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Hoarding Disorder

Author

Ramar G

Assistant Professor in Psychiatric Nursing

Hind Institute of Medical Science, Safedabad, Lucknow, Uttar Pradesh, India

Email: *ramargurusamy8@gmail.com*

ABSTRACT: *This article reviews the literature on compulsive hoarding, including the definition and manifestations of the problem and a conceptual model for understanding hoarding behavior. This model addresses information processing deficits (e.g., attention, organization, and memory, decision-making), beliefs about and emotional attachments to possessions, and distress and avoidance. Research regarding the diagnostic categorization of hoarding, its course and phenomenology, and evidence to support the model is presented. The limited research on treatment provides evidence that current serotonergic medications for OCD are largely ineffective for treating hoarding, but cognitive and behavioral treatments, especially those focused on deficits identified in the model, have some utility. Recommendations for further research on the psychopathology and treatment of hoarding are provided.*

Keywords: *Collecting, Acquisition, Buying, Saving, Clutter.*

1. INTRODUCTION

Compulsive hoarding (more accurately described as "hoarding disorder") is a pattern of behavior that is characterized by the excessive acquisition of an inability or unwillingness to discard large quantities of objects that cover the living areas of the home and cause significant distress or impairment. Compulsive hoarding behavior has been associated with health risks, impaired functioning, economic burden, and adverse effects on friends and family members. When clinically significant enough to impair functioning, hoarding can prevent typical uses of space so as to limit activities such as cooking, cleaning, moving through the house, and sleeping. It can also be dangerous if it puts the individual or others at risk from fire, falling, poor sanitation, and other health concerns.

Researchers have only recently begun to study hoarding, and it was first defined as a mental disorder in the 5th edition of the DSM in 2013. It is not clear whether "compulsive" hoarding is a separate, isolated disorder, or rather a symptom of another condition, such as OCD. Prevalence rates have been estimated at 2-5% in adults, though the condition typically manifests in childhood with symptoms worsening in advanced age when collected items have grown excessive and family members who would otherwise help to maintain and control the levels of clutter either die or move away. Hoarding appears to be more common in people with psychological disorders such as

depression, anxiety and attention-deficit hyperactivity disorder. Other factors often associated with hoarding include alcohol dependence as well as paranoid, schizotypal, and avoidance traits. Family histories show strong positive correlations.

In 2008 a study was conducted to determine if there is a significant link between hoarding and interference in occupational and social functioning. Hoarding behavior is often so severe because of poor insight of the hoarding patients in that they do not recognize it as a problem. Without this insight, it is much harder for behavioral therapy to be the key to the successful treatment of compulsive hoarders. The results found that hoarders were significantly less likely to see a problem in a hoarding situation than a friend or a relative might. This is independent of OCD symptoms as patients with OCD are often very aware of their disorder.

2. SYMPTOMS

Compulsive hoarding in its worst forms can cause fires, unclean conditions (e.g. rat and roach infestations), and injuries from tripping on clutter, and other health and safety hazards. A few symptoms hoarders might experience are: (1) they tend to hold onto a large number of items that most people would consider not useful or valuable. For example: junk mail, cooking equipment, old catalogues and newspapers, things that might be useful for making crafts, clothes that "might" be worn one day, broken things/trash, "freebies" or other promotional products picked up. (2) The home is so cluttered that many parts are inaccessible and can no longer be used for intended purpose. For example: beds that cannot be slept in, Kitchens that cannot be used for food preparation, refrigerators filled with rotting food, stovetops with combustibles such as junk mail as well as old food piled on top of burners. Tables that cannot be used for dining, chairs or sofas that cannot be used, filthy unsanitary bathrooms; piles of human feces collected in areas of the home, sometimes there are animal feces over the floors of the home, giant bags of dirty diapers hoarded for many years. Tubs, showers, and sinks filled with items such that they cannot be used for washing or bathing. Hoarders would thus possibly forgo bathing. Some hoard animal they cannot even marginally care for; often dead pets cannibalized by other pets are found under the heaps. (3) The clutter and mess is so bad it causes illness, distress, and impairment. For example, they: do not allow visitors such as family and friends, or repair and maintenance professionals because the clutter embarrasses them, keep the shades drawn so no one can see inside, get into a lot of argument s with family members about the clutter, are at risk of fire, falling, infestation or eviction and feel depressed or anxious much of the time because of the clutter.

3. DIAGNOSIS

The proposed DSM-5 diagnostic criteria for hoarding disorder are: (a) persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions. (The Work Group is considering alternative wording: "Persistent difficulty discarding or parting with possessions, regardless of their actual value."), (b) this difficulty is due to strong urges to save items and/or distress associated with discarding, (c) the symptoms result in the accumulation of a large number of possessions that fill up and clutter active living areas of the home or workplace to the extent that their intended use is no longer possible. If all living areas become decluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities), (d) the symptoms cause clinically significant distress or impairment

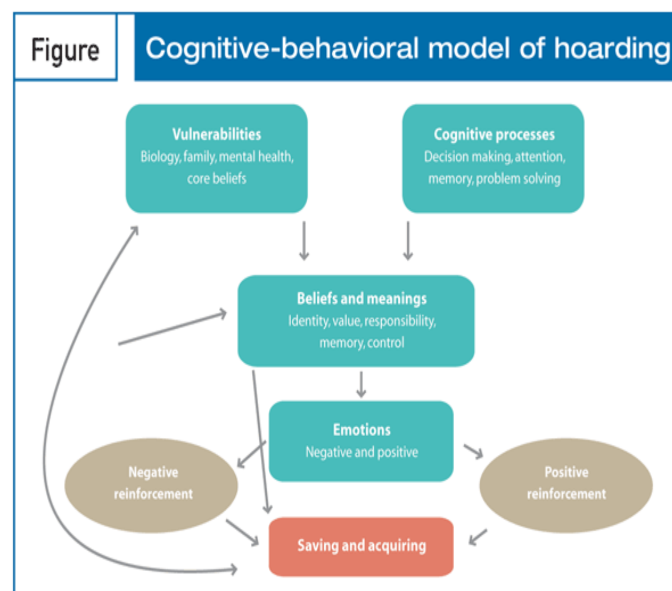
in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others), (e) the hoarding symptoms are not due to a general medical condition (e.g., brain injury, cerebrovascular disease), (f) the hoarding symptoms are not restricted to the symptoms of another mental disorder (e.g., hoarding due to obsessions in Obsessive-Compulsive Disorder, decreased energy in Major Depressive Disorder, delusions in Schizophrenia or another Psychotic Disorder, cognitive deficits in Dementia, restricted interests in Autism Spectrum Disorder, food storing in Prader-Willi syndrome).

Understanding the age of onset of hoarding behavior can help develop methods of treatment for this “substantial functional impairment”. Hoarders are dangers to not only themselves, but others as well. The prevalence of compulsive hoarding in the community has been estimated at between two and five percent, significantly higher than the rates of OCD and other disorders, such as panic disorder and schizophrenia.

3.1. Neuropsychology

Brain imaging studies using positron emission tomography (PET) scans that detect the effectiveness of long-term treatment have shown that the cerebral glucose metabolism patterns seen in OCD hoarders were distinct from the patterns in non-hoarding OCD. The most notable difference in these patterns was the decreased activity of the dorsal anterior cingulated gyrus, a part of the brain that is responsible for focus, attention and decision making. A 2004 University of Iowa study found that damage to the frontal lobes of the brain can lead to poor judgment and emotional disturbances, while damage to the right medial prefrontal cortex of the brain tends to cause compulsive hoarding. Some evidence based on brain lesion case studies also suggests that the anterior ventromedial prefrontal and cingulated cortices may be involved in abnormal hoarding behaviors, but sufferers of such injuries display less purposeful behavior than other individuals that compulsively hoard, thus making the implication of these brain structures unclear. Other neuropsychological factors that have been found to be associated with individuals exhibiting hoarding behaviors include slower and more variable reaction times, increased impulsivity, and decreased spatial attention.

Figure: 1



4. SUBTYPES AND RELATED CONDITIONS

4.1. Obsessive–Compulsive Disorder

For many years hoarding has been listed as a symptom or a subtype of Obsessive Compulsive Disorder (OCD) and Obsessive Compulsive Personality Disorder (OCPD). The current DSM says that an OCD diagnosis should be considered when:

1. The hoarding is driven by fear of contamination or superstitious thoughts

2. The hoarding behavior is unwanted or highly distressing

3. The individual shows no interest in the hoarded items

4. Excessive acquisition is only present if there is a specific obsession with a certain item. Recent findings suggest to differentiate between three types of hoarding, that is: pure hoarding, hoarding plus OCD (i.e., comorbid OCD), and OCD-based hoarding.

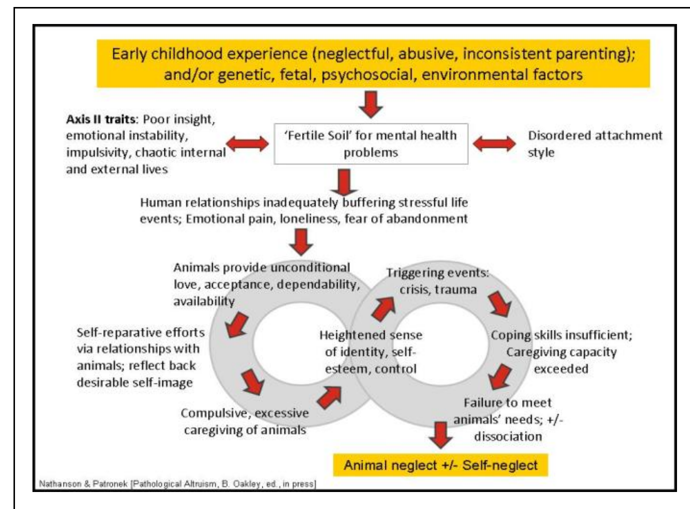
4.2. Book Hoarding

Bibliomania is a disorder involving the collecting or hoarding of books to the point where social relations or health are damaged. One of several psychological disorder associated with books (such as bibliophagy or bibliokleptomania), bibliomania is characterized by the collecting of books which have no use to the collector nor any great intrinsic value to a more conventional book collector. The purchase of multiple copies of the same book and edition and the accumulation of books beyond possible capacity of use or enjoyment are frequent symptoms of bibliomania.

4.3. Animal Hoarding

Animal hoarding involves keeping larger than usual numbers of animals as pets without having the ability to properly house or care for them, while at the same time denying this inability. Compulsive animal hoarding can be characterized as a symptom of a disorder rather than deliberate cruelty towards animals. Hoarders are deeply attached to their pets and find it extremely difficult to let them go. They typically cannot comprehend that they are harming their pets by failing to provide them with proper care. Hoarders tend to believe that they provide the right amount of care for their pets. The American Society for the Prevention of Cruelty to Animals provides a "Hoarding Prevention Team," which works with hoarders to help them attain a manageable and healthy number of pets. Along with other compulsive hoarding behaviors, it is linked in the DSM-IV to obsessive-compulsive disorder and obsessive-compulsive personality disorder.

Figure: 2



Alternatively, animal hoarding could be related to addiction, dementia, or even focal delusion. Animal hoarders display symptoms of delusional disorder in that they have a "belief system out of touch with reality". Many hoarders lack insight into the extent of deterioration in their habitation and the health of their animals, and tend not to recognize that anything is wrong. Delusional disorder is an effective model in that it offers an explanation of hoarders' apparent blindness to the realities of their situations. Another model that has been suggested to explain animal hoarding is attachment disorder, which is primarily caused by poor parent-child relationships during childhood. As a result, those suffering from attachment disorder may turn to possessions, such as animals, to fill their need for a loving relationship.

5. TREATMENT

5.1. Psychopharmacological Interventions

Obsessive-compulsive disorders are treated with various antidepressants: from the Tricyclic

antidepressant family clomipramine (brand name Anafranil); and from the SSRIfamilies paroxetine (Paxil), fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft) and citalopram (Celexa). With existing drug therapy, OCD symptoms can be controlled but not cured. Several of these compounds (including paroxetine, which has an FDA indication) have been tested successfully in conjunction with OCD hoarding.

5.2. Therapeutic Interventions

Cognitive-Behavioral Therapy (CBT) is a commonly implemented therapeutic intervention for compulsive hoarding. As part of cognitive behavior therapy, the therapist may help the patient to: a) discover why he or she is so compelled to hoard; b) Learn to organize the possessions in order to decide what to discard; c) develop the decision-making skills; d) declutter the home during in-home visits by a therapist or professional organizer; e) gain and perform relaxation skills; f) attend family and/or group therapy; g) be open to trying psychiatric hospitalization if the hoarding is serious and have periodic visits and consultations to keep a healthy lifestyle. This modality of treatment usually involves exposure and response prevention to situations that cause anxiety and cognitive restructuring of beliefs related to hoarding. CBT programs that specifically address the motivation of the sufferer, organization, acquiring new clutter, and removing current clutter from the home have shown promising results. Other therapeutic approaches that have been found to be helpful are:

1. Motivational Interviewing: originated in addiction therapy. This method is significantly helpful when incorporated in hoarding cases whereby insight is poor and ambivalence around change is marked;

2. Harm Reduction Rather Than Symptom Reduction: also borrowed from addiction therapy. The goal is to decrease the harmful implications of the behavior, rather than the hoarding behaviors;

3. Groups Therapy: reduce social isolation and social anxiety and are cost effective compared to one-on-one intervention.

6. CONCLUSION

Mental health professionals frequently express frustration towards hoarding cases, mostly due to premature termination, and poor response to treatment. Respectively, patients are frequently described as indecisive, procrastinators, recalcitrant, and as having low or no motivation, which can explain why many interventions fail to accomplish significant results. In order to overcome this obstacle, some clinicians recommend accompanying individual therapy with home visits to assist the clinician: (a) getting a better insight into the hoarding severity and style, (b) devising a treatment plan that is more suitable to the particular case, and (c) desensitizing sufferers to visitors. Likewise, certain cases are assisted by professional organizers as well.

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