Compulsive hoarding

Compulsive hoarding is not a new disorder, but it is only recently that researchers are beginning to understand its psychopathology in attempts to implement more effective treatment. After examining compulsive hoarding as a mental health issue in some depth, including reference to the current Diagnostic and Statistical Manual (DSM IV) of the American Psychiatric Association (2000) and anticipated amendments in the DSM V, this case study will describe a fictional client, Mrs F. and her presenting issues as they emerged during an unstructured clinical interview. This will include the client's perception of the problem, her emotional and behavioural responses, resources, coping mechanisms and strengths. Following a brief outline of the diagnostic process, the case study will conclude with some thoughts on an action plan incorporating current best practice in the treatment of compulsive hoarding.

Compulsive hoarding, also known as 'pathological collecting' or 'chronic disorganisation' (Tolin, Frost & Steketee, 2007) is "**a syndrome characterized by excessive collecting and saving behavior that results in a cluttered living space and significant distress or impairment**" (Grisham & Norberg, 2010, p. 233). In recent years, this mental illness has been brought to public attention through numerous television shows, documentaries and social media offerings. This exposure reflects the sudden upsurge in academic research and clinical interest in the disorder (Mataix-Cols et al., 2010), partially due to the revision work being undertaken for the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-V) scheduled to be published by the American Psychological Association (APA) in 2013 (Kyrios, 2012).

Although hoarding has long been considered by many to be a relatively rare symptom or subtype of obsessive-compulsive disorder (OCD) (Abramowitz, Wheaton, & Storch, 2008), it has not been listed as an Axis I diagnostic criterion for OCD in previous versions of this benchmark publication, being included only as one of eight possible diagnostic criteria for obsessive-compulsive personality disorder (OCPD), a DSM-IV Axis II diagnosis (Grisham & Norberg, 2010). In previous editions hoarding was defined as the inability "to discard worn-out or worthless objects even when they have no sentimental value" (APA, 2000, p. 728). Interestingly, the 10th edition of the International Classification of Diseases (ICD-10) (World Health Organisation, 1993) does not include hoarding at all under its OCD equivalent, Anankastic Personality Disorder (Mataix-Cols et al., 2010).

Not only are the diagnostic boundaries for compulsive hoarding still a matter of debate (Pertusa et al, 2010), but there is growing evidence from epidemiological, phenomenological, neurobiological, and treatment studies to suggest that "it is misleading and invalid to classify hoarding as part of OCPD" (Grisham & Norberg, 2010, p. 234) and that it should be considered as "a discrete disorder with its own diagnostic criteria" (Pertusa et al, 2010, p. 371). Not only do compulsive hoarders tend to experience pleasure from engaging in their hoarding behaviour, unlike OCD sufferers (Grisham et al., 2005), but just 15-17% of the former are diagnosed with comorbid OCD (Steketee, 2012). In contrast, 60% have depression, 30% social phobia and 25-30% general anxiety disorder (Tolin, Frost & Steketee, 2007). This growing evidence also includes findings that hoarding correlates only moderately with other symptoms of OCD (Wu & Watson, 2005), symptoms of ADHD predict the severity of acquiring, cluttering, and impaired discarding (Tolin & Villavicencio, 2011), there is an overlap with symptoms of impulse control disorder (ICD) (Hartl et al, 2005), and neuroimaging indicates that brain activity discriminates hoarders from normal and OCD subjects (Mataix-Cols et al., 2004).

Consequently, this disorder involving the **acquisition and chaotic storage of large volumes of possessions which appear to be worthless, combined with an inability to discard them** (Frost & Gross, 1993), is currently under consideration for inclusion as a distinct syndrome designated as Hoarding Disorder, with six distinctive diagnostic criteria in the DSM-V (Frost et al., 2011). These criteria encompass the three basic features of compulsive hoarding, i.e. **excessive acquisition**, **clutter resulting from poor organisation**, and the **inability to throw things away** (Frost, 2012b), while excluding other possible causes.

Steketee & Frost (2007a) have proposed a complex cognitive-behavioural model of compulsive hoarding and acquiring that is consistent with Durand & Barlow's (2010) integrative approach based on the diathesis stress model and recent research findings. Steketee & Frost (2007a) see hoarding as "a problem of emotional, mental, behavioral and social well-being" (p. 29) with distinct, yet interrelated aspects.

The first involves certain core vulnerabilities or diatheses, including (genetically predisposed) emotional dysregulation, a family history of hoarding, parental values, and information processing deficits encompassing problems with attention (focusing and staying on task), categorisation (ordering possessions efficiently into manageable groups), excessive attention to aesthetic detail, decision-making about specific action and poor memory that results in an over-dependence on visual aids (Frost, 2012c). Secondly, hoarders have intense emotional or sentimental attachments to a wider range of objects than non-hoarders, such as anthropomorphising inanimate objects, feeling grief at the prospect of getting rid of objects, and deriving a sense of safety or control from being surrounded by possessions. Thirdly, people who hoard hold

a number of dysfunctional beliefs about possible usefulness, prospective opportunities, saving, security, aesthetic beauty, wastefulness, need for perfection, and personal identity (i.e. “I am what I have”). These information processing deficits, attachments and beliefs leading to behaviour patterns resulting in clutter are ultimately maintained through both positive emotional reinforcement, such as pleasure, excitement, pride, relief, joy, fondness and satisfaction, and negative emotional reinforcement through avoiding grief/loss, anxiety, sadness, guilt, anger, frustration and confusion (Steketee, 2007).

While signs of hoarding can often be seen early in life, the typical age of onset of hoarding behaviour is around 13 years, often progressing chronically to be a severe problem by the age of 50 (Steketee, 2012). Late onset of hoarding seems to occur when a vulnerable person suffers a loss of some kind, such as the death or departure of a spouse or a security-related issue and epidemiological research suggests that up to five percent of people may have a hoarding problem (Frost, 2012a). Despite popular conceptions, hoarding is seldom associated with material deprivation in childhood (Frost & Steketee, 2010). Compulsive hoarding often impacts the sufferer’s well-being dramatically, leading in the worst cases to social isolation, familial estrangement, mental health issues in their progeny, divorce, homelessness following eviction, personal injury from falling and even death resulting from the inability of rescue services to access the hoarder in an emergency (Neziroglu, 2012).

Case study

The client, Mrs F. has only come to see a counsellor on the advice of her GP, whom she consulted for a routine check up. In passing, she mentioned her increasing anxiety and sleeplessness. As she is averse to pharmaceuticals, she rejected his recommendation of anti-anxiety medication, instead agreeing to see a counsellor. She is otherwise in good health for a woman her age. Mrs F. now reports that this anxiety is linked specifically to a fear that as she ages she may be forced to move out of her home into an aged care facility, the thought of which fills her with dread as she values her independence above all else. When asked why this might eventuate, Mrs F. reluctantly suggests that people could find the state of her home a cause for concern. Mrs F. is worried that if health authorities paid her a visit they would find some things unacceptable, such as her malfunctioning toilet and the large hole in the ceiling of the hallway caused by the ingress of storm water. She admits she has not had these repaired for fear that a tradesman would need to enter her home and see the mess – about which she is rather embarrassed.

She knows that the inside of her home is vastly different from that of her friends‘ houses in terms of her “lack of free space“, which is the reason why nobody is allowed to come in. When asked about her social network, she describes a large circle of friends whom she meets regularly in different locations, but almost never at home. On the rare occasions she does entertain there, she does so in a makeshift gazebo in her backyard. She accepts that her friends know, but they probably think she is just a bit quirky.

On being asked to describe the inside of her home, Mrs F. indicates that “it’s a bit messy”, but says she is used to it and the “stuff” makes her feel safe from anyone who might try and sneak in as “they wouldn’t get very far”. Upon further questioning regarding her safety concerns, she recalls that her house was once broken into a number of years ago, the first time anything like that had ever happened to her. She feels her situation is acceptable as she is not hurting anyone, she does not share the space with anyone else and she can easily put up with the “minor inconveniences“ associated with the structural wear and tear. Mrs F. is not concerned about the state of her house per se, only about the possible consequences. She also thinks she is helping the local community in these hard times by purchasing small items from various local businesses and charity stalls, especially considering she is “much better off than so many others”. However, she is frustrated by the arthritis in her hands as it is preventing her from completing so many projects she has been planning, including a scrapbook of newspaper clippings charting the 20-year history of the local pony club. She is now forced to save all the papers until her condition improves, a strategy that seems to indicate the absence of any plans for self harm.

In terms of the **diagnostic process**, the referring physician had provided little information prior to the appointment, except to write that Mrs F. suffered from general anxiety and sleeplessness without any apparent physiological causes. As the prevalence of Generalised Anxiety Disorder (GAD), an illness characterised by anxious apprehension (Barlow, 2002), is highest in the elderly (Brown, O'Leary, & Barlow, 2001), the counsellor commenced with the first question posed in the GAD section of the Anxiety Disorders Interview Schedule for DSM-IV: Lifetime Version (ADIS-IV-L; Di Nardo et al., 1994): “Over the last several months have you been continually worried about a number of events or activities in your daily life?” It rapidly became apparent that Mrs F. was primarily concerned about the state of her home and the possible realistic ramifications. In order to validate the description of her home, Mrs F. was shown the three sets of photos comprising the **Clutter Image Rating Scale** (Steketee & Frost, 2007b) for a living room, bedroom and kitchen, scoring “6” from a possible “9” on all three, thus confirming her assessment. Further exploration was

undertaken using the 23-item Compulsive Hoarding Rating Scale (Frost, Steketee, & Grisham, 2004) and the 29-item Activities of Daily Living Scales (Tolin, Frost & Steketee, 2007).

The general clinical consensus is that hoarding is highly resistant to therapy, especially as compulsive hoarders value their possessions and often have poor insight into the severity of their condition (Pertusa et al. 2010). Furthermore, pharmacotherapy has had little success (Steketee, 2007). However, in recent years a multidisciplinary team of experts has developed a 26-week program of cognitive behavioural therapy for hoarding disorder (Steketee, 2007) that could provide a template for working with Mrs F. It involves client education about the disorder, motivational interviewing to alleviate feelings of hopelessness and establish realistic goals, organisational, problem-solving and decision-making skills as specific tools, graduated exposure to non-acquiring and discarding to break reinforcement cycles, and cognitive restructuring to challenge core beliefs. Therapy is undertaken in the counsellor's office, at the client's home, and at common acquisition locations, such as charity stores or stalls. The treatment program should also ideally include family members and self-help group involvement if possible (Frost, 2012e). Treatment of the different aspects can be monitored using the initial diagnostic tools, various scales included in the Steketee & Frost workbook (2007b) and clinical distress ratings during exposure 'experiments' (Frost, 2012d).

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