Hoarding in Late Life: Implications for Clinicians

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DSM-5 criteria for hoarding disorder necessitate that the hoarding behaviors cause clinically significant impairment in the patient’s ability to function.

Hoarding disorder (HD), a recent addition to DSM-5, is characterized primarily by difficulty in discarding current possessions, urges to save items, and excessive clutter in the home. In addition to HD, hoarding behaviors may result from obsessive-compulsive disorder (OCD), schizophrenia, depression, and even some eating disorders. DSM-5 criteria for HD necessitate that the hoarding behaviors cause clinically significant impairment in the patient’s ability to function and that the symptoms are not the result of either a medical condition or other psychiatric disorder.

Prevalence of HD in older adults
Epidemiological reports of hoarding in the community are based on the estimated prevalence of individuals with some degree of hoarding behaviors, not of individuals meeting criteria for HD. Estimates of hoarding symptoms in non-geriatric community dwellers range from 2% to 5.3%.1,2 One major confound of any review of the literature on HD prevalence is the lack of consistent measurement of hoarding symptom severity, which greatly limits comparisons between studies. In addition, the lack of rigorous inclusion criteria in determining the prevalence of HD severely limits the generalizability of any prevalence study to date.

Clinicians should consider the demographic traits of older adults who may present with HD. The characteristics of older adults with HD can be generalized from the individuals who present for treatment. In a large study of older adults who met DSM-5 criteria for HD, 69% were women and 85% were white, unmarried, and lived alone.3 Older adults with HD who live alone reported significantly higher levels of clutter, but no difference in their urges to save or difficulty in discarding. Assessments that rely on clutter levels may be misleading for individuals who live with a roommate or partner, because that person may be artificially deflating the physical manifestation of the hoarding symptoms. When assessing for hoarding symptoms, it is important to inquire about living spaces that are solely controlled by the individual, such as personal sleeping space or study, in addition to communal living spaces, such as the living room or kitchen.

Onset and course of HD
Knowledge of the common age of onset of hoarding behaviors in adults with HD can help clinicians struggling with a differential diagnosis. Research on the progression of hoarding behaviors may be generalizable to adults with HD. Studies of the reported age of onset of hoarding symptoms in adults who either have self-identified as having hoarding problems or have met criteria for HD report a consistent pattern of onset: hoarding symptoms generally appear before age 20, and few individuals experience onset of problems after the age of 40. During intake, take the time to conduct a thorough history of the individual’s life and the progression of the symptoms, including if they have ever experienced a time in which they did not struggle with clutter.

There is some debate about the progression of hoarding symptoms across the life span. Individuals who self-report as having hoarding problems report that symptom severity tends to stabilize after...
middle age and remains steady into old age. On the other hand, individuals who meet criteria for compulsive hoarding report that their hoarding symptoms increased in severity over time, including into older adulthood. This may be the result of the accumulation of objects over time, although it is also possible that individuals with HD experience a “ceiling effect” on their amount of clutter. A study that contrasted hoarding symptom severity in middle-aged and older adults who met DSM-5 criteria for HD concluded that there are no age-related differences in hoarding symptoms. However, it is possible that there are cohort differences in hoarding that may confound any cross-sectional investigations of symptom severity across the life span. Older adults may also be reporting an increase in hoarding symptoms. Because of decreased mobility and other effects associated with the aging process, the consequences of hoarding become more evident. Longitudinal studies of hoarding symptoms and behaviors are necessary to make any definitive conclusions of the progression of hoarding symptoms.

Be mindful of any cycles in the patient’s symptoms, and help the patient recognize the patterns within his or her behavior. For example, if a patient is a teacher who reports that his urges to save increase every spring when the school year ends, help him understand the reasons for saving certain objects, which may be tied to emotional context (e.g., saving the work of a favorite student).

**Impact on well-being**

While many of the risks associated with hoarding behaviors are prevalent across the life span, hoarding symptoms may have a particularly devastating impact on the well-being of geriatric populations. Older adults with HD are at increased risk for falling, fires and mold in the home, poor hygiene and nutrition, and medical problems. The level of perceived risk increases with hoarding symptom severity. Food contamination, social isolation, and medication mismanagement are also problems with older adults who are compulsive hoarders. Dust or insect/rodent infestations may aggravate existing health problems. Because much of the current research on risks associated with clutter levels relies on patient self-reporting, it is possible that the risks associated with HD may be underreported because of low insight into consequences of hoarding.

Older adults with HD also report having medical conditions at a significantly higher rate than older adults without HD, which may be due in part to the increased health risks associated with hoarding. The most common medical conditions reported by older adults with HD include hypertension, high cholesterol levels, arthritis, and sleep apnea. The majority of older adults with HD report never having friends or family visit their home; the frequency with which older adults with HD have visitors to their home is significantly related to symptom severity.

Findings suggest that homelessness may be more prevalent in older adults with HD than in the general population and that HD may be more prevalent in older adults facing imminent homelessness. Normative life transitions, such as moving because of the need for a higher level of medical care or relocation to be closer to family, may create high levels of distress for individuals with HD. Consider using a task-force approach that includes a social worker or a case manager when working with a geriatric patient with HD.

**Psychiatric comorbidities**

During the intake session with an older adult in whom HD is suspected, it is important to assess for other psychiatric disorders that may affect the presentation and treatment of symptoms. The most common comorbid disorders in geriatric patients with HD are MDD, OCD, generalized anxiety disorder, and dysthymia. Presence of a comorbid disorder significantly predicts symptom severity in geriatric patients, with the exception of alcohol use. Symptoms of anxiety and depression were found to be predictive of core hoarding symptoms related to urges to save and difficulty with discarding.

Problems related to executive functioning have been observed in middle-aged adults with compulsive hoarding, older adults with hoarding symptoms, and older adults with HD. Problems with organization and categorization, key aspects of executive functioning, may play a critical part in the development and maintenance of hoarding symptoms in older adults with HD and thus should be thoroughly evaluated when treatment is being planned.

**Assessment and treatment strategies**

Diagnosis of HD can be made using the Structured Interview for Hoarding Disorder (SIHD), which assesses for the DSM-5 criteria for HD. The SIHD also queries for any diagnostic specifiers, such as low insight or excessive acquisition. Several well-validated self-report measures are also available for assessing HD symptom severity, such as the Clutter Image Rating Scale (CIRS) and the Saving Inventory-Revised (SI-R). For individuals with suspected HD, administer the SIHD to initially assess for HD criteria, and consider administering the CIRS and the SI-R weekly or semi-weekly to assess for changes in symptom severity over time.
Both psychotherapy and medication-based interventions have demonstrated positive results for the treatment of compulsive hoarding and HD. The most promising psychotropic intervention is extended-release venlafaxine, an antidepressant that works through the inhibition of serotonin-norepinephrine reuptake. Venlafaxine has been shown to decrease HD symptoms by up to 36% after 12 weeks. However, older participants in the study improved significantly less than the younger cohort. There have been no long-term studies of venlafaxine for HD symptoms nor have there been any comparison studies of venlafaxine against psychotherapy-based interventions of similar durations. Paroxetine, an antidepressant that works through the inhibition of serotonin reuptake, has also been found to be effective in reducing hoarding symptoms but, unfortunately, it may not be well tolerated in hoarding samples.

The Steketee and Frost cognitive-behavioral therapy (CBT) protocol is the only manualized treatment for HD currently available to clinicians in private practice. CBT for HD is a lengthy undertaking (26 sessions) and involves heavy use of motivation interviewing and cognitive restructuring. Its focus is on the distorted thinking associated with hoarding behaviors, including the person’s specific reasons for saving certain objects. Cognitive restructuring is used to help patients alter their associations with their possessions, with the hypothesis that the act of sorting and discarding will become easier once the patient has a more realistic view about the need to save objects.

The validation of the protocol has been limited to mid-life compulsive hoarding samples. Investigation of CBT for HD in older adults is limited primarily to case studies or open trials. Two pilot studies of CBT for older adults with compulsive hoarding found decreases in hoarding symptom severity. Unfortunately, participants’ severity of symptoms remained clinically significant and there was little to no change in the clutter levels.

A novel intervention uses a combination treatment composed of compensatory cognitive training skills as a work-around to the executive functioning problems often seen in older adults with HD paired with exposure therapy for acquiring/discarding. The compensatory cognitive training includes sessions dedicated to skills training related to using a calendar, composing to-do lists, problem solving, flexible thinking, and planning. The exposure portion of the intervention is based on underlying principles similar to those for exposure therapy for obsessive-compulsive-, anxiety-, and trauma-related disorders, which is considered the most evidence-based behavioral treatment of OCD in older adults. Following a 26-week protocol, participants’ hoarding symptoms had improved by an average of 41% and the majority of participants had subclinical levels of hoarding symptom severity.

**CASE VIGNETTE**

Richard is a 67-year-old widower. He presents with severe hoarding symptoms that are assessed using the SI-R and a visual inspection of his home. Over 85% of Richard’s home is filled with clutter; he has a large storage unit that also is full. Richard has hypertension; he mismanages his medications and is largely immobile as a result of excessive clutter. In addition to excessive acquiring of newspapers, Richard keeps magazines and other informational mail items. Richard has a high degree of insight into the consequences of his diagnosis (eg, financial strain, lack of visitors), and he displays a willingness to commit to the treatment intervention. He is able to develop an exposure hierarchy for not acquiring (ie, going to book store and not purchasing magazines) and for discarding (ie, sorting and discarding newspapers). After 26 sessions, including 4 home visits, Richard demonstrates a 35% reduction of hoarding symptoms.

**Conclusions**

HD is a chronic and progressive disease, and it can be a challenge to treat, even for more experienced clinicians. Often, the best course of action is to focus on the safety of the individual and a mitigation of the most severe problems related to hoarding (eg, clearing away fire hazards, fall risks). However, many individuals with HD are eager to receive evidence-based treatment for their symptoms, and substantial progress can be made using either pharmacotherapy or psychotherapy.

**Disclosures:**

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References:


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