"I Can't Let Anything Go:" A Case Study with Psychological Testing of a Patient with Pathologic Hoarding

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Pathologic hoarding is a symptom generally recognized as related to obsessional dynamics (Gutheil, 1959). The hoarder cannot, without great anxiety, tolerate separation from or dispose of his possessions. Thus the hoarder accumulates vast amount of possessions, often in such amounts as to compromise freedom of movement in the residence. Popular in tabloid reportage, such news items portray persons found dead among floor-to-ceiling piles of old newspapers and similar detritus, while in actual clinical practice such dramatic cases are not common (Bryk, 2005; Duenwald, 2004). More importantly, such individuals are rarely available for psychological intervention or testing, both because of social isolation and injury or death caused by the hoarded materials. Additionally, a majority of the current literature regarding hoarding is linked with Obsessive Compulsive Disorder (OCD), though other major disorders have been noted.

This report describes a particular individual with characteristic features of hoarding, which is explored through formal psychological testing.

KEYWORDS: hoarding; psychological testing; social isolation; obsessional dynamics

HOARDING—DEFINITION

Frost and Hartl (1996) define hoarding as follows:

a. The acquisition of, and failure to, discard a large number of possessions that appear to be useless or of limited value.
b. Living spaces sufficiently cluttered so as to preclude activities for which these spaces were designed.

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c. Significant distress or impairment in functioning caused by the hoarding.
d. Reluctance or inability to return borrowed items. As boundaries blur, impulsive acquisitiveness could lead to kleptomania or stealing (p. 341).

CASE EXAMPLES IN LITERATURE

The small but striking literature on hoarding contains a number of dramatic case examples, such as that of a 32–year–old singer, which captures some of the classic features of hoarding dynamics (Gutheil, 1959).

> The patient's separation anxiety included . . . separation from objects. The patient was unable to throw away or discard anything. The result was that her apartment, in the course of time, resembled a huge garbage bin. The patient considered all objects in her possession, even the most insignificant ones, such as burnt out matchsticks, cigarette butts, or candy wrappers, as parts of her ego, and discarding them as tantamount to weakening of her ego integration. Giving them away was like giving away parts of herself (p. 799).

Perhaps the most famous example of hoarding was that of the Collyer brothers (Lidz 2003). Set in the later 1940s, two brothers Homer and Langley lived a highly reclusive hermit-like existence in a Harlem brownstone, which at the time of their death, contained over 100 tons of trash that they had collected over a lifetime. The material in the house included:

> baby carriages, rusted bicycles, old food, potato peelers, guns, glass chandeliers, bowling balls, camera equipment, the folding top of a horse-drawn carriage, a saw horse, three dressmaking dummies, painted portraits, pinup girl photos, plaster busts, Mrs. Collyer's hope chests, rusty bedsprings, a kerosene stove, a child's chair . . . , more than 25,000 books, human organs pickled in jars, eight live cats, the chassis of [a model T Ford], tapestries, hundreds of yards of unused silks and fabric, clocks, fourteen pianos . . . , a clavichord, two organs, banjos, violins, bugles, accordions, a gramophone and records and countless bundles of newspapers and magazines, some of them decades old (p. 5).

Based on their expressed fears of intruders, both realistic and paranoid, the brothers had rigged a number of booby traps within their residence. Langley, who had been crawling through tunnels in the debris to bring food to his blind and paralyzed brother, was caught in one of his own traps and killed. Then Homer starved to death. The stench of Langleys' decaying corpses led the police to attempt to break into their house, only to find infinite piles of objects blocking their way. Police confronted rat-infested

piles of detritus stacked to the ceilings in rooms and stairwells. While Homer was found dead in his chair shortly after the police entered, Langley was not found until nearly a month later, a short distance away from his brother, but concealed under debris from the trap. (Lidz, 2003)

Discover Magazine Online (Duenwald, 2004) provides another succinct case of hoarding:

> [For years] . . . Patrice Moore received . . . load[s] of mail—newspapers, magazines, book, catalogs and random solicitations. Each day the 43-year-old recluse piled the new with the old, until floor-to-ceiling stacks of disorganized paper nearly filled his windowless 10-by-10-foot apartment in New York City. In late December, the avalanche came, and Moore was buried standing up. He stood alone for two days, until neighbors heard his muffled moaning. The landlord broke in with a crowbar; it took another hour for neighbors and firefighters to dig Moore out and get him medical help (p. 1).

New avenues of understanding about hoarding have opened through brain imaging and cortical function studies (Saxena et al., 2008; Anonymous, 2008; Steller, 1943). However, our focus here is on the psychological aspects of hoarding.

REPORT OF THE CASE

Prelude to Admission

Michael (identifying data in this case report have been altered to preclude recognition) is a middle-aged, White, unmarried male who attended two years of community college and briefly worked as a box cutter until 1992, after which he subsisted solely on Social Security income. He is a tall, balding man with hair grown out on the sides of his head to his shoulders; he refuses to cut his hair and nails. He wears thick glasses, which magnify his eyes, and tends to stare intensely at others, sometimes without speaking.

Michael was brought to the hospital after being evicted from his apartment for causing disturbances, playing music very loudly, calling the police with allegations of the neighbors' making noise, and knocking on neighbors' doors late at night. His landlord had offered to let him stay if he engaged in treatment, but Michael was very erratic about attending therapy: During conversation he was agreeable to the plan but then did not appear. Eventually, when his landlord took him to court, he was ordered to attend a treatment program if he wanted to leave his possessions in his apartment. As treatment, Michael entered a daytime partial hospital program and resided in the evenings in the adjacent shelter.

At the point of his planned eviction, the landlord, without informing Michael, entered his apartment in order to clean it. There he encountered piles of magazines, trash, sheet music, and many other items stacked all over the apartment's floor space up to the ceiling. Ultimately, a cleaning team required two weeks to clear out the apartment contents sufficiently to open fully the front door.

On an unauthorized visit home, Michael arrived at the apartment while the landlord and his team were cleaning it. Upon seeing his things being thrown away, he became acutely anxious and defecated on himself. He returned, in great distress, to the partial hospital program shelter.

Family and Social History

Michael has no known living relatives or friends and had interpersonal difficulties throughout his life. His mother died of cancer when he was in early grade school, and his father died when Michael was in his mid-thirties, and his stepmother died roughly around the same time. During this time, Michael's stepfamily pushed him from his father's house so that they could sell it, and Michael moved to the above-mentioned apartment mentioned. Some of the items from his stepfamily's house were of high emotional significance to Michael and were part of the hoarded materials.

The diagnoses for the current hospitalization included Major Depressive Disorder (MDD) with psychotic features and paranoid personality disorder with a history of treatment noncompliance. Michael had a significant depressive history. He had been hospitalized five times for suicidal ideation and attempts, the most recent of which was 12 years before this admission, though he experienced a waxing and waning depressive mood throughout that time.

Mental Status

At the time of the interview, Michael was oriented to person, place, and time. He had an unusual cadence of speech, but did maintain a regular rate. His thought form was goal oriented, and he was preoccupied with relational difficulties with others, primarily women. Michael denied any current or past auditory and visual hallucinations.

Psychological Testing

Instruments Used

Interview, Wechsler Adult Intelligence Scale (WAIS-III), Rorschach, Thematic Apperception Test (TAT), Minnesota Multiphasic Personality Inventory (MMPI-2)

Behavioral Observations

Michael appeared on time for each of the four sessions of the evaluation, and was cooperative and pleasant throughout. He stated repeatedly that he enjoyed the testing process very much. Michael, who had previously displayed only a flat affect with the examiner, smiled and laughed a few times during the testing sessions. Michael did not appear to be anxious, except during the inquiry section of the Rorschach when the question, "What made it look like that?" was repeated. He became visibly agitated. These observations were confirmed by Michael's verbal acknowledgment of his anxiety during that particular time as well as his denial of anxiety during any other tests. His speech was perfunctory but appropriate, and his affect was usually flat with intermittent episodes of more appropriate affect.

Michael's thinking appeared confused, as many of his answers were not appropriate to the questions asked. For example, on the vocabulary section of the WAIS-III, when asked the definition of breakfast, Michael gave elements of what could be considered breakfast, such as "eggs, food," but also included "energy and vitamins," material not entirely appropriate to the definition. Although Michael's stated his mood was "good," he appeared to be somewhat morose.

Generally, Michael was very aware of his personal struggles and his differences compared to others. Cognitively, his dysregulation created an inability to change his behavior or cognitive sets. Because of this Michael appears to be somewhat lost in his world, which has increased his desire for self–harm, social isolation, and paranoid thought.

The following table describes the breakdown of Michael's full–scale IQ. In testing terms, "index scores" break down the categories of Verbal and Performance into slightly smaller subcategories that narrow the focus of the tasks tested. It is important to note that Michael's total Performance and Verbal IQ scores do not adequately describe the significant discrepancies *within* each of these categories. These discrepancies, seen through Michael's index scores in the VCI, WMI, POI and PSI cells shown above, much more accurately elucidate Michael's cognitive fingerprint.

Michael's profile reveals relative strengths and weaknesses in both his right and left hemispheres. Michael scored high on the Verbal Comprehension index in comparison to his other scores, showing that he retained a good base of knowledge from his formal education, which stayed with him throughout the years. In comparison to his other scores, Michael also scored high on the Perceptual Organization index, demonstrating that he

Table I. FULL SCALE IQ

76/5th percentile			
Verbal IQ (Left Brain) 79/8th percentile		Performance IQ (Right Brain) 77/6th percentile	
Verbal Comprehension (VCI) 93/32nd percentile	Working Memory Index (WMI) 61/. 5th percentile	Perceptual Organization Index (POI) 82/12th percentile	Processing Speed Index (PSI) 66/1st percentile
Digit Span-5	Information- 12	Picture Completion-6	Symbol Search-1
Letter Number Sequencing-2	Comprehension-4	Block Design-7	Coding-5
Arithmetic-4	Similarities-7	Matrix Reasoning-8	
	Vocabulary-7	Object Assembly-5	
		Picture Arrangement-6	

was able to organize and work with data fairly well. Interestingly, Michael's answers to many items on the Information, Comprehension, and Vocabulary sections were not as integrated, as his scores indicate; though he received credit for many of his answers, they tended to be superficial and tangential.

Michael also showed weaknesses in his profile. He scored lowest on Working Memory Index, which primarily tests auditory memory. Michael's lowest subtest score within this index was on Letter–Number Sequencing, a task that requires the individual to remember numbers and letters while rearranging their order. Letter–Number Sequencing requires a high level of planning as well as flexibility. Michael is a concrete thinker, so that the complexity of this task may have been too difficult for him. Additionally, because of the concreteness of his thinking, Michael might not have had the ability to think flexibly enough to engage well in this task. Furthermore, this task can be highly influenced by anxiety; if the individual is experiencing anxiety, then the ability to remember numbers and letters while reorganizing their sequence is highly compromised.

Michael also had relative difficulty in the Processing Speed index, which falls under the Performance IQ composite score. Michael received a scaled score of 1, a very low score, on the Symbol Search subtest, a test that requires an individual to determine whether a series of symbols contains any symbols presented in another group. This task also requires quick visual–motor speed, efficiency, and graphomotor output. Michael

might not have these skills, partially due to his poor working memory; thus it would be nearly impossible for Michael to hold the figure designs in his mind while searching for them in a new location. An alternative explanation would be that Michael might have had an obsessive concern with detail, which would prevent him from moving quickly through the task. This reason is plausible given Michael's history with hoarding and its obsessional roots.

In the emotional realm, the results from the Rorschach, MMPI-2, and TAT are convergent in many regards. Michael's awareness of his own differences can be seen through his high level of dependency and narcissistic defenses as shown by his responses on the Rorschach, which indicate that he may rely on others for direction and support and may believe that people will be more tolerant of his demands than they may actually be. Michael appears to be experiencing more needs for closeness than are being met; he is, therefore, likely to feel lonely, emotionally deprived, and interpersonally needy. This also is observed in Michael's responses on the TAT, which were primarily about family and loss. One of the cards indicated that, when fear is evoked in Michael, he becomes extremely disorganized and confused.

This disorganization leads Michael to become cognitively rigid. Michael's Rorschach responses show an avoidant style in which he tends to view himself in an overly narrow focus of attention. This was seen in the multitude of solely form–determinant responses on the Rorschach and his refusal to use the whole card in many of his responses. This rigidity and confusion about events in his daily life would likely cause Michael to feel depressed and trigger him to isolate from others.

Michael's cognitive rigidity, in combination with his impairment in reality testing, leads him to have an unusual and incorrect perception of reality. Michael's adaptation is compromised by instances of arbitrary and circumstantial reasoning and moments in which loose and scattered ideation confuses him. Although his insight is limited, Michael is able to recognize that his confusion and perception do not fit into the world in which he lives. This awareness significantly contributes to his low self–esteem, desire for self–harm, social isolation, and paranoid thinking. This is confirmed on the MMPI-2, where Michael scores extremely high on the sections outlining paranoid thinking and schizophrenia characteristics, and he endorses such ideas as "It is safer to trust no one," and "If people had not had it in for me, I would have been much more successful."

Michael's feelings of social isolation can be surmised from his answers to Card 13B on the TAT, in which it seems that Michael projects his

feelings of being different. He states: "A boy it sitting outside his house . . . watching the world go by . . . he is wondering 'why can't I go to school? Why can't I do what they're doing?'" This response illustrates that Michael feels different from the world he lives in and that he knows he is not fully incorporated into the world around him.

Michael's responses on the Rorschach also show that he tends to overvalue his personal worth and to become preoccupied with his own needs as a defense against the continual rejection he feels in his world. Michael exhibits narcissistic tendencies such as entitlement and externalization of blame and responsibility as defenses against his substantial self–doubt and low self–esteem.

An example of Michael's low self–esteem and sadness can be seen in his response to Card 3 BM on the TAT where Michael says:

> Woman that is crying. She is very sad and depressed . . . she just lost her house, case, and family . . . she is homeless and doesn't know what to do. Fragile. She has lost everything . . . lost her family too.

This response captures Michael's apparent feeling that he is upset about the substantial loss in his life.

Michael's hoarding behaviors can be connected to these neuropsychological findings. Although hoarding can be understood in terms of obsessive and compulsive symptoms, it can also be seen through the lens of loss. Michael's history shows that he has suffered many losses throughout his life, leading to anxiety around separation, which he viewed as equivalent to death. This explains why Michael refused to get rid of a multitude of items. As in the literature excerpts at the start of this article illustrate about those who hoard, Michael might have experienced objects as being a part of his ego and therefore, a loss of these items would feel to him like a loss of a part of himself. Similarly, if Michael suffered a loss through rejection, he might overcompensate his own feelings of rejection by refusing to reject anything.

DISCUSSION

Michael is a 50–year–old man with a diagnosis of recurrent MDD, with psychotic features, rule out anxiety disorder, and paranoid personality disorder. Michael suffers from significant depression and suicidal ideation, anxiety, coping deficiencies, disordered thinking, social isolation, paranoia, hoarding behaviors, and a possible history of trauma. Michael is also painfully aware of his lack of connectedness and deficits in fitting in with his peers. Although Michael has a borderline IQ, he has some relative

strength in both verbal competence as well as perceptual organization. Despite experiencing high anxiety, Michael is somewhat willing to engage in situations that increase his anxiety level. Michael would likely benefit from a psychopharmacological evaluation to clarify whether his medication suits his needs, continued individual therapy, and continued group therapy aimed at practicing social and therapeutic skills.

Hoarding behaviors, though usually connected with OCD dynamics, have been linked to major depression, information–processing deficits, problems with emotional attachment, decision–making deficits, and behavioral avoidance (all of which Michael experiences), as well as schizophrenia, and other disorders. As in the case of the Collyer brothers, death can result from physical dangers associated with hoarding; death may also occur following separation from the hoarded objects.

Hoarders tend to view their possessions as extensions of themselves, "with objects valued as safety signals because of the sense of security derived from them . . . hoarders often report that discarding possessions becomes akin to losing a loved one" (Kyrios et al., 2004, p. 244). This distorted view of their processions may bring a sense of safety to hoarders because they lack an appropriate alternative attachment (Kyrios et al. 2004). Previous studies have indicated the correlation between ambivalent attachments and low self-worth. A family environment characterized by overprotective, yet highly demanding parenting styles, not only leads an individual to seek security elsewhere, but also strengthens their alternative attachments to objects as a compensation for the high levels of perceived parental criticism that the individual received (Kyrios et al. 2004). Although not much is known about Michael's past, it is possible that he possessed this kind of attachment style and similar familial environment, possibly leading him to develop hoarding behaviors.

Michael was discharged from the partial hospital program to a day program in the area. Michael's attendance has been is nearly nonexistent, and he declined group or congregate housing options. Michael has also been inconsistent in making his appointments with any of his outpatient treaters.

CONCLUSION

Our case report with psychological testing has illuminated some of the underlying dynamics of hoarding behavior. Although hoarding is a recognized aspect of mental illness, hoarding unrelated to OCD has been given very little attention. In cases such as Michael's, treatment plans would likely be more effective with a deeper understanding of the origin of his

hoarding. Future research is needed to understand hoarding in a broader context and in relation to mental disorders beyond OCD.

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