1-1-2001

Hoarding By Elderly People

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Although hoarding has been studied in adults, little is known about problems of hoarding by elderly people. This study used a structured telephone interview with elder services providers to investigate hoarding behaviors in relation to functional impairment, cognitive deficits, and physical and psychological conditions in 62 elderly clients. Most elderly hoarders were female, unmarried, and lived alone. Extensive clutter was associated with significant impairment, interfering with basic hygiene, and posing a serious physical threat for many elderly clients. Clients were rarely insightful about their collecting and often resisted change, rendering interventions generally ineffective. Never-married status was associated with more severe hoarding and greater impairment and possibly with worse outcomes of intervention efforts. Health and mental health implications of hoarding by elderly people and implications for treatment are discussed.

Key words
clutter
collecting
elderly people
hoarding
obsessive–compulsive disorder

In recent years compulsive hoarding has gained increased public and research attention because of frequent and detailed media coverage of hoarding cases involving tragic circumstances (Frost, Steketee, & Williams, in press). Hoarding is a debilitating disorder characterized by the acquisition of a large volume of possessions that clutter living areas to such a degree that living spaces cannot be used for their intended purpose (Frost et al., in press; Frost & Hartl, 1996). In addition, the disorder causes impairment in normal life functioning and often affects others in the environment (Frost, Steketee, Youngren, & Mallya, 1999; Frost et al., in press). Hoarding often is associated with significant distress, but the lack of insight in many people who hoard often prevents their seeking treatment until family or others insist (Frost & Steketee, 1998). A cognitive–behavioral model of hoarding that suggests problems in acquisition, discarding, organization, and beliefs about possessions has been partly supported by empirical studies of student, community, and clinical samples (Frost & Steketee).

Hoarding symptoms occur in nearly one-third of obsessive–compulsive patients (Frost, Krause, & Steketee, 1996). However, virtually no formal epidemiological studies have systematically examined the prevalence rate of this problem outside of the context of obsessive–compulsive disorder (OCD). A survey of local health departments to study the frequency and characteristics of compulsive hoarding complaints in Massachusetts found that .26 cases of compulsive hoarding per 1,000 population were reported to authorities in a five-year period (Frost et al., in press). Undoubtedly, this is a low estimate because hoarding referred to public health enforcers likely represents only very severe cases.

Although empirical literature regarding compulsive hoarding in student, subclinical, and clinical adult populations is growing, only case reports and commentary have been published about this problem in the elderly population (Hogstel, 1993; Thomas, 1997). The paucity of information, however, should not be taken to imply that hoarding rarely occurs in this age group. In fact, a recent study showed that more than 40 percent of hoarding complaints to the local health departments involved elder services agencies (Frost et al., in press). Similarly, other studies have consistently found that hoarding individuals were significantly older than nonhoarding individuals

CCC Code: 0360-7283/01 $3.00

(Frost et al., 1999; Frost et al., 1998), possibly because hoarding problems increase in severity with age.

Hoarding symptoms in older adults have been studied mainly in the context of Diogenes' syndrome, which is characterized by gross self-neglect, domestic squalor, and hoarding of trash; it occurs annually in 0.5 of 1,000 cases in people over age 60 (Clark, Mankikar, & Gray, 1975; Drummond, Turner, & Reid, 1997). The validity of this syndrome, however, is disputed because of the overlap of its symptoms with OCD and other disorders (for example, dementia or psychosis). The prevalence of hoarding behaviors also has been examined in elderly patients with various types of dementia in a geropsychiatric ward (Hwang, Tsai, Yang, Liu, & Ling, 1998). Findings revealed that 30 (23 percent) of 133 patients exhibited hoarding behaviors, suggesting that hoarding is a common symptom in dementia patients (Hwang et al.).

The purpose of this study was to examine compulsive hoarding in older adults. We sought to determine how hoarding manifests itself in this age group, the degree of impairment in various areas of functioning, and the association of hoarding with cognitive deficits and physical and psychological conditions. In particular, we hypothesized that information-processing deficits would play an important role in compulsive hoarding in older adults such that the majority would exhibit problems with memory. We interviewed service providers who made home visits for agencies serving elderly people and therefore had directly observed evidence of clutter and other hoarding behaviors.

METHOD

Respondents

We interviewed 36 service providers who work with older people (for example, case managers, visiting nurses, and social workers) and eight officials from the board of health in the Boston area. To qualify for the study, providers must have encountered the problem of compulsive hoarding in at least one client age 65 years or older and must have observed the living conditions in the home of the elderly client on at least one occasion in the past year. Compulsive hoarding was defined as significant clutter in the home, inability to use parts of the living space for intended purposes, and impairment in functioning as a result of the hoarding problem. On the basis of this description of hoarding, service providers reported 62 cases, with a mean of 1.5 cases (range = 1 to 5) per provider. Because some questions about mental health status and interventions required familiarity with the case, analyses of these variables included only 42 cases in which the provider had visited the client's home at least five times.

Procedure

A letter explaining the nature of our study and asking for participation was sent to elder services agencies in the greater Boston area. The letter was followed by a phone call, during which the researcher introduced the study objectives and rationale and provided a description of the project and a definition of compulsive hoarding. The elder services agent was then asked whether she or he or someone in the agency had encountered cases of compulsive hoarding in their elderly clients within the past three years. If the agent had not worked on such a case, we asked the person to refer us to someone who had. Telephone interviews were conducted with all providers who had worked on a case that fit the description and who were willing to be interviewed. The interviewer obtained informed consent at the beginning of the interview. At the end of a case report, providers were asked if they had another such client in their caseload and if they were willing to be interviewed about the other case. If not, providers were thanked for their participation.

Interview Protocol

After pilot testing and revision, the semi-structured interview contained 30 questions divided into eight major topics: (1) demographics, (2) use of services, (3) nature of hoarding, (4) effect of the hoarding problem, (5) sanitary conditions, (6) mental health information, (7) types of intervention, and (8) hoarding outcomes. One of the authors trained the interviewers by reviewing all questions with regard to the type of information requested. A written coding scheme was devised to ensure consistency in the interviewers' recorded responses. However, a reliability assessment across raters was not conducted. Demographic information included the location and type of residence, other people living in the household, and clutter outside the house. Providers identified the services (for example, homemaker or home health aid) the elderly client was currently receiving from their agency and other service agencies and described how the hoarding case had come to their attention.

To obtain information about the kinds of possessions hoarded and the extent and location of the

clutter by room, the interviewer rated the severity of clutter by category (for example, newspaper or clothing) and the overall orderliness of the clutter on a scale from 0 = none/very organized to 3 = severe/very chaotic. Providers then evaluated the client's personal hygiene and the cleanliness of the home on a scale from 0 = clean/no odor to 3 = extremely dirty/overpowering odor. Ratings of the severity and functional effect of the problem (0 = none to 3 = severe) included the extent to which hoarding interfered with service delivery, impaired normal functioning around the home, led to nonfunctional major appliances (for example, refrigerator, stove, or sink), and represented a threat to the client's physical health. Providers also were asked about their knowledge of the existence of mental disorders other than hoarding, apparent problems with cognition and memory, and the degree of insight into hoarding exhibited by their client. These were assessed by providers' clinical judgment rather than through any formal testing.

Questions about intervention and outcomes examined the involvement of other agencies (for example, the police or mental health department) because of the hoarding, observations about changes in the amount of clutter, and descriptions of any interventions and the intervening party (for example, family). Providers were asked to evaluate changes in the amount of clutter during the time they had known their client, regardless of whether an intervention had been used or whether the hoarder took an active part in it. Finally, the provider reported on whether interventions (if any) led to sustained improvement, improvement and relapse, no change, or the worsening of clutter.

Data Analysis

In the description of the findings on elderly hoarding cases, percentages do not always add to 100 percent because providers rated some questions as unknown and gave more than one answer to others. To compare elderly hoarders on selected variables, we created two measures of hoarding severity. The first was the amount of clutter, calculated by averaging the four-point severity ratings for the seven main types of clutter: newspaper, paper, containers, clothing, food, books, and trash. The second was impairment resulting from hoarding, calculated by averaging across providers' four-point ratings for restriction of movement, access to furniture, food preparation, and hygiene. Spearman correlations were used to test the strength of association of severity measures to home sanitation, client appearance, physical danger, and service interference. Analyses of variance (ANOVAs) were used to compare severity ratings with marital status and gender. In addition, because marital status appeared to be an important factor in severity, we compared ever-married (n = 25) with never-married (n = 34) hoarders on various measures of functioning using t tests and chi squares as appropriate to the type of data.

Results

Demographics

Demographic information for the sample of elderly hoarders (N = 62) is shown in Table 1. Most were white women who lived alone, and over half had never married. According to an analysis of variance, never-married hoarders had more clutter (M = 1.69) and more interference from clutter (M = 2.02) than their ever-married counterparts (M = 1.34 and 1.50, respectively) [$F(1, 57) = 5.58$, $p < .05$ and 6.81, $p < .02$, respectively]. Gender had no significant effect ($ps > .19$).

Most elderly hoarders lived in an urban location in apartments (50 percent) or single family homes (34 percent). Of those living in homes with yards (n = 22), 36 percent had clutter outside their homes. The annual income of hoarding clients

Table 1. Demographic Characteristics of Elderly Hoarders (N = 62)

Variable	%
Age	
M = 76.9 years	
(SD = 6.72, range 65–92)	
Gender	
Female	73
Male	27
Ethnicity	
White	90
Other	10
Marital status	
Never-married	55
Divorced	16
Widowed	13
Ever-married	11
Living situation	
Alone	82
Apartment	50
Urban	56
With family	16
Single family house	34
Suburban	44
Condominium	11
Other	5

ranged from under $10,000 to $40,000, and most fell into the lowest income bracket. However, this may be a function of the sample selection, because 26 percent of the hoarding cases were generated from agency programs that had income restrictions.

Utilization of Services

Nearly all of the 62 clients (91 percent) received at least one type of service from the provider's agency, including case management (37 percent), homemaker services (26 percent), mental health services (24 percent), home-delivered meals (18 percent), grocery services (16 percent), and chore services (13 percent). Eleven percent received help specifically for their hoarding problem (for example, encouragement or structured supervision of cleaning efforts).

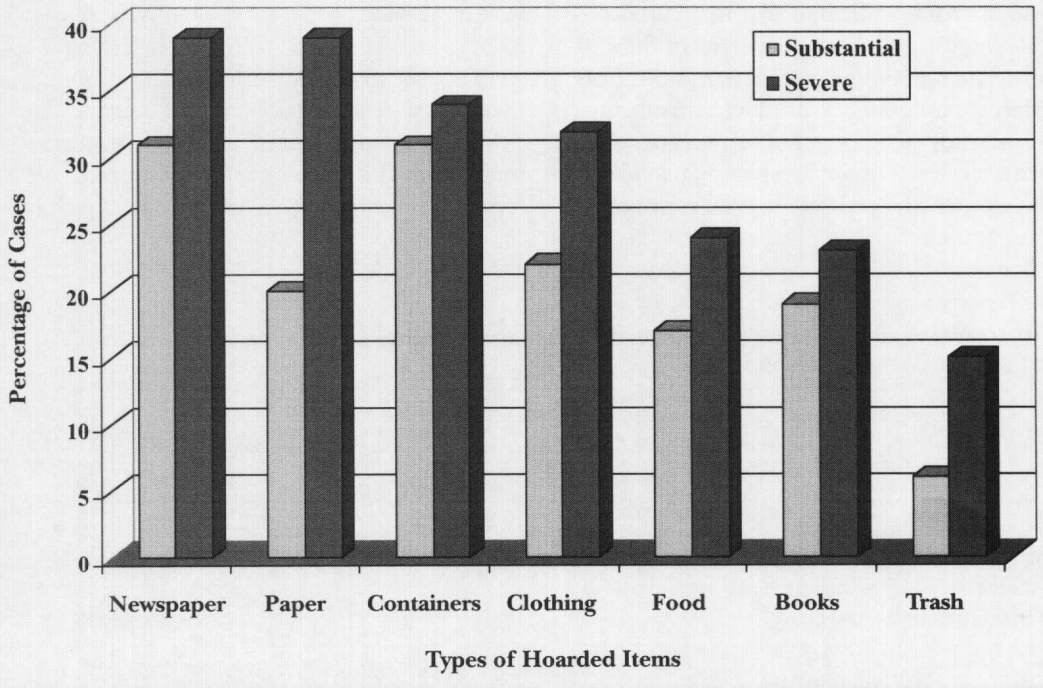
A wide range of social services agencies had become involved in these clients' lives because of their hoarding problems. The most frequently reported were health services (52 percent), health departments (49 percent), mental health services (45 percent), fire departments (30 percent), and the police (23 percent). Elders-at-risk programs and Councils on Aging were involved in 21 percent and 13 percent of the cases, respectively. Less frequently, the housing authority (11 percent), legal services (8 percent), and animal welfare (3 percent) became involved. Marital status (ever- or never-married) did not distinguish number or type of services received from the interviewees' or other agencies.

Service providers indicated that most hoarding cases came to their attention through referral from another agency (73 percent) and complaints (21 percent) by neighbors, family members, or anonymous parties. Very few cases were self-referred (3 percent) or discovered by service delivery workers (3 percent). The high percentage of referrals from other providers indicates that the majority of hoarding cases had been long-standing. The mean duration of the agency service delivery for these cases was 68.3 weeks ($SD = 100.6$), with a range of 0 to 520 weeks. Because we do not know the original source of the referrals from other agencies, the percentage of cases detected through service delivery may be much higher than documented in this study.

Nature of Hoarding Problem

The most frequently hoarded items (rated 2 = substantial and 3 = severe) are presented in Figure 1. Consistent with other studies, elderly clients commonly hoarded paper, containers, clothing, food,

Figure 1. Type and Severity of Clutter in the Homes of Elderly Hoarders ($N = 62$)



books, and objects from other people's trash. Less frequently collected (fewer than six cases rated substantial or severe) were objects from store and catalogue purchases, collectibles, electric appliances, containers, and furniture. Nearly all clients had severe clutter in their living rooms, dining rooms, kitchens, and bedrooms (92 percent to 96 percent). Hallways (87 percent), bathrooms (75 percent), and stairwells (57 percent) were frequently cluttered also.

Clutter was typically chaotic or very chaotic with no apparent organization (70 percent), but in 23 percent of cases possessions were somewhat organized. Only 5 percent reported that the clutter was very organized and tidy. Thus, a large majority of elderly collectors showed evidence of substantial disorganization.

Physical Appearance of Client and Sanitary Conditions in Home

Although 36 percent of elderly hoarders were described as clean and well kept, sometimes with the help of home health aids or nurses, nearly two-thirds showed some difficulty with self-care. Of these, more than one-third were moderately to substantially dirty and unkempt, and 17 percent were extremely filthy, sometimes with blackening of the skin, filthy hair, and soiled clothing. Likewise, although one-half of the clients had no unpleasant body odor, 25 percent had overpowering body odor. Pertinent to these findings, 44 percent of service providers indicated that the clutter did not interfere with the personal hygiene of the elderly client. The remainder reported that the clutter interfered moderately (30 percent), substantially (16 percent), or severely (14 percent) with their client's ability to maintain personal hygiene. Examples were clutter obstructing the use of tubs, showers, and bathroom sinks or nonfunctional bathroom fixtures. Marital status was not significantly related to the clients' physical appearance.

Providers indicated that only 10 percent of their clients' residences were clean, whereas most homes were moderately (34 percent), markedly (23 percent), or extremely (33 percent) dirty or filthy. Despite the high frequency of unsanitary conditions at home, providers indicated that there was no unpleasant household odor in 34 percent, mild odor (for example, mildew or stale air) in 16 percent, and moderately unpleasant odor in 18 percent of homes. In the remaining 32 percent, the providers noticed overpowering odors from rotten food and animal or human feces. Marital status did not affect the cleanliness of the home. However, according to Spearman correlations, home sanitary condition, odor, and physical appearance were all significantly related to clutter and impairment from clutter (Table 2). More clutter was especially associated with poorer sanitation in the home.

Effect of Hoarding

Clutter interfered with the service delivery in 63 percent of cases, and no services could be delivered in 5 percent of cases. In these cases elderly hoarders refused entry or claimed that the provider was stealing or throwing away valuable possessions, or the provider refused to enter the residence because of deplorable living conditions. Nearly one-fifth of hoarding clients restricted agency services, especially cleaning services. The 37 percent who had no difficulty receiving services were mainly provided with meals, counseling, and medical check-ups. Problems with agency service delivery were significantly related to more impairment from clutter but not to the amount of clutter (Table 2) or the marital status of the client.

Table 2. Spearman Correlations of Hoarding, Elderly Client Characteristics, and Amount of Impairment from Clutter (*n*s = 58 to 62)

Client Characteristic	Amount of Clutter	Impairment from Clutter
Home sanitary condition	.46***	.40**
Odor in the home	.35**	.27*
Body odor	.36**	.38**
Unkempt appearance	.39**	.40**
Physical danger	.34**	.51***
Interference in agency service	.22	.30*

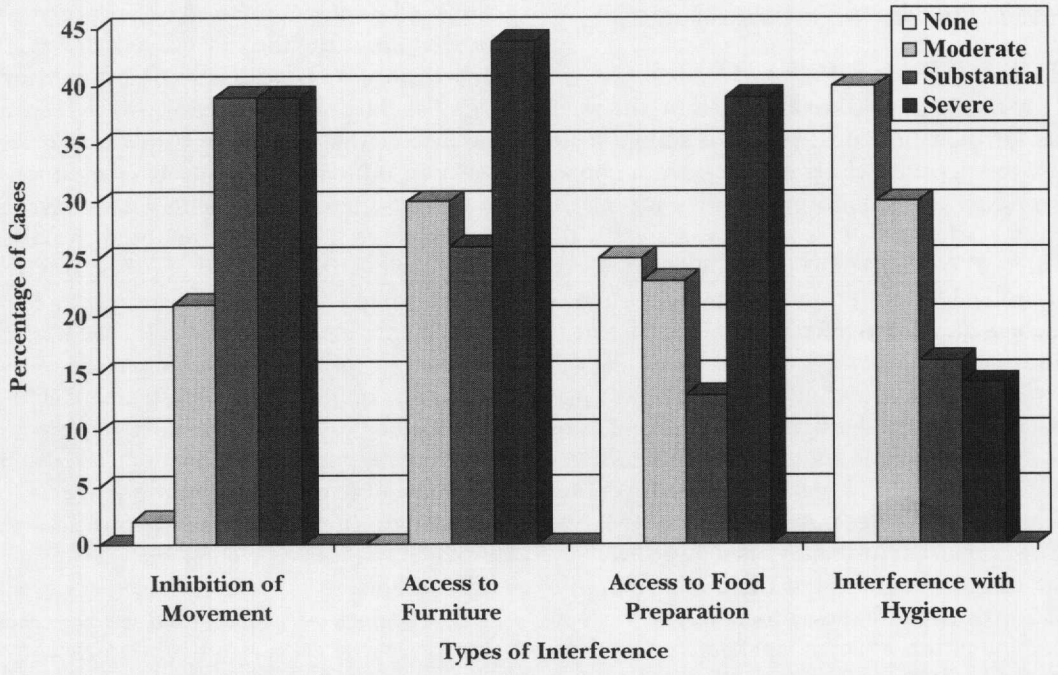
*$p < .05$. **$p < .01$. ***$p < .001$.

Clutter substantially prevented many elderly clients from functioning effectively at home. All but one client experienced at least a moderate degree of difficulty moving around the house, whereas nearly 80 percent experienced substantial to severe inhibition of movement (Figure 2). In some cases clutter was knee-high or higher, requiring elderly clients to climb over possessions to reach another location. One client was described as literally swimming over the top of clutter to reach other rooms. Nearly 70 percent of elderly hoarders were unable to use their furniture (for example, bed or sofa), and several elderly clients slept on a chair or a couch because their beds were covered. Interestingly, never-married hoarding clients had significantly greater problems moving about the house [$t(57) = 2.54, p < .014$] and using furniture [$t(57) = 2.79, p < .007$] than their ever-married counterparts.

In over half the cases, clutter prevented food preparation, and 45 percent could not use their refrigerators and freezers because of spoiled food or the use of these appliances to store nonfood items. Likewise, many clients could not use their kitchen sink (42 percent), bathtub (42 percent), bathroom sink (20 percent), or the toilet (10 percent) because of clutter or lack of repair. Marital status did not affect these functions.

In the view of service providers, the hoarding constituted a physical health threat for 81 percent of their elderly clients, and nearly half faced substantial (11 percent) or extreme (36 percent) threats to their well-being. Not surprisingly, greater physical threat was correlated with more clutter and more impairment from clutter and was significantly greater in never-married clients [$t(57) = 2.36, p < .022$] (see Table 2). Among clients considered at physical risk ($n = 38$), the clutter constituted a fire hazard for 45 percent because of flammable materials and blocked exits. In 39 percent of cases, providers expressed strong concern about the risk of falling because of the clutter, particularly for the one-quarter of clients who had problems with ambulation. In some cases elderly clients had fallen, and help was delayed because EMTs had difficulty reaching the client. About one-third of clients faced unsanitary conditions in their homes in the form of infestations, feces, and rotten food. For some elderly people, medical conditions were attributed to hoarding behavior.

Figure 2. Extent to Which Clutter Interfered with Normal Functioning in the Homes of Elderly Hoarders ($N = 62$)



Mental Health Status

Providers in frequent contact with their hoarding clients ($n = 42$) estimated that 44 percent had a mental disorder and suspected a disorder in 33 percent, leaving 22 percent who were believed to have no mental health problem. The most frequent confirmed or suspected mental disorder was unipolar depression (16 clients). Providers believed seven clients had one or more personality disorders, six had paranoia, and five had an unspecified anxiety disorder. Less common were bipolar depression, psychotic disorder, agoraphobia, obsessive–compulsive disorder, unspecified phobia, and substance abuse (one to three clients each).

Contrary to our expectation that elderly hoarders would have cognitive deficits, providers reported 76 percent to have no problems with cognitive functioning (for example, orientation to place and time); 19 percent had mild to moderate impairments; and only 5 percent had severe deficits. Similarly, 67 percent were thought to have no deficits in memory; 24 percent had mild deficits; and only 10 percent showed moderate to severe problems. The relative rarity of cognitive deficits suggests that this could not account for the hoarding behavior of most of these clients. With regard to insight, only 15 percent had definitely acknowledged the irrationality of their hoarding behavior to their service provider. The majority had either no (73 percent) or little (12 percent) insight. No differences in marital status were evident for these mental health and cognitive variables.

Interventions and Outcomes

Elderly clients ($n = 42$) received various interventions for their hoarding: partial cleaning of the house (69 percent), clearing out the entire house (17 percent), or assistance in cleaning and organizing the clutter (14 percent). In some cases the hoarder (19 percent) or a family member (17 percent) initiated the intervention, but most often an outside agency did so (69 percent). These agencies included cleaning services (59 percent), elder services (38 percent), building management (21 percent), public health department (10 percent), and the court (7 percent). Although providers indicated that the amount of clutter had decreased over time for one-third of clients, most had observed no change (55 percent) or some worsening (8 percent), suggesting that hoarding remained a chronic problem. Consistent with these observations, most intervention efforts appeared ineffective. Of clients receiving some type of change effort, 43 percent did not improve, 15 percent worsened, 8 percent improved somewhat and then relapsed, and only 15 percent sustained gains. Interestingly, only 20 percent of never-married hoarding clients showed any type of improvement compared with 45 percent of ever-married clients, although a chi-square analysis showed only a trend ($p < .10$) toward significance.

No intervention—complete removal of clutter, partial cleaning by others, or support for cleaning their own home—was consistently effective. In seven cases in which the house was completely cleared, one hoarder relapsed partially, one did not change, three were placed in nursing homes, and the outcome was unknown for two others. For 29 clients whose homes were partially cleaned, 17 percent maintained clutter-free areas by themselves or with help (for example, homemaker), 7 percent improved and then relapsed, 38 percent did not change or had their possessions relocated (for example, rented storage space), and 21 percent worsened. For six clients who received support and encouragement through counseling or supervision of the cleaning efforts, one sustained improvement, four exhibited no change, and the outcome was unknown for one.

Discussion

This study is the first to examine the nature of problems that occur because of compulsive hoarding by older adults. The study has several limitations. All findings are based on service providers' observations, and the viewpoint of the elderly clients themselves is lacking. Furthermore, our sampling of elder services agency providers willing to be interviewed about their hoarding cases may have introduced some bias into the sample, particularly with regard to clients with lower incomes and greater frailty or functional impairment. Nonetheless, this method appears to have captured a range of severity of hoarding problems and related conditions among elderly clients, perhaps because of the wide range of services provided. Reliability of the interview instrument across raters or time (test–retest) was not completed, so validity of responses cannot be ensured. Finally, without a comparison group, we are unable to draw definitive conclusions about how service providers perceived elderly hoarders relative to other clients.

The majority of elderly hoarders were women, consistent with earlier studies in which we found a preponderance of women in nonelderly samples

(Frost & Steketee, 1998; Frost et al., 1999). However, because of insufficient control in these studies, we are unable to determine whether there is a true gender difference. In older samples the discrepancy may be attributed to the greater longevity of women compared with men or to gender-specific differences in patterns of help seeking. Also, women may more readily disclose to others and volunteer in experiments than men. Thus, gender among hoarders needs further investigation using epidemiological methods.

Like the findings for people with Diogenes' syndrome and OCD, we found that more than half of our elderly hoarder sample had never married and lived alone (Clark et al., 1975; Drummond et al., 1997; Frost & Steketee, 1998; Macmillan & Shaw, 1966). This finding is remarkable, given that the base rate of never-married men and women over age 65 is 4 percent to 5.4 percent (U.S. Bureau of the Census, 1997), but it is possible that never-married hoarders are overrepresented as clients of elder services agencies. However, a review of recent demographic statistics from elder services agencies suggests that the never-married rate among hoarders is substantially higher than for elderly clients in general.

Never-married status was linked to more severe hoarding symptoms, possibly reflecting greater attachment to objects for those who had not had partners. In addition, more objects may be saved when no live-in partner is present to curb their accumulation. This hypothesis is consistent with the greater inhibition of movement, reduced access to furniture, and greater physical threat experienced by never-married hoarding clients compared with ever-married counterparts.

Congruent with findings by Frost et al. (1999) for adult hoarders ranging widely in age, elderly hoarders in the present sample most frequently collected newspapers, containers, and other paper trash, which were predominantly found in the living room, dining room, kitchen, and bedroom. Contrary to earlier findings indicating that the bathroom was the least-cluttered area of the home (Frost et al., 1999), bathrooms were cluttered in three-quarters of elderly hoarding cases and were difficult to get to in more than half the cases. The clutter was associated with significant impairment for one-half to three-quarters of clients in movement, accessibility of furniture, and ability to prepare food. For more than 80 percent of clients, the clutter also represented a serious physical threat, including fire hazard, falling, and unsanitary conditions, and more severe hoarding appeared to increase the risk of physical threat. A very large number of clients lived in unsanitary home conditions with an unpleasant odor and showed poor personal hygiene, again similar to those identified with Diogenes' syndrome (Clark et al., 1975). The correlation of poor sanitation with more severe hoarding suggests that hoarding may have adverse effects on personal functioning, perhaps particularly in elderly clients, or that other factors such as mental deterioration lead to both effects.

This study did not address when the hoarding began and therefore provided little insight into possible causal factors. Providers estimated that many elderly hoarders had some form of mental disorder, such as affective, personality, psychotic, and anxiety disorders. Because this incidence rate of mental disorders is not based on reliable reports from experienced clinicians, further study is needed to determine whether hoarding behavior is linked to mental disorders.

Our assumption that hoarding might be especially problematic among elderly people with cognitive and memory deficits was not supported. Hwang and colleagues (1998) found that nearly one-quarter of their dementia patients had hoarding symptoms. However, in our findings few hoarding clients showed deficits in cognitive functioning according to providers' observations, indicating that hoarding behaviors can frequently occur among older adults in the absence of dementia and that hoarding was not a function of dementia. Again this finding requires substantiation in subsequent research using appropriate assessment methods. Nonetheless, insight into the problematic nature of hoarding was very limited for most elderly hoarders in our sample, consistent with reports by Damecour and Charron (1998) and Thomas (1997) that most hoarders denied, rationalized, or minimized their problems. Clearly, in this study lack of insight was not explained by cognitive impairments. Although we were unable to identify a link in this study, we continue to suspect that lack of insight impedes the efficacy of interventions to address hoarding problems. Further research on this topic is needed.

Nearly all clients in this study received some form of social service (for example, case management or homemaker services), but many providers noted that services were either accepted reluctantly or could not be delivered fully because of clients' restrictions. It appears that elderly hoarders may be especially difficult to assist, and perhaps especially

those who have never married, despite their apparent need for services from multiple agencies (see also Thomas, 1997). In more than two-thirds of cases, some form of hoarding intervention was undertaken, often by an outside agency. Only occasionally were the courts involved in the intervention, suggesting that most cases were not so severe as to require legal interventions. Partial and sometimes complete removal of clutter without involvement of the elderly person did not appear to be effective and instead typically led to the recluttering of cleared areas. It is unclear whether nursing home placement occurred because of the hoarding problem or for other reasons (for example, cognitive or physical impairment).

Thus, our findings suggest that involuntary cleaning of the home is not a solution to this problem. As Frost and Hartl (1996) indicated in their cognitive–behavioral model, hoarding is a multifaceted problem that involves difficulty with information processing and emotional attachment, erroneous beliefs about possessions, and behavioral avoidance. Effective treatment is likely to require modification of faulty beliefs, assistance with organizing and decision making, and examination of emotional attachment and behaviors that promote hoarding. Whether such efforts will prove useful for older hoarders remains to be demonstrated.

Future research should study elderly hoarders directly in comparison with younger hoarders and with elderly nonhoarders to establish features that require particular attention with regard to interventions (for example, marital status and attachment to significant others, comorbid complicating conditions, and possible causes). Assessment of cognitive functioning, physical and mental disorders, and other aspects of hoarding should use reliable and valid standardized assessments where possible. Interventions likely to alleviate the functioning and health problems associated with hoarding are ultimate goals to enable elderly individuals to live effectively and safely in their homes. **HSW**

References

Clark, A.N.G., Mankikar, G. D., & Gray, I. (1975). Diogenes' syndrome: A clinical study of gross neglect in old age. *Lancet, 1,* 366–368.

Damecour, C. L., & Charron, M. (1998). Hoarding: A symptom, not a syndrome. *Journal of Clinical Psychiatry, 59,* 267–272.

Drummond, L. M., Turner, J., & Reid, S. (1997). Diogenes' syndrome—A load of old rubbish. *Irish Journal of Psychiatric Medicine, 14,* 99–102.

Frost, R. O., & Hartl, T. L. (1996). A cognitive–behavioral model of compulsive hoarding. *Behavior Research and Therapy, 34,* 341–350.

Frost, R. O., Kim, H. J., Morris, C. V., Bloss, C., Murray-Close, M., & Steketee, G. (1998). Hoarding, compulsive buying, and reasons for saving. *Behavior Research and Therapy, 36,* 657–664.

Frost, R. O., Krause, M., & Steketee, G. (1996). Hoarding and obsessive–compulsive symptoms. *Behavior Modification, 20,* 116–132.

Frost, R. O., & Steketee, G. (1998). Hoarding: Clinical aspects and treatment strategies. In M. A. Jenike, L. Baer, & W. E. Minichiello (Eds.), *Obsessive compulsive disorder: Practical management* (3rd ed., pp. 533–554). St. Louis: Mosby Press.

Frost, R. O., Steketee, G., & Williams, L. F. (in press). Hoarding: A community health problem. *Health and Social Care in the Community.*

Frost, R. O., Steketee, G., Youngren, V. R., & Mallya, G. K. (1999). The threat of the housing inspector. *Harvard Review of Psychiatry, 6,* 270–278.

Hogstel, M. O. (1993). Understanding hoarding behavior in the elderly. *American Journal of Nursing, 93,* 42–45.

Hwang, J.-P., Tsai, S.-J., Yang, C.-H., Liu, K.-M., Ling, J. F. (1998). Hoarding behavior in dementia: A preliminary report. *American Journal of Geriatric Psychiatry, 6,* 285–289.

Macmillan, D., & Shaw, P. (1966). Senile breakdown in standards of personal and environmental cleanliness. *British Medical Journal, 2,* 1032–1037.

Thomas, N. O. (1997). Hoarding: Eccentricity or pathology: When to intervene? *Journal of Gerontological Social Work, 29,* 45–55.

U.S. Bureau of the Census. (1997, March). *Marital status and living arrangements* (Current Population Reports, PPL-90). Washington, DC: U.S. Government Printing Office.

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An earlier version of this article was presented at the annual conference of the Anxiety Disorders Association of America, March 1999, San Diego.

Accepted October 18, 2000