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Later-life Hoarders: Clinical Symptomatic Progression and Multi-Faceted Clinical Interventions

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Clinical Symptomatic Progression and Multi-Faceted Clinical Interventions

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The age at onset and the clinical symptomatic progression of hoarding behaviors through successive decades are important factors in concerting appropriate interventions for later-life hoarders. The onset of hoarding begins at an early age, progresses in severity with each season of life, and has serious personal and social consequences. If left unimpeded, hoarders' lives often become sufficiently maladjusted to require professional interventions, which should be multi-faceted to relieve symptoms more successfully and resolve underlying emotional issues for later-life hoarders. Multi-faceted interventions may play a key role in countering chronic hoarding behaviors and related personal dysfunction in older individuals.

Typically, chronic hoarding behaviors are difficult to treat successfully because most current interventions are initiated (a) after hoarding behaviors are deeply entrenched and (b) after the magnitude of clutter has become overwhelming. Although many scholars have examined hoarding behaviors and potential interventions, few have examined the implications of age at onset and clinical symptomatic progression, particularly with the goal of defining appropriate interventions for older hoarders (Ayers, Saxena, Golshan, & Wetherell, 2010). Multi-faceted interventions for later-life hoarders, as discussed later in this paper, may play a key role in countering dysfunctional habits and chronic hoarding behaviors (Tolin, Meunier, Frost, & Steketee, 2010). In this review article, I begin by defining hoarding. I will then focus on the age at onset of hoarding behaviors and on the progression and consequences of hoarding patterns through successive decades. Finally, I will propose viable, multi-faceted interventions that could successfully relieve symptoms and address underlying emotional issues for later-life hoarders.

Definition

Hoarding has been defined traditionally in terms of four observable aspects: excessive accumulation, collecting, lack of capacity to discard, and pathological attachment to material objects (Frost & Gross, 1993). As this malady has become better understood, the definition of hoarding has been broadened to include the core symptoms of excessive acquisition, urges to save, difficulty discarding, and accumulation of clutter, as well as the personality traits of indecisiveness, perfectionism, procrastination, disorganization, and avoidance (Steketee & Frost, 2003). Hoarding behaviors and the related personality traits result in clutter sufficient to disrupt hoarders' lives and to cause potential health and safety issues. Over time, hoarding behaviors may become chronic,

and later-life hoarders eventually amass an accumulation of items and exhibit personal dysfunction requiring professional intervention.

Clinical Symptomatic Progression

Hoarding tends to be progressive and persistent, with initial hoarding symptoms beginning during childhood (Ayers, Wetherell, Golshan, & Saxena, 2011) and definitive hoarding behaviors starting between the ages of 11 and 14 (Tolin et al., 2010). Hoarding behaviors show mild levels during middle adolescence (Grisham, Frost, Steketee, Kim, & Hood, 2006), become moderately entrenched in early-to-mid 20s (Tolin et al., 2010), and reach relentless levels starting in the mid-thirties (Ayers et al., 2011). Severe symptoms become prominent after the age of 40 (Tolin et al., 2010).

Hoarding behaviors can be divided into four categories: logical, irrational, compulsive, and pathological. Each category manifests progressive symptomatic dysfunction. Examining the dynamics and consequences of each category may help to explain the mentality and habits of those who hoard.

Logical hoarding has its basis in need. The "pack rat" collects and saves for several reasons, including the intent to share in response to economic deprivation or governmental transitions that require a pragmatic insurance against scarcity or to gain the reciprocal advantage of bartering—all of which may result in positive emotional experiences and economic savings (Maycroft, 2009). This rational hoarding may be useful during particular intervals and then be discontinued when circumstances change. Hoarding generally stops unless the logical hoarder's habits are practiced and emotionally comforting, in which case personal spending capacity will tend to entrench these behaviors.

Hoarding behaviors are favored in a wealthy society, especially when one's capacity to purchase increases and material goods are in abundance (Shankar & Fitchett, 2002). These conditions may lead

logical hoarders to irrational hoarding habits. As goods accumulate and begin to cause chaos, irrational hoarders begin to reposition them in order to make room for more without the attendant activities of discarding, recycling, or sharing (Maycroft, 2009). Nor do irrational hoarders dispose of items that age, break, or become less useful. Instead, they tend to mask their now-irrational acquisitiveness; and in the process, may become emotionally overwhelmed.

As irrational hoarding behaviors become deep-rooted, personal dysfunction begins to set in because of the magnitude of the messes that result from the hoarder's gathering practices and failure to discard. Hoarders often become compulsive. They frequently leave their clutter temporarily to seek relief from the internal conflict it causes them. Sadly, they may acquire more goods while away from their hoard and thus add to it upon their return (Maycroft, 2009).

Researchers also have found that hoarders avoid the anxiety of decision-making, even as possessions attain a comforting quality (Grisham et al., 2006). Hoarders often report that discarding possessions is akin to losing a loved one (Kyrios, Frost, & Steketee, 2004). This distorted view may provide a reassurance of safety (Koretz & Guthiel, 2009), especially if the hoarder lacks alternative attachments. Clearly, compulsive hoarding can also be socially isolating (Maycroft, 2009).

Social Consequences of Hoarding

Hoarding has far-reaching social consequences. A surprising number of U.S. citizens are classifiable as chronic hoarders, with estimates ranging between two and five percent of the general population (Ayers et al., 2011; Samuels et al., 2008) or upwards of about 1.8 million people (Tolin, Frost, Steketee, Gray, & Fitch, 2008). This number likely is a serious underestimate because chronic hoarding is usually not reported unless in conjunction with a mental disorder or a

public health or safety hazard (Tolin et al., 2008) The large number of hoarders results in unsanitary living conditions, increased fire hazards, and the compromised health and safety of both hoarders and those living nearby (Tolin et al., 2008). Hoarding can also interfere with the hoarder's work, social interactions, eating, and sleeping (Grisham et al., 2006). These consequences underscore the severe social implications and costs of hoarding.

Later-life Hoarders

Hoarding is more prevalent in older people and specifically more likely to occur in females who are fully mobile with relatively few health and functional disabilities, which tend towards agitated behaviors (Marx & Cohen-Mansfield, 2003). Some older, chronic hoarders have received some kind of psychiatric treatment in their lifetime, but most have never requested nor received treatment specifically for hoarding (Ayers et al., 2010). Even when intervention is indicated, the hoarder repeatedly rejects or sidesteps it unless pressured by family, social services, or public health officials (Tolin et al., 2008). Some accept treatment only under threat of divorce, separation, family breakup, or eviction (Christensen & Greist, 2001). In treatment, later-life hoarders exhibit low or fluctuating levels of motivation (Tolin et al., 2008). Rates of premature exit from treatment are between 14 and 30% (Steketee, Frost, Tolin, Rasmussen, & Brown, 2010).

Multi-faceted Professional Intervention

Professionals have sought to treat later-life hoarding using a number of interventions, including cognitive-behavioral therapy (CBT), cognitive-behavioral group therapy (CBGT), and biblio-based therapies.

Cognitive behavioral therapy is a traditional intervention for hoarding that typically involves home visits and last from 7 to 19

months. It includes "building insight, increasing motivation, problem-solving training, and focuses on organizational skill building, cognitive restructuring, decision making and exposure to acquiring and discarding" (Ayers et al., 2011, p. 689). Treatment effectiveness is mixed because of the chronic, progressive nature of hoarding over a longer lifetime (Ayers et al., 2011). In a recent study, older adults who received 26 sessions of CBT and were followed up with after six months did not respond well (Ayers et al., 2011). That is, only 14 to 20% of the participants were classified as responding to treatment, and these gains were not maintained at the six-month follow-up. Although no participants dropped out, homework compliance (meaning both reducing their accumulated collection and reducing hoarding habits) was not consistent (Ayers et al., 2011). Because these findings substantiated that CBT did not produce clinically meaningful change in older adults, Ayers et al. (2011) suggested that a different behavior-treatment protocol be implemented, specifically one that de-emphasized cognitive restructuring and focused on specific, concrete between-session assignments.

Cognitive behavioral group therapy is an alternative to CBT that involves groups meeting together for about 12 weekly two-hour sessions. In CBGT, a therapist describes commonly-held dysfunctional beliefs and provides exercises and assignments for cognitive restructuring (Meyer et al., 2010). CBGT has been shown to improve the success rate from 10 to 21% over CBT (Muroff, Steketee, Himle, & Frost, 2010), possibly because CBGT reduces social isolation and stigma (Muroff et al., 2009).

Another treatment for hoarding is biblio-based therapy, a multi-session support group that is action oriented and not facilitated by a professional, which reduces time commitment and expense, as compared to CBT or CBGT. According to Frost, Pekareva-

Kochergina, and Maxner (2011), these "nonprofessional interventions may provide a cost-effective pre-treatment, adjunct, or alternative for individuals who want to work on hoarding problems but are unable or unwilling to engage in [psychological] treatment" (p. 628). Participants are able to develop and maintain motivation in a casual group setting without homework assignments. Additionally, as they become comfortable within the group, they may challenge their fellow group members' maladaptive beliefs and behaviors more knowingly and productively. Informal social encounters during biblio-based therapy appear to effectively restructure beliefs (Frost et al., 2011) and promote successful behavioral modification.

In a study by Frost et al. (2011), biblio-based therapy outcomes had large effect sizes for the relatively short intervention period and did not involve costly fees, trained clinicians, and home visits (traditional elements of CBT and CBGT). Symptoms were reduced 23 to 28%, with 61% of participants considering themselves much or very much improved. This type of therapy also showed significant reduction of the core hoarding symptoms (clutter, difficulty discarding, and compulsive acquisition), life interference due to hoarding, and hoarding beliefs (Frost et al., 2011).

A promising follow-up intervention is the inclusion of booster sessions after informal or formal therapy has terminated. These post-treatment sessions may be held periodically with group members to re-enforce principles taught during earlier treatment sessions. Barlow (2000) found that 82% of patients, once they had formed new, healthier habits, continued them for a minimum of one year with the help of pre-scheduled booster sessions.

Later-life hoarders have special challenges during therapy, including difficulty completing homework, finding alternatives to acquisition, reducing accumulation, and reshaping their discarding habits. Later-

life hoarders well may benefit from a combination of CBGT, biblio-based therapy, and follow-up booster sessions. This multi-faceted combination of treatments might decrease cognitive dysfunction through CBGT, increase social accountability through biblio-based therapy, and encourage continued compliance through booster sessions. Ayers, Wetherell, Golshan, and Saxena (2011) aptly argued that "it is necessary to know when standard treatments do not work well for subgroups, such as older adults, so treatments may be refined" (p. 692).

Future Research

In addition to addressing the intervention needs of later-life hoarders, other possibilities for future research might be explored. The delayed recognition and diagnosis of hoarding problems by professionals demonstrate a "need for earlier identification and intervention before the hoarding problem reaches a severe level that is difficult to treat because of the sheer magnitude of the clutter" (Grisham et al., 2006, p. 683). Establishing a "treatment classification or staging system … is an important next step for hoarding outcome research" (Ayers et al., 2011, p. 692) because it will improve researchers' capacity to communicate effectively about later-life hoarding behaviors. Identifying and educating potential hoarders at an earlier age could reduce the lengthy and intensive course of treatment necessary after hoarding symptoms have become entrenched (Ayers et al., 2010; Tolin et al., 2010). New research could be focused on identifying and educating earlier-life hoarders with the hope to displace entrenched hoarding behaviors and later-life hoarding dysfunction.

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