From the Director's Desk

It has been an unusually cold and snowy winter in St. Louis, but temperatures finally are beginning to warm. The hope of longer days, with more sunlight and warmer temperatures, is now so alluring. The emergence of spring is a reminder of the possibility of change and the undying quality of hope. In the same way, as we progress through these final days of Lent, I hope that your Lenten journey this year has blessed, intensifying the promised joy of the Easter season.

In this issue of *UpDate* we feature an article on the problem of hoarding, a behavior which we recognize as a form of Obsessive Compulsive Disorder. The problem of hoarding has gotten attention recently in the popular media; reality television series have even been devoted to documenting the characteristics of the disordered behavior. We in the Program for Psychology & Religion are very much aware that some clergy and religious also struggle with hoarding. In its extreme, it can interfere with the ability to carry out mission and maintain community.

The author of this article, Dr. Heather Chik, is a post-doctoral resident in the Anxiety Disorders Center, one of the specialty programs of the St. Louis Behavioral Medicine Institute. One of the great strengths of the Program for Psychology and Religion is our ability to draw upon experts like Dr. Chik to develop integrative, patient centered and research based treatment plans. The Anxiety Disorders Center, for example, led by Dr. Alec Pollard, is recognized nationally for its expertise in the treatment of Obsessive Compulsive Disorder.

If someone in your diocese or community is struggling with hoarding behaviors, the good news is that there is hope. Hoarding can be overcome: thoughts and behaviors about acquiring and retention can be modified, and new skills for organizing can be learned. Once free of the compulsive behavior, the individual can invest more energy in ministry and relationships. Life becomes again more fulfilling.

Spring and Easter remind us that change is possible. When there is need, please remember that we are here for you. Call on us. If you have further questions about a particular situation or about our program in general, I am always very happy to receive your calls.

Blessed Triduum and Happy Easter,

Christopher S. M. Grimes, Psy.D.

Christopher S. M. Grimes, Psy.D.
Director, Program for Psychology and Religion
Assistant Clinical Professor of Family & Community Medicine at St. Louis University

Saint Louis Behavioral Medicine Institute is an affiliate of Saint Louis University Health Sciences Center

Saint Louis
BEHAVIORAL
MEDICINE
Institute
1129 Macklind
St. Louis, MO 63110
(314) 534-0200

PROGRAM FOR PSYCHOLOGY AND RELIGION

UpDATE

Paul N. Duckro, Ph.D., Editor
SPRING 2011

1-877-245-2688
(314) 534-0200
www.slbmi.com

COMPULSIVE HOARDING AND ACQUISITION

by Heather M. Chik, Ph.D

These days, it is almost impossible to spend an evening surfing television channels without stumbling onto a show about hoarding. A&E's *Hoarders,* TLC's *Hoarders: Buried Alive,* and Animal Planet's *Confessions: Animal Hoarding,* all examine the lives of people who have difficulty parting with their possessions—animate or inanimate. While these shows have certainly raised awareness of hoarding and clutter as a serious problem, they seldom take time to accurately portray the often arduous intervention process as people struggle to overcome very powerful emotional attachments and beliefs.

Among mental health professionals, hoarding is understood as a form of obsessive-compulsive disorder (OCD). Individuals who hoard typically acquire and have difficulty discarding possessions that appear to most other people to be minimal value or even disgusting: for example, newspapers, empty containers, books, clothing, or food that is going bad.

There are many sub-types. Compulsive acquisition can take the form of buying or collecting items. Animal collections can become quite extensive, well beyond the individual's need or ability to maintain. Retention of objects may be based on sentimental attachment, perceived need or inflated estimation of artistic value.

The results are the same. The extreme clutter in the home, yard, office or car prevents the normal use of those spaces: cooking, cleaning, walking through the house, retrieving needed items, sleeping or driving. Occasionally, the interference with normal use actually constitutes a health or safety risk, resulting in a report to public health, adult protective services or other agencies. For example, clutter may make it impossible to access toilets and sinks. Rotting food or garbage can increase the risk of disease by attracting pests. Inability to maintain the home may result in the loss of running water, heating or cooling. Items scattered throughout the house increase the risk of injury by falling. The accumulation of combustible materials such as paper and clothing may enhance fire risk.

Cognitive and behavioral therapy (CBT) is the primary intervention for the

Continued on Page 2

THIS ISSUE

Compulsive Hoarding . . . Cont. from page 1

treatment of compulsive hoarding and acquiring. Psychiatric medications have not been shown to produce significant improvement in hoarding symptoms. Generally, the focus of treatment is on three areas: disorganization, difficulty discarding, and compulsive acquisition. In therapy, individuals with compulsive hoarding learn to 1) develop organizational, decision-making, and problem-solving skills, 2) face thoughts or situations that trigger anxiety leading to acquisition or difficulty sorting or discarding items, and 3) change problematic beliefs and automatic thoughts about self, others, and their possessions. Most persons require at least 6 months to 12 months of treatment. Sessions may be conducted in a therapist's office, in the individual's home, or at other locations where hoarding presents a problem.

Many individuals who hoard recognize their impairment but are ambivalent about treatment.

It is important to be aware of the unique challenges that frequently emerge in the course of treating hoarding.

Low motivation

Many individuals who hoard recognize their impairment but are ambivalent about treatment. Sometimes this is because well-meaning community members have intervened in the past and thrown out the hoarded possessions without the individual's permission. In other situations, it may be that the individual is simply overwhelmed by the magnitude of the task. In either case, the individual with compulsive hoarding associates the therapy process with a loss of control and is therefore unlikely to participate wholeheartedly.

To counter this impaired motivation, the therapist must plan carefully to help the individual recognize the advantages of change. A partnership with the person with compulsive hoarding works best; he or she must be treated as a person with the right to make informed choices.

The individual is also encouraged to discuss deeply-held beliefs about acquiring and losing possessions. Occasionally, there are some individuals with hoarding problems who deny the inappropriateness of their hoarding behavior and fail to recognize the impairment that is so evident to others. In such cases it is necessary also to encourage the local community members to speak frankly about how the hoarding affects their lives or causes them concern. Sometimes becoming aware of the impact of the hoarding on others is the only foundation on which to build motivation for change. Maintaining motivation is a constant concern in the early stages of treatment.

Clean-out:

Necessary but not sufficient

Many television shows focus on the dramatic transformation from clutter to order by employing professional organizers. Once done, the television crew moves on. What the audience does not see is the return to clutter in many of these homes. This "rebound" occurs because the clean-out itself has been traumatic and the individual with compulsive hoarding has not learned any skills to modify his or her acquiring and retaining behaviors. The rapid loss of possessions and control only amplifies fear and discomfort, increasing sensitivity to any form of loss in the future.

The rapid loss of possessions and control only amplifies fear and discomfort, increasing sensitivity to any form of loss in the future.

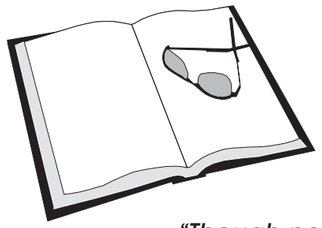
Clean-outs are helpful only when the individual with compulsive hoarding is ready for them. Typically, readiness occurs only after the individual has practiced discarding repeatedly in treatment so that she or he can make decisions quickly and with limited discomfort. Ground rules need to be established in collaboration with the individual as to how others will touch, make decisions about, and remove various items. A well-timed and carefully planned clean-out can result in renewed motivation, faster improvement and more sustained reduction in clutter.

Community/family members

Community members sometimes accommodate the individual with compulsive hoarding just to keep the peace. The unintended consequence is that this accommodate prevents the individual from learning new behaviors. For example, when community members take over duties like trash removal or work around the clutter, insight into the severity of the problem is mitigated. It is not unusual that the therapist will spend much time with community members to help them allow the individual to live with natural consequences and to offer more frank commentary.

At the same time, it is important for community members to provide positive comments on progress and avoid overt frustration with the slow or erratic process of change. It can take months for people to learn new ways of perceiving and managing possessions or collections. A successful reduction in hoarding can free up community space that is then used by others who have been constrained; arguments may ensue if the individual in treatment perceives others as taking over "their space." Some negotiation may be needed; the therapist make seek to enlist the help of community members who are especially calm and oriented toward the common good to help resolve such disputes during the treatment process.

In summary, successful treatment relies on collaboration among the individual with compulsive hoarding, the members of their community, and the therapist. All must come to greater empathy as the ground for the steady, though perhaps uneven progress toward freedom from the compulsion of hoarding and the associated, debilitating clutter.



Book Reveiw

Hungry: Lessons Learned on the Journey from Fat to Thin

by Allen Zadoff

"Though no one can go back and make a brand new start, anyone can start from now and make a brand new ending."

In this inspiring book, Allen Zadoff recounts years of unhappiness, frustration, even desperation as he struggled with an ever increasing waistline. In the course of those years, he had tried many diets, lost and regained many pounds. At 28 years of age and 350 pounds, Allen came to an important understanding: what he was doing was not working. That understanding was the beginning of a new direction and is the heart of this book.

He sought help to learn more about what was underlying his uneven course. He came to believe that overeating can be profitably understood as a disease, an addiction. He found three distinct and powerful components to this addiction: physical, emotional and spiritual. He realized that he had been focusing only on the physical dimension; once he began to give equal attention to his emotional and spiritual development, the problem of excess weight seemed to care of itself.

Allen's first great insight was that his real problem was his response to life's issues. He had come to respond to the stresses of life with great fear and then "fixed" this emotional distress with food. Food had become the friend to whom he turned in distress, but this friend, he learned, gave only transient consolation. As the fear returned, so did his need for food.

He could not stop. Life was out of control. He had become a food "junkie." He was now eating to avoid pain. To make matters worse, the relationship between feelings and food reversed: the more he ate the worse he felt. Allen was in crisis, a spiritual crisis.

The second great insight was that there might be a Power greater than his need to overeat. It changed his entire direction. Believing led to seeing. He found therein the strength to actively manage his disease.

Allen is wise enough to know that he is not "cured." Nevertheless, he is in "recovery," and he finds it to be "the best thing that has ever happened."

In writing this book, Allen's goal is modest: he does not present a solution so much as he simply states what worked for him. He recounts his reaching out for help and his ongoing management of appetites. His hope is that his experience will lead readers to take their own next step: coming to see in a fresh way and seeking professional and peer support.

We applaud Allen's journey and his motivation in sharing this journey for the good of others. His journey embodies so much of what we try to do in the Weight Management Program. Physical, emotional and spiritual: these are the elements of the problem and these are the elements of its resolution.

The book is a great read for anyone struggling with their weight and praying to the Lord that he or she might see.

About the Author: Reviewed by: Martha Vatterott, R.D., L.D. is the Clinical Dietitian for the Weight Management Program.