Hoarding disorder in adults: Treatment

AUTHORS: David Mataix-Cols, PhD, Lorena Fernández de la Cruz, PhD, Pino Alonso, MD, PhD
SECTION EDITOR: Murray B Stein, MD, MPH
DEPUTY EDITOR: Michael Friedman, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Oct 2023.**
This topic last updated: **Mar 28, 2022.**

INTRODUCTION

Individuals with hoarding disorder feel a need to save or collect objects and experience persistent difficulties parting with possessions, regardless of their value. Possessions congest and clutter their living areas, compromise the use of these spaces, interfere with the individual's daily life, and cause clinically significant distress.

Hoarding disorder was newly included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [1], replacing the conceptualization of extreme hoarding in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) as a form of obsessive-compulsive disorder (OCD) [2]. As a more recently specified mental disorder, there is less research available on hoarding disorder and its treatment compared with many disorders.

The treatment of hoarding disorder in adults is reviewed here. The epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis of hoarding disorder are reviewed separately. OCD in adults is also reviewed separately.

- (See "Hoarding disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis".)
- (See "Management of obsessive-compulsive disorder in adults".)
- (See "Obsessive-compulsive disorder in adults: Psychotherapy".)

PRINCIPLES OF TREATMENT

Individuals with hoarding disorder may have poor or absent insight or delusional thinking. They may not seek help and they may be resistant to accepting treatment. We use the following methods to engage these individuals in treatment while addressing health and safety concerns. (See "Hoarding disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Differential diagnosis'.)

Patient education — We assess and, if appropriate, address the risks of hoarding early in the treatment (eg, first or second session). Individuals with hoarding disorder are often unaware of the dangers associated with hoarding (eg, fire hazards, falling, unsanitary conditions, infestation). Education may provide motivation for change. (See 'Administration and components' below.)

Involvement of supports — We involve relatives or other significant supports when possible. Individuals with hoarding disorder may be isolated, suspicious of others, and unwilling to accept treatment. Trusted supports can enhance trust, lessen barriers to treatment (eg, poor or absent insight), and improve engagement in treatment.

Assessing need for protective and other services — We often arrange home visits to assess the need for social and support services. We arrange services for all individuals with limited ability to care for themselves. For example, in individuals with hoarding disorder that are unable to attend medical appointments or take medications without assistance (eg, due to clutter, disorganization), we often involve social or support services. If vulnerable individuals are living in the home (eg, children or disabled persons) and thought to be at risk, we involve the appropriate agencies as part of the overall care plan.

Assess for comorbidity or disorders with similar presentation — Excessive accumulation may be a presentation of other psychiatric disorders (eg, psychotic disorder, dementia, obsessive-compulsive disorder) and a differential diagnosis is crucial to guide treatment decisions. Additionally, individuals with hoarding disorder may have comorbid psychiatric disorder such as mood or anxiety disorders, which may negatively affect response to treatment [3]. (See "Hoarding disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Comorbidities' and "Hoarding disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Differential diagnosis'.)

In cases with unaddressed comorbid psychiatric disorders, our treatment plan addresses both disorders. (See 'Individuals with prominent comorbid conditions' below and 'Pharmacotherapy' below.)

Establish goals — We establish goals early in the treatment. Treatment goals may vary based on the level of functioning of the patient, the presence of comorbidities, and the level of psychosocial support. Examples of goals include not acquiring more objects for a specified period of time, or organizing the objects to assess need. We typically reassess and, when needed, revise our treatment plan every three to six months. (See 'Administration and components' below.)

COGNITIVE-BEHAVIORAL THERAPY

We suggest first-line treatment of hoarding disorder with cognitive-behavioral therapy (CBT), preferably CBT for hoarding disorder [4]. Although evidence supporting this treatment approach is limited, it is more robust than available alternatives.

Conceptual model — The cognitive-behavioral model of hoarding theorizes that problems with acquiring, saving, and clutter result from vulnerability factors (such as genetic influences and early life events) interacting with other factors such as information processing deficits and beliefs about possessions (figure 1) [4,5]. Additionally, maladaptive emotional responses to hoarding are thought to play a role [5,6].

- Information processing deficits – Processing deficits affecting the following domains may lead to excessive build-up of objects:
  - Attention and categorization – Difficulty with categorization and sustained attention may lead to inability to organize and discard objects.
  - Perceptions and associations – Failure to notice clutter or to a tendency to generate many ideas for its use.
  - Complex thinking and decision making – Considering too many facets of a problem and focusing on nonessential details (eg, inability to separate out important from unimportant details). Fear of making incorrect decision (eg, discarding a “needed” object).
- Meaning of possessions – The meaning of possessions may contribute to the accumulation of objects and difficulty discarding objects. As examples:
  - Beauty, uniqueness – Attributing beauty, opportunity or uniqueness to many objects.
  - Sentimentality, comfort – Perceiving or assigning emotional significance to objects; seeing objects as a source of safety.

- Identity, validation – Belief that objects are part of the person or represent who the person can become; belief that objects validate an individual's worth.

Additionally, some individuals have strong beliefs about not wasting possessions, polluting the environment, using possessions responsibly. Some individuals with hoarding disorder are fearful that giving up the objects will lead to loss of control.

- Emotional responses – Emotional responses, both positive and negative, can affect hoarding and discarding of objects.
  - Positive emotions related to the hoarding behaviors. Joy, pleasure, comfort, and satisfaction are the emotions most associated with acquiring possessions or being surrounded by possessions.
  - Negative emotions related to the hoarding behaviors include anxiety, guilt, grief, sadness, and anger. These are most commonly associated with discarding or losing possessions.
- Vulnerabilities – Family history, learned values, and traumatic events play a role in the development of hoarding disorder.

Administration and components — CBT for hoarding disorder is a multimodal, psychosocial intervention based on the cognitive-behavioral model of therapy. It has been developed specifically to address hoarding. The availability of this intervention is limited to a handful of specialist academic centers and by lack of therapists trained in its delivery. When CBT specific to hoarding disorder is unavailable, we typically prefer peer groups as the next option. (See "Overview of psychotherapies", section on 'Cognitive and behavioral therapies'.)

CBT for hoarding disorder is typically delivered over 7 to 12 months. Weekly office sessions and home visits every two to four weeks generally range from 12 to 35 total sessions. We typically offer an individual format; however, group formats are also shown to be effective [7-9].

The components of the CBT-based intervention include [5]:

- **Motivational interviewing methods** – We employ motivational interviewing methods such as open-ended questions, reflective listening statements and complex reflections in the administration of CBT for hoarding. Motivational interviewing allows for introspection, addresses ambivalence about the treatment, and conveys a sense of understanding to the patient. (See "Substance use disorders: Motivational interviewing".)

- Open-ended questions – We ask a question in a way that allows for introspection (eg, "Why do you think the clutter got out of hand?" or, "How do you think the clutter affects your daily life?").

- Reflective listening statements – We communicate interest and confirm understanding of what the individual reports by active listening, paraphrasing and offering the idea back (eg, "I understand that you believe that you need to have these objects because…").

- Complex reflections – We amplify what the individual has said with educated guesses about their thoughts and feelings (eg, "You seem to be annoyed that our sessions are prompting you to address this difficult issue").

- **Goal setting** – We set clear goals for the treatment as early as possible in the process. (See 'Principles of treatment' above.)

- **Skills training** – We assist the individual in improving skills such as organizing objects (to assess objects type and amount), problem solving (what to do with objects, how to accomplish tasks) and decision making (whether to keep or discard objects).

- **Curbing excessive acquisitions** – We address excessive acquisition first to stop the influx of objects. We address difficulties discarding objects and clutter after the flow of items coming in is lessened.

- **Graduated exposure** – We encourage graduated exposure to limiting acquisition of objects and discarding possessions. This helps to lessen (ie, habituate) the discomfort associated with these behaviors. As an example, we encourage individuals who acquire excessively to expose themselves to progressively stronger triggers (eg, flea markets) without buying anything.

  Once this is mastered, we might focus on a particular area of the home (eg, a cluttered coffee table) and ask the individual to decide what to keep and what to discard. Gradual habituation of the discomfort may make further gains possible.

- **Cognitive strategies** – We use cognitive restructuring exercises to identify and modify errors in thinking. We use challenging questions to help critical thinking when sorting, discarding, and practicing nonacquiring. Examples include: "How many of these do I already have?" or "How do I plan to use this?" or "Have I used this in the past year?"

Efficacy — Clinical trials investigating CBT (individual or group CBT) for hoarding disorder have reported mixed results. Interpretation of results has been limited by small sample sizes,

heterogenous treatments, and high drop-out rates [7-15].

In a meta-analysis of 16 studies, including 505 individuals with hoarding disorder, subjects treated with CBT (12 to 41 weeks) showed improvements in hoarding symptoms from pretreatment to posttreatment and pretreatment to three- to six-month follow-up (effect sizes g = 1.11 and 1.25 respectively [9]).

Furthermore, in another trial, 323 adults with hoarding disorder were randomized to either 15 weeks of group peer-facilitated (G-PFT) therapy or 16 weeks of group psychologist-led CBT (G-CBT) [13]. Both treatments appeared to be effective at reducing hoarding symptom severity (effect sizes: G-PFT 1.20; G-CBT 1.21), with similar effect between groups. The treatment gains were maintained for up to the three months in follow-up. Interpretation of data was limited by a high dropout rate (ie, nearly 30 percent). Other trials appear to support these findings [10-12,14].

The long-term benefit of CBT for hoarding disorder is unknown; however, data from a trial of 31 patients found that the treatment gains were largely maintained at 12 months [15].

Inadequate response — We examine the possible reasons and the next steps for individuals with a poor response to CBT. Examples include:

- **Insufficient emphasis on exposure** – We use graduated exposure techniques to lessen the anxiety associated with limiting acquisition of objects or discarding of objects. Some individuals with hoarding disorder may find these experiences to be too aversive and some therapists may be inexperienced in the treatment.

    - **Failure to stop excessive acquisition** – Individuals who make progress discarding objects may nonetheless continue to acquire new objects. In these cases, additional emphasis on measures to prevent such acquisition are indicated. As an example, the therapist might accompany the patient on trips to high-risk places while avoiding acquiring objects (eg, flea markets, charity shops).

    - **Insufficient discarding of objects** – We expose individuals to discarding objects gradually. We intensify this as the therapy progresses. In individuals with poor response to CBT, we review our treatment to ensure that sufficient exposure has been practiced. In some cases, we increase the intensity of exposure by home visits with direct guidance or assistance in discarding objects.

- **Presence of an undetected comorbid disorder** – We review and verify past history of psychiatric disorders (eg, obsessive-compulsive disorder, mood disorder, cognitive

disorder) for all individuals with poor response to CBT. When possible, we also engage support systems for further history. (See 'Principles of treatment' above and 'Individuals with prominent comorbid conditions' below.)

ALTERNATIVE FIRST-LINE TREATMENTS

Individuals who cannot access or refuse CBT — We prefer mutual help groups for individuals who cannot access or refuse cognitive-behavioral therapy (CBT). Mutual help groups may contribute to symptom reduction in individuals with hoarding disorder [10,13]. As an example, in a clinical study of 38 patients with hoarding disorder, individuals were randomized to a 13-week support group versus wait list (control). Individuals in the support group experienced a greater mean symptom reduction compared with the wait list control group (31 versus 2 percent) [10]. In another clinical trial, peer-facilitated group therapy appeared to be similar in effect to psychologist-led groups [13].

In some communities, no psychosocial treatments are available (eg, CBT, mutual help groups). There is no evidence to support the use of pharmacotherapy in individuals with hoarding disorder without comorbidities. In individuals with comorbid conditions, such as depression, we treat with pharmacotherapy. (See 'Pharmacotherapy' below.)

Individuals with prominent comorbid conditions — For individuals who present with hoarding disorder with prominent comorbid conditions such as an anxiety or a mood disorder, we often initiate treatment with a combination of CBT (preferably CBT for hoarding) and pharmacotherapy with a selective serotonin reuptake inhibitor. As there is a lack of data supporting the efficacy of this approach, we base our treatment on the efficacy of antidepressants in treating psychiatric disorders such as anxiety or mood disorders and our clinical experience. (See "Management of obsessive-compulsive disorder in adults" and "Unipolar major depression in adults: Choosing initial treatment", section on 'Antidepressant pharmacotherapy'.)

SUBSEQUENT TREATMENT FOR NONRESPONSE

Cognitive remediation — We prefer cognitive remediation for individuals with suboptimal response to treatment with cognitive-behavioral therapy (CBT) or mutual help groups. (See 'Individuals who cannot access or refuse CBT' above.)

Cognitive remediation is a behavioral intervention designed to improve cognitive abilities. It has been used to improve cognitive abilities in individuals with traumatic brain injury and attention

deficit hyperactivity disorder. Cognitive remediation involves training in a specific set of tasks designed to improve cognitive abilities (information processing, attention, working memory, executive functioning) or social functioning. This contrasts with CBT which aims to change the cognitions and behaviors related to hoarding difficulties.

Clinical trials provide limited evidence of efficacy for cognitive remediation. For example, in one trial, 58 individuals with hoarding disorder were randomized to cognitive remediation and exposure sorting therapy (CREST) versus case management [16]. Subjects managed with CREST showed greater improvements on self-reported measures of hoarding (Saving Inventory-Revised [SI-R]) than the case management group (38 versus 25 percent decrease). However, improvements on other clinician-rated scales were similar in both groups. In another trial, 17 individuals with hoarding disorder were randomly assigned to computer assisted cognitive remediation versus relaxation control [17]. At eight-week follow-up, similar effect was seen on measures of hoarding severity between groups.

Pharmacotherapy — We typically offer a trial of pharmacotherapy in cases where psychosocial treatments are unavailable or in those who are resistant to all psychosocial interventions. However, there are no randomized trials supporting pharmacotherapy for individuals with primary hoarding disorder and data from uncontrolled trials are inconclusive regarding efficacy. For individuals with comorbid conditions such as mood or anxiety disorders, pharmacotherapy may be helpful.

Strategies for the treatment of hoarding disorder have not been standardized. Much of the existing research was conducted in patients with obsessive-compulsive disorder (OCD) and hoarding symptoms rather than with DSM-5 hoarding disorder [18]. For example, in a meta-analysis of case series and uncontrolled trials of pharmacologic treatment for individuals with pathological hoarding, of the 92 individuals in the trial only 27 met DSM-5 criteria for hoarding disorder [18]. (See "Hoarding disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Overview'.)

The following pharmacologic agents have been studied in the treatment of hoarding disorder and for prominent hoarding symptoms in other disorders. (See 'Individuals with prominent comorbid conditions' above.)

- **Serotonin-reuptake inhibitors** – In a single uncontrolled trial, 24 individuals with hoarding disorder were treated with venlafaxine (up to 300 mg) [19]. After 12 weeks, 16 patients (67 percent) experienced a 30 percent or greater reduction on the UCLA Hoarding Severity Scale and the SI-R scales, as well as a rating of at least “much improved” on the Clinical Global Impression – Improvement Scale.

- **Atomoxetine** – In an uncontrolled trial, 12 individuals with hoarding disorder (75 percent of whom had failed prior treatment with a selective serotonin reuptake inhibitor [SSRI] or CBT) were treated with atomoxetine for 12 weeks [20]. Six individuals had full response to treatment (mean reduction of 57 percent on UCLA Hoarding Severity Scale) and three individuals had partial response (mean reduction of 27 percent). Eleven individuals completed the trial. Mean dose of atomoxetine was 62 mg and good tolerance was reported.

- **Methylphenidate** – In a case series, four individuals with hoarding disorder treated with methylphenidate. At four weeks, reductions in hoarding symptoms (25 and 32 percent) were seen in two subjects [21]. Reductions occurred in the excessive acquisition domain of the SI-R scale. No subjects chose to continue the medication after the study (mean dose 50 mg), because of side effects (eg, insomnia, palpitations).

- **Others** – Agents such as quetiapine [22], naltrexone [23], and minocycline [24] have not been found to be effective as augmenting agents for individuals with prominent hoarding symptoms in the context of other disorders. In a single trial of eight individuals with prominent hoarding symptoms in the context of OCD, augmentation of SSRI with quetiapine 200 mg over eight weeks was effective in only one individual [22].

PREVENTION OF RELAPSE

We provide individuals who respond to treatment with strategies to prevent relapse. These include learning how to manage stressful situations or other potential triggers for new acquisition behaviors, increasing socialization, keeping an active lifestyle, participating in ongoing peer groups, address outstanding medical conditions, and when possible, returning to the workforce [25].

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Obsessive-compulsive disorder and related disorders".)

SUMMARY AND RECOMMENDATIONS

- **Principles of treatment** – Individuals with hoarding disorder feel a need to save or collect objects and experience persistent difficulties parting with possessions, regardless of their value. Possessions congest living areas and compromise use of these spaces. This interferes with the individual's daily life and causes clinically significant distress.

  We educate individuals with hoarding disorder about the risks of hoarding such as fire safety and unhealthy living conditions. We attempt to involve significant relations or other support services and establish goals early in the treatment. Additionally, we assess for comorbid disorders such as mood disorders. (See 'Principles of treatment' above.)

- **Cognitive-behavioral therapy (CBT) as first-line treatment** – We suggest first-line treatment of hoarding disorder with CBT for hoarding disorder rather than medication or other psychosocial interventions (**Grade 2C**). (See 'Cognitive-behavioral therapy' above.)

  The cognitive-behavioral model of hoarding theorizes that excessive acquiring and saving result from vulnerability factors (eg, genetic influences, early life events) interacting with beliefs about possessions, information processing deficits, and maladaptive emotional responses. (See 'Conceptual model' above.)

  Components of CBT for hoarding include motivational interviewing methods (eg, open-ended questions and reflective listening), goal setting, skills training, graduated exposure, and cognitive restructuring. (See 'Administration and components' above.)

- **Reassessing treatment for poor response to CBT** – We reassess our treatment in individuals with poor response to CBT. Reasons such as insufficient emphasis on graduated exposure to acquiring or discarding objects are addressed. Additionally, we verify the presence or lack of comorbid conditions. (See 'Inadequate response' above.)

- **Treatment for others**

  - **Individuals who cannot access or refuse CBT** – We prefer mutual help groups for individuals who cannot access CBT or refuse treatment with CBT. (See 'Individuals who cannot access or refuse CBT' above.)

  - **Individuals with prominent comorbid conditions** – We typically initiate treatment with CBT or other psychosocial intervention plus medication management with a selective serotonin reuptake inhibitor in individuals with untreated comorbid mood or anxiety disorders. (See 'Individuals with prominent comorbid conditions' above.)

- **Adjunctive cognitive remediation** – We suggest cognitive remediation rather than pharmacologic management for individuals who do not respond to initial treatment with

CBT (**Grade 2C**). (See 'Inadequate response' above.)

- **Treatment resistance** – We typically offer a trial of pharmacotherapy for individuals who remain resistant to psychosocial interventions. However, there are no randomized trials supporting pharmacotherapy for individuals with primary hoarding disorder. Efficacy data from uncontrolled trials are inconclusive. (See 'Pharmacotherapy' above.)

- **Subsequent treatment for treatment responders** – We provide individuals who respond to treatment with strategies to prevent relapse. These include learning how to manage stressful situations or other potential triggers for new acquisition behaviors, increasing socialization, keeping an active lifestyle, participating in ongoing peer groups, address outstanding medical conditions and, when possible, returning to the workforce.

Topic 107912 Version 13.0

→