Spring 4-6-2020

Hoarding: Beyond the Mess, A Training for Mental Health Professionals

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Hoarding: Beyond the Mess
A Training for Mental Health Professionals

A Project Presented to
The Graduate Faculty of
Minnesota State University Moorhead

By

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In Partial Fulfillment of the
Requirements for the Degree of
Master of Science in
Clinical Mental Health Counseling

April 2020

Moorhead, Minnesota

Abstract

This literature review examines hoarding disorder with a close lens. This is a diagnosis that is new to licensed professionals across the helping professions. This training will allow participants to better understand what it means to be diagnosed with hoarding disorder, assessments that aid in detecting severity, best practices that are continually emerging, and the impact it can have on clients, their loved ones, and the community. This training takes a collaborative approach as an integrated way of treatment for all individuals involved in the process.

Keywords: hoarding, behaviors, treatment

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Introduction

Mental Health has a stigma overall, but certain diagnoses have even further stigma attached to them. When I found out that Hoarding Disorder was a stand-alone mental health diagnosis, I could not begin to imagine the stigma that surrounded this diagnosis. I felt that this was my opportunity to educate professionals in the mental health field about this diagnosis. This document contains a literature review, training narrative to go along with the training slides, and the training on hoarding disorder for mental health professionals. I have encountered people in my life who exhibit symptoms of this disorder and saw the impact it can have on not only the individual with the symptoms, but as well as their loved ones. Between my education in the field of mental health and counseling as well as my personal experience related to hoarding behaviors, I feel grateful for this opportunity to help a population of clients that otherwise may be too afraid to seek help.

Literature Review: Hoarding Disorder

Hoarding Disorder (HD) is in its infancy as it just became its own diagnosis in the Diagnostic and Statistical Manual Fifth Edition (DSM-5) in 2013. Therefore, the research surrounding the treatment of the disorder is still emerging. Hoarding disorder affects anywhere from two to six percent of Americans, which is predicted to continue to rise as awareness of the disorder increases and trainings become available for mental health professionals (Kress, Stargell, Zoldan, & Paylo, 2016). The goal of this literature review is to create awareness of this complex, new diagnosis and how it effects more than just the individual diagnosed.

How Does One Get Diagnosed?

Hoarding disorder has an onset of twelve to thirteen years of age. However, most clients are being diagnosed in their thirties. Seventy five percent of individuals diagnosed with hoarding disorder have a co-occurring disorder. Frequently, hoarding disorder can co-occur with depression and/or attention-deficit/hyperactivity disorder (Kress et al., 2016). Individuals may be attached to both inanimate and animate objects. If hoarding disorder goes untreated, increased severity and resistance to treatment can occur. There are six diagnostic criteria for hoarding disorder. According to the American Psychiatric Association (2013), the criteria is as follows:

> A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
>
> B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
>
> C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially

> compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).
>
> D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
>
> E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome). F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder). (p. 247)

There are two specifiers for the diagnosis. The first is excessively seeking possession of new objects of value (purchased or not), and the other is a client's level of insight into their present hoarding behaviors. When a client understands that their hoarding behaviors are an issue they are said to have fair insight, poor insight describes that a client does not believe that these behaviors are a problem most of the time, and absent insight is where a client absolutely does not think there are any issues related to their hoarding behaviors. This diagnosis is accepted throughout most cultures, but it is still essential that a clinician take culture into consideration anyway when assessing hoarding disorder (APA, 2013).

Though an underlying cause has not been identified, there has been a positive correlation between those who have experienced some trauma in their early development (i.e., parents get a divorce, loss of a loved one, abuse/neglect, etc.) and the onset of hoarding disorder. This

correlation is built on the idea that getting rid of hoarded items of high value is associated with a fear that the memories will also be gone, that the person will be forgotten, or the abuse will come back once the items are gone. (Kyrios, Mogan, Moulding, Frost, Yap, & Fassnacht, (2017).

Assessment of the Disorder

Before the DSM-5, hoarding behaviors were scaled by assessment measures for obsessive-compulsive disorder (OCD). There are a handful of assessment tools that can be used to assess for the hoarding disorder and its severity. The Saving Inventory-Revised (SI-R) assessment measures one's difficulty with discarding items, the accumulation of items, and the presence of avoidant behavior. The Hoarding Rating Scale-Interview (HRS-I) examines the same items as the SI-R, but also assesses for impairment in functioning. (Kress et al., 2016).

Another useful assessment tool is the Obsessive-Compulsive Inventory-Revised (OCI-R). This assessment is used to differentiate between OCD and HD. Individuals with HD will score higher on the assessment than those with a diagnosis of OCD. The scores on the OCI-R are highly correlated with the HRS-I and SI-R, however, due to the OCI-HD being condensed into such a small measure, the authors suggest that it cannot be used effectively for an outcome measure, but can be utilized as a screening tool (Wootton et al., 2015). Another formal assessment is the Structured Interview for Hoarding Disorder, which is the only assessment that includes an assistant to detect a potential differential diagnosis. The assessment has difficulty identifying hoarding disorder if there is a co-occurring diagnosis present (Novara, Cavedini, Dorz, Pardini, & Sica, 2017).

Due to hoarding disorder being relatively new, researchers are analyzing new approaches and inventories to aid in detecting hoarding behaviors prior to an individual's adult years. This

could lead to an advancement in early diagnosis and treatment for hoarding disorder. For example, Dozier, Taylor, Castriotta, Mayes, and Ayers, (2017), examined a pictorial assessment called Object Connectedness, that uses Venn diagrams to visually showcase the relationship the client has of oneself and the items that are hoarded. This allows individuals who lack proper verbal skills or need a differential way to be assessed.

According to Sumner, Noack, Filoteo, Maddox, & Saxena (2016), those who present symptoms of hoarding disorder often exhibit inconsistencies throughout their assessment scores. For example, take two clients presenting the same behaviors of hoarding; one scores well on the assessment, so well that the assessment does not show any hoarding tendencies. The other client may present with hoarding behaviors as well as neurocognitive deficits such as lack of skills in memory or impulsivity. This makes it difficult to examine treatment or supporting medication interventions to best aid clients with hoarding disorder.

Treatment Approaches

Individuals with hoarding disorder are likely to seek services. However, services are often sought to treat co-occurring diagnosis rather than the hoarding disorder (Kress et al., 2016). Cognitive Behavioral Therapy (CBT) is often utilized to treat hoarding disorder due to thought distortions that are often present (Tolin et al., 2019). To begin, a provider would examine the client's behavior when given tasks, this will allow for discussion about the client's thoughts and emotions they feel when discarding of items and helps to gauge how severe their symptoms are. The next step would be a provider setting up training that exposes the client to stressful situations/stimuli, which is paired with reinforcement, and changes distorted thoughts about hoarding (Tolin et al., 2019). There is a therapist manual and client workbook available for use (Tolin et al., 2019). Tolin et al., 2019, found that a CBT approach in a group setting is effective.

It is important that clients are being held accountable when engaging in structured treatment. Treatment has been found to be effective in both group and individual settings and often requires a balance of in office work and homework (Kress et al., 2016). Motivation for treatment can be low, which in turn leads to high dropout rates (Williams & Viscusi, 2016). Research from Kyrios et al., (2017) found that mood level, cognition, and warmness of family can predict the severity of one's HD. Research has shown that an insecure parental attachment can be an indicator for how severe an individual's HD may become and predicts that there might be a strain in therapeutic alliance (Kyrios et al., 2017). Cognitive processing of individuals with HD are impaired and lower than others in the study, which supports the cognitive-behavioral model of hoarding behaviors.

At this time there are no medications specifically for hoarding disorder, one may only be medicated if there is a co-occurring diagnosis that can be treated with medications (i.e., anxiety). With time, this may change, it is just difficult to professionals to gauge what approach to take and for what, as behaviors can differ so greatly within the diagnosis of HD (Sumner et al., 2016).

There has yet to be any non-CBT treatment tested for hoarding disorder and that modifying CBT for those with HD can be found to be beneficial to clients receiving treatment. (Tolin et al., 2019). CBT for HD is a slow progressing treatment and requires great patience and hard work from all parties involved (Kress et al., 2016).

Limitations of Research

There are several limitations found throughout research. The first limitation is that most research articles sport a small sample size, this could be due to lack of information that licensed professionals have of HD or a lack of clients seeking treatment for hoarding behaviors. This serves as a barrier as researchers feel that there is a large portion of clients that struggle with

hoarding behaviors. Small sample sizes do not account for a majority of those with Hoarding Disorder, therefore, research could be biased on a small percentage.

The next limitation is that most of the studies on hoarding disorder exclude participants from the research if the participant presented a co-occurring disorder. This was done in hopes that the research would be based solely on HD, however, due to the high comorbidity rate of HD, this leaves out a bulk of the individuals who are willing to participate in research. Additionally, due to high rates of comorbidity, participant samples that include individuals with HD and co-occurring disorders would be more representative of the client population.

Who Needs Support

Media such as TLC's "Hoarders: Buried Alive" is streamed worldwide. Media of this nature has led to our society to having a negative stigma towards those who exhibit hoarding behaviors (Brien, O'Connor, & Russell-Carroll, 2018). This stigma leads clients to feel hesitant to seek treatment. Due to hoarding disorder being progressive in nature, it is critical that clients receive treatment sooner rather than later. Brien et al. (2018) states that as a professional it is pertinent to remember that one is treating the hoarder, not the hoard. A client can feel lost in the overabundance of items they have in their possession. Supporting not only the client, but as well as their treatment team is essential. The course of treatment for HD can be intense, therefore, being sure that clients/helping professionals are aware of the physical limitations, community involvement, and family support is important (Kress et al., 2016). This includes the client's self-control when getting rid of items. The more valuable the objects are to the client, the lower their self-control is for discarding of those objects and can cause symptoms to worsen (Timpano & Schmidt, 2013).

Like many mental health disorders, hoarding disorder not only affects the individual that is diagnosed, but also impacts family, friends, and community of the client (Bratiotis, Davidow, Glossner, & Steketee, 2016). As a professional, it is necessary to be knowledgeable of resources in one's community as the family and friends may be suffering emotionally, mentally, or physically due to the hoarding behaviors of their loved one. By aiding the client's support system, the issue is being treated in multiple ways. Most public figures (helping professionals, first responders, etc.) are unsure of community resources that are readily available throughout their communities for HD (Bratiotis et al., 2016). Providing resources and support to family members of those with HD can be beneficial, as many families may misinterpret what it means to be suffering from HD. Most family members are uncertain about what to ask for when contacting help. Members of the community are involved if agencies or volunteers are needed to clean up the client's environment(s) and as a professional in the field it is best to prepare those involved to reduce stigma (Bratiotis et al., 2016).

As hoarding disorder goes undiagnosed and untreated professionals are not able to best serve clients. There are clients that are not being reached by professionals that are in need of help. I hope to educate licensed professionals in a variety of communities so clients can receive the help that they deserve. Hoarding can be detrimental to one's life and I want my training to be the spark that lights a fire in the conversation surrounding hoarding disorder.

Training Manual

With the predicted increase of prevalence, scarcity of resources, and lack of information associated with Hoarding Disorder, it is critical to fill this gap. This gap can best be filled by educating front line providers in the mental health field. We can fill the gap with training mental health providers, it can allow clients who struggle with hoarding behaviors to feel more comfortable with their provider and allow the provider to have a more empathetic approach to the client. Providing a training may allow an opportunity of new assessments and treatment approaches to arise in the field, contributing to the overall wellness of the client and the communities in which a provider serves.

Once a branch of Obsessive-Compulsive Disorder, Hoarding Disorder is often overlooked as a mental health issue. This is due to the media that surrounds hoarding behaviors. This has led to stigmatizing individuals with hoarding disorder which can cause suffering clients to feel shame or guilt. These clients are often misunderstood for being unkept, insanitary, and unhygienic. However, with proper education one will discover that these behaviors and mental health issues can happen to anyone. As mental health providers, we should be supportive in our client's struggles with hoarding behaviors, even if it seems overwhelming at first. This training manual is an overview of how to best navigate the diagnoses, assessment, treatment, and resourcing of Hoarding Disorder as a stand-alone diagnosis.

This training is targeted towards mental health professionals that diagnose and treat mental health disorders. This can include but is not limited to: Licensed Professional Counselors (LPC), Licensed Professional Clinical Counselors (LPCC), Licensed Independent Clinical Social Workers (LICSW), Licensed Graduate Social Workers (LGSW), Licensed Marriage and Family

Therapists (LMFT), Psychologists, Psychiatrists, or graduate students in a related field. This training is designed to be a breakout session within a conference and is structured to be forty-five to sixty minutes of lecture followed by thirty to forty-five minutes of discussion and has ability to be adapted.

Learning Objectives

There are four learning objectives for this training that should be introduced before the body of the training is presented. After this training participants will gain the following:

- LO1: Mental Health Professionals will be able to confidently differentiate diagnosing Obsessive Compulsive Disorder (OCD) and Hoarding Disorder (HD)
- LO2: Mental Health Professionals will gain an understanding of how different comorbid disorder diagnoses can affect the treatment of HD
- LO3: Mental Health Professionals will learn about existing treatment modalities.
- LO4: Mental Health Professionals will gain access to resources to best serve clients with HD

The Difference Between OCD and HD

The information provided on this slide is in accordance to the diagnostic criteria of the DSM-5. Differentiation these diagnoses is based on close examination of behaviors of the client. A client with OCD presents their behavior in a repetitive manner, this can be to reduce symptoms that occur with another disorder (i.e., anxiety) and compulsions are used as a method to suppress any recurrent thoughts that might be intrusive to the client. Compulsions also take up a significant amount of time out of the client's day. Hoarding disorder is focused on the client's

inability to part with items that they perceive as important to them whether it is associated with a memory, person, or make the client feel safe. The diagnosis also focused on the quantity of items that client is having difficulty discarding or parting with. While both OCD and HD hold the same specifier on client insight (fair, poor, absent), Hoarding Disorder details a specifier related to excessive accumulation. Eighty to ninety percent of clients with hoarding disorder meet this specifier's criteria. While OCD has a specifier for individuals who have had or currently have Tic Disorder.

Different Ways One May Hoard

Hoarding can manifest in a variety of ways. Hoarding looks different in every single client a professional will encounter. Some clients accumulate items of basic need to feel safe and secure (food, toiletries, bedding, etc.). A client may do this because they struggle to make ends meet and do not want to get rid of anything that may be needed to meet their families basic needs or be of use to them at a later date, even if it is not in the greatest of shape, overly used, or expired.

Hoarding behaviors can be shown through grasping onto a memory, person, or place. This may exhibit itself differently depending on each client. Listed below are some examples:

- "I can't get rid of anything from my mother's house, it was all so special to her and I don't want to forget her now that she is gone" (person)
- "I loved how my kids used to smile and laugh while we baked together, I can't possibly part with my rooms full of baking supplies" (memories)

- "I loved the way the sand felt between my toes, the salty smell of the air, and the warmth of the sun. I keep anything that reminds me of that Floridian beach." (place)

It can be difficult to work with a client who does not want to part with such a significant part of their lives. Creating a framework in which the client recognizes the abundance of items may be a good place to begin.

Some hoarding behaviors can be the exact opposite of holding onto a memory. Sometimes clients hold onto items to suppress memories from coming back. An example of this might be: "Every time the police came to our house because my mom and dad fought, they gave me and my siblings teddy bears, now every time I see a teddy bear, I buy one to feel good. If I get rid of my teddy bears all the memories of my parents' abusive relationship will come back and I can't go through that again".

Other behaviors of hoarding can become extremely hazardous to the client and whoever may come into contact with their environment. Some clients may accumulate an abundance of animals because they make them feel safe or they rescue strays. This can become too much for some clients, which may lead to animal urine and fecal matter spread throughout the home. Some may have a hard time disposing of garbage or recycling properly and it accumulates to the point in which they feel stuck and now live in a home full of trash.

It is important to remember that no matter the type of hoarding, all clients started these behaviors somewhere, and as mental health professionals it is imperative that clients are detected sooner before extreme conditions of hoarding may occur or worsen.

Co-Occurring Diagnoses

This section is also in accordance to the DSM-5. More than 75% of clients with Hoarding Disorder have a co-occurring diagnosis. Co-occurring disorders can include major depressive disorder, social anxiety, and generalized anxiety disorder. Of clients with Hoarding Disorder, 20% will also present symptoms that are related to other diagnoses in the DSM-5 chapter labeled "Obsessive-Compulsive and Related Disorders". It is important to consult with colleagues and supervisors often when working with HD. It is also pertinent to note that most clients seek mental health services because of the symptoms of a comorbid disorder, it is not until they are in services that a professional starts to gain insight on behaviors related to hoarding.

How Can it be Assessed?

There are a handful of assessments available to professionals to gain insight on a client's hoarding behaviors. Three of the four are self-report assessments (SI-R, HRS-I, and OCI-R) which can lead to underreporting from the client. As a professional one should express the available options for help when it comes to hoarding and that reporting accurately is essential. The Saving Inventory-Revised (SI-R) is a 23 question assessment that uses a 5 point Likert scale (0=not at all to 4=extreme) that is utilized to measure the client's difficulty to discard of items, how outstanding their accumulation is, and examines if the client's actions towards the hoarding is avoidant. The Hoarding Rating Scale-Interview uses 5 questions on a 9-point Likert scale (0=no problem to 8=extreme, very often) and assesses if a client is experiencing impairment in their functioning. The Obsessive-Compulsive Inventory-Revised (OCI-R) differentiates between OCD and HD based on the score of the client, it is an 18-question assessment that uses a 5-point Likert scale (not at all to extremely). However, this is still controversial as the research shows

that clients who score in the range intended for a HD diagnosis sometimes does not exhibit behaviors of hoarding. Lastly, the Structured Interview for Hoarding Disorder is the only assessment available at the moment that is not a self-report assessment. It is conducted by a mental health professional. This assessment has a tool for professionals that aids in detecting differential diagnoses and assesses multiple areas of functioning and behavior.

Treatment Approaches

Cognitive Behavioral Therapy (CBT) has been the only effective treatment found for HD thus far. This is said to be because hoarding behaviors stem from a distorted pattern of thinking. Mental health professionals will first examine the way a client behaves when a task is given related to hoarding, this leads to a conversation about the thoughts and feelings a client experiences that are associated with discarding items. These thoughts, feelings, and behaviors set a foundation for the skills training that will be conducted, this phase will work on exposure to discarding items and reinforcement (negative and positive) of the behaviors. The next step is rebuilding the client's thinking patterns in relation to the behaviors surrounding and supporting hoarding. The highly structured nature of CBT holds the client accountable. This approach is also commonly utilizing to treat disorders that co-occur with Hoarding Disorder.

It is most beneficial for clients to work in multiple environments when in treatment (in home independently with homework, in office, and in home with professionals). This way, the professional can work on thoughts, feelings, and behaviors in action on site with the accumulation of items present. Homework should be should be structured so expectations are clearly understood. Although homework is an effective intervention, it should be presented to the

client as a suggestion. In office work is most beneficial in group settings. Group allows clients to see that they are not alone and provides an opportunity for processing.

There are many considerations when treating hoarding disorder. The most important is that as a professional it is essential to keep in mind that it is not the hoard that is being treated, it is the client. Many clients with hoarding disorder present low motivation which is correlated with high dropout rates. It is key to take time and let the client process on their own time rather than rush them through treatment. As a professional consider that the way clients with hoarding disorder process cognitive thought very differently than most other mental health diagnoses. As a professional one also needs to keep in mind the way that the media portrays hoarding and those who struggle with it. Our society has a very negative stigma towards this diagnosis. Which can be addressed by providing education and engaging in advocacy. The last consideration is family support. Clients who come from experiencing an insecure parental attachment and a cold family have greater severity of hoarding behaviors and symptoms. The next barrier is that at this time, there is no Pharmalogical treatment for the behaviors of hoarding. If a client is on medication is more than likely because they are diagnosed with a comorbid disorder, however, there is no correlation in medication for comorbid disorders and behaviors associated with hoarding.

Limitations of Research Pertaining to Client Outcomes

Some of the barriers associated with effective treatment are related to research. When analyzing research of hoarding disorder, all articles present a low sample size, which is said to be due to the low prevalence of the diagnoses and is hopefully going to increase as awareness and advocacy increases. This is a barrier because of the lack of present treatment options available for hoarding disorder, as prevalence increases hopefully treatment options and flexibility

increases. Another barrier related to research is that all information that has been presented thus far rules out those with a co-occurring disorder, as mentioned before, that is a majority of the population that is in fact diagnosed with hoarding disorder. Due to the lack of research on this diagnosis, there is no other treatment modality beyond CBT.

Support Beyond the Client

Those who struggle with accumulating items and hoarding behaviors need assistance beyond their capabilities. Many times, family, friends, community members and agencies are involved in the process. As a mental health professional, it is highly valued to work in collaboration with those in the client's life. In many cases, there are strains on relationships due to family and friends misinterpreting what it means to struggle with hoarding disorder, and they are often unsure in how to help their loved one. Professionals should check in on these individuals to be sure that their physical, mental, and emotional needs are being met, and if not, referring them to appropriate providers.

Community members and agencies are also often called on to aid in the process of discarding items or gaining additional services to the client. Mental health professionals should meet with whoever is being resourced to educate on the basics of hoarding to aid in reducing stigma and to debrief before and after the process of helping the client.

A treatment team is highly suggested for clients with hoarding disorder, these can look different depending on the client's situation, but it is crucial for a team of professionals to meet often.

Local Resourcing

This section will be modified depending on where the training is being delivered. Give those attending time to take pictures of the slide or write down the given information.

Final Thoughts

As stated earlier, this training has a time for discussion and questions built into the end of it. Presenters should leave thirty to forty-five minutes of their allotted time to allow participants to discuss what they have learned and ask the presenter any questions they may have about the information presented. The presenter may choose in what way they would like this done. Some ideas are for small groups to have open discussion as the presenter walks around for any questions the room may have, for the group to raise hands and ask their questions or prompt a discussion topic, or the presenter has participants write down comments and questions they have throughout the presentation that participants drop in a container that the presenter goes through at the end of the presentation.

Evaluation

Prior to dismissing participants, the presenter should hand out and collect the evaluation of the training. The evaluation is structured as a nine question form, six of which are five-point Likert scale questions ranging from 1 (strongly disagree) to 5 (strongly agree) determining if the participants felt that this training was informational and will positively effect their work with clients who have a diagnosis of Hoarding Disorder. A mean of 3 or lower will determine that improvements need to be made to the training. The last three questions of the evaluation are

structured as open-ended questions and are subjective as to what participants enjoy most, improvements, and additional feedback they may have about the training or presenter.

Adaptations to the Training

This training is flexible when it comes to its format. Depending on the trainer and training, this can be edited to specific discipline areas of the mental health professional audience. This training is written for and has resources for the community members of the Fargo-Moorhead metro areas and/or Cass and Clay counties. However, the slide of "How you can help?" can be edited according to the area in which the training is being presented (i.e., resources for the Minneapolis/St. Paul great metro area may have two slides full of resources, while Minot may have less resources available to list).

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Appendix A

Presentation Slides

How is this any different than OCD?

Obsessive-Compulsive Disorder

- Emphasis on repetition
  - To reduce symptoms
- Compulsions are time consuming
- Recurrent thoughts
- Tic Specifier
  - Past or Present

Hoarding Disorder

- Difficulty with departing of items
  - Due to a perceived need
- Hoarding is accumulation
- Holding onto...
  - Memories, Safety
- Excessive Acquisition Specifier
  - 80-90%

Different Ways One May Hoard

- Items of Basic Need
  - Feeling of safety/security
- Association with memories and/or people
  - I loved when my mom and I baked, I miss her
- Connection to abuse
  - If I get rid of these teddy bears...
- Hazardous Hoarding
  - Animals
  - Garbage

Snowball effect: once it starts, it is extremely difficult to stop. This is a progressive disorder.

Co-Occurring Diagnoses

According to the DSM-5...

- 3 out of 4 clients with HD also suffer from a comorbid diagnoses
  - Major Depressive Disorder
  - Social Anxiety
  - Generalized Anxiety Disorder
- 1 out of 5 clients with HD also present symptoms of other diagnoses in the OCD chapter
  - CONSULTATION
- Individuals with hoarding disorder are likely to seek services. However, services are often sought to treat co-occurring diagnosis rather than the hoarding disorder (Kress et al., 2016).

How Can it be Assessed?

•Saving Inventory-Revised (SI-R)

measures one's difficulty to discard items, how outstanding the gathering of the items is, and if they exhibit avoidant behavior

•Hoarding Rating Scale-Interview (HRS-I)

additionally scales if the client has an impairment in their functioning

•Obsessive-Compulsive Inventory-Revised (OCI-R)

Differentiates OCD vs. HD—still controversial

•Structured Interview for Hoarding Disorder

assistant to detect differential diagnoses

Treatment May Look Like...

Cognitive Behavioral Therapy

- Distorted thought pattern
- Examine behavior when given a task
- Thoughts and feelings associated with discarding
- Foundation for skills training
    - Work on exposure and reinforcement
- Rebuild distorted thinking patterns
- Popular with the comorbid disorders
- Importance of accountability

Multiple settings

- Group and Individual settings
- Balance in home, in office, and homework

Considerations

- Low Motivation=High dropout rate
- Hoard vs. Hoarder
- Cognitive Processing
- Media Impact
- Parental attachment and warmth
    - Insecure

Limitations of Research Pertaining to Client Outcomes

According to the research...

1. Small sample sizes are being tested
    a. As prevalence increases this will too
2. Those with a co-occurring disorder are ruled out
3. No pharmacological treatments
4. Does not expand beyond CBT at this time

https://www.colourbox.com/vector/kids-climbing-on-a-wall-vector-5825306

Support Beyond the Client

https://clipartix.com/cleaning-clip-art-image-17781/

Family and Friends
- Often misinterpret
- Resourcing to support their needs
- Unsure how to help

Community Members and Agencies
- Reduce Stigma by Educating
- Debrief

Treatment Team
- Consultation

Other
- Social Services
- First Responders
- MANY MORE

How Can You Help?

Clean Up Assistance:

City of Fargo Solid Waste: 701-241-1449
City of Moorhead Sanitation: 218-299-5347
Clay County Solid Waste: 218-299-7332
Conway Cleaning Services: 701-715-0926
Roe N Jo Junk Haul & Removal: 701-850-6529

Organization Assistance:

Everything Has a Home: 701-238-9030
Project Know: 701-912-6294

Other:

Animal Control: 701-235-4493

https://www.facebook.com/HelpingHandsInHomeChildcare/

Final Thoughts:
Open Discussion and Questions

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Appendix B

Training Evaluation

Please help us improve this training by completing this evaluation fully and honestly. The following six questions you will rank on a five-point scale, the final three questions are open ended, you will answer these by filling in any comments you may have pertaining to the prompts.

Question:	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
I am more confident in differentiating OCD and HD					
I am more confident in defining hoarding as a diagnosis					
I am more confident in understanding the relation between hoarding disorder and the comorbid disorders correlated with it					
I am more confident in how to best serve my clients with hoarding disorder					
I am more confident in supporting my client and their loved ones in relation to hoarding					
I am more confident in my ability to resource clients who struggle with hoarding to community agencies					

I think this training was a positive experience because:

I think something this training could improve on is:

Additional comments and feedback for this training/presenter: