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The Structured Interview for Hoarding Disorder (SIHD): Development, usage and further validation

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ABSTRACT

The Structured Interview for Hoarding Disorder (SIHD) is a semi-structured instrument designed to assist clinicians and trained interviewers with the nuanced diagnosis of hoarding disorder (HD). The manuscript introduces the rationale, development, and design of the SIHD and presents a test of the instrument's inter-rater reliability and convergent/discriminant validity. Ninety-nine individuals with self-reported hoarding behavior, originally recruited as part of a large two-wave epidemiological study, were evaluated in their homes using the SIHD. Diagnoses of HD were determined by consensus, following a best estimate diagnosis procedure. To enable the assessment of inter-rater reliability, a psychiatrist with extensive experience diagnosing HD also independently and blindly reviewed each participant's SIHD. In addition, agreement of SIHD diagnoses with those indicated by other screening instruments for HD and depression were examined. Results indicate "substantial" or "near perfect" inter-rater reliability for all core HD criteria and specifiers. Convergent and discriminant validity were, furthermore, excellent. Overall, the SIHD offers an intuitive, valid, and reliable means of diagnosing HD. The interview also facilitates the assessment of other relevant features, such as risk. We offer recommendations for its use in both research and clinical settings, as well as suggestions for the training of interviewers.

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1. Introduction

The recent inclusion of hoarding disorder (HD) as a new diagnostic category in DSM-5 (American Psychiatric Association, 2013) has underscored the need for valid and reliable tools tailored to the task of its diagnosis. As highlighted in prior research (e.g., Mataix-Cols et al., 2010), since DSM-III "hoarding" has been framed as a symptom (either of obsessive–compulsive disorder [OCD] or obsessive–compulsive personality disorder [OCPD]) rather than a syndrome unto itself. Consistent with this conception, the assessment of hoarding behaviors has, historically, largely taken place in the context of an alternative condition or construct. For example, the Yale–Brown Obsessive Compulsive Scale (Y-BOCS)—widely viewed as the gold standard for assessing OCD symptom severity—prompts the evaluation of "hoarding and saving obsessions" and "hoarding and collecting compulsions" in its symptom checklist (Goodman et al., 1989, 1989). While it is true that hoarding can be a symptom of OCD (Pertusa, Frost, & Mataix-Cols, 2010), it is increasingly acknowledged that these items fail to capture the core features of the syndrome (i.e., clutter, distress, interference, etc.), and provide an inadequate assessment of the severity of HD (Mataix-Cols et al., 2010).

In the wake of seminal work framing "hoarding" as an independent and definable construct (Frost & Hartl, 1996), the options for assessing hoarding features have expanded. Currently, a number of clinician and self-administered measures exist to assess hoarding features, in particular the severity of aspects such as difficulties discarding, clutter, and distress (for a review see Frost, Steketee, & Tolin, 2012). Some of the most widely used measures include the Hoarding Rating Scale—Interview (HRS-I; Tolin, Fitch, Frost, & Steketee, 2010), the Hoarding Rating Scale—Self Report (HRS-SR; Tolin, Frost, & Steketee, 2010), the Clutter Image Rating (CIR; Frost, Steketee, Tolin, & Renaud, 2008), and the Saving Inventory—Revised (SI-R; Frost, Steketee, & Grisham, 2004). These measures, typically, have empirically derived cut-offs that offer an indication of whether an individual is likely to have clinically-significant hoarding problems. However, while practical—particularly as a means of screening in population-based studies—these tools do not permit a formal diagnosis of HD as they cannot rule out other disorders that may also present with hoarding behavior.

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Table 1
DSM-5 diagnostic criteria and specifiers for hoarding disorder (American Psychiatric Association, 2013).

Criterion	Content
A	Persistent difficulty discarding or parting with possessions, regardless of their actual value
B	This difficulty is due to a perceived need to save items and to distress associated with discarding them
C	The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities)
D	The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others)
E	The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader–Willi syndrome)
F	The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive–compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder)
Specifier[a]	**Content**
Excessive acquisition	[To be endorsed] if difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space
Level of insight	*With good or fair insight:* The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic *With poor insight:* The individual is mostly convinced that hoarding-related beliefs and behaviors are not problematic despite evidence to the contrary *With absent or delusional insight:* The individual is completely convinced that hoarding-related beliefs and behaviors are not problematic despite evidence to the contrary

[a] These specifiers are only relevant for individuals meeting criteria A–F for hoarding disorder.

Hoarding disorder is a complex diagnosis, often of exclusion, which requires the careful evaluation of the motivations underlying any hoarding activity. As such, diagnosing HD requires a direct and thorough psychopathological interview, ideally in the sufferer's living environment. As a diagnosis of HD requires endorsement of all core diagnostic criteria (Table 1), the aim of such an interview is to establish whether these features are present, and to rule out other general medical conditions (e.g., brain injury) and/or psychiatric disorders (e.g., OCD, autism spectrum disorders [ASD], psychosis) which also can account for hoarding behavior. Furthermore, an in-home interview offers the unique opportunity to complete a risk assessment—an important step as the clutter resulting from prolonged hoarding behavior may result in fire hazards, infestations, unsanitary living conditions, and additional health concerns (Snowdon, Pertusa, & Mataix-Cols, 2012; Tolin, Frost, Steketee, Gray, & Fitch, 2008). In some cases, particularly where vulnerable children or elderly persons live in the cluttered property, these risk assessments may highlight the need for further intervention (e.g., fire brigade, social services; Tolin et al., 2008).

We have developed a semi-structured interview that maps directly onto the DSM-5 criteria for HD. The Structured Interview for Hoarding Disorder (SIHD) is intended to assist with the assessment of each diagnostic criterion required to determine an HD diagnosis, as well as the corresponding specifiers. Through a series of skip rules, it also aids clinicians in excluding other possible causes of hoarding with particular emphasis on the differential diagnosis of OCD and ASD (Criterion F). The SIHD also assists with the assessment of risk, and where helpful, may be used in conjunction with additional measures of hoarding severity (e.g., CIR).

While routinely used in all our studies, and in the work of other research groups, there is limited data on this interview's reliability and validity. The SIHD was recently employed in the London field trial for hoarding disorder (Mataix-Cols, Billotti, Fernández de la Cruz, & Nordsletten, 2013) and found to reliably discriminate, with high sensitivity and high specificity, between HD and other forms of object accumulation, including normative collecting, sub-clinical hoarding, and hoarding secondary to OCD. Across raters, reliability of the HD diagnosis and each individual HD criterion were also excellent (Mataix-Cols et al., 2013). The current study formally introduces the SIHD, extends investigation of its validity and reliability to a large, population-based sample, and offers practical recommendations for its use in both research and clinical settings.

2. Methods

2.1. Development

The SIHD was developed in 2010 alongside the drafting of the DSM-5 criteria. It was informed by our substantial experience assessing hoarding difficulties among the several hundred individuals who have participated in the team's research at the Institute of Psychiatry. Initially the instrument was organized into 3 main subsections designed to assist in: (1) the assessment of core HD diagnostic criteria, (2) the evaluation of HD specifiers, and (3) establishing the differential diagnosis with OCD. As it was, from the outset, intended to be a diagnostic instrument, the content of the SIHD evolved alongside the provisional criteria for HD, with the wording and structure of the current version mirroring key components of the final DSM-5 entry (American Psychiatric Association, 2013). This latest version (version 2.0, available from the authors upon request) includes an additional section to help conduct a risk assessment and an optional appendix to facilitate the differential diagnosis with OCD and ASD.

2.2. Interview structure and administration

The first section of the SIHD corresponds directly to the HD diagnostic criteria and its questions are designed to evaluate each of the disorder's six core features. These items are grouped and labeled by their corresponding criteria (e.g., "Criterion A") and, as a reference, include the DSM-5 diagnostic wording for the criteria being evaluated (e.g., "Persistent difficulty discarding or parting with possessions regardless of their actual value"). Within each criteria sub-section, the first questions are often close-ended and invite a "yes" or "no" response, with subsequent items requesting clarification or elaboration on the part of the interviewee. Consistent with other widely-used diagnostic interviews (e.g., the Structured Clinical Interview for DSM-IV [SCID]; Spitzer, Williams, Gibbon, & First, 1992; Williams et al., 1992), the SIHD permits the interviewer to supplement these structured questions with his or her own probes, particularly where answers are unclear and clarification is required to make an informed rating.

Psychiatric comorbidities are common in hoarding populations and, in some cases, determining the appropriateness of an HD diagnosis will hinge on the question of whether the hoarding activities are secondary to — or merely comorbid with — an alternative condition (Criterion F). To assist in the parsing process required in such cases, the SIHD includes an optional appendix (the "differential diagnosis assistant"), which is designed to aid raters in distinguishing HD from two conditions where difficulties with differential diagnosis might arise: OCD and ASD. This section includes a series of structured questions relating to the core features of these conditions and their bearing on a sufferer's hoarding behavior (e.g., "Are your discarding difficulties caused by a specific obsession or fear?").

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