., Frost, R., & Tolin, D. (2014). Cognitive behavior therapy for hoarding disorder: Follow-up findings and predictions of outcome. *Depression & Anxiety, 31*(2), 964-991. doi: 10.1002/da.22222

Pollock, L., Kellett, S., & Totterdell, P. (2014). An intensive time-series evaluation of the effectiveness of cognitive behaviour therapy for hoarding disorder: A 2-year prospective study. *Psychotherapy Research, 24*(2), 485-495. doi: 10.1080/10503307.2013.843802

Raines, A., Portero, A., Unruh, A., Short, N., & Schmidt, N. (2015). An initial investigation of the relationship between insomnia and hoarding. *Journal of Clinical Psychology, 71*(7), 707-714. doi: 10.1002/jclp.22161

Rees, C., Valentine, S., & Anderson, R. (2018). The impact of parental hoarding on the lives of children: Interviews with adult offspring of parents with hoarding disorder. *Clinical Psychologist, 22*(3), 327-335. doi: 10.1111/cp.12135

Taylor, J., Theiler S., Nedeljkovic, M., & Moulding, R. (2019). A qualitative analysis of emotion and emotion regulation in hoarding disorder. *Journal of Clinical Psychology, 75*(3), 520-545. doi: 10.1002/jclp.22715

Tolin, D. (2011). Challenges and advances in treating hoarding. *Journal of Clinical Psychology, 67*(5), 451-455. doi: 10.1002/jclp.20796

Tolin, D., Frost, R., Steketee, G., & Muroff, J. (2015). Cognitive behavioral therapy for hoarding disorder: A meta-analysis. *Depression & Anxiety, 32*(3), 158-166. doi: 10.1002/da.22327

Williams, M. & Viscusi, J. (2016). Hoarding disorder and a systematic review of treatment with cognitive behavioral therapy. *Cognitive Behaviour Therapy, 45*(2), 93-110. doi: 10.1080/16506073.2015.1133696