Compulsive hoarding is a pattern of thoughts (obsessions) about discarding items and repetitive behaviors (compulsions) of collecting things. One in 20 people experiences compulsive hoarding, with severity ranging from mild to life-threatening. According to the American Psychiatric Association, the onset of symptoms is usually between ages 11 and 15, becoming problematic in the 20s and progressively increasing in severity with advancing age. Hoarding is twice as common among men as women, but women are more likely to seek treatment. One study demonstrated a genetic vulnerability, with at least one first-degree relative also exhibiting hoarding behavior.

In this article, I’ll give you an overview of hoarding disorder, including how to recognize it, available treatment options, and patient and family teaching points.

Classifying hoarding behavior

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has included a new diagnostic category for hoarding disorder. In the past, hoarding behaviors were included in the obsessive-compulsive disorder (OCD) category, but research has demonstrated that hoarding is a distinct disorder requiring distinct treatment (see OCD or hoarding disorder?).
disorder
By creating a separate diagnosis, the hope is that more research and development into specific treatments for hoarding behavior will occur.

The DSM-5 diagnostic criteria for hoarding disorder start with persistent difficulties discarding or parting with possessions, regardless of the value. These behaviors result in an accumulation of possessions that clutter the active living areas of the home, workplace, yard, or vehicle, preventing normal use of the space. Other diagnostic criteria include:

- severe distress that occurs when any attempt is made to throw away items
- indecision about what to keep or discard
- suspicions of other people touching the items
- obsessional thoughts of running out of an item or needing it in the future
- checking the trash for accidentally discarded items
- functional impairment, such as loss of living space, social isolation, dysfunctional interpersonal relationships, financial problems, and health hazards.

In addition, these symptoms can’t be attributed to any medical condition, such as brain injury, or another mental illness, such as OCD or delusions from psychosis.

**Why can’t hoarders let go?**

Brain imaging shows a pattern of brain changes in people with hoarding disorder. These individuals have less activity in the cingulate gyrus—the part of the brain that communicates with the limbic, or emotional, center and the neocortex, or thinking, center. If activity is reduced in the neocortex, a person may have difficulty with attention, problem solving, and decision making. And when communication between the neocortex and limbic system is compromised, a person assigns more emotional meaning to stimuli. This means that an individual with hoarding disorder can have trouble with both the emotional and cognitive aspects of stimuli.

Other studies have looked at the neuropsychological testing of compulsive hoarders who didn’t exhibit any criteria for OCD. These studies also found brain hypoactivity, with slow decision making and difficulty with attention and spatial tasks, contributing to difficulty staying focused, organizing, and developing strategies for categorizing and sorting that are necessary for decreasing accumulation. The result for individuals with hoarding disorder? Making decisions about items, sorting them, and discarding them becomes unpleasant and insurmountable.

So what drives the behavior of those with hoarding disorder? The behaviors of people with OCD are driven by reducing anxiety. However, the behaviors of the compulsive hoarder are driven by intrusive thoughts about not having something that may be deemed valuable and not being able to discard something. Individuals with OCD are

<table>
<thead>
<tr>
<th>OCD or hoarding disorder?</th>
<th>OCD</th>
<th>Hoarding disorder</th>
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<tbody>
<tr>
<td>Are obsessions present?</td>
<td>Yes</td>
<td>Yes, fear of losing something deemed valuable</td>
</tr>
<tr>
<td>Are compulsions present?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is behavior motivated by anxiety?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do medications work?</td>
<td>Yes</td>
<td>Not as well as with OCD</td>
</tr>
<tr>
<td>Does the patient understand that the behaviors aren’t rational?</td>
<td>Yes</td>
<td>No</td>
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</table>
usually aware of the irrationality of their thoughts or behaviors, but individuals with hoarding disorder lack this insight and don’t see their behaviors as a problem. Usually, compulsive hoarders are identified by social agencies or law enforcement when the hoarding starts to present a community danger.

Consequences of hoarding
Hoarding disorder causes social and economic burdens, as well as environmental hazards and health risks. There’s a high rate of divorce among compulsive hoarders; family members may experience frustration at and anxiety about their loved one’s hoarding behaviors. People with this disorder miss more days of work and use mental health services five times more than the general population. In addition, individuals with hoarding disorder have increased medical comorbidities, such as stroke, gastric ulcers, diabetes, and heart disease. Often, compulsive hoarders fail to seek medical care either because they’re embarrassed about their behavior or they don’t feel that they have a problem.

Environmental hazards
In one study, 42% of hoarders had blocked access to the refrigerator, stove, and bathrooms, causing filthy or unsafe living conditions. Often, feces and urine were found in containers on the bed or in the house; dead animals were also found. People with hoarding disorder have clutter throughout their houses with small, navigable trails or areas that are no longer navigable. Excessively cluttered bathrooms, kitchens, and bedrooms cause sanitation, hygiene, and food preparation problems. The weight of the items may also lead to structural damage to the house that can result in collapse. Large amounts of clutter also pose a fire hazard, especially when outlets are blocked or electrical appliances are being used with things piled on or in them. If there was a fire, the house of a compulsive hoarder would be difficult to leave in an emergency and difficult for firefighters to get in quickly.

Health risks
Health risks include injuries from falls or objects falling from piles and infestations of fleas, rats, mice, or bed bugs. The cluttered condition makes it difficult for extermination to occur. Dust, mildew, and high ammonia levels from waste products can increase respiratory problems. Lastly, the risk of parasites and food-related illnesses are also increased.

Financial burdens
Individuals with hoarding disorder often spend most of their money buying items, causing problems with meeting financial obligations such as rent, heat, and food. With the cluttered environment making it hard to cook in the kitchen, the added expense of takeout food can also limit the money available for other bills. Legal difficulties are also increased for people with hoarding disorder. They may risk eviction or their homes being condemned for public safety reasons. Children may be removed from the home and the individual with hoarding disorder may be charged with child neglect. People who hoard animals

key points
Nursing interventions
- Build trust with the patient and be nonjudgmental.
- Assess the patient’s hoarding behaviors.
- Instruct the patient about stress reduction techniques.
- Teach the patient about the possible consequences or risks of hoarding behaviors.
- Help the patient set small, realistic goals to remove clutter.
- Educate the patient’s family members about hoarding disorder and to expect slow change and possible relapse.
may be charged with animal cruelty, which is a felony charge in some states. The cost of legal problems further increases the financial burden.

Effects on children
Often, compulsive hoarders have small children living with them. The children of parents with hoarding disorder may feel isolated and experience depression. Having friends over is most likely not an option because the child feels embarrassed with the living situation or may be told not to invite friends to the home. In addition, children are exposed to environmental and health hazards if there isn’t a place to perform hygiene tasks, wash their clothes, or eat safely. Lastly, they often compete with the hoarded items for attention and love from the parent.

Intervention mention
There’s no cure for hoarding, but you can help your patient develop healthier behaviors and attain a better quality of life. Nurse can screen for hoarding disorder and make a referral to mental health services. In fact, the Hoarding Rating Scale (HRS) and Clutter Image Rating Scale (CIRS) are screening tools that can be used to identify people at risk for this disorder. The HRS uses verbal cues, whereas the CIRS uses pictures to help screen for hoarding behaviors.

Mental health professionals may use family intervention, medications, and cognitive behavioral therapy to treat hoarding disorder.

Family intervention
When family members are interested in an intervention for their loved one’s compulsive hoarding behaviors, they first meet with a therapist to learn about the disorder and treatment options. The family members must be cohesive and agreeable to the intervention because the person with hoarding disorder can’t be helped if the family fears the consequences of the intervention. Sometimes the therapist will have the family practice the intervention before it actually occurs.

Next, the family members arrange to talk as a unit to their loved one about the effect of the clutter on their lives and what help is available. Each of the family members explains in a nonjudgmental way why he or she is concerned. It’s a critical element for all family members to communicate clearly that the treatment is mandatory. The intervention may take place in the hoarder’s home or in a therapist’s office. The therapist may be present during the initial intervention or available immediately after the intervention for the first therapy session.

The goal is that when the individual with hoarding disorder faces a cohesive group of people who are concerned for him or her, it will be hard to hide or minimize the problem. The intervention is just the first step. Both the hoarder and his or her family members must commit to ongoing therapy to address the issues that surround the behaviors and learn how to handle future behaviors or issues that may arise during the change process.

Medications
Selective serotonin reuptake inhibitors (SSRIs) are effective in treating the symptoms of OCD; however, they aren’t as effective in treating people with hoarding disorder. If the individual with hoarding disorder has coexisting anxiety disorder or depression, he or she may benefit from treatment with SSRIs. Treatment of anxiety and depression may increase the success of engaging the compulsive hoarder in psychotherapy. Fluoxetine, sertraline, paroxetine, citalopram, and escitalopram are the SSRIs most commonly used.

Potential adverse reactions of SSRIs include sexual dysfunction, gastrointestinal (GI) upset, mild sedation, and restlessness. For many patients, these adverse reactions

Because the chance of relapse is high, educate the patient’s family about what to expect during therapy.
diminish after 2 to 4 weeks of taking the medication. If they persist, the healthcare provider may prescribe a different type of SSRI. Patients shouldn’t abruptly stop taking an SSRI; if they do, they may develop discontinuation syndrome. Symptoms of discontinuation syndrome include dizziness, headache, diarrhea, insomnia, irritability, nausea, and lowered mood. The FDA has a black box warning indicating that antidepressants may increase the risk of suicidal thinking and behavior in some people. Patients taking SSRI medications should be closely monitored for an increase in depression or the start of suicidal ideation for the first 4 weeks of treatment.

SSRIs use the same drug metabolizing enzyme pathway in the liver as other medications, such as anticoagulants, cardiac drugs, or drugs used to treat diabetes. Be prepared to intervene if the patient is showing signs of a drug-drug interaction while taking an SSRI. For example, if an SSRI is prescribed for a patient taking warfarin, his or her international normalized ratio should be closely monitored to ensure adequate anticoagulation. The warfarin dosage may have to be adjusted up or down.

Serotonin syndrome is a potentially life-threatening drug interaction. It can occur when two medications that increase the serotonin level are combined, potentiating serotonin neurotransmission. The increased serotonin level throws off the body’s autonomic regulation. Symptoms of serotonin syndrome include hyperthermia, restlessness, tachycardia, labile BP, changes in mental status, diaphoresis, and tremors. Serotonin syndrome progresses rapidly; if the early signs aren’t promptly recognized, the patient can develop seizures and respiratory failure leading to coma. If your patient develops serotonin syndrome, immediately discontinue all medications, notify the healthcare provider, and treat the symptoms. The healthcare provider may prescribe medications to block the effects of the SSRI and treat hyperthermia and seizures.

Tricyclic antidepressants (TCAs) may also be used to help with coexisting anxiety or depression. TCAs have a high anticholinergic effect due to their action on histamine receptors. Sedation, dry mouth, weight gain, and constipation are some of the adverse reactions that may result in nonadherence (see Managing adverse reactions of antidepressants). Cardiotoxicity can occur with slowing of cardiac conduction due to increased PR and QRS intervals. In addition, TCAs can be fatal in overdose, which may cause safety concerns.

Managing adverse reactions of antidepressants

<table>
<thead>
<tr>
<th>Condition</th>
<th>Suggestion</th>
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<tbody>
<tr>
<td>Dry mouth</td>
<td>Advise your patient to drink plenty of water, chew sugarless gum, and clean his or her teeth at least once daily.</td>
</tr>
<tr>
<td>Constipation</td>
<td>Encourage your patient to eat whole-grain cereal, prunes and other fruits, and vegetables.</td>
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<tr>
<td>Sexual problems</td>
<td>Inform your patient that sexual functioning may change; encourage the patient to discuss problems with his or her partner and consider switching to another medication if problems persist.</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Teach your patient to rise slowly from a sitting position.</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>Advise your patient not to drink alcohol while taking an antidepressant and not to drive while drowsy.</td>
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Clomipramine is effective in treating the symptoms of OCD and may be effective for treating hoarding disorder. When any psychiatric medication is prescribed, thoroughly explain its actions and adverse reactions in appropriate language to the patient and family (see Medications used to treat hoarding disorder). Awareness of cultural differences is also valuable when initiating psychotropic treatment. In your assessment history, determine any genetic or dietary/herbal influences on metabolism. If English isn’t the patient’s primary language, take steps to ensure that he or she understands the information you provide. Enlisting the support of translators is advantageous to aid in adherence.

Cognitive behavioral therapy
Cognitive behavioral therapy is effective in treating hoarding disorder and considered a first-line treatment. In this therapy, the goal is to change a person’s automatic thoughts, which occur spontaneously and lead to dysfunctional thinking. According to this type of therapy, psychological pain stems from what the person thinks an event means rather than what actually happened. In hoarding disorder, cognitive behavioral therapy focuses on excessive acquisition, difficulty discarding possessions, disorganization, and clutter.

The therapist can first help the patient identify his or her beliefs and attachments to an item. Then an exploration into feelings about getting rid of possessions occurs. Finally, a strategy for organization and decision making about removal of the clutter is taught. After treatment begins, the change is slow, with relapse twice as high due to the difficulty that the compulsive hoarder may have in understanding or accepting the disorder. Because the belongings are often viewed as an extension of the person who hoards, many patients will resist the change or procrastinate.

Group treatment can be an important part of recovery for the compulsive hoarder. Shame and isolation can be decreased by getting people together who have a similar problem. By listening to each other’s stories, groups can increase motivation and instill hope. The Internet may be helpful in supporting compulsive hoarders. Virtual self-help groups provide advice for dealing with the clutter or shame. Web-based cameras can allow family members who live far away to monitor a relapse into hoarding behavior. Also, virtual face-to-face therapy can be facilitated through sites such as Skype.

<table>
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<tr>
<th>Class</th>
<th>Medications</th>
<th>Adverse reactions</th>
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<tbody>
<tr>
<td>SSRIs</td>
<td>Escitalopram</td>
<td>General: sexual dysfunction, GI upset, sedation, and restless</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine</td>
<td>Discontinuation problems: nausea, headache, dizziness, and flulike symptoms</td>
</tr>
<tr>
<td></td>
<td>Paroxetine</td>
<td>Serotonin syndrome: confusion, hallucinations, agitation, BP changes, nausea/vomiting, and seizures</td>
</tr>
<tr>
<td></td>
<td>Sertraline</td>
<td></td>
</tr>
<tr>
<td>TCAs</td>
<td>Amitriptyline</td>
<td>Dry mouth and eyes</td>
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<tr>
<td></td>
<td>Imipramine</td>
<td>Constipation</td>
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<td></td>
<td>Nortriptyline</td>
<td>Weight gain</td>
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<tr>
<td></td>
<td>Desipramine</td>
<td>Sedation</td>
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<tr>
<td></td>
<td>Clomipramine</td>
<td>Cardiac dysrhythmias</td>
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</table>
Your eyes and ears are needed

Nurses are key in the identification of patients with hoarding disorder. When a person seeks healthcare for a medical problem, you can listen to the patient and family’s concerns about the living environment. Observe if the patient is collecting things during his or her hospital stay, such as medicine cups, silverware, or trays. Does the patient have trouble throwing out items while hospitalized? Part of your nursing assessment can include questions about collections that the patient may have, any difficulty he or she has discarding items from the collection, trouble organizing the collection, or hard feelings when someone else touches items from the collection. Talk to family members to get an additional view on the behaviors.

The first step is to build trust with a caring attitude and nonjudgmental approach that demonstrates respect for the patient. Encourage the patient to talk about the effects of hoarding behaviors. To provide this open communication, first examine your own feelings about compulsive hoarding. Empathy with the patient involves trying to understand the attachment that he or she has to the belongings. Instead of confronting the patient about hoarding behaviors, help him or her identify feelings attached to the behaviors and the reasons that giving them up may be hard.

Next, discuss the consequences of hoarding behaviors, such as eviction, loss of valuable relationships, and safety hazards. Then talk about the benefits of changing these behaviors, such as reuniting with loved ones and increased living space. Help the patient identify ways that he or she can improve home safety, such as removing clutter from hallways, stoves, and heating sources. Because discussion about hoarding behaviors can cause anxiety, teaching the patient relaxation techniques may be valuable.

When social agencies or law enforcement are involved, include family members or social workers so that an action plan can be communicated to the agency. Referral to a mental health professional who has expertise in hoarding disorder can be valuable for both the patient and the family. Offer a list of practitioners or help the patient call for an appointment. Because the family will probably be involved in the intervention, include them during education about hoarding disorder and offer local resources that can help. With the family, stress the importance of not just emptying the house of all belongings as a quick solution to the problem; the hoarding behaviors will return. It’s important that the compulsive hoarder be involved in removing the items so he or she can develop decision-making and sorting skills and have a sense of control over the environment.

Lastly, after the patient with hoarding disorder is in treatment, family members should continue to encourage and coach healthy behaviors. It’s important to acknowledge the patient’s need for control and emotional attachment to the items. Also, family members must recognize that progress will be slow and the patient may relapse.

Healthier and happier

Although there’s no cure for hoarding disorder, you can help your patient develop healthier behaviors and become more content with daily living and relationships.

[on the web]

- American Psychiatric Association: http://www.psychiatry.org/hoarding-disorder
- Anxiety and Depression Association of America: http://www.adaa.org/understanding-anxiety/obsessive-compulsive-disorder-ocd/hoarding-basics
- Columbia University Medical Center: http://www.columbiapsychiatry.org/hoarding/
- International OCD Foundation: http://www.ocfoundation.org/hoarding/
- Mayo Clinic: http://www.mayoclinic.com/health/hoarding/DS00966
- University of California, San Diego: http://psychiatry.ucsd.edu/OCD_hoarding.html


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