

Chapter 1 *Introductory Information for Clinicians*

Background Information and Purpose of This Program

Throughout much of the developed world, the number of personal possessions owned by ordinary people has exploded during the last 50 years. Modern civilizations are based on the commerce of consumption, and they thrive when people are accumulating belongings. For most people, managing their possessions is not difficult and often it is pleasurable. We buy what we need, sometimes more, and we discard, recycle, give away, or sell what we don't. Almost all of us keep some things we don't need and don't use. When these unneeded objects impinge on our living space, we no longer want them and usually get rid of them. But for people who suffer from compulsive hoarding, this process is not so easy. For them, possessions never "feel" unneeded or unnecessary, and trying to get rid of them is an excruciating emotional ordeal. For some it is easier to divorce a spouse, sever ties with children, and even risk life and limb. This manual is the culmination of more than 10 years of work on understanding this compulsive hoarding problem and building an effective intervention to address its myriad components. The intervention program is the result of a treatment development project funded by the National Institute of Mental Health.

The intervention relies on collaboration between clinicians and clients to achieve a shared understanding of the client's hoarding problem. Although the 10 chapters in this manual suggest a sequence of intervention strategies, we do not provide session-by-session instructions, but instead adopt a modular approach because of the many features that contribute to clients' hoarding symptoms. We strongly recommend that clinicians read all chapters before starting. After completing a basic assessment and case formulation, decide what aspects of hoarding to focus on first and

what methods to use. Understanding clients' hoarding problems fully will help you empathize with their struggle to overcome very powerful emotional attachments and strong beliefs as they make steady, often uneven, progress toward the goal of ridding their homes of debilitating clutter.

This manual first describes compulsive hoarding in sufficient detail to enable clinicians to understand the problem and answer clients' and family members' basic questions. We consider this crucial information to dispel misunderstandings about hoarding behavior before trying to provide effective intervention. The next several chapters prepare clinician's to conduct the intervention. Chapter 2 covers methods for assessing the problem, along with illustrations of several forms for this purpose. In chapter 3, clinicians collaborate with clients to formulate a model for understanding how the client's hoarding symptoms develop and occur in real time. Chapter 4 focuses on treatment preparation and planning to select intervention methods based on the case formulation. Chapter 5 addresses a major problem in hoarding: ambivalence about change. It includes methods to enhance motivation, drawing from motivational interviewing methods originally developed for substance abuse problems.

The next four chapters cover the core cognitive and behavioral interventions for organizing, saving, and acquiring problems. In chapter 6, clinicians train clients in skills for making decisions and organizing possessions, and how to solve problems that inevitably arise during this process. Chapters 7 and 8 cover exposure methods to habituate discomfort while sorting, and cognitive strategies for restructuring problematic beliefs and automatic thoughts. Chapter 9 focuses on cognitive and behavioral methods for reducing acquiring. The final chapter (chapter 10) provides tips on preventing relapse. Throughout these chapters we illustrate the use of various forms for use during assessment and intervention to gauge clients' symptoms and progress. Blank copies of these forms are available in the accompanying client workbook, as well as on the *Treatments That Work*TM website at www.oup.com/us/ttw.

The Problem of Compulsive Hoarding

Three features define compulsive hoarding: (1) the accumulation and failure to discard a large number of possessions that appear to most people to be useless or of limited value, (2) extensive clutter in living spaces that precludes activities for which the rooms were designed, and (3) significant distress or impairment in functioning caused by the hoarding (Frost & Hartl, 1996). This definition distinguishes hoarding from collecting, in which individuals maintain collections of objects that are generally considered interesting and valuable. Descriptions of unusually severe cases of compulsive hoarding, including the Collyer brothers in New York City, can be found on several Internet sites. The behavior can result in serious and even life-threatening pathology (Frost, Steketee, & Williams, 2000), and severity appears to increase with age (e.g., Grisham, Frost, Kim, Steketee, & Hood, 2006). The average age of people who seek help for hoarding is about 50 years.

Acquiring

People who hoard often acquire excessively in the form of compulsive buying (usually considered an impulse control disorder) and acquiring free things, such as extra newspapers, advertisements, promotional giveaways, and discarded items from street trash or dumpsters (Frost & Gross, 1993; Frost, Kim, Morris, Bloss, Murray–Close, & Steketee, 1998). Occasionally, acquisition includes stealing and kleptomania. Acquiring is often associated with positive feelings and even euphoria, which reinforce the behavior and make it difficult to curtail. Compulsive acquiring is also sometimes associated with dissociated states and may be used to soothe negative moods (Kyrios, Frost, & Steketee, 2004), colloquially reflected in the phrase “retail therapy.”

Difficulty Discarding

A principal feature of hoarding is the failure to discard objects judged by observers (but not the person who has collected them) to be worthless or worn out. Most people who hoard view their possessions as having

sentimental (emotional), instrumental (useful), or intrinsic (aesthetic) value in excess of their worth in most people's eyes. These reasons for saving are no different from most people, but these values are applied to a much larger number and wider range of possessions. People who hoard are often able to discard some items, but the process of doing so is so elaborate and time-consuming that the number of newly acquired items easily exceeds removed ones, so the home gradually fills with things.

Clutter

Excessive acquisition and difficulty discarding possessions are not sufficient to be considered compulsive hoarding unless these behaviors are accompanied by significant clutter. The presence of clutter probably reflects a deficit in the ability to organize possessions (Wincze, Steketee, & Frost, 2005). In severe cases, clutter prevents very basic activities like cooking, cleaning, walking through the house, and even sleeping. The interference with these functions can make hoarding a dangerous problem, putting people at risk for fire, falling, poor sanitation, and health problems. Elderly clients may face particular challenges because of the clutter in their homes (Damecour & Charron, 1998; Steketee, Frost, & Kim, 2001; Thomas, 1997).

Special Features

Occasionally, hoarding occurs in squalid conditions that constitute a public health problem that threatens occupants of the home. In such cases, public health officials or other agencies may become involved. Another serious variant of hoarding is animal hoarding, defined as the accumulation of a large number of animals, typically in excess of 20, that are not intended for the purpose of breeding or sale. The owner fails to provide an adequate living environment for the animals, as indicated by overcrowded or unsanitary living conditions, inadequate veterinary care and/or nutrition, and the unhealthy condition of the animals. Even when they are clearly unable to provide adequate care, most people who hoard animals are reluctant to place the animals in the custody of others. Animal hoarding is often identified through complaints by neigh-

bors to legal authorities such as animal control agencies. This manual is not designed to address animal hoarding, because there is currently insufficient research to indicate what causes this problem and how to treat it. For further information about animal hoarding, contact the Hoarding of Animals Research Consortium at their website (www.tufts.edu/vet/cfa/hoarding) and see the Angell Report published by this organization.

Relationship to Other Psychiatric Disorders

Hoarding behavior has been reported in a variety of axis I disorders, including schizophrenia (Luchins, Goldman, Lieb, & Hanrahan, 1992), organic mental disorders (Greenberg, Witzum, & Levy, 1990), eating disorders (Frankenberg, 1984), brain injury (Eslinger & Damasio, 1985), and various forms of dementia (Finkel, Costa, Silva, Cohen, Miller, & Sartorius, 1997; Hwang, Tsai, Yang, Liu, & Lirng, 1998). Hoarding is also considered one of eight symptoms of obsessive–compulsive personality disorder (OCPD) (American Psychiatric Association, 1994), but its role in OCPD has not been well studied.

Whether hoarding is a symptom of obsessive–compulsive disorder (OCD) remains open to debate. In studies of adult OCD clients,¹ the frequency of hoarding ranges from 18 to 33% (Frost, Krause, & Steketee, 1996; Rasmussen & Eisen, 1989; Samuels, Bienvenu, Riddle, Cullen, Grados, Liang, Hoehn–Saric, & Nestadt, 2002; Sobin, Blundell, Weiller, Gavigan, Haiman, & Karayiorgou, 2000). Hoarding was the primary symptom in 11% of a large sample of OCD clients of Saxena and colleagues (2002). Supporting an association of hoarding to OCD symptoms is the excessive doubting, checking, and reassurance seeking before discarding possessions, which appear similar to compulsive rituals (Rasmussen & Eisen, 1989, 1992), and the moderately frequent cooccurrence of hoarding and other OCD symptoms in psychiatric patients and community samples (Frost & Gross, 1993; Frost et al., 1996; Frost, Steketee, Williams, & Warren, 2000; Samuels et al., 2002). On the other hand,

¹Most studies of hoarding have recruited clients through OCD clinics rather than soliciting them from community or independent sources. This introduces a bias in favor of finding OCD symptoms among those with hoarding. It is necessary to recruit people with hoarding problems directly from the community to understand best the symptoms of hoarding and how they relate to other psychiatric disorders.

people who hoard often view their symptoms as reasonable, in contrast to most people with OCD symptoms, who view them as senseless and are greatly disturbed by them. Five of six recent studies of OCD subtypes have identified hoarding as a separate symptom category (Abramowitz, Franklin, Schwartz, & Furr, 2003; Calamari, Wiegartz, & Janeck, 1999; Leckman, Grice, Boardman, Zhang, Vitale, Bondi, Alsobrook, Peterson, Cohen, Rasmussen, Goodman, McDougle, & Pauls, 1997; Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999; Summerfeldt, Richter, Antony, & Swinson, 1999; but see Baer, 1994). Research by Saxena and colleagues (2004) suggests that cerebral metabolic patterns observed in hoarding are different from those seen in OCD. Whatever the relationship of OCD and hoarding, we recommend assessing the presence of other symptoms of OCD and determining their role, if any, in compulsive hoarding. For example, contamination fears and checking problems may exacerbate or even generate clutter problems and complicate treatment.

Prevalence, Course, and Family Patterns

Formal prevalence estimates for compulsive hoarding are not yet available. Frost and associates (2000) reported a five-year prevalence of hoarding-related complaints to public health departments of 26 per 100,000, but this figure undoubtedly seriously underestimates the number of people with compulsive hoarding problems, many of whom have not had a public complaint filed against them. In view of our own recent finding that 52% of clients seeking treatment in our program for compulsive hoarding did not have other OCD symptoms (Steketee, Frost, Tolin, & Brown, 2005), together with reports indicating that approximately 25% of OCD clients (who represent 1–2% of the population) have hoarding problems (Steketee & Frost, 2003), our own guess is that approximately 1 to 2% of the population has hoarding problems. Of course, this requires confirmation from epidemiological researchers.

Existing case reports suggest that compulsive hoarding runs a chronic and unchanging course, beginning in childhood. When we assessed onset and course of hoarding using a retrospective timeline to facilitate accurate recall, hoarding symptoms (acquisition, difficulty discarding, clutter) began around age 13 years on average (Grisham et al., 2006). In some

cases, trauma precipitated the hoarding, usually at a later age of onset. The course of hoarding tended to be chronic, with very few participants reporting improvement after onset. Currently we have no evidence that chronic cases do not respond to intervention, although some entrenched patterns of behavior may require more effort to change.

Hoarding appears to run in families, according to several studies (Samuels et al., 2002; Winsberg, Cassic, & Korran, 1999), and may have a genetic component (Zhang, Leckman, Pauls, Tsai, Kidd, Rosario-Campos, & Tourette Syndrome Association International Consortium for Genetics, 2002). This suggests that many of those seeking help will have family members who condone and engage in hoarding behavior. This has proved problematic for some clients when only one family member is interested in reducing hoarding behaviors whereas the others see no reason to change and resent the intrusion of clinicians. The low rate of marriage among people who hoard is another striking finding (Samuels et al., 2002; Steketee et al., 2001) and may be related to the greater social anxiety and schizotypal features of those who hoard (Frost et al., 2000; Samuels et al., 2002; Steketee, Frost, Wincze, Greene, & Douglass, 2000). Clients who live alone may have difficulty with motivation to change their hoarding, because no one at home is encouraging them to change.

Insight and Motivation

Many people who hoard do not consider their behavior unreasonable (e.g., Frost & Gross, 1993; Frost et al., 1996), and this may be particularly true among elderly people (Hogstel, 1993; Steketee et al., 2001; Thomas, 1997). A study of complaints made to health departments about hoarding indicated that less than one third of those identified in the complaint willingly cooperated with health department officials, and only half recognized the lack of sanitation in their home (Frost et al., 2000). This lack of insight may also contribute to the high rates of dropout and poorer treatment outcomes observed for compulsive hoarding (e.g., Black, Monahan, Gable, Blum, Clancy, & Baker, 1998; Mataix-Cols et al., 1999). This problem can be particularly troublesome for family members seeking help and for service providers. Even those who seek help for their hoarding become ambivalent when faced with decisions

about removing clutter. For this reason, chapter 5 includes specialized interviewing techniques for motivational problems.

Comorbidity

Social phobia has been associated with compulsive hoarding (Samuels et al., 2002; Steketee et al., 2000), and social isolation has been reported among elderly hoarding clients (Steketee et al., 2001). Such clients may rely on hoarding to shield themselves from social interaction. Several studies have reported a high frequency of depressed mood among hoarding sufferers (Frost et al., 2000; Samuels et al., 2002). This may merely be a side effect of severe clutter that seems overwhelming, but can also deplete the energy needed to work on clutter during treatment. Symptoms of attention deficit hyperactivity disorder (ADHD) appear to be a relatively common accompaniment to hoarding (e.g., Hartl, Duffany, Allen, Steketee, & Frost, 2005), contributing to difficulty staying on task while sorting and to general disorganization. Assessment of these complicating comorbid conditions is important for planning the intervention and preventing relapse.

Acquiring problems may manifest as compulsive buying, which is considered an impulse control disorder (ICD) (McElroy, Keck, & Phillips, 1995). Indeed, researchers have speculated about a compulsive–impulsive spectrum of disorders linked to OCD and other anxiety disorders (e.g., Black & Moyer, 1998; McElroy et al., 1995; McElroy, Keck, Pope, Smith, & Strakowski, 1994; Schlosser, Black, Repertinger, & Freet, 1994). Hoarding has also been associated with a greater frequency of ICDs such as trichotillomania, skin picking, and gambling (Frost, Meagher, & Riskind, 2001; Samuels et al., 2002). At issue here is whether acquiring behaviors associated with hoarding reflect broader impulsivity problems that will require specialized intervention to enable clients to cope with strong impulsive urges.

Hoarding is associated with frequent personality problems (e.g., Frost et al., Mataix-Cols, Baer, Rauch, & Jenike, 2000; Samuels et al., 2002), the most common of which are perfectionism, indecisiveness, dependency, and compulsive personality traits. We have also observed avoidant, schizotypal, and paranoid traits among some of our clients. The treatment pro-

gram outlined here includes cognitive and behavioral strategies to reduce perfectionistic standards and rigid rules for saving and discarding, and to reduce dependency on others to make decisions. When clients exhibit paranoid personality traits, clinicians must work harder to gain clients' trust, and interventions move more slowly to accommodate these concerns.

Diagnostic Criteria for Hoarding

There are no currently accepted diagnostic criteria for compulsive hoarding in the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2000). We propose the following diagnostic criteria currently being tested by our research group:

1. The client accumulates a large number of possessions that clutter the active living areas of the home (e.g., living room, kitchen, bedroom), workplace, or other personal surroundings (e.g., vehicle, yard) and are kept in a disorganized fashion. If disorganized clutter is not present in these areas, it is only because of other's efforts (e.g., family members, authorities) to keep these areas uncluttered.
2. The client has current or past difficulty resisting the urge to collect, buy, or acquire free things that contribute to the clutter.
3. The client is extremely reluctant to part with items, even those with very limited monetary value or utility.
4. The accumulation of clutter or difficulty parting with items causes marked distress or interferes significantly with normal use of the home, workplace, or other personal surroundings, occupational (or school) functioning, usual family and social activities; poses significant health or safety risks (e.g., blocked egress, cluttered stairs, fire hazard); or causes significant conflict with family members, neighbors, or authorities (e.g., work supervisors, landlord).
5. The problem has persisted for at least six months and is not the result of a recent move, repairs to the home, the accumulation of many items resulting from the death of a family member, or other temporary circumstances.

6. The clutter and the difficulty parting with items are not better accounted for by another mental disorder such as OCD (e.g., fears of contamination, checking rituals), dementia (e.g., cognitive impairment that interferes with decision making and organizing), major depressive disorder (e.g., diminished interest in normal activities, fatigue, indecisiveness resulting from difficulty concentrating), schizophrenia (e.g., retention of items resulting from delusions or hallucinations about objects, paranoia regarding personal information), or bipolar disorder (e.g., impulsive buying sprees, distractibility that interferes with organizing). The disturbance is not the result of the direct physiological effects of a substance (e.g., drug abuse, medication) or a general medical condition (e.g., stroke, brain injury).

Specifiers

With poor insight: if for most of the time during the current episode, the person does not recognize that the clutter, acquisition or difficulty parting with items are excessive or unreasonable.

With unsanitary conditions: if condition of the home reflects squalor (presence of human or animal waste, rotting food, insect infestation, etc.) or if personal hygiene is poor (e.g., significant body odor, unkempt appearance, dirty clothing, etc.).

Development of Hoarding Interventions

The intervention program described here grew out of our work with two individual clients studied intensively in single case designs and six clients who participated in 10 weekly group sessions followed by five group sessions spaced two weeks apart for a total of 20 weeks; home visits were scheduled every other week. An advanced doctoral student and two less experienced students in clinical psychology treated that group while we both observed from behind a one-way mirror. During the past few years, this therapy has been tested on nearly 50 patients, a handful treated under our own care, but most by our graduate students whom we have super-

vised by listening to tapes of their sessions so we have firsthand knowledge of the process and outcomes.

The clients who received treatment exhibited moderate to severe hoarding behaviors and substantial comorbidity that included attention deficit disorder (ADD), major depression, serious marital problems, and problematic personality traits. Some were highly functional in their employment and social lives, but were unable to make headway with severe clutter that filled all living spaces and rendered the home useless for all but bathing and sleeping. Others who were less functional with regard to work, social, and family life also responded to intervention, but possibly with less overall improvement, although we have not yet studied this. Our experience in training relatively novice clinicians is that this treatment is more easily delivered, and perhaps more effectively, in the hands of more experienced clinicians able to field a range of personality traits and motivational problems often evident in this group.

We have modified the manual to include some in-home sessions to enable hoarding clients to make progress that strongly reinforces their efforts. Although the therapy content is similar to cognitive behavior therapy (CBT) methods for other conditions, its structure is atypical in that every fourth meeting occurs in the client's home, usually for extended periods of 1.5 to 2 hours. The intractability of compulsive hoarding and the associated motivational difficulties have led us to conclude that such methods are necessary to successful outcomes in many, although undoubtedly not all, cases. Clearly, effective intervention for compulsive hoarding will require more work throughout the coming years, but we believe we have made a good beginning with the procedures described in this manual.

Evidence Base for CBT for Hoarding

In 1996, Ball and coworkers suggested that clients in OCD clinics with hoarding problems refuse and drop out of treatment more often than OCD clients without hoarding and that CBT interventions were more difficult to design for these individuals. Several studies support these conclusions. In large sample trials of OCD treatment outcomes, Black and colleagues (1998) found that that hoarding symptoms strongly predicted nonresponse to CBT. Likewise, Mataix-Cols and associates (2002)

found that more people with hoarding dropped out of exposure and response prevention (ERP) treatment, and, among those who remained, only 25% improved compared with 48% of nonhoarding OCD clients. Early case studies are consistent with these findings (Chong, Tan, & Lee, 1996; Cole, 1990; Damecour & Charron, 1998; Frankenberg, 1984; Greenberg, 1987; Herran & Vazquez-Barquero, 1999; Shafran & Tallis, 1996). Christensen and Greist (2001) also reported poor outcomes in a brief computerized behavior therapy program (BT Steps) for three hoarding clients, citing resistance to intervention, ego-syntonic symptoms, and significant pressure from others to get help as complicating factors. They described a pattern of passive resistance to therapy and concluded that prognosis for hoarding was poor.

In contrast to the disappointing results of these investigations, more encouraging evidence has accumulated for the efficacy of CBT specifically designed to treat hoarding and based on our cognitive behavioral model of compulsive hoarding (Frost & Hartl, 1996; Frost & Steketee, 1998). Hartl and Frost (1999) reported a successful outcome in a single-case experimental design using the modified CBT approach for a 53-year-old woman with a long-standing hoarding problem. Using similar methods, Cermele and colleagues (2001) reported a successful outcome for a 72-year-old woman with chronic hoarding. We also reported modest benefits for seven clients treated individually and in a group format using an updated version of Hartl and Frost's approach (Steketee et al., 2000). Of these seven clients, all of whom also suffered from major depression and/or social phobia, four improved moderately after 20 weeks (15 sessions) of intervention. Of the four who continued on in individual therapy, three continued to improve at a one-year follow-up. Self-rated improvement was greatest in the areas of acquisition, confidence in their ability to improve, and recognition of cognitive errors.

More recently, Saxena and colleagues (2002) reported good success using a combination of hoarding-specific CBT modeled after Hartl and Frost (1999) plus serotonin reuptake inhibitor medication in an intensive six-week intervention program. As in other trials, OCD clients without hoarding improved more than those with hoarding problems, but the latter group showed significant reductions in Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores (10 points on average) after intervention. They concluded that multimodal intervention tailored to specific features of

hoarding led to clear improvement, and selective serotonin reuptake inhibitors (SSRIs) may help clients tolerate the CBT more easily.

Frost and coworkers (2005) tested an earlier version of methods described in this treatment manual in an open trial in which nine clients (all women) with primary hoarding problems (mean age, 47.8 years; range, 25–70 years) completed 26 sessions over a period of six to nine months, with every fourth session held in the home (or occasionally in acquiring settings). Therapists were graduate students with limited experience in CBT methods who were trained by us. The clients showed significant reductions (25–34%) in global measures of hoarding severity, in ratings of clutter (20% improved) and acquiring (33% improved), and in observational measures of clutter in which clients rated themselves somewhat more improved (33%) than did therapists (23%). In 57% of treatment “completers,” both the therapist and the client rated the client as “much improved” or “very much improved.” However, full remission of hoarding behaviors and clutter was infrequent, and substantial residual symptoms remained in this preliminary test of CBT methods.

The treatment manual was revised prior to a second wait list-controlled study in which we randomly assigned clients with primary hoarding problems of at least moderate severity to either treatment or a 12-week wait list followed by treatment. Participants were excluded if they showed significant cognitive impairment that would interfere with learning, were on psychotropic medication, or were unable to participate consistently in this relatively lengthy intervention. Doctoral students in psychology and social work, trained and supervised closely by us, provided 26 weekly sessions that followed the format described in this manual. Treatment duration ranged from 6 to 12 months. Forty-three clients entered the program and six (14%) dropped out for various reasons, including changing priorities, limited time to devote to the treatment, and comorbid conditions needing more attention. Mean age for the clients was 56.2 years (range, 42–66 years). At the time of this writing, 10 clients who had completed the wait list period were compared with 13 clients who completed 12 weeks of treatment. These 23 clients included nine men and 14 women. Groups did not differ at pretreatment on a measure of hoarding severity developed for this project and were rated after the diagnostic interview. Treated clients showed significant reductions ($p < .007$) in hoarding symptoms (26%) even at week 12, outperforming wait listed

patients who improved slightly (11%), with an effect size (Cohen's *d*) of 1.26 for this comparison. After 26 sessions, the 17 patients who completed treatment showed a 45% reduction in hoarding symptoms ($p < .001$) with a very large effect size (Cohen's *d*) of 2.04. These data indicate very positive outcomes for this sample of clients based on the methods used in this manual.

Currently we do not have information on factors that predict outcome from this intervention, nor is there sufficient information regarding its generalizability to various populations with hoarding problems. Our sample contains both men and women from various backgrounds (five black clients, one Asian, and one Latina), but the sample is too small to determine any differential effects by gender or ethnicity. It is our impression that men and women did not differ in their outcomes, and that our black clients did benefit, despite the presence of trauma histories and comorbid problems in this subgroup.

CBT Model of Compulsive Hoarding

The cognitive and behavioral model of compulsive hoarding is based on the limited research and clinical experience with this problem, and thus must be considered a work in progress. The model presumes that problems with acquiring, saving, and clutter result from (1) personal vulnerabilities that include past experiences and training, negative general mood, core beliefs, and information processing capacities, which contribute to (2) cognitive appraisals about possessions, which in turn result in (3) positive and negative emotional responses that trigger (4) hoarding behaviors of clutter, acquiring, and difficulty discarding/saving. These behaviors are reinforced either positively through the pleasure gained from saving and acquiring or negatively through the avoidance of negative emotions of grief, fear, or guilt. The overall model is depicted in figure 1.1. This model is intended to depict many variants of hoarding elements seen across clients. In chapter 3 we provide a simplified version of this model that is suitable for use with individual clients.

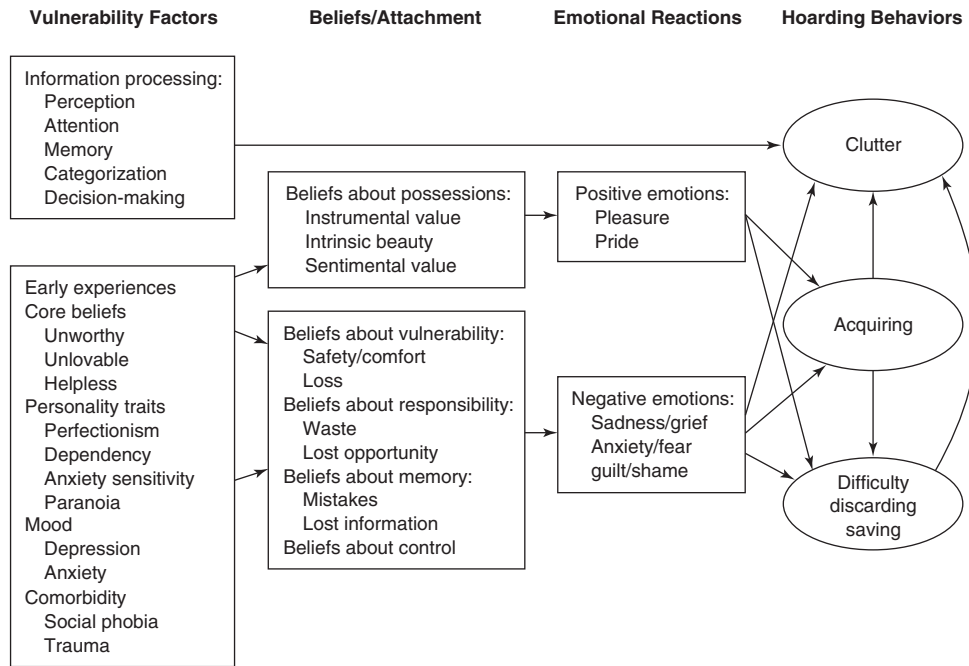


Figure 1.1
Model of compulsive hoarding.

The components of this model are described further in chapter 2, which describes how to assess vulnerability factors, beliefs about possessions, emotions, and behaviors related to hoarding. Chapter 3 clarifies how to construct idiosyncratic models for clients who hoard.

Risks and Benefits of CBT for Hoarding

There are few risks associated with the hoarding treatment program described here, but we believe they are strongly outweighed by the potential benefits. Risks include encountering traumatic memories and unresolved grief reactions (e.g., past rape, childhood losses) that provoke strong emotions requiring extra clinical time to help clients process their feelings. Another risk is that clinicians will encounter a home environment that triggers mandated reporting because of abuse or neglect of children or elders (including self-neglect for older clients). If the assessment indicates that children or older adults are living in the home and

that conditions may impair their health or safety, clinicians should warn clients that they may have to report such problems to the relevant authorities. In our experience, the investigative authorities can be cooperative with the therapeutic efforts aimed at hoarding and may also provide a motivational “stick” to the clinician’s “carrot” of treating the problem. A third concern is the extent of squalor present that may require clinicians to wear masks or protective clothing when in the home or to request the aid of cleaning crews to remove waste that could cause health problems.

The benefits of treatment are apparent in the earlier description of outcomes following treatment in our recent studies. Treatment takes time and clients may not be recovered (out of episode) at the end of the intervention, but most experience significant reduction in clutter, difficulty discarding, and excessive acquiring, and have gained many skills to continue their work. The comprehensive intervention methods typically have positive side effects of improving self-esteem, mood, and functioning, along with improvements in clutter.

Alternative Interventions

Currently, there are no alternative treatments that can be considered evidence based. Standard exposure and blocking of rituals for OCD symptoms appear to work in some cases, but is generally less successful for hoarding than for OCD symptoms. Many of our clients have experienced forced “clean-outs” by authorities or relatives. Their strong angry and hurt reactions and continuing struggle with hoarding indicate that this is not an effective alternative.

The Role of Medications

Several investigators have reported poor outcomes with SSRIs in retrospective studies. In large samples, Black and colleagues (1998) found that that hoarding symptoms were the strongest predictor of nonresponse to medication, and Mataix-Cols and associates (1999) found that higher hoarding scores predicted worse outcomes. Winsberg and coworkers (1999)

also reported poor response to medication treatment among people with compulsive hoarding. However, in a prospective study, Saxena and colleagues (2005) reported that the SSRI paroxetine produced similar benefits for both hoarding and nonhoarding OCD patients, although improvement was modest in both groups. Our own treatment studies have not included clients receiving SSRI medications, so we cannot provide useful information on combining medications with the CBT methods described here. We would recommend that unless medications are needed for other conditions such as attention deficit symptoms or severe depression, hoarding clients can be treated without medication.

Outline of This Intervention Program

This cognitive and behavioral intervention program is designed for 26 weekly sessions spaced over a period of approximately six months. However, the number of treatment sessions might vary from a minimum of 15 for a case of mild hoarding to 30 or more spaced over a one-year period. Duration of treatment will likely be related to motivational factors, the amount of clutter, presence of comorbid conditions that slow progress, and availability of cooperative assistants in decluttering the home. The approximate number of sessions for various aspects of the CBT intervention are as follows:

- Assessment: two to three sessions at the beginning of treatment
- Case formulation: two sessions after assessment
- Skills training: two to three sessions, including organizational and problem-solving skills, repeated as needed during other sessions
- Exposure and cognitive therapy: 15 to 20 sessions, beginning with exposure and adding cognitive methods immediately during all sorting sessions and for acquiring problems
- Motivational interviewing to address ambivalence and low insight: portions of several sessions, especially early in treatment
- Relapse prevention: two final sessions

Three weekly clinic sessions alternate with one monthly home visit or a visit to an acquisition site throughout treatment. The first two assessment sessions may require approximately 1.5 hours each. Allow approximately one hour for each office visit, during which boxes or bags of items brought from the home are used for sorting. In-home appointments will typically last two hours. We have also had good success with two or three “marathon” sessions of several hours in the home, or a “clean-out” for which we enlisted the help of a closely supervised cleaning crew with the client’s permission. These sessions produce substantial progress that enhances motivation, helps clients feel less overwhelmed, and helps clients consolidate skills to work more independently on the remaining clutter.

The flow of the CBT methods varies considerably from client to client as clinicians alternate their focus among the three problems of organizing, acquiring, and removing objects depending on the client’s immediate goals and needs. Developing an organizing plan and gaining control over compulsive acquiring are usually more easily accomplished than removing items. However, many clients are more strongly motivated to clear their clutter because of outside pressure or because the clutter is the most frustrating aspect of their symptoms. Skills are taught whenever needed. Alternating among cognitive and exposure strategies for clearing clutter will be necessary, because progress on sorting and removing items depends on changing thinking and reducing distress. For example, a clinician may begin by sorting items in the kitchen, using cognitive strategies as problematic beliefs surface, and then switch focus to acquiring as the client faces an immediate need to purchase a birthday present for a family member and fears losing control.

Session Structure

Each treatment session follows a basic format outlined briefly here. Clients use the Personal Session Form from the workbook to make notes during and between sessions. These forms provide a record of what clients learned during therapy and are used to facilitate recall of helpful treatment methods during relapse prevention. Clinicians check in briefly (five minutes) to ask about mood, recent events, and important issues discussed during the previous session, and then set the agenda for the session together

with the client. Encourage clients to express their own wishes and, if the agenda seems overly long for one visit, prioritize and hold less important items until the next session. Be sure to discuss previous homework early during the session to emphasize its importance.

Then, introduce agenda topics and intervention strategies to ensure that important points are covered within the time available. After any segment with new information, ask clients to summarize what they learned in order to consolidate new learning. New homework assignments for the week can be developed during the discussion or devised at the end of the session to fit the topics covered. Clients should write down the assignment on their Personal Session Form to prevent uncertainty and minimize avoidance of homework. Sessions end with clients summarizing what was covered. Then ask for feedback about the session (How did you feel about today's session? Is there anything I did or said that bothered you?), encouraging clients to be honest about their reactions. Clinicians should complete their own Clinician Session Form (see chapter 2) to keep an accurate record for future reference.

Use of the Client Workbook

The accompanying client workbook contains brief information and instructions to clients that follow the format of this manual, as well as blank versions of all forms used during treatment and for homework assignments. These include scales for assessment, a Personal Session Form for recording notes and homework, various forms for recording thoughts and beliefs as they occur naturally, case formulation, treatment goals, organizing plans, behavioral experiments, cognitive techniques, and a list of interventions learned during treatment. Thus, the client workbook reinforces what is learned during sessions and is a critical part of therapy. Clinicians should advise clients which parts to read and which forms to complete. Books are easily lost in the clutter at home, so it is critical to refer regularly to the workbook so clients become accustomed to bringing it to all sessions. Discuss where they will keep the workbook to avoid losing track of it.

