

## How To Get Hoarders Into Treatment

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While compulsive hoarding may be observed in individuals with or without Obsessive-Compulsive Disorder (OCD), compulsive hoarding is typically conceptualized on the OCD spectrum. However, unique clinical obstacles interfere with treatment attendance, compliance, and disclosure of hoarding symptoms, distinguishing hoarding among other obsessive-compulsive symptoms. It has been estimated that between one quarter and one third of obsessive-compulsive disordered individuals exhibit symptoms of compulsive hoarding or acquisition. However, it is also speculated that this figure may underestimate the prevalence of hoarding due to the shame and stigma associated with the hoarder's lifestyle. Hoarders demonstrate a corresponding reluctance to discuss their hoarding behaviors and/or acknowledge a hoarding problem. Furthermore, compulsive hoarding may be related to diminished insight into the insidious nature of disordered behaviors; increased rates of depression, anxiety, functional impairment, and personality-disordered symptoms; and diminished treatment response when compared to individuals with OCD who do not hoard. For this reason, clinicians must be prepared to institute a more intensive CBT model, recognize treatment resistance, and place greater emphasis on collaboration with significant others in order to increase the breadth and influence of treatment.

The clinician's initial challenge involves getting the hoarder on board and ready to comply with treatment exercises. Given that insight is frequently very poor, hoarders are less likely to independently enter treatment, or endorse hoarding symptoms. Therefore, the clinician may initially interact exclusively with concerned family member(s) regarding potential treatment plans and intervention strategies. The more information that family members have available to them the greater the likelihood that they will have success when trying to persuade their hoarding relative to enter treatment. Family members should be encouraged to remain informal, empathic, and supportive during initial discussions with their loved ones.

If increasing resistance is observed, family members should be advised to form an empathic united front, confronting their loved one in a systematic, deliberate manner, following recommendations outlined in Overcoming Compulsive Hoarding. Intervention strategies are frequently used by family members in order to communicate to their loved one the seriousness of his/her problematic behaviors. When consulting with family members, this process should be carefully planned, with prior participation from all relevant individuals. Participants must be chosen among those who have witnessed/been impacted by the hoarder's behaviors; Friends, spouses, adult/adolescent children, parents, friendly coworkers/supportive bosses, and other close family may be considered for participation. Ultimately, the more exposure to the hoarding behaviors that significant others have had, the more salient their message will be when confronting the hoarder. However, only those who are sure to remain supportive and even-tempered should be invited to contribute, as excessive defensiveness is likely to be counter-productive. After family members have been selected to participate, they should be invited to prepare the intervention content. An extended session should be planned in order to listen to all participants' observations and delineate

who will say what and in what order. During this consultation session, the exact date and time for the intervention should be arranged, and a tentative appointment should be scheduled for directly following the intervention session in order to ensure that the willing hoarder immediately speaks to a caring professional.

During the intervention, family members should be instructed to calmly “take the floor,” describing in detail how hoarding behaviors have interfered with a comfortable lifestyle (fostering shame, conflict, health/financial concerns, etc.) It is important that an advising clinician carefully instruct family members regarding language choice, emotional tone of speech, and other qualities of communication that will either reel in or turn off the family member with hoarding habits. Feelings will be understandably strong on all sides, but it is important to maintain perspective that the purpose of any united intervention is to create a convincing argument that the loved one explores treatment options; this is not the time for concerned family members to back down, but this is not a time for blood-letting, either.

Once consent to participate in psychotherapy has been attained, it is of critical importance that the clinician bolsters the convenience and palatability of therapy. Initiating a discussion of functional impairment and pertinent distress may prove to be more difficult when working with a hoarder, rather than patients with other clinical presentations. Hoarders tend to be extremely secretive about or dismissive of hoarding behaviors, avoiding visitors and glossing over problematic behaviors during clinical dialogue. Therefore, initial trust-enhancing efforts may be prudent. Clinicians must be mindful of this tendency in order to correctly identify hoarding habits. Once hoarding has been acknowledged, an inordinate amount of time must be spent increasing a hoarder’s motivation to change. Poor insight interferes, once again at this stage, as compulsive hoarders are likely to attribute anxieties and personal failures to a myriad of irrelevant or secondary factors. Traditional Motivational Interviewing (MI) techniques may be useful during this treatment phase, as hoarders may need to be empathically guided toward deliberate conclusions regarding desired/current lifestyle discrepancies. Establishing motivation for change and insight into disordered behaviors will increase the likelihood that hoarding patients continue to participate in therapeutic discussions/exercises. This is crucial, as *active* attendance during CBT sessions establishes the foundation for all subsequent treatment.

Treatment attendance and motivation represent the mere tip of the iceberg regarding successful remediation of hoarding behaviors. Intensive integrated treatments are often required to bring-about significant treatment effects. Such intensive multimodal therapies often include CT, psychoeducation, exposure/response prevention (ERP) targeting discarding and organizing clutter, teaching organizational skills and decision-making, as well as prioritizing responsibilities. Often it is necessary to see hoarding patients several times per week, and when cooperation and trust has been established, home visits will be needed in order to fully remediate hoarding behaviors. Intensive outpatient treatment is necessary because one session per week is not sufficient. The need for an aggressive therapeutic regimen is congruent with findings that hoarding, above all other central OCD symptoms predicts poorest response to CBT. However, many researchers have speculated that treatment noncompliance/refusal and premature termination are at least partially responsible for these discouraging findings. This possibility highlights the importance of initial clinical efforts.

If you wish to take a small quiz to see if you or your loved one is a hoarder you may go to [www.Bio-Behavioral Institute.com](http://www.Bio-Behavioral Institute.com).

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