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**Hoarding Disorder**

**A Guide to Effective Interventions**

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# Introduction

Hoarding disorder (HD) is characterized by the acquisition of and failure to discard or part with possessions regardless of the value attributed to those possessions by others, even those that appear to be useless or of limited value, resulting in cluttered living spaces and significant distress and impairment in functioning. Strong attachment to items interferes with the ability to discard them based on three types of values:

**Signs of HD:**

* **Difficulty getting rid of items**
* **A large amount of clutter in the office, at home, in the car, or in other spaces (i.e., storage units) that makes it difficult to use furniture or appliances or move around easily**
* **Losing important items like money or bills in the clutter**
* **Feeling overwhelmed by the volume of possessions that have “taken over” the house or workspace**
* **Being unable to stop taking free items, such as advertising flyers or sugar packets from restaurants**
* **Buying things because they are a “bargain” or to “stock up”**
* **Not inviting family or friends into the home due to shame or embarrassment**
* **Refusing to let people into the home to make repairs**

1. **Sentimental value**, which is the affect associated with possessions (e.g. old photos, diaries, or albums) because they signify or represent parts of the self that may act as reminders of a person’s life, or relationships with others. (“This helps me remember. This represents my life. It’s part of me.”)
2. **Intrinsic value** which refers to something that is of value in and of itself such as foreign currency. (“Isn’t this beautiful?”)
3. **Instrumental value**, which refers to being able to make future use of an item such as old clothes that could be used to repair other clothes, items that can be recycled. (“I might need this. I could fix this. Somebody could use this. Think of the potential!”)

Three types of hoarding have been identified:

**Inanimate objects**, the most common type of hoarding, can include one type of object or a collection of a mixture of objects (e.g., old clothes, newspapers, books, paperwork, food, containers, bags, and papers, etc.).



* **Animal hoarding** is the obsessive collecting of animals, often with an inability to provide even minimal standards of care to the animals. The individual is unable to recognize that the animals are or may be at risk because they feel they are saving them. In addition to the inability to adequately care for the animals, people who hoard animals are often unable to take care of themselves. The homes of people who hoard animals are often eventually destroyed by the accumulation of animal feces and infestation by insects. (The section below on [animal hoarding](#_Animal_Hoarding) offers more detailed information on this topic.)
* **Data hoarding** is a newer phenomenon of hoarding that consists of the need to store copies of emails and other information in an electronic format. It can also manifest in the storage of data collection equipment such as computers and electronic storage devices.

Research on hoarding has burgeoned during the last two decades and much has been learned about the unique biological, cognitive, emotional, and behavioral features of the disorder.

Hoarding disorder is now classified as a separate disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Prior to this new classification, hoarding was viewed as a variant, symptom, or subtype of obsessive-compulsive disorder[[1]](#footnote-1) (OCD). While HD may share similarities to OCD, it is distinct from OCD and is about one and more common than OCD.

The five diagnostic criteria used to identify HD are:

* Persistent difficulty discarding or parting with possessions, regardless of their monetary value.
* This difficulty is due to a perceived need to save the items and distress associated with discarding them.
* The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas.
* The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
* The hoarding is not attributable to another medical condition or mental disorder.

Individuals with HD differ from people who are collectors. Most children, and up to thirty percent of adults, collect items at some point in their lives. While collectors report the acquisition of, attachment to, and reluctance to discard objects, they do not experience the disorganized clutter, distress, and impairment that is characteristic of HD. In contrast to hoarding, the process of collecting is highly structured and planned, very selective (i.e., confined to a narrow range of items), pleasurable, and is often a social activity.

**“Hoarding is both a gift and a curse.”**

− Randy Frost, PhD

**Gift:**

* **Recognition of potential & opportunity**
* **Appreciation of the physical world**

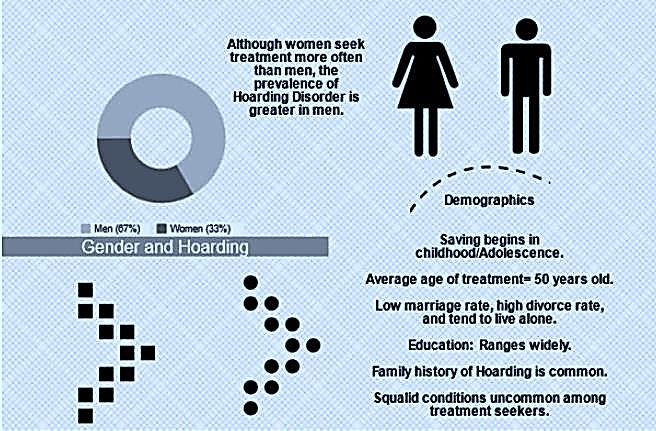
**Curse:**

* **Living in a landfill**
* **Collecting life without living it**
* **Aesthetics gone awry**

People who hoard seldom seek to display their possessions which are usually kept in disarray, while collectors typically display their collections proudly and keep them well organized. The quantity of collected items is another distinguishing feature: individuals with HD accumulate a large number of possessions that often fill up or clutter active living areas of the home or workplace to the extent that their intended use is no longer possible.

HD is a fairly common, chronic condition that is estimated to affect from two to five percent of the population (or six to fifteen million people) in this county, two percent of whom are adolescents. People with HD often have a family history[[2]](#footnote-2) of hoarding. Although the disorder is more prevalent among men, women are more likely to seek treatment for the disorder. Epidemiological analyses indicate that HD occurs at twice the rate obsessive-compulsive disorder (OCD) and at almost four times the rate of bipolar disorder and schizophrenia.

Research suggests that comorbidity with HD is the rule, rather than the exception. The majority of individuals with HD have one or more co-occurring mental health disorders, including major depressive disorder, generalized anxiety disorder, social anxiety disorder, attention deficit/hyperactivity disorder, and personality disorders. In addition, persons with HD have been found to have experienced trauma at higher rates than their counterparts in the general population. Hoarding is particularly common in children and adults with autism spectrum disorder (ASD), both with and without intellectual disabilities, many of whom collect material that is related to their special interest.

Individuals with HD have been found to experience more medical problems and be in poorer overall health than their counterparts in the general population. For example, diabetes and obesity are associated with HD. Most women with HD have been found to be overweight or obese and report at least one chronic and severe medical condition (e.g., fibromyalgia, chronic fatigue syndrome).

Common characteristics of people with HD include a low marriage rate, a high divorce rate, and a tendency to live alone. Hoarding is found in all cultures, income strata, education levels and racial groups.

Symptoms of HD often develop during childhood or adolescence[[3]](#footnote-3) (usually around age thirteen) and become clinically significant during middle age. The course of the disorder tends to be chronic and progressive, with the onset of severe levels of hoarding developing when the person reaches their mid-thirties.

*(Samuels, et al., 2008)*

Persons with HD who seek treatment typically do not do so until mid-life (around the age of fifty, on average). And, the most common way in which they come into contact with professionals is through initiation by a third party such as a social service agency, mandated reporter, housing provider, neighbor, or family member, etc. subsequent to an incident such as a fall or a fire or odors emanating from their home.

The cognitive and emotional features of hoarding are linked to beliefs about possessions. These include a belief that clear and absolute control must be maintained over one’s possessions, and that ownership carries with it the responsibility for ensuring that possessions are not wasted. Another pronounced belief is concern about the fallibility of memory and the need to remember everything perfectly. Many persons with HD focus on beliefs regarding lost opportunities and/or lost information and the potential consequences of both.

People with HD display a strong emotional attachment to their possessions which makes those possessions feel like extensions of the self or a part of one’s identity. The person’s possessions often represent past events and discarding them feels like losing part of oneself or life. Possessions also become sources of comfort or safety; their removal results in feelings of vulnerability.

A strong desire not to cause additional damage to the environment may contribute to difficulties with disposal. Many people with HD have strong commitment to repairing, re-using and recycling items. In some cases, value may be less strongly attached to the items themselves, but more strongly attached to places that are used for landfill.

Hoarding is associated with numerous information processing deficits in memory, attention, decision-making, and categorization. Research suggests that persons with HD have unique patterns of brain[[4]](#footnote-4) activity when faced with making decisions about their possessions. Regions of the brain associated with monitoring for errors under conditions of uncertainty are activated when people with HD are deciding whether or not to discard personal items. Consequently, persons with HD take much longer to make decisions about discarding their possessions and feel more distress (i.e., sadness and anxiety and even anger) about such choices. Moreover, individuals with HD not only demonstrate difficulties with deciding whether and where to keep possessions, but they also tend to experience problems with making any type of decision.

It has been pointed out that hoarding both relieves anxiety and produces it. The more the person accumulates, the more insulated they feel from the world and its dangers. And, the more they accumulate the more isolated they become from the world, including family and friends.

Finally, it is interesting to note that hoarding allows for the avoidance of difficult or unpleasant situations (e.g., decision-making, potential mistakes, loss of emotional attachments, loss of opportunities, and emotional distress). And, leaving items piled in the middle of a room avoids the discomfort of facing the difficulties of organizing (i.e., deciding where the items belong).

The impact of HD on a per-person basis exceeds that of many other psychiatric disorders and the high costs of hoarding affect not only individuals, but also society as a whole in terms of lost work productivity, mental health service utilization, non-psychiatric medical costs, and community agency involvement.

HD has an adverse impact on activities of daily living and can pose a significant risk to physical health due to rodent infestations, mold, and the buildup of dust. The accumulation of clutter can create a substantial public health burden and is linked to occupational impairment, poor physical health, eviction or threat of eviction, removal of a child or elderly adult from the home, and demand for social services. Public agencies can be burdened with complaints about unsanitary conditions and fire hazard risks.

HD is associated with high levels of disability and significant impairments in occupational social roles and family functioning. The literature documents reports of persons with HD having been fired from their jobs due to hoarding and, among those who are employed, many report difficulty with hoarding at work. A number of adults with HD have also reported failing to file income taxes in at least one of the past five years and a significant number report incomes below the poverty level. Data on indices of family burden, including lost time and wages, health care costs absorbed by family members, health care needs of family members (e.g., counseling), and the costs of excessive acquisition of objects suggest that the burden on family members is quite high.

|  |  |
| --- | --- |
| **Hazards of Hoarding** | |
| Fire Hazards | * Lack of clear pathways for exit in case of fire * Clutter preventing professionals from entering the home to extinguish a fire * Combustible materials either near heat sources or on top of the stove * Large quantities of combustible materials in the home (e.g., newspapers) * Absence of working smoke detectors * Defective electric or heating systems |
| Health Hazards | * Accumulation of garbage including spoiled food items * Rodents, insects or other pests that can contribute to the spread of disease * Lack of a useable sink * Lack of a usable toilet and/or sewage disposal system * Lack of an accessible wash basin, shower or bathtub * Accumulation of animal waste |
| Safety Hazards | * Fall risk from excessive debris on floor blocking pathways * Cluttered and impassable stairways * Inability to provide needed home care services due to excess clutter * Compromise to the structure of the home from the weight of accumulated debris (e.g.: ceiling or floor collapse) * Lack of a safe place to sleep, eat or sit |
| Emotional Distress | * Childhood exposure to conflicts between parents, if only one parent hoards (high stress household) * Limited opportunities for socialization * Learned helplessness resulting from a child’s inability to effect change over their situation |

HD causes public health problems when clutter attracts infestations of pests or obstructs fire exits in apartment buildings thereby endangering the safety of the occupant, neighbors and first responders. These conditions may lead neighbors and landlords to complain, resulting in legal proceedings and potential eviction thus placing the individual at risk of homelessness. Courts often order cleanouts without the active participation of the client/resident and charge the resident or landlord for cleanouts or put a lien on the dwelling. Indeed, hoarding is one of the leading causes of eviction (besides non-payment of rent). Extreme clutter/hoarding situations may also result in a referral to Adult Protective Services (APS) which may result in the initiation of legal action for the appointment of a guardian.

**In addition to the risk for loss of housing due to hoarding, adults with HD are at risk for having a child or elder removed from the home.**

It should be noted that if a hoarding problem is caused or made worse by a disability, the person has certain legal rights under the Americans with Disabilities Act (ADA) and the Fair Housing Amendments Act (FHAA), including the right to ask the landlord to adapt their rules, policies or practices so that the person is given an equal opportunity to use and enjoy their unit. Typically in this type of situation, the reasonable accommodation request will be for the landlord to give the tenant more time to get help to get rid of the clutter. If the landlord refuses to give the tenant additional time, or believes the tenant is requesting too much time, or moves forward with an eviction, the tenant is advised to see help from a legal organization that assists individuals with eviction matters.

Cities and municipalities have local ordinances requiring homeowners to keep their homes in a habitable condition in order to prevent homes from becoming a public nuisance. The city or municipality’s code enforcement office may inspect a home and issue a citation if the home is not in compliance with local ordinances. For example, the code enforcement office may issue a citation to a homeowner if the home is so cluttered that doors and stairways are blocked. Homeowners who are cited may try to appeal the citation to the city or municipality’s property maintenance or housing board of appeals and request a reasonable accommodation.

Studies suggest that a significant proportion of individuals diagnosed with HD smoke which compounds fire safety problems. In addition, data suggests that they are also more likely to smoke a greater number of cigarettes, may experience more difficulties quitting and experience greater relapse rates.

Fires that start in hoarded homes are more difficult to extinguish and more apt to spread to nearby dwellings or buildings and cause harm to neighbors due to exces­sive smoke and fire conditions. Blocked exits often prevent escape and many people are injured when they trip over things or when materials fall on them. Firefighters may be placed at risk from obstructed exits, falling objects, and excessive fire loading that can lead to collapse. Moreover, fighting fires and searching for occupants is far more challenging. Many occupants die in fires in hoarded homes.

**Hoarding is associated with a significant burden on social service agencies**

It can be very challenging and costly to eliminate infestations of insects or rodents in a hoarded home due to the presence of an enormous amount of clutter or possessions. A single heat treatment to remove bed bugs can cost more than $1,000 per unit. In a hoarded home or apartment, treatment may need to be repeated several times to be effective. Cleanouts can cost $16,000 or more and may need to be repeated if the hoarding continues. This can represent a significant financial burden to landlords as well as city, state or federal or housing authorities. The community costs for repeated visits to private homes from health inspectors or other public agencies can also be significant. In fact, data from various sources indicates that a relatively uncomplicated hoarding case can cost thousands of dollars, and a complicated case can cost more than $100,000.

While hoarding is harmful to all age groups, it poses particularly significant risks to older adults including falls, fire hazards, food contamination, social isolation, and medication mismanagement. Studies suggest that sixty four percent of older adults with HD experience difficulty with self-care, and over eighty percent experience physical health risks resulting from the disorder. The older adult with HD is at risk for premature relocation to senior housing and loss of independence or eviction and even homelessness.

Living in a hoarded house poses specific health risks to children including bites from rodents, asthma from cockroaches, illnesses stemming from the inability to store or prepare food hygienically, lack of personal hygiene due to inaccessible bathrooms, smothering from inadequate sleeping arrangements, mobility issues for young walkers, unsafe ground, crush risk, blocked exits in case of fire, etc.

(*Bratiotis, et al, 2014*)

Hoarding also results in fewer opportunities for socialization, parent-child relationship distress, feelings of isolation and rejection, lack of personal space within the home, shame and embarrassment, and it places the child at risk for hoarding. Studies have found an association between living in a severely cluttered environment during early childhood and elevated levels of distress (e.g., less happiness, more difficulty making friends, reduced social contact in the home, and increased familial distress and embarrassment about the condition of the home).

Family members report HD symptoms cause social, marital, and recreational impairment. Family members are often rejecting with high levels of expressed emotion (i.e., critical, hostile, or emotionally overinvolved patterns of interaction between family members and the consumer) which can interfere with treatment effectiveness or lead to relapse following successful treatment. Providing education to families about the harmful effects of such negative attitudes (e.g., using cognitive strategies to reframe the consumer’s behavior as manifestations of an illness rather than as a personality flaw or malicious behavior) and improving coping strategies among family members are recommended (and discussed in the section on treatment).

## Animal Hoarding

Animal hoarding leads to extreme suffering for hundreds of thousands of animals each year, jeopardizes the health of the individuals who hoard animals as well as family members who reside in the home, results in substantial costs for communities, and is rarely effectively or permanently resolved using existing statutory remedies for the crime of cruelty to animals. In fact, animal hoarding is one of the most significant causes of animal suffering in the United States, and people who hoard animals are responsible for causing more injuries, suffering, and deaths to animals than results from the intentional abuse of animals.

Although people who hoard animals profess a profound love and desire to care for animals, they invariably ignore, deny or minimize the neglect and suffering of the animals including starvation, severe illness and death along with environmental hazards and the squalor they are living in.

Animal hoarding is defined as the accumulation of a large number of animals and a failure to provide minimal standards of nutrition, sanitation, and veterinary care, and to act on the deteriorating condition of the animals (including disease, starvation or death) and the environment (e.g. severe overcrowding, extremely unsanitary conditions).

The Hoarding of Animals Research Association (HARC) uses the following criteria to identify animal hoarding:

* Having more than the typical number of companion animals
* Failing to provide even minimal standards of nutrition, sanitation, shelter and veterinary care
* Neglect often resulting in illness and death from starvation, spread of infectious disease and untreated injuries/medical conditions
* Denial of the inability to provide minimum care and the impact of that failure on the animals, the household and the human occupants of the dwelling
* Persistence in accumulating and controlling animals

There is significant evidence that animal hoarding exists along a continuum of severity and involves a variety of typologies, each of which is more responsive to one type of intervention than another. Three types of people who commonly hoard animals have been identified:

1. **Overwhelmed caregivers** often began with a few, well-cared for pets but, over time, passive acquisition of animals and a decline in their health or resources leads to an inability to provide proper care.
2. **Rescuers** actively acquire animals in an effort to protect them and, although they are not providing adequate care, the belief that they have a special responsibility toward the animals makes them oblivious to the poor conditions.
3. **Exploiters** collect animals to serve their own purposes (e.g., dog fighting) and lack empathy for both animals and humans.

According HARC, while domestic species are the largest group of animals found in hoarding cases, almost every type of animal has been a victim of hoarding, including a wide range of companion animals (e.g., cats, dogs, rabbits, ferrets, birds, potbellied pigs, and guinea pigs), farm animals, exotic and sometimes dangerous wildlife (whose special handling requirements compound costs for shelters charged with their care) and miniature ponies, deer, various species of fowl, and spitting llamas. Studies conducted by HARC show that most people who hoard animals tend to concentrate on one species, although it is not uncommon for multiple species to be present in an isolated hoarding case. Studies also reveal that the majority of people who hoard cats are women while more men than women hoard dogs.

The hoarding of cats is very common. It is postulated that the availability and ease of concealment may explain the high frequency of cat hoarding in comparison to some other species. Also, the “crazy cat lady” label is actually inaccurate and deceptive because people who hoard animals have been shown to function well in other aspects of their lives and are often described as high achievers and intelligent. In fact, this high level of intelligence is of particular significance because it can enable an animal hoarder to manipulate donors and animal humane organizations as well as seasoned judges and prosecutors.

In addition to issues regarding the welfare of the animals involved in a hoarding situation (e.g., starvation, illness and death), there are also health and safety issues beyond those created by other forms of hoarding for both the animal hoarder and anyone who visits the property including self-neglect, neglect of others, and the destruction of the household.

Although significantly less research has been conducted on animal hoarding in comparison to object hoarding, clear-cut distinctions between the disorders have been identified. One of the most notable is that animal hoarding is not defined solely by a large number of animals in the home. For example, breeders may have a large number of animals in the home but provide appropriate care for the animals and humans in the environment, while the lack of proper care in animal hoarding cases prompts concerns about animal mistreatment. In addition, animal hoarding creates a significant public health issue due to the accumulation of animal urine and feces in the home which poses serious health risks for humans in the environment as well as contributing to housing code violations.

**Animal hoarding is not necessarily defined by the number of animals in a household, but rather by the ability to properly care for the animals.**

− Hoarding of Animals Research Consortium (HARC)

According to the literature, animal hoarding is a complex and multi-faceted problem that requires a multi-agency response. A [taskforce](#_Hoarding_Task_Forces) approach (discussed below) is recommended because each animal hoarding case requires the response and resources of numerous agencies including those that provide animal care and control, public health, mental health, child and adult protective services, zoning, fire and police departments, veterinarians, and the legal system.

There is currently no recommended standard treatment for people who hoard animals. Therapeutic interventions that focus on motivation (e.g., Motivational Interviewing) as well as treatments that address any co-occurring mental health diagnoses have been found to be of benefit.

The literature indicates that there are three overall approaches to dealing with animal hoarding: (1) persuasion/verbal agreements, (2) threats of legal action, and (3) prosecution. Persuasive offers of help are often effective for overwhelmed caregivers who are frequently open to reducing the number of animals they own. In fact, threats of legal action may be sufficient to prevent recidivism; prosecution is often unnecessary and counterproductive. On the other hand, rescuers are unlikely to respond to persuasion and frequently require threats of legal action to curtail their rescue efforts. Prosecution may be necessary when threats fail. Persuasion and threats are frequently ineffective for exploiters and prosecution is usually required in order to get them to stop hoarding animals.

It should be noted that prosecution, removal of animals, and the sterilization of animals that remain with a person who hoards animals have not been found to be effective deterrents and the person subsequently amasses more animals.

***An animal hoarder will pick up a stray cat on the way home from the courthouse.***

(Avery, 20015)

Because recidivism is close to one hundred percent, optimal interventions include civil and criminal prosecution as well as therapeutic measures tailored to each individual in order to increase the likelihood of compliance as well as provide humane and effective outcomes for the people and animals involved. This starts with a thorough evaluation of the mental and physical health of the animal owner/caretaker, any previous history of animal collecting and animal cruelty, past interventions, and an in-home assessment. And, like persons who hoard objects, ongoing support and monitoring from professionals, family members, and friends are considered essential to reducing recidivism. However, while such long-term monitoring and ongoing support are required to mitigate the high risk of relapse, the close monitoring that is needed is difficult, if not impossible, for less well-funded animal care agencies. Moreover, many people who hoard animals simply move after they have been discovered or charged which impedes ongoing monitoring efforts.

While only a limited number of states specifically outlaw animal hoarding[[5]](#footnote-5) (e.g. Hawaii) or include a definition of animal hoarding (e.g. Indiana) into laws, in every state and/or city, people who hoard animals can be prosecuted under animal cruelty laws. Each state has laws that prohibit cruelty to animals and impose upon caretakers a duty of providing minimal care. Although the laws may differ somewhat in each state, all states require that owners or caretakers of animals do the following:

* Provide adequate food and clean, potable water daily in sufficient quantities to maintain an animal’s normal body weight
* Provide shelter from the elements that will allow the animal to stay dry and maintain a normal body temperature
* Provide a clean, sanitary environment free of animal feces, urine, and trash.
* Provide veterinary care necessary to relieve suffering from disease, injury, or illness

# Treatment of Hoarding Disorder

A number of challenges to effective intervention for HD have been identified including co-occurring mental health problems; physical problems (e.g., disability); dementia, and personality traits that interfere with daily living and that help maintain hoarding behavior such as excessively high standards and perfectionism; an excessive focus on details at the cost of the “big picture”; indecisiveness; difficulty with emotional regulation; difficulty trusting others; and difficulty taking another’s perspective. Other significant impediments to treatment are a low level of motivation to engage in activities necessary for change and a lack of recognition of problem behavior. Many individuals with HD do not believe they have a problem (which may necessitate starting with a focus on organizing rather than discarding possessions which can be a more acceptable, less upsetting goal and can also help the client appreciate the advantages and discarding and the disadvantages of saving).

## Capacity-Risk Model for Hoarding Intervention

A capacity-risk model has been developed to help practitioners determine how and when intervention is appropriate. This model, which does not address working with people with HD at their own request, considers three areas of three areas of functioning (i.e., capacity):

1. Physical: the person’s ability to perform the activities of daily living (ADLs) – feeding, dressing and bathing
2. Social: the availability of support, finances, etc.
3. Psychological: the individual’s cognitive capacity and competency

The model plots these capacity findings along one axis and the level of risk along the other with the goal of increasing capacity and reducing risk, with an emphasis on the latter due to the difficulty in altering capacity. When capacity is high, irrespective of risk, the model indicates that intervention is inappropriate; unless there is significant danger to others, the individual’s right to self-determination takes precedence. If capacity is moderate and risk is low, no action is required. If risk is moderate or high, intervention should focus on encouraging the client to accept services in order to mitigate risk. If capacity is low and risk is moderate or high, intervention is appropriate (even to the extent of seeking guardianship).

It should be noted that studies have clearly demonstrated that forced de-cluttering and cleanouts can exacerbate the problem because the forced removal of items often reinforces the need to excessively hoard items to guard against further distress and loss. Thus, while a cleanout addresses the immediate public health issue of hoarding, the problem will be not resolved by another person discarding or organizing the person’s possessions; the person will simply re-hoard and quickly refill their home, and often within a shorter timeframe and at a more rapid pace than previously.

In addition, forced cleanouts can have an adverse effect on mental health and have been found to lead to suicide. Cleanouts are also an expensive and time-consuming effort that is frequently wasted due to the rapid return of the clutter.

Families often try to help by scheduling a cleanout when the person with HD is away from their home. But this often results in subsequent traumatization of the person upon their return and it engenders feelings of anger and betrayal and can disrupt family relationships.

In sum, it is recommended that any intervention to declutter/clean out the home be carefully planned with the co-operation of the person with HD. And, unless ongoing treatment and support are provided, it is likely to have only a short-term effect.

**The recidivism rate is nearly 100% for a person who has HD without any type of behavioral treatment.**

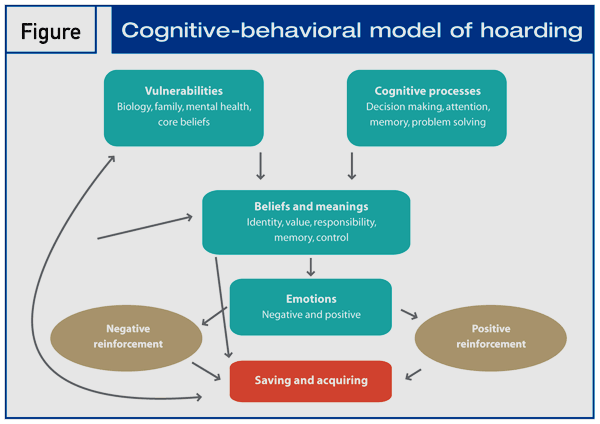
The literature recommends implementing screening for HD across levels of care to increase access to interventions for clients in a timely and supportive manner and recommends using a structured interview and employing standardized and validated instrument(s) to diagnose HD (see [Appendix B](#_Hoarding_Rating_Instruments) for examples). Once a diagnosis has been made, an assessment of risk (e.g., infestation or fire) to the person and other household members should be conducted.

Treatment with multicomponent CBT (discussed below) including education about HD, goal-setting, motivation-enhancing techniques, organizing and decision-making skills training, practicing sorting and discarding objects, and resisting the urge to acquire new items should be provided with results monitored using standardized rating scales. Engaging family members in the therapeutic process may help reduce family burden and conflict. In addition, the engagement of other agencies may be needed – e.g., housing, adult protective services. Pharmacotherapy for co-occurring conditions may also be warranted (e.g., antidepressant or antianxiety medication).

Studies have shown that addressing motivation, organizational skills and the acquisition of new clutter as well as removing current clutter from the home, and home-based work combined with between-session homework are associated with better treatment outcomes.

## 

## Cognitive-Behavioral Model of HD

A well-accepted and research-supported cognitive-behavioral model of hoarding posits that the excessive acquisition, difficulty discarding, and clutter that characterize HD are the result of information processing deficits, problematic beliefs and behaviors, and emotional distress and avoidance. Studies show that persons with HD experience problems with focusing and sustaining attention, categorizing possessions, decision-making, and have problematic beliefs about possessions. This model suggests that strong negative emotional reactions to possessions (e.g., anxiety, grief, guilt) lead to avoidance of discarding and organizing, while strong positive emotions (pleasure, joy) reinforce acquiring and saving possessions.

*(Otto & Steketee, 2011)*

CBT for HD is based on the above-noted conceptual model which postulates that a person’s genetic, neurobiological and environmental vulnerabilities, combined with deficits in information processing (i.e. attention, categorization, association, perception), contribute to the formation of distorted beliefs about possessions. These distorted beliefs and the emotions they evoke create a cycle of positive and negative reinforcement that maintains and deepens an attachment to objects.

## Cognitive-Behavior Therapy for Hoarding Disorder (CBT for HD)

CBT for HD is a manualized, multi-component twenty-six session intervention that was developed by Randy O. Frost and Gail Steketee. It is conducted over the course of six to twelve months. It includes office and home visits and incorporates: motivational interviewing to address low insight and limited motivation; decision-making training to improve cognitive processing; exposure to reduce negative emotions associated with discarding and resisting acquiring; and cognitive restructuring to alter distorted beliefs. Participation in this treatment has been found to result in reductions in clutter, difficulty discarding, and acquiring items.

The components of CBT for HD are as follows:

* **Assessment** using validated instruments (some of which are included in [Appendix B](#_Hoarding_Rating_Instruments) of this paper)
* **Case formulation** to develop an individualized model that explains the function (i.e., the how and why) of hoarding for the client (e.g., personal and family vulnerabilities, information-processing difficulties, beliefs about and attachment to possessions, emotional reactions, and reinforcement of the behavior)
* **Goal-setting**: Treatment goals are developed collaboratively with the client and often include: (1) increasing the client’s understanding of hoarding; (2) creating living space; (3) expanding the appropriate use of space; (4) organizing items in order to make them more accessible; (5) improving decision-making skills; (6) reducing acquiring; (7) evaluating beliefs about possessions; (8) reducing clutter; (9) learning problem-solving skills; and (10) preventing hoarding in the future.
* **Psychoeducation** about hoarding and the cognitive-behavioral model of HD are provided to the client along with a discussion about treatment and its effects, and an individualized model of the disorder is formulated
* **Motivational interviewing** to enhance motivation[[6]](#footnote-6) for change by helping clients deal with ambivalence, recognize problems, self-motivate for change, make a plan, and take immediate steps to be effective in their new intentions. (Additional information on [motivational interviewing](#_Motivational_Interviewing_(MI)) can be found below.)
* **Cognitive therapy** includes treatment for organization problems, helping clients to reduce the number of categories and locations for saved items as well as categories for unwanted items. It includes **cognitive restructuring**[[7]](#footnote-7) to help clients recognize, challenge, and ultimately change patterns of faulty thinking including beliefs about possessions.

**Cognitive Restructuring:**

* **Socratic questioning (helps clinician and client understand the logic)**
* **Identify and correct cognitive distortions**
* **Downward arrow technique**
* **Advantages/disadvantages (pros & cons)**
* **Taking another perspective**
* **Behavioral experiments**
* **Value of time**

The cognitive therapy component of the treatment focuses on automatic thoughts, interpretations, general beliefs, and core beliefs that maintain hoarding behavior. It starts with educating clients about cognitive errors (e.g., all-or-nothing thinking, catastrophizing, emotional reasoning, etc.) and then asking them to identify their own cognitive errors. Clients are helped to become familiar with their thought patterns (e.g., “I won’t remember anything,” “If I get rid of this, I won’t be able to take it,” etc.) and underlying beliefs (e.g., responsibility for items, ability to tolerate discomfort, etc.), which can be accomplished with the use of thought records and during sessions. Methods for challenging or testing these thoughts and beliefs are used including: (1) preparing challenging questions to ask when considering discarding an item, (2) considering advantages and disadvantages, (3) using the downward arrow technique, (4) engaging in Socratic questioning[[8]](#footnote-8), (5) taking another’s perspective, (6) defining what is important, (7) following a continuum of perfectionism, (8) incorporating metaphors and stories, (9) valuing their own time, and (10) finding alternatives to core beliefs.

The **Downward Arrow Technique**, which is also known as laddering, is a tool to help uncover the belief systems (i.e., core beliefs) that influence behavior and mood. The method starts with identifying a situation that provokes an unhealthy emotion (e.g., guilt or depression) and then moves to uncovering the negative automatic thought by asking what the situation says about the persons, other and or the environment. The question is repeated until an absolute or conclusive statement is apparent.

**If you got rid of this, what would happen?**

**🡻**

**If that happened, why would that be so upsetting?**

**🡻**

**If that were true, what’s so bad about that?**

**🡻**

**What’s the worst part about that?**

**🡻**

**What does that mean about you?**

**Socratic Questioning (thinking it through):**

* **What’s the probability of the negative outcome you fear?**
* **How catastrophic would this be?**
* **How well could you cope with not having this?**
* **How much distress would you feel?**
* **How long would the distress last?**
* **Can you tolerate with feeling?**
* **Skills training** sessions include organizing, problem-solving, and decision-making. CBT for HD focuses on the development of organizing and problem-solving skills. Education regarding these skills and the rationale for their use are provided to the client in a collaborative manner that fosters goal development around skills, and the identification of methods to minimize attentional problems and distraction. For example, clients are taught a simple format to address problems and enhance problem-solving skills that includes the following steps: (1) defining the problem, (2) generating as many solutions to the problem as possible, (3) evaluating the solutions and choosing one or two that seem likely to work, (4) breaking the solution into manageable steps, (5) implementing the steps, (6) evaluating the results, and (7) starting the process again if the problem is not resolved.

The skill training phase usually takes two to three sessions and includes strategies for increasing organizational skills such as: (1) categorizing unwanted objects (e.g., for trash, recycling, donation, sale, and undecided), (2) categorizing saved items, (3) choosing final destinations for saved items, (4) creating a plan for sorting and moving saved items, (5) implementing the plan for organization, and (5) maintaining the system. The rule of OHIO (only handle it once) has been found to help expedite the process of sorting items.

* **Exposure and practice** sorting, discarding, and non-acquisition (e.g., “non-shopping” trips to the store) includes Exposure and Response Prevention (ERP) is an evidence-based, treatment that consists of controlled and prolonged exposure to the objects or situations that trigger an anxiety while preventing the habitual response.
* **Exposure therapy** requires the client to confront their anxiety by organizing, sorting, and making decisions regarding what should be discarded and what will be retained while at the same time monitoring their anxiety level. It is designed to subject clients to emotionally challenging contexts in order to reduce anxiety and avoidance behavior as well as increase comfort when engaging in those behaviors. It starts with education regarding how habituation of emotional reactions occurs and what the client can expect during emotionally intense cleanout work. The therapist and client identify current avoidance behaviors (e.g., distraction, churning[[9]](#footnote-9), etc.) as well as construct a graduated hierarchy of feared and avoided situations in order to prepare for direct exposure. Rules for how exposure sessions will be handled by both the client and therapist (i.e., what would support/challenge look like) are established, especially for longer cleanout sessions in order to maximize benefits.

Exposure therapy can cause significant distress initially, and even low levels of discomfort can have a negative impact on progress. Imaginal exposure exercises can be an effective means of reducing discomfort by allowing the client to gain comfort prior to engaging in actual exposure work. It is recommended that exposure therapies be framed as **behavioral experiments** in order to appear less intimidating and also help with challenging maladaptive hoarding beliefs (e.g., needing to keep items in sight, clutter not affecting functioning in the home).

* **Strategies for reducing acquisition** include: (1) avoiding triggers to acquire (i.e., going into a favorite store), (2) identifying advantages and disadvantages of acquiring, (3) establishing rules for when and what can be acquired (e.g., needs versus wants), (4) using alternative pleasurable activities, and (5) challenging beliefs that perpetuate acquiring behaviors. Exposure methods include imagined exposure and graduated levels of a non-shopping spree during which the client practices not acquiring objects. This stage of treatment lasts for about fifteen to twenty sessions.
* **Acquisition Exercises:** Problems with acquiring are fundamental to hoarding. Imaginal exercises can be used to practice response prevention during sessions. This entails asking the client to visualize a non-shopping/non-acquiring excursion (e.g., imagine the place where they experience the most challenge controlling the impulse to acquire or purchase something).

In this exercise, the client is asked to imagine going to that shop or place and looking at something they want to acquire, rate the strength of the urge to buy or acquire, and then imagine just looking at the item and not picking it up. The client enumerates their thoughts and is subsequently asked to visualize the scene and imagine walking away without purchasing or acquiring the item and then rate their level of distress.

A discussion is held after this procedure to help the client identify their hoarding beliefs, following which the advantages and disadvantages of not acquiring the imagined possessions are enumerated. During a repeat of the visualization exercise, the client assigns ratings to the level of discomfort they experience in response to not acquiring the item. After discussion of the exercise, the client creates an in vivo non-shopping/non-acquiring exposure and completes it as homework for the week. This may include the construction of a non-acquisition hierarchy starting with driving to the store and browsing without purchasing anything.

* **Relapse prevention** is the last stage of CBT for HD and it consists of a collaborative review of the treatment process, symptoms, and interventions. The client then identifies the strategies that have been effective and they will continue to use in order to prevent relapse. In addition, this stage includes discussion of how the client will deal with setbacks, including resources they can avail themselves of.
* **Booster sessions** following the cessation of treatment are commonly utilized to help clients maintain gains and to cope with specific setbacks. Relapse prevention is usually reserved for the final two sessions of treatment.

CBT for HD adheres to the following rules:

* The clinician may not touch or remove any item without explicit permission from the client The client makes all decisions about their possessions and determines the rules for acquiring, keeping and discarding
* Treatment proceeds systematically and adheres to a plan
* An organizing plan is established before sorting possessions
* The client must think aloud while sorting possessions
* Only handle it once (OHIO), or at most twice
* Treatment proceeds in a flexible manner

Incorporating a **group format** for a portion of treatment has been shown to be helpful because a group provides social contact and support. Additional benefits include modeling appropriate behaviors, peer pressure, and structured exercises and practice in decision-making, discarding, non-acquiring, as well as in identifying and challenging hoarding-related beliefs.

It should be noted that **family members** can have a very positive impact on treatment outcomes, Because family members living in the home can be significantly impacted by hoarding, they are typically highly invested in the outcome and may be able to serve as behavioral coaches throughout the CBT process (although this may require significant therapeutic work with the family members and the client). Additional information on [working with families](#_Working_with_Families) is provided later in this document.

In the absence of therapists with training in specialized CBT techniques, community health workers, case managers and outpatient therapists can utilize knowledge and principles from the model to promote harm reduction measures (e.g., limiting acquisition, discarding objects, and addressing immediate safety concerns).

More cost-effective methods of delivery of CBT for HD including group therapy, self-help materials, peer led support groups, and Internet-based therapy have been developed and used with comparable success. Research on internet-based CBT treatments for the disorder (where participants have access to educational resources, cognitive strategies, and chat groups) has shown promising results for both short and long-term recovery from HD.

**Internet-based CBT** interventions may be especially helpful for people with HD because the problem is home-based and because many people with the disorder may not seek treatment due to feelings of shame and embarrassment. Participants in internet-based CBT for HD have been found to experience statistically significant reductions in hoarding symptoms and marginal reductions in loneliness with improvements directly correlated with the duration of participation.

**Webcam delivered CBT for HD** is a promising, cost-effective, alternative to standard office-based CBT for HD. Outcomes of this twenty six-session, weekly home-based CBT treatment that is delivered over the course of thirty to thirty eight weeks (versus an average of forty nine weeks for in-person treatment) via Webcam suggest moderate improvement in symptoms of hoarding symptoms.

## CBT for Older Adults with HD

Standard CBT for HD has been found to be less effective for older adults (aged sixty and over). Neurocognitive changes in executive functioning combined with limited insight and limited motivation can make cognitive-based interventions less effective for older adults, many of whom may benefit more from intervention focused on [harm reduction](#_Harm_Reduction_Therapy) (per the discussion on this intervention that follows later in this document). The literature recommends emphasizing behaviorally-based strategies (e.g., dividing tasks into small, time-limited parts, scheduling harm reduction tasks on calendars, and placing written reminders such as post-it notes in highly visible locations) as well as linking new behaviors to pre-existing automatic tasks (e.g., placing a recycling bin next to the mailbox and encouraging sorting and discarding every time the client gets their mail).

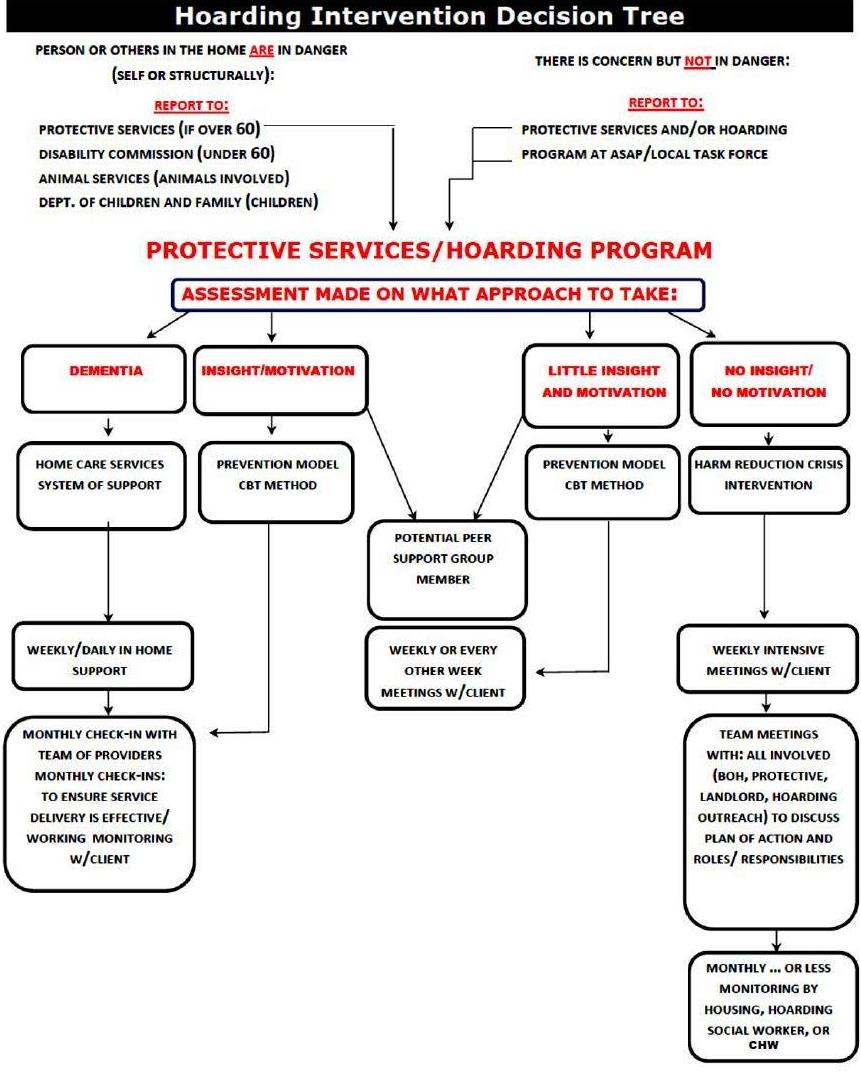
**A combination of cognitive rehabilitation and exposure-based treatment has been shown to result in clinically and statistically significant reductions in the severity of HD symptoms in older adults.**

Adaptations of CBT for HD for older adults include additional cognitive rehabilitation, fewer cognitive strategies, more exposures (simple & concrete), accommodation for health and energy limits, and consideration of barriers, transportation to sessions, ability to complete homework; treatment adherence and available space. Combined cognitive rehabilitation (targeting neurocognitive deficits) and behavior therapy (i.e., exposure therapy to promote habituation to distress by discarding or not acquiring possessions) has been shown to be a promising approach in the treatment of older adults with HD.

One effective protocol for older adults includes six sessions of cognitive rehabilitation sessions targeting prospective memory (e.g., calendar use, to-do lists, prioritizing) and categorization/organization, problem-solving and cognitive flexibility, followed by sixteen sessions that focus on behavioral therapy for discarding and acquiring, followed by two sessions of relapse prevention. In contrast to standard CBT for HD, this intervention focuses on behavioral interventions (exposures) to discarding and not acquiring while reducing emphasis on cognitive therapy techniques.

In addition, six full sessions are devoted to problem-solving and organizational skills rather the standard two to three sessions and then on as-needed basis throughout treatment sessions in order to provide cognitive rehabilitation of these skill deficits. Prospective memory and cognitive flexibility modules are also added to the standard CBT for HD. The skills are presented in a concrete, manualized workbook format, and clients are asked to practice with their own personal examples. Finally, three to six home visits are made based on individual needs (e.g., mobility problems) during the exposure to discarding phase in order to provide in vivo (i.e., home-based) exposure exercise practice as well as practical assistance for clients with physical impairments.

The following page depicts a proposed decision-tree for determining a course of intervention for older adults with HD:



*(Adapted from* [*Hoarding: Best Practices Guide*](#Bestpracticeguide)*)*

## Group Cognitive-Behavior Therapy (GCBT) for HD

Group treatment may be of particular benefit to people with HD because of the opportunities this modality provides to reduce the social isolation and stigma linked to HD as well as increase intrinsic motivation for change. It is a cost-effective alternative to individual treatment that also appears lead to increases in participants’ awareness and insight regarding hoarding.

Four group dynamics have been shown to be of particular benefit to persons with HD:

* Universality (or inclusion) can mitigate the stigma and shame associated with HD through meeting others with the disorder and the recognition of not being alone in experiencing HD, which can facilitate self-disclosure and help establish safety in the group.
* Cohesion (or the connectedness of members to one another, to the group and to the therapeutic process that develops within the group) fosters affiliation and results in feelings of comfort, belonging, and acceptance of one another and fosters the sharing of personal information in a manner that incorporates positive peer pressure to motivate change as well as have a positive impact on attendance, all of which can help attenuate interpersonal attachment difficulties.
* Mutual aid (or group members’ provision of help to one another by sharing advice and experiences, tools, and strategies for problems) can instill hope and motivate change through the support, empathy, and understanding members provide which results in feeling emotionally supported, being helped directly, new insights and perspectives gained from others who are struggling with similar problems.
* Social contact and socializing (or the range of social exchanges of members within and between sessions) may reduce social isolation and co-occurring social anxiety by providing opportunities for interacting with peers in a contained and relatively safe setting in which they can learn and practice social skills.

GCBT typically consists of sixteen to twenty sessions of six to eight participants that are held once a week and include home visits. The first few sessions are devoted to explaining the [cognitive-behavioral conceptual model of hoarding](#_Cognitive-Behavioral_Model_of) (previously discussed) and enumerating the goals of treatment for each participant in order to help them understand the nature of their behavior and its effects on functioning as well as to foster adherence to treatment processes. Feedback is solicited from participants regarding how the model applies to their specific symptoms along with examples from their own experience.

Each group member uses a client manual that contains relevant forms to complete during or following group or home sessions and that can be used to follow along with the educational presentations provided during the group sessions. Subsequent to the initial educational presentation, a review of homework and a discussion of the therapist-assisted home-based session occur followed by one of several topics about the manifestations of hoarding including: (1) problems with decision-making; (2) categorization and organization; (3) memory; (4) emotional attachment to saved items; (5) concerns about loss and waste and other hoarding beliefs; and (6) problems with acquisition, discarding, and behavioral avoidance.

The acquisition and discarding components primarily focus on setting up behavioral experiments or exposure experiences during the group session and for homework assignments. Final group sessions are devoted to preventing new clutter. Each group session concludes with the selection of homework assignments.

It should be noted that although group sessions provide structure, opportunities for socialization, and important information, the majority of the work is accomplished during individual home-based cleanout sessions (which can be conducted by a case manager, peer support specialist, or community health worker). The presence of home-based staff has been found to be of significant help with sorting, organizing and discarding in particular since persons with HD seldom force themselves to discard on their own.

**A Practical Approach to Cleanouts (Four Key Actions):**

* **Throw Away (TA)**
* **Recycle (R)**
* **Give Away (GA)**
* **Keep and Put Away (KAPA)**

Home-based sessions initially focus on the development of an organizational scheme for the storage of saved items and the identification of areas or types of saved items that should be addressed first.

The cleanout session format entails structured decision-making regarding possessions. All decisions are made by the client while the therapist poses questions in order to facilitate the process. For example, in response to questions regarding which items are worth saving, the reasons for saving some items are reviewed and the client is helped to identify beliefs and emotional reactions as they make choices. In addition, exposure to discarding and cognitive restructuring of hoarding beliefs are individually tailored during these sessions during which the client’s tolerance for the discomfort involved in cleaning out the area is established and enhanced.

Procedures and concepts used during cleanout are presented first during group sessions along with group exercises designed to help clients to recognize hoarding-related beliefs and behaviors as well as model strategies for challenging hoarding cognitions.

Clients are asked to bring in a box or bag of possessions from their home for each group session which is used for exercises designed to help them identify hoarding-related beliefs, challenge those beliefs and expose them to the distress produced by discarding. They are asked to select an item from their box or bag and place it on the so-called Purgatory Table (i.e., the way station between keeping and discarding) in the middle of the room and then make decisions about the items, identify beliefs about the loss, and receive group reinforcement and support for decisions to discard.

In order to identify beliefs about hoarding, each participant is asked to consider discarding the item they placed on the Purgatory Table and to rate the level of distress associated with the thought of discarding it. The [downward arrow technique](#Downarrow) (previously discussed) is then used to identify dysfunctional beliefs about discarding the item.

Another group exercise entails generating a set of questions that group members can ask themselves when making decisions about saving and discarding. Each participant selects an item from their box or bag and places it on the Purgatory Table and then answers a set of questions about that item that are designed to help them make the decision regarding saving the item.

Examples of questions include:

* *Do I need it?* A discussion regarding the difference between “need” and “want” is encouraged with an emphasis on a very narrow definition of “need,” which consists only of those items that are absolutely necessary (e.g., food, clothing, shelter).
* *How many do I already have?* People who hoard often save multiples of items so the discussion focuses on the disadvantages of keeping multiple copies and the likelihood that more than one copy would be needed.
* *Is it significant for MY purposes?* Discussion focuses on helping clients recognize when something is useful to them and when it is not, irrespective of the usefulness of the item to another person. In other words, if the item is not of use to the owner but might be to another person, it remains a useless item from the perspective of the person who has it. While giving the item to another person who could use it is a worthwhile endeavor, keeping such an item is not.
* *Do I have a specific plan to use this item?* People with HD often feel that there is a potential use for an item but lack a definitive plan for its use. Therefore, thinking concretely about using an item and applying that information to help decide whether to save it can help enhance decision-making about items lacking a specific plan for use.
* *Will I really use it within a reasonable time frame?* Individuals with HD often maintain unrealistic thoughts about their ability to use items, especially when their dwelling is full. Feedback from group members can help correct erroneous thinking.

Other questions that can be used to help broaden the focus of the impact of hoarding and how an item actually functions in the individual’s life (rather than only considering the potential costs and risk of discarding it) as well as the immediate goal of gaining control over possessions and prompt helpful discussion include:

* *What are the advantages and disadvantages of getting rid of this?*
* *Do I really care? Is this important to me?*
* *Do I want it taking up space in my home?*
* *Will getting rid of this help me solve my hoarding problems?*
* *By getting rid of this, will I have more opportunity to use truly important items?*

Participation in GCBT for HD has been shown to lead to reductions in acquiring items, increasing awareness of problematic beliefs about saving, and improving participants' ability to organize. Twenty office-based GCBT sessions for HD combined with in-home coaching has been found to be especially effective. And, evidence suggests that GCBT for HD is also effective in alleviating symptoms of co-occurring disorders including major depression and OCD. In addition, groups show efficacy even when conducted via web-cam, which can substantially increase access to treatment.

Moreover, GCBT is cost effective and efficient; more clients can be treated in a given period thus fostering efficient use of scarce resources (e.g., access to clinicians trained in CBT and CBT for HD). Finally, the opportunities for interactions among group members and group facilitators help to reduce feelings of isolation, destigmatize the disorder, and improve client well-being.

## Effective Therapeutic Approaches for Addressing HD

Specific therapeutic approaches that have been found to be of benefit to persons with HD include:

* [**Motivational interviewing**](#_Motivational_Interviewing_(MI)), which is particularly helpful when incorporated into treatment for individuals whose insight is limited and ambivalence around change is significant.
* [**Harm reduction**](#_Harm_Reduction_Therapy_1) (rather than symptom reduction) to decrease the harmful effects of hoarding, rather than the hoarding behaviors.
* [**Group therapy**](#_Group_Cognitive-Behavior_Therapy)(previously discussed), which can be of help in reducing social isolation and social anxiety and are cost effective when compared to one-on-one intervention.

### Stages of Change

Change takes time and most people are not successful during their first attempt at change; periodic failure is part of the process of change. Moreover, people do not progress in a linear fashion through the stages of change; they to tend cycle in and out of the stages, move back and forth between stages, and can be in different stages for different problems (e.g., recognizing a mental health problem but not a co-occurring substance use disorder). Even individuals who are highly motivated experience slips at some point, returning to a previous stage before renewing their efforts. But, analyzing and learning from mistakes when lapses occur can foster future success.

The Stages of Change Transtheoretical Model (developed by Prochaska and DiClemente) posits the following stages of change:

*(Taxman, et al, 2004)*

* **Precontemplation:** In this stage individuals either deny that a problem exists or do not recognize the problem and therefore are not considering changing their behavior, or are unwilling to change. At this stage, the focus is on readiness to change through educational awareness and engaging the person in self-assessment and motivating them to move to the contemplative stage of change.
* **Contemplation:** In this stage individuals recognize that a problem exists are thinking about how to solve it by seeking information and considering options. Ambivalence is manifest in vacillation regarding the seriousness of the problem and understanding the potential benefits of dealing with it while feeling conflicted about giving up benefits associated with it. The goal at this stage is to tip the balance in the direction of change using questioning techniques that help the person weigh the risks of the status quo and the potential benefits of change.
* **Determination:**The person recognizes the problem behavior and begins to make a commitment to change. At this stage, the individual planning to make a change in the near future, but still faces obstacles (e.g., lack of full commitment to change, other obligations that require immediate attention, or a lack of awareness of how to take the first step). An effective tactic at this stage is to jointly develop a menu of options for the person to help them think even more about changing and solidify their decision to change. Focusing on the development of cognitive skills that can help them make decisions that support changing their behavior can be effective.
* **Action:** The individual is actively making changes in their life. They define a strategy for change with detailed steps that include changes in support systems, personal relationships, living situations, and other necessities. Tactics that are effective for this stage include positive reinforcement for progress. In addition, emphasis is placed on the development of social and cognitive skills (e.g., problem-solving) and the development of a relapse prevention plan that includes all of the person’s triggers (i.e., people, places, and things) that can lead to the reemergence of problematic thoughts and behaviors.
* **Maintenance:** The person has met key milestones in changing factors associated with the problematic behavior and is in the process of maintaining and solidifying the changes they have made. The focus of this stage is stabilizing new behaviors and preventing relapse while continuing to provide support and reinforcement for progress and elimination of as many triggers as possible. A trigger analysis is used to help the person recognize patterns (i.e. people, places, and things) and develop alternative responses and supports in the community that can help to when trouble arises.
* **Relapse:** The person experiences a slip as a one-time event, a series of mishaps, or a period of prolonged return to the problematic behavior. Each slip should be addressed with attention to its causes and an action plan to address the people, places or situations that triggered the slip should be developed.

Intervention needs to start where the person is in the change process. For example, if the person is in the pre-contemplative stage, motivational interviewing techniques are used to explore ambivalence about change and create discrepancy between the people’s stated goals and their current behaviors. Or, if the person has decided change is needed, focus is placed on teaching skills necessary to make the change, reinforcing pro-social thinking, modeling coping strategies, and directing the practice of those strategies. Thus interviewing strategies can be employed to move individual to the next stage of change. In addition, it is important to match services to where the person is in the process of change.

**Motivating change in person with HD entails recognizing ambivalence to change, enhancing ambivalence, resolving ambivalence and reinforcing change talk and** **action.**

### Motivational Interviewing (MI)

Three types of persons with HD who struggle with motivation have been identified: non-insightful, insightful but reluctant, and insightful and motivated but non-adherent. Ambivalence towards treatment may be manifest in complaints or changing the topic (to something other than treatment), arguing, not following through on commitments to appointments, and not completing homework assignments.

Motivational interviewing is a client-centered, directive method that is designed to enhance intrinsic motivation to change by exploring and resolving ambivalence. MI is a collaborative (rather than confrontational) and evocative (rather than educational) style that promotes autonomy (rather than imposing authority) and the specific techniques used are matched to the individual’s stage of change. It focuses on four basic listening and speaking techniques/strategies (known as **OARS**) that help guide the conversation toward change:

**O**pen-ended questions

**A**ffirm (positive talk and behavior)

**R**eflect (what is being heard or seen)

**S**ummarize (what has been said and what has been agreed upon)

**Principles of Motivational Interviewing:**

* **Express empathy:** A nonjudgmental and accepting relationship using reflective listening without communicating criticism or blame fosters engagement and openness to change. Understanding of the person’s position is conveyed irrespective of agreement with their point of view.
* **Develop discrepancy.** The gap between a person’s goals or values and their current behavior creates discrepancy and is the basis for amplifying their own reasons for change. Assistance with self-assessment is provided by asking questions and making statements to help the person identify their own reasons for change, rather than telling people why they should change their behaviors, the outcome of which is the ability recognize the incongruence between personal goals and values and their actual behaviors and leads the person to determine that there is a need for change. Developing discrepancy is an effective strategy when a person is ambivalent about change. Showing people the difference between their present behaviors and their goals prompts them to realize that they must change to succeed.

A decisional balance sheet, which lists the benefits and costs of changing or continuing current behavior, can be a helpful tool for clients when they are considering whether to make a change.

|  |  |
| --- | --- |
| **Decisional Balance Sheet** | |
| **Continue to hoard**  **Benefits:**   * Get to keep stuff * Avoid decision-making * Don’t have to do the work of cleaning   **Costs:**   * Can’t find anything * Can’t have people over * House smells * Can’t use rooms * Friends/relatives get upset | **Clean house**  **Benefits:**   * I know what I have & where it is * Can invite people over * Family/friends will be happy * Can move around easily   **Costs:**   * I’ll have to part with my stuff * It will be hard work * Emotional stress of discarding |

* **Roll with resistance:** Counterproductive confrontations are avoided when resistance, reluctance or ambivalence are expressed in recognition of the normality of mixed feelings when thinking about change. Thus, resistance is understood as part of the change process and also functions a signal that a new strategy may be warranted.
* **Avoid arguments:** Arguments increase defensiveness and resistance to considering new ideas. Conversations about behavior change often provoke arguments. Arguments can be avoided through a variety of techniques including reflections.
* **Reflections** (restatements of what an individual has said) can help reduce defensiveness and confusion or ambiguity, and let the person know that they are being listened to and understood as well as ensure that roles in and responsibilities in are clearly understood.
* **Simple reflections** include**:**
* **Parroting** consists of repeating what someone has said
* **Paraphrasing** repeats the meaning of what has been said without using the same words
* **Reflecting feeling** is accomplished by showing the persons the emotion that they are displaying at that time
* **Reflecting content** focuses on why the person feels the way they do
* **Getting the gist** entails repeating the information in a more concise manner
* **Getting the meaning** entails finding the underlying significance of what the person has said
* **Double-sided reflections** point out discrepancies in individuals’ statements or situations in order to call attention to discrepancies, evoke ambivalence, and induce the desire for change.
  + **Amplified reflections** magnify individuals’ statements to ascertain whether they can withstand closer scrutiny. An amplified reflection can show the gaps in a statement by pointing out the opposite extreme.
  + **Summarizations** consist of a number of reflections strung together and can be used throughout interviews to ensure that major points are understood. Summarizing key points helps build rapport and reduce apprehension by demonstrating that the person is being listened to and understood. Summarizations are used periodically throughout an interview to recap major points.
* **Support self-efficacy (situational-based self-confidence):** Pointing out instances where the person has been successful enhances their confidence. Maintaining optimism, reminding the person of their personal strengths and past successes, and affirming all of their efforts toward change serves to convey confidence that the person is capable of successful change and overcoming difficulties. Eliciting and reinforcing a person’s belief in their ability to successfully achieve a goal has been found to be essential an essential component of change. Techniques such as affirmations can be used for affirming successes.

**Affirmations** include:

* Positive statements that are used to reinforce individuals’ self-efficacy and reinforce pro-social behavior as well as build rapport, provide feedback, and increase the likelihood of positive behaviors
* Calling attention to something admirable or interesting about the person
* “Blaming” people for their successes rather than dwelling on failures by focusing on successes

To promote change, the optimal ratio is four affirmations for every critical comment. It is recommended that as many affirmations as possible be used and to affirm any desired behavior.

* **Open-ended questions** require the person to talk about and answer in a more detailed way rather than a yes/no response. Research has shown that asking multiple closed questions in a row effectively ends communication while open questions can lead to less resistance and fewer arguments.
* **Elicit self-motivational** **speech (DARN-C):**

**Desire:** The person expresses a wish to attain or succeed (e.g. “I really want to live in a clean house.”)

**Ability:** The person talks about confidence (e.g., “I could clean my bedroom. I’ve done it before, and it’s possible.”)

**Reasons:** The person expresses a tangible incentive, motive, or rationale for change (e.g., how change would make things better or how continued behavior would make things worse such as “All of the dust makes my asthma worse.”)

**Need:** Initially need may overlap with logical reasons and then becomes an urgency (e.g., from “I have to.” to “I must.”)

**Commitment:** The person expresses a readiness or agreement to change (e.g., “Remove five items from my bed? Yes, I will do that.”)

MI can also be applied to HD within the context of a team approach to intervention that allows for sharing information and resources which can be particularly helpful in managing complex cases. Teamwork also allows individuals to function in different roles to enhance motivation to change. For example, two individuals or agencies can assume two basic roles that can help motivate a change process when they communicate with one another and maintain a united front:

* The enforcer, which can be assumed by a housing inspector, judge, fire department, or department of social services, can be used to clarify the conditions that would lead to a negative outcome and enforce the consequences of not meeting these conditions. This role entails clarifying conditions that would result in eviction, condemning the dwelling, penalties, loss of custody of children, etc. It also includes enforcing the outcome if the specified conditions are not met (e.g., removal of children, condemning the dwelling).
* The support role can provide assistance in meeting the conditions to avoid a negative outcome. This role sets clear yet firm limits in a non-judgmental manner (reminding but not enforcing) and offers support to provide assistance (e.g., with ideas or hand-on help) to help the client to meet the conditions laid out by the individual or agency in the enforcement role and may be provided by a community health worker, case manager, therapist, or lawyer.

**Housing inspections** can be an effective way to help monitor the change process as well as motivate the person to change. The literature recommends meeting with the occupant outside the home and asking permission prior to opening doors. It is also recommended that the inspection process be explained and the occupant given as much control as possible, while using calm and respectful, but firm, language, acknowledge strong feelings and reporting findings in objective (nonjudgmental) terms.

### Harm Reduction Therapy (HRT)

Addressing HD based on a chronic illness management model for harm reduction that focuses on self-care, coordination within systems of care, consistent follow-up and managing and mitigating the negative impact of hoarding (rather than eradicating the behavior entirely) is considered a promising approach.

Harm reduction therapy presumes that mitigation of harm is not contingent upon stopping all compulsive acquiring or completely clearing out the home. HRT entails setting small, achievable goals to reduce the risk of harm in the home. Harm reduction methods can be used to communicate the potential harm of hoarding behaviors can cause to others living in the home. It may also include enlisting the help (e.g., from the local health department, mental health or other relevant agency) to assist a family in communicating the dangers of hoarding to their loved one.

The literature recommends that the person’s safety (including any other people living in the home and/or pets) as well as the safety of the structure of the building to the person and others visiting the home be assessed. In addition, the person’s insight regarding their situation and capacity to address the hoarding need to be assessed along with available resources (i.e., financial help to pay for cleaning services, insurance to assist with paying for mental health and local agencies that may be able to assist).

The following helpful acronyms can be used to describe strategies and principles in working with clients with HD:

**Three P’s of Decluttering**:

**Plan:** Prior to each visit, the client’s harm reduction targets, how items will be removed from the environment, and when the next visit will occur are reviewed.

**Pace:** Start with short periods of decluttering; some clients cannot tolerate even a half hour in the beginning and recognize the pace will be slow.

**Partner** with other agencies, professional organizers, home care staff, or visiting nurses to clarify the safety and cleanliness level required to prevent eviction or maintain safety; focus on meeting necessary standards, need exceeding them.

Keep Harm Reductions Clear (**W.A.T.C.H.**):

**W**hy do you have this here?

**A**ffirm explanation that the client gives

**T**ouch only with permission

**C**reatively brainstorm other locations for possessions that maintain similar function and convenience with the client

**H**elp the client clear, relocate, and protect (CRP)

**L.E.A.R.N.** to clear targets:

**Listen** to the client’s ideas and plans for their possessions and explore their solutions to the problem (both realistic and unrealistic) and accommodate them if possible

**Empathize** by letting the client know that the therapist has similar feelings about their own possessions and that sometimes it is also difficult for the therapist to part with them

**Affirm** by letting the client know that the therapist understands how attached they are to their possessions and how much their possessions mean to them

**Redirect** the client back to the harm reduction target and harm reduction agreement in a gentle but firm and clear manner

**Negotiate** using creativity around adherence to the harm reduction contract

A contract with client is developed that includes agreed-upon goals and strategies. These goals should be specific, measureable, achievable and relevant time-bound (SMART) as in the following example:

**S.M.A.R.T.** Harm Reduction Targets:

* + Keep clutter out of swing areas of front and back doors (specific)
  + Keep clutter out of swing areas of front and back doors so that doors swing fully to the door stops (specific and measurable)
  + Work with community health worker to clear clutter from swing areas (attainable) of front and back doors so that doors swing fully to the door stops (specific, measurable, attainable)
  + Target is relevant when focused on safety (and then comfort)
  + Work with community health worker to clear clutter from swing areas of front and back doors so that doors swing fully to the door stops between visits (time-bound)

Next, an action plan is determined based on prioritized areas of critical need including (e.g., blocked egress, fire hazard, animal/human waste, trash and spoiled food, fall risk, access risk for fire department/first responders) and any other areas that may be of concern.

Implementation of the plan may include the following harm reduction activities:

* Reduce incoming paper (stop the delivery of junk mail and limit magazine and newspaper subscriptions to two magazines and one newspaper per year)
* Eliminate trailing electrical leads, especially under carpets and through doorways
* Eliminate areas that represent a fire risk
* Eliminate areas that represent a fall risk
* Reduce overloaded sockets
* Clear doorways to allow doors to close (maintain a clean path to the door and make sure it opens fully)
* Clear windows that are blocked
* Make utility shut-offs accessible
* Move flammable materials away from heat sources
* Ensure the smoke alarms are clear from clutter and are working
* Create alternative escape routes
* Manage materials used for smoking
* Clear blocked heating vents
* Keep the stove top clear (maintain a thirty six inch clearance around the stove top)
* Remove expired/unsafe food and trash that is attracting pests (only purchase food for the week; discard spoiled food that is over sixty days old)
* Address areas that interfere with activities of daily living (e.g., bathroom, stove, refrigerator)
* Protect important documents and prevent overdue payments and late fees (set up a filing system for important documents and automatic payments of recurring bills such as utilities; set up a box for current bills, checkbook, pen and stamps)

Ongoing monitoring and support are provided to the client via home visits. In addition, harm reduction often includes a team-based case management/wraparound approach that can include a mental health professional, case manager, community health worker, city code enforcement, natural support system (i.e., supportive family and friends), professional organizer, and others. (The section on [hoarding task forces](#_Hoarding_Task_Forces_1) offers additional ideas for potential members.)

## Working with Families

**Family therapy** can be of benefit in addressing strained family relationships that commonly result from living with a family member who has HD. However, family therapy is considered adjunctive and supportive for clients undergoing [CBT for HD](#_Cognitive-Behavior_Therapy_for). Research indicates that the combination of family therapy and individual CBT for HD results in improvement. Additional benefits accrue with pharmacotherapy for comorbid conditions (e.g., depression) or working with a professional organizer in the home.

The employment of [harm-reduction](#_Harm_Reduction_Therapy) methods in family therapy to address hoarding behavior is another option. Harm-reduction therapy focuses on helping family members develop a management plan for improving the safety and comfort of a hoarded home, including, for example, addressing structural issues resulting from the weight of accumulated items, the potential for fire, mold and dust, and vermin infestation.

**Family-focused Harm Reduction** for HD is designed to address the negative emotions and experiences of family members in response to hoarding behaviors. It is used when the individual with HD refuses to engage in treatment. As noted above, HR methods focus on reducing the consequences of harmful behaviors without demanding that the individual stop the behaviors. The HR therapist often assumes the role of consultant and seeks to involve family members who have been disengaged with the client for any reason.

The process entails: (a) using motivational interviewing with the family present either observing or actively participating to engage the client in the idea of harm reduction; (b) assessing the potential for harm in the client’s home, and (c) creating and maintaining an HR plan. While HR may result in requests for treatment by clients as they become ready for change, treatment is not a requirement for this approach.

**Family Focused Harm Reduction for HD**

* **Assess risk**
* **Modified or full cleanout**
* **Engage client in HR approach**
* **Assess harm potential**
* **Create HR team**
* **Develop HR plan & formalize HR plan**
* **Manage HR team & plan**
* **Implement & manage HR plan**

Intervention starts with an assessment of harm potential and includes the following:

* Environmental risk (i.e., environmental elements that contribute to risk and discomfort)
* Physical capacity (i.e., how well the client functions in the environment including any physical disabilities, and medical problems)
* Psychological capacity (i.e., the client’s motivation and openness to help; decisional capacity, and any other psychiatric conditions)
* Social capacity (i.e., how extensive the client’s support system is and how willing the members are to participate; what are formal and informal social supports; financial resources)

Harm reduction techniques have been found to be of help in reducing clutter and acquisition of new items.

## Interventions for Individuals with Intellectual/Developmental Disabilities

There is a paucity of empirical research on HD among persons with intellectual/developmental disabilities, and with the exception of some individual case write-ups and small quasi experimental studies, little is known about the most effective interventions for this population. Of note, however, there is some promising evidence that home-based [CBT for HD](#_Cognitive-Behavior_Therapy_for) is effective for persons with mild intellectual disabilities

In general, the literature on this topic recommends avoiding forced cleanouts or surreptitiously removing items as such methods will likely cause distress. Habilitation programs that focus on limiting acquiring may be effective. Elements of intervention may include helping the consumer differentiate between needs and wants, developing a budget, making lists of items already owned with clear, measureable goals that are achievable, leveraging the consumer’s strengths and including personally-motivating rewards.

Behavior modification using token economies to reinforce positive behavior with rewards can be effective. For example, tokens can be earned stars placed on a chart that can be later exchanged for a desired reward such as eating out or seeing a movie. The use of Positive Behavioral Support (BPS)[[10]](#footnote-10) techniques may also be of benefit. The goal of PBS is to respect and promote self-determination by seeking to understand the person within the context of their life and helping them to attain a life that they value. It determines the function that a behavior services and replaces maladaptive behaviors with those that are effective. Key PBS strategies have been found to be particularly helpful in altering hoarding behavior.

## Hoarding Task Forces

Hoarding task forces[[11]](#footnote-11) have become an increasingly common strategy that many communities use to dealing with hoarding. These multi-agency groups provide a means for communities to develop coordinated, collaborative, managed and directed responses to hoarding cases while maximizing resources across agencies and producing more positive outcomes than can be achieved by individual agencies working alone. Such task forces may also organize and provide public education about hoarding, training to providers, and support to families. Hoarding task forces thus enhance a community-wide response to a problem using a multifaceted, cross-system, cross-disciplinary collaborative approach.

Hoarding task forces facilitate stakeholders coming together to consult with regard to individual cases, some engage in training and education for the courts, other public agencies, and the general public, and/or provide support groups for people with hoarding behaviors.

The membership of hoarding task forces may include the following:

|  |  |
| --- | --- |
| * + Housing (Public Housing Authority/Landlords Association)   + Public Health Department   + Mental Health (agencies/providers)   + Protective Services (Adult, Child)   + Aging services (Area Agency on Aging)   + First Responders   + Sanitation   + Occupational Therapy   + Crisis intervention/Emergency services   + Home Health Care (visiting nurses/social workers)   + County corporation counsel   + Private practice attorney   + Prosecutor   + Attorney General’s Office   + Court personnel   + Veterinarians   + Clergy   + State Department of Agriculture   + Community Leaders | * + Legal system/legal services   + Fire Department   + Law Enforcement (Police/Sheriff)   + Animal Control and Public/Private Animal Care Agencies   + Pest management/control authorities   + Code Enforcement   + Professional Organizers   + Humane Society   + Physician and/or Nurse   + Clean-up services providers   + Health care systems/hospitals   + Advocates for persons with disabilities and/or older adults   + Long-Term Care Ombudsman   + Public Guardians   + City Utility Companies   + Local fatality review teams   + Building Inspectors   + Family members |

Three primary models[[12]](#footnote-12) of hoarding task force structure have been identified:

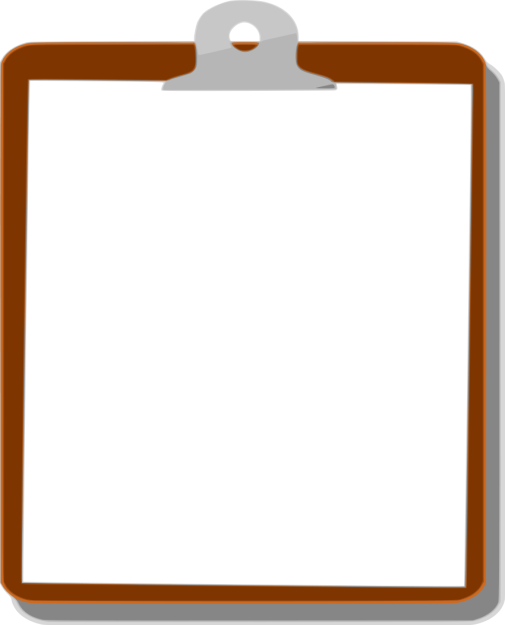
1. **Education:** The primary purpose is to provide education about the problem of hoarding and appropriate interventions. This model focuses on internal education for task force members and agencies or on community education for members of the general public and may include support groups, family education/support, trainings, symposia, etc. Many hoarding task forces provide both forms of education and function as a mechanism for disseminating the latest research and best practices.
2. **Case Consultation:** The primary purpose is for members of the task force to discuss cases and receive feedback and input. One or two cases are typically presented at each meeting in accordance with HIPAA and other relevant confidentiality and privacy laws. The advantage of this is that since many agencies on a task force either share or are aware of similar cases, professional support can be provided along with promoting the use of best practices.
3. **Direct Intervention:** The primary purpose is for the task force to serve as the intervention/response mechanism for hoarding cases in the community. Such models include pure and ad-hoc forms in which the member agencies join together to intervene in cases. This model allows for a coordinated response. It also lets the community know where to make referrals and who will respond to referrals.

Some hoarding task forces focus on systemic and policy issues in order to reduce harm and improve the quality of life for persons with HD by assessing current community needs and services; identifying gaps in services and barriers to services; identifying best practices to improve coordination of services and promote housing stability; raising awareness of the public and policymakers; and making policy recommendations.

Common hoarding task force activities include:

* Developing an assessment/crisis team to respond to referrals of hoarding cases and coordinate appropriate next steps to facilitate meaningful, long-term improvement for persons with hoarding problems
* Increasing access to treatment for HD, including home-based intervention that can include therapists, organizers, coaches, and peers
* Expanding support groups, including those that are peer-based and target persons with HD, as well as those that are designed for families
* Offering treatment groups for people at different [stages of change](#_Stages_of_Change) (e.g., ranging from early awareness to maintenance groups)
* Developing a community resource guide for people with HD and their families that can also be used by community agencies (so that people know which agencies to contact in different situations when seeking assistance with a hoarding problem)
* Establishing a single point of entry into the system of supports and resources that uses a single form for referrals, follows a roadmap of services, and engages an assessment team
* Developing evaluation guidelines for landlords that are coordinated with fire departments and adhere to health regulations
* Providing long-term case management services as an extension of initial assessment and treatment
* Offering training for therapists, 2-1-1 staff, landlords, agency staff, peer support staff, and families; recruiting and training trainers; and providing cross-training for identification/screening/assessment across agencies
* Appointing a hoarding czar
* Evaluating successes and barriers

The literature recommends that hoarding task forces effectively coordinate systems of care and address the following:

* How public cases of hoarding are identified
* Who the referral is made to
* How cases are triaged
* Who makes the determination regarding the urgency of a case
* What interventions are needed and who makes that determination
* Who coordinates and manages the intervention activities
* Who follows the case over time
* At what point is the case determined to be successfully closed

**Sample Hoarding Task Force Case Protocol:**

1. Evaluate the threat/hazard
2. Determine legal directives
3. Develop a case plan
4. Implement the plan
5. Evaluate outcomes and modify the plan as needed
6. Continue to monitor

A hoarding task force can have a number of functions based on the needs of the community. Recommendations from the literature include the following:

* Create a protocol and understanding of how and where to report cases of hoarding. This includes ensuring that the roles and responsibilities of agencies (police, fire, department of health, Protective Services, etc.) are understood and connected to one another to create an organized, preventive response (rather than respond to a crisis as a last minute effort).
* Establish a point person who can engage key players and coordinate the community effort and response towards the individual with HD.
* Allot time for case consultation and discussion during task force meetings.
* Provide education and community awareness of hoarding as a mental health issue and a general understanding of what each discipline is able to do in accordance with law or regulation that governs them as well as what their role can and should be when discovering a hoarding situation or when trying to work with a person who hoards.
* Ensure that task force members work as a team. (e.g., planning ahead of time who will give the violations [the stick or bad cop] and who will offer the support [the carrot/good cop] in order to move forward in assisting the individual.
* Provide advocacy and work on local and state policy change
* Engage in fundraising (for monetary and in-kind resources).

The characteristics of successful hoarding task forces have been identified and include the following attributes:

* Consistent and dedicated leadership
* A clear purpose and mission that is periodically reevaluated and updated
* Organizational support in order to institutionalize the task force and provide ongoing support/resources
* Amelioration of turf issues and the formation of partnerships
* Individual, organizational and community needs are met
* Consideration and incorporation of the voices of people HD and their families
* A willingness to try a different course of action or to do something different

## Support Groups

**Self-help support** group meetings and self-help internet groups are available to persons with hoarding issues. Members are encouraged to set goals and are supported by other members. The groups welcome open discussion in an effort to help participants overcome their embarrassment and shame and start to clear their houses.

Members of support groups who have been studied tend to be socially isolated and the groups have been found to help reduce participants’ isolation as well as offer an opportunity to become more comfortable around other people. Although there is a paucity of research to date, mutual-help groups for hoarding show promise, especially with regard to discarding clutter. There is also some evidence to suggest that support groups led peers, including those who are in recovery from HD, using a workbook/manual, may be effective (e.g., Buried in Treasures).

### Image result for hoarding disorder clip artBuried in Treasures (BIT) Workshop

BIT is a fifteen-session, twenty-week, manualized workshop that is facilitated by non-clinical staff. It was developed by Lee Shuer, a Certified Peer Specialist, and Randy Frost, PhD. Sessions are held for groups of between six and ten members and are comprised of the following:

Session 1: Introduction & Welcome

Session 2: Do I have a problem with hoarding?

Session 3: Meet the bad guys:

BG #1: It’s just not my priority.

BG #2: Letting unhelpful beliefs get in the way.

BG #3: Overthinking or confusing yourself.

BG #4: Avoidance and excuse-making.

BG #5: Going for the short term payoff.

Session 4: Meet the Good Guys

GG #1: Keeping your eyes on the prize.

GG #2: Downward arrow.

GG #3: Thinking it through.

GG #4: Behavioral experiments

GG #5: Developing the right skills

Session 5: How Did This Happen?

Exercise − Instructions

1. Select possessions that would be easy, moderate, or difficult to discard
2. Attempt to discard them (you can decide later to retrieve them)
3. Indicate how you felt during the process

Put the item in the trash and indicate whether you experienced the following:

* I had difficulty keeping my mind on the task
* I had difficulty deciding what category it fit into
* I had a hard time making the decision
* I thought of more and more reasons to keep it
* I felt like I needed to keep it to help my memory
* I was concerned about being wasteful or irresponsible
* I was worried about making a mistake
* I felt sentimentally or emotionally attached to it
* I felt like it was part of who I am
* It felt unsafe or out of control to part with it
* It felt too uncomfortable to part with it

Session 6: Enhancing motivation

Session 7: Help with reducing acquisition

Session 8: More help with acquisition

Session 9: Sorting /discarding: Getting ready

Session 10: Sorting and Discarding: Let’s go!

Session 11: Sorting and Discarding: Succeeding

Session 12: Here come the bad guys again: Motivation and working time

Session13: Here come the bad guys again: Taking on your brain

Session 14: Maintaining success

Session 15: Reuniting for success

Of note is the fact that participation in BIT, like that of individual and group CBT for HD, leads to significant declines symptoms of HD even though it is of a shorter duration and is not conducted by a trained therapist. BIT may therefore be considered an effective adjunct to CBT for HD or an alternative when CBT for HD is not available.

**Elements of WRAP**

* **Wellness toolbox**
* **Daily maintenance plan**
* **Triggers & action plans**
* **Early warning signs & action plans**
* **When things are breaking down & action plans**
* **Crisis plan**
* **Post crisis plan**

### WRAP (Wellness Recovery Action Plan) for Reducing Clutter

WRAP for Reducing Clutter is a self-support and empowerment tool that focuses on decluttering, organizing, and limiting acquiring that is an adaptation of WRAP for people who struggle with clutter) that was developed by Lee Shuer, a Certified Peer Specialist and Advanced Level WRAP Facilitator (who worked with Randy Frost, PhD to develop the Buried In Treasures workshop).

WRAP is an evidence-based, manualized, group intervention that is conducted by peer facilitators for adults with mental illness. It guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. Additional information on WRAP can be found in two Saginaw County Community Mental Health Authority publications: [*A Guide to Evidence-Based Practices for Adults with Mental Illness*](https://www.sccmha.org/userfiles/filemanager/260/)and [*A Guide to Evidence-Based Wellness Practices*](https://www.sccmha.org/userfiles/filemanager/1058/)*.*

In the WRAP for Reducing Clutter group, participants create tools and action plans to assist them with the emotional and physical demands of reducing clutter. The group is also designed to help alleviate the stigma and shame associated with hoarding (e.g., by using terms that directly relate to the person’s experience, such as “finding” and “keeping”, rather than terms such as “hoarding”). Additional information on WRAP for Reducing Clutter can be found at <http://www.peersnet.org/audio/2014/may/how-wrap-can-help-hoarding-and-clutter>.

## Other Approaches

Efforts to adequately address HD can be significantly impeded without the availability of effective mental health services. Due to the expense and limited availability of individual treatment including group CBT, Web-based treatment, in-person self-help groups, and in-home coaching assistance have been developed to provide sustainable and affordable alternatives.

Studies indicate facilitated bibliotherapy and self-help groups may be of some benefit to persons with HD as well. These modalities offer opportunities for a stepped care model in which treatments are delivered and monitor so that the most effective yet least resource intensive, treatment is delivered to and only stepping up to intensive/specialist services as clinically required. In addition, referrals for help with financial management, housing, and other community resources may also be helpful.

### Self-Help

Internet based self-help for hoarding has been found to be helpful in relieving symptoms, building motivation, and reducing feelings of loneliness. In addition, it can be used as a resource to expand access to mental health care, complement existing evidence-based practices, reduce treatment costs, and it may be an attractive alternative to persons with concerns about stigma.

The limited studies available suggest this is a promising, cost-effective strategy with participation leading to mild reductions in clutter and symptoms of hoarding.

### Coaching

Coaches may be of benefit to people with HD and often work with therapists as part of a treatment team. A coach can be a family member, friend, home health aide, chore provider, community health worker, peer support specialist, etc. Coaches can function in a number of roles including providing help to the client with sorting and discarding. Coaches are taught about hoarding and meet as a team with the client and therapist to determine their role.

Coaches have been found to be helpful in enhancing motivation; elevating the client’s mood; scheduling hoarding reduction activities; helping clients stay on task; providing feedback and encouragement to clients; monitoring the condition of the client’s home; helping clients appraise the true value of their possessions; and improving the effectiveness of sorting and cleaning.

Other benefits of a coach include the provision of nonjudgmental home-based assistance and helping clients develop a non-hoarding lifestyle while maximizing the appropriate use of space in the home. Finally, a coach has the effect of a visitor to the home (which people with HD typically avoid due to embarrassment).

### Professional Organizers

Professional organizers can provide a range of services to people with HD such as helping them with sorting and organizing their possessions and making decisions about what to discard. In addition, professional organizers help clients design and implement organizational systems, establish routines, and prioritize personal and professional activities.

Clinicians can benefit from collaborating with a professional organizer who has expertise in the area of organization. Finally, many professional organizers have specific training and experience working with hoarding.

The literature recommends finding a professional organizer through the [National Association of Professional Organizers (NAPO)](http://www.napo.net/) and the [Institute for Challenging Disorganization (ICD)](http://challengingdisorganization.org/). Members of ICD attain a specific competency in professional organizing and often have worked with hoarding dynamics.

### Pharmacotherapy

Despite their lack of efficacy, anxiolytic as well as antidepressant medications, including SSRIs (selective serotonin reuptake inhibitors) such as paroxetine (Paxil), fluoxetine (Prozac) and the serotonin norepinephrine reuptake inhibitor, venlafaxine (Effexor) are often used off-label to treat HD and are considered first-line agents. Venlafaxine, which is taken at a high dose for the treatment of HD, has been found to be of benefit to individuals with other comorbid psychiatric conditions including major depression and anxiety disorders.

Some studies of paroxetine have shown that it may not be tolerated well by some older and middle-aged individuals due to adverse effects (e.g., sedation, fatigue, constipation, and sexual dysfunction). Venlafaxine extended-release may be effective for older adults as well as other individuals who have not responded well to more selective SRIs (serotonin reuptake inhibitors). Venlafaxine has been tested extensively in older populations and has found to be safe and well tolerated as well as produces significant improvement in hoarding symptom severity, comorbid symptoms, and overall functioning.

However, it should be noted that persons with HD generally do not benefit from SSRIs unless they also have co-occurring OCD and/or depression. In fact, the higher the person with HD scores on a scale of hoarding symptoms the less likely they are to respond to SRIs. Also, while treatment with paroxetine and venlafaxine may lead to clinically significant improvements in hoarding and associated symptoms, placebo-controlled trials are lacking and responses tend to vary.

# Summary and Conclusions

Hoarding disorder is a chronic condition that has far-reaching and costly consequences for persons affected by the disorder, their families and the community. It creates a substantial public health burden and is linked to occupational impairment, poor physical health, homelessness and other adversities.

The disorder creates a significant demand for social services. Public agencies can be burdened with complaints about unsanitary conditions and fire hazard risks. Addressing HD often includes the involvement of multiple agencies which, in many communities, has resulted in the establishment of community-wide task forces such as the Saginaw Hoarding Task Force (which is working on creating protocols to address HD in a coordinated, collaborative and effective fashion).

Selective effective interventions for HD have been developed. A specialized, multicomponent, twenty-six session, cognitive-behavioral intervention for HD that is conducted over the course of six to twelve months and includes home visits (for in vivo discarding and organizing) has been developed. CBT for HD incorporates: (1) education about hoarding, (2) goal-setting, (3) motivational interviewing techniques, (4) cognitive restructuring to challenge entrenched beliefs about emotional attachment to items and to the items themselves, (5) organizing and decision-making skills training, (6) exposure and response prevention along with practice in sorting and discarding objects to target the avoidance of anxiety-producing experience, (7) practice in resisting acquisition, and (8) cognitive techniques designed to alter dysfunctional beliefs about the importance of possessions. Participation in this treatment has been found to result in reductions of the major manifestations of hoarding (extreme clutter, difficulty discarding, and acquiring).

Due to the expense and limited availability of CBT for HD, group CBT for HD, internet-based treatment, support groups (e.g., Buried in Treasures), self-help options, and in-home coaching models have been developed to provide sustainable and affordable alternatives and enhance access to effective intervention.

Other promising approaches to addressing HD are based on a chronic illness management model for harm reduction that addresses self-care, coordination within systems of care, and consistent follow-up. These approaches focus on managing and mitigating the negative impact of the disorder rather than eradicating the hoarding behavior entirely.

Finally, interventions for HD do not offer quick-fixes and services need to be continued for an extended period of time in order to be effective. It is hoped that with further research, more efficient, evidence-based practices will be developed to promote recovery from the disorder.

# Appendix A: Selected References

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# Appendix B: Resources

## Websites

**Institute for Challenging Disorganization (ICD):** <https://challengingdisorganization.org/>

**Compulsive Hoarding:** <http://www.compulsive-hoarding.org/>

**Mayo Clinic:** <http://www.mayoclinic.com/health/hoarding>

**Web MD:** <http://www.webmd.com/mental-health/features/harmless-pack-rat-or-compulsive-hoarder>?

**Messies Anonymous**: [www.messies.com](http://www.messies.com)

**Moderated self-help group:** <http://health.groups.yahoo.com/group/H-C>

**Cluttergone:** <http://www.cluttergone.co.uk/>

**International OCD Foundation (IOCDF):** <https://iocdf.org/>

**International OCD Foundation Hoarding Center:**  <https://hoarding.iocdf.org/>

**Institute for Chronic Disorganization:** <http://www.challengingdisorganization.org/>

**The Organizer Lady:** [www.messies.com](http://www.messies.com);

**Children of Hoarders (COH):** [www.childrenofhoarders.com](http://www.childrenofhoarders.com)

**1-800-GOT-JUNK:** <https://request.1800gotjunk.com/>

**Michigan Hoarding Cleanup Directory:** <http://hoardingcleanup.com/michigan>

**Hoarding Task Force of Washtenaw County c/o Synod Community Services:** <http://htfwashtenaw.org/resources>

**Hoarding Fact Sheet:** <http://www.beachpsych.com/pages/cc80.html>

**Understanding OCD/ Hoarding:** <http://understanding_ocd.tripod.com/hoarding.html>

**Hoarding of Animals Research Consortium (HARC):** <https://vet.tufts.edu/hoarding/>

**Online Hoarding Support Group:** <http://hoardingcleanup.com/hoarding_support_group>

**Association for Behavioral and Cognitive Therapies (ABCT)**:<http://www.abctcentral.org/xFAT/>

**Mental Health Association of Orange County. International Exchange on Hoarding:** <http://www.hoardingtaskforce.com>

**Squalor Survivors:** <http://www.squalorsurvivors.com/squalor/hoarding.shtml>

**National Association of Professional Organizers (NAPO):** <http://www.napo.net/>

**Institute for Challenging Disorganization (ICD):** <http://challengingdisorganization.org/>

**Film and Media:**

**Stuffed:** <http://www.snagfilms.com/films/title/stuffed>

**Packrat:** <http://www.snagfilms.com/films/title/packrat>

**Possessed:** <https://vimeo.com/603058>

## Books

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## Hoarding Rating Instruments

The literature recommends using a standardized and validated instrument in the assessment of consumers with HD, such as one of those in the examples that follow.

The **HOMES Multi-disciplinary Hoarding Risk Assessment (HOMES)** is a brief checklist that uses informal rating scales that can be completed by anyone who is involved with a hoarding situation. HOMES assesses five domains associated with hoarding: health; obstacles; mental health; endangerment; and structure/safety. It can be downloaded from <http://vet.tufts.edu/wp-content/uploads/HOMES_SCALE.pdf>.

The **Activities of Daily Living in Hoarding (ADL-H)** investigates the effect that hoarding has on daily activities as well as the risks associated with clutter and hoarding. It presents 16 ordinary activities which are scored by totaling all of the activities that are recorded as being affected by hoarding/clutter. Seven questions refer to the quality of living conditions and six items investigate safety and health concerns and other harmful conditions. It can be downloaded from <http://www.springfieldmo.gov/DocumentCenter/View/3183>.

The **Saving Inventory – Revised (SI-R)** is a well-validated 23-item self-report questionnaire that is designed to measure three features of hoarding: excessive acquisition, difficulty discarding, and clutter. Scoring instructions are located at the end of the questionnaire together with a table of average scores of people who do not suffer from hoarding, as well as cutoffs for what may indicate a probable hoarding problem. The maximum score is 92 and score of 41 or higher typically indicates a clinical hoarding problem.  The SI-R can be downloaded from <http://www.psychologie.tu-dresden.de/i2/klinische/mitarbeiter/materialien/si-r.pdf>.

The **Hoarding Rating Scale (HRS)** is a 5-item semi-structured interview that can also be used as a questionnaire. The five questions ask about clutter, difficulty discarding, excessive acquisition, distress caused by hoarding, and impairment resulting from hoarding. The initial studies suggest that a score of 14 or higher indicates a probable hoarding problem. Each item is rated on a 9-point scale from 0 (none/no problem) to 8 (extreme problem). It can be downloaded from

<http://www.philadelphiahoarding.org/resources/Hoarding%20Rating%20Scale%20Assessment%20Tool.pdf> or from

<http://dhhs.ne.gov/children_family_services/ProtectionSafetyPolicy/APS%20Policy/Hoarding%20Rating%20Scale%20with%20Interpretation.pdf>

The **Clutter Image Rating (CIR)** is a pictorial measure of in-home clutter severity intended for use by clients, family members, clinicians, or independent assessors that can be used during office-based sessions as well as during home-based work. This scale contains three cards, each containing 9 equidistant, standardized photographs of severity of clutter, with one card for each of three main rooms of most people's homes: living room, kitchen, and bedroom. Participants and independent raters select the photograph that most closely resembles the level of clutter in each room of the participant's home. The rater selects the picture that is closest to the clutter in the living room, kitchen, bedroom, dining room, hallway, garage, car, and other area. Pictures are ranked from 1- 9. The CIR is available from the Boston University School of Social Work at

<http://www.bu.edu/ssw/research/hoarding/cirtool/>.

The **Saving Cognitions Inventory (SCI)** is a24-item self-report instrument that assesses beliefs regarding emotional attachment to items, possession control and responsibility, and concerns regarding overall memory. The scale ranges from 1 to 7, increasing in severity, and is scored by adding all of the sub-scores together. Each section (emotional attachment, memory, control, and responsibility) is scored separately to provide a measure of hoarding severity and attachment issues. It can be used when attempting to discard times. The SCI can be downloaded from

<http://www.philadelphiahoarding.org/resources/Saving%20Cognitions%20Inventory.pdf>.

The **Home Environment Index (HEI)** captures the extent of squalor or unsanitary conditions in the home. It is a 15-item instrument that can be downloaded from <http://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199340965.001.0001/med-9780199340965-interactive-pdf-008.pdf>.

The **Structured Interview for Hoarding Disorder (SIHD)** is a brief structured interview based on the DSM-5 diagnostic criteria for Hoarding Disorder. It consists of detailed questions and specifiers regarding each of the 6 DSM-5 criteria. The SIHD is available from <http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199937783.001.0001/oxfordhb-9780199937783-appendix-1>.

Instruments for determining the health of animals that can be used in animal hoarding situations include the following:

**Tufts Animal Care and Condition (TACC) scales** for assessing body condition, weather and environmental safety, and physical care in dogs can be downloaded from  <http://vet.tufts.edu/wp-content/uploads/tacc.pdf>

**Purina Body Condition Scoring** for cats and dogs can be downloaded from <http://www.neacha.org/resources/BODY%20CONDITION%20SYSTEM.pdf>

# Appendix C: Tips & Guidelines for Working with Consumers with HD

* Be respectful; use nonjudgmental words and behavior
* Do not impose your feelings (e.g., “You will feel better if…”)
* Value the person’s belongings
* It may be helpful to remember that the person’s attachment to their possessions may be as intense as those they have with people; possessions or objects often substitute for human relationships for people with HD.
* Initially, use a harm reduction approach to ensure safety
* Show empathy by indicating that while you understand that your presence is upsetting for the person, some kind of change is necessary
* Establish rapport by empathizing with the client’s point of view (e.g., by allowing them to tell stories) and providing emotional as well as physical support
* Show concern for the consumer’s safety
* Place the problem outside of the person
  + - Avoid using “you” or “your” (e.g., “You have got to get rid of some stuff”) and instead, say to the person, “I want to help you declutter your bed”
    - Refer to the items as the problem, not the person (e.g., “This stuff makes it hard for me to have the relationship I want with you”)
* Focus on safety issues, such as fires, fall hazards, and avalanche conditions
* Note possible ignition sources or trip hazards and try to build support for addressing these issues instead of insisting on an immediate and overwhelming cleanup
* Match the language of the person; use their language.
* If the person talks about their “collection” or their “things”, use that language
* Avoid using derogatory terms (e.g., “junk”, “trash”, or “hoarding”)
* Assign small achievable tasks/past achievements
* Offer praise frequently and with sincerity
* Never remove anything without discussion and the individual’s permission; never conduct a surprise cleanout.
* Expect slow progress; removing two bags of trash may seem insignificant to an outsider, but may feel like a great deal to a person with HD.
* Clearing a bed in order to use it for sleeping may take many hours and many sorting sessions.
* Ideal notions of cleanliness may not apply to hoarding situations; the person with HD may value items that appear to others as worthless or trash.
* The goal is not to create the ideal home environment or to be a reflection of others’ values of cleanliness.
* Goals should be based on minimum safety requirements and these should be reviewed with the client (e.g., “The home health agency will not provide services unless there are 24-inch paths for circulation and access to the bathroom is clear,” or “The retirement community has safety codes for the protection of all the residents that we need to meet…”).
* The individual’s ideas and plans for their belongings should be heard and their hopes (both realistic and unrealistic) explored.
* Intervention should be designed to help the person achieve at least some of their goals.
* The pace worked at should be set by the client, if possible, beginning with short periods of time in order to minimize the anxiety evoked by the decision-making process.
* Fall prevention should be a focus for older adults; pathways that are free of debris, loose cords, or slippery rugs should be created.
* Since some frail older persons hold onto furniture or other items while moving through the home, the client should be asked how they get around and props are not removed until other assistive devices (e.g., canes, walkers) can be introduced.
* Fire prevention should be a focus; the dwelling should have a working smoke detector; belongings should be moved from hazardous areas (e.g., newspapers stored on or inside the stove or near radiators) to safe places.
* Be creative, flexible and negotiate options; look for creative donation opportunities; perhaps the client can keep the previous year’s copy of a magazine, but discard the collection of issues from the past twenty years.
* Ask the person what they would like to do that they currently cannot because of the clutter (e.g., “Would you like to be able to take a bath? How could you do this differently so you could use the bathtub, which is currently being used for storage?”)
* Help the person conceptualize their situation in a realistic manner in order to increase their motivation for change.
* Some individuals will only take steps to reduce clutter when they are confronted with eviction or cannot be discharged to their home after a hospital stay.
* Offer gentle, but firm, pressure along with a reminder of the consequence if conditions are not improved is recommended.
* Establish a limited number of categories for belongings in order to minimize decision-making anxiety.
* Minimize the number of decisions the consumer needs to make at one time, with a focus on “keep” or “not keep” rather than “keep, donate, auction, eBay,” etc.
* Consider getting help from volunteers and informal support groups for de-cluttering which can require hundreds of hours; many people with HD may not be able to afford to hire professional organizers.
* Consider having a mental health professional who has established a supportive relationship with the client available during a major cleanout because cleanouts can be emotionally distressing for people with HD.
* Have a back-up plan in case emergency psychiatric services are needed.
* Draft a collaborative contract for the therapeutic work that is signed by the client, therapist and CHW/coach/professional organizer.
* The contract should spell out specific attainable goals and objectives with reasonable time frames and includes task the client is to accomplish
* Establish S.M.A.R.T. (specific, measurable, attainable, reasonable, and timely) goals with the client.
* Discuss how to safeguard valuables during the cleaning process with client; hoarded objects are typically piled without order so it is common to find valuables amidst trash.
* Document the agreement regarding what to do with valuables (e.g., money, jewelry, checks, bonds, stock certificates and collectibles) in the contract.
* If needed, contact the ASPCA to help find a temporary or permanent home for pets while a cleanout is being conducted.
* Consider relocating the individual to a new apartment if the clutter is due to a physical or mental difficulty; a new environment can provide a fresh start and enable the person to receive needed services sooner.
* Help the client maintain a sense of control over the cleanout process by involving them in setting goals for both the project as a whole as well as for each session while balancing their need to maintain control with the goals of the project.
* Be persistent and establish firm boundaries and time frames for getting tasks accomplished.
* Plan cleanouts ahead of time to minimize the occurrence of unexpected problems, including arrangements with the building for entrance and removal of trash and other possessions, use of elevators, for cost, rental and removal of dumpsters and for storage, if needed, including cost of transportation to a storage facility.
* Never leave dumpster and/or trash bags on the property after a cleanout, even overnight.
* Create a plan for ongoing maintenance and supervision after a cleanout.
* It is likely that the client will continue to hoard after a cleanout, and, without ongoing assistance, the home may become cluttered again because the underlying factors that contribute to hoarding remain.

# Appendix D: Best Practice Structure

According to the literature, the most effective intervention for HD incorporates the following components:

* Conduct an assessment of the client
* Focus on harm reduction
* Conduct an assessment of the home (through a home visit and/or pictures)
* Focus interventions on acquiring, discarding and organizing
* Provide exposure to sorting (in the home or in the office) and learning to recognize and manage the accompanying anxiety
* Establish a partner (home coach, professional organizer or community health worker, etc.) who can assist with home-based work
* Secure funding to help pay for services if the client does not have access to financial resources

# Appendix E: HD Treatment Components

* **Assessment and Case Conceptualization** 
  + - Start with client’s explanation
    - Add features based on interview and experimentation
    - Identify feelings, beliefs, core beliefs
    - Connect these to acquiring and saving behavior and clutter
    - Link vulnerabilities to feelings, beliefs and behaviors
    - Do functional analyses of individual features
* **Establishment of Personal Goals and Values**
* Values
  + - * What does the client care most about? (e.g., family, friends, honesty, achievements, etc.)
* Personal goals
  + - * What does the client most want to do in the remainder of his/her life?
      * Refer to personal goals and values throughout treatment to clarify ambivalence and increase motivation
* **Psychoeducation**
* Education about cognitive-behavioral model of hoarding
* Discussion of treatment and its effects
* Personalized model-building
* **Motivational Interviewing/Motivational Enhancement**
* Recognize ambivalence
* Enhance ambivalence
* Resolve ambivalence
* Reinforce change talk and action
* **Skills Training for Organizing and Problem-Solving** **(Cognitive Rehabilitation)**
  + Manage attention/distraction
  + Teach problem-solving skills:

Problem-solving steps:

1. Identify/define the problem
2. Generate as many solutions as possible
3. Evaluate solutions & select one or two that seem feasible
4. Divide solutions into manageable steps
5. Implement the steps
6. Evaluate the outcome
7. Repeat the process until a good solution is found

* **Cognitive Therapy** 
  + Identify common thinking errors
* All-or-nothing thinking (e.g., Most, everything, nothing)
* Overgeneralization (e.g., Always, never)
* Jumping to conclusions (e.g., I will need this just as soon as I do not have it anymore)
  + Identify distorted beliefs
    - Listen closely to statements during acquiring and discarding tasks
    - Use the Downward Arrow technique:

What would happen if you threw that out?

“I’ll never find it again.”

Why would that be so bad?

“I would lose an opportunity.”

What would be so bad about that?

“I’d be stupid for not taking advantage of an opportunity.”

What’s the worst part about that?

“Just that, I’d be a stupid person.”

Downward Arrow 2:

It sounds like you are worried that if you threw this out, that would mean you were a stupid person. Let’s take a look at that idea.

“I guess I never thought about it. I do worry about doing something stupid.”

Sounds like you also worry that you might be a stupid person. Does that seem right?

“Yeah, I guess so. All through school….”

* Evaluate and challenge beliefs
* Standard questions to challenge beliefs (e.g., How many do you already have? Do you have a plan for its use?)
* Socratic questioning to examine the beliefs (e.g., How well could you cope without having this? How distressing would it be?)
* Other cognitive strategies (e.g., advantages/disadvantages; taking another perspective: distinguishing need versus want)
* Behavioral experiments
* **Sorting/discarding/categorizing**
* Develop a hierarchy of increasingly difficult items for sorting, ranked from easy to hard

Remind the client that:

* Discomfort is expected
* Tolerating discomfort allows progress on clutter
* Reduction in anxiety and other negative emotions comes only through confronting them via exposure activities
* Select the target area and the type of possession
  + - Create categories for this type of possession
* Work in easier locations first (with highest motivation)
* Work on easier objects first; set aside harder objects into box labeled “to be sorted later”
* Continue cleanout until the target area clear
* Plan the appropriate use of cleared area
* Create a plan for preventing new clutter to area
* Gradually reduce therapist assistance in making decisions
* **Categorizing and Sorting Items:**
* Clients must think aloud when sorting
* OHIO (Only Handle It Once)
* Categorize unwanted items:
* Trash, recycle, donate, sell, and undecided
* Develop a list of items to be removed
* Develop an action plan for removing items
* Define categories for saved objects (non-paper):
* Keep similar items together (“like with like”)
* Choose a limited number of locations for each category
* Help client select final locations for categories of items
* Categorizing and filing paper:
* Help the client identify where to store paper
* Determine the materials needed to organize paper
* Ensure each paper category is included in the filing system
* Make categories for mail, newspapers, magazines
* **Establish Personal Rules for Saving and Acquiring:**

I must have:

* + - an immediate use for it
    - time to deal with it appropriately
    - money to afford it comfortably
    - space to put it
    - … [others]
* **Questions to Challenge Acquiring:**
* Do I need it?
* How many do I already have?
* Do I have an immediate use for this?
* Have I used this in the last year?
* Do I have a plan to use this?
* Can I manage without it?
* Can I get it elsewhere?
* Do I want it taking up space in my home?
* Does buying/keeping this help meet my personal goals?
* Will not buying/getting rid of this help my hoarding problem?
* Is this truly important or do I want it just because I was looking at it?
* What are the advantages and disadvantages of acquiring this?
* **Practice and Homework**
* Collect a box or bag of items from home to bring to the office
* Work from easier to harder items
* Sort similar items at home between sessions
* As skills are gained, bring in only difficult items to sort in office
* Make sure sorted items are moved to storage locations or out of home
* **Relapse Prevention**
* Review progress
* Plan strategies to continue progress
* Identify therapy methods that worked best
* Anticipate stressors, setbacks and lapses
* Plan strategies to deal with setbacks and determine resources for the future
* Discuss end-of-treatment concerns
* Review all skills and techniques
* Review rules and establish future rules
* Develop strategies to continue self-work
* Identify social support and pleasurable maintenance activities
* Develop strategies for setbacks
* Schedule booster sessions

# Appendix F: Saginaw Hoarding Task Force 2015 – 2016

**Mission**

*The Saginaw County Hoarding Task Force is a partnership of local public and private agencies whose purpose is to collaboratively seek to raise public awareness of hoarding and to preserve safe and appropriate housing by development and utilization of tools, best practices and early intervention strategies, by: 1) working with individuals to help achieve goals, mitigate the level of consequences of hoarding, and re-establishing home environmental quality and safety; 2) focusing on harm reduction principles; 3) recognizing that even if harmful behavior cannot be completely changed, modest behavioral change is beneficial, and meaningful and significant improvements can be made in quality of life; and 4) reducing the severity, impact and/or and harm for any individual citizen, families, neighborhoods, and the community, as well as the lead responding organizations.*

**Hoarding Definition**

*Hoarding definition includes the collection of many items, even things that are useless or are of little value to most people, and items clutter the living spaces and keep the person from using their rooms as they were intended, and these items cause distress or problems in day-to-day activities.*

**Community Task Force Members**

*Representatives on the Saginaw Hoarding Task Force include: Saginaw County Community Mental Health Authority; Saginaw County Commission on Aging; Saginaw Housing Commission; Saginaw Charter Township; Health Delivery, Inc.; Saginaw County Sheriff; The Ezekiel Project; City of Saginaw; Saginaw County Public Health Department; Saginaw Landlords Association; Training & Treatment Innovations; Saginaw County 911; City of Saginaw Police; Covenant HealthCare Visiting Nurse Association; City of Saginaw Fire Department; Saginaw County Department of Health and Human Services; Saginaw County Animal Control; Parishioners on Patrol.*

**Work Plan Goals**

● *Development and deployment of an evidence-based treatment model with trained clinicians/supports, with associated funded services and resources in Saginaw*

*● Development of treatment/intervention protocols including coordination with community first responders, home visitors, municipalities and other health and social resources*

*● Implementation of a public community education and information campaign, with a local central referral/information number and website*

*● Coordination of habilitation and/or property clean ups to reduce evictions/loss of usable homes, including deployment of volunteers and/or use of professional companies when indicated*

*● Coordinated community tracking and monitoring of at-risk home sites, with outreach and follow up as indicated*

*● Update of the Saginaw First Responder Guide to include hoarding resources and intervention and monitoring protocols*

*● Overall goal: Prevention and/or mitigation of the extent and seriousness of hoarding situations in Saginaw County through early and effective identification and intervention whenever possible*

# Appendix G: A Famous Case of Hoarding

One of the most famous cases of hoarding was that of Homer and Langley Collyer, two brothers from a prominent, if somewhat eccentric, New York family. They were known as the hermit hoarders of Harlem and both were killed by one of the many booby traps they had set to deter outsiders, but their bodies were hidden by tons of garbage and were not found for weeks.

For decades, the two lived in seclusion in their Harlem brownstone at 2078 Fifth Avenue (at the corner of 128th Street) where they obsessively collected books, furniture, musical instruments, and myriad other items, with booby traps set up in corridors and doorways to ensnare intruders. In March 1947, both were found dead in their home surrounded by over 140 tons of collected items that they had amassed over several decades.

Homer and Langley Collyer were born in 1881 and 1885, respectively, to Dr. Herman Livingston Collyer, a gynecologist at Bellevue Hospital, and Susie Gage Frost, a former opera singer. Not only was Dr. Collyer a first cousin to his wife Susie, but the two insisted that they could trace their family’s lineage back to a fictional ship, which they claimed landed in America a week after the Mayflower. In actual fact, they were descendants of the Livingston family, which while still an old and established New World line, didn’t immigrate to America until 1672 – more than half a century after the Mayflower.

Dr. Collyer was known to be eccentric. He’d often use a canoe to paddle himself from Manhattan to the City Hospital on Blackwell’s Island (now Roosevelt Island) where he sometimes worked. Neighbors would see him carrying the canoe through the city streets during his commute to and from the river. The brothers, as they aged, followed increasingly in their father’s odd footsteps.

Born in the late 1800s, the brothers both attended Columbia University. Homer had been Phi Beta Kappa at Columbia, where he studied maritime law. Langley studied engineering and chemistry, while also playing concert piano well enough to have performed at Carnegie Hall.

Their father abandoned the family in 1919, and the boys lived with their mother until she died in 1926 and they continued living in their three story brownstone. Homer practiced law, Langley sold pianos, and both taught Sunday school. The pair routinely socialized in and outside of the brownstone.

In 1933, Homer suffered hemorrhages in the back of his eyes, and, went blind. Langley devised a remedy diet for Homer of 100 oranges a week accompanied by black bread and peanut butter. Langley quit his job to care for his brother, and the two began to have less and less contact with the outside world.

Despite their ample inheritance, the brothers allowed first their phone, then their gas, water, and steam heat to be shut off. The brothers heated the house with a kerosene heater and attempted to convert a Model T into a device to generate electricity. Langley brought water home from a park four blocks away.

While both brothers were cordial, no one was allowed into their home. After Homer became blind, he was rarely seen in public. The brothers might have continued to live their lives in relative anonymity had they not come to the attention of a reporter for the World-Telegram, who wrote an article citing the many fantastic rumors that been circulating about the brothers and their home, including that the brownstone was full of expensive furnishing and huge amounts of cash. People began attempting to visit them, and schoolchildren began vandalizing the house.

Over the years, Langley was seen visiting his neighbor’s trashcans at night and hauling rubbish home with him. He then arranged the materials in such a way as to create tight tunnels through which he traveled about the house. He also constructed traps made of large piles of debris.

 When the police responded to an anonymous call reporting a dead body on the premises on March 21, 1947, they were unable to force their way into the first floor of the building. While additional police officers arrived to cordon off the swelling crowd of onlookers (estimated at 600), officers used ladders to access the second floor of the building. The body of Homer Collyer was soon found, emaciated, and dressed in a ragged grey bathrobe, dead for ten hours.

Officers began their search for Langley Collyer. Hampered by the clutter, it was nineteen days before they discovered his body, pinned by one of his own booby-traps, only eight feet from his brother’s cot. By then, the crowd of several thousand onlookers had seen 140 tons of rubbish hauled from the home, including: a kiddy car, the folding top of a horse-drawn carriage, a Steinway piano, a horse’s jawbone, a cavalry saber, more than 25,000 books, and the chassis of a Model-T Ford.

# Appendix H: Common Misconceptions about Hoarding

* Individuals who hoard have low standards of cleanliness.

FALSE: Hoarding is not a result of low standards of cleanliness, housekeeping, or a lack of responsibility. In fact, the opposite can be true.

* Individuals who hoard are lazy.

FALSE: Hoarding is a mental health disorder not a personality trait. People who hoard value items beyond the items’ actual worth.

* A hoarding problem can be solved by doing a major clean out.

FALSE: At times a clean out is needed to preserve the individual’s housing or for safety reasons; however, a major clean out is traumatic and only addresses the symptom. The individual has a strong need to acquire and save items and the items are very important to the individual; so important that the hoarder might risk losing their home or relationships

* Hoarding primarily affects older adults who lived through the Great Depression.

FALSE: Hoarding habits cross all ages and is not deprivation based. Those who lived through the Great Depression are not more likely to hoard than those who did not.

* Hoarding primarily affects people who are poor.

FALSE: Hoarding spans all economic, educational, and professional levels.

* Individuals who hoard do not feel shame or embarrassment.

FALSE: Individuals who hoard often put off repairs and will avoid asking for help so as not to let people into their home.

* People who hoard are selfish.

FALSE: Some individuals hoard in order to save for others. They feel the items are useful and someone else may be able to put them to use.

1. It is estimated that only about eighteen percent of individuals with hoarding symptoms meet the full criteria for OCD. [↑](#footnote-ref-1)
2. HD has been found to have a high degree of heritability and individuals with the disorder tend to have first-degree relatives who engage in hoarding. There is some initial evidence suggesting a linkage might exist on chromosome 14 (specifically, the L/L genotype of COMT Val158Met polymorphism on chromosome 14). [↑](#footnote-ref-2)
3. Late onset of HD is rare but symptoms may develop subsequent to a brain injury, specifically, damage to the medial prefrontal and orbitofrontal cortex (which disrupts a mechanism that modulates subcortically driven predispositions to acquire and collect and adjusts these predispositions to environmental context). [↑](#footnote-ref-3)
4. While research on the pathophysiology of HD is relatively nascent, studies using fMRI imaging show fronto-limbic abnormality in persons with HD. In addition, excessive activation in the anterior cingulate cortex (which is involved with decision-making, particularly in situations involving conflicting information or uncertainty) and the insula (a region that monitors emotional and physical states which is also involved in disgust, shame and other strong negative emotions) have been found. Together, these regions help assign relative levels of importance or significance to objects. [↑](#footnote-ref-4)
5. The first animal hoarding law was enacted in Illinois in 2001 due to a proliferation of severe animal hoarding cases. It amended the Illinois Humane Care for Animals Act to include a legal definition for a “companion animal hoarder,” and specific prohibitions against hoarding animals with felony criminal consequences. It provides prosecutors with a legal definition of animal hoarding, increased penalties for animal abuse from a misdemeanor to a felony and enables judges to order psychiatric evaluation and treatment for offenders, at the expense of the convicted person. Animal owners are required to pay a bond for the care of animals seized in abuse cases and to provide assistance to shelters charged with the animals’ care. If a court-ordered bond is not posted within five days of the seizure, ownership of the animals transfers to the sheltering agency, and the animals can then be offered for adoption. The statute also allows veterinarians, animal welfare investigators, or law enforcement officers to take an animal into protective custody without a court order if it is believed that the animal had been abused or its life was in danger. Finally, it stipulates the procedural process for allegations of animal hoarding to prevent the inclusion of individuals operating lawful animal rescues. [↑](#footnote-ref-5)
6. Persuasion should be avoided since it can lead to further strengthening of beliefs that disposal of items is unnecessary. [↑](#footnote-ref-6)
7. Cognitive Restructuring (CR) entails learning to identify and dispute irrational or maladaptive thoughts known as cognitive distortions (e.g., all-or-nothing thinking (splitting), magical thinking, filtering, over-generalization, magnification, and emotional reasoning) which are commonly associated with many mental health disorders. [↑](#footnote-ref-7)
8. Socratic questioning is a cognitive restructuring technique that is used to help uncover the assumptions and evidence that underpin thoughts with respect to a problem. Socratic questioning enables a therapist to challenge recurring or isolated instances of illogical thinking while maintaining an open position that respects the internal logic to even the most seemingly illogical thoughts. [↑](#footnote-ref-8)
9. Churning consists of moving items around and not disposing of any items. [↑](#footnote-ref-9)
10. Additional information on PBS can be found in the Saginaw County Community Mental Health Authority’s publication titled [*A Guide to Evidence-Based Practices for Individuals with Developmental Disabilities*](https://www.sccmha.org/userfiles/filemanager/292/). [↑](#footnote-ref-10)
11. The first hoarding task force started in Fairfax County, VA in 1989. [↑](#footnote-ref-11)
12. A hybrid model combines two or more of the primary structures (i.e., education and case consultation; case consultation and direct intervention). [↑](#footnote-ref-12)