Compulsive Hoarding by Dr. Christopher Mogan

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Compulsive hoarding is a psychological condition that implicates the complex relationships between people and objects or possessions. The importance to people of possessions or objects varies, ranging from individuals who keep only bare essentials to those who collect chaotically, and are unable to manage the amount of possessions they have. Many people can identify with the packed garage, the inaccessible 'junk' room and the periodic clean-up of such spaces; or the isolated eccentric whose property is littered with car bodies.

Awareness is growing about compulsive hoarders whose saving of things has a more pervasive and disruptive quality that dominates the sufferer's space, time and personal functioning. Chaos results not only from the clutter, but also from a seeming inability to stop collecting more possessions, incapacity to either organize or dispose of them, and the sense of attachment and responsibility felt for these things. All of this results in high distress levels, unsafe and unhygienic environments, and/or a decreased quality of environment and life for the hoarders and those close to them. There is increasing interest in public housing, community, fire and other emergency services in working on what has been an under-reported and misunderstood clinical and social problem. For example, hoarding households are now being shown to be a major cause of fatalities in domestic fires, and disabling falls that curtail independent living.

Frost and Hartl (1996) provided a useful working definition of compulsive hoarding: (1) the acquisition of and failure to discard a large number of possessions that appear to be useless or of limited value; (2) living spaces sufficiently cluttered so as to preclude activities for which those spaces were designed; and (3) significant distress or impairment in functioning caused by the hoarding; resulting in the cluttering of rooms and the overall impairment of personal functioning. This definition emphasizes the

acquisition of items, usually with sentimental, symbolic or useful characteristics, and an apparent difficulty in discarding anything, even seemingly worthless things. There are a range of associated factors like the intense emotion about objects, the surge of anxiety if possessions are touched by others, a hyper-sentimentality towards objects, and a comfort-seeking 'churning over of their things'.

Why do people hoard?

A hoarder accumulation may be based on sentimental or useful links that are symbolic attachments or even markers of personal history. In other situations, an object might be seen as needed by the individual or someone else they could assist. The acquiring of things seems to provide psychological needs not yet fully understood but linked to personal variables like attachment, identity, impulsivity, or compulsiveness. Saving things for the hoarder's own use or to be useful to others becomes so much part of the person that nothing of value or significance can be left uncollected and/or thrown away. Thus, such affected individuals compulsively collect objects from many sources, including family, roadside dumps, council pick-ups and garage sales. There are yet those for whom the focus is very singular in terms of keeping a narrow range of objects. For example, individuals may collect newspapers because of the need to have ready access to the enclosed information, or for the purposes of reading particular articles before recycling or disposing. This could also apply to videotapes, cassettes, magazines or books, or even emails and computer software. This collecting seems driven by a need to have information available, and possibly as an aid for information processing. Finally, there are those for whom clutter is consequential to the struggle to manage the demands of life – for the depressed, the overwhelmed, and the procrastinators – for whom things build up because they are personally disorganized as a result of personal style, cognitive deficits, or clinical symptoms of anxiety or depression.

When does hoarding start?

Hoarding can take a chronic and insidious course that takes years to develop and become overwhelming. The age of onset in a group of self-identified hoarders was usually in childhood or early adolescence. One retrospective assessment by Dr Jessica Grisham showed an early onset of hoarding at about age 10, with mild hoarding symptoms about age 17, moderate in mid-20's and extreme levels occurring in mid-30's. The average age of those seeking help for hoarding is estimated at about 50 years underlining the long-term disability of compulsive hoarding.

Other conditions associated with hoarding

Compulsive hoarding is thus a disabling clinical problem that has remained under-reported by the secretive sufferers and untreated by clinicians who are largely unaware of the problem or its management. Even when offered helped hoarders are resistant to treatment. The reported prevalence of hoarding by individuals with OCD is up to 38% of OCD patients. The co-occurrence of depression and anxiety in hoarding seems associated with the reported sense of loss and heightened anxiety experienced when hoarders are discarding possessions, as well as the over-attachment issues in relation to possessions. There is also an over-responsibility factor, such that anxiety and saving are increased when something is discarded. For example, one hoarder would only save the newspaper for later thorough reading, if he perceived that no one else had read it, even very briefly. Such perceived non-reading created excessive anxiety that led the individual to keep the newspaper in case there was information useful to them or to others.

Hoarding commonly presents in the elderly, particularly those with dementia, other organic brain diseases, and psychotic conditions. Hoarding in schizophrenia has been associated with bizarre objects secondary to delusional thinking. In a similar way, Diogenes' syndrome, which is characterized by domestic squalor, self-neglect and hoarding –

shows a deteriorating, then complete breakdown of social and personal organization. There is not a clear link of such hoarding with the compulsive hoarding described in the cognitive-behavioural model (Frost & Hartl, 1996).

Assessment of Hoarding

There has been strong collaboration between scholars from the United States and Australia in developing hoarding measures:
1) The Hoarding Interview with questions about cluttering rooms, whether or not friends or officials had suggested reduction of clutter, about a current episode of hoarding;
2) The Savings Inventory, a self-report scale that measures the major features of compulsive hoarding – acquiring things, amount of clutter, difficulty discarding things - as well as the distress and interference caused by hoarding;
3) The Savings List, a descriptive list of 82 common objects ranging from clothes to light bulbs, from sentimental objects to receipts, flower pots and old furniture;
4) To screen for hoarding problems, the Hoarding Rating Scale asks five questions: 1) Clutter: Because of clutter…how difficult is for you to use the rooms in your home? 2) Discarding: do you have difficulty in discarding ordinary things other people would get rid of? 3) Acquiring: do you currently have a problem with collecting free things or buying more things than you need…? 4) Distress: do you experience emotional distress because of clutter, difficulty discarding…or acquiring things? 5) Impairment: do you experience impairment in your life because of clutter, difficulty discarding or problems with acquiring things? More recently, the Boston group have developed a Clutter Image Rating scale that provides a series of graded pictures of cluttered rooms in a house that can act as a guide to the extent of any hoarding problem. Use of the visual scale and the hoarding screening questions can precede a more detailed assessment using the more detailed measures of hoarding mentioned above.

Treatment of hoarding

Treatment of compulsive hoarding remains relatively undeveloped. In summary, the systematic search for effective hoarding treatments has begun with the release of CBT working manuals for therapists and patients (Steketee and Frost, 2007) and self-help books (Tolin et al, 2008). Such manuals comprise a number of components such as identifying target clutter areas by photograph or home-visit, putting possessions into set categories for better organization, therapist-assisted exposure for discarding items, and decision-making training. Other cognitive techniques focus on excessive emotional attachment to possessions, beliefs related to perfectionism and responsibility, doubts about memory, and the negative consequences of clutter. Therapists use skills training to assist in categorization, decision-making and counter-conditioning. Behavioral tasks provide learning experiences that improve conceptualisations of problem hoarding, increase motivation and introduce step-by-step changes.

Compulsive hoarders are rigid and inflexible, have excessive needs for control, and high levels of problem worry. These characteristics bring therapy-interfering behaviours, such as the reluctance to even divulge the existence of hoarding problems, refusal to participate in any therapy, and denial that there is any problem at all. Not only is it necessary to help hoarders with organizing and managing things, but to also develop shifts in how people relate to things, improve their management of negative feelings and other adaptive behaviours.

The object-self-fusion expressed in compulsive hoarding needs to be expressed and processed as a self-limiting ego-defence. Experiencing the self-without-things requires graded and repeated personal experiences that build improved concepts of the self. Shifts in such thinking about hoarding are the goal for therapy if hoarding treatments are to be efficacious. Prognosis based on short-term clean-ups and rigid behavioural controls are very guarded as problem clutter seems to quickly re-emerge when such controls are lifted, bringing rapid relapse and a highly

reinforcing resumption of hoarding practices. It is expected that there will be high anxiety associated with recycling, disposing or even touching objects with marked personal meaning. However, when done in a gradual and supported way, confidence in the approach grows as the predicted patterns occur, that is, anxiety is expected to rise and then to fade over time. Similarly, fear of making decisions increases anxiety; graded practice with decision-making tasks has been shown to be effective in increasing the tolerance of anxiety and making gains in de-cluttering.

What now?

Assessment and diagnosis tools are now available which demonstrably identify problem hoarding. Shifts in thinking and feeling can be detected and measured, and hope for change offered through the implementation of affect-change strategies such as brief tasks for challenging defined clutter targets, and known workable strategies to assist with negative mood states like attention refocusing and mindfulness. The frequent comorbidities involved with hoarding are a clinical reality, and proper management of any disorder begins with adequate assessment and diagnosis. Hoarding will remain a serious source of disability until it is better understood by health and community workers. This is best achieved through the established paths of community education, systematic research and training of staff in dealing with this misunderstood, under-recognized and under-treated clinical problem.

References

Steketee, G., & Frost, R.O. (2007). **Compulsive Hoarding and Acquiring OUP: New York.**

Tolin, D., Frost, R.O., & Steketee, G. (2007). **Buried in Treasures: Help for compulsive hoarding. OUP: New York**