03 - 10.3 Hoarding Disorder

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Hoarding is associated with high rates of personality disorders in addition to OCD. These include dependent, avoidant, schizotypal, and paranoid types. Deficits in attention and executive function that occur in hoarding may resemble those seen in attention-deficit/hyperactivity disorder (ADHD). In one study, 20 percent of hoarding patients met the criteria for ADHD. This finding correlates with

the fact that OCD patients with hoarding symptoms had a ten times higher rate of developing ADHD than those without. Hoarding behaviors are relatively common among schizophrenic patients and have been noted in dementia and other neurocognitive disorders. One study found hoarding in 20 percent of dementia patients and 14 percent of brain injury patients. Onset of hoarding has been reported in cases of frontotemporal dementia and may follow surgery resulting in structural defects in prefrontal and orbitofrontal cortex. In a study of patients with focal lesions of the telencephalon, 15 percent exhibited a sudden onset of severe and persistent collecting and saving behavior. Other disorders associated with hoarding include eating disorders, depression, anxiety disorders, substance use disorders (particularly alcohol dependence), kleptomania, and compulsive gambling. Among anxiety disorders, hoarding is most associated with generalized anxiety disorder (27 percent) and social anxiety disorder (14 percent). ETIOLOGY Little is known about the etiology of hoarding disorder. Research has shown a familial aspect to hoarding disorder, with about 80 percent of hoarders reporting at least one first-degree relative with hoarding behavior. Biological research has shown a lower metabolism in the posterior cingulate cortex and the occipital cortex of hoarders, which may also account for various cognitive impairments within hoarders such as attention and decision-making deficits. One study of the molecular genetics for hoarding found a link between hoarding behavior and markers on chromosomes 4q, 5q, and17q. Another study found that the catecholamine-O-methyltransferase (COMT) gene on chromosome 22q11.21 might contribute to the genetic susceptibility to hoarding. DIAGNOSIS Hoarding disorder is characterized by (1) the acquiring of and failure to discard a large amount of possessions that are deemed useless or of little value; (2) greatly cluttered living areas precluding normal activities; and (3) significant distress and impairment in functioning due to hoarding. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes diagnostic specifiers that relate to insight, which may be rated poor, fair, or good. Some patients are completely unaware of the full extent of the problem and totally resistant to treatment. At times, delusional beliefs about hoarded items are present. CLINICAL FEATURES

Hoarding is driven by the fear of losing items that the patient believes will be needed later and a distorted belief about or an emotional attachment to possessions. Most hoarders do not perceive their behavior to be a problem. In fact, many perceive their behavior to be reasonable and part of their identity. Most hoarding patients accumulate possessions passively rather than intentionally, thus clutter accumulates gradually over time. Common hoarded items include newspapers, mail, magazines, old clothes, bags, books, lists, and notes. Hoarding poses risks to not only the patient, but also to those around them. Clutter accumulated from hoarding has been attributed to deaths from fire or patients being crushed by their possessions. It can also attract pest infestations that can pose a health risk both to the patient and residents around them. Many sufferers have been evicted from their home or threatened with eviction as a result of their hoarding. In severe cases, hoarding can interfere with work, social interaction, and basic activities such as eating or sleeping. The pathological nature of hoarding comes from the inability to organize possessions and keep them organized. Many hoard to avoid making decisions about discarding items. Patients with hoarding disorder also overemphasize the importance of recalling information and possessions. For example, a hoarder will keep old newspapers and magazines because they believe that if discarded the information will be forgotten and will never be retrieved again. In addition, patients believe that forgetting information will lead to serious consequences and prefer to keep possessions in sight so as not to forget them. Ms. T, a 55-year-old single woman, presented to a therapist accompanied by her adult son, who expressed concern about Ms. T’s inability to “throw things away.” He reported

that Ms. T's home was extremely cluttered with "needless things." Whenever he attempted to help her "organize things," however, Ms. T would become agitated and argumentative. Ms. T confirmed her son's complaint and reported having this difficulty for as long as she could remember, but never really viewed it as a problem. Over the past 5 years, Ms. T's home had become increasingly cluttered to the point that it became more and more difficult to move around within it. She was able to keep the kitchen and bathroom relatively clutter free, but the rest of her home was filled with boxes and bags filled with papers, magazines, clothes, and miscellaneous gifts and trinkets. Her living room was the most affected. Her son reported no longer being able to visit his mother because it was so difficult to move around and there were very few places for them to sit comfortably. This, Ms. T admits, has been a major source of depression for her. Ms. T used to enjoy entertaining family and friends, especially on holidays, but has not had any guests over in years because she felt that her home was no longer "suitable for company." She had made a few attempts to clean out her home, but was unable to discard most items. When asked why she was keeping them, she replied "I may need them later."

DIFFERENTIAL DIAGNOSIS The diagnosis of hoarding disorder should not be made if the excessive acquisition and inability to discard possessions is better accounted for by another medical or psychiatric condition. Until recently, hoarding was considered to be a symptom of OCD and obsessive-compulsive personality disorder. However, there are some major differences. Hoarding disorder patients do not display some of the classic symptoms of OCD such as recurring intrusive thoughts or compulsive rituals. Unlike symptoms of OCD, symptoms of hoarding worsen with time, rituals are not fixed, and obsessions about dirt or contamination are absent. OCD patients have better insight into their condition. Symptoms are usually ego-dystonic, whereas in hoarding disorder they are ego-syntonic. Hoarding behavior is seldom repetitive and is not viewed as intrusive or distressing to the hoarder. Distress mainly comes at the prospect of discarding items, and it manifests more as guilt and anger than anxiety. Hoarding disorder also tends to be less responsive to classic treatments for OCD such as exposure therapy, cognitive-behavioral therapy (CBT), and selective serotonin reuptake inhibitors (SSRIs). Some case reports show the onset of this behavior in patients after suffering brain lesions. Hoarding associated with brain lesions is more purposeless than hoarding that is motivated by emotional attachment or high intrinsic value of possessions. It is a common symptom in moderate to severe dementia. In cases of dementia, hoarding is often associated with a higher prevalence of hiding, rummaging, repetitive behavior, pilfering, and hyperphagia. Onset of the behavior usually coincides with onset of the dementia, starting in an organized manner, and becomes more disorganized as the disease progresses. The onset of dementia in a patient who has hoarded throughout his or her lifetime can aggravate the hoarding behavior. Hoarding behavior can be associated with schizophrenia. It is mostly associated with severe cases and is seen as a repetitive behavior associated with delusions, self-neglect, and squalor. Bipolar disorder is ruled out by the absence of severe mood swings. COURSE AND PROGNOSIS The disorder is a chronic condition with a treatment-resistant course. Treatment seeking does not usually occur until patients are in their 40s or 50s, even if the hoarding began during adolescence. Symptoms may fluctuate throughout the course of the disorder, but full remission is rare. Patients have very little insight into their behavior and usually seek treatment under pressure from others. Some patients begin hoarding in response to a stressful event, while others report a slow and steady progression throughout life. Those who report onset due to a stressful event have a later age of onset than those who do not. Those with an earlier age of onset run a longer and more chronic course. TREATMENT Hoarding disorder is difficult to treat. Although it shows similarities to OCD, effective treatments for OCD have shown little benefit for patients with

hoarding disorder. In one

Revision #1
Created 2026-01-04 19:50:53 UTC by Omar Ayman
Updated 2026-01-04 19:50:53 UTC by Omar Ayman