Working With Families of People Who Hoard: A Harm Reduction Approach

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Abstract

Approximately, 3-5% of the U.S. population suffers from compulsive hoarding but others suffer as well, in particular the family members who care about them. This article describes the manifold ways family members suffer because of their loved one's hoarding behavior, including the frustration and hopelessness many family members experience in the face of their loved one's steadfast refusal to accept help for their hoarding problem. The article presents harm reduction as a way for family members to help a loved one unwilling to accept treatment of the hoarding problem. The article then presents two clinical examples – a private hoarding situation and a public hoarding situation – to illustrate the application of harm reduction to hoarding.

Keywords: hoarding, family, harm reduction, psychotherapy

Those who hoard face significant health and legal risks. Approximately 6% of hoarding cases reported to health departments pose significant health risk to the individual with the problem, and in several situations, officials believed that the hoarding behavior contributed directly to the individual's death in a house fire (Frost, Steketee, & Williams, 2000). People who hoard may experience serious medical problems, including headaches, breathing problems, and obesity (Tolin, Frost, Steketee, Gray, & Fitch, 2008). Many hoarders are unable to sleep in their beds or sit at their dining tables. Often people who hoard cannot heat or cool their homes because clutter blocks the heating or cooling vents. Their homes are often in disrepair because they will not let someone into their home to repair the roof, sink, or toilet because they are ashamed or because they fear discovery. About half of those who suffer from compulsive hoarding are unable to use their stovetops, refrigerators, tubs or sinks, and one in ten is unable to use the toilet (Frost et al., 2000). They are at risk of slipping and falling in the clutter, which is particularly dangerous for frail older adults.

Those who suffer from compulsive hoarding face numerous economic hardships as well. Hoarding is associated with significant impairment at work. In a large sample of people who hoard, almost 6% reported that their supervisor fired them because of their hoarding behavior. This same group reported a mean of 7.0 psychiatric work impairment days per month, equivalent to that reported by participants with bipolar and psychotic disorders (Kessler et al., 1994). Property managers or municipalities have evicted or threatened to evict 8% of those who hoard due to the hoarding behavior (Tolin, Frost, Steketee, Gray, et al., 2008). Those who compulsively acquire spend their savings or run up their credit cards. Many lose their homes through foreclosure because they cannot pay the mortgage. For others, failure to pay their bills, either because they do not have the money or because they cannot find their checkbooks among

the clutter, leads to a loss of credit such that they no longer qualify for credit, loans, or other financial assistance.

However, researchers and clinicians less often mention and study the effects on the family members of hoarders. In this article, I describe the effects of hoarding behavior on family members. I present a family-based harm reduction approach to hoarding behavior and illustrate it with two cases.

Effects of Hoarding Behavior on Family Members

Unlike many psychological conditions, hoarding behavior hits people where they live and thereby affects all who live with the person who hoards. Approximately two-thirds of hoarding participants stated their hoarding constituted a problem for family members (Frost & Gross, 1993). Another measure of family distress is that frustrated family members contact hoarding experts approximately twice as often as does the individual with the problem (Tolin, Frost, Steketee, & Fitch, 2008).

Family members who live in a hoarding situation face the same health and safety risks, as the person who hoards, including chronic headaches, respiratory problems, and poor nutrition, the risk of slip and fall injuries, and the way a highly cluttered home slows or prevents emergency medical personnel from responding to a person in need (Frost, Steketee, Youngren, & Mallya, 1999; Steketee, Frost, & Kim, 2001). Because of these hardships, many family members are angry, resentful, and critical of the family member who hoards. Children typically have a strained relationship with the hoarding parent. Children often blame the parent not only for the condition of the home but also for the effect the hoarding behavior had on them when growing up. In a recent study, researchers reported that the level of rejection toward the person who

hoards was comparable to the rejection among family members of clients with schizophrenia (Tolin, Frost, Steketee, & Fitch, 2008).

In addition, many people who hoard appear to lack the interpersonal skills necessary to repair and maintain effective relationships with family members (Grisham, Steketee, & Frost, 2008). This combination of poor interpersonal skills on the part of the hoarder and the high level of rejection or expressed negative emotion toward the hoarder by family members make for a volatile mix that often leads to the alienation of family members and fragmentation of families. Adult children may limit their contact and their children's contact with the person who hoards, further isolating the individual and likely worsening the hoarding problem. Relationships among siblings may suffer as well. One adult child may defend the hoarding parent against the attacks of his or her siblings, or an adult child may criticize siblings for trying too hard or not trying hard enough.

Nonetheless, many family members wish to help their loved one. Spouses, children, siblings, and even parents of compulsive hoarders suffer from worrying about things that could go wrong in their loved one's home. Adult children of people who hoard, for example, fear they will receive a phone call in the middle of the night informing them that their mother's home has burned down with her trapped inside. They worry about falls, poisoning from expired foods, or eviction.

However, in spite of the pleas from concerned family members, many people who hoard consistently refuse help for the problem. This steadfast refusal to accept help is one of the most frustrating aspects of this condition. As one family member asked me, "How do I help someone who doesn't want help?"

Harm Reduction for Hoarding Behavior

Harm reduction is a comprehensive, effective, and humane health approach (Marlatt, 1998) first developed as a way to minimize the risks of intravenous drug use (by providing clean needles). The aim of harm reduction is to decrease the harmful consequences of high-risk behaviors without requiring that the individual stop the behavior (Denning, 2000). Numerous clinical trials have demonstrated the effectiveness of harm reduction for alcohol and substance abuse in many settings and with many populations (Logan & Marlatt, 2010). To date, there are no clinical trials into the effectiveness of harm reduction as applied to hoarding behavior. However, as researchers apply harm reduction more broadly to other mental health issues, we hope to see effectiveness studies in this area as well.

Although harm reduction is most frequently associated with substance abuse, clinicians are increasingly applying the approach to a growing list of behavioral disorders (Marlatt & Tatarsky, 2010). We have begun to apply harm reduction to the problem of compulsive hoarding (Tompkins & Hart, 2009), and we view it as a viable alternative to treatment for a number of reasons. I have already described two reasons in favor of harm reduction for compulsive hoarding. The behavior poses significant health and safety risks for the hoarder as well as to the family members and the communities in which he/she resides. Other reasons harm reduction makes sense for compulsive hoarding are: 1) many people who hoard refuse help; 2) an over-emphasis on discarding may make things worse; and, 3) in most cases, compulsive hoarding is too big a problem for any one person to manage.

Many People who Hoard Refuse Help

Many of those who suffer from compulsive hoarding show little awareness of the severity of their hoarding behavior and do not consider their behavior unreasonable (Frost & Gross, 1993; Frost et al., 2000). They do not see mounds of clutter as a problem. They believe that bringing

home possessions from their neighbors' garbage bins is a sign of their resourcefulness, not a symptom of a disorder. Many individuals who hoard identify the best solution to the problem as the acquisition of more space or money to accommodate, rather than change their behaviors (Greenberg, 1987). Many tell clinicians that the only problem they have is that others will not stop pestering them about their possessions.

In a recent study, 53% of family members described the person who hoards as having "poor insight" or "lacks insight/delusional" (Tolin, Fitch, Frost, & Steketee, 2010). A large majority (73%) of social service workers with elderly hoarding clients described their client as having severely impaired insight (Steketee et al., 2001). Investigators report that people who hoard often have poor insight and display a disorganized, tangential, or detached style of interaction that reflects difficulty with perspective-taking and problems relating to others (Grisham et al., 2008).This lack of insight into their problem means few seek treatment or help (Greenberg, 1987; Steketee & Frost, 2007). Harm reduction may be the most reasonable approach for an individual who refuses treatment and continues to live in unsafe conditions.

Over-focusing on Treatment or Discarding Can Make Things Worse

Over the years, many family members have tried to help, often by haranguing the loved one to get treatment for the hoarding problem, demanding that he/she throw things out, or even discarding the person's possessions without permission. The person who hoards typically reacts to this "intervention" with outrage and anger, which amplifies the mistrust, resentment, and resistance to accepting help for the hoarding problem. Already, the number of people with a significant hoarding problem who are open to treatment is small (Tolin et al., 2010) because, as some authors have argued, they are at the precontemplation stage of change (Prochaska & DiClemente, 1982) and will likely refuse treatment offered to them (Frost et al., 2000). An

overemphasis on clearing homes and discarding possessions may further limit the number of hoarders accepting professional help (Tompkins & Hartl, 2009, in progress). Family members or clinicians who force those in the precontemplation stage to accept treatment may inadvertently increase the person's resistance and the likelihood that the person will refuse treatment, drop out of treatment, or comply half-heartedly.

Harm reduction sidesteps the hoarder's acceptance of treatment, which emphasizes discarding possessions and stopping hoarding behavior. Instead, harm reduction focuses on discarding only that which is necessary to maintain the person in their home safely and comfortably (Tompkins & Hartl, 2009, in progress).

Too Big a Problem for One Person to Manage

Most instances of compulsive hoarding require ongoing monitoring and help, even for those who benefit from treatment. Few hoarders who reject treatment but permit or are forced to accept clear-out interventions can keep their homes clear without ongoing assistance (Frost & Steketee, 2010; Frost et al., 2000). Anyone who has entered a home of a compulsive hoarder realizes quickly that clearing and cleaning the home is a formidable task. Even when the goals are quite modest -- such as moving papers away from the stove or clearing a staircase -- the task of moving, organizing, and storing so many possessions can take many hours or days. Adding to the challenge is the fact that the person is often at imminent risk for harm and that family members feel great pressure to resolve the situation quickly.

Adding to the challenge is that the clinician must coordinate all of this with someone who does not want his/her help. Therefore, much of the work of harm reduction (HR) is managing the relationship with the compulsive hoarder. The aim of HR entails negotiating and renegotiating

small steps toward managing the clutter in the home, always with the goal of minimizing risks. For this reason, we favor a team approach to share the work.

Family-Based Harm Reduction for Hoarding Behavior

Our HR model for compulsive hoarding (Tompkins & Hartl, in progress) involves five steps: 1) engage the person who hoards in the harm reduction approach, 2) build the harm reduction team, 3) assess harm potential, 4) create the harm reduction plan, and 5) implement the harm reduction plan. I will briefly describe each step here and present two cases that illustrate the application of these steps to compulsive hoarding.

Engage Person Who Hoards in the Harm Reduction Approach

Because, as described above, individuals who hoard often have little or no insight about hoarding as problem, engaging them in any process to reduce hoarding is challenging. Because HR de-emphasizes discarding, many times, individuals are more open to this option than to conventional treatment. However, they are frequently skeptical and often mistrustful.

HR engages the person who hoards and his or her family with motivational interviewing (Arkowitz, Westra, Miller, & Rollnick, 2008; Miller & Rollnick, 2002; Tolin & Maltby, 2008). This engagement approach can take several forms (Burke, Vassilev, Kantchelov, & Zweben, 2002): family members as participants in the hoarder's motivational interviewing; motivational interviewing applied to dyads within the family in meetings; and, motivational interviewing that targets specific interactions between the hoarder and a family member or interactions between other family members. In the first approach, we engage the hoarder in motivational interviewing while family members observe or participate. Family members who observe in this way obtain essential information about the limits of their loved one's level of insight. In this approach, family members observe for themselves that their loved one's refusal is not about laziness or

stubbornness but about poor insight, fear, and mistrust. Family members who mistrust the intentions of the hoarder or who harbor a high level of anger and resentment toward the hoarder may benefit most from just listening. For family members who have a more resilient and caring relationship with the family member who hoards, they may actively participate in the motivational interviewing of the hoarder. The clinician may ask the family member, with the hoarder's permission, to share relevant information about the risks the hoarder faces, the loved one's concerns for the hoarder, and to collaborate in developing harm reduction goals and a plan to achieve them.

The second approach applies motivational interviewing to dyads within the family. This often includes the hoarder and the spouse, a family member, or other team member. However, clinicians may as likely apply the approach to other dyads within the family that do not include the hoarder, such as siblings, or a parent and sibling. The clinician may spend some time interviewing one family member, using key motivational interviewing strategies (Miller & Rollnick, 2002), such as responding to resistance, supporting self-efficacy, and eliciting change talk, then swing back to the other family member and do the same. The approach targets the ambivalence of all family members about changing the status quo. For example, through motivational interviewing, the clinician may elicit the ambivalence one family member has about trying to help the loved one because he fears more angry rebukes and resentment from the hoarder.

The final approach targets specific interactions between dyads within the family, which again may or may not include the hoarder. In a sense, this approach relies on teaching each member of the family how to practice motivational interviewing with each other. After years of trying to help, many family members no longer listen to the hoarder or other family members.

Instead, they threaten, cajole, harangue, and argue with the hoarder, which leads to greater distress and interpersonal distance. This final approach is perhaps the most important aspect of engagement because family-based harm reduction relies on family members working through ambivalence and interpersonal distress in order to keep the harm reduction plan on track over months and sometimes years. However, teaching motivational interviewing strategies to family members is complicated because family members, unlike clinicians, may have great difficulty remaining detached from the hoarding problem because they have very personal investments in the outcome of harm reduction.

Build the Harm Reduction Team

Next, the clinician works to build the HR team. The team includes not only the clinician and the person who hoards but also family members, friends, and other stakeholders, such as Adult Protective Service workers, housing code enforcement officers, property managers, or visiting nurses.

The primary way to engage potential team members and help them work together productively is to clarify and include their goals in the HR plan. This process involves a series of conversations. The larger the team, the more complicated are these discussions, because each person brings a unique history with the person who hoards and often a different point of view or goal for the harm reduction process.

Assess Harm Potential

After building the harm reduction team, the clinician arranges a series of home visits to assess the harm potential of the hoarding situation. The clinician focuses the assessment on three factors -- environmental, person, and support -- that influence the degree of risk persons who hoard experience living in their homes.

Environmental factors focus on features of the living situation itself, such as whether clutter covers the heating and cooling vents, stairs, and stovetops, or whether the person who hoards can easily exit in case of a fire. *Person* factors focus on features of persons who hoard themselves, such as their motivation to reduce the danger of their hoarding behavior, whether they have medical problems, whether they use walkers or canes, and whether they have additional psychiatric conditions. *Support* factors focus on features of the support system of hoarders, such as whether they have family members who live with them or nearby, whether they are receiving social support services, whether they are spending time with others (friends, family, and caregivers) outside their homes.

Create the Harm Reduction Plan

With the person who hoards engaged, the team assembled, and the harm assessment completed, the clinician then works with the team members to develop the HR plan and formalizes it with a contract. The harm reduction plan specifies the targets, the frequency of home visits and team meetings, and the role of each team member. HR targets include not only areas to clear and keep clear but also the ways people acquire possessions or the ways possessions enter their homes that the team strives to stop or limit. In addition, the plan targets other factors, such as co-occurring mental conditions that may worsen the hoarding behavior. The harm reduction contract might then include a referral for a medication evaluation or psychotherapy for co-occurring conditions, such as social phobia or post-traumatic stress disorder, or even family or couple therapy.

Implement the Harm Reduction Plan

With the plan and team in balance, the team then takes on the task of implementing the HR plan over time, so long as the person continues to engage in hoarding behavior. The focus

remains on safety first and comfort second. Managing the HR plan means attending to all targets specified in the plan and, as importantly, working with the client to accept help and continue to accept help with the problem.

Case Illustrations

Typically, family members call me with two types of hoarding situations: private and public. A *private hoarding situation* occurs when government authorities do not yet know about the hoarding situation. A private hoarding situation is not an emergency -- yet. However, private hoarding situations are dangerous and most are on the brink of a crisis. Generally, a private situation comes to my attention when family members can no longer tolerate doing nothing. They cannot tolerate another sleepless night of worrying that their loved one has perished in a fire or from eating rotten food. They cannot tolerate another day with the knowledge that their mother has scabies or is using a bucket for a toilet. In a *public hoarding situation*, authorities are involved and the person is facing eviction, removal of a child or dependent adult from the home, or some other consequence that signals things cannot continue as before.

I now present two cases -- a private and a public hoarding situation. Each case illustrates the five steps of a harm reduction plan for hoarding behavior.

Gloria's Private Hoarding

Gloria's adult children called for a consultation after years of worrying about their mother. At the meeting were Stephen, who lived in the same city as his mother; Betty, who lived in Southern California; and, Donna, Gloria's oldest daughter, who lived on the East coast. They told me that their 62-year-old mother had always collected things, mostly newspaper clippings, magazines, and cookbooks. However, she had managed the problem until their father had died and Donna and Betty had moved out of town. Then the hoarding behavior spiraled out of control.

Now, Gloria totters from room to room on an uneven mass of damp and rotting newspapers and paper bags, and she cannot use her kitchen because she has covered the stove with newspapers and magazines. She eats all her meals out and brings home half-eaten meals in plastic and Styrofoam containers that litter the home.

Because Gloria adamantly refused to meet with us, we began the engagement process with a series of meetings over ten days with the adult children only. As is often the case, each of them had different experiences with their mother and the hoarding situation. Donna, who was the most eager to help her mother, had left home before Gloria's hoarding behavior escalated. Betty harbored great anger and resentment toward her mother and had not seen or spoken to her in seven years. Stephen accepted that it made the most sense for him to help because he was on the best terms with his mother and lived in the same city. At the same time, he tearfully admitted that he worried that his sisters would pressure him to take Gloria into his home.

During these meetings, we developed an engagement plan that called for the adult children to mend fences with each other and generate more trust and caring in their relationships with Gloria. Betty was the most tentative, but she agreed to reach out to Gloria in small ways. Betty agreed to call her mother and leave messages inquiring about how she was doing, updating her about good things going on in Betty's life -- but not mentioning the hoarding situation. I prepared Betty for the likelihood that her mother would not pick up the telephone to speak with her or return her calls immediately Gradually, Gloria began to pick up the telephone, and she and Betty had pleasant conversations that did not include discussions about the clutter. Donna began to do the same. Stephen started dropping over more often, and he and his mother would clear a place on the sofa to sit and chat. After several visits, Stephen noticed that the sofa was often clear when he arrived.

Over many weeks, the children reported that their mother seemed less despondent and their conversations with her were less tense. At this point, I asked Stephen to ask Gloria if she would be willing to meet with me and Stephen for a single meeting to discuss how we might help her live a bit more comfortably. I coached Stephen to emphasize comfort and safety over discarding, and he was thrilled when Gloria agreed to meet me.

After several more meetings with Gloria and Stephen in my office, Gloria agreed to a harm reduction approach to her problem, and we negotiated who would participate on her HR team and their roles. Gloria was reluctant to include Betty on her team, and we agreed that Betty's role would be limited to providing financial support at this time, while Stephen would help in her home. Donna agreed to visit every three months and to pay a professional organizer to help Gloria and Stephen implement the HR plan. Gloria asked her friend Laura to participate on her team and was open to allowing several other members of her church, including her pastor, to help too.

With the HR team in place, Gloria permitted me to enter her home for a series of visits. We reviewed the harm potential domains -- environmental, person, and support. In the environmental domain, we targeted Gloria's kitchen, and agreed to keep papers 12 inches away from the stove and to declutter so that she could cook and wash dishes. We agreed to keep the stairs to the second floor clear and to declutter the areas around the front and back doors so that they could fully open. In the person domain, Gloria admitted to feeling quite depressed and gave me permission to contact her physician to discuss antidepressant medication and to schedule an examination to rule out other medical conditions, including dementia, which might increase her harm potential. In the support domain, Gloria was fortunate in that she had an extensive social support system. I worked with Gloria to share with select friends her struggles with hoarding and

to solicit their help with the HR plan. She was pleased when several offered to help. I then formalized the harm reduction targets and agreements (such as taking antidepressant medications as prescribed by her physician), the team members, and their roles in the harm reduction contract.

With the plan in place, Gloria, Stephen, and the professional organizer set to work clearing the harm reduction targets. This was not easy, but Gloria developed a good working relationship with the professional organizer, who was the daughter of one of her church friends. With help from frequent calls from Betty and Donna, who praised Gloria's progress, she was able to declutter the areas in accordance with the HR contract. Gloria agreed to permit Stephen to shop for her in order to limit her purchases, and she agreed to limit her subscriptions to magazines and newspapers and to remove her name from catalog and other junk mail lists. These steps greatly reduced the flow of paper into Gloria's home.

Gloria was now able to use a small microwave in the kitchen to prepare breakfast and lunch, though she continued to eat her dinner out. She permitted Stephen to remove all to-go food containers from her home each week and, when possible, to bring a meal for her, transfer the meal to nice plates or bowls, and take the to-go container with him when he left. This strategy greatly improved the sanitation in Gloria's home.

Gloria's HR plan is still in place, and I continue to meet with her and her children four times each year to fine tune the plan. At our last meeting, Gloria asked whether it might help her to meet with a psychotherapist to help her with the hoarding behavior. To her children's credit, they said nothing and waited for me to encourage her to accept a referral to a cognitive-behavior therapist experienced in treating the problem.

Alice's Public Hoarding

Alice's adult children were in a panic when they called to arrange a consultation. A week ago, an Adult Protective Services (APS) worker had called, Jill, Alice's oldest daughter, to inform her that her mother was living in filth without a functioning toilet or shower. Jill cried when the APS worker told her that her mother had scabies and had not bathed in over 6 months. Jill and her younger sister Maggie lived out of state and saw Alice every year for the holidays but never at Alice's home. Jill and Maggie knew about their mother's hoarding problem but did not realize that her condition had escalated to this degree. When a concerned neighbor called APS, Alice's private hoarding situation went public, and both Jill and Maggie felt the situation spiraling out of their control.

Alice agreed to meet with Jill, Maggie, and me but refused to include the APS worker until her daughters reminded her that the APS worker would decide whether Alice could continue to live in her home. In the first team meeting, the APS worker validated Alice's wish to live independently but reminded everyone that Alice's safety was the agency's foremost concern. This was my opening to present harm reduction, an approach I had already discussed with Jill and Maggie. Alice reluctantly agreed to HR but had many questions about it. I encouraged the APS worker, who was familiar with HR, to answer Alice's questions, particularly regarding discarding possessions, and solicited her input into designing the plan and selecting team members. I reasoned that the APS worker would remain involved in Alice's case and wanted to build a good working relationship between Alice and the worker.

We then began the process of selecting additional team members. Jill and Maggie agreed to visit every other month with their spouses, with whom Alice was on good terms. Alice wanted to limit the team to her children, the APS worker and me, but all agreed that Alice needed more help. Alice crossed her arms and insisted she could handle the situation on her own, but came

around when the APS worker reminded Alice that if she did not accept the help required, she would force the APS worker to remove her from her home and let others handle the situation. With this carrot and stick strategy, Alice agreed to add to the team a professional organizer with whom she would meet weekly.

I invited the APS worker to accompany me on the home visit to assess harm potential. The situation was serious. The home was dilapidated and required not only de-cluttering but also extensive repair of the bathroom and kitchen. In addition, several other factors increased the harm potential of Alice's living situation. Alice had suffered a small stroke several years ago that had compromised her gait and balance. Alice used a walker for support when out of the home but could not use it in her home because of the clutter. Alice had a heart condition but often could not locate her medications, thus missing doses for days and weeks at a time, and she had cataracts that limited her vision. We identified these targets and others and formalized them in her HR contract.

The team focused on clearing the bathroom and kitchen enough for someone to repair the toilet, shower, and kitchen sink. We installed small baskets on the back of the front door to hold Alice's prescription medications, wallet, checkbook, and other important possessions. We asked Alice to wear her cell phone on a necklace around her neck so that she could summon help quickly in the event of a medical emergency, and arranged for a visiting nurse to join her HR team. The team installed track lightening to improve the visibility in her home.

Jill, Maggie, and their spouses did most of the work of helping Alice clear the targets. After the team cleared the targets, Alice re-cluttered them, but over time, she became more willing to accept help to declutter and did so faster with less distress. As the team cleared the bathroom and kitchen, Alice agreed to permit their repair, which greatly improved her hygiene

and health. After six weeks of steady work, Alice's living situation remains uncomfortable, but the APS worker agrees that Alice is safe enough for the time being.

I now meet with Alice and the team on an as needed basis. The team anticipates the harm reduction plan will change over the next year as Alice's heart condition worsens. The fiercely independent Alice bridles at this suggestion but is now more open to renegotiating the HR plan as things shift and change for her.

Clinical Issues and Summary

Hoarding is a difficult, frequently refractory problem and many suffer because of it. Many individuals with the problem do not seek or accept help, in part, because they do not see that they have a problem. This leaves family members with few good options. As a family member once told me, "If I do nothing, he could lose his home or worse, lose his life. If I do something -- force him to accept help -- I may lose him anyway. You tell me – do these options sound like good options to you?" Clinicians who work with family members with a loved one who hoards face this heartbreaking dilemma with them. As we learn more about hoarding behavior, we may find ways to reach those who refuse our help. Until then, however, harm reduction may provide family members and clinicians with another option to assist those who are at serious risk but refuse help nonetheless.

Family-based harm reduction does raise interesting ethical issues, in part, because of its reliance on home visits and on the participation of people other than the client and clinician. Similar issues arise when clinicians provide cognitive-behavior therapy for hoarding behavior because this treatment also relies on home visits and coaches who operate in similar ways to clinicians on a home visit (Frost, Steketee, & Greene, 2003; Steketee & Frost, 2007). Investigators have described these ethical issues, which include boundary issues, dual roles, and

privacy and confidentiality, and offer guidance for dealing with anticipated ethical dilemmas during the course of treatment (Gibson, Rasmussen, Steketee, Frost, & Tolin, 2010).

Because family-based harm reduction is not strictly speaking treatment, in the way we think of cognitive-behavior therapy as treatment, a harm reduction approach does raise the interesting question, "Who is the client?" Is the client the hoarder? Is the client the family and hoarder together? Is the client the broader system, that is, is the client the harm reduction team? Over the course of our work, we have found that we shift between two roles – clinician and consultant. As the clinician, we assume responsibility for evaluating the client who is the hoarder, developing a plan to help the hoarder, and to assist the hoarder to receive appropriate treatment for other co-occurring conditions or problems. As the consultant, our responsibility is to the harm reduction team and we see the harm reduction team as the client. Family-system theory (Broderick, 1993) offers the clinician some guidance on this issue and the concept of family-as-client is common in service areas such as family therapy, family law and family or community nursing. In the role of consultant, our goal is to set up a plan and teach HR team members the skills necessary to carry out the plan over time with limited involvement on our part. In truth, we shift between these roles, often assuming the role of the clinician earlier in the harm reduction process and moving toward the role of consultant over time.

We recognize that this is a complicated dance; however, we believe that the success of any harm reduction plan is not limited to protecting the person who hoards but also strives to assist families and communities as well.

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