Hoarding disorder: overview

ARTICLE

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SUMMARY

This article presents a narrative review of the literature on hoarding disorder, its aetiology and management. Hoarding disorder is defined by the excessive accumulation of items, leading to living environments that become so cluttered that their functionality and safety are compromised. It is a multifaceted condition that has an impact on both health and social care systems. Some individuals with this disorder show no signs of additional mental health problems, whereas for others, the effects on their mental well-being, their families and the surrounding community can be profound. Given the societal issues that hoarding generates, effective treatment strategies must extend beyond a clinical focus on the individual to encompass a collaborative approach that addresses both the home environment and the potential repercussions for the wider community.

LEARNING OBJECTIVES

After reading this article you will be able to:

- identify hoarding disorder
- understand the aetiological factors contributing to hoarding disorder
- identify the various available treatment modalities.

KEYWORDS

Hoarding disorder; harm reduction; multidisciplinary approach; cognitive–behavioural therapy for hoarding; hoarding.

Hoarding disorder is a relatively uncommon syndrome affecting 2–6% of the adult population in countries in the Global North. It involves the excessive accumulation of items that stems from both persistent urges or behaviours associated with gathering possessions and a profound difficulty in discarding items, often driven by a perceived necessity to retain them and the emotional distress linked to their disposal. As a result, the person may be socially isolated and neglectful of their self-care. It can also have an impact on various aspects of life, including personal, familial, social, educational and occupational functioning (Postlethwaite 2019). Specific subtypes of the disorder include animal and digital hoarding.

Under section 6(1) of the UK's Equality Act 2010, a person is classed as having a disability if they have a physical or mental impairment that has a substantial, long-term adverse effect on that person's ability to carry out normal day-to-day activities. Hoarding disorder can meet the criteria for disability such that people with this condition can be regarded as being legally disabled.

The phenomena of hoarding and squalor may arise from various factors, including dementia, such as frontotemporal dementia, frontal lobe damage due to a stroke, depression, obsessive–compulsive disorder (OCD), alcohol use disorder and chronic schizophrenia. However, many individuals have no additional psychiatric conditions and often resist assistance.

Background

As early as 1947, Erich Fromm identified a 'hoarding orientation', wherein an individual's sense of security was linked to the accumulation of objects. In 1962, the psychiatrist Jens Jansen introduced the term 'collector's mania' to characterise older adults who excessively filled their living spaces with numerous items. Bratiotis et al (2021) note that hoarding disorder significantly affects employment because people who hoard take an average of 7 days off work a month for psychiatric reasons: a number equal to that for people with bipolar and psychotic disorders and significantly higher than for individuals with mood disorders. These negative outcomes also affect those living with person with the disorder. Severely cluttered family environments are associated with increased childhood distress, reduced social interaction and greater family conflict.

Historically, hoarding was viewed as a subtype of OCD; however, distinctions between the two are more pronounced than previously thought. Hoarding behaviours have been observed in individuals with various anxiety disorders beyond OCD, particularly in those diagnosed with generalised anxiety disorder (GAD) or social phobia. Major depressive disorder, GAD and social phobia appear to be more common among individuals with hoarding disorder compared with those with OCD (Frost 2011). Unlike OCD, those with hoarding disorder typically do not experience distress regarding their symptoms, even when the symptoms are evident to others. Conversely, individuals with OCD typically express distress and show greater awareness of their symptoms. These distinctions support

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BOX 1 ICD-11 diagnostic requirements for hoarding disorder

Essential (required) features:

- Accumulation of possessions that results in living spaces becoming cluttered to the point that their use or safety is compromised. Note: If living areas are uncluttered this is only due to the intervention of third parties (e.g., family members, cleaners, authorities).
  Accumulation occurs due to both:
- Repetitive urges or behaviours related to amassing items, which may be passive (e.g., accumulation of incoming flyers or mail) or active (e.g., excessive acquisition of free, purchased, or stolen items).
- Difficulty discarding possessions due to a perceived need to save items and distress associated with discarding them.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

(World Health Organization 2025: 6B24)

Source: https://icd.who.int/browse/2025-01/mms/en#1991016628.

classifying hoarding disorder as distinct, although commonly comorbid with other psychiatric conditions. Over 60% of individuals with hoarding disorder also meet the criteria for at least one additional psychiatric disorder. Research on comorbid conditions associated with hoarding has identified particularly high prevalence rates of major depressive disorder (50–52%), GAD (24%) and social phobia (23%) (Frost 2011). The symptoms linked to depressive and anxiety disorders may contribute to the persistence of negative emotional states driving hoarding behaviours.

The diagnostic criteria from ICD-11 are shown in Box 1. The diagnostic criteria for DSM-5 (American Psychiatric Association 2013) are similar to ICM-11; the differences are that DSM-5 does not make the distinction between active and passive amassing of items, and DSM-5 also requires the symptoms not to be better explained by other medical conditions (such as Prader–Willi syndrome) or mental disorders (such as obsessive-compulsive disorder or autism spectrum disorder).

Neuroimaging studies of hoarding symptoms and hoarding disorder

The neurobiological mechanisms underlying hoarding disorder remain inadequately explored. Various studies have identified a relationship between hoarding symptoms and particular brain regions.

A positron emission tomography (PET) study demonstrated significantly reduced glucose metabolism in the posterior cingulate gyrus and cuneus in individuals with OCD who exhibit compulsive hoarding behaviours (Saxena 2004).

A functional magnetic resonance imaging (fMRI) investigation found that people with OCD and pronounced hoarding symptoms displayed heightened activation in the bilateral anterior ventromedial prefrontal cortex compared with those without hoarding symptoms and healthy controls when exposed to anxiety-inducing stimuli related to hoarding (An 2009).

Structural brain studies utilising voxel-based morphometry (VBM) have indicated a correlation between hoarding symptom severity in OCD and grey matter volume in regions such as the left caudate, left Brodmann area, left lateral orbitofrontal cortex (OFC) and right parahippocampal gyrus (Alvarenga 2012).

However, the findings of these various imaging studies exhibit inconsistencies, and most of the research has concentrated on compulsive hoarding as a subtype of OCD. Little research has specifically investigated the structural alterations associated with hoarding disorder using the diagnostic criteria outlined in DSM-5 (American Psychiatric Association 2013). One study focused on 17 patients who fulfilled the DSM-5 criteria for hoarding disorder, employing VBM techniques (Yamada 2018). It found a significant increase in grey matter volume in the OFC, particularly in Brodmann areas 10 and 11, compared with both the OCD and healthy control groups. Although the OFC has often been linked to the pathophysiology of OCD, the results from VBM studies have, as mentioned, been inconsistent thus far. It is important to acknowledge that the presence of mixed hoarding symptoms may have affected the outcomes of the studies. Yamasa et al's study suggests that structural abnormalities in the prefrontal regions may be linked to the pathophysiology of hoarding disorder. Further research is necessary to elucidate the underlying mechanisms of hoarding disorder.

The aetiology of hoarding disorder

Genetics

Twin studies indicate that as much as 50% of the variance in hoarding behaviours may have a genetic basis. Hoarding and its associated symptoms exhibit heritability estimates ranging from 45 to 71%, which is slightly lower than that of OCD, reported at 74% with a confidence interval of 60–83% (Cath 2017). A study in community-based paediatric sample revealed a significant

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association between the [L_G + S] variant of *5-HTTLPR* and hoarding in males, and a trend was observed linking variations downstream of *HTR1B* to hoarding in females (Sinopoli 2020). Additionally, associations were noted between T-allele carriers and hoarding, as well as Val-allele carriers and hoarding. Genotyping of a subsample ($n = 3410$) of White twins from a genome-wide association study did not yield genome-wide significance; however, suggestive evidence for associations with hoarding traits was found at two genomic loci on chromosomes 5 and 6 (Perroud 2011). Furthermore, there appears to be a connection between hoarding traits and the glutamatergic system (Xiong 2023), although further research is warranted to explore this relationship.

Self-reported family histories also support a genetic component in hoarding symptoms. Older adults with hoarding disorder typically report an average of two biological relatives exhibiting similar hoarding behaviours, with nearly half of geriatric patients indicating that their mothers displayed hoarding tendencies. Although such self-reported data cannot entirely disentangle the influences of genetics and environmental factors – such as the roles of genes, epigenetics and social learning – they do imply a significant familial connection in the development of hoarding disorder. Therefore, although biological factors play a crucial role in hoarding, they do not fully explain the complete clinical picture. Additional genetic research is necessary to enhance our understanding of the biological underpinnings of this disorder (Ayers 2015).

Evidence indicates that genetic factors may play a role in the comorbidity of hoarding disorder with other psychiatric disorders. Specifically, Zilhão et al (2016) found that genetic influences accounted for 50.4 and 70.1% of the covariance between hoarding disorder and OCD symptoms and Tourette's disorder respectively. Notably, specific genetic variations were significantly correlated with hoarding disorder and OCD symptoms (correlation of 0.41) and Tourette's syndrome (0.35), suggesting a shared genetic foundation for these conditions. Current research on the genetics of hoarding disorder remains limited, highlighting the need for comprehensive studies to identify genetic risk factors and distinct genetic signatures associated with hoarding disorder and other obsessive–compulsive related disorders (Davidson 2019).

Neuropsychological factors

Neurocognitive functioning

Cognitive impairment, characterised by challenges in planning, problem-solving and memory, is frequently observed in older adults who engage in hoarding behaviours, thereby complicating both assessment and treatment processes.

A review of cognitive performance (Woody 2021) in individuals with hoarding disorder has revealed impairments across various cognitive domains, with a particular emphasis on executive functioning. Those with hoarding disorder exhibit compromised decision-making abilities in unstructured sorting tasks when compared with individuals without hoarding tendencies, although they do not show similar deficits on standardised neuropsychological tests. Such decision-making challenges may exacerbate the distress experienced by hoarding patients when they are required to decide whether to retain or discard an item. Additionally, hoarding behaviour may be associated with problems related to attentiveness and inhibition, making it more difficult for individuals with hoarding disorder to resist the initial impulse to acquire new objects.

Individuals with hoarding disorder may experience signs of accelerated cognitive ageing. Older adults with hoarding disorder demonstrate executive functioning impairments that exceed what would typically be anticipated from normal ageing processes. In comparison with healthy non-clinical controls, older adults with hoarding disorder exhibit significantly greater executive dysfunction. In a geriatric sample of individuals with hoarding disorder, heightened hoarding symptoms have been linked to impaired executive functioning, even after accounting for comorbid psychiatric conditions (Ayers 2016). Despite several limitations in the current literature regarding neurocognitive functioning and hoarding – such as reliance on non-clinical samples and the absence of control groups – there is a discernible trend of cognitive difficulties associated with hoarding disorder (Dozier 2016).

Trauma and life events

Numerous studies have reported an association between traumatic or stressful life events and hoarding. For example, Frost et al (2011) found that individuals diagnosed with hoarding disorder reported a higher incidence of past traumatic experiences compared with those with OCD, although there was no significant difference in the prevalence of comorbid post-traumatic stress disorder between the two groups. Tolin et al (2010) reported that 76% of a sample of individuals identifying as hoarders in an online survey had a history of experiencing interpersonal violence. In a sample of individuals with compulsive hoarding difficulties, Grisham et al (2006) found that 55%

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reported having experienced a stressful life event, whether positive or negative, prior to the emergence of their hoarding symptoms. Those who indicated a stressful life event before the onset of hoarding symptoms also reported a later age at onset. The two groups (with and without prior stressful life event) showed no differences in current symptom severity, implying that the impact of the stressful life event did not carry over to the present symptomatology. In a community-based sample, Samuels et al (2008) found that self-reported experiences of 'childhood adversities' such as home invasions and physical abuse were significantly linked to heightened hoarding behaviours.

Attachment, beliefs, behaviours and emotions

The heightened attachment to belongings and the increased tendency to attribute human-like qualities to inanimate objects were integral to the initial understanding of hoarding and remain essential components of the cognitive–behavioural framework for hoarding disorder. In the realm of OCD, the severity of hoarding symptoms has been identified as a predictor of the emotional attachment formed to new items that lack objective sentimental value (Grisham 2009). Notably, the initial emotional connection to an object serves as the strongest indicator of future attachment to that same item.

Both individuals with hoarding symptoms and those without often cite emotional attachment as the primary reason for retaining an object (Yap 2020). However, people with hoarding disorder and self-identified collectors are also inclined to mention potential usefulness as a significant factor in their decision to keep items. A study focusing on adults with hoarding disorder examined specific motivations for saving items – such as the fear of losing important information, sentimentality, the potential utility of an object and aesthetic appeal – and found that participants generally endorsed all these reasons at moderate to severe levels (Levy 2017). After adjusting for the tendency of people with hoarding disorder to overstate their reasons for saving, potential usefulness emerged as the most significant predictor of hoarding symptom severity.

Studies involving undergraduate populations have shown that elevated sensitivity to anxiety and diminished tolerance of distress are associated with greater hoarding symptom severity, even when controlling for coexisting depression, anxiety and obsessive–compulsive symptoms. Moreover, the relationship between distress tolerance and hoarding appears to be moderated by anxiety sensitivity, indicating that the link between these two factors is significant only at high levels of anxiety sensitivity (Keough 2010).

Emotional reactivity, which refers to the intensity and duration of emotions experienced in response to emotional stimuli, has been proposed as a potential vulnerability factor for hoarding disorder. An online survey involving participants who self-identified as experiencing serious hoarding difficulties revealed that those exhibiting greater emotional reactivity also reported more severe hoarding symptoms (Shaw 2015). This correlation was particularly pronounced among individuals who expressed a heightened fear of making erroneous decisions and demonstrated lower confidence in their memory.

Family

Family members residing with individuals who hoard face similar health and safety hazards. Children of hoarders endure ongoing disruptions, such as the loss of usable living space, unsanitary home environments, social isolation, financial strain and strained family relationships (Sekhon 2023). The repercussions of these difficulties can have lasting effects on children, with psychological distress potentially extending into their adult years. Recent studies reveal that adult children of hoarders often experience grief over the diminished relationship with their parent, alongside feelings of anger due to the perception that their parent prioritises possessions over their well-being (Kocol 2025). As these parents age, their adult children frequently assume additional caregiving responsibilities.

The caregiver burden reported by relatives of individuals who hoard has been found to be on par with, or even exceed, that experienced by family members of individuals with dementia (Drury 2014). Older adults who hoard often require significant assistance with basic daily activities that may otherwise be overlooked, a duty that typically falls to their adult children and other family members. Additionally, relatives of hoarders frequently report heightened levels of frustration, hopelessness and distress due to the hoarding individual's lack of self-awareness and ambivalence towards treatment and the dangers posed by unsafe living conditions (Sekhon 2023). Feelings of shame and embarrassment hinder family members from inviting guests into their homes, thereby increasing the risk of social isolation. The negative emotions experienced by family members of hoarders often lead to a complete rejection of the individual who hoards.

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Demographic factors

Personality traits

Clinicians have characterised hoarding patients as displaying personality traits associated with perfectionism and indecisiveness. Dozier & DeShong (2022) indicate that elevated scores on self-report measures of perfectionism, indecision and procrastination are significant predictors of a hoarding disorder diagnosis. The typical person who hoards struggles to make decisions regarding their possessions, primarily due to a fear of making incorrect choices, such as discarding an item they may need in the future, and a desire to ensure they make the right decision, like retaining an item of necessity. This fear often leads the person to avoid making any decision altogether or to default to the choice of keeping or acquiring the item. Beyond specific personality traits, individuals with hoarding tendencies may also exhibit a higher prevalence of certain personality disorders. Samuels et al (2008) found that increased hoarding behaviours in a community sample correlated with a greater likelihood of fulfilling the criteria for paranoid, schizotypal, avoidant or obsessive–compulsive personality disorders.

Socioeconomic status

Socioeconomic status could serve as a moderating factor in the emergence and advancement of hoarding symptoms. Samuels et al (2008) reported an inverse relationship between income levels and the prevalence of hoarding behaviours in their community sample. Individuals with hoarding disorder who have a low income may face a higher risk of homelessness compared with those without hoarding tendencies, a situation that is particularly pronounced among elderly people.

Age

Currently, there is a lack of longitudinal studies investigating the factors that precede the onset of hoarding disorder or focused on hoarding disorder in children. The literature on age at onset of hoarding disorder primarily relies on retrospective data (Zaboski 2019). Dozier et al (2015), utilising a sample of participants who met the DSM-5 criteria for hoarding disorder, suggested that the emergence of hoarding symptoms, whether associated with hoarding disorder or not, typically occurs before the age of 20, aligning with the usual onset age for OCD. However, unlike the generally cyclical nature of OCD symptoms throughout an individual's life, hoarding symptoms tend to be chronic and progressive. Cath et al (2017) revealed that the prevalence of provisional hoarding disorder diagnoses increased by 20% for every 5-year increment in age, with difficulties in discarding items being a significant factor contributing to the rise in hoarding disorder diagnoses as individuals age.

It is estimated that approximately 2% of adolescents exhibit symptoms of hoarding disorder (Whomsley 2020). Hoarding symptoms in children and adolescents are linked to various challenges, including poor insight, indecisiveness, inattention, memory deficits, impaired problem-solving and planning abilities, increased avoidance and the presence of comorbid conditions such as Tourette's syndrome and attention-deficit hyperactivity disorder (ADHD). Research indicates that youths with OCD who also exhibit hoarding symptoms experience more severe lifetime trajectories of OCD compared with their peers without such symptoms (Whomsley 2020).

Cath et al (2017) reported that the prevalence of hoarding among older adults is approximately three times higher than the estimated population prevalence of 2–6%. Hoarding behaviours pose distinct challenges for older adults, as the accumulation of clutter can lead to risks, including fire hazards, falls, medication mismanagement, inadequate nutrition, social isolation, difficulties in performing daily activities and an overall decline in quality of life (Kim 2001). Notably, 64% of older adults with hoarding disorder struggle with self-care tasks, and 81% face health risks related to fires, falls and unsanitary conditions.

Gender

Gender may influence the effects of genetic and environmental factors on the onset and manifestation of hoarding disorder. A greater number of women than men seek treatment, and women often report more severe hoarding symptoms. Gender differences may also affect the motivations for saving items among hoarding patients. Women are more inclined than men to save items based on their aesthetic appeal or perceived informational value (Dozier 2017). Given that women with hoarding disorder are more likely to pursue treatment, our current understanding of gender disparities in hoarding symptom severity may be skewed.

There are conflicting findings regarding gender differences in the prevalence of hoarding. Initial epidemiological studies indicated that hoarding behaviours might be more prevalent in men (4–6%) than in women (2–3%). However, no significant gender differences have been observed in the prevalence of individuals meeting the DSM-5 criteria for hoarding disorder, nor in a population-based study (Cath 2017). Conversely, a study

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focusing on paediatric OCD revealed that hoarding symptoms are more common in girls than in boys (Samuels 2014).

Risks associated with hoarding disorder

As already mentioned, hoarding disorder is associated with many risks for the individual (and potentially their family and neighbours). Individuals with hoarding disorder often live alone and are less inclined to have family or friends visit their homes and as a result they may be socially isolated and neglectful of their self-care. Although hoarding typically does not cause distress to the individual, they often face condemnation from neighbours, local authorities and landlords.

Severe hoarding behaviour often leads to various public health and safety issues, which necessitate the involvement of interventions, resources and professional expertise from multiple sectors in the community, such as fire safety, sanitation, housing, protective services, legal assistance, and health and mental health services. The objectives of these community-based interventions typically encompass reducing the prevalence of severe hoarding, enhancing the physical and mental well-being of individuals affected by hoarding, and safeguarding housing stability.

Common risks include fire risks, risk to physical health such as exacerbation of asthma and other conditions when dust accumulates on the hoarded items, falls, injuries and blockage of access in case of fire or a medical emergency.

Treatment and management: the evidence base

Addressing hoarding disorder can be challenging. The primary approach cognitive–behavioural therapy (CBT). Patients have identified several key elements that contribute to a successful intervention, including respectful and timely engagement, interventions that are part of a continuous relationship, and support tailored to the individual's needs. At present, there are no medications specifically approved for the treatment of hoarding disorder. However, medications may be prescribed to manage co-occurring conditions such as anxiety and depression that frequently accompany hoarding disorder.

Psychological interventions

Cognitive–behavioural therapy

Cognitive–behavioural therapy is currently recognised as the leading evidence-based intervention for hoarding disorder, as it helps the individual to learn how to better manage beliefs and behaviours that are linked to keeping the clutter.

Individual and group CBT for hoarding typically incorporates elements such as decision-making training, exercises for sorting and discarding items, organisation skills training, exposure therapy, cognitive restructuring related to non-acquisition, and motivational interviewing (Steketee 2000). CBT is particularly effective in tackling challenges related to discarding items, reducing the volume of clutter and curbing acquiring behaviours. However, the availability of this specialised CBT is limited, as few mental health professionals possess the necessary expertise to deliver hoarding-specific interventions. A systematic review and meta-analysis on group CBT revealed that it leads to clinically significant improvements (ranging from 21 to 68% across treatment groups) in the severity of clutter, acquisition behaviours and challenges in discarding items (Bodryzlova 2019). A broader systematic review and meta-analysis confirmed that psychological therapies are effective in reducing hoarding symptoms, but found no superiority for CBT (O'Brien 2025).

In alignment with exposure therapy approaches used for anxiety, trauma and OCD, exposure sessions for hoarding disorder aim to assist patients in evaluating the actual threat level of feared situations and avoiding distressing situations, such as sorting or discarding items, which have been reinforced over time. For instance, they may learn that discarding an item perceived as 'valuable' carries a low risk of negative outcomes, while also recognising their ability to tolerate the distress associated with such actions. Additionally, research indicates that the severity of hoarding symptoms correlates with the individual's behavioural avoidance, even when accounting for coexisting anxiety and depressive symptoms.

Virtual and blended therapies

Technology-assisted interventions for hoarding, as discussed by Fitzpatrick et al (2018), offer several advantages. These include increased access to qualified professionals, flexibility in terms of implementation, content and personalisation, improved scheduling convenience, ongoing support and feedback between sessions, and enhanced cost-effectiveness. Virtual reality (VR) may be particularly beneficial for individuals who have difficulty using mental imagery techniques to visualise everyday settings (a common problem in people with hoarding disorder), and it may serve as an alternative to home visits.

A preliminary study of VR and inference-based therapy in a group format found a significant

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difference in the post-treatment level of bedroom clutter in the experimental group compared with the control group (St Pierre-Delorme 2016). Another study that used VR to simulate participants' home environments without existing clutter found that participants reported higher confidence and motivation to engage in behaviour change post-immersion (Chasson 2020).

Compassion-focused therapy

Compassion-focused therapy (CFT) fosters self-compassion, alleviating self-blame and managing any negative emotions that surface during cognitive restructuring efforts. A pilot study of CFT as a follow-up treatment for individuals with hoarding disorder who continued to experience symptoms after initial CBT treatment reported satisfactory feasibility and acceptability (Chou 2020). Among those who completed the treatment, 77% achieved severity scores below the threshold for clinically significant hoarding and 62% experienced a clinically meaningful reduction in symptom severity. Nonetheless, CFT showed limited effectiveness in addressing issues related to memory concerns and emotional attachment to possessions, as well as in mitigating hoarding-related beliefs.

Coordinated community interventions and harm reduction

The objectives of community-based interventions typically encompass reducing the prevalence of severe hoarding, enhancing the physical and mental well-being of individuals with hoarding disorder and protecting the person from eviction.

Case management has emerged as a widely adopted strategy within these interdisciplinary efforts. These case management activities are typically employed to deliver comprehensive social services to vulnerable and marginalised groups and have proven to be particularly effective in addressing the intricate needs of individuals who hoard (Bratiotis 2019).

People with hoarding disorder might be forcibly moved to a different home, or a service might be hired to thoroughly clean out the house. However, involuntary cleaning out of homes can be traumatising for the hoarder and ultimately ineffectual. As a result, community-based responders are increasingly choosing to frame their service delivery through a harm-reduction approach (Box 2). The objective of harm reduction is to lessen or mitigate the risks connected to hoarding, not to eradicate the behaviour itself. To implement this strategy, the hoarder must be involved in decision-making, and a supportive, non-judgemental client–provider relationship must be established. Instead of removing items completely, hoarding response teams that employ a harm-reduction strategy might help the hoarder reduce the amount of clutter to protect housing or even reorganise belongings into safer arrangements (Tompkins 2015).

BOX 2 Case vignette: multidisciplinary harm reduction for hoarding disorder

Anna is a 72-year-old single woman who is isolated from her neighbours and has little family contact. She has been hoarding for over 50 years. Her mother was a hoarder. It took 2 years to clear her house of unnecessary items, as she was very much attached to everything. She refused to go into a care home as she thought it expensive.

A multidisciplinary harm reduction approach was used. She had input from a social worker, community nurse, occupational therapist and physiotherapist. She had long-term cognitive–behavioural therapy for hoarding and was prescribed a selective serotonin reuptake inhibitor to reduce the anxiety associated with decluttering.

Medication

The current literature on medications has mostly concentrated on selective serotonin reuptake inhibitors (SSRIs), owing to their effectiveness for OCD, of which hoarding disorder was first thought to be a subtype. According to some studies on pharmacotherapy for OCD that looked back at patients with both OCD and hoarding symptoms, hoarding was associated with a poorer response to SSRI medication (Landeros-Weisenberger 2010). Other studies, however, found that hoarding had no discernible impact on OCD patients' response to pharmacotherapy. Those with hoarding disorder who did not also exhibit other symptoms of OCD were excluded from these studies, which were exclusively focused on OCD sufferers. More than 80% of people with hoarding disorder do not also have OCD (Chakraborty 2012).

In a prospective study (Saxena 2007) individuals with OCD with ($n = 32$) and without hoarding ($n = 47$) received 12 weeks of the SSRI paroxetine (mean 41.6 mg/day, s.d. = 2.8 mg/day). Similar proportions of participants in each group were identified as full responders (hoarders, 27%; non-hoarders, 32%) and as partial responders (hoarders, 22%; non-hoarders, 15%), but paroxetine was not well tolerated.

In a subsequent open-label trial to test a better-tolerated medication (Saxena 2014) 24 individuals who met the DSM-5 criteria for hoarding disorder were given extended-release venlafaxine (37.5 mg increments to 225 mg/day) for 12 weeks. Venlafaxine was well tolerated and symptoms

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decreased by an average of 32–36%. However, other research involving patients with OCD and hoarding symptoms has not demonstrated any response to this class of medication, so the efficacy of serotonergic/noradrenergic medications for treating hoarding disorder is still debatable (Grassi 2016).

Among participants with hoarding disorder who displayed symptoms of inattention and impulsivity, a 12-week open trial of 40–80 mg/day (mean 62.72 mg/day) of atomoxetine, a medication used to treat ADHD, resulted in a 41.3% decrease in hoarding severity. The participants' global functional disability decreased in tandem, with a mean 18.5% decrease in their impulsivity and inattentional symptoms. Three of the twelve participants were classified as partial responders (mean hoarding symptom reduction of 27.3%) and six were classified as full responders (mean hoarding symptom reduction of 57.2%) (Grassi 2016).

Extended-release methylphenidate was used to treat four hoarding disorder sufferers without comorbid ADHD in a small open-label case series. Three of the four participants self-reported ≥50% improvement in their inattention on the ADHD Symptom Scale after 4 weeks of treatment with an average of 50 mg of methylphenidate (Rodriguez 2013).

In a case study, a person with bipolar II disorder and hoarding symptoms responded well to lamotrigine and methylphenidate but not to high doses of SSRIs or second-generation antipsychotics (Laurito 2016).

There is no proof that second-generation antipsychotics such as risperidone and quetiapine are helpful for hoarding disorder, according to a review of their use in treating the disorder (Kim 2018).

In a meta-analysis on CBT for hoarding disorder that also considered the use of concomitant psychiatric medications, Tolin et al (2015) discovered that although medication did not significantly improve the severity of hoarding or most hoarding symptoms, it did significantly improve the difficulties of discarding. The effectiveness of drugs for hoarding disorder, both alone and in combination, and combining medication with CBT requires more investigation (Piacentino 2019).

Discussion

Multidisciplinary intervention

Hoarding disorder is a multifaceted condition that has an impact on both health and social care systems. Some individuals with this disorder show no signs of diagnosable mental health conditions, whereas for others, the effects on their mental well-being, their families and the surrounding community can be profound.

Clinicians should be aware of adult care guidance for their catchment areas. For example, the multi-agency hoarding guidance that covers a region of south-east England (Hoarding UK 2018) recommends a collaborative approach among staff to facilitate a coordinated effort aimed at achieving positive outcomes for all parties involved. The matter of multidisciplinary team working should particularly draw attention to the possible need for psychiatrists to consider detention under mental health legislation (in England and Wales the Mental Health Act 1983), the need to consider mental capacity and to contribute to risk assessment and management processes. UK clinicians can draw patients' attention to the resources available on the National Health Service website (www.nhs.uk/mental-health/conditions/hoarding-disorder/).

According to the National Institute for Health and Care Excellence (NICE) guidelines, CBT and SSRIs may be beneficial for individuals displaying OCD and hoarding behaviours (NICE 2005). However, it is essential to acknowledge that hoarding disorder is often seen as resistant to treatment, highlighting the need for a tailored approach.

A thorough team-oriented treatment plan helps ensure that all facets of the disorder are effectively managed. The involvement of family members and caregivers is vital in the treatment process, making their education and support crucial for fostering a sustainable recovery environment. Advocacy and education directed at decision makers are often required to secure funding for services addressing hoarding disorder. Training initiatives for healthcare professionals and community workers are essential in enhancing the capacity to tackle hoarding issues; examples include workshops focused on assessment methods and intervention techniques. Additionally, specialised equipment may be required for home-based interventions and decluttering efforts, making budgeting for these resources a significant consideration.

Collaborating with local organisations can broaden the reach of services, and partnerships with housing authorities, fire departments and animal welfare organisations can offer further support and resources.

Psychosocial interventions for individuals with hoarding disorder show improvements in outcomes such as fire safety, tenancy preservation and quality of life, with effect sizes ranging from $d = 0.86$ to $d = 1.41$ (Twigger 2024).

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Consent and confidentiality

Acquiring informed consent in the treatment of hoarding disorder presents significant challenges. It is essential for clinicians to evaluate the patient's decision-making capacity to ascertain whether they can comprehend the treatment options and their potential consequences. In cases where capacity is diminished, it may be necessary to involve proxy decision makers. A careful equilibrium must be maintained between honouring the patient's choices and preventing harm.

Implementing clear policies regarding information sharing is crucial to protect patient privacy while facilitating necessary care coordination.

Enforced action and safeguarding

In extreme situations, legal measures may be required to mitigate safety risks or protect vulnerable individuals. These might involve environmental health orders or court-ordered clean outs. Such actions should be considered a last resort, following unsuccessful attempts to gain voluntary cooperation, as they can lead to trauma and damage to the therapeutic relationship. If self-neglect or abuse is suspected, safeguarding procedures may be necessary, and clinicians should be familiar with local protocols for reporting concerns. A multidisciplinary approach that includes mental health, social care and legal professionals is essential to effectively balance rights and risks. Community and family care models are of great interest, given the need for harm reduction strategies. Certain groups, such as a hoarder's children, elderly hoarders or those who do not actively pursue treatment, require particular attention when it comes to intervention strategies.

Also, it is helpful to draw attention to the perspective of primary care, as referrals to community mental health teams may originate from general practitioners (GPs) and long-term care will involve GPs and their teams alongside support services (Morein-Zamir 2023).

Future research

Questions remain regarding many aspects of hoarding disorder, including its genetic component, neuropsychology and demographics. Treatment modalities need more research and a more collaborative approach. We hope that the future brings more clarity, better screening tools and clear direction in helping those vulnerable individuals.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

All authors contributed to the literature search and to the writing up of the article and its revision.

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Declaration of interest

None.

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MCQ answers
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MCQs

Select the single best option for each question stem

1 Hoarding disorder has been associated with:
a cerebral palsy
b frontotemporal dementia
c Huntington's disease
d progressive supranuclear palsy
e cerebellar ataxia.

2 The leading evidence-based intervention for hoarding disorder is:
a SSRIs
b antipsychotics
c cognitive–behavioural therapy
d combined SSRIs and cognitive–behavioural therapy
e atomoxetine.

3 Areas of the brain implicated in hoarding disorder include:
a Broca's area
b hippocampus
c basal ganglia
d orbitofrontal cortex
e cerebellum.

4 Factors contributing to hoarding disorder include:
a genetics and heritability
b cognitive impairment such as challenges in planning, problem-solving and memory
c past traumatic experiences
d personality traits associated with perfectionism and indecisiveness
e all the above.

5 The main aim of cognitive–behavioural therapy for hoarding disorder is to:
a help the individual to better manage beliefs and behaviours that are linked to keeping the clutter
b help the individual remove clutter in the home
c help the individual to save expensive items
d help the individual to get more items
e help the family cope better.

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