

Treatment of Compulsive Hoarding: A Case Study

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ABSTRACT

The present case report describes an intensive treatment approach combining aggressive pharmacotherapy with daily cognitive behavioral therapy (CBT) directed at helping "Dee," a 63-year-old female suffering from compulsive hoarding. The successful intervention consisted of individualized exposure and response prevention (ERP), in addition to cognitive restructuring to improve insight, decrease depressive and general anxiety symptoms, and address distorted beliefs. Pretreatment evaluation included assessment of clutter for all living spaces, including rooms in the house in addition to the car. After the six-week intensive treatment program, clutter decreased substantially in each of the rooms targeted for intervention. In addition, Dee's scores on self-reported measures of obsessive-compulsive symptoms and anxiety steadily decreased during the intervention. Compulsive hoarding, when present in patients with obsessive-compulsive disorder (OCD), has been associated with poor response to both anti-anxiety medications and typical CBT. This case report illustrates that specific CBT strategies targeting the characteristic features of compulsive hoarding may provide better results for patients suffering from compulsive hoarding syndrome.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is currently classified as a single entity in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) (American Psychiatric Association, 1994). However, it is becoming evident that several different symptom groups of OCD exist and have been identified as obsessions and compulsions related to checking, symmetry and order, contaminations, and hoarding. Furthermore, these symptom groups have been shown to carry different patterns of comorbidity and response to treatment.

Frost and Hartl (1996) defined clinical compulsive hoarding as the acquisition of, and failure to discard, a large number of possessions that appear to be useless or of limited value to others. In addition, acquisition of objects is not sufficient to fulfill the criteria of compulsive hoarding; as in criteria for most other mental disorders, the behavior must be shown to cause impairment in everyday functioning as well as psychological and emotional distress. Hoarding has been observed

in several psychiatric as well as organic disorders ranging from obsessive-compulsive personality disorder to anorexia nervosa, schizophrenia, and certain organic brain lesions. However, previous clinical research has linked hoarding most commonly with obsessive-compulsive disorder (Maier, 2004).

Frost and Hartl (1996) proposed a cognitive-behavioral model that associated compulsive hoarding with four main problem areas, including deficits in information processing, emotional attachment problems, behavioral avoidance issues, and erroneous beliefs about the nature of possessions. Deficits in information processing include difficulties in decision-making regarding possessions, difficulty in organization and categorization of items, low confidence in memory, and inaccurate judgments about the importance of remembering certain pieces of information. These specific deficits lead to the acquisition and saving of items for future use and monetary value.

Problems related to emotional attachment include the sentimental attachment to physical possessions that function as meaningful past events. Behavioral avoidance relates to the difficulty patients have discarding items as a method of avoiding feelings of anxiety about making decisions, feelings of loss, and the tremendous task of actually sorting through and removing years of acquired clutter. False beliefs center on emotional attachment to possessions and safety that possessions provide, the reciprocal need to protect items and have them available for future use, and beliefs about perfectionism and fear of failure if an important item is mistakenly discarded.

The significance of this theoretical model lies in its application to intervention (Hartl & Frost, 1999). Past studies have consistently shown that patients with compulsive hoarding are more resistant than non-hoarding OCD patients to both pharmacologic and CBT (Steketee and Frost, 2003). At the UCLA Obsessive Compulsive Disorders Intensive Treatment Program, a multi-model CBT approach has been formulated to target the above-mentioned problem areas experienced by compulsive hoarders, including difficulties with information processing, erroneous beliefs about and attachment to possessions, emotional distress associated with discarding possessions, and avoidance behaviors that limit the distress associated with discarding possessions (Saxena et al., 2002). Treatment protocol includes comprehensive

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education about hoarding, motivational support, aiding in organizing, reducing acquisition, assisting discarding, and preventing relapse. Importance is also given to setting concrete goals that focus on improving daily functioning such as creating living space for its appropriate use. In addition, established rules for therapy require that the patients make all decisions (save vs. discard) about their own possessions. Group therapy, including didactic sessions, provides additional support.

The UCLA OCD Intensive Treatment Program consists of sessions for six weeks, five days a week, Monday through Friday, from 9:00 a.m. to 1:00 p.m. The patients also have daily homework assignments as part of their treatment. The presented case report describes a 63-year-old divorced female suffering from compulsive hoarding who was a participant in the UCLA OCD Intensive Treatment Program.

METHOD

Client Description

"Dee" was a 63-year-old divorced woman who lived alone in her house. She described her current hoarding behavior as "difficulty throwing things away." She was referred to the UCLA Intensive Treatment Program by her daughter, who had been living in New York for the past three decades.

Dee's difficulties with organization and discarding of her possessions had resulted in a clutter-filled environment in her home. As a result, her main disability had been complete social isolation due to embarrassment about others seeing her home in this state. She had desired to seek treatment but had not taken that step until urged by her daughter.

Dee's problems with hoarding began in childhood. She admitted to hiding things under her bed so her mother would not discard them. She also recalled being a fearful and anxious child. Dee's symptoms of hoarding had waxed and waned since childhood. Dee's problems with severe hoarding began to worsen since moving into her new home 16 years ago, and continued to worsen in the last 10 years. Her family history was significant for hoarding behaviors in her mother and maternal grandmother.

Dee also described having mild symptoms of depression. She admitted to "crying spells" and "painful emotions" when thinking about being a failure due to wasted time and inability to control her hoarding problem. Her OCD mainly revolved around compulsive hoarding behaviors, as she denied other symptoms of OCD.

Case Formulation

Dee's house consisted of three bedrooms, two baths, and a den. The volume of cluttered possessions took up

approximately 80-90% of the living space. The clutter reached as high as four feet in some areas. No rooms in the house could be used for their intended purpose, especially the kitchen, which was completely unusable secondary to the accumulated clutter. Getting around the house was only partially possible by using trails, as tables, chairs, couches, and floors were almost completely covered with items. In addition, Dee's car, garage, and yard were almost completely filled with clutter. Dee's hoarded possessions included newspapers, magazines, bills, videos, pictures, clothing items, and musical instruments, books, and notes. Dee's main hoarding revolved around musical items accumulated from work and numerous volunteer organizations dating back 15 years. Dee allowed only her cleaning lady into the house. She had not allowed people to visit her home in many years, causing her to lose touch with many friends and relatives.

During the interviewing process, Dee admitted that she did not need all possessions that she kept but that she was overwhelmed with the process of sorting through and discarding items. She also conveyed her fear of throwing away valuable items that might be useful in the future or have monetary value. She denied acquiring new items. Dee realized that her avoidance and tendency to procrastinate had played a major role in her disability. Dee also hoarded activities, which had led to her overextending herself to multiple organizations.

Dee's psychiatric history included two previous episodes of depression, which she described as involving difficulty with motivation and getting out of bed. She received short periods of supportive psychotherapy during both episodes. The first episode was at the age of 27 and the second at the age of 50, which was related to alcohol use. She had drunk beer or wine daily for ten years, but had been successfully treated in a chemical dependency program and then attended Alcoholics Anonymous for six months thereafter. She had been sober for nine years at time of starting the OCD treatment program. She had never been on psychotropic medications.

Dee met the DSM-IV criteria for OCD and was diagnosed with compulsive hoarding syndrome. Physical and laboratory findings revealed no abnormalities upon starting the program.

Course of Treatment

The program consisted of intensive, multi-modal treatment in the UCLA OCD Intensive Treatment Program, four hours per day, five days per week, for six weeks. In addition to hoarding-specific CBT, Dee was started on escitalopram oxalate (trade name: Lexapro) and her dosage was increased from the initial 10 mg to 30 mg per day after the first week.

The pretreatment phase began with a thorough assessment of the amount and type of clutter, beliefs about

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possessions, motivation for treatment, and level of insight and understanding of the disorder. The first phase of treatment revolved around education regarding hoarding behavior, setting goals, and cognitive restructuring. A major issue for Dee had been her isolation from friends and family due to the embarrassment she felt about her cluttered home. Therefore, a major goal for Dee was to reduce the clutter and improve her hoarding symptoms so that she would be able to invite people to her home. The next phase of treatment was exposure and response prevention (ERP), consisting of sorting through and making a decision on each item, leading to habituation to discarding previously saved possessions. Dee decided to start working on the car, which she would use on a daily basis to come to the program. Each day, she brought in several boxes of clutter, which she would remove from her car without sorting through. Dee spent two and a half to three hours a day sorting through and discarding clutter that she had brought in from her car. Her daily homework consisted of putting saved items in their designated places at home. Dee was entirely responsible for deciding the status of her possessions (save vs. discard) and their placement at home if items were to be saved. The therapist working with Dee did not make any decisions and did not touch her possessions. The role of the therapist in the treatment program was to assist in the development of decision-making skills, to provide feedback regarding normal saving behaviors, and to identify and challenge Dee's erroneous beliefs about her possessions.

During the first week of the program, Dee had started out sorting through one box every hour. She would scan over and read each item and had the greatest difficulty deciding on personalized items and any items related to her work or volunteer organizations, including sheets of music. After emptying her car of clutter, which lasted more than a week, Dee started on the computer room in her house, which took nearly two weeks to completely empty of clutter. By the end of the fourth week, Dee had clearly habituated to the process. She was able to sort through one box every 15 minutes and was discarding 90% of the items. She conveyed less emotional attachment to the possessions and expressed the importance of her set goals and her desire to be able to reach them. To help Dee with the process of ERP, she was prompted to cognitively reframe her obsessive fears about discarding her possessions. She was often asked, "What's the worst thing that would happen if you didn't have this item?" and "If you needed this information later, how could you access it if you threw this away now?" Dee herself started using certain key phrases such as, "If you have to ask, it means it's not that important" and, "When in doubt, throw it out." This type of cognitive restructuring was important for Dee, who needed assistance in learning how to think differently about her possessions. When Dee was asked to think about the consequences of throwing away her clutter, she was challenging her

erroneous beliefs that terrible consequences would occur if she threw something away.

Outcome and Follow-Up

By the end of the six-week treatment program, Dee had completely cleared her computer room and kitchen of all clutter. She had taken "before" and "after" photos to track progress and for future encouragement. Her pictures served as a reminder of the advantage of setting and sticking to specific goals. The plan for Dee after graduating from the program was to follow up in an outpatient setting to maintain her gains and continue improving. Weekly outpatient follow-up therapy was set up with a therapist in addition to in-house visits by interns twice a week. During in-office visits with the therapist, Dee would continue her ERP process with direct supervision by the therapist. In addition, Dee would meet with her psychiatrist for medication management once every three months.

SUMMARY

Dee presented to the UCLA OCD Intensive Treatment Program with symptoms of severe compulsive hoarding as her primary OCD manifestation. Dee's remarkable improvement during the program had clearly been an exception rather than the norm when considering hoarders' response to treatment. The success of this hoarding intervention depended on several factors. Most importantly, Dee was extremely motivated to engage in cognitive restructuring, in addition to making changes in her decision-making process and in her beliefs about the necessity of keeping all of her possessions. She openly welcomed the support and assistance of her therapist and of the treatment team overall. Secondly, the cognitive behavioral approach to Dee's therapy was tailored to target her compulsive hoarding symptoms. Traditional CBT has focused on cognitive restructuring of maladaptive thought patterns and behavioral modification. It has become evident that a crucial component of CBT targeting compulsive hoarders should include instilling decision-making and organizational skills to support reformed beliefs and altered behavior with the goal of decreasing the likelihood of relapse.

Reports and studies have consistently indicated the difficulty of treating compulsive hoarders. With Dee, cognitive behavioral strategies targeting her indecisiveness and maladaptive beliefs regarding possessions and avoidance behavior had been effective during the six-week program. Future research is indicated to identify those patients who will benefit from this type of directed cognitive behavior therapy and establish successful methods of outpatient follow-up to prevent relapse and ensure maintenance of gains made during intense treatments.

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