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Essay

Hoarding Disorder: A Sociological Perspective

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Abstract: Hoarding disorder (HD) is a recently recognized psychiatric condition, now classified under the category of obsessive-compulsive and related disorders in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). It leads to an unwarranted attachment to material possessions, such that the individual is unable to separate themselves from them. There is still a lack of awareness of the critical sociological implications of this disorder, which is too often considered a purely health-related issue. This article endeavors to frame hoarding disorder from a unique socio-criminological and legal perspective, proposing an alternative approach to HD that considers it not only as a mental disorder, but also as a genuine societal issue. We also explore potential avenues for protection, considering both the well-being of individuals with this mental disorder and the communities in which individuals suffering from HD reside. This paper presents a fresh perspective on HD, aiming to delineate its impact and significance as an affliction affecting both individuals and society at large.

Keywords: hoarding disorder; DSM-5; obsessive-compulsive and related disorders

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1. Introduction

Hoarding disorder (HD) is a condition classified within the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) under the category of obsessive-compulsive and related disorders (OCRD) along with trichotillomania, excoriation disorder, and body-dysmorphic disorder [1]. This groundbreaking classification deviates from the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-4-TR) [2], which previously listed hoarding as one of the eight diagnostic criteria for obsessive-compulsive-personality disorder (OCPD). It also recommended that healthcare professionals consider a diagnosis of obsessive-compulsive disorder (OCD) in severe hoarding cases. Consequently, the DSM-IV-TR regarded hoarding disorder as a subtype of OCD, lacking a distinct nosography.

The recognition of this independent nosological qualification reflects an awareness of the complexity and specificity of the disorder, which, while undoubtedly sharing traits with obsessive-compulsive disorder (OCD), must be considered a pathologically distinct entity. This is because, from a neurofunctional point of view, different brain areas are affected and, furthermore, because hoarding disorder has different features from OCD (such as poorer insight, a much more significant impairment of family balance and social status, and suffering that is generally not immediate and mediated by third-party intervention) [3].

In terms of psychological pathophysiology, the development and maintenance of hoarding disorder can be explained through various psychological theories and empirical studies. Some of the major theories include:

- Attachment Theory [4]: this theory is used as a foundation to examine HD and better understand the dysfunctional relationships seen in those who hoard. It proposes that maladaptive cognitions and dysfunctional attachments to people and possessions jointly underlie the saving behaviors characteristic of the disorder.

- Psychological Ownership [5]: this concept suggests that people with HD have strong motives for psychological ownership, such as efficacy and effectance (a tendency to explore and influence one's environment), as well as self-identity. These motives contribute to the development and maintenance of hoarding behavior.
- The Cognitive-Behavioral Model [6]: this model posits that hoarding behavior is maintained through a combination of cognitive, emotional, and behavioral factors. The pathological attachment of individuals with HD to their possessions is not well understood or integrated into cognitive-behavioral models.

Empirical studies exploring these theories and models have helped to advance our knowledge of HD, identify potential factors that can be targeted in intervention and prevention efforts, and provide important future directions for empirical work.

According to a 2017 population study, hoarding disorder has an overall prevalence of 2% [7]. A more recent meta-analysis revealed that the prevalence of the disorder falls within the range of 1.5% to 6% [8]. Studies estimate that hoarding symptoms typically begin at the age of 13.4 years, with the majority of patients (60%) reporting that symptoms manifested before the age of 12. By the age of 18, this percentage increases to 80% [9]. Hoarding disorder is a condition characterized by specific criteria related to dysfunctional emotional and behavioral patterns, rather than a medically defined disease. Although there may be an underlying biological component, the current understanding of this feature is limited, leading psychologists to focus on addressing the emotional and behavioral aspects during intervention. The presence of significant impairment in social, emotional, and work functions is congruent with the criteria of distress and functional impairment required for the diagnosis of hoarding disorder, indicating the profound impact that the condition has on individuals' lives. Accumulation can also often lead to unhealthy or unsafe living conditions. The neglectful situations faced by those afflicted with HD may escalate to severe degrees, creating unhealthy environments that can pose a real danger to community safety. This aspect provides insight into how hoarding disorder can be seen as a true borderline health issue. In fact, it can be addressed through two complementary approaches, of which one is medical and the other is criminalistic. Thus, we can consider hoarding disorder as a registered disorder defined by medical science or as a form of socially inappropriate conduct with a negative impact on collective well-being.

In this article, we propose a new way of approaching the condition from a dual perspective, medical and criminological, emphasizing the social nature of the disorder. The primary aim of this article is to offer a novel perspective on hoarding disorder by shifting the focus from individual mental health to the broader societal implications of the condition. By examining HD through a socio-criminological and legal lens, we hope to contribute to the existing body of knowledge with fresh insights and a unique approach that has not been extensively explored in previous research.

The specific value of our work lies in its potential to foster a more comprehensive understanding of HD, taking into account its impact on the communities in which affected individuals reside, as well as the legal challenges that may arise as a consequence of the disorder. Moreover, a key innovation of this article is the attempt to quantify the sociological significance of hoarding disorder through a function. This exploratory approach aims to present a new and alternative method for assessing the societal impact of the disorder, ultimately improving our capacity to devise efficient interventions and policies that address the needs of both individuals living with HD and their surrounding communities. By presenting this novel perspective and methodological approach, our work seeks to bridge the gap between individuals' experience of HD and its broader societal consequences, ultimately contributing to a deeper and more nuanced understanding of this complex disorder.

In order to dispel any misconceptions, it should be noted that, despite the occasional use of strong terminology throughout this paper, our intention is by no means to perpetuate a derogatory or discriminatory perspective on hoarding disorder.

2. The Medical Perspective

In the DSM-5, the essential characteristic of hoarding disorder is persistent difficulty in throwing away or parting with one's possessions. The term "persistent" excludes temporary circumstances. It is precisely the persistence over time of this difficulty in disposing of objects that creates an accumulation and cluttering of living spaces and daily use to the point of making them unusable. The accumulated goods are, in most cases, magazines, books, newspapers, documents, mail, bags, and clothes [10–12]. Often, they are goods that most people consider useless and worthless; in other cases, valuable items are piled up among possessions with no intrinsic or extrinsic value. This list is not exclusive, as anything can potentially be hoarded. Value is not decisive. The main justifications for the difficulty of parting with objects are their emotional value, perceived usefulness or aesthetic value, the feeling of waste, or the fear of losing important information [13,14]. The accumulation that creates clutter consists of a large group of unrelated objects grouped together in a disorderly manner. Objects are piled up in the kitchen, bathroom, or bedroom and in peripheral spaces in the home, such as basements, garages, and patios. Sometimes, objects overflow outside living spaces, occupying cars, yards, and workplaces. The piles create chaos that overwhelm living spaces, making them unusable. Individuals suffering from hoarding disorder intentionally hoard their possessions, and the mere thought of disposing of them causes them suffering and distress.

For hoarding disorder to be identified, the symptoms resulting from discarding (and indeed hoarding) items must create clinically significant distress, that is, they must impair functioning in the social or work sphere or other important domains. In these cases, third persons or family members ascertain functional impairment. Intense distress arises if an attempt is made to clean or discard objects. The distressing symptoms may be absent only in combination with a low level of insight. The individuals suffering from hoarding disorder may exhibit characteristics such as indecision and avoidance, tendency to procrastinate, difficulty in planning and organizing activities, and ease of distraction [15]. When the level of hoarding compromises living spaces, there may be a lack of personal hygiene due to the inability to use the bathroom and utilities, such as water, gas, and electricity. Hoarding disorder can also be diagnosed in cases in which the accumulation of objects is no longer present, in which spaces are reorganized only through the intervention of third parties, family members, or authorities.

The simple passive accumulation of objects that do not create discomfort and distress upon separation cannot be identified as hoarding disorder, nor can collecting, in which objects are divided according to a specific order [16]. In hoarding disorder, the individual may also engage in the rescue and housing/homing of animals without caring for them, leading to states of malnutrition, illness, and even death [17]. Research is underway to assess the similarities and differences between object-hoarding disorder and animal-hoarding disorder, in order to establish a distinction between the two conditions is considered [12]. In terms of therapeutic aspects, the first-line treatment consists of cognitive-behavioral therapy. At present, there are no approved drugs for the treatment of hoarding disorder, but research data suggest the efficacy of selective serotonin-reuptake inhibitors (SSRIs) [18–20].

3. The Sociological Perspective

Hoarding disorder becomes clinically relevant when symptom outcomes create social distress. The hoarder tends to fill the house with objects. Before long, all rooms become flooded with items that have been haphazardly aggregated and often collected in overflowing bags, sacks, containers, boxes, and cartons. Eventually, piles of items develop in the home, and people can only move along narrow paths, walking on layers of things that are no longer identifiable. Even food becomes part of the accumulation, attracting pests and unpleasant smells that, especially in summer, permeate rooms.

Often the individual suffering from HD not only saturates rooms in the home, but spreads items to outbuildings, the landing, the garage, or the car, and clogs common spaces. In addition, the accumulation of objects prevents the use of the kitchen, ignition facilities,

and other rooms in the home. This disorder also has consequences for the individuals themselves: difficulties in maintaining personal hygiene and changing clothes, leading to an unkempt appearance, the inability to prepare and eat hot meals on clean dishes, and a failure to use the bed for sleeping, causing them to curl up in corners of their home to rest. The literature describes an extreme case of HD-related neglect that resulted in the amputation of a finger due to necrosis [21].

Afflicted individuals rarely spontaneously seek help for this specific disorder. As documented firsthand by one of the authors (a police officer, frequently summoned to address public health disturbances in public spaces or private areas due to extreme accumulation scenarios), in nearly all instances of hoarding disorder, the input (i.e., the request for intervention) is provided by third parties, particularly individuals who inadvertently experience the consequences of hoarding behavior. These are usually neighbors and family members. The former may be driven by concern for their neighbor's health, by exasperation at the foul odor of the neighboring apartment, which invades the lobby of the apartment building, becoming unbearable over time, by the presence of invading garbage landings, basements, hallways, by the presence of insects, by a fear of fire risk (the accumulated material is often flammable), or out of suspicion of animal abuse (in the case of animal hoarders). The hoarder's car may also be a sign: it is often full of unnecessary, dirty, unused items, and may be reported as abandoned. Family members may be concerned about their loved one's health due to their living conditions, or they may inadvertently experience the consequences of hoarding behavior if they share a home with a relative with HD. The distress experienced by family members of hoarders is also the subject of studies and research [22]. Finally, the primary-care physician may report the problem if they directly notice that the patient's health status has been directly compromised. In addition to the cases described above, specialized clinical contact with a person with hoarding disorder may also result from a request for intervention by authorities or public-service representatives. In other cases, the disorder is detected directly by a clinician, not through intermediaries, as a comorbidity. The clinician ascertains symptoms only in the second instance, when deepening an initial conversation about the treatment of other disorders. For this reason, in the DSM-5, the chapter on obsessive-compulsive and related disorders is structured to make it easier for clinicians to investigate associated conditions. In other situations, a referral may be made to municipal social services.

The accumulator may be impaired by permanent job loss [23]. Accumulators risk eviction because of the condition of their home, and family relationships are jeopardized, with separations and the removal of vulnerable people, such as minors or the elderly [24]. In this compromised framework, the community affected by the consequences of accumulation inevitably requires the intervention of the authorities and physicians. In this way, the relationship between "public power" and the individual begins. Mental disorder thus becomes an inconvenience to the community. It is also common for third parties to report when a significant level of neglect already exists. Emergency interventions usually involve the interruption of electricity and gas supplies for domestic use. People with HD may live in dirty, insect-infested, cold, and uncomfortable environments. Thus, pragmatically, from a social perspective, in cases in which HD is severe, the following syllogism may be valid:

Neglect is a form of social distress
Hoarding disorder is a form of neglect
Hoarding disorder is a form of social distress

4. Legal and Procedural Aspects

Drawing from the field experience of one author, a police officer who frequently dealing with individuals with hoarding problems for public-order reasons, it is evident that few individuals with hoarding disorder acknowledge their condition, and even fewer admit that they require psychiatric support. Otherwise, users, neighbors, and the community, especially in cases of hoarders with animals or garbage, claim compulsory medical treatment to restore health and public order. It can be preliminarily stated that the compulsory

health-treatment route is absolutely impractical under both European law and Italian national laws. Pursuant to Article 17 of the Recommendation of the Committee of Ministers of the Council of Europe on the Protection of the Rights and Dignity of Persons with Mental Disorders (2004) [25], involuntary psychiatric hospitalization may be ordered only if the individual has a mental disorder and his or her condition poses a significant danger to his or her own safety or that of others. Hospitalization is for therapeutic purposes, in cases in which less "restrictive" treatment alternatives cannot be found. In addition, the patient's opinion must at least be considered [26].

From a procedural point of view, the European Convention on Human Rights [27], which protects the right to liberty and security, allows the restriction of personal liberty in Art. 5(e) only if the subject is deemed mentally ill and his or her internment takes place in a hospital facility (Kadusic versus Switzerland 2018; Hutchison Reid versus UK 2003) [28,29], provided the measures taken to manage the condition are proportional to its severity. Normally, the measures taken are justified by the purpose of the treatment, but there are cases in which they apply to ill persons for whom there is no possible cure, emphasizing the need to prevent the person from causing harm to themselves or others (Hutchison Reid versus UK 2003). Instead, in the case of Italian law (Law No. 180 of 13 May 1978), compulsory coercive health treatment is possible when immediate and appropriate out-of-hospital health measures cannot be taken, by order of the mayor as the health authority, upon the reasonable proposal of a physician, with additional medical certification by a local health-board physician. Such proceedings must be validated by a tutelary judge. In order to proceed with compulsory medical treatment, all the conditions listed above must be fulfilled. Therefore, it seems clear that for hoarding disorder, compulsory health treatment is not feasible. Although a mental disorder is involved and consent may be lacking, it is unlikely to be urgent, and it may be impossible to implement suitable out-of-hospital measures. Therefore, it is not possible to interfere with an accumulating person's freedom with compulsory health treatment.

An alternative approach to addressing social unrest is the implementation of force through an immediate and provisional decree issued by the mayor. As the health authority, the mayor mandates the site's cleaning and evacuation within a specified timeframe under Article 650 of the Penal Code. Non-compliance with this directive leads to a referral to the Public Prosecutor's Office for prosecution under the same article. Consequently, the municipality is obligated to undertake the necessary clean-up and restoration efforts. The offense in itself is punished with a very mild penalty, as a "contravvenzione" (the least serious form of crime), which is itself always convertible into a fine. Furthermore, the offense is committed by a person who is in a state of mental disorder, so the general considerations on the irrelevance of the criminal act established by Art. 131 bis et seq. of the Penal Code apply (the exclusion of punishability due to the particular tenuousness of the act).

On the other hand, in order to carry out forced cleaning, it is necessary to gain access to the private dwelling, and this is provided for in Article 5 of the Italian Single Text of Public Security Laws. The use of public force is authorized. If there is a situation involving the accumulation of animals, an emergency intervention can be carried out on the basis of the suspicion of the crime perpetrated against animals, such as "animal abuse" under Article 544 of the Penal Code (animal abuse). The state of flagrancy of the crime (substantially permanent) under Article 382 of the Code of Criminal Procedure authorizes the judicial police to search personal and private residences with appropriate safeguards. With the assistance of a veterinarian, abused animals may be seized under Article 321 of the Criminal Code (subject of the preventive seizure) to prevent the continuation of their mistreatment and entrusted to third parties or kennels for necessary care. However, conceptually, even this procedure does not appear viable, since the hoarder's situation cannot be equated with the true mistreatment of animals; indeed, animals are often cared for as far as is logistically possible. However, it is imperative to emphasize that is not simple for the police to take action immediately, nor is it obvious that they should.

In fact, in situations of severe accumulation, it may be impossible to retrieve all the animals inside the accommodation. Piles of garbage may overhang doorways and hallways, and some rooms may not be accessible. Frightened animals tend to hide, and it is not always possible to establish beforehand an accurate count of which or how many animals are to be found, dead or alive.

5. Discussion

Mental disorder in HD turns into neglect and social distress. Furthermore, a mental disorder is present when social distress is detected. As is known, individuals suffering from hoarding disorder seldom seek medical attention for their condition, unless a third party intervenes because the condition affects the external environment and community, or a family member moved by a bond of affection is concerned about the relative's health. Moreover, it is by no means a given that an individual with HD will want to receive help or accept treatment. Therefore, what is the threshold between lifestyle and mental disorder in HD? The DSM-5 differentiates hoarding disorder from obsessive-compulsive-personality disorder based on the severity of the hoarding. If the hoarding is mild, it can be classified as obsessive-compulsive-personality disorder. What is the minimum hoarding threshold, below which it is not considered a disorder? When is it severe, and when is it mild?

From an objective point of view, these questions are not precisely defined: the lack of an exact and quantitatively established limit implies the potential paradox of continuous quantities, universally known as the "sorites paradox". According to the DSM-5, one of the diagnostic criteria for hoarding disorder is: "Hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for oneself or others)". The impairment of functioning in the social and occupational spheres and other vital spheres of life occurs when the members of society close to the individual, "the group", as the noted social psychologist Kurt Lewin calls it, perceives discomfort resulting from the behavioral outcomes of the individual with HD. Social discomfort transforms a behavior or lifestyle into a mental disorder, and it is also the balance that separates bizarre behavior from mental conditions.

In "La Vie des Hommes Infâmes" (The Life of Infamous Men) [30], Michel Foucault points out how, analyzing old documents, in another era, people were considered insane for engaging in behaviors that are now considered normal, and he describes their form and the punishments inflicted. Therefore, what appears to be a disorder now will be considered a simple way of life in the future. Let us compare a person living alone, in an isolated house he or she owns, and a person living in a city, in a rented apartment, in a popular apartment building: the former is free to live without outside interference, implementing a lifestyle with "problematic" accumulation, without causing social distress and, consequently, without necessitating intervention from authorities. In the second case, the person is reported for the discomfort felt by the citizenry close to them, and the "public power" will have to address the situation with them. All this occurs in the presence of objective situations of accumulation that could have radically different amounts. This discrimination is examined in detail by Foucault in his work "Folie et Déraison: Histoire de la Folie à l'âge Classique" (History of Madness in the Classical Age) [31], in which he analyzes how mental illness has been placed, since the classical age, as a limit on the freedom of the individual, and the boundary of this freedom determines what public power accepts as "normal". Public power is responsible for overseeing societal administration and determining the boundaries between normalcy and deviance, including mental health disorders. The distinction between acceptable and unacceptable behavior is not always clear-cut, and it depends on social consensus and the prevailing public power at a given time and place. The concept of insanity often lies within this gray area, characterized by the social discomfort it generates.

Society, shaped by shared emotions and collective authority, delineates the boundaries of acceptability in specific places and at particular times. Insanity in this gray area is identified through the social discomfort it creates. This leads to the difficulty of defining

competence in managing the containment of this "social discomfort", understood as perceived neglect by the community group. Should it be managed by a doctor or the police? Is it understood as a law-and-order problem or as a simple mental disorder? In this limbo, a strategy for solving the problem needs to be defined, which does not currently seem to be simple, let alone clarifying and defining what is the problem is.

Quite hypothetically, it is possible to trace the hoarding disorder back to a function: in fact, disorder can be seen as a function that links an independent variable (the social distress caused) to a constant (the existence of the minimum objective elements for the classification of the illness itself) to lead to a dependent variable that expresses the formal existence of the disorder itself: disorder = f (distress caused, K), where K represents the minimum objective elements required to define the disorder.

How did the idea of translating HD into a function come about? Mental health issues, including hoarding disorder, can be measured using specific criteria and scales. For instance, the Hoarding Rating Scale—Interview (HRS-I) [32] and the Saving Inventory—Revised (SI-R) [33] are tools used to assess the severity of hoarding symptoms. These quantitative aspects suggest that it is plausible to represent hoarding disorder as a function. Studies have shown that individuals with hoarding disorder often experience significant social distress, such as isolation, strained relationships, and poor quality of life. The suggestion of the function is an attempt to capture this relationship by incorporating social distress as an independent variable. Furthermore, it acknowledges the importance of considering the minimum objective elements needed to define hoarding disorder. This is in line with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which outlines specific criteria for diagnosing hoarding disorder.

While the proposed function is primarily theoretical, it aligns with existing evidence from empirical research. Multiple studies have found associations between hoarding disorder and various factors, such as social distress, environmental influences, and neurobiological factors. The proposed function is an attempt to integrate these findings to create a more comprehensive understanding of the disorder.

The function is a preliminary step in understanding hoarding disorder from a mathematical perspective. It is essential to recognize that this function is a simplification and may not capture the complexity of hoarding disorder fully. Future research could refine this function by incorporating additional variables, such as genetic factors, childhood experiences, and cognitive processes.

Although the proposed function is a simplification of hoarding disorder, it provides a theoretical foundation for understanding the relationship between social distress and HD. By incorporating quantifiable aspects of hoarding disorder and corroborating evidence from empirical research, the proposed function offers a starting point for further investigation and refinement. Ultimately, this could contribute to a more comprehensive understanding of hoarding disorder and inform interventions aimed at improving the lives of those affected.

6. Conclusions

The theoretical findings from this study contribute to the development of a working hypothesis emphasizing the crucial role of social dynamics in understanding hoarding disorder. This interpretation aligns with cultural perspectives associated with similar phenomena in psychological and sociological fields, which assign social significance as the primary factor in determining the extent of mental disorders. The notions of social relapse and social response, along with defining the very existence of the condition, decisively influence its outcomes, which can manifest in medical, criminal, or even entirely neutral forms when specific micro-variables nullify the process as a whole. In the final analysis, the use of these hermeneutic tools involves the characterization of the disorder in question as a function connecting an independent variable (the social distress generated) to a constant (the presence of the minimal and objective elements framing the disorder itself).

Examining the complexities of hoarding disorder (HD) from both medical and social perspectives necessitates a multicultural and multidisciplinary approach. This method should involve collaboration between various stakeholders, including authorities, social workers, and psychologists, to effectively address the issue [34].

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