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AN UNUSUAL CASE OF FOOD HOARDING: THE WEIGHT OF ANOREXIA NERVOSA IN HOARDING DISORDERS

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INTRODUCTION

Hoarding Disorder (HD) is a complex clinical phenomenon characterized by the persistent difficulty of separating oneself from one's property. Regardless of the real value of objects, patients with HD show the tendency to excessively acquire new things that generate an encumbrance of living spaces (Postlethwaite et al. 2019). Besides a Primary Hoarding Disorder occurring when HD is not in comorbidity with other psychiatric disorders, HD frequently coexists with other clinical and psychopathological pictures (DSM-5 2013). In particular, hoarding could act as a mood regulator in Major Depressive Disease (MDD) or it could occur in comorbidity with disorders that significantly alter the decision-making process like Obsessive-Compulsive Disorder (OCD), Dementia, and Schizophrenia (Mataix-Cols et al. 2010). Conversely, the association between HD and Eating Disorders (ED) is rare in literature. Most of the studies have focused mainly on the correlation between pathological accumulation and ED with higher emotional dysregulation, such as BN and BED (Hall et al. 2013), while there is little evidence on the relationship between HD and Anorexia Nervosa (AN).

This paper aims to illustrate the case of a young woman with a history of AN, who developed a selective accumulation disorder for specific categories of food.

CASE REPORT

A 28-year-old woman came to the outpatient clinic for ED to be assisted for her behavior of food hoarding. In particular, she started hoarding specific types of food: fruits, vegetables, and breakfast products. With time, the food she was collecting started to cause her a relevant state of anxiety, especially when she had to throw the rotten foodstuffs. The patient reported that she often chose not to eat the vegetables that she had accumulated and had taken care of them. According to the patient, this behavior has arisen over the year before, and it was experienced, only later, as highly distressing. Indeed, she had a room of her house exclusively dedicated to the storage of hoarded foods, which she took care of, tidying them up and looking after them, at different times of the day.

In 2017, when the patient had 22-year-old, she had crossed a phase of severe weight loss reaching a body weight of 39 kg (Body Mass Index = 15 Kg/m^2), with a diagnosis of AN. At the first outpatient evaluation, the patient had a regular body weight (58 kg) with a normal BMI (23.8 Kg/m^2). Her eating disorder, previously classified as AN, had a switch to binge eating in the past 12 months, producing a weight gain. The eating behavior at the time of her evaluation was characterized by bingeing once a week, without self-provoked vomiting. From a medical point of view, her laboratory tests showed low plasma estrogens levels, and she had low bone mass density at the MOC/DEXA analysis, giving her long-standing amenorrhea. The BIA-vector analysis showed instead no significant alteration in the body composition. Carrying out the Structural Clinical Interview for Personality Disorder (SCID5-PD) traits of Obsessive-Compulsive Personality Disorder emerged, such as an extreme intransigence in terms of morality, ethics, values, manifested rigidity, stubbornness, and a certain reluctance to delegate tasks.

Furthermore, when the fifth version of the Diagnostic and Statistical Manual (DSM-5) was used for diagnostic purposes, the patient did not fulfill all required criteria, showing the inability to throw away consumed or valueless objects. Indeed, this criterion was only partially satisfied: after taking care of accumulated vegetables, she forced herself to throw them away when they rot.

The assessment of HD was carried out by conducting a scheduled clinical interview and through self-administered questionnaires that allowed us to integrate and deepen the psychopathological picture of the patient. We employed the most frequently used aids which are used for HD assessment: the Saving Inventory-Revised (SI-R) and the Hoarding Rating Scale (HRS).

We proposed to the patient a treatment based on cognitive-behavioral psychotherapy (CBT) as indicated in main psychiatry guidelines (NICE 2004). The CBT was conducted once per week for six months. It should also be noted that the patient refused any kind of pharmacotherapy. After this period, the patient's clinical picture improved, and the hoarding symptoms seemed to be more controlled (Table 1).

Table 1. The assessment of HD

At the assessment	At follow-up	Cut-off value
SI-R		
58	Total score / 9	41
21	Clutter / 3	17
24	Difficulty discarding / 4	14
13	Excessive acquisition / 2	9
HRS		
16	Total score / 2	14
4	Hoarding / 2	3
4	Difficult to get rid of the object / 3	4
4	Acquisition / 1	2
4	Distress / 2	3
6	Interference / 1	3

DISCUSSION

Amongst others, this case report provides some intriguing suggestions. Firstly, the age at which the hoarding behavior arose in the patient analyzed in this case is unusual. Indeed, according to the literature, the age of hoarding begins in the third decade, and the severity of problematic hoarding behaviors increases in aging, peaking among people over age 65 (Kim et al. 2001).

Furthermore, the hoarding behaviors of our patients are extremely specific, and they greatly differ from the HD classic presentation. To improve her pathological hoarding, we suggested individual psychotherapy. In the last years, a specialized CBT for HD has been developed, and some treatment manuals were published (Tolin et al. 2011). Individual CBT has a large effect from pre- to post-treatment, and it has demonstrated effectiveness on the core behavioral feature of HD, such as difficulty discarding (Steketee & Frost 2014), which was our main target. The efficacy of group-CBT for HD is comparable with results reported for individual CBT for HD (Tolin et al. 2015). Despite many limitations, a meta-analysis revealed that treatment response to pharmacotherapy occurred in 37-76% of people with pathological hoarding (Bodryzlova et al. 2019). SSRIs, such as Paroxetine and Sertraline, showed effectiveness for hoarding: in our case, however, the patient was not compliant with drug treatment.

CONCLUSIONS

We aimed to outline that greater knowledge and disclosure of HD and its eating comorbidity would be important, especially when taking into consideration AN. Indeed, we noticed the little quantity of scientific information linking HD with AN, with our case probably representing the first case of food hoarding described.

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Disclaimer

Consent was obtained from the patient to publish the case report.

Conflict of interest: None to declare.

Contribution of individual authors:

Valentina Baldini: diagnosis, patient follow-up, first draft, draft review.

Margherita Magro, Cristiano Parmigiani & Anna Rita Atti: patient follow-up, first draft, draft review.

Paolo Scudellari, Fabio Panariello & Diana De Ronchi: draft review.

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