

Hoarding Disorder: A New Diagnosis in the DSM-5

Chelsey A. Zoldan, Nicole A. Stargell, & Victoria E. Kress

Years before Hoarding Disorder (HD) became a distinct *DSM-5* diagnosis, hoarding behaviors exploded into popular culture, captivating television audiences with depictions of clutter, unsanitary living conditions, and staunch resistance to change—even in the face of severe consequences. A quick search of your TV-guide will undoubtedly present you with numerous opportunities to watch as mental health professionals and cleanup crews assist individuals and their families in addressing this debilitating disorder and its associated costs. The typically limited insight and extreme distress associated with a HD diagnosis make for an intense and engaging drama for viewers, but this disorder is the source of much hurt and suffering for those who are living with the disorder as well as their loved ones. Thankfully, those who have HD are able to change and live more adaptive lives and counselors have an important role to play in facilitating this change process.

Hoarding Disorder Characteristics

HD has historically been conceptualized as a form of Obsessive-Compulsive Disorder (OCD). However, there is no mention of hoarding-related symptoms in the OCD criteria in any of the *DSMs*. HD is now a unique diagnosis that shares some similarities with OCD, but it has its own unique set of diagnostic criteria. HD is classified in the *DSM-5* under the heading *Obsessive-Compulsive and Related Disorders*. Individuals with OCD and HD both have obsessive thoughts, rational or irrational, that affect their daily lives. These obsessions link certain behaviors with grave and undesirable consequences. For example, those with OCD might obsessively believe that they will get into an automobile accident if they do not lock their front door three times before leaving the house. On the other hand, those with HD might believe that they will suffer great sadness and loss if they discard an item of sentimental value. A fear of discarding items is one of the most notable features of HD, and those with this disorder often fear that they will accidentally discard an item that is valuable, or will become valuable. The only mention of hoarding behaviors in the *DSM* prior to the inclusion of HD in the *DSM-5* was in relation to Obsessive-Compulsive Personality Disorder (OCPD), in which a criterion for this diagnosis was an unwillingness to discard items that appear to have no monetary value. An important distinction to make between HD and OCPD-related hoarding behaviors is that those with HD have an emotional connection to the items that are collected, and experience great distress at the thought of getting rid of them. An additional distinction is that hoarding behaviors associated with OCPD do not typically result in an impaired ability to complete activities of daily living or impede free movement about one's living space.

Regardless of whether individuals' obsessions are rational or irrational, they are still a very real part of their lives. These distressing thoughts can be calmed, however, by completing a behavior (compulsion) to minimize the likelihood that they will come to fruition. Those with HD calm their thoughts by hoarding mass quantities of objects, ranging from paper cups to animals.

Hoarding Disorder is characterized by a client's desire to obtain and accumulate possessions. These possessions might hold some monetary value, or they might be relatively worthless (e.g., used napkins and newspapers). The value that individuals with HD place on hoarded objects is often not monetary; they are valuable due to their usefulness or sentimental qualities. Individuals with HD place unjustified value on objects and fear harmful, often unrealistic, consequences if they are discarded. This can make their lives very difficult as they work to balance constant accumulation of new objects and maintenance of their previously-collected possessions.

Individuals who hoard animals have less insight into the problematic nature of their behaviors than individuals who hoard inanimate objects. The prognosis for individuals who hoard animals is not always strong, as these individuals often develop delusions or unrealistic thought patterns. For example, the hoarded animals are often very unhealthy; feces and overpopulation can lead to sickness and sometimes death. However, those with HD

believe that they are responsible for helping the animals and that they are saving them from an otherwise hopeless life. The delusional thoughts that accompany animal hoarding are especially difficult for individuals to overcome.

Development of Hoarding Disorder

It is important to note that hoarding behaviors typically begin during adolescence, but are not often diagnosed as HD until the mid-30s. This is due to a number of reasons. Primarily, individuals with this disorder do not experience debilitating consequences as the result of hoarding until the behaviors have increased and material items have collected over time. Additionally, individuals with HD are able to hide their behaviors rather well because it is only obvious if an outsider is permitted inside their homes. HD behaviors become more engrained and severe across time, and prevalence of the disorder is highest in the older adult population. Because of symptom progression, the average age of those seeking treatment for hoarding disorder is 50. By this age, symptoms have begun to create significant social impairment, financial difficulty, and hazardous conditions.

Hoarding symptoms present somewhat differently in childhood than in adulthood. Children with HD may exhibit extreme personification of inanimate objects that is distinct from age-appropriate behavior, and may also stockpile various items. The acquisition and accumulation of objects may be less apparent in children, as parents and other caregivers are likely to intervene. In cases involving children, counselors must consider factors associated with hoarding behaviors, such as abuse and neglect history. For example, children who were malnourished and neglected may hoard food, and this presentation does not necessarily warrant a diagnosis of HD. Recognizing the symptoms of HD in children may provide an opportunity for early intervention, as symptoms tend to worsen in severity over time. These children are also likely to experience additional issues that can diminish overall mental health, including symptoms of panic and tendencies to externalize problems.

While HD presents similarly across cultural boundaries, cultural factors must be assessed for their possible implications in symptom development and maintenance. Poverty-related cultural factors, such as lack of food, shelter, clothing, and money, do not appear to be related to the development of HD. Each individual's unique motivations for hoarding behaviors must always be considered, as clients who have experienced extreme poverty may have appropriate fears of being unable to purchase or obtain an item in the future. Thorough assessment of trauma history is also beneficial, as it is common for symptom onset to coincide with the occurrence of traumatic life events.

Gender differences may also impact the presentation of hoarding behaviors. Women are more likely to present with symptoms of excessive acquisition, which describes the acquisition of items that are not needed and/or for which there is not available space that may accompany the inability to discard items. Excessive acquisition may include frequent purchasing of unneeded items, stealing, and/or collecting free items (e.g., pamphlets, flyers, etc.). Women are also more likely to engage in hoarding behaviors that include animals. However, it is worth noting that most research on hoarding disorder has used primarily female samples, and therefore gender differences may be exaggerated.

Family members or other loved ones are typically the motivation for individuals with HD to seek treatment. Individuals with HD do not typically see their behaviors as problematic and have limited insight into the impact of their symptoms upon their overall functioning. The *DSM-5* even offers specifiers to describe insight levels associated with HD, ranging from "good or fair insight" to "absent insight/delusional beliefs." This limited insight provides individuals with little internal motivation to change, and this is why many clients with HD are viewed as resistant. However, individuals with HD are simply maintaining behaviors that serve an important function in their lives and have very little understanding of the harmful consequences of their actions. As such, individuals with HD often seek counseling to address a comorbid mental health disorder that does cause distress to them such as depression or ADHD.

Treatment

Hoarding Disorder is a community-wide problem that poses emotional, health, and financial consequences to individuals who hoard, their significant others, and community members. The functional impairment associated with HD is often compared to schizophrenia and bipolar disorders. Those with HD often experience job loss and an increased need for public assistance. They are also more likely to have chronic medical conditions, such as heart disease and fibromyalgia. The unsanitary condition of their homes presents a hazard to surrounding homes in the form of increased rodent populations, bug infestations, and fire hazards. Cluttered living spaces present significant

challenges to medical first responders in reacting to emergency situations, which may be more likely to occur due to the fire hazards and chronic health conditions that are associated with HD. Overall, counselors can provide services to individuals with HD that will increase clients and their family members' wellness and the community.

Cognitive-behavioral interventions are supported as an effective way to help individuals with HD gain insight into their thoughts and behaviors. Counselors should work to address the major cognitive difficulties associated with HD: excessive acquisition, disorganization, and difficulty discarding. The first step is to nonjudgmentally join with the client to gain an understanding of his or her perspective. Joining with the client is important as it facilitates counselors' ability to accurately assess the situation and determine an accurate diagnosis.

The next step is to help the client begin to connect his or her thoughts with feelings and behaviors. After the client becomes more adept at linking thoughts with feelings, counselors can help clients restructure irrational thoughts and delusional thinking. Finally, counselors can use behavioral interventions to teach problem-solving, decision-making, and organizational skills.

It is important that counselors move slowly with clients who have HD. Attending to the development of a strong therapeutic relationship and demonstrating acceptance are essential, as clients with HD typically feel embarrassed and ashamed. These clients may also have limited social engagement as a result of their hoarding behaviors, and may be sensitive to perceived rejection and judgment. As previously mentioned, clients must gain insight into the unhealthy consequences of their hoarding behaviors before they will be motivated to change. Additionally, clients with HD often have trouble translating what they learn in a counseling office to practical behaviors in their home. As such, counselors must gain the trust of the client in order to help facilitate their openness to new ways of thinking, to help them restructure cognitions, and to provide behavioral interventions that clients can translate to their home. Because home-visits by counselors are not always a possible treatment option, visits by case managers and non-professional staff who are trained in working with those with HD may be an alternative. Home-visits by non-professionals often bolster treatment outcome. This population must feel supported and understood before they can gain insight and become invested in the counseling process.

Once clients feel supported and open to change, it is important to incorporate the family, other loved ones, and other helping professionals into treatment. Exposure therapy can be used to help clients practice discarding items in a gradual, methodical manner. When clients are ready, counselors can enlist the help of a cleanup crew to remove large quantities of material from the home. Some counselors might not have enough time to slowly integrate exposure therapy due to impending evictions or community orders. In this case, counselors should do their best to support the client and process mass cleanup events as a traumatic experience before working toward continued insight. In situations that require immediate action, counselors should be prepared for the client to experience extreme emotional distress, and may wish to include assessment for suicidal ideation. Even when clients are not faced with immediate cleanup or serious consequences, incorporating a safety plan into treatment during the preparation process can be beneficial.

Multi-disciplinary treatment teams, similar to those that have been formed to deal with issues like domestic violence, have been suggested as a community-based intervention to address HD. Clients with HD are often involved with various community agencies and providers, which may include medical and mental health professionals, waste management and cleanup services, Child Protective Services, animal welfare agencies, and fire departments. These treatment teams may provide a more comprehensive approach to addressing all areas that are affected by a client's hoarding behavior. Because the treatment of HD often entails the use of many community resources, counselors should be prepared to provide clients with referrals to various services. For example, counselors may refer clients to primary care physicians to address chronic health conditions or to vocational services to deal with unemployment.

It might be helpful to provide individuals with pharmacotherapeutic interventions before they are able to cope with mass cleanings or any smaller portion of the counseling process. As previously mentioned, HD is often comorbidly found with depression, anxiety disorders, and ADHD. Clients with HD often have trouble with medication compliance due to depressive symptoms, inattention, or losing medication in their homes. Because those with HD often have chronic medical conditions and poor overall physical, assessing for compliance with medications for physical issues is important as well. Clients can be encouraged to take their medicine on a regular basis with the help of family and friends. Because it is a relatively new diagnosis, medication options for HD are still being explored, and selective-serotonin reuptake inhibitors (SSRIs) have been found helpful. However, SSRIs have actually been associated with increased risk of suicidality due to an improvement in physical symptoms, but

persistent emotional difficulties. As such, pharmacotherapy should always be accompanied by counseling, and counselors should always take care to assess for safety in clients with HD.

Counseling individuals with HD can be challenging. However, those with HD can and do change. The new, independent diagnosis of HD validates the disorder as a real concern for clients and a potential area of expertise for counselors. As research regarding the etiology and treatment of HD develops, counselors will develop a better understanding of how to best support those who have this disorder.