Compulsive Hoarding in Children

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This article discusses the nature and treatment of compulsive hoarding among children. We summarize the phenomenology of compulsive hoarding, including its clinical presentation, comorbidity with varied mental disorders, and associated impairment. The limited data on treatment outcome are presented along with a behavioral framework that we utilized to treat youth who hoard. Our approach is highlighted in the context of a case illustration of an 11-year-old girl suffering from compulsive hoarding and several comorbid mental health disorders. We conclude with recommendations for clinical work with this challenging and neglected population. © 2011 Wiley Periodicals, Inc. J Clin Psychol: In Session 67:507–516, 2011.

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Compulsive hoarding is characterized by the accumulation of useless items, associated clutter, and difficulty discarding hoarded items, which together cause interference in functioning (Frost & Hartl, 1996). Severe hoarding is a serious public health concern that may result in precarious living situations, in which the acquired items intrude on the available living space within the home and/or create a toxic environment where the residents are exposed to an array of potentially toxic materials such as bacteria, rotting foods, dust, and pollen. The majority of research and application on hoarding has been focused on adult populations with relatively scant attention devoted to compulsive hoarding among youth.

The dearth of attention to compulsive hoarding among children poses a clinical problem for several reasons. First, because many adult hoarders report childhood onset of symptoms (Samuels et al., 2007), better understanding of hoarding during childhood will advance our knowledge of its etiology and our assessment and treatment methods. Second, most disorders in the Diagnostic and Statistical Manual for Mental Disorders (DSM; American Psychiatric Association, 2000) are age-downward extensions of adult diagnoses. Yet there are critical differences between adults and children that call for specific attention to the latter. The clinical manifestation of compulsive hoarding in youth may differ from that of adults as clutter may be limited to a smaller area in youth (e.g., bedroom) and the nature of certain items is more constrained because of limited resources of children. Third, the limited research on childhood hoarding translates into fewer research-supported assessment instruments and treatment methods. To date, the majority of research on compulsive hoarding in youth has been conducted in samples diagnosed with obsessive-compulsive disorder (OCD). OCD originates during childhood in as many as 80% of cases (Grisham, Frost, Steketee, Kim, & Hood, 2006), and without treatment, it tends to run a chronic course in adulthood (Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995). The categorization of obsessive-compulsive symptoms into four factors has been demonstrated through factor analytic research in both adult and pediatric OCD, with symptom groupings as follows: (a) aggressive/sexual/religious/somatic/checking, (b) contamination/cleaning, (c) symmetry/ordering/counting/repeating, and (d) hoarding (Stewart et al., 2008).

The consistent separation of hoarding in presentation, treatment outcome, etiology, and factor analytic study has called into question its diagnostic inclusion under OCD (Pertusa

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et al., 2010). Indeed, a separate hoarding disorder is planned in the forthcoming DSM-V in which hoarding would be largely removed from OCD (Pertusa et al.). However, much of the extant data are derived from adult OCD studies with considerably less being known about hoarding in pediatric patients with and without OCD.

Within this context, what follows is a summary of the nature of hoarding in youth with and without OCD, detailing what is known about its clinical presentation, assessment, and treatment. We then provide a detailed case illustration about the assessment and treatment of a child suffering from hoarding. Finally, the article concludes with a discussion of clinical recommendations for this challenging and neglected population.

Presentation of Hoarding in Children

Hoarding is characterized by (a) the acquisition of and failure to discard a large number of useless possessions, (b) unusable cluttered living spaces, and (c) significant distress or functional impairments caused by the hoarding (Frost & Hartl, 1996). Frequently hoarded items in both adults and children include old clothing (e.g., a 10-year-old child keeping their baby clothes), bags, books (e.g., early childhood books), newspapers, magazines, and other paper rubbish. In addition, child hoarders commonly acquire and save toys or school-related paraphernalia (e.g., pencil nubs, old school papers or books), nonvaluable collectables, food items, and broken family possessions (e.g., plates, old appliances). In some cases, children may accumulate items by “borrowing” possessions from friends and failing to return the items to the owners (Plimpton, Frost, Abbey, & Dorer, 2010). In a recent case series of child hoarders, children had difficulty discarding useless and potentially deleterious items, such as dirty napkins, rotting foods, empty potato chip bags, and, in one case, lint from their clothing. All parents reported that their children experienced great distress and agitation when their collected items were discarded (Plimpton et al.). In its most severe form, hoarding can lead to a variety of problems. In our experience, hoarding among children often contributes to negative health outcomes, such as weight gain related to eating hoarded food, dust allergies, and injuries due to tripping on hoarded possessions. Caregiver accommodation is not uncommon among child hoarders, as preventing or disturbing hoarding behaviors is often met with substantial resistance and distress (including tantrums), which can strain parent-child and child-sibling relationships.

Among children with OCD, the incidence of hoarding is similar to that of adults (approximately 25%–30%; Storch et al., 2007), and our clinical experience suggests that relatively few youth with OCD present with hoarding symptoms alone. The prevalence of hoarding in community and psychiatric samples of youth remains unclear. Hoarding seems to be more prevalent in girls than in boys with OCD (Mataix-Cols, Nakatani, Micali, & Heyman, 2008). Among youth with OCD, those who hoard have a greater frequency of both ordering/arranging rituals and magical thinking, higher levels of overall anxiety, somatic complaints, internalizing and externalizing behaviors, and poorer insight than do nonhoarders (Storch et al., 2007). Given that poor insight may negatively impact treatment response, youth with hoarding difficulties may benefit from more intensive and multimodal treatments (e.g., home visits to discard collected items, concurrent parent-training to target disruptive behavior).

Normal saving and collecting behavior is a developmentally appropriate phenomenon and seems to occur on a continuum of severity. Reasons underlying collecting behaviors are multifaceted and generally due to instrumental (i.e., may need the item at a later time), intrinsic (i.e., sheer pleasure of collecting such items as toy cars or sports cards), or sentimental purposes (i.e., emotional attachment). The authors’ clinical experience suggests that many child hoarders frequently hoard items that hold emotional value for them (e.g., a broken item that had belonged to a deceased relative), fear not having the item when it is needed, and/or may have a “just right” feeling that motivates collecting behaviors (e.g., “it just feels like I need to save this”). Although the reasoning is fairly similar across those who do and do not hoard, our experience indicates that the strength of the bond and belief is much stronger in the former group. In case studies of child hoarders (including two separately diagnosed with OCD and one with Pervasive Developmental Disorder [NOS]; Plimpton et al., 2010), one child
studied (via parent report) expressed a strong intertwining of emotion with object, such that a robe given to him on Christmas must be kept indefinitely but worn only on the anniversary of the joyous occasion, and pieces of an old dishwasher, of which the child had pleasant memories, were hidden in the backyard. Another child patient had an extreme sense that her possessions comprised an integral part of herself.

The overabundant acquisition and clutter apparent in adults with hoarding symptoms might not exist or may be more confined in pediatric presentation. The vast majority of children and adolescents will not have the means to accumulate or may not be able to keep hoarded items in common family space. Additionally, as children are embedded in the family context, parents may impact hoarding behaviors through their unwillingness to accommodate collecting and by discarding hoarding items. Indeed, we have noticed that hoarding behaviors in pediatric OCD patients are primarily confined to bedrooms as opposed to family common areas. Thus, clutter may not extend throughout the house as is common in adults who hoard.

Comorbidity in Hoarding

Hoarding behaviors are prevalent in a multitude of other mental and genetic disorders, most notably Prader-Willi Syndrome, eating disorders, attention deficit hyperactivity disorder, and autism spectrum disorders (ASD). A brief review of hoarding in these conditions follows.

Prader-Willi Syndrome

Prader-Willi Syndrome is a genetic disorder appearing in 1 in 15,000 live births that is characterized by distinctive physical and behavioral phenotypes. Physically, Prader-Willi Syndrome is associated with a shortness of stature and smallness of extremities, hypopigmentation, and hypogonadism (diminished hormonal or reproductive functioning). In addition, motor, speech, and cognitive impairments are common, as is hyperphagia. The insatiable need for food, in turn, may lead to obesity as individuals with Prader-Willi Syndrome given free access to food may consume three to six times more than would those without Prader-Willi Syndrome and exhibit more frequent food obsessions and food-related hoarding behaviors (Dykens, Leckman, & Cassidy, 1996; Miller et al., 2007). Hyperphagia may also lead to the eating and hoarding of nonfood substances (Miller et al.). For example, among 91 individuals (aged 5-47 years) with Prader-Willi Syndrome, 58% engaged in clinically significant hoarding behaviors of a wide variety of food and nonfood items. In fact, when compared with individuals with OCD, those with Prader-Willi Syndrome exhibited significantly more hoarding symptoms (Dykens et al.). In a more recent population-based survey of Prader-Willi Syndrome (aged infancy and up; Mean age $= 20.8$ years), hoarding was present in 24% of the individuals (Clarke et al., 2002).

Anorexia Nervosa

Like Prader-Willi Syndrome, the hoarding behaviors most common to anorexia nervosa regard food acquisition and saving. In anorexia nervosa, though, hoarding rituals and related food obsessions stem from self-imposed eating and weight-restrictions rather than from hyperphagia. A survey of 324 women (aged 13-65 years) with a history of anorexia found that 22% and 13% of the women with anorexia restricting subtype and anorexia binge/purge subtype, respectively, exhibited hoarding symptoms of both food and nonfood items. Relative to an OCD comparison group, there was no significant difference in terms of incidence of hoarding behaviors (Halmi et al., 2003).

Attention-Deficit/Hyperactivity Disorder (ADHD)

In association with ADHD, there seems to be an elevated prevalence of hoarding behavior (Hartl et al., 2005). A study of 26 adult hoarders found significantly higher rates of ADHD when compared with 36 controls (Hartl et al.). This association with hoarding may be a factor of impulsivity, such that those with comorbid ADHD accumulate things impulsively, related
to executive functioning deficits, and/or an inability to process and organize possessions in a meaningful manner. Clinically, our experiences support this as we have seen youth who hoard and have comorbid ADHD acquire items by impulsively collecting trash or worthless possessions or having trouble organizing possessions resulting in an unnecessary accumulation of possessions. Typically youth with ADHD do not have strong emotional connections with their hoarded items and do not display higher than expected levels of distress when such possessions are discarded.

**Autism**

Hoarding is believed common in ASD, perhaps because of the focused set of interests that are held or as an attempt to counteract a characteristic discomfort with change (e.g., children hoard objects to maintain a sense of familiarity). Not surprisingly—and similar to many youth who hoard and do not have ASD—hoarded items tend to be coveted by youth with ASD, and youngsters experience great distress when items are discarded or limits set. A study comparing OCD symptoms in 50 adults with autism and 50 adults with OCD (matched for age and sex) found that hoarding symptoms were significantly higher in the autistic group than the OCD group, suggesting that the prevalence of hoarding behaviors in autism may be more prominent than those with only OCD (McDougle et al., 1995). Similar results have been reported among children with ASD (Ruta, Mugno, D’Arrigo, Vitiello, & Mazzone, 2010), but in contrast; in an unpublished study by our group contrasting 35 youth with ASD and OCD to 35 youth with OCD alone, there was no difference in rates of hoarding symptoms.

**Case Illustration**

**Presenting Problem and Client Description**

“Abby,” a 10-year-old girl, presented with her parents for evaluation and treatment of compulsive hoarding symptoms, generalized anxiety disorder, and trichotillomania. According to her parents, Abby engaged in food hoarding on a daily basis. Several times a day, she secretly took food items and placed them in her room. These typically included fruit, cereal, bread, leftover food from meals, beverages (e.g., milk), and other snacks. Often, Abby ate these items partially and hid the remaining portions under her pillow, under the bed, or in a drawer or cabinet, which sometimes resulted in items rotting and creating a foul odor. After recognizing a pattern of behavior in Abby, her parents started to check her room for hoarded food regularly. They estimated that, on average, approximately 20–30 hoarded food items were discovered each week, and that her food hoarding was costing the family in excess of $100 per month.

Not surprisingly, Abby’s food hoarding behavior was a significant household stressor and led to frequent arguments and disruptions when the parents tried to impose limits. Withholding privileges and removing reinforcers (e.g., toys or activities) did not reduce Abby’s hoarding behavior. At the time of assessment, Abby had engaged in compulsive hoarding for more than one year. Initially, Abby denied a reason for hoarding and was reluctant to participate in treatment. After several treatment sessions, however, she admitted that she was worried about going hungry and not having food to eat.

In addition to hoarding, Abby displayed several other obsessive-compulsive symptoms that were impairing. She repeatedly checked doors and windows at night to ensure that they were locked, and counted multiple objects/movements (e.g., steps, shapes, breaths). Her stated reason for the latter behavior was to avoid boredom, as opposed to a specific feared outcome. Abby also exhibited considerable pathological doubt; for example, she had difficulty making up her mind about virtually any decision (e.g., deciding what to order at restaurants) because of a fear of making the wrong decision or regretting her decision later. In the past, Abby frequently washed, cleaned, and exhibited considerable avoidance of “dirty” stimuli (e.g., doorknobs) secondary to contamination fears. This symptom domain, however, had improved significantly by the initial visit. Although her insight into the nature of her
obsessive-compulsive symptoms was good, she made little effort to resist symptoms and often sought family accommodation in ritual completion, such as asking her parents to check doors. Abby met criteria for diagnoses of trichotillomania and generalized anxiety disorder as well as OCD. Regarding the former, she pulled hairs from the right side of her head by twisting the hairs in bunches until they broke off. No premonitory urge was noted preceding hair pulling, and her awareness of hair pulling was only fair. Abby’s hair pulling behavior usually occurred when engaged in nonstimulating activities (e.g., watching TV, riding in the car). At the time of her initial visit, Abby had thinning hair on the right side of her head, but did not have any bald patches. Regarding anxiety symptoms, Abby exhibited frequent and uncontrollable worry about multiple domains coupled with considerable somatic reactivity (e.g., stomachaches). Although her conduct was generally good, Abby’s parents reported that Abby was often irritable when anxious and had frequent “meltdowns” when hoarded items were discarded or her anxiety not accommodated in some manner. Developmentally, Abby’s medical history and psychosocial development were unremarkable, except for some emotional immaturity and mild gross-motor coordination difficulties. Abby lived with her parents and younger brother and sister (ages 7 and 9 years) in a stable and loving home environment. She and her siblings were home-schooled by her parents because of religious reasons; Abby was reportedly a good student, consistently earning As and Bs and demonstrating grade-level abilities. Family history was positive for generalized anxiety disorder in the father; no mental disorders were noted in the mother, siblings, or grandparents. Before presentation, Abby had received supportive therapy for approximately 10 sessions with minimal benefit. She had never taken a psychotropic medication.

Case Formulation

Abby’s symptom presentation was consistent with a primary diagnosis of OCD as well as secondary diagnoses of trichotillomania and generalized anxiety disorder. Abby experienced distressing thoughts that she would be hungry and not have access to food. Her hoarding served the function of reducing associated obsessional anxiety. Although many instances of hoarding are not reflective of an OCD diagnosis, Abby’s symptom pattern, including both hoarding and nonhoarding obsessions and compulsions, was conceptualized as OCD given the functional relationship between obsessions and compulsions (i.e., obsessional anxiety motivated compulsions to reduce her distress). Abby’s insight was generally good into the nature of her obsessive-compulsive symptoms; however, she exhibited relatively little motivation to change her behavior and rarely resisted symptom engagement. These factors complicated the course and outcome of her treatment.

Cognitively, Abby’s fears were based on inaccurate perceptions of reality (cognitive errors) that are common in OCD and other anxiety disorders. Such thoughts motivated her to engage in rituals, including food hoarding or checking, that were designed to reduce her anxiety. Like other people with OCD, this strategy was successful in reducing her acute anxiety, but over time reinforced ritual engagement and, in turn, increased the anxiety related to her fears. Abby also struggled with adaptive decision making and problem solving with regards to her hoarding, neglecting to account for the fairly constant availability of food within her home and her ability to access food when hungry. Her decision-making and problem-solving deficits contributed to her not viewing alternative strategies for food hoarding behaviors.

Regarding comorbid psychopathology, Abby’s generalized anxiety disorder is a common comorbid condition in pediatric OCD patients regardless of hoarding status. Cognitively, Abby exhibited a tendency to overestimate the chance of bad things happening and the associated consequences and underestimate her ability to cope with such negative events. Behaviorally, Abby would avoid things that evoked anxiety (e.g., going out if the sky looked gray) and seek her parent’s reassurance frequently when anxious. Abby’s trichotillomania was conceptualized as a body-focused repetitive behavior characterized by limited awareness. Given this, initial treatment efforts were geared towards improving awareness and, thereafter, implemented competing responses.
Abby received 14 cognitive-behavioral therapy (CBT) sessions adapted to address her dual hoarding and obsessive-compulsive symptoms, as well as comorbid conditions. Several sequential strategies addressed her hoarding; all sessions were family oriented with parents participating alongside Abby. Family-oriented sessions were used given Abby’s limited motivation to change and to teach her parents to serve as Abby’s “coaches” in addressing hoarding and other problem behaviors. As well, because a significant component of Abby’s treatment involved contingency management, parental involvement was critical for its implementation.

Initially, Abby’s hoarding was addressed using weekly targets paired with contingency management, as well as several other behavioral strategies described below. We co-created a stimulus hierarchy, which ranked the difficulty of not accumulating a certain number/amount of food items on a weekly basis. For instance, the initial target was having 20 or fewer items discovered in her room upon random parental inspection; the final step on the hierarchy was having no food items in her room. Abby was reinforced for her effort; if she achieved a targeted goal (or made appropriate effort), then she received an immediate consumable reward (e.g., selecting a movie for the family to watch). Moreover, if she took an item but then told her parents about it and returned it before it was discovered by her parents, then she was not held accountable for that item.

To further address anxiety related to fears of being without food, imaginal exposures were conducted about being hungry and not having food to eat. For instance, Abby was asked to write a scenario in which she was hungry and did not have any food. She was then asked to read the scenario and imagine what she would feel if that was happening. At first, imagining being hungry and without food caused Abby moderate levels of anxiety. In each instance, however, Abby’s anxiety would habituate after several readings of the script, thus allowing her to progress to more distressing imaginal exposures.

In addition, Abby and her parents developed a list of alternative behaviors to hoarding for times when she might be hungry, such as making a sandwich or eating a particular snack in the kitchen. The purpose of this was to address Abby’s fears about food access. As well, the parents were guided to allow food to be freely available for Abby and siblings. Having these alternatives modestly reduced Abby’s fear about being hungry and having food available.

The following exchanges come from a session:

Therapist: Okay, Abby, let’s talk about what you could do if you were in your room and got hungry.
Abby: Well, I usually have some food in the room.
Therapist: What I mean is what would you do if there wasn’t any food in your room when you got hungry?
Abby: I suppose I could go and get some food from the kitchen.
Therapist: How would you go about doing this?
Abby: I guess just go to the kitchen.
Therapist: And once you got there…
Abby: My parents keep snacks for us to eat in a cabinet. I could take some things out from there.
Therapist: What has been difficult about doing that in the past?
Abby: My parents like for me to sit at the table and eat, but I don’t like doing that when I have a snack. So, I like to have food in my room so I don’t have to sit at the table.
Therapist: Well, what if your parents said it was ok for you to not sit at the table to eat snacks, as long as you didn’t take the food back to your room?
Abby: Yeah, I could do that.
Therapist: Dad, would this be an ok compromise with you?
Father: Absolutely. How about using the playroom as a place to eat snacks?

In the above example, Abby and the therapist, together with Abby’s father, developed a behavioral plan to reduce food hoarding and increase a more adaptive alternative behavior.
Cognitive strategies were also incorporated throughout treatment, in which Abby was taught to generate self-statements about the availability of food, past experiences with being hungry (e.g., she might be hungry for a short while but always was fed), and ways of evaluating the chances of being left without food. For example, Abby used past experience with her parents to establish that in virtually all circumstances, she would not be left without food for long periods of time. The use of these cognitive strategies was paired with decision-making training that focused on helping Abby realize when she needed to seek food or appropriately ask her parents for a snack.

An example of cognitive restructuring from a session is as follows:

Therapist: Abby, tell me about your fear of being hungry and not having any food in your room.
Abby: Well, I’m afraid that I might get hungry and not have anything to eat.
Therapist: If that happened, what could you do?
Abby: Well, if that happened, I could go and get some food.
Therapist: Yes, and we have already discussed how you might do that.
Abby: Yeah, I remember what to do.
Therapist: Has there ever been a time when you have been hungry and have not had any food available to you?
Abby: No, I guess not.
Therapist: And what would happen if you couldn’t find any food on your own?
Abby: I could ask my parents.
Therapist: And what would your parents do?
Abby: They would find me something to eat.
Therapist: Has there ever been a time when you have told them you were hungry and they have not provided you with any food?
Abby: Sometimes they’ve asked me to wait a little while.
Therapist: For how long? And what did you do?
Abby: Probably about 30 minutes or so. And, I just waited until I could eat.
Therapist: How did that work for you?
Abby: It actually worked out OK. I was a little hungry for a while but it wasn’t too bad. I didn’t die at least!
Therapist: So, things worked out well it sounds like? And, you didn’t die? (stated jokingly)
Abby: Right! (smiling)

Outcome and Prognosis

Using a combination of these treatment components, Abby’s hoarding was reduced to seven or fewer items per week at post-treatment. Her scores on the Children’s Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) decreased from 24 at pretreatment to 17 at posttreatment. Perhaps the most significant reason for the modest improvement was Abby’s lack of motivation to make changes. Although her reduction in CY-BOCS score was modest in magnitude, Abby’s parents’ reported qualitative improvements such that Abby’s hoarding was less frequent and usually did not include rapidly perishable foods (e.g., ice cream, milk). In addition, Abby’s parents’ noted more confidence in their ability to manage her hoarding and other problem behaviors. Because of the parents’ satisfaction with treatment progress together with the limited progress over the last several sessions, the therapist and family together decided to terminate treatment.

Abby presented with several comorbid conditions that impacted treatment. Habit reversal training was provided to address her hair pulling, which comprised implementing competing responses (e.g., making fists with both hands) together with awareness training and social support (Franklin & Tolin, 2007). Habit reversal tasks were practiced in session and then assigned for the between session interval homework. Regarding her anxiety, traditional CBT
for anxiety symptoms was implemented, namely, exposure and response prevention for checking rituals and cognitive restructuring for anxiety in general. For example, homework for Abby’s checking rituals included tasks in which she was not able to check doors or windows before going to bed. This was repeated until associated anxiety related to not checking habituated to a manageable level. Both behavioral and cognitive approaches were modestly helpful in reducing the respective symptom domain.

Of note, however, was that Abby’s compliance with homework tasks—even with reinforcement—was fair. In addition, Abby’s comorbid conditions were quite impairing to her; addressing them during session took up valuable session time that may have otherwise been spent on addressing compulsive hoarding. This issue highlights the utility of modular treatments, in which multiple modules can assist the clinician in addressing the array of problems with which a person may present.

Clinical Practices and Summary

The case of Abby illustrates the clinical complexity often associated with the pediatric client who compulsively hoards. There are two aspects of her case—and compulsive hoarding among children in general—that warrant further clinical consideration: clinical assessment and evidence-based intervention for childhood hoarders.

Assessment approaches for children who hoard are limited. We recently developed the Child Saving Inventory (CSI), a 23-item parent-proxy report of hoarding and saving behaviors (Storch et al., in press). The CSI assesses parents’ perceptions of the extent to which their child has problems with acquiring items, discarding possessions, overall clutter, and distress and impairment related to the hoarding behaviors. Initial psychometric properties and clinical utility of the CSI are quite promising.

Aside from the CSI, assessment of hoarding in children has been primarily through anecdotal reports, or responses to two items on the CY-BOCS Symptom Checklist. Regarding the former, the child’s clutter may be relatively limited in scope and location as caregivers may not accommodate clutter/collecting and independently discard hoarded possessions. Regarding the latter, a hoarding factor has consistently emerged as a separate factor in factor analytic studies (Stewart et al., 2008), again supporting the behaviors’ validity as a separate construct. As illustrated in Abby’s presentation, the CY-BOCS is not particularly sensitive to changes in hoarding as it is a global measure of obsessive-compulsive symptoms. A number of child-report and parent-report questionnaires assess the presence and severity of a range of obsessive-compulsive symptoms, including items pertaining to hoarding (e.g., Children’s Obsessive Compulsive Inventory; Obsessive Compulsive Inventory–Child Version). Broad-band measures, such as the Behavior Assessment Scale for Children, often include individual items that assess hoarding. However, such measures assess a limited range of hoarding behaviors and are likely not sensitive as either assessment tools or outcome measures for childhood hoarding.

Only two treatments have demonstrated efficacy for youth with OCD, namely, CBT (involving exposure and response prevention) and serotonin reuptake inhibitors (SRI). Effect sizes favor CBT over SRIs as a monotherapy, but evidence suggests an additive effect of combined treatment for severe cases. Although informative, these outcome studies do not provide information on whether hoarding has a differential response to CBT or SRI treatment among child patients, or whether these treatments would be suitable for hoarding behaviors presenting outside of an OCD diagnosis.

Little research has examined differential CBT outcome as a function of hoarding symptoms in youth with OCD; to our knowledge, nothing has been published on youth who hoard outside of OCD. One notable exception is a study (Storch et al., 2008) that examined how the presence of certain symptom subtypes impacted outcome to family-based CBT in 92 children and adolescents with OCD. In this study, hoarding did not significantly differ from other symptom presentations in terms of CBT outcome. On balance, most children did not present with primary hoarding symptoms, and the flexible and family-nature of the treatment allowed behaviorally oriented strategies such as those used in Abby’s case.
Another small study (Storch et al., 2010) described a behaviorally oriented family-treatment targeting compulsive symptoms, particularly food and nonfood hoarding, among youth with Prader-Willi Syndrome. Of the three children described, all exhibited significant hoarding symptoms of both food and nonfood related items. The treatment components included contingency management, exposure, and response prevention for hoarding triggers. After 10 family therapy sessions, CY-BOCS scores were markedly reduced from an average of 25.0 to 15.3.

As previously noted, literature regarding the efficacy of pharmacotherapy in child hoarding is limited. In a naturalistic treatment study with 220 children with OCD, hoarding symptoms were associated with attenuated pharmacotherapy response (Masi et al., 2009). To date, no rigorous studies exist on the relative or absolute efficacy of pharmacotherapy in child hoarders. Inconsistent results from published pharmacotherapy case reports may be due to a variety reasons. It may be helpful to consider the function of the hoarding behavior when deciding on whether to use pharmacotherapy. For those pediatric patients whose hoarding is motivated by anxiety or fear, or the child has concurrent anxiety and/or depression at clinical levels, antidepressant treatment may yield results.

In sum, clinical and research reports have indicated that hoarding is a difficult disorder to treat, regardless of age. As the onset of hoarding is often during childhood, early intervention is crucial to curtail its progression into adulthood. Clinically, we have utilized a multimodal treatment illustrated in the present case with children who hoard and have achieved some success.

Selected References and Recommended Readings


