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Cognitive behavioural treatment for problematic hoarding: A case study

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Abstract

A fifty one year old man's difficulties associated with hoarding are presented using a case study methodology. A psychological formulation and treatment plan is constructed following the work of a case study by Frost and Steketee, (1998). Despite some improvements in his functioning and clinical scores the overall reduction in clutter did not meet expectations. The focus of the discussion is the lack of published literature on hoarding behaviour, and the implications this has on interventions. Also highlighted are the issues associated with psychiatric diagnosis and the way in which this can influence decision making.

Keywords: CBT, Hoarding Case study

Introduction

Hoarding is the gathering of, and failure to throw away, large numbers of possessions that appear to be useless, or have limited value. For hoarding to be seen as a disorder living spaces must also be sufficiently cluttered so as to stop activities for which those spaces were designed, the individual also needs to be significantly distressed or to show an impairment in functioning caused by the hoarding (Frost and Hartl, 1996). Frost, Steketee and Williams (2000) performed a scoping exercise by contacting 88 health departments in Massachusetts, USA, serving a population of 1.79 million people. From their study a prevalence of 2.6 people in 10,000 displaying problematic hoarding behaviour can be calculated. The authors concluded that hoarding behaviours were judged to seriously jeopardise the health of the individual and those around them. However, the actual prevalence of problematic hoarding may be a lot higher as the above study only investigated cases that had already come to the attention of the health departments.

Hoarding behaviour can be present in a variety of disorders, including anorexia nervosa, organic mental disorders, psychotic disorders, obsessive-compulsive personality disorder and learning disability; however, the majority of research links hoarding to obsessive-compulsive disorder (OCD; Frost and Hartl, 1996). Frost and Hartl (1996) found that compulsive hoarding is a little studied phenomenon within published literature and that the information is diverse and not well integrated. The limited research on treatment for hoarding behaviour suggests that medications for OCD are largely ineffective and that the current evidence base concerning treatment supports cognitive and behavioural approaches (Steketee and Frost, 2003). However, the evidence base for individual interventions for problematic hoarding is mainly derived from case studies (e.g. Frost and Steketee, 1998; Hartl and Frost, 1999; Cermele, Melendez-Pallitto and Pandina, 2001; Seedat and Stein, 2002). Of the available research on hoarding found, the majority centres on theory and not practice; most single case studies and reports have been descriptive rather than treatment orientated. It is apparent that to ascertain the effectiveness of cognitive and behavioural treatments in managing hoarding behaviours there is a need for additional research (Seedat and Stein, 2002). The most practice based case report found was the work by Frost and Steketee (1998).

Frost and Steketee (1998) suggest that hoarding involves four types of deficits:

1) Information-processing deficits; in particular decision making difficulties, categorisation/organisational issues, and memory problems
2) Problems with emotional attachments to possessions; whether it is sentimental or security based
3) Behavioural avoidance; saving possessions allows the hoarder to avoid the loss of objects that may be needed someday, hoarding prevents emotional upset associated with discarding possessions, and also hoarding avoids decision making.
4) Distorted beliefs about the nature or importance of possessions; i.e. unrealistic beliefs about the probability and severity of negative consequences if possessions are discarded.

Frost and Steketee (1998) applied their hoarding model to a single case study, and from this developed a treatment strategy that involves the three processes described above. The first of these is training in decision making and organisational skills: This involves category creation (keep object, sell/donate object, or discard object), the primary goal is to create uncluttered living space, with a secondary goal of increasing the appropriate use of space. This training should be performed in the context of weekly excavation sessions with homework between sessions. The excavation session incorporates the second aspect of the treatment, exposure to discarding: the primary goal being to habituate the associated anxiety. Cognitive restructuring of hoarding related beliefs is the third component: this can also be done during the excavation sessions when unhelpful beliefs are expressed. Frost and Steketee (1998) put forward that each session should begin with a target area being agreed upon, then category creation, excavation can then begin with cognitive restructuring utilised where appropriate. In their study, Frost and Steketee (1998) worked with their client for 35 sessions.

With the inherent limitations of basing treatment on case study methodology the current study has tentatively explored existing research in order to find a model and associated treatment plan. How this was applied an individual with problematic hoarding will now be presented.

Clinical case presentation

Background

Fred[1] was a fifty-year-old man living in an inner city area of London. He described his early home atmosphere as difficult, as his father was an alcoholic and suffered from depression. School was hard for Fred as he felt he didn't fit in, like he was a "leper". From seven to ten years old Fred went to a boarding school where he suffered physical and sexual abuse, he describes this period as "hell". He left school with six O-Levels and begun an art course. After this he worked as a photographer, he worked on and off until the age of thirty-six. He had some relationships but none that lasted long term. Although he had always drunk alcohol heavily since being an adult his alcohol use became out of control in his thirties and he had periods of homelessness.

Fred first came into contact with mental health services at the age of forty-four when he was referred to a psychiatrist due to his alcohol misuse. In addition to his problems with alcohol it was suggested that he had a diagnosis of OCD, characterised by ruminatory thinking and hoarding behaviour. He successfully completed a community alcohol detoxification and then attended group psychotherapy for two years. He was then referred to a day hospital for further group work and key working. On meeting Fred he had been abstinent from alcohol for two years. He had not had a relationship for many years and rarely contacted his family. He lived alone in a one-bedroom housing association flat and was training in alternative medicine. Although engaged in community activities he was socially isolated and had no real connections apart from at college and with health professionals. He presented as stable throughout our time together, he was relaxed and calm and responded well in conversation, however at times he came across as very

[1] name changed to assure confidentiality, and consent given to be the subject of this case study

intense in regards to his mannerisms. Fred was always on time for our appointments and seemed fully engaged with the process.

Presenting problems

Fred reported that his flat was full of his possessions and there wasn't enough living space. For years Fred had brought, and also found, lots of items that he took home. Whilst at home he spent his time 'churning' the objects around the house and putting them into different categories. Fred got the urge to go through his possessions, without throwing them out, all the time he was in the flat, he acted on the urge until he distracted himself doing college work, listening to the radio, or by sleeping. What Fred feared most of all was that he would get too anxious when throwing things away as he thought he may need them again in the future. Fred found as a result of his problem that he had less time to do the things he wanted to. He never had people around to the flat; he reported that no one had been there in over 18 months. Fred described the problem as a sense of hopelessness, which lead to a low mood and despair. Practically Fred was unable to bathe or shower at his flat, unable to cook anything but simple meals and had to sleep on a board on top of the clutter.

Fred believed that his problem with hoarding went back to childhood, as he had always been messy and his home life was chaotic. Fred stated that the urge to hoard had been with him as long as he could remember; and once he was allocated his own flat a few years ago he was able to act on his urges. He had never had treatment for his hoarding behaviour, only for alcohol misuse. Fred had read books and papers regarding hoarding and he sometimes looked into alternative medicine to find help.

Measurement tools and goals for therapy

Obsessive Compulsive Inventory

The Obsessive Compulsive Inventory (OCI; Foa et al., 1998) is a measure of the frequency of a range of obsessions and compulsions and associated distress. The measure can be used for diagnosis and to determine the severity of OCD. The OCI has 42 items,

for each item a rating is made for frequency from 0 (never) to 4 (almost always), and for distress from 0 (not at all) to 4 (extremely). Total frequency and distress scores can be calculated, scores range from 0 (no frequency or distress) to 168 (highest frequency and distress). For an OCD group the mean total frequency score was found to be 66.36 (SD = 29.4), and for total distress score was 66.33 (SD = 31.9). For a control group the mean total frequency was 34.15 (SD = 21.2) and for mean total distress was 25.25 (SD = 20.8) (Foa et al. 1998).

At assessment Fred's total frequency score was found to be 85 and his total distress score was 83. With these scores Fred would compare to the OCD group.

Clutter Ratios

A visit to Fred's flat was undertaken after the initial meeting to assess the level of hoarding. The flat and the areas of cluttered space were measured. Clutter ratios (Frost and Steketee, 1998) were taken: For floor areas: Living room/kitchen = 92%, Bathroom = 88%, Hallway = 81%, Bedroom = 100%. For all surfaces and furniture = 100% (Clutter ratios are calculated by dividing the area of total room or surface space by the by the area that is cluttered. Mean score for sample populations is 5%). A video recording and still images of the flat were also taken (images can be found in the appendix 1).

Goal Statement

"I would like to feel comfortable with having a friend around for dinner. I would also like a 50% reduction in the clutter in my flat; I would like to achieve this in 3 months." Fred rated that to achieve this now would be extremely difficult (8 on a scale of 0-8, 8 being the highest).

Psychological formulation

Fred believed that "he had an unsatisfactory relationship with his parents and therefore had formed relationships with his possessions". It could be hypothesised that the possessions hold an unrealistic value to Fred, as he is so reluctant to throw them away.

Furby (1978) developed this notion of relationships with objects by suggesting that there are two types of hoarding; instrumental saving, where the possession fulfils some desire or purpose; and sentimental saving, where the possession serves as an extension of the self (i.e. it has an emotional attachment). From Fred's early experiences of an unsettled home life and abuse it can be speculated that he had difficulties forming appropriate attachments to care givers. He may have seen himself in a negative way and not trusted others. To cope with the difficult feelings this would have produced he turned to alcohol as a way of coping. This eventually led him to being homeless, thus emphasising the importance of security and possessions. Then years later when he stopped drinking and found new accommodation the difficult feelings returned and he started to hoard as a way of fulfilling his need for meaningful attachments.

The problem was maintained through Fred's collecting of 'useful' items and his avoidance of throwing away items in his flat. When he was in his flat looking at the 'clutter', Fred thought "I must get rid of all these things". He then mentally pushed these thoughts away, as he began to feel anxious and tired, as a result Fred either left the flat, went to sleep or more often than not spent time 'churning' and categorising the clutter, but not throwing it away as he makes information processing errors. Fred believed that throwing away possessions causes anxiety, if he purposely avoided the discarding then he would not experience the anxiety; therefore he learnt, through negative reinforcement, that avoidance is beneficial as it stopped him becoming anxious. Also, through his avoidant behaviours he did not disconfirm the original unhelpful thought that every object is useful. The development and maintenance of Fred's problems with hoarding can be shown diagrammatically:

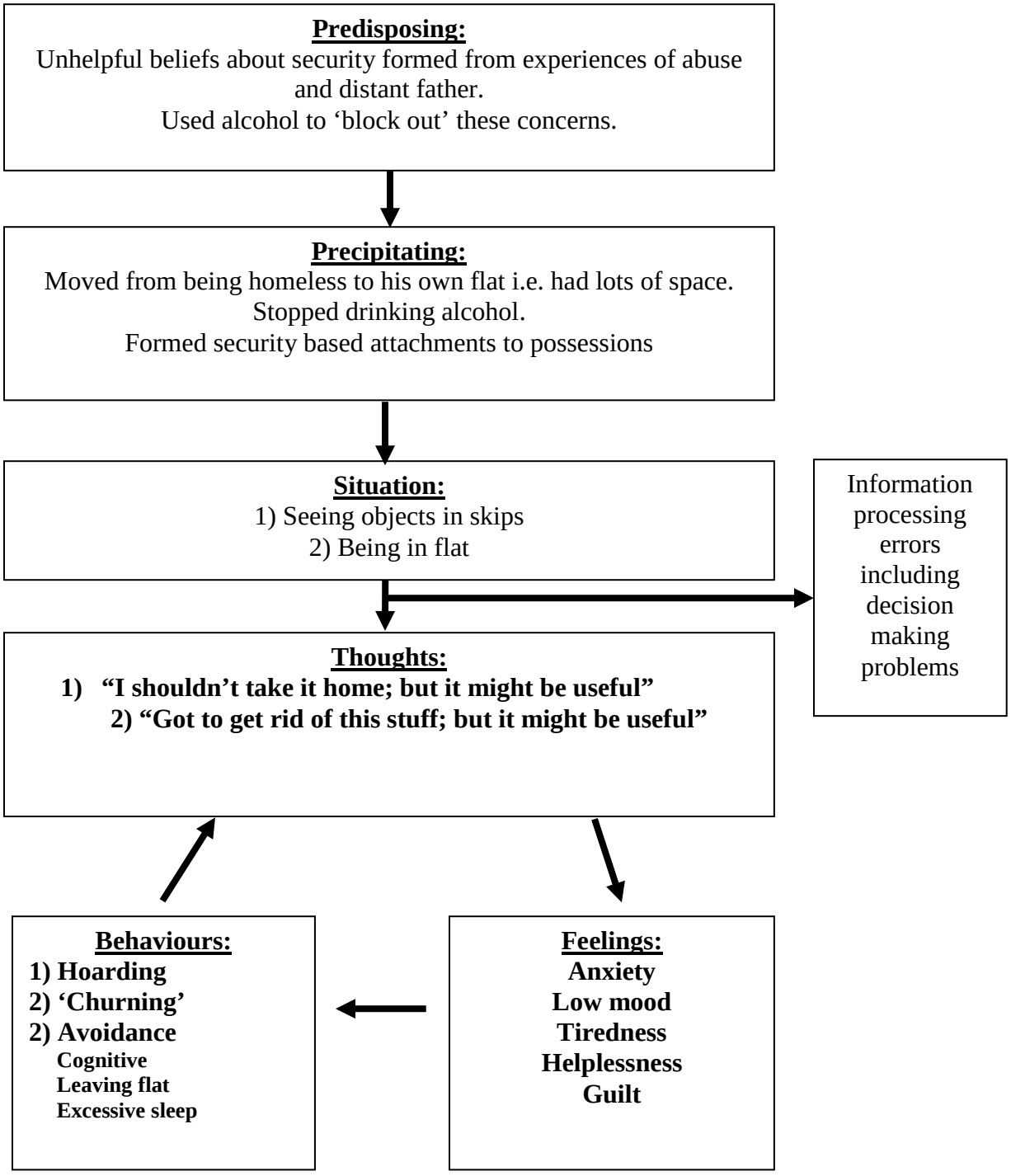

Figure 1: Diagrammatic formulation

Treatment rationale

It has been described how Fred's avoidant behaviours, decision-making deficits and emotional attachments perpetuated his hoarding behaviour, resulting in a disturbance in his lifestyle and distress. For Fred to unlearn his unhelpful behaviour (i.e. his avoidance of discarding possessions), he needed to habituate to the associated anxiety that he experienced when he contemplated discarding possessions and learn that when he discarded possessions, after time his anxiety would decrease naturally. This mechanism intended to enforce change through interrupting the negative reinforcement of Fred's avoidance of discarding possessions. With repeated exposure to the feared situation of discarding possessions, Fred's unhelpful learnt behaviours would become unnecessary and therefore redundant. This technique is supported by Baer (1991) who found a behavioural programme of exposure to discarding beneficial in cases of individuals with hoarding symptoms.

It was hoped that through the behavioural programme Fred would habituate the associated anxiety. However, he would still have poor decision making abilities and overvalued ideas related to the possessions, and could bring more items back to the flat in the future. To counteract this possibility, it was intended to 'train' Fred in decision making and organisational skills. The purpose of this was that once Fred learnt how to place items into defined categorises, it would become easier and less anxiety provoking to discard them (Frost and Steketee, 1998). To ease this process cognitive restructuring of hoarding related beliefs could be initiated using Beck's (1985) model of cognitive therapy; the aim of which is to propose alternatives to unhelpful beliefs, through techniques such as Socratic questioning, generation of alternative thoughts, behavioural experiments (Beck, Emery and Greenberg, 1985).

Interventions

Fred was reluctant to let me see his flat, therefore the first treatment session consisted of planning the therapy and explaining the treatment rationale, during this session cognitive re-structuring was begun in regards to his hoarding related ideas. The week after Fred agreed to let me see his flat, base line measurements of the flat were taken to help

calculate the clutter ratios. To help increase his daily functioning the bedroom was the first target area. Categories were set (keep object, sell/donate object, or discard object) and excavation began. Fred found this less anxiety producing than expected as he could identify a lot of items as rubbish. Homework was set to continue to discard possessions each day for at least an hour or until anxiety reduced. In the subsequent session it was discovered that although Fred had done some discarding for homework he had not been doing it every day and that he had moved possessions from the bedroom to the bathroom, rather than throwing them away. Practical considerations were discussed as to the best way forward and we agreed that to focus on discarding larger objects first would be better as this would create more room to move about and allow further discarding.

A pattern soon developed whereby Fred would ruminate excessively on decisions whether to throw items away and this reduced any possible habituation to discarding. We therefore developed a timetable to help him plan his time and to focus on less emotionally charged items. Fred responded to this well and by the time I saw him next seven bags of clutter had been discarded; however more possessions had been moved from one room to another. To counter-act this behaviour, I witnessed Fred as he cleared areas. I tried to teach him that decisions should not be dwelt on, as one of the purposes of treatment was for him to experience anxiety when throwing away items and for him to experience the anxiety naturally decreasing and therefore habituate it. This process of therapist assisted discarding and decision making training was repeated in subsequent sessions. Fred became more confident in the discarding and the levels of associated anxiety decreased. We therefore set more ambitious targets: 15 bags of clutter per week. This process continued for the remaining sessions. Due to the levels of clutter in his flat Fred was able to identity much that could be discarded. However, when we discussed throwing out items he saw as potentially more useful (e.g. the third broken oven) he was unable to remove them and they became almost a barrier between us. When this occurred I spent time first of all drawing up lists of pros and cons of discarding the object; when this was not effective I would bring Fred back to his goals to allow him to see the object as working against them.

Fred was seen for 25 sessions of active treatment over six months, each session took place in his home and followed the structure above. Towards the end of our sessions together it became apparent that, although considerable amounts of clutter were being removed from the flat, progress had plateaued. The main reason for this was the sheer scale of the project and Fred not having access to friends or family that could physically help. As Fred had learnt and practised the excavation routine and also changed his relationship to objects as he had prioritised his goals, we decided to end our sessions and agreed to meet in three months for a follow up session.

Outcomes

	Pre	**Post**
OCI:		
Frequency	85/168	50/168
Distress	83/168	43/168
Clutter Ratios:		
Kitchen	92%	65%
Living area	95%	50%
Bathroom	95%	70%
Bedroom	100%	60%

By the end of sessions noticeable changes had been made in the flat; in the kitchen especially, Fred reported that it used to take him four hours to cook dinner before sessions, at the end of sessions it took him an hour. In addition, he was able to use his bathroom facilities and there was considerably more floor space in the bedroom, allowing him to sleep in there. Fred had stopped bringing in new objects into the flat. However, despite his progress there was still a large amount of clutter that impacted on his day to day functioning.

At follow up there had been some progress but not the amount that had been expected. Fred reported that he had been removing clutter but was also spending time enjoying his time in his flat and this reduced the amount of time he was devoting to removing clutter.

Again, new objects had not been brought back to the flat. His goal of having someone round to dinner had not been realised. By the end of our time together Fred had reduced his clutter by 34% over the nine months.

Discussion

The cognitive behavioural assessment and treatment of a client with hoarding behaviour has been described. The practical interventions used were based on a specific case study by Frost and Steketee (1998). Integral to the majority of the case studies that focus on hoarding is the implicit assumption made by clinicians and researchers that hoarding tends to be predominately associated with OCD (Grisham and Norberg, 2010). This assumption also influenced Fred's treatment and lead to the focus being on the role of anxiety and exposure (evidence based practice for anxiety disorders). However, some of Fred's symptoms could have been found in other disorders such as anankastic personality disorder (obsessive-compulsive personality disorder). Fred would have also fulfilled the criteria for this as he presented with at least three of the set characteristics: feelings of excessive doubt and caution, preoccupation with details, rules, list or order, and intrusion of insistent and unwelcome thoughts or impulses (ICD-10, W.H.O, 1992). It has been put forward that individuals with OCD and one or more comorbid personality disorders are less responsive to drug and behavioural treatments (Baer and Jenike, 1998). With this in mind this may account for why Fred did not experience the expected levels of anxiety whilst discarding. Therefore, basing his treatment on diagnosis lead to difficulties as one, the diagnosis may have been incorrect, and two because psychiatric diagnosis are in themselves neither valid or reliable (Kutchins and Kirk, 1999; Bentall, 2003). By assuming the validity and reliability of psychiatric diagnosis therapists (including myself at times) often lack a critical perspective and fail to see the client as an individual with individual problems. In addition, hoarding can be seen as a disabling problem in its own right rather than aligning itself to a psychiatric diagnosis which has to cover so many variables and cannot ever account of the rich variation in clinical presentations (Stein,

Seedat and Potocnik, 1999)[2]. From re-examining Fred's psychological formulation it can be hypothesised that the maintaining factors for Fred may have been more cognitive than behavioural and thus should have been the focus of the sessions. For example if more attention had been given to Fred's beliefs about objects (influenced by his history of trauma) then perhaps Fred's treatment may have progressed differently. This criticism echoes the move to transdiagnostic ways of working and rejecting the dominance of diagnosis driven therapy.

Conclusion

This study aimed to demonstrate how CBT was applied with a particular client. The effectiveness and implications of the assessment have been discussed in detail, as have the treatment outcomes. Focussing clinical practice on the available evidence base has been discussed; it has been found that although certain methodologies may be unscientific they can still provide a framework to help benefit clients with compulsive hoarding if a case conceptualisation leads interventions rather than a diagnosis.

[2] The latest version of the DSM, which was published after the interventions with Fred, now include a category called 'hoarding disorder' (APA, 2013). Although this may help with classifying people with a label, the clinical utility is questionable.

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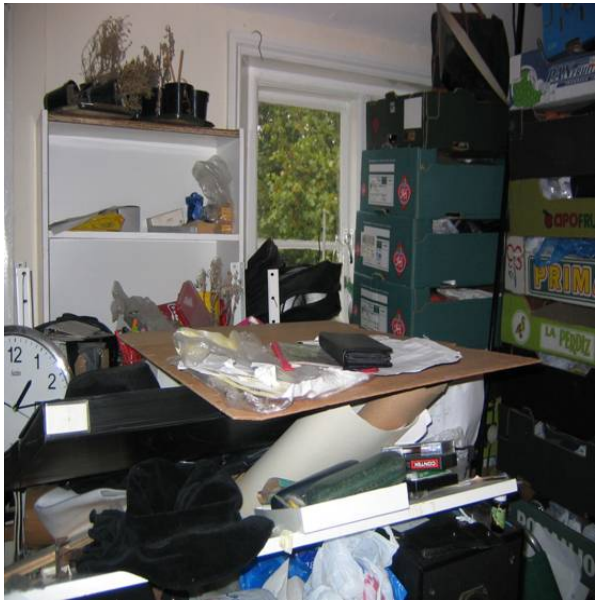
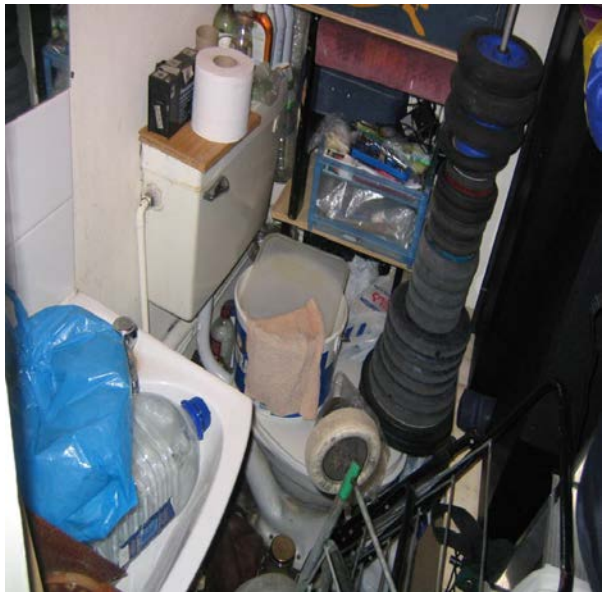
Appendix 1: Before intervention

Kitchen

Kitchen



Living Area

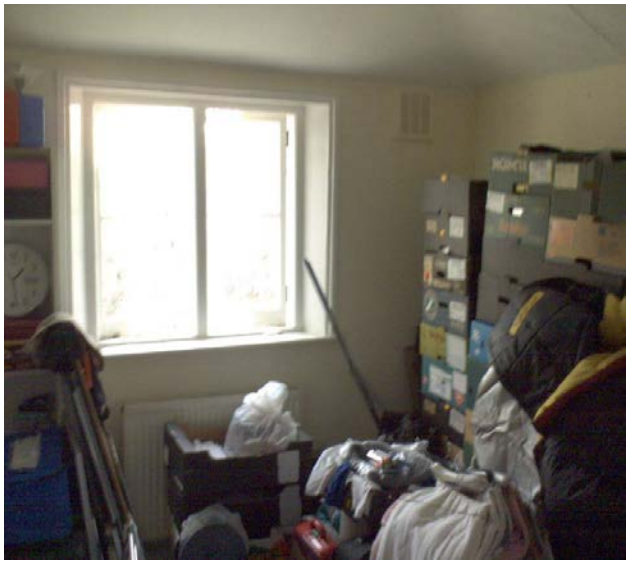


Bathroom

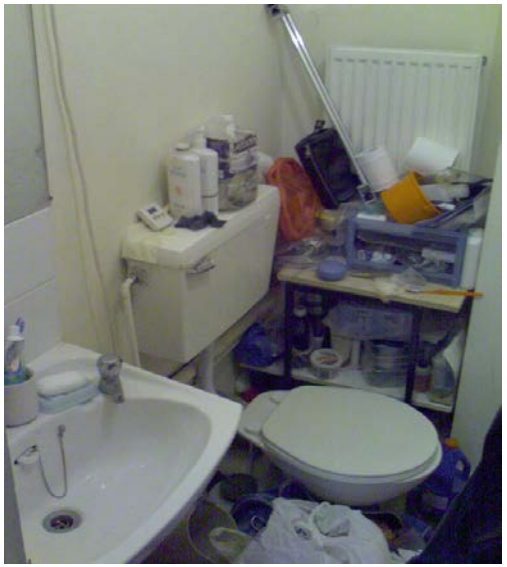
Bedroom

Appendix 2: After intervention

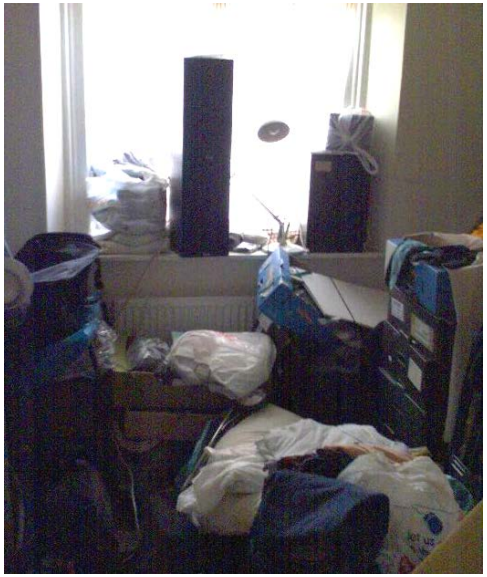
Kitchen



Living Area



Bathroom



Bedroom