Hoarding

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Objectives

- Why Hoarding is important
- How do you recognize and diagnose Hoarding, including vs. OCD
- How do you treat Hoarding

OCD Resources in Pittsburgh

- Center for Treatment of OCD and Anxiety Disorders at WPIC
- Staff include:
  - Robert Hudak MD
  - Terri Laterza LSW
  - Kaylie Pierce LSW

OCD Resources in Pittsburgh

- Obsessive Compulsive Foundation of Western PA www.ocfwpa.org
- GOAL Group, North Hills
- Handouts of this lecture available at http://ocfwpa.org/speakers1.html

Disclosure

- Cambridge University Press

Diagnostic Criteria for OCD

- Either obsessions or compulsions
- Recognized by patients as excessive or unreasonable
- Obsessions or compulsions cause marked distress, are time consuming, or significantly interfere with functioning

OCD: Obsessions

- Recurrent and persistent unwanted thoughts, impulses, or images that are inappropriate or intrusive and cause marked anxiety
- Distinguished from worry about real-life problems
- Recognized as the product of one's own mind
- Attempts made by patient to ignore, suppress, or neutralize the obsession

What are the Most common Obsessions?

• Contamination	• 50%
• Pathologic Doubt	• 42%
• Somatic	• 33%
• Symmetry	• 32%
• Aggressive	• 31%
• Sexual	• 24%
• Multiple Obsessions	• 72%

Rasmussen and Eisen

Obsessions can be:

- Thoughts
- Images
- Impulses
- Sounds
- Smells and/or gustatory sensations
- Obsessional slowness

OCD: Compulsions

- Repetitive behaviors or mental acts that the person must perform
- The compulsion, in the short-term, reduces distress or prevents a dreaded event

What are the Most Common Compulsions?

• Checking	• 61%
• Cleaning/washing	• 50%
• Counting	• 36%
• Need to Confess	• 34%
• Ordering	• 28%
• Hoarding	• 18%
• Multiple Compulsions	• 58%

Rasmussen and Eisen

Compulsions

- Compulsions are an active avoidance of the feared stimulus
- If they become severe enough, they can develop into passive avoidance

OCD Subtypes

- Factor I: Aggressive/Sexual/Religious/Somatic/ Checking
- Factor II: Symmetry/Counting/Ordering/Arranging
- Factor III: Contamination/Cleaning
- Factor IV: Hoarding/Collecting

DSM-IV Diagnostic Criteria for Hoarding

DSM-IV does mention hoarding, but not in criteria for OCD

- One of the 8 criteria listed for OCPD, an illness that is poorly defined, but is NOT related to OCD

Hoarding Alone vs. Hoarding plus OCD

- Pure hoarders have less negative affect and more positive affect
- May be due to lessened insight
- Higher ICD in hoarders

DSM-V Hoarding Criteria (proposed)

- Work group recommending inclusion into DSM-V
- Still examining whther this will be in main manual or included in Appendix for further research

DSM-V Hoarding Criteria (proposed)

- A. Persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions.
- B. This difficulty is due to strong urges to save items and/or distress associated with discarding

DSM-V Hoarding Criteria (proposed, cont.)

- C. The symptoms result in the accumulation of a large number of possessions that fill up and clutter active living areas of the home or workplace to the extent that their intended use is no longer possible. If all living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

DSM-V Hoarding Criteria (proposed, cont.)

- D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
- *Specify if:*
  With Excessive Acquisition: If symptoms are accompanied by excessive collecting or buying or stealing of items that are not needed or for which there is no available space
- Specify insight: Good, poor, absent

Clinical Features

- Excessive acquiring
- Failure to discard possesions
- Clutter which makes living space unusable
- Significant distress or functional impairment

Attachment to Objects

- Heightened sense of responsibility
- Emotional attachment to possessions
- Avoidance of sorting, organizing, and discarding
- Low motivation for treatment

Diagnostic Algorithm

- Determine if clutter is present
- Determine if a psychiatric illness is present
- Distinguish Hoarding vs OCD hoarding
- If Hoarding, examine for comorbidity

Epidemiology

- Prevalence may be as high as 5%, making it twice as common as OCD (the fourth most common psychiatric disorder)
- Most cases do not meet criteria for OCD or OCPD
- Often begins in childhood, more prevalent in adults
- ?relationship with gender or race
- ?one or many disorders

Impact

- 64% of health departments received a complaint in the last 5 years
- Most reported by neighbors: clutter often extends beyond their home
- Deaths have been reported
- Work impairment similar to psychosis
- Significant family consequences

Biopsychosocial Model

- Cognitive deficits and maladaptive behaviors (executive functioning)
- Genetic transmission
- Higher rates of trauma
- Decreased attention and memory, yet memory is overtaxed

Comorbidities

- 92% of patients have other Axis I or Axis II disorders
- Dementia or organic brain syndromes
- Personality disorders (not counting the OCPD difficulty)
- ADHD
- Impulse control disorders

Obsessive-Compulsive Personality Disorder

- Perfectionist, stiff, formal, rigid
- Preoccupied with details, lists
- Workaholic, cannot finish a task
- Not related to OCD

Treatment

- Pharmacotherapy- Results are mixed, most data is with SSRI's
- CBT has shown the best results, and is modeled after work by Frost and Hartl

Integrated Approach to OCD or Hoarding Treatment

- Moderate to severe cases usually require both medications and CBT
- With mild cases, using CBT alone can be appropriate
- May choose CBT alone even in more severe hoarding cases
- Be sure to treat comorbid Axis I disorders

Pharmacologic Treatment of OCD

	Starting dose (mg/d)	Maximum dose (mg/d)	Occasional dose (mg/d)
Fluoxetine	20	80	120
Sertraline	50	200	400
Paroxetine	20	60	100
Fluvoxmine	50	300	450
Citalopram	20	80	120
Escitalpram	10	40	60
CMI	25	250	250

Side Effects of SSRI's

- Initial or short term: include nausea, activation or anxiety, night sweats, night-mares, excessive yawning, headache, tremor, diarrhea
- Persistent or long-term: **Weight gain, decreased libido and anorgasmia, frontal lobe amotivational syndrome/sedation**

SSRI Pearls

- Fluoxetine- late appearing side effects
- Sertraline- diarrhea
- Paroxetine- sedation, weight gain, anti-cholenergic, d/c syndrome
- CMI- TCA side effects
- Citalopram- reflux
- Fluvoxamine- drug/drug interactions

Strategies for Nonresponders to Pharmacotherapy

- Ensure sufficient dose and duration
- Add behavior therapy
- Switch medication
- Augmentation

Discontinuation of Medication

- Abrupt discontinuation may result in high rate of relapse
- Relapse rate may be reduced by adding behavior therapy and tapering medication slowly