HOARDING DISORDER

What is hoarding disorder?

"People with hoarding disorder excessively save items that others may view as worthless. They have persistent difficulty getting rid of or parting with possessions, leading to clutter that disrupts their ability to use their living or work spaces."

https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder

Hoarding is not "collecting"...

Hoarding behavior is a disorder listed with OCRD that results in social and occupational impairment and often leads to an unsafe living environment.

1. Hoarding affects 2-6% of the population and those who suffer experience substantial distress and problems functioning.

2. It is more common in males than females, and three times as likely to affect adults 55-94 years of age compared to adults 24-44 years of age.

https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder
ATI RN Mental Health Nursing, pg. 58

Clinical characteristics of hoarding include:

Note: hoarding differs from OCD in that individuals do not hoard as a way to relieve anxiety. Rather, they feel a strong personal and emotional attachment to possessions or find them useful or beautiful and are therefore unable to discard them.

Familiality

Often people who hoard have other members of their family who hoard.

High Unmarried Rate

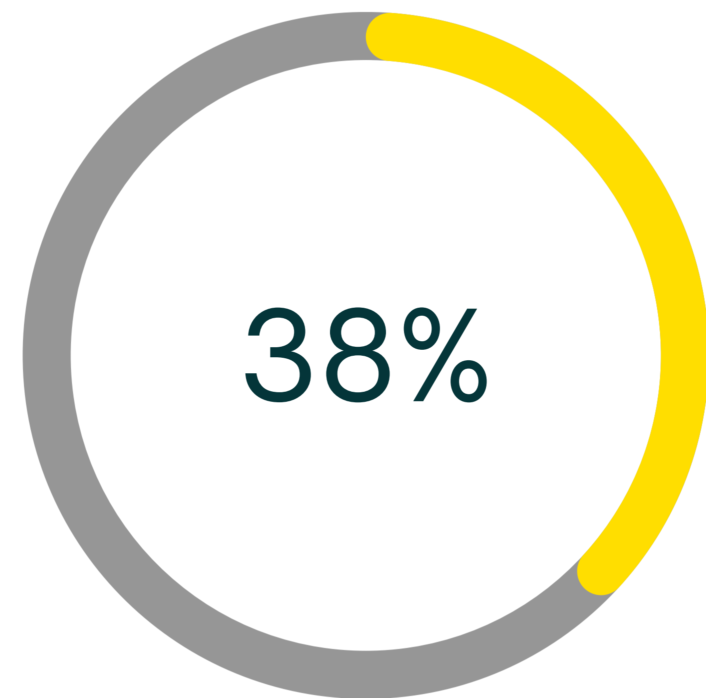
Individuals with hoarding disorder may have difficulty maintaining relationships.

Co-morbidities

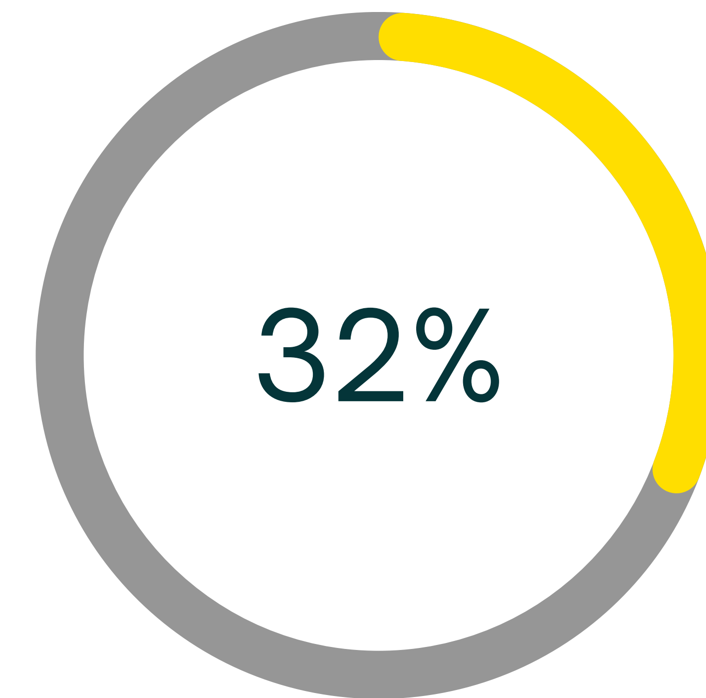
One study showed a high rate of ADHD in individuals who hoard, and another found high rates of depression, anxiety and impulse control disorders.

How do you treat hoarding?

Two small studies found significant improvement in hoarding symptoms through separate modalities.



Patients who received Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) showed a 38% reduction in symptoms over patients who received standard Case Management.



Patients who received pharmacological therapy with venlafaxine showed a 32% reduction in SI-R scores, a measure of hoarding severity.

Treating Hoarding Disorder with CREST

Abstract

Go to:

Objective:

To compare the efficacy of Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) with geriatric case management (CM) in a sample of older adults meeting *DSM-5* diagnostic criteria for hoarding disorder (HD).

Methods:

Fifty-eight older adults with HD were enrolled in a randomized controlled trial between December 2011 and March 2014. Thirty-one participants received CREST, and 27 participants received CM. Both interventions consisted of 26 individual sessions over a period of 6 months and included several home visits by the study therapists (CREST) or nurses (CM).The Saving Inventory-Revised (SI-R) and the UCLA Hoarding Severity Scale (UHSS) were the main outcome measures.

Results:

Participants in the CREST condition had significantly greater improvement on the SI-R than participants in the CM group (group × time interaction: $\beta = 3.95$, SE = 1.81, $P = .029$), with participants who completed the CREST condition averaging a 38% decrease in symptoms and participants who completed the CM condition averaging a 25% decrease in symptoms. In contrast, there was not a significant group × time interaction effect on the UHSS ($\beta = 1.23$, SE = 0.84, $P = .144$), although participants did report greater improvement in symptoms in the CREST condition (35%) than in the CM condition (24%). Treatment gains were maintained at 6-month follow-up.

Conclusions:

CREST appears to be an efficacious treatment compared to CM for older adults, but CM also showed meaningful benefits.

Ayers, C. R., Dozier, M. E., Twamley, E. W., Saxena, S., Granholm, E., Mayes, T. L., & Wetherell, J. L. (2018). Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) for Hoarding Disorder in Older Adults. The Journal of Clinical Psychiatry, 79(2), 85–93. https://doi.org/10.4088/jcp.16m11072

Treating Hoarding Disorder with CREST

Table 1.

CREST Modules, Target Domains, and Manual Content

Module	Session/Homework Content
CCT (target domain)	
Session 1. Introduction to CCT and psychoeducation about the link between brain functioning and HD	Discussion of patient's experienced consequences of HD, barriers to treatment adherence and possible solutions, and treatment goals and expectations
Session 2. Calendar use (prospective memory)	Discussion of current/past calendar system; goal setting of where to keep calendar and when to use it; practicing use of calendar with "real-world" type scenario; using linking tasks and automatic places to help with daily activities
Session 3. Linking tasks, using a "to-do" list (prospective memory)	Review of calendar use and linking tasks; using "to-do" lists along with calendar; determination of to do categories and frequencies; short-term prospective memory strategies (eg, "can't miss reminders")
Sessions 4–5. Problem solving	Brainstorming practice exercises (therapist- and patient-provided examples); 6-step problem solving method; practice evaluating solutions for feasibility
Session 6. Thinking flexibly and planning (cognitive flexibility)	Self-talk and self-monitoring; brainstorming steps to meet a goal; practicing setting time lines for long-term goals.
Session 7. Home visit and organizational preparation (cognitive flexibility)	Creating a plan for organizing home (ie, where types of items should be stored); brainstorm "to-do" list for organization; rules of organizing; home maintenance system (current and proposed rules)
ET	
Session 8. Exposure preparation	Discussion of expectations, decision making, habituation, and avoidance; rules of discarding; motivational interviewing about willingness to change; acquisition hierarchy; fear of discarding hierarchy
Session 9. Introduction to exposure therapy	Review of organizational plan, rules of organizing, maintenance system, and rules of discarding; introduction to Subjective Units of Distress (SUDS) Ratings; discarding exposure
Sessions 10–22. Exposure to discarding and acquiring	Evaluation of progress; discarding exposure; discussion of reasons for saving and strategies for making discarding choices; introduction to advanced exposure (eg, discussion of rules, preparing for sorting for a longer time, and use of outside help); review of treatment goals
Sessions 23–24. Advanced exposure	Longer exposure time (2–4 hours) with outside help; evaluation of progress; discussion of reasons for saving and strategies for making discarding choices; review of

Abbreviations: CCT = compensatory cognitive training, ET = exposure therapy, HD = hoarding disorder.

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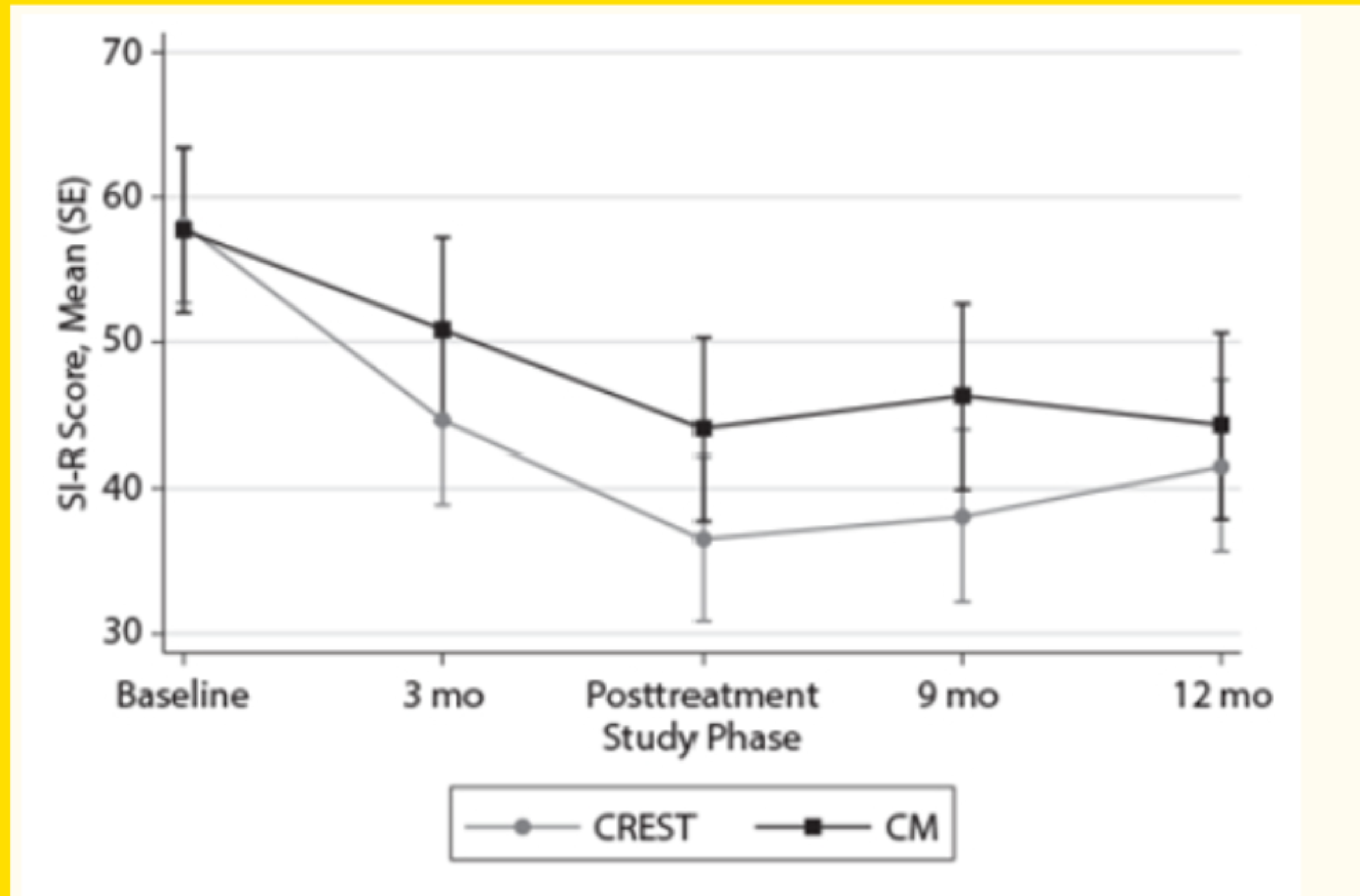
Treating Hoarding Disorder with CREST



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Treating Hoarding Disorder with venlafaxine

Abstract

Go to:

Objectives

Hoarding Disorder, classified as a separate disorder in DSM-5, is a common, chronic, and potentially disabling syndrome that can be difficult to treat. Only one prior study prospectively measured response to pharmacotherapy in compulsive hoarders, finding that hoarders responded as well to paroxetine as did non-hoarding OCD patients. However, paroxetine was not tolerated well in that study, and overall response was moderate. Therefore, we conducted an open-label trial of venlafaxine extended-release for Hoarding Disorder.

Methods

24 patients meeting DSM-5 criteria for Hoarding Disorder were treated with venlafaxine extended-release for 12 weeks. All patients were free of psychotropic medications for at least 6 weeks prior to the study. No other psychotropic medications, cognitive-behavioral therapy, organizers, or cleaning crews were permitted during the study. To measure hoarding severity, the Saving Inventory-Revised (SI-R) and the UCLA Hoarding Severity Scale (UHSS) were administered before and after treatment.

Results

23 of the 24 patients completed treatment. Hoarding symptoms improved significantly, with a mean 36% decrease in UHSS scores and a mean 32% decrease in SI-R scores. Sixteen of the 23 completers (70%) were classified as responders to venlafaxine extended-release.

Conclusions

These results suggest that venlafaxine extended-release may be effective for treatment of Hoarding Disorder.

Keywords: Hoarding, Disorder, Venlafaxine, Extended-Release, Treatment, Compulsive, Pharmacotherapy

Saxena, S., & Sumner, J. (2014). Venlafaxine extended-release treatment of hoarding disorder. International Clinical Psychopharmacology, 29(5), 266–273. https://doi.org/10.1097/yic.0000000000000036

Treating Hoarding Disorder with venlafaxine

Table 1

Symptom Rating Scale Scores Before and After Treatment

Symptom Rating Scale	Pre-Treatment Score	Post-Treatment Score	Wilcoxon signed-rank test	
			Z	p
UHSS	24.4 +/− 3.9	15.5 +/− 4.9	−4.20	<.001
SI-R	68.8 +/− 9.9	46.5 +/− 15.4	−4.02	<.001
HDRS (17)	11.0 +/− 6.3	5.7 +/− 3.5	−3.34	.001
HAM-A	11.0 +/− 5.6	6.3 +/− 3.7	−3.54	<.001
YBOCS	22.3 +/− 4.2	13.7 +/− 5.5	−4.03	<.001
GAS	52.9 +/− 6.0	63.0 +/− 6.4	−4.20	<.001

UHSS = UCLA Hoarding Severity Scale; SI-R = Saving Inventory-Revised; HDRS = Hamilton Depression Rating Scale; HAM-A = Hamilton Anxiety Scale; YBOCS = Yale-Brown Obsessive-Compulsive Scale; GAS = Global Assessment Scale.

Saxena, S., & Sumner, J. (2014). Venlafaxine extended-release treatment of hoarding disorder. International Clinical Psychopharmacology, 29(5), 266–273. https://doi.org/10.1097/yic.0000000000000036

Both studies worked with a very small group of patients...

The CREST study worked with 58 older adults over the course of a year. The venlafaxine study worked with 24 patients over 12 weeks.

1. While both studies are encouraging, it is evident that more research needs to be done with larger samples.

2. Both studies worked with middle aged or older adults, but there is evidence that hoarding behaviors can begin in the adolescent or teenage years.

3. Continuing to find ways to help individuals with hoarding disorders is not only prioritizing the safety of the patient, but also the community, as HD can have significant impact on the health of neighborhoods and families.

What does it mean for your future nursing practice?

Empathy and understanding is key! Hoarding disorder can lead to severe distress and emotional upset for folks who suffer from it. The more we know, the better.

Treatment of HD benefits both the patient and the community. We can help educate so that others can help identify and help individuals who suffer from HD.

We will need to check our bias. HD can manifest in extremely unsafe and unsanitary ways. We will need to see past the symptoms to the suffering.

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THANK YOU.