OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Hoarding Disorder

HD

DSM-5-TR 300.3 | ICD-10-CM F42.3

Persistent difficulty discarding possessions regardless of value, producing clutter that renders living spaces unusable and unsafe.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~2.5% (US adults)	Ages 11-15; worsens by decade	Roughly equal	Chronic and progressive

CLINICAL PICTURE

- Clutter accumulates until kitchens, bedrooms, and bathrooms cannot be used for their intended purpose, often without the patient recognizing it.
- Distress arises from discarding rather than from acquiring; patients describe possessions as extensions of identity, memory, or future usefulness.
- Excessive acquisition through buying or collecting free items is present in 80-90% of cases and must be targeted as a separate behavior.
- Insight is frequently poor, and referrals typically originate from family, landlords, adult protective services, or fire marshals rather than the patient.
- Fire hazard, falls, infestation, and eviction create genuine medical and legal risk, particularly for older adults living alone.
- Animal hoarding involves large numbers of animals with failure to provide minimal care and near-uniformly absent insight into the squalor.

DIAGNOSTIC CRITERIA AT A GLANCE

- Persistent difficulty parting with possessions regardless of actual value, driven by a perceived need to save and distress at discarding them.
- Accumulated items congest and clutter active living areas and substantially compromise the use those areas were intended to serve.
- Symptoms cause significant distress or impairment, explicitly including maintaining a safe environment for the patient and for others.
- Not attributable to another medical condition such as brain injury, and not better explained by OCD, depression, autism, or a neurocognitive disorder.
- Specify with excessive acquisition, present in most cases, and specify insight from good or fair through poor to absent and delusional.

NEUROBIOLOGY & PHYSIOLOGY

- Imaging shows abnormal anterior cingulate and insula activity during discarding decisions, hypoactive at rest but hyperactive when deciding about one's own items.
- Neurocircuitry differs from OCD, with ventromedial prefrontal and cingulate decision-making systems dominating over orbitofrontal-striatal loops.
- Neuropsychological testing reveals deficits in categorization, sustained attention, and decision-making beyond what comorbid mood symptoms explain.
- Twin studies indicate roughly 50% heritability, and about half of patients report a first-degree relative with significant hoarding behavior.
- Prevalence rises steeply with age, roughly tripling between ages 30 and 70, and severity increases each decade without active intervention.
- Acquired hoarding after frontal or anterior cingulate lesions and in frontotemporal dementia supports a frontal decision-making model of the disorder.

PSYCHOLOGICAL MECHANISMS

- The cognitive model implicates information-processing deficits, erroneous beliefs about possessions, and intense emotional attachment to objects.
- Saving is negatively reinforced by relief from anticipated distress, while acquiring is positively reinforced by a brief surge of pleasure.
- Beliefs cluster around responsibility for waste, control over possessions, reliance on visual cues for memory, and inflated aesthetic or sentimental value.
- Traumatic loss, material deprivation, and interpersonal rejection frequently precede onset and shape object-based rather than person-based attachment.
- Avoidance of decision-making perpetuates churning, in which items are repeatedly moved from pile to pile but never categorized or discarded.

DIFFERENTIAL & COMORBIDITY

- In OCD, saving follows intrusive obsessions such as contamination or harm and feels ego-dystonic, whereas hoarding-related saving feels justified.
- Rule out major depression with psychomotor slowing, psychotic disorders, autism spectrum disorder, and neurocognitive decline in older adults.
- Comorbidities include major depression in about half of patients, anxiety disorders, and inattentive-presentation ADHD in roughly 30%.
- Normal collecting is organized, bounded, and non-impairing, whereas hoarding is disorganized and blocks the functional use of living space.
- Coordinate with public health, fire, and protective services when squalor, minors, dependent adults, or animals are involved in the household.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication carries an FDA indication; **SSRIs** show modest benefit, with paroxetine 20-60 mg/day and **venlafaxine XR 150-225 mg/day** best studied.
- Response rates fall below those seen in OCD, so expect partial symptom reduction rather than remission from pharmacotherapy alone.
- Treat comorbid ADHD, depression, and anxiety directly, since inattention and low motivation undermine the sustained sorting work required.
- **Stimulants** such as methylphenidate may improve categorization and task persistence when ADHD is comorbid and confirmed.
- Avoid framing medication as the primary treatment; presenting it as support for psychotherapy preserves engagement and realistic expectations.

PSYCHOTHERAPY

- **CBT for hoarding** over 20-26 sessions with in-home visits is the best-supported treatment, with roughly 70% of patients showing improvement.
- Core components are motivational interviewing, skills training in sorting and decision-making, cognitive restructuring, and non-acquiring exposure.
- Practice discarding within sessions and between them; therapist or coach presence during sorting is among the strongest predictors of gain.
- Group CBT and peer-led **Buried in Treasures** workshops deliver comparable benefit at substantially lower cost and greater scalability.
- Never permit forced cleanouts in place of treatment; they are experienced as traumatic and the clutter reliably returns within months.

ADJUNCT & SUPPORTIVE

- Measure with the **Saving Inventory-Revised** and the **Clutter Image Rating** photographs, which bypass poor insight and self-report bias.
- Home visits are essential, since office-based report consistently underestimates clutter volume, squalor, and safety risk.
- Harm reduction focused on fire exits, walkways, and sanitation is the appropriate goal when full remission is unrealistic.
- Coordinate multidisciplinary hoarding task forces spanning housing, fire services, aging services, and animal control agencies.
- Family psychoeducation reduces coercive cleanouts and hostile confrontation, both of which drive dropout and rupture the alliance.

CLINICAL PEARLS

- Distress comes from discarding, not from acquiring; that is the core of the diagnosis.
- Forced cleanouts traumatize and fail; clutter returns without skills training.
- Use the Clutter Image Rating photos when the patient minimizes the clutter.

References

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NOTE

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