Cognitive and Behavioral Treatment of Compulsive Hoarding

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Compulsive hoarding appears to be a common variation of obsessive-compulsive disorder that is associated with elevated anxiety, depression, and disability, and that is commonly accompanied by a variety of comorbid conditions. In this article, we present a model for understanding this multifaceted problem, from which we derive specific treatment interventions that pertain to problems with information processing; excessive attachment with strong beliefs pertinent to saving possessions; avoidance of distress associated with discarding or making decisions about possessions; and excessive acquisition and difficulty discarding possessions. A case example illustrates these problems, methods of assessment, and interventions that proved successful during cognitive and behavioral treatment. [Brief Treatment and Crisis Intervention 3:323–337 (2003)]

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living nearby. We assume that this number represents only a tiny fraction of people with clinically significant hoarding problems, since relatively few hoarders whom we have encountered report having been contacted by a health department official. Our recent research also suggests that hoarding problems are associated with elevated levels of anxiety, depression, and disability, at least as severe as for nonhoarding OCD patients (Frost, Steketee, Williams, & Warren, 2000). Furthermore, OCD patients with hoarding symptoms had higher levels of avoidant, dependent, compulsive, paranoid, and schizotypal personality disorder symptoms.

Successful treatment of OCD hoarding is rare. Some investigators have suggested that hoarders may display behaviors that interfere with usual behavioral treatments for OCD (Kozak & Foa, 1997) or that they do not easily habituate during exposure (Baer, 1994). Outcome studies that include information about specific OCD symptoms seldom mention the inclusion of hoarding subjects (Ball, Baer, & Otto, 1996). This omission may indicate that hoarders are underrepresented in the OCD treatment outcome literature and are potential treatment nonresponders (Basoglu, Lax, Kasvikis, & Marks, 1988). Recent evidence supports this hypothesis. The presence of compulsive hoarding predicted failure in both medication and behavioral therapies (Black et al., 1998; Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002; Winsberg, Cassic, & Koran, 1999).

As a result of our research on compulsive hoarding, our interviews with people who have hoarding problems, and our attempts to alter hoarding behavior, we have proposed a cognitive behavioral model of compulsive hoarding (Frost & Hartl, 1996; Frost & Steketee, 1998). This model has guided our attempts to develop a treatment program for compulsive hoarding. It proposes that hoarding stems from four types of deficits or difficulties: information-processing deficits; problems with emotional attachments to possessions; erroneous beliefs about the nature and importance of possessions; and behavioral avoidance. An early attempt to apply this model of hoarding to treatment has shown promise (Hartl & Frost, 1999).

Information-processing deficits include problems with making decisions, problems with organizing (information and possessions), and possibly problems with memory. Hoarding subjects (both clinical and nonclinical) have shown clear deficits on measures of decision making (Frost & Hartl, 1996). Not only do hoarders have difficulty deciding on whether and where to keep possessions, they often have problems making any kind of decision. Hoarders seeking treatment have also reported having difficulty organizing and categorizing information and possessions (Steketee, Frost, Wincze, Greene, & Douglass, 1999), although this deficit still needs empirical confirmation. Finally, nearly all compulsive hoarders complain that they have poor memories, which suggests potential memory deficits along the same lines found among other OCD patients (Savage et al., 1996).

People who hoard show several forms of emotional attachment to possessions. Sentimental attachments make possessions feel like extensions of the self, a part of one’s identity. Possessions often represent past events. Discarding them feels like losing part of the self or one’s life. Possessions also become sources of comfort or safety, and their removal results in feelings of vulnerability (Frost & Hartl, 1996).

Linked to the such cognitive and emotional features of hoarding are beliefs about possessions. Similar beliefs are experienced by other OCD patients; but for hoarding clients, they have a specific connection to possessions. For example, people who hoard often believe they must maintain clear and absolute control over their possessions, and many strongly believe that ownership carries with it the responsibility...
for making sure possessions are not wasted. Another prominent belief is in the fallibility of their memory and, related to this factor, the necessity for remembering everything perfectly. Many are especially focused on beliefs about lost opportunities or lost information and on the possible consequences of either.

Hoarding allows avoidance of many difficult or unpleasant situations, including decision making, potential mistakes, loss of emotional attachments, loss of opportunities, and emotional upset. Leaving things piled in the middle of a room avoids the discomfort of facing the difficult chore of organizing (i.e., making decisions about where things belong). For a more detailed account of these features of hoarding, see Frost and Steketee (1998).

Here we detail the case of a man with extensive hoarding problems, who exhibited many of the features of hoarding just described. Treatment spanned a 17-month period, during which he made substantial progress on multiple areas of his hoarding difficulties and his resulting functional impairments.

Case Description

Jim is a white male in his midthirties with some college education and a job as a maintenance man. He sought treatment for hoarding problems that dated back to high school. Jim shared an apartment with his mother who was very meticulous and did not allow Jim to keep any possessions outside of his bedroom and a storage area in the basement. Consequently, although the main living areas of his home were relatively clear, his bedroom was severely cluttered with possessions, mostly old clothing and papers (i.e., magazines, newspapers, bank statements, old postcards, etc.). Jim also maintained a “storage car” parked in a lot near his home. The trunk and interior of this car were packed with an assortment of clothing, newspapers, napkins, food items, plastic kitchen utensils, paper packets of salt and pepper, antiques, postcards, photographs, and knickknacks. The trunk and back seat were filled to the ceiling, and the front seat was approximately half full. The car could not be driven as a result of the clutter, and he paid to keep it parked there. Jim also packed the attic of his father’s house with his possessions. No apparent organization of the possessions was evident in either Jim’s car or his room; they appeared simply thrown into piles, with no attempt to separate items by category.

At the outset of treatment, Jim reported that his main concerns about discarding things were doubting whether he had retained all the information he needed from them and feeling uncertain about his saving decisions. In response to these fears and doubts, Jim not only kept most things he acquired, but he also engaged in checking written material. The main things he saved were newspapers, racing memorabilia, and anything sentimental. He believed that if he were prevented from keeping and acquiring something, he would lose an opportunity to be happy. He also experienced a high level of anxiety when forced to discard any of these items, because he imagined a future use for them.

Jim also engaged in excessive acquisition. At the time he entered treatment, Jim bought three daily newspapers, saving each, and he spent 3 to 4 hours every weekend going to garage sales. From these sales he purchased various knicknacks. Most of what he collected, however, were free things, such as calendars, bags, and posters. Although he had little use for them, he liked the colors and could not bring himself to discard them. He frequently attended library giveaways and had accumulated many books, as well as pens, pencils, and bags. In addition, he went to the local landfill twice a day to pick up things.

The diagnostic interview revealed that Jim met criteria for obsessive-compulsive disorder and social phobia, and that he had a history of one major depressive episode. The self-report
Personality Diagnostic Questionnaire-4 (Hyler, 1994) indicated that Jim met criteria for avoidant personality disorder, as well as obsessive-compulsive personality disorder. Besides the hoarding behavior, Jim’s OCD symptoms included obsessional doubting, especially with regard to making decisions. Specifically, he worried that he did not have enough information to make decisions and that his mistakes would “haunt” him later in the form of ruminations about having done something wrong. These fears made it especially difficult for him to complete forms and resulted in some delays in completing our assessments, a problem we have encountered with other hoarders as well. He displayed mild checking compulsions related to these concerns. Jim also experienced minor contamination obsessions, mostly regarding public rest rooms and public telephones. His single episode of major depressive disorder occurred a year prior to seeking treatment for hoarding. At that time he was placed on Prozac (25 mg), but it had no impact on his hoarding problems.

Beginning in junior high, Jim experienced severe social anxiety that eventually led to his dropping out of high school. As an adult, he reported considerable anxiety in social situations, imagining that he would say the wrong thing and thus feel extremely awkward and nervous. Although he later finished high school, he reported that his social anxiety had significantly interfered with his educational and job attainment, as well as his pursuit of a romantic relationship. He had one close friendship of 10 years’ duration with a man who also had a hoarding problem. He reported few other significant social relationships, except for one romantic relationship that ended several years before he came for treatment.

Jim’s parents divorced 10 years before treatment began. The dissolution of his parents’ marriage was a source of sadness for Jim. He frequently discussed his desire to have his family together again. His most significant attachment was to his grandmother, for whom he held a great deal of respect and admiration. He described her as a meticulous saver. In fact, she saved every letter and bill since the 1920s, a feat Jim admired. She also kept a careful record of every penny she ever had, where it came from, and how she spent it. Jim saved and treasured these records, as well as many other possessions belonging to his grandmother. Not surprisingly, Jim also saved his own bills, though not in such a meticulous fashion. Soon after Jim returned to high school, his grandmother died, and his parents’ marital difficulties began. It was at this time that Jim’s hoarding problems began.

General Description of Hoarding Treatment

Treatment for Jim’s hoarding followed the model described earlier to address the multiple components of hoarding problems. The treatment protocol included group sessions, as well as individual sessions with a therapist assistant (TA) in the clients’ home. Treatment was structured around five general themes: Education about hoarding, improving decision making, organizing, exposure, and cognitive restructuring of problematic beliefs. These topics were addressed in both group and individual sessions. Individual sessions focused more specifically on exposure to discarding and to not acquiring, plus practice in organizing and decision making, as well as cognitive interventions for problematic beliefs experienced in the context of exposures.

Assessment of Hoarding Problems

Treatment began with a 2-hour office visit during which the therapist interviewed Jim about his symptoms and established treatment goals. Jim received several questionnaires about hoarding and other OCD symptoms to complete be-
between appointments. His pretest scores on these measures, as well as those for comparison groups of people with and without hoarding problems are shown in Table 1. Jim’s difficulties with decision making delayed the pretest assessment so that some of his questionnaires were not completed until a month after the beginning of treatment. Jim reported extremely high levels of family, work, and social disability, as measured by the Sheehan Disability Inventory (Leon, Shear, Portera, & Klerman, 1992). He was not particularly depressed on the Beck Depression Inventory compared to the nonclinical sample. Two early measures of hoarding severity—the Hoarding Scale and a Yale-Brown Obsessive-Compulsive Scale, which were adapted specifically to assess hoarding—indicated that Jim’s pretest scores were slightly lower than those of other compulsive hoarders. These measures were precursors to the recently developed Saving Inventory-Revised (Frost, Steketee, & Grisham, in press). Jim’s score on a measure of compulsive buying was comparable to that of other compulsive hoarders. His beliefs about possessions were measured using an early version of the Saving Cognitions Inventory (Steketee, Frost, & Kyrios, in press). These beliefs included that he must maintain absolute control over possessions, that ownership means being responsible for not wasting, that possessions must be saved as memory aids, and that possessions are important sources emotional comfort. Although they were slightly lower on emotional attitudes, Jim’s belief scores were generally comparable to those of other hoarders and were considerably above nonhoarders’ beliefs. Thus, Jim presented as nondepressed, but seriously afflicted and disabled by hoarding problems and compulsive buying.

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<th>Table 1. Means and Standard Deviations of Hoarding and Nonclinical Comparison Groups, with Jim’s Pretreatment and 1-Year Scores</th>
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A second assessment appointment took place at Jim’s home, where the therapist assessed the amount of clutter and began to plan treatment by identifying specific target areas for treatment. Jim and the TA decided to begin working on his “storage car.” Their initial focus was on organizing the newspapers and magazines there.

General Treatment Outline

Jim attended 15 two-hour group treatment sessions, scheduled weekly for the first 10 weeks and then twice monthly for the next 10 weeks; that is, group sessions were gradually spaced out after the first 2 months of treatment. Concurrent with group sessions, a therapist assistant also visited Jim at home weekly for 90 minutes throughout the first 20 weeks of therapy, and then approximately twice monthly for the next 6 months, according to a preplanned schedule established at the outset of treatment. Jim then took a hiatus from treatment for 1 month and later returned for office visits to his therapist assistant, accompanied by his close friend, also a hoarder, who had attended the original group sessions. At this time, he and his friend agreed to assist each other with homework assignments on a weekly basis. Thereafter, in-office 90-minute sessions occurred every 2 to 3 weeks and were used to review homework, discuss problems, work on persistent problematic beliefs, and assign new homework for the coming period. Altogether, Jim attended 67 sessions over a period of 17 months. He elected to stop after considerable improvement, but not complete recovery, when other concerns in his life took precedence over hoarding problems.

Group Treatment Methods

The group format provided a number of advantages in the treatment of hoarding. Like Jim, each of the members of the group was somewhat socially isolated, consistent with reports for other clients with hoarding problems (Frost, Steketee, Williams, & Warren, 2000). The group helped reduce participants’ isolation and offered an opportunity to become more comfortable around other people. Like others in the group, Jim gradually became more at ease and spoke more often, though he remained one of the more reserved members.

The first few sessions of group treatment were devoted to explaining the model of hoarding problems and defining the goals of treatment for each client. In our view, clients who understand the nature of their behavior and its effects on functioning are better able to cooperate with treatment procedures. To accomplish this objective, the group leader presented the cognitive behavioral model for hoarding, then solicited feedback from all clients about how the model applied to their specific symptoms, asking for examples from their own experience. Each group member was provided with a client manual to follow along with the presentation. The manual also contained relevant forms to complete during or following group or home sessions.

As part of this psychoeducational portion of treatment, Jim completed an assessment of the extent to which each of the major features of the cognitive behavioral model for compulsive hoarding applied to him. He reported the most difficulty with clutter and acquiring free things, and he also reported modest problems with compulsive buying and being able to discard. The information-processing problems most relevant to Jim were problems with decision making and being able to keep his attention focused when sorting through his possessions. Jim also indicated that sentimental attachments to possessions and feelings of loss at discarding were especially problematic. He kept most ticket stubs and fliers, especially those he acquired while traveling. They reminded him of periods of his life that he believed would be lost if he discarded them.
A variety of beliefs appeared to maintain Jim’s hoarding problem. Chief among these was Jim’s belief that once he threw something away, he should never think about it again. He feared the memory would generate overwhelming anxiety that he would have no way to stop. He did not feel “ready” to throw something away until he was convinced it was something he would never remember. Further, he believed that thinking of an item after discarding it only proved that he had made a mistake in discarding it in the first place. Other central beliefs included perfectionism (e.g., the belief that he must read and remember everything), the belief that his possessions could provide him with emotional comfort, and the belief that by discarding possessions he was losing opportunities. Finally, he believed that he had to maintain control over his possessions and prevent others from borrowing or using them.

Jim’s problems with decision making and attention focus, as well as his emotional attachment to possessions and dysfunctional beliefs, led him to avoid making decisions and feel upset or uncomfortable because of feelings of loss or grief. Because he recognized the potential for opportunity in an object, his not acquiring that object had the same impact as his throwing away an existing possession. These features, together with a highly valued role model for whom saving was a virtue, left Jim not only unable to manage the possessions he had but also unable to stop himself from acquiring new ones.

After the initial educational presentation, group sessions followed a consistent format that included homework review and discussion of the therapist-assisted home session. This format was followed by one of several modular topics that covered the major manifestations of hoarding. These topics included problems with decision making; categorization and organization; memory; emotional attachment to saved items; concerns about loss and waste and other hoarding beliefs; and problems with acquisition, discarding, and behavioral avoidance. The acquisition and discarding modules were largely devoted to setting up behavioral experiments or exposure experiences, during the group session and for homework assignments. Final group sessions were devoted to preventing new clutter. Each group session ended with selection of homework assignments. Group treatment appeared to provide support for increasing their awareness of hoarding problems, and it also served as an important motivational impetus for members to complete assignments.

**Individual At-Home Treatment Sessions**

While the group provided structure, socialization, and information important for the treatment, the individual excavation sessions with the therapist assistant were where the bulk of the work was done. These in-home sessions initially focused on developing an organizational scheme for how to store saved items—paper and other—and on identifying which areas or types of saved items should be addressed first. In Jim’s case, organization of his newspaper and magazine collections were the first goals.

The excavation session format involved structured decision making regarding possessions. All decisions were made by the client while the therapist assistant merely asked questions to facilitate. While the focus of the task was initially organization, questions about what was worth saving invariably arose. During these times, the therapist inquired about reasons for saving some items and helped clients identify beliefs and emotional reactions as they made choices. Exposure to discarding and cognitive restructuring of hoarding beliefs were individually tailored during these sessions. Here clients’ tolerance for the discomfort involved in excavation could be tested and developed. At his first therapist assistant session, Jim was exhausted after only 15 minutes and had to stop. Jim related his fatigue...
to the severe anxiety he experienced when contemplating discarding. He stated that it simply “wears me out.” His stamina was slowly built until he was able to spend over an hour excavating.

Because of the discomfort associated with throwing cherished possessions away, hoarders seldom force themselves to discard on their own. The presence of the TA made a significant difference for most clients. With the TA present, they were able to discard at least some possessions. All of the clients had difficulty doing the sorting, organizing, and discarding assigned for homework. Like others, Jim initially had difficulty working alone, but he became quite good at carrying out excavation/discarding sessions on his own.

**Sorting and Discarding: Exercises and Behavioral Experiments**

Most of the procedures and concepts used during excavation were presented first in the group sessions. Group exercises were designed to get clients to recognize hoarding-related beliefs and behaviors, and to model strategies for challenging hoarding cognitions. For each group meeting, clients were asked to bring in a bag or box of possessions from their home. Most often these were paper items, but occasionally someone brought in a small object or a piece of clothing. These items were used for exercises designed to get clients to identify hoarding-related beliefs, to challenge them, and to expose them to the anxiety and grief caused by discarding. For these exercises, group members were asked to select an item from their bag and place it on the table in the middle of the room. We called this table the “Purgatory Table” since it was a way station between keeping and discarding. The exercise involved making decisions about objects placed on the Purgatory Table, identifying beliefs about the loss, observing reactions to the possible discarding of the object, and receiving group reinforcement and support for decisions to discard the object.

To begin the process of identifying hoarding beliefs, each member was asked to consider discarding the item he/she had placed on the Purgatory Table and to rate the level of distress associated with the idea of discarding it. Then, the downward arrow technique was used to identify dysfunctional beliefs about discarding this possession. In Jim’s case, these beliefs related to waste, lost opportunity, forgetting or losing parts of his life, and experiencing overwhelming anxiety from discarding. These beliefs were transformed into hypotheses, and behavioral tests were generated to test these hypotheses. At the end of the exercise, group members were encouraged to discard their item on the Purgatory Table. Most group members were able to do so and thus served as strong coping models. No intensive effort was made to convince members to discard at this time.

Jim’s strongest dysfunctional belief about possessions was his concern that if he discarded something, he would later regret his decision and then be unable to stop thinking about it. He believed the anxiety associated with regret over making such a mistake would be overwhelming. This belief and the behavioral experiment used to test it were exemplified by the following. In one of the early excavation sessions, he came across a small green box that he acquired from as a promotional giveaway. He liked the color but had no immediate use for the box. However, he believed that if he got rid of it, he would think about it and constantly feel overwhelmed with anxiety. With his TA, Jim created a behavioral experiment to test this belief. Jim was at first unable to discard the box, but he allowed the TA to take it. Each subsequent week the TA asked Jim a series of questions about his experience concerning the box. How often had he thought about the box? How anxious was he when he did so? Jim was surprised at how infrequently he thought about the box and that, even when
he did think of it, the anxiety was not as severe as he anticipated. The experience changed Jim’s view about what would happen to him if he discarded something.

This behavioral experiment uncovered another dysfunctional belief regarding discarding. Although Jim reported seldom thinking about the box and relatively little anxiety when he did, he did, however, become anxious when the TA asked him about it. Further questions revealed that Jim believed that once he threw something away, he should never think of it again. Doing so was a sign of weakness that indicated he had made a bad decision by discarding the possession. His belief was, “If I think about something I have thrown away, then it means I should not have thrown it away. Further, it means I’ve once again made a mistake in getting rid of something I should have saved.” Cognitive restructuring concerning this belief greatly improved Jim’s ability to discard.

On his own, Jim carried out a second, related behavioral experiment on this topic. For years, Jim had been making copies of, and saving, his telephone answering machine tapes. The majority of these tapes contained messages from friends and relatives. Jim believed that the tapes would remind him of how his friends and family felt about him, when he listened to the tapes later. Although he noted that nothing important was on the tapes, he was afraid of ruminating about the lost messages if he discarded them. Following the success of his experiment with the box, Jim used a paper-and-pencil form (handed out in the group) to design an exposure task to test his beliefs about the phone messages. The form consisted of a series of questions, which lead him through the process. The following are the questions from the behavioral experiment form and Jim’s written responses to each one.

Question 1. What is the behavioral experiment to be completed?

Jim: Try to not save new messages to my machine.

Question 2. What are the feared consequences?

Jim: I am afraid that I will dwell on not saving them, and that they are something I still want.

Question 3. What is the strength of your belief in the feared consequences (0–100%)?

Jim: 75%.

Question 4. What were your SUDS ratings before and after discarding?

Jim: [left blank]

Question 5. What were the actual consequences?

Jim: I could not believe I was not saving them. I did think of it many times, but I did not dwell on it the way I thought.

Question 6. Did your predictions come true?

Jim: Somewhat, but not as bad as I thought.

Question 7. How did you challenge your feared consequences?

Jim: I kept telling myself how many tapes I have saved. I kept on saying, when am I going to listen to them?

After this experiment, Jim was able to discard many of his old tapes, and he subsequently stopped saving new ones. He experienced little postdecisional regret and seldom thought about these tapes again.

As noted earlier, Jim’s ability to make decisions was influenced by a powerful role model (his grandmother) from whom he learned to save everything. Consequently, he had no sense of what was appropriate to discard and what was not. One of the group exercises designed to help with this problem involved generating a set of questions that group members could ask themselves when making decisions about saving and discarding. As before, each group member picked something out of their bag and placed it on the Purgatory Table. Next they answered a set of questions about that item, which were designed to help them make the decision about saving the item. Discussion about individual
questions helped clarify their meaning to group members. Jim found these questions quite helpful and kept a copy of them nearby for reference when sorting and discarding. The following questions proved most useful for the group:

*Do I need it?* An extensive discussion of the difference between “need” and “want” was encouraged here. Group leaders emphasized a very narrow definition of “need,” which covered only those things absolutely necessary to live in a modern society (e.g., food, clothing, shelter). People may have a strong desire for many things, but they may not have a strong need for them. Like many hoarders, Jim did not distinguish need from want. For virtually all of his possessions, he could imagine a scenario in which he could use the object—and this meant he needed it. Distinguishing this want from a true need helped Jim a great deal.

*How many do I already have?* People who hoard often save multiples of things. For instance, Jim always kept several copies of any magazine he saved. He reasoned that if something happened to one copy, he would always have others. Discussion on this question focused on the disadvantages of keeping multiple copies and the likelihood that more than one copy would be needed. This question also helped Jim give up some of his duplicate possessions.

*Is it significant for MY purposes?* If Jim could imagine a use for a possession (even if it were not his own use), he felt an obligation to keep the possession in case the opportunity arose to get it to someone who might use it. The discussion of this question is designed to help the hoarding clients recognize when something is useful to them and when it is not, regardless of the usefulness of the possession to someone else. That is, if the possession is not of use to the owner but might be to someone else, then it remains a useless possession from the perspective of the person who has it. Actively getting the possession to someone who could use it is a worthwhile endeavor, but keeping such a possession is not. Jim’s box was a good example. He kept it for many years, but had never used it. It was a useless and valueless possession, though he could easily imagine its potential value.

*Do I have a specific plan to use this item?* People who hoard frequently sense the possibly of being able to use a possession, but this plan is often only a vague idea. Thinking concretely about usage and applying this information to help decide whether to save something helped Jim sharpen his decision making about the many calendars he kept with no specific plan for their use.

*Will I really use it within a reasonable time frame?* People with this problem frequently have unrealistic ideas about their ability to use possessions, particularly when their house is full. Feedback from the group leaders and other group members can help correct these ideas. It became clear to Jim that he had many things that he would never have time to use or review, such as his saved answering machine messages. This question became part of Jim’s cognitive challenge during several behavioral experiments.

The following additional questions also prompted useful discussion:

*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?*

These last questions focused attention on the broader context of their lives. When consider-
ing the saving of a possession, hoarders have a tendency to be heavily influenced by the sight of a possession (Frost & Steketee, 1998). That is, when looking at a possession, the hoarder thinks only about the potential risks and costs of discarding it, and not about the “bigger picture” of how this possession actually fits into their lives and their immediate goal of gaining control over their possessions. For Jim the sight of his free calendars made it especially difficult to discard them because once in view, they seemed too valuable to throw out. These questions brought the issue of value to his attention in a very concrete way.

Acquisition Exercises

As mentioned earlier, problems with acquisition are central to hoarding. Treating these problems like other compulsions, we attempted to create exposures to acquisition cues in order to activate the urge to buy or acquire, and then we asked clients to practice response prevention by not acquiring. We began with a group exercise to visualize a nonshopping (nonacquiring) excursion. In Jim’s group each member imagined the place where he or she had the most difficulty controlling the urge to acquire or buy something. They were asked to imagine going to that shop or place and looking at something they want to acquire. Each was asked to rate the strength of the urge to buy and then to imagine just looking at the item and not picking it up. During this imagery, members listed the thoughts they were having. Subsequently, they were asked to visualize this scene and imagine themselves walking away without purchasing or acquiring the item. At this point they rated their level of distress.

A brief discussion following this procedure enabled group members to identify hoarding beliefs. Group leaders then asked the group to list the advantages and disadvantages of not acquiring the imagined possessions. The visualization task was repeated with group members assigning ratings to the level of discomfort they felt by not acquiring the item. After a thorough discussion of the exercise, each group member constructed an in vivo nonshopping/nonacquisition exposure and completed it as homework for the week. In some cases, doing so required that they construct a nonacquisition hierarchy, beginning with driving to the store and browsing without buying anything.

For Jim, the nonshopping exposure included many factors. First was a trip to the discount store, where he saw several things he would have otherwise purchased. He left without buying, but he partially neutralized his anxiety by telling himself he could always go back and get it if he really wanted it. His next attempt at nonacquisition was more successful. He went to a library giveaway and saw several books he desperately wanted. He walked away, however, by focusing on the question, “What am I going to do with them when I get home?” He frequently thought about this “nonacquisition” over the course of the subsequent week but found that the anxiety associated with it was minimal.

Results

The overall results indicate that Jim gained substantially from treatment. At the end of the group treatment phase of the therapy (approximately 5 months into treatment), Jim rated his frequency of acquisition as 60% improved and his organization of possessions as 50% improved. Other areas showed relatively little change. For instance, he estimated only a 20% improvement in his ability to detect and alter problematic thinking related to hoarding, and only a 10% improvement in perfectionism. Though no comparable estimates were collected later in treatment, he showed substantial im-
provement in each of these areas over the next 12 months. The slow early progress may be attributed to the fact that Jim had some initial difficulty understanding the cognitive elements of the program. He also had very little stamina for tolerating discomfort while making decisions about his possessions at the outset of treatment. The emotional arousal he experienced when trying to organize and discard left him exhausted after a very short time. Gradually, he learned to tolerate the decision-making process and eventually could work for over an hour at a time.

After Jim incorporated the cognitive elements of the program, he demonstrated steady progress, which was reflected in the hoarding YBOCS scores collected at intervals throughout the treatment. At pretest (1 month into treatment), Jim’s Hoarding YBOCS was 17. At the end of the group phase (5 months), it had declined to 15. At the 1-year point, this score reduced to 12; at 17 months, 11.

Twelve months after the beginning of treatment, Jim showed a 27% decline in his Hoarding Severity Scale score, although this score remained substantially above the mean of a non-clinical group (see Table 1). His scores on the Compulsive Buying Scale also reduced substantially (52%) from pretest, falling to just below the mean for nonhoarders. Measures of hoarding beliefs reflected a more moderate level of change. Beliefs about emotional attachment to possessions (i.e., “I could not tolerate it if I were to get rid of this”) declined by 30%, so that the one year score was very similar to mean scores for nonhoarders. Beliefs about the importance of possessions as memory aids declined by 19% and remained about one standard deviation above the nonhoarding mean. Beliefs about responsibility and waste declined 50%, below the mean for nonclinical, but beliefs about control over possessions remained unchanged at about the mean for most hoarders. Jim’s scores on disability declined to very near the means for nonhoarders. It was clear from Jim’s perspective that the hoarding no longer created much interference for him.

With respect to his living spaces, Jim (over the course of treatment) completely cleared out his “storage car” and most of his room at home, where he discarded all his newspapers, many of his magazines, and a large number of containers that prevented any movement throughout the room. During the last few weeks of therapy, Jim was even creating his own behavioral experiments. For example, he discarded a number of magazines that he thought he might need, and he gave away some of his old clothes. Although he experienced some anxiety, he also experienced sufficient accomplishment and confidence to continue with the program on his own.

**Discussion**

Jim displayed most of the features described in the cognitive behavioral model of compulsive hoarding. He had significant information-processing problems, reflected in his difficulty making decisions and organizing possessions. He found both of these tasks physically exhausting and emotionally draining, which may have contributed to his tendency to avoid both. Jim used possessions as reminders of events in his life, so that discarding these felt as if he were losing a part of his life and identity. He was emotionally attached to his possessions and worried about intense and uncontrollable emotional responses if he discarded them. He showed numerous erroneous beliefs about the nature and function of possessions, which influenced his hoarding behavior. One of the most prominent was the belief that if he discarded something, he would be “haunted” by memories of it. The inaccuracy of this belief, as demonstrated by his behavioral experiments, suggests that he had never tested these beliefs. That is, he avoided exposing himself to discarding. Once he began
discarding, Jim learned that the feared emotional reactions did not occur.

The measures of hoarding indicated substantial improvement after 1 year, although he remained symptomatic at a level significantly above nonhoarders on measures of hoarding severity. However, our operating definition of clinical compulsive hoarding suggests that Jim no longer qualifies as a compulsive hoarder. His room was no longer significantly cluttered, and his storage car was cleared out. Furthermore, the level of impairment as a result of the hoarding was markedly reduced. From the standpoint of relapse prevention, the improvement in compulsive buying/acquisition problems was most significant. Without the previously large volume of possessions entering his home, especially newspapers and books, we expect Jim to maintain an uncluttered room more easily. His practice at nonacquiring may strengthen his new belief that not all possessions are worthy of being acquired. Jim’s ability at the end of treatment to create behavioral experiments on his own to challenge his hoarding beliefs and behaviors bodes very well for continued improvement.

Jim’s beliefs about emotional reactions to loss of possessions and opportunities were reduced to nonclinical levels, as were his reactions about responsibility and waste. However, his beliefs about the role of possessions as memory aids, and about the necessity for maintaining control over his possessions, remained problematic. The extent to which these beliefs are related to relapse remains to be seen.

Compulsive hoarding is associated with several impediments to treatment. The first is a low level of motivation to engage in activities necessary for change. Many hoarders view organizing their possessions as a monumental task that is beyond their capabilities. Although Jim was eager to change, without the presence of his TA it is doubtful that he would have continued his discarding sessions. His usual response to the anxiety and fatigue he experienced in trying to make decisions was to avoid them. The social pressure created by the TA probably kept Jim from abandoning treatment.

Another problem concerns the extent to which clients recognize their problem behavior. Some hoarders clearly do not believe they have a problem, despite their being ordered to clean, organize, and discard by the local health department (Frost, Steketee, & Williams, 2000). Others, like Jim, recognize their problem, but when faced with having to discard specific cherished possessions, their insights falter, which may be partly caused by a lack of appropriate information regarding responsible saving. Jim’s understanding of what should be saved was shaped by a grandmother who hoarded. His beliefs about usefulness, opportunity, memory, and control rigidified his tendency to save everything, and they left him with little ability to judge the true value of possessions. He knew he had a problem, but he could not recognize it when considering each individual possession.

This recognition problem among compulsive hoarders has led us to begin treatment by focusing on organization of possessions, rather than discarding. As has been suggested elsewhere, when treating an egosyntonic problem, it is important to understand and operate from the client’s frame of reference (Vitousek, Watson, & Wilson, 1998). Many hoarding clients are too frightened by the possibility of discarding possessions. At the outset of treatment, Jim was convinced that he would not be able to discard any of his valued possessions. Rather than challenging this belief, the initial treatment focus was on organizing possessions, a much more acceptable and less frightening goal, and one that nearly all hoarders can adopt. The advantages of discarding and the disadvantages of saving become very apparent in the organization process, and addressing discarding becomes easier.

Progress in this treatment program is slow, in part because all decisions about discarding are made by the client. Whereas it may be faster
to have someone simply go into the hoarders home and remove their possessions, examples of hoarders whose homes have been emptied in this way suggest that hoarding recurs and that it makes subsequent efforts to intervene much more difficult.

Incorporating the group format for a portion of the treatment had a variety of positive effects. It provided this group of socially anxious and isolated individuals with social contact, support, and an environment in which to feel comfortable with others. Like some others, Jim was quite anxious at first, but he came to enjoy participating in the group. Further, a significant amount of modeling behavior occurred during the group, sometimes in the context of highly structured exercises and other times through the informal discussions of progress and observed decisions by other group members. Beyond modeling, group social pressure helped some group members overcome the initial inertia to discarding. Finally, the group format provided structured exercises and practice in decision making, discarding, nonacquiring, as well as in identifying and challenging hoarding-related beliefs. This comprehensive group and individual hoarding treatment program requires further refinement and empirical testing, but it appears to be a promising and potentially more effective alternative to medications and the standard exposure-and-response-prevention treatment.

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References


