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Clinical Case Studies 2011 10: 291 originally published online 1 June 2011
DOI: 10.1177/1534650111411293

The online version of this article can be found at:
http://ccs.sagepub.com/content/10/4/291
Inference-Based Therapy for Compulsive Hoarding: A Clinical Case Study

Marie-Eve St-Pierre-Delorme¹, Magali Purcell Lalonde¹, Valérie Perreault¹, Natalia Koszegi¹, and Kieron O’Connor²

Abstract
Compulsive hoarding (CH) is a chronic and debilitating condition that generally shows poor treatment response to both psychopharmacotherapy and cognitive-behavioral therapy. The present case study describes the application of a cognitive inference-based therapy program to the treatment of a 39-year-old woman diagnosed with CH. During a 24-week treatment period, her hoarding behavior and associated beliefs significantly decreased. Specifically, Yale–Brown Obsessive-Compulsive Scale scores became subclinical at the 6-months follow-up. There was also a clinically significant decrease in Beck Depression Inventory–II, Beck Anxiety Inventory, Overvalued Ideas Scale, and Saving Inventory–Revised scores. The single case study has implications for the treatment of CH and other problems showing ego-syntonic beliefs.

Keywords
compulsive hoarding, cognitive therapy, obsessive-compulsive disorder

1 Theoretical and Research Basis for Treatment

Compulsive hoarding (CH) is characterized by excessive accumulation of worthless items, inability of discarding these items, and impairment in mobility created by the home being almost completely filled with clutter. Such acquisition of items leads to an inadequate use of the personal environment and significant distress in individuals suffering from the disorder (Frost & Hartl, 1996). CH is a disabling disorder that has a strong impact on the social, financial, and the family level (Tolin, Frost, Steketee, & Fitch, 2008). In addition, many environmental and health risks are associated with CH such as an elevated fire hazard (Tolin, Frost, & Steketee, 2007). CH, also known as syllogomania, is presently regarded as a subtype of obsessive-compulsive disorder (OCD; Steketee & Frost, 2003). However, a debate is currently underway as to whether CH is an OCD subtype (Rachman, Elliott, Shafran, & Radomsky, 2009). In fact, CH is likely to be classified as a separate psychiatric disorder in the new fifth version of the Diagnostic and Statistical

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Manual of Mental Disorders (DSM-V) published by the American Psychiatric Association (APA; Mataix-Cols et al., 2010).

Moreover, the nature of hoarding is ego-syntonic, and people who acquire and hoard in an excessive manner do not always consider that the hoarding behaviors or thoughts that accompany their actions are unreasonable. In contrast, in other subtypes of OCD (e.g., fear of contamination), the individual usually recognizes that his or her thoughts can be exaggerated and excessive. According to Rachman et al. (2009), such lack of insight supports the argument that CH is not a typical form of OCD. An individual with CH is also prone to indecisiveness, procrastination, perfectionism, disorganization as well as feeling an urgency to save and acquire many items (Frost, Tolin, & Maltby, 2010). According to the cognitive-behavioral model, CH results from primary deficits in information processing, erroneous beliefs concerning the attachment to objects causing marked emotional distress, and observable avoidance behaviors (Frost et al., 2010; Tolin et al., 2008).

Cognitive-behavioral therapy (CBT) applied to other OCD subtypes has shown some success in treating individuals suffering from CH (Frost et al., 2010). However, attrition rates are often high and a number of counterproductive thoughts and behaviors interfere with therapy, such as lack of motivation and not completing homework assignments and lead to treatment resistance (Frost et al., 2010; Pertusa et al., 2010). Medication and CBT are less effective for individuals suffering from CH compared with other OCD subtypes (Frost et al., 2010; Steketee & Frost, 2003). Lack of compliance with CBT exercises in fact predicts a weak treatment response in compulsive hoarders (Tolin et al., 2007). In many cases, the cause of noncompliance to treatment can be attributed to the individual’s poor insight (Saxena et al., 2004) and to the ego-syntonic nature of symptoms (Frost et al., 2010). Furthermore, Kozak and Foa (1997) noted that compulsive hoarders exhibit a lot of perfectionistic behaviors and overvalued ideas (OVI) as well as magical thinking regarding their problems.

The literature reports that OVI are very present in individuals suffering from CH (Steketee, Frost, Wincze, Greene, & Douglass, 2000). OVIIs represent an overinvestment in an obsessional conviction, which is usually ego-syntonic (O’Connor, Aardema, & Pélissier, 2005). For example, a worthless item can be considered almost as an extension of the person, which makes it very difficult for the person to consider discarding it. Often it feels as if they are throwing away a part of themselves (Veale, 2002). Compulsive hoarders believe that they are responsible for the well-being of their items and grow attached to them. For this reason, they may feel guilty when they are abandoning their items. Changing these OVI seems the primary challenge in treating people with CH (Frost et al., 2010). In fact, even when presenting a logical explanation that challenges their investment in their items, hoarders may counterargue on the virtue of their possessions, leading to a counterproductive exchange of arguments (Frost et al., 2010). Achieving insight about the obsessional nature of their thoughts seems essential for progress.

Extant psychological treatments are based primarily on the Frost and Hartl’s (1996) CBT model. The latter involves home visits and a larger number of sessions, namely, 26 therapy sessions compared with around 15 for other OCD subtypes. In addition, the therapist works on four primary aspects: psychoeducation to demystify CH, improvement of decision making and organization, exposure and response prevention as well as cognitive restructuring (Frost, Steketee, & Greene, 2003). So far no randomized studies have been conducted to produce firm empirical evidence concerning efficacy of CBT therapy.

Inference-based therapy (IBT) seems effective for individuals with OVI, which are particularly resistant to exposure and response prevention techniques or treatment models based on cognitive evaluation. A small-scale, randomized controlled trial compared efficacy of IBT, exposure and response prevention, and therapy based on cognitive evaluation (O’Connor et al., 2005). Although all approaches were effective in treating OCD without OVIIs, IBT worked more consistently in
treating OCD with higher conviction levels. A recent open trial \((n = 91)\) confirmed IBT’s efficacy in treating all subtypes of OCD, and two other studies have shown equally effective treatment outcome in people with and without OVI (O’Connor, Koszegi, Aardema, van Niekerk, & Taillon, 2009; Taillon & O’Connor, 2009).

IBT has also been shown to be effective in treating all OCD subtypes (O’Connor & Aardema, 2004) and essentially addresses a process preceding obsessional development termed \textit{inferential confusion} (confusing remote possibility with reality), thus side stepping the need to confront more distal personal values and obsessional beliefs. IBT considers that the origin of OCD is an initial inference of obsessional doubt (e.g., “Maybe I will need this household appliance someday”), which is a product of inferential confusion. In this model, two levels of inferences\(^1\) are recognized as contributing to development and maintenance of OCD: primary inferences that refer to the obsessional doubt and secondary inferences that refer to anticipated consequences associated with primary inferences (e.g., “If I do not take this washer–dryer and I need it in the future, I will have to buy myself a new one and that will ruin me financially”).

There are significant differences between current CBT and IBT in the treatment approach to hoarding (see O’Connor, 2002; O’Connor et al., 2005; O’Connor et al., 2009, for more details). CBT generally focuses on downstream cognitive processes such as the appraisals of importance accorded to thoughts of acquiring and cognitive challenges of personal beliefs about responsibility and attachment toward objects and hoarding. IBT, in contrast, does not address appraisals or Beckian-style cognitive distortions because it locates the source of the hoarding in the primary obsessional doubt driving the difficulty in getting rid of objects. This primary doubt is considered an inference, not an intrusive thought.

In IBT, this obsessional inference of doubt is distinct from normal doubt because a normal everyday doubt (e.g., “Does this object fit in well with my collection?”) can be answered and resolved through appeal to observation or common sense. But the obsessional doubt has no resolution and the hoarder enters into a “doubting cycle,” for example, “Maybe one day I will need this object.” And this doubting cycle prevents the person from basing decisions on realistic criteria. The obsessional doubting inference is arrived at through a reasoning process. A number of reasoning devices mislead the person to infer a doubt that seems logical, where in fact, there is no reason to doubt.

The reasoning devices include category errors, blending terms, and inverse inferences. Category errors involve confusing separate events or objects as if one is the same as the other, for example, “This vase is like the vase my mother used, so I should keep it,” and “I heard of a man who threw away a tool and the next day he needed it, so this could be the case here with this tool.” Blending terms occurs where two terms or activities with often opposing attributes become blended to represent the same construct, for example, when hoarding useless objects becomes justified as ecological. Inverse inference involves reversing the premise and the conclusion in a deduction, for example, instead of “my daughter needs an ornament to fit with her bedroom décor, so I will seek out for a match for her,” the inverse logic is applied: “This object could fit somewhere, sometime, so I am sure I will find a place for it.”

These reasoning devices are collectively termed \textit{inferential confusions} and the aim of IBT is to undo the inferential confusion and return the person to making decisions based on senses, common sense, and realistic need. This resolution is accomplished through reasoning exercises where the person gains insight into the inferentially confused nature of the reasoning narrative and so, ceases to infer doubt where, in reality, there is no reason to doubt.

The initial doubt is maintained by an idiosyncratic reasoning process leading to secondary inferences. In the case of hoarding, an example would be a person convinced that her hoarding behavior allowed her to be ecologically responsible, in a “throwaway world,” and basing her reasoning on association and facts about wastefulness remote from the “here and now.” The inference about the self “I could become a wasteful superficial person by discarding valuables” was
supported by a narrative about her mother saving old clothes to turn into cloths, and being
told as a child how lucky she was to have toys, and how she should not waste anything. Also,
the narrative included unrelated stories about people who discarded objects and later found
that their items were really antiques, and how people in Africa were glad to receive any spare
goods, and so on (O’Connor et al., 2009).

The case study presented here is of a participant who received IBT therapy. Steps of the therapy
are detailed as well as the progresses of therapy over sessions.

2 Case Introduction

Rose was a 39-year-old woman, mother of two children, and recipient of employment insurance.
She decided to consult a psychologist in 2000 to receive help with her severe CH problem. She
revealed that she had suffered from this problem for 20 years now and was no longer able to face
it on her own. She had never undertaken psychotherapy for this specific problem. However, she
had tried several pharmacological treatments (e.g., Wellbutrin and Paxil), which were not effec-
tive. She feared that her problem would become as severe as her father’s problem, for which he
had never received help. She described her father as a packrat, cluttered in a house full of junk.

3 Presenting Complaints

Impact. Rose emphasized that her hoarding behavior had had many consequences in her life. She
specified that her situation had led her to avoid inviting friends and family to her house because she
feared that they would judge her negatively. She said the overcrowding in her house interfered with
her daily activities, as approximately 75% of the household was difficultly accessible.

Clutter. She complained primarily of her bedroom and kitchen being cluttered with food cans,
empty boxes, little appliances, and so on. However, she admitted that her exterior shed as well as
the storage space that she rented close to her house were full with other objects. Regarding the kitchen,
she mentioned that the stove was covered with items, which did not allow her to cook. Concerning
her bedroom, she said that there was no more room in her closet and therefore that it was not very
functional. A part of her bed was also covered with clothes and empty boxes, which seemed to
cause her great distress because she conceded that she was not capable of discarding any of these
items at this time. Furthermore, she had received a warning letter from her landlord threatening
her to evict her if she did not take action.

During the pretreatment evaluation, pictures from different rooms of the house were taken. There
were no rooms that were easily accessible, with the exception of the bathroom. Furniture surfaces
were often covered (dressers, washer–dryer appliances, tables, desks, chairs, etc.) and floors were
completely or partially crowded by objects. Closets were no longer functional because many items
were piled up. Half of the bed was cluttered and the bedroom floor was covered with magazines,
newspapers, bills, and post-it notes. Boxes and items piled up everywhere made most sections of
her home inaccessible. It was impossible to eat in her dining room because the chairs and the table
were buried under all the items she has collected over the years. Finally, boxes, televisions, lamps,
and garbage bags were stacked and covered her entire basement floor. Rose admitted many rooms
of her house were unusable because of this clutter.

4 History

Rose stated that her problem began in her adolescence. Since then, she said that she tried many
times to clear some parts of her house but without any success. She informed us that there was
a history of CH in her family, as her mother, father, maternal grandfather as well as her son had
CH. She revealed that both her parents’ problem was very severe.
Rose presented significant avoidant personality traits. Specifically, she stated that she avoided working with anyone who could criticize her. She also found that initiating was very difficult if she had to do it herself and that she was afraid of meeting new people, as she felt inadequate.

Prior to this study, Rose had completed several therapy programs for victims of incest and for substance abuse. She had been a victim of incest by her father during her childhood. He abused her from the ages of 6 to 14 years, at which point he was incarcerated for child abuse. Although the abuse was very difficult for Rose, she reported that she had since forgiven her father. Rose associated onset of her hoarding behavior with her father’s abuse. For Rose, her hoarding behavior was a way to feel alive. Rose had no contact with her father since his incarceration, and he died several years ago. She was diagnosed with major depression after the death of her husband in 1995. During this period, she temporarily lost custody of her children because of her hoarding symptoms. After starting a therapy for her major depression, she regained custody of her children. Rose had not been working for several years, and she said it was directly related to her CH disorder. However, it was during her major depressive episode that she stopped working. Rose also had compulsive buying behavior. She described having uncontrollable urges to excessively buy or acquire items, much as tissue boxes, clothes, and food.

She had once succeeded in preparing about 30 bags filled with items to give to charity organizations. Since then, she avoided dealing with her cluttered home. She recognized having a CH problem and realized that she acquired items because she rapidly felt attached to them and because she was worried she would need them in the future. Furthermore, she mentioned that her disorder kept her alive as she feared to lose the sense of who she was without her hoarding problem. Her expectations related to therapy seemed realistic because she was aware that the probability of eliminating her problem entirely was low, but she wished to, at the least, clear her home to make it more functional and welcoming.

5 Assessment

The participant was assessed by an independent clinical evaluator at pre-, mid-, and posttreatment, and at 6-months follow-up. Semistructured interviews that were administered included the Yale–Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989), the Structured Clinical Interview for DSM-IV (APA, 1994) Clinical Version (SCID-I/CV; First, Spitzer, Gibbon, & Williams, 1996), and the Overvalued Ideas Scale (OVIS; Neziroglu, McKay, Yaryura-Tobias, Stevens, & Todaro, 1999). Self-report measures that were used included the Personality Disorders Questionnaire–4+ (PDQ-4+; Hyler, 1994), the Padua Inventory (PI; Sanavio, 1988), the Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), the Saving Inventory–Revised (SI-R; Frost, Steketee, & Grisham, 2004), the Saving Cognitions Inventory–Revised (SCI-R; Steketee, Frost, & Kyrios, 2003), and the Clinical scales and daily diaries (O’Connor & Robillard, 1999). The measures employed to assess the participant were chosen because they are gold standard measures of OCD symptoms (Y-BOCS, SCID-I/CV, OVIS, and PI), CH symptoms (SI-R and SCI-R), personality traits (PDQ-4+), mood (BDI-II), and anxiety (BAI). Daily diaries were completed everyday for the duration of the therapy program to measure OCD-related variables such as time spent performing and the degree of investment in ritualized hoarding and acquiring compulsions (O’Connor & Robillard, 1999). Furthermore, pictures of Rose’s home taken at pre- and posttreatment served as an objective measure of the degree of clutter in her environment. In addition, monthly telephone calls to the participant allowed the clinical evaluator to assess her progress maintenance after the end of therapy. The Therapy Evaluation Scale, an adaptation of the Therapist Rating Scale (TRS; Williams & Chambless, 1990), is a measure of the therapeutic alliance and assesses participant perceptions of the following therapist characteristics: caring/involved, modeling self-confidence, unconditionally accepting, challenging, explicit, and willing to be known. It was
administered at 6-months follow-up to assess Rose’s satisfaction with the therapist and IBT program.

To establish whether changes in pre- and posttreatment measures were relevant to treatment outcome, Emmelkamp’s (2002) criterion of 33% or more improvement posttreatment as compared with pretreatment scores was used. A significant decrease in all measures was observed, except in the SCI-R. This measure nonetheless showed a 27% decrease (Table 1).

Results on the Feeling of Personal Efficacy Clinical Scale indicate that the client was significantly more confident in her capacity to resist hoarding.

### 6 Case Conceptualization

This presentation of Rose’s clinical case corresponds to a diagnosis of CH. Her principal doubt for acquiring and hoarding was “Maybe I will need this item in the future” and it was associated to her secondary inference “I will regret it.” A detailed explanation of her doubts follows this section.

### 7 Course of Treatment and Assessment of Progress

The therapy protocol was composed of four clinical evaluation sessions, which allowed the therapist to identify a hierarchy of the participant’s obsessions and compulsions degree of insight into her disorder, and primary as well as secondary inferences. Measures were taken at the end of therapy, namely, at 20 weeks, 3 months as well as 6 months post treatment.

Evaluation sessions were followed by 20 weekly sessions of IBT therapy. According to the IBT model, OCD is always developed and maintained from an initial unfounded inferentially confused doubt, no matter what type of obsessions and compulsions are present (see Figure 1). First, a trigger generates an obsessional doubt (or a primary inference). Next, when the doubt is established in the person’s mind, it leads to anticipation of disastrous consequences associated with this doubt. For example, when Rose would see an old washer–dryer appliance in a yard sale (trigger), she started doubting: “I will surely need this item in the future.” Then, she anticipated a negative consequence that provoked feelings of anxiety and pushed her to compulsively bring the item home with her: “I am sure that if I do not bring it home with me, I will regret it. I can always use a washer–dryer; mine is old, it will probably break soon, and so on.” It is important to understand that a participant’s internal narrative plays a significant role in the development and maintenance of the doubt. This narrative is based on important reasoning biases such as selective use of out-of-context facts where abstract facts are inappropriately applied to specific personal contexts to justify the compulsion.

### Table 1. Pretreatment, Posttreatment, and Follow-Up Scores on Self-Reported Clinical Measures

<table>
<thead>
<tr>
<th>Self-reported clinical measures</th>
<th>Pretreatment total score</th>
<th>Posttreatment total score</th>
<th>Follow-up total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory</td>
<td>23</td>
<td>13</td>
<td>—</td>
</tr>
<tr>
<td>Beck Anxiety Inventory</td>
<td>16</td>
<td>9</td>
<td>—</td>
</tr>
<tr>
<td>Yale–Brown Obsessive-Compulsive Scale</td>
<td>28</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Yale–Brown Obsession Subscale</td>
<td>14</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Yale–Brown Compulsion Subscale</td>
<td>14</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Saving Inventory–Revised</td>
<td>77</td>
<td>45</td>
<td>—</td>
</tr>
<tr>
<td>Saving Cognitions Inventory–Revised</td>
<td>126</td>
<td>92</td>
<td>—</td>
</tr>
<tr>
<td>OVIS</td>
<td>61</td>
<td>15</td>
<td>19</td>
</tr>
</tbody>
</table>

Note: OVIS = Overvalued Ideas Scale.
IBT therapy allows the participant to change the internal narrative that maintains primary inferences to adhere to a more realistic scenario, which can in turn help change behavior. Furthermore, IBT considers that obsessions originate from interior narratives based on invalid inductive arguments specific to each client. Clients learn to change their narrative. The key point to clarify with individuals is whether the obsessional doubt is realistic; their narrative is never derived from evidence confirming the doubt in the “here and now.” Narratives help maintain the obsessional doubt (primary inference) and the compulsions because the person behaves as if the doubt was highly probable. The IBT model of the maintenance of OCD is schematically presented below. The model’s components are defined in further detail below.

The 10 IBT steps involve establishing (a) the distinction between an obsessional doubt and a normal doubt, (b) the OCD logic, (c) the OCD doubt is 100% irrelevant to “here and now,” (d) the power of a narrative, (e) crossing the barrier over from reality into imagination, (f) identification of reasoning errors that create and maintain the obsessional narrative, (g) establishing the false nature of the OCD doubt, (h) the selective nature of OCD doubt, (i) the vulnerable self-themes in OCD doubt, and (j) reality sensing and tolerating the void.

The primary aim of IBT therapy is to decrease conviction toward primary inferences. Thus, as primary inferences are the first step in the OCD sequence, it is expected that addressing them in therapy will lead to therapeutic effects on the rest of the OCD sequence, including secondary inferences, anxiety, and compulsive behavior.

In the first therapy sessions, Rose’s psychologist helped her recognize that obsessions arise from a doubt and explored with her the difference between an obsessional doubt and a normal doubt. She understood this concept and admitted that the doubt partly explains why she had this problem. She mentioned that one of the reasons that she had a CH problem was indeed because she felt that she might not exist without her hoard. Without them, she had the feeling that nobody would remember who she was. After each therapy session, Rose was asked to complete a homework assignment related to the therapy content. Following the first two sessions, Rose succeeded in throwing away many items during the week because she applied the strategies that she had learned in the sessions. When she grasped the OCD sequence, her psychologist helped her identify her primary inference (“I will surely need this item in the future”) and secondary inference (“I am sure that if I do not bring it home with me, I will regret it.”). Figure 2 shows how the probability of the primary and secondary inferences identified by Rose decreased through the course of therapy. Weeks 12 to 17 indicate marked increases in perceived probability of the primary inference. These increases correspond with the periods in which Rose broke through her pattern of avoidance and began to try to remove some of the clutter in her home.

The therapist then explored with Rose the concept of a doubt as an imaginary component, which allowed the therapist to work on her obsessional narrative. Rose was asked to create a nonobssional scenario for her to understand that both scenarios are stories that can seem realistic. For example, Rose’s scenario was “if I throw away the statues that my mother brought me from Japan, she will hate me and never talk to me again.” Her alternate scenario was “as the Japanese statues that my mother gave me are lying in the bottom of my drawer, I could give them away to charity.
and it would allow someone else that likes this art to enjoy them. My mom would be happy that someone is putting them to good use.”

In subsequent therapy steps, the psychologist helped Rose recognize that her doubt arises from her imagination and she learned what led her to cross the boundary from reality to imagination. The psychologist then attempted to convey to her how the reasoning devices of the OCD which are part of the narrative let an unreal doubt be experienced as though a real doubt. She was showed examples of the most common OCD-related reasoning devices and how they lead to confusion between reality based on her five senses and her imagination. To arrive at the next step, the therapist showed Rose that in nonobsessional situations, she is perfectly able to reason in a non-selective and realistic manner. In fact, Rose identified a series of questions to ask herself before surrendering to a hoarding and acquiring compulsion. In her case, she asked herself whether she still had the item or a similar item at home, whether she really needed the item, and if she needed it, she evaluated her need in detail. For example, she wanted to register her daughter in a day camp. The people in charge of the camp told her that she should buy a yellow T-shirt as yellow was the camp’s official color. Rose thus went to clothing store to buy a T-shirt, but when she arrived, she had the idea of buying many T-shirts because children easily dirty themselves and one T-shirt might not be enough. However, she decided to take a break in the store and asked herself the series of questions. First, she told herself that her daughter had many T-shirts because children easily dirty themselves and one T-shirt might not be enough. However, she decided to take a break in the store and asked herself the series of questions. First, she told herself that her daughter had many T-shirts because her brother gives her all his daughter’s hand-me-downs when she outgrows the clothes. She also knew her daughter did not particularly like day camps and so, if she accepted to participate, it will only be for a very brief period. Finally, her daughter was a very calm child who rarely got dirty; therefore, a second T-shirt
would not be necessary. She was able to reason that if there was a need for a second T-shirt, she would purchase one when the time came. With the help of this logical reasoning and decision making, Rose was able to resist her compulsion and limit herself to one T-shirt. Rose could recognize which reasoning devices maintained the credibility of her doubt and validated her doubt. She also understood that her obsessional doubt was not valid because of these reasoning devices and that it reflected selective reasoning.

The last therapy step consists in helping the participant find the vulnerable self-themes that maintain their problem and that reinforce their obsessional doubts. Rose had a lot of difficulty throwing away a gift from a close friend. Even at the end of therapy, she continued to feel vulnerable to all the items that were gifts from her loved ones. By exploring this tendency of hers with her psychologist, it became clearer to her that her hoarding behavior was linked to her self-theme “I am nothing without my things; people around me will not realize that I exist if I do not have all my things.”

The IBT was delivered by a licensed psychologist who was trained in IBT at the Fernand-Seguin Research Center. The participant’s reactions and perceptions regarding her psychologist, the therapy process, and the therapeutic alliance were measured by the Therapy Evaluation Scale. Rose stated that she was very satisfied with all aspects of the therapy and the therapeutic relationship she had with her psychologist.

8 Complicating Factors

Rose demonstrated considerable motivation and a high degree of insight throughout therapy. Rose’s level of motivation was evaluated by her psychologist based on her attendance and participation in therapy as well as her desire to change. Her degree of insight was measured by Question 11 in the Y-BOCS and Question 9 in the OVIS. However, Rose often did not complete the necessary homework exercises that were required of her and she gave her psychologist many reasons why she did not. For example, her son had significant behavioral problems at school and she constantly needed to meet his teachers and the school principal who threatened to expel him. Although Rose no longer used benzodiazepines, she reported regular use of marijuana for its relaxation effects. These resistances were addressed in therapy and the participant admitted being aware of the disabling nature of her behaviors but mentioned that she could not behave otherwise in periods of high stress. Moreover, her avoidant personality traits could have affected her prognosis negatively. Indeed, Rose experienced a difficulty initiating any discarding by herself. Since the end of treatment, she has been capable of initiating many tasks on her own such as starting to clear her basement.

9 Follow-Up

At 3-month follow-up telephone interview, she revealed that she had continued to prioritize taking action. For example, she had delegated household tasks to her children, which reduced her daily obligations and allowed her to apply the strategies she learned in therapy.

At the 6-months posttreatment follow-up, the Y-BOCS score was subclinical and the score on the OVIS remained low. Further follow-ups with Rose are planned. Two months after the end of therapy, during the follow-up telephone interview, Rose mentioned that she was able to partly maintain the skills she acquired during therapy. Nevertheless, she emphasized her low persistence in discarding items since the end of therapy. However, at the next follow-up, she revealed that she was capable of cleaning her home, which is according to her “a very big step.” Furthermore, when asked to what extent she believed she could resist the compulsion of acquiring souvenir items or items that maybe needed in the future, she said she could resist them 95% of the time, which is an outstanding accomplishment.
**10 Treatment Implications of the Case**

Several clinical implications stem from understanding Rose’s therapeutic trajectory. First, aside from certain lack of compliance (e.g., daily diaries not always completed), Rose was a motivated participant, which was probably a crucial factor in her adherence to treatment. She was generally able to be insightful regarding her problem. In fact, even after one session, she was capable of being objective toward her compulsive behavior and could ask herself the right questions to reason realistically. For example, when she went shopping, she asked herself whether she really needed 15 jars if jam was on sale. Before therapy, she had revealed buying more than 10, and following therapy, she stated that she limited herself to one or decided not to purchase any.

IBT was adapted to meet the needs of compulsive hoarders. In fact, because the nature of their obsession is often very ego-syntonic, and compulsions are often passive or mostly avoidance behaviors, the distress is less linked to obsessions and more to the subsequent clutter in the home environment. Nevertheless, it is very difficult for hoarders to accept to throw out the items to which they are very attached. According to them, their hoarding behavior is justified. In addition, beliefs supporting the excessive acquisition and keeping of items can be overinvested in contrast to other OCD subtypes, such as fear of contamination.

Unlike traditional CBT that uses techniques such as exposure to a hierarchy of items according to their anxiogenic potential, IBT uses cognitive exercises that permit generalization of learned skills across all items in the home (O’Connor & Aardema, 2004). It was notable that Rose improved her compulsive tendency to acquire items. She completely stopped acting on her compulsions related to compulsive buying or acquiring items from neighbors’ recycling bin or garbage can. However, it was more difficult for her to throw away what she had already collected over the years, especially if the object was a gift from a loved one. She nevertheless succeeded in preparing and delivering enormous bags to charity organizations. Thus, she threw away a significant quantity of items that cluttered her home but was not able to completely achieve her objectives regarding certain cluttered rooms of the house. For example, she aimed to clear out everything she had stored in one of the bedrooms and use it instead as a guestroom.

**11 Recommendations to Clinicians and Students**

Clinicians and students should be vigilant when treating an individual suffering from CH. It is necessary to not only utilize clinician-administered semistructured interviews and self-report measures but also use objective pictures to evaluate all therapy gains, including improvements in the state of the individual’s environment following the therapy program. Indeed, Rose’s psychologist noticed that she underestimated her progress during the course of the therapy program and pictures of her home at pre- and posttreatment reflected the degree of this objective change.

Moreover, although there is usually a need for extended therapy sessions when treating individuals with this disorder, Rose responded well to a 20-week cognitive-based program. In the first session, she understood the logic of the IBT model and that the arguments maintaining her doubt are relatively unrealistic. This underlines the importance of working on doubt, decision making, and reflecting on the nature of the person’s acquiring and hoarding compulsions to overcome CH.

In addition, environmental factors associated with individuals suffering from CH are important to keep in mind. In many cases, these individuals live alone, are isolated, and have very little social resources. In addition, CH is often comorbid with another personality disorder (Samuels et al., 2002; Steketee & Frost, 2003). In fact, Rose’s case presented comorbid avoidant personality traits, which made her reluctant to be involved with people and avoid contact with others. This tendency could have influenced her prognosis. However, this did not interfere with the IBT treatment outcome but suggests that she identified strongly with the IBT model. To conclude,
although current opinion considers CH distinct from OCD, within the IBT conception of OCD as arising from an initial inference of doubt, CH possesses clear obsessional characteristics. Finally, as expected by the IBT model, posttreatment OVI were significantly reduced as well as all other OCD and CH symptoms.

Authors’ Note

Rose’s personal characteristics were modified to conserve her anonymity.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or the publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Note

1. Inference: a conclusion reached on the basis of evidence and reasoning (O’Connor, 2002).

References


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