

2.11 PARAMETERS FOR HOARDING DISORDER

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I. INTRODUCTION

- A. People with Hoarding Disorder (HD) save items excessively in collections and retain items that others may view as worthless. Collections of objects or animals interferes with day-to-day functions such as home, health, family, work and social life. Severe hoarding causes safety and health hazards. The collection of newspapers, magazines, old clothes and other items may cause fires while animal hoarding can spread contagious diseases.
- B. Collecting is not the same as hoarding. Collections include specific items and are organized and displayed. Hoarding includes random items and they are stored haphazardly.
- C. Estimations are that older adults (55-94) represent three times more likely to be affected by HD compared to adults 34 – 44. HD is estimated in 2 – 6 % of the general population. Average age of onset of symptoms is 13.
- D. Etiology remains unknown. Risk factors include family member correlations, brain injury or triggering of a life event such as death of a loved one. HD is distinct from OCD in brain function abnormalities and neuropsychological performance.

II. EVALUATION AND ASSESSMENT

- A. Hoarding Disorder (HD) is classified in the DSM 5 with specific symptoms:
 - 1. Lasting problems with throwing out or giving away possessions, regardless of their actual value
 - 2. Problems are due to a perceived need to save the items
 - 3. Distress is linked with parting of items
 - 4. Items fill, block, and clutter active living spaces so that they cannot be used or are hampered in use.
 - 5. Insight may or may not be prevalent
 - 6. Associated problems with indecisiveness, perfectionism, procrastination, disorganization and distractibility.
- B. The behavior of hoarding is seen in various illnesses. Historically HD had been difficult to place in a diagnostic category. Age of onset and length of time are variable and the behavior can differ from person to person. Frequently, older adults hoard for the following reasons:
 - 1. Items are perceived as valuable
 - 2. Items provide a source of security
 - 3. Fear of forgetting or losing items

4. Constant need to collect and keep things
5. Obtaining love not found from people
6. Fear others will obtain their personal information
7. Physical limitations and frailty
8. Inability to organize
9. Self-neglect
10. Stressful life events

C. Hoarding, like other addictions and mental disorders, may not always be recognized by outward appearances. Huge piles of clutter may be a symptom, but they may not be enough for a diagnosis without supporting evidence such as:

1. Inability to part with useless or worthless items with rationalizations
2. Insatiable desire to increase the amount of possessions
3. No problem with getting rid of other people's possessions
4. Issues of hoarding which threaten health and safety

III. TREATMENT CONSIDERATIONS

- A. Hoarding is recognized as both a mental health issue and a public health problem.
- B. It is typically not an immediate crisis. The hoarding behavior usually has been occurring for a long time and hasty interventions will not resolve it.
- C. In addition, interventions without the person who hoard's cooperation, can lead to the development of dangerous behaviors.
- D. Careful assessment of the individual situation is essential for a successful outcome. And collaborative interventions should involve the person who hoards, family and other agencies, i.e. mental health, adult protective services, code enforcement, building & safety, animal control and criminal justice.
- E. Several guidelines should be followed when engaging the person who hoards:
 1. Contact the person face-to-face
 2. Use a soft, gentle approach and let the person tell his/her/story
 3. Treat the person with respect and dignity
 4. Respect the meaning and attachment to possessions which may be as intense as affections to humans
 5. Remain calm and factual, but caring and supportive
 6. Evaluate for safety
 7. Refer for medical and mental health evaluation
 8. Go slowly and expect gradual changes
 9. Reassure the person that others will try to help and work with him/her
 10. Involve the person in seeking solutions
 11. Work with other agencies to maximize resources.

IV. PSYCHOSOCIAL CONSIDERATIONS

- A. Cognitive Behavioral Therapy (CBT) is considered the first treatment choice for HD.
 - 1. Maladaptive belief and behavioral patterns are confronted
 - 2. Emotional distress related to discarding of items is managed
 - 3. Active discarding and avoidance of acquiring new objects
 - 4. Exposure to discarding and avoidance of acquisition of new possessions
- B. Pharmacotherapy requires more control trials.
- C. HD is most prevalent in adults over 50 although documented in all age levels. Population based studies suggest nearly 10% 6-17 year olds have moderate levels of hoarding behaviors and 3% have high levels.
- D. Much higher rates in children with OCD or OC symptoms, Prader-Willi Syndrome, autism, intellectual or developmental disabilities and learning disabilities.
- E. Significant impairment in daily functioning noted on psychosocial, occupational and family domains.
- F. Some consequences of hoarding behaviors include:
 - 1. Social isolation
 - 2. Divorce
 - 3. Separation
 - 4. Alienation from family members
 - 5. Risk of eviction and homelessness
 - 6. Removal of children or elders
 - 7. Risk of death and injury
 - 8. Health risks due to unsanitary conditions
 - 9. Financial stressors due to excessive acquisition
 - 10. Structural instability and fire
- G. Individuals with HD are more likely to have low socio economic resources
 - 1. 40% live in poverty
 - 2. Mental health services are 5 time higher than the general population
 - 3. Pathological hoarding contributes to morbidity and mortality

V. SAFETY, REPORTING AND LEGAL CONSIDERATIONS

Consideration of interventions should include safety, reporting requirements and legal considerations. Hospitalization for HD may not accomplish positive outcomes unless there is a clear plan. Forced interventions are often unsuccessful. When approaching HD discussions with

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the client, using formal, and non-judgmental approaches are recommended. Consultation with professionals who have expertise in this area is recommended.

Adult Protective Services — (877) 477- 3646 Investigation & Crisis intervention for elder and dependent adult abuse including self-neglect, 24 hours a day, 7 days a week.

California Department of Social Services – Adult Protective Services

Elder Abuse: Prevention through Prosecution – Collaboration with WISE & Healthy Aging, with funding from the County of Los Angeles Area Agency on Aging and The City of Los Angeles Department of Aging.

VI. **RESOURCES**

- A. Cognitive Behavioral Therapeutic approach
[NIH article from: Clin Psychol Psychother 2017 Jan;24\(1\):235-244](#)
[NIH article from: Cogn Behav Ther 2016;45\(2\):93-110](#)
- B. Comparison of Objects and Animal Hoarding
[NIH article from: Depress Anxiety. 2011 Oct 3; 28\(10\):885-891](#)
- C. DSM 5 Clinical Description and Cognitive Approach
[NIH article from: Psychiatriki 2017 Apr-Jun;28\(2\): 131-141](#)
- D. Hoarding Throughout the Life Span from Psychiatric Times
[Psychiatric Times Volume 34 Issue 9](#)
- E. [5 Levels of Hoarding and Guidelines for Recognizing the Disorder](#)
- F. [8 Common Myths About Hoarding Disorder](#)