Gregory S. Chasson
Jedidiah Siev

Advances in Psychotherapy –
Evidence-Based Practice

# Hoarding Disorder


hogrefe

# Hoarding Disorder

## About the Authors

**Gregory S. Chasson**, PhD, is a licensed clinical psychologist, Associate Professor in the Department of Psychology at Illinois Institute of Technology, and owner of Obsessive-Compulsive Solutions of Chicago. His research laboratory at Illinois Tech (i.e., Repetitive Experiences and Behavior Lab – REBL) and clinical work focus on obsessive-compulsive spectrum conditions (including hoarding), autism spectrum conditions, and anxiety and traumatic stress. He received his PhD at the University of Houston and completed pre- and postdoctoral fellowships at Harvard Medical School at McLean Hospital and Massachusetts General Hospital, respectively.

**Jedidiah Siev**, PhD, is a licensed clinical psychologist and Assistant Professor in the Department of Psychology at Swarthmore College, where he directs the Swarthmore OCD, Anxiety, and Related Disorders (SOAR) Lab. Previously, he founded and directed the OCD and Related Disorders Program at Nova Southeastern University, after completing training at the Massachusetts General Hospital and the University of Pennsylvania. Dr. Siev has considerable clinical and research experience with individuals who have hoarding, obsessive-compulsive, body dysmorphic, and anxiety disorders.

## Advances in Psychotherapy – Evidence-Based Practice



The basic objective of this series is to provide therapists with practical, evidence-based treatment guidance for the most common disorders seen in clinical practice – and to do so in a reader-friendly manner. Each book in the series is both a compact "how-to" reference on a particular disorder for use by professional clinicians in their daily work and an ideal educational resource for students as well as for practice-oriented continuing education.

The most important feature of the books is that they are practical and easy to use: All are structured similarly and all provide a compact and easy-to-follow guide to all aspects that are relevant in real-life practice. Tables, boxed clinical "pearls," marginal notes, and summary boxes assist orientation, while checklists provide tools for use in daily practice.

## Continuing Education Credits

Psychologists and other healthcare providers may earn five continuing education credits for reading the books in the *Advances in Psychotherapy* series and taking a multiple-choice exam. This continuing education program is a partnership of Hogrefe Publishing and the National Register of Health Service Psychologists. Details are available at https://us.hogrefe.com/cenatreg

The National Register of Health Service Psychologists is approved by the American Psychological Association to sponsor continuing education for psychologists. The National Register maintains responsibility for this program and its content.

Advances in Psychotherapy – Evidence-Based Practice, Volume 40

# Hoarding Disorder

**Gregory S. Chasson**
Illinois Institute of Technology, Chicago, IL

**Jedidiah Siev**
Swarthmore College, Swarthmore, PA

hogrefe

**Library of Congress Cataloging in Publication** information for the print version of this book is available via the Library of Congress Marc Database under the Library of Congress Control Number 2018952155

**Library and Archives Canada Cataloguing in Publication**
Chasson, Gregory S., 1981-, author
Hoarding disorder / Gregory S. Chasson, Illinois Institute of Technology, Chicago, IL, Jedidiah Siev, Swarthmore College, Swarthmore, PA.

(Advances in psychotherapy--evidence-based practice ; v. 40)
Includes bibliographical references.
Issued in print and electronic formats.
ISBN 978-0-88937-407-2 (softcover).--ISBN 978-1-61676-407-4 (PDF).--ISBN 978-1-61334-407-1 (EPUB)

1. Compulsive hoarding. 2. Compulsive hoarding--Treatment. 3. Hoarders. 4. Hoarders--Family relationships. I. Siev, Jedidiah, 1977-, author II. Title. III. Series: Advances in psychotherapy--evidence-based practice ; v. 40

RC569.5.H63C43 2018 618.85'84 C2018-904343-1
C2018-904344-X



PUBLISHING OFFICES
USA: Hogrefe Publishing Corporation, 7 Bulfinch Place, Suite 202, Boston, MA 02114
Phone (866) 823-4726, Fax (617) 354-6875; E-mail customerservice@hogrefe.com
EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION
USA: Hogrefe Publishing, Customer Services Department,
30 Amberwood Parkway, Ashland, OH 44805
Phone (800) 228-3749, Fax (419) 281-6883; E-mail customerservice@hogrefe.com
UK: Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave.,
Milton Park, Abingdon, OX14 4SB, UK
Phone +44 1235 465577, Fax +44 1235 465556; E-mail direct.orders@marston.co.uk
EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

OTHER OFFICES
CANADA: Hogrefe Publishing, 660 Eglinton Ave. East, Suite 119-514, Toronto, Ontario, M4G 2K2
SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, 3012 Bern



Format: PDF

ISBN 978-0-88937-407-2 (print) • ISBN 978-1-61676-407-4 (PDF) • ISBN 978-1-61334-407-1 (EPUB)
http://doi.org/10.1027/00407-000

# Dedication

Dedicated with love to my parents and siblings for instilling in me the critical ingredients of a successful scientist–practitioner. To the memory of my dad, Fred, for modeling a robust work ethic and untiring intellectual curiosity. To my mom, Robin, for teaching me about compassion and the effective navigation of a complex social world. To my brother, Brian, for demonstrating remarkable strength and humor in the wake of adversity. To my sister, Courtney, for reminding me of the benefits of life balance and free thinking.

G.S.C.

Dedicated with love to:

Brendy – the best writer I know

Shimmy – who, at age 7, let the world know that "what my father does best is to dilevir the pizza for my birthday"

Ayelet – who, at age 9, wrote that "my future career is going to be an author and psycoligist because I am good at both and I really like doing them"

Ella – who, at age 6, described fear accurately: "my heart couldn't stop beeping"

and

Asher – who, at age 6, wrote *his* first hardcover book, "All About Elephants"

J.S.

# Acknowledgments

The authors would like to thank Keith Lit, Ivy Rouder, and Victoria Schlaudt for assistance with clinical examples and manuscript preparation.

# Contents

# 1

# Description

## 1.1 Terminology

Hoarding disorder is a new disorder in the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5; American Psychiatric Association, 2013, Sect. 300.3), as well as in the International Classification of Diseases, 11th edition (ICD-11; World Health Organization, 2018, Sect. F42, subsection 6B24), where it is included in the respective "Obsessive-Compulsive and Related Disorders" chapter. However, hoarding behavior is not a new or newly discovered phenomenon. The roots of the term *hoarding* and the presence of hoarding behavior throughout human history are outlined extensively elsewhere (Penzel, 2014). The word *hoarding* comes from the word *hord* in Old English, meaning "treasure, valuable stone or store" (Penzel, 2014). According to Penzel, there is evidence of hoarding behavior as early as the very beginning of humankind, and classical literature is peppered with references to hoarding, such as in Dante Alighieri's well-known poem "Inferno"; Gogol's main character in *Dead Souls* from 1842; and Krook, a character in Dickens' *Bleak House* from 1862. There are even possible allusions to hoarding in both the Old and New Testaments of the Bible. Specific individuals in history have also been associated with hoarding – for example, the Collyer brothers, Howard Hughes, and the Bouvier Beale mother-and-daughter pair.

Recently, hoarding behavior has received considerable media exposure. Reality television shows such as *Hoarders* and *Buried Alive* garner sizable and profitable viewerships. Popular films, like the 2004 Howard Hughes biographical drama *The Aviator*, have increased the spotlight on hoarding for the public. On the museum circuit, the clutter of Zhao Xiangyuan, the late Chinese citizen from Beijing with hoarding difficulties, has been displayed as an exhibit by her artist son, Song Dong.

The visibility of hoarding behavior throughout history is not reflected in its relative lack of attention in the community of medical and social scientists and theoreticians. Exceptions include early discussions of hoarding by William James (1890), who wrote of instinct and the importance of acquisition behavior in the formation of personal identity; and by Erich Fromm (1947), who introduced the *hoarding orientation* as one of several personality types, characterizing it as a tendency to view the world as composed of possessions to keep and value.

Hoarding behavior was included in previous versions of the DSM, but only as a single criterion for obsessive-compulsive personality disorder (OCPD), starting in 1980. However, in the early 1990s, Frost and colleagues set the stage for modern theory and research on hoarding behavior when they

published seminal research (Frost & Gross, 1993) and articulated a cognitive behavioral model of hoarding (Frost & Hartl, 1996). Since Frost and Gross (1993), the number of research articles in PsycINFO with a keyword *hoarding* (with *human* participants set as a parameter of the search) has increased nearly 19-fold, highlighting the increase in scientific attention and growing evidence base.

## 1.2 Definition

Hoarding disorder is characterized by difficulty parting with items because of the need to save them and distress from discarding them, regardless of their value. Hoarding behavior results in clutter that interferes with the ability to use living spaces as intended, unless someone else intervenes to limit the clutter. The majority (60–90%) of individuals with hoarding disorder engage in excessive acquisition of new objects as well, and the clinician can code this (e.g., for billing or research purposes) by specifying "with excessive acquisition" (Frost, Rosenfield, Steketee, & Tolin, 2013; Frost, Tolin, Steketee, Fitch, & Selbo-Bruns, 2009; Mataix-Cols, Billotti, Fernández de la Cruz, & Nordsletten, 2013; Timpano et al., 2011).

**Most individuals with hoarding disorder also engage in excessive acquisition of new objects**

Hoarding disorder is a new diagnosis in DSM-5 and ICD-11; previously, individuals with hoarding would have been diagnosed with obsessive-compulsive disorder (OCD) or OCPD. In fact, before DSM-5, diagnostic criteria pertaining to hoarding behavior were mentioned in only one section of the DSM: the fifth criterion of OCPD, where "[he or she] is unable to discard worn-out or worthless objects even when they have no sentimental value" (American Psychiatric Association, 2000, p. 729). Notably, apparent hoarding behavior (e.g., unwillingness to discard, excessive acquisition) can indicate numerous diagnoses, and hoarding disorder is not diagnosed when the symptoms are better accounted for by another condition, including OCD. For example, an individual with excessive clutter because of obsessions related to contamination or because of the need to complete elaborate compulsions before discarding would be diagnosed with OCD, not hoarding disorder.

*Poor insight* is common among individuals who hoard, and when coding the diagnosis, the clinician should specify degree of insight. In fact, more than half of individuals with hoarding have poor or delusional levels of insight (Tolin, Frost, & Steketee, 2010). Poor insight can manifest in several ways, including lack of appreciation of the severity of the problem or its impact on related consequences; rigid, fixed, and unreasonable beliefs about possessions; and defensiveness (Frost, Tolin, & Maltby, 2010). Degree of insight is a particular concern with this population because low insight has been associated with lack of motivation, treatment dropout, therapy-interfering behaviors, and poor treatment outcome (Frost et al., 2010).

The DSM-5 criteria for hoarding disorder are provided in Table 1. The ICD-11 criteria for the disorder are similar to those found in DSM-5 and emphasize the accumulation of possessions as a result of difficulty discarding or excessive acquisition, accumulation of belongings that results in the inability to use or remain safe in living spaces, and associated functional impairment

# 4

# Treatment

**CBT is the treatment of choice for hoarding disorder**

Cognitive behavior therapy (CBT) is the first-line treatment of choice for hoarding disorder. Serotonin reuptake inhibitors (SRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) may be effective treatments for hoarding, but controlled research trials are warranted and necessary to reach more confident conclusions. In addition, psychiatrists sometimes augment SRI or SNRI treatment with antipsychotic mediation, although the efficacy of this approach has not been demonstrated empirically. Case studies and theory suggest the possibility that glutamate modulators may help, but their use is experimental at this time. Finally, emerging evidence (Rodriguez et al., 2013) suggests that psychostimulants may be useful for treating hoarding behavior.

## 4.1 Methods of Treatment

Treatment research for hoarding is much less robust than research on related conditions such as OCD. A quick search of PsycINFO at the time of submission of this book suggested that the ratio of OCD treatment research to hoarding treatment research is higher than 10 to 1. Nonetheless, a systematic theme has emerged in the research literature on hoarding treatment: CBT designed specifically for hoarding has received the most empirical support, and alternative approaches outside of the CBT orientation have received little to no attention, and therefore, little to no empirical support. Within the orientation of CBT, evidence suggests that standard CBT approaches for OCD are not sufficient for treating hoarding (Muroff, Bratiotis, & Steketee, 2011), prompting the development of a CBT for hoarding protocol (Steketee & Frost, 2013a). This hoarding-specific CBT approach has received promising empirical support. In a randomized waitlist controlled trial, after roughly half of the treatment protocol was completed (i.e., evaluation occurred after the 12th week of a 26-week treatment model), CBT for hoarding was associated with significant reductions in self-reported hoarding severity (CBT vs. waitlist $d = 1.07$), clinician-reported hoarding severity (CBT vs. waitlist $d = 0.71$), and clinician-rating of overall improvement (CBT vs. waitlist $d = 1.64$) compared with the waitlist condition (Steketee et al., 2010). Because of this emerging research, CBT for hoarding disorder is highlighted below as a promising evidence-based treatment. Other CBT-based approaches (e.g., inference-based cognitive techniques; St-Pierre-Delorme, Lalonde, Perreault, Koszegi, & O'Connor, 2011) have also emerged and are variants of existing CBT for hoarding techniques, but they require more research, as does CBT for hoarding.

### 4.1.1 Cognitive Behavior Therapy for Hoarding Disorder

**Overview**

The manual of therapist-delivered CBT for hoarding has been described in detail in a published book (Steketee & Frost, 2013a) and associated patient workbook (Steketee & Frost, 2013b). This treatment protocol is designed based on a cognitive behavioral conceptualization of hoarding that has received empirical support (e.g., Kyrios et al., 2017). The protocol allows for a range of total treatment sessions, depending on the complexity of the case. The manual specifies that treatment can range from 15 to over 30 sessions, depending on factors such as severity, co-occurring conditions, treatment compliance, and case tailoring to determine what treatment elements to exclude (e.g., a case of hoarding without pathological acquisition does not require ERP targeting acquisition behavior), but the model is typically based on 26 sessions over roughly 6 months. An approximate breakdown of treatment elements and descriptions of activities is illustrated in Table 2. Each of these higher-level treatment protocol components will be discussed below. Although not considered a unitary module of CBT for hoarding, motivational approaches are also discussed below, as motivational enhancement is essential for successful treatment. Motivational techniques must therefore be weaved throughout all sessions of CBT for hoarding.

**Table 2**
**Description of Treatment Components of CBT for Hoarding**

| Treatment component | No. of sessions (approx.) | Locations of sessions | Description of activities |
|---|---|---|---|
| Assessment | 2 | Office & home | Office: Administer self-report measures of hoarding and clinical correlates; conduct interviews of hoarding symptoms and co-occurring disorders<br>Home: Assess and photograph clutter; assess daily functioning; identify a family member who could serve as a coach |
| Psychoeducation and case formulation | 2 | Office | Provide psychoeducation about hoarding; develop a personalized cognitive behavioral model of hoarding with the patient; include vulnerability factors, beliefs about possessions, information processing and learning styles, emotional responses, the identified function of the hoarding behavior; develop |

At this point, the therapist can introduce Step B by illustrating the sawtooth effect. People tend to engage in compulsions, escapes, avoidances, rituals, and other safety behaviors to cope with anxiety, such as delaying a discarding task through distraction or seeking reassurance from others (e.g., "Hey, mom, do you think my grandmother would turn over in her grave if she knew I threw out her comb?"). These compulsions tend to reinforce compulsive behavior and strengthen the underlying anxiety. Thus, an individual's anxiety score either within a given anxiety-provoking situation or in the long run (i.e., as they encounter similar situations in the future) resembles the jagged edges of a saw – hence the term *sawtooth effect*. Compulsions may provide temporary relief of anxiety during an exposure exercise, but they typically do not result in 100% relief, and the anxiety still tends to grow, often to an even higher level than before.

This is a good segue to Step C, which shows what happens when one sits with and processes the anxiety during an exposure exercise, instead of engaging in compulsions and rituals. By sitting with the anxiety, the patient would experience the natural waning of that distress over time – in other words, habituation. This is contrary to the common patient expectation in Step A, and an important remedy for the problems elicited by the sawtooth effect in Step B. Lastly, Step D should be illustrated to show what happens when the ERP exercises are repeated across sessions. This last step is the selling point that makes the distress of ERP seem worth it. A common cliché can be communicated to a patient: "ERP is a lot like going to the gym and building muscles – no pain, no gain."

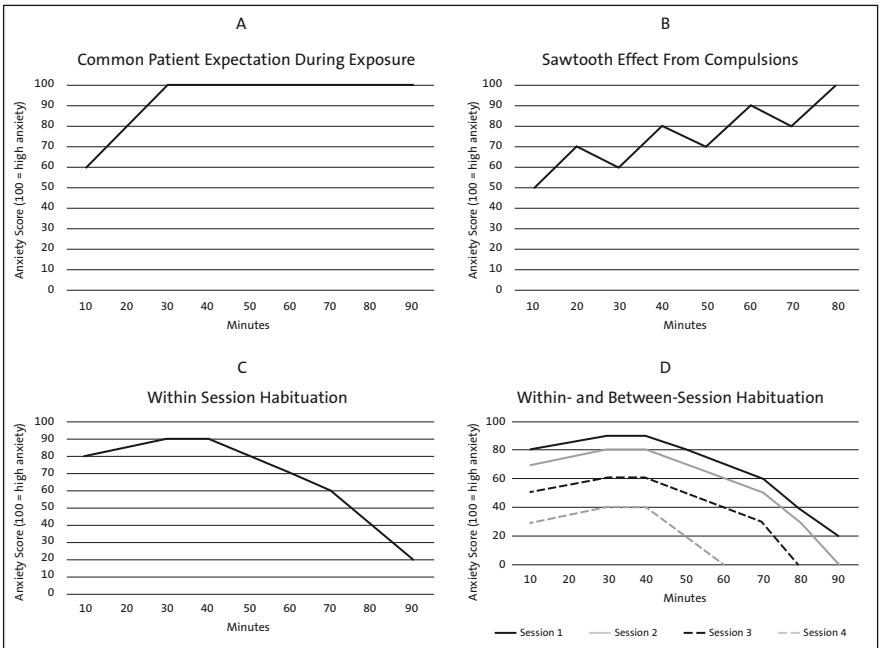


**Figure 1**
**Habituation graphs illustrating (A) patient expectations of anxiety score over time, (B) the sawtooth effect elicited by invoking compulsions to reduce anxiety over time, (C) within-session habituation during exposure and response prevention (ERP), and (D) within- and between-session habituation during ERP.**

Once a patient commits to starting the ERP process, the next step is for the patient and therapist to develop an exposure hierarchy collaboratively. The patient and the therapist brainstorm ideas for exposures in session, discard unfeasible or unhelpful ideas, and retain feasible options, which are rank ordered from highest to lowest in terms of anticipated anxiety score. After establishing an initial list of approximately 10 exposure exercises reflecting a wide range of anxiety scores, usually from 50 to 100, the next step involves negotiating a starting point and carrying out the first exposure exercise. This initial list of exposure tasks is expanded as needed once the patient has successfully completed exercises from the original list. See Appendix 1 for an example of an exposure hierarchy for a patient with hoarding disorder.

**Clinical Pearl**
**Starting With a Less Anxiety-Provoking Exposure Exercise as a Strategy**

After creating the hierarchy and negotiating a starting point for exposure exercises, sometimes it is necessary to start with a less anxiety-provoking exercise compared with what the therapist would recommend. In the case of patients with hoarding difficulties, who usually present with treatment ambivalence, starting with the easier exposure exercise is usually the best approach. This has the benefit of engaging the patient in treatment, and the lower-level task may be easier to accomplish, thereby enhancing treatment self-efficacy.

**Clinical Vignette 3**
**Example of ERP for Difficulty Discarding Symptoms**

Mike, a 55-year-old man with severe hoarding, presented with considerable clutter on his car dashboard. The clutter often slid around or fell off the dash while Mike was driving – a tremendous safety hazard. Mike and the therapist worked together to address this priority using ERP techniques. As an overarching plan, Mike was asked to sort the belongings on his dash (mostly coupons and magazines) and discard some of the items and move the remainder to a safer location. These exercises, however, varied in difficulty based on an ERP hierarchy. Mike rated his anxiety score based on a series of hypothetical tweaks to the discarding task. For instance, Mike reported the highest anxiety score would be associated with reaching onto the dash, grabbing all of his papers, and throwing them away without first inspecting them. Variations of this task yielded different levels of Mike's anxiety score. Mike reported less anticipated anxiety if he were to grab just five items and throw them away without looking at them. He reported even less anxiety if he grabbed five items but was permitted 30 s to inspect them before tossing them in the trash.

An example of ERP for difficulty discarding symptoms is presented in Clinical Vignette 3. From that case, Mike's ERP hierarchy for the treatment target is presented below (Table 3). Please note that this hierarchy is based on the patient's individual behavior and presentation, and it was negotiated in advance (i.e., never forced or coerced). Note that the hierarchy builds in a systematic reduction of the compulsion to inspect the items. This type of gradual reduction of a compulsion is not uncommon and can be directly included in a treatment plan or ERP hierarchy. As part of the negotiation process with the patient, it may be infeasible to eliminate a compulsion altogether without first reducing it.

## Types of Cognitive Errors

### All-or-None Thinking

A person who engages in this type of cognitive error thinks in absolute terms. There is no middle ground in all-or-none cognitions: Things are black or white, good or bad. Words such as *always* and *never* frequent the vocabulary of someone who displays all-or-none thinking.

*Hoarding Examples*
"Keeping these photos is the only way to remember my mom."
"I can never throw away these things. I would always regret it."

### Catastrophizing

A person who catastrophizes thinks of the worst-case scenario for the outcome of a given situation. They do not believe that less terrible outcomes are likely to occur. Further, the worst-case scenario outcome is often overestimated or exaggerated.

*Hoarding Examples*
"If I throw this bag out without checking what's inside it, I will lose all my money because someone will steal my identity and I'll have to live on the street."
"If I don't keep a gift from my best friend, she will notice I don't have it and will never forgive me."

### Emotional Reasoning

Emotional reasoning is a cognitive error that occurs when someone uses emotion as the evidence for something they think or believe. When engaging in this cognitive error, the patient is likely to trust emotions over logic.

*Hoarding Examples*
"I feel nervous when I throw my things away, so it's a bad thing to do."
"I know that it's important to de-clutter my home and that I don't need all of these clothes, but giving things away makes me feel scared. That means it's dangerous."

### Overgeneralization

Cognitive errors based in overgeneralization consist of making conclusions about the future, self, and others based on a single situation or with limited evidence from one experience.

*Hoarding Examples*
"Because I couldn't throw this item away, I'm going to fail with the rest of the items, too."
"I can't do this right, and I can't do anything right. My life will never get better, and my house will never be uncluttered."

### Unfair Comparisons

A person making unfair comparisons may compare their hoarding with perfect homes on television or with other unrealistically high standards. This cognitive error leads one to feel inferior when compared with these unfair expectations.

## Sample Thought Record

| Date and time | Situation | Automatic thoughts (% certainty) | Emotions (SUDS) | Alternative ways of thinking | Outcome:<br>• Certainty of AT<br>• SUDS<br>• Plan |
|---|---|---|---|---|---|
| Thursday 1/4, 1:00 p.m. | Waiting for the therapist, Albert, to show up for first home visit | He's going to think I'm crazy. (80%) | Anxiety, shame (90) | He's a professional; he'll understand. | AT – 40%<br>SUDS – 70<br>Plan – Go ahead with the home visit and face my fears. |
| | | He won't want to help me. (80%) | Sadness, anxiety, anger (90) | I've already shown him pictures of my house, and he helped me feel ok about that.<br><br>I trust him not to judge me. | |
| Friday 3/15, 2:00 p.m. | Trying to sort and discard clothes, deciding about discarding several pairs of shorts | If I need these in the future, I won't have the money to buy them again. (70%) | Anxiety, sadness (70) | I bought them 5 years ago, and I've never worn them, so I probably won't need them in the future. | AT – 30%<br>SUDS – 50<br>Plan – Donate the shorts. |
| | | If I donate them, I will miss out on the money I could get by selling them online. (90%) | Anxiety, shame (70) | Freeing myself from hoarding is more important than a few dollars. | |

*Note*. AT = automatic thoughts; SUDS = subjective unit of distress.

**This compact book equips clinicians with the latest knowledge on how to tackle the complexities of hoarding disorder**

Hoarding disorder, classified as one of the obsessive-compulsive and related disorders in the DSM-5, presents particular challenges in therapeutic work, including treatment ambivalence and lack of insight of those affected. This evidence-based guide written by leading experts presents the latest knowledge on assessment and treatment of hoarding disorder. The reader gains a thorough grounding in the treatment of choice for hoarding – a specific form of CBT interweaved with psychoeducational, motivational, and harm-reduction approaches to enhance treatment outcome. Rich anecdotes and clinical pearls illuminate the science, and the book also includes information for special client groups, such as older individuals and those who hoard animals. Printable handouts help busy practitioners. This book is essential reading for clinical psychologists, psychiatrists, psychotherapists, and practitioners who work with older populations, as well as students.

*"Hoarding disorder is a difficult problem to treat, yet clinicians can learn to treat it once they understand the condition and the evidence-based treatment for it. This thoughtful, concise, and well-written text presents the most current treatment approaches for this challenging condition. If you wish to help those who suffer with the debilitating problem of hoarding, get this book and learn from these experienced scientist–practitioners."*
**Michael A. Tompkins,** PhD, ABPP, Co-Director, San Francisco Bay Area Center for Cognitive Therapy; Assistant Clinical Professor, University of California at Berkeley

*"Drs. Chasson and Siev have written a delightfully concise and accurate summary of the critical features of hoarding disorder, along with models for understanding these complex symptoms and how to treat them. This quick-to-read volume is especially useful for professionals and others who respond to the needs of people with hoarding problems."*
**Gail Steketee,** PhD, MSW, Professor, Boston University School of Social Work, Boston, MA

*"This book belongs on the shelf of every mental health clinician who wants to deliver state-of-the art treatment for hoarding patients – I know I will be referring to it regularly. Chasson and Siev have compiled a succinct protocol that outlines the most critical elements of cognitive-behavioral therapy, and provide numerous extra features such as how to deal with diminished insight and motivation, working with families, and working in groups."*
**David F. Tolin,** PhD, Director, Anxiety Disorders Center, The Institute of Living, Hartford, CT; Author, *CBT for Hoarding Disorder: A Group Therapy Program* and *Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding*

*"Chasson and Siev have done an outstanding job summarizing what is known about the newest DSM-5 disorder. From beginning to end, their book serves as a roadmap for understanding, diagnosing, and treating hoarding disorder. It will be a useful addition to every health care professional's library."*
**Randy O. Frost,** PhD, Harold and Elsa Siipola Israel Professor of Psychology, Smith College, Northampton, MA; Author of *Stuff: Compulsive Hoarding and the Meaning of Things*

**Advances in Psychotherapy – Evidence-Based Practice**
*Volume 40*
Hoarding Disorder

Series editors
**Danny Wedding**
**Larry Beutler**
**Kenneth E. Freedland**
**Linda Carter Sobell**
**David A. Wolfe**

The book series *Advances in Psychotherapy – Evidence-Based Practice* has been developed and is edited with the support of the Society of Clinical Psychology (APA Division 12). Continuing education credits are available for reading books in the series (for more information see p. ii).

**Hogrefe Publishing Group**
Göttingen · Berne · Vienna · Oxford · Paris
Boston · Amsterdam · Prague · Florence
Copenhagen · Stockholm · Helsinki · Oslo
Madrid · Barcelona · Seville · Bilbao
Zaragoza · São Paulo · Lisbon

www.hogrefe.com

ISBN 978-0-88937-407-2