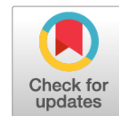
УДК: 616.894-053.9
DOI: https://doi.org/10.17816/nb262939



Хординг (патологическое накопительство): новый диагноз против традиционной интерпретации. Случай Артёма Л.

В.Д. Менделевич[1, 2], К.А. Габутдинов[1], В.В. Руженкова[2]

[1]Казанский государственный медицинский университет, Казань, Россия
[2]Белгородский национальный исследовательский университет, Белгород, Россия

Автор, ответственный за переписку: Владимир Давыдович Менделевич, mendelevich_vl@mail.ru

АННОТАЦИЯ

В статье представлен случай 20-летнего Артёма Л., в клинической картине заболевания которого доминировало сверхценное увлечение в виде патологического накопительства. Случай проанализирован с позиции выделения нового диагноза — хординга — в международных психиатрических классификациях. Проведена дифференциальная диагностика хординга с шизотипическим и обсессивно-компульсивным расстройствами, а также с расстройством аутистического спектра. Сделан вывод о том, что появление нового диагноза хординга (патологического накопительства) нуждается в формировании у психиатров новых алгоритмов диагностического мышления и отказа от трактовок парадоксального, кажущегося вычурным поведения как относящегося к кругу шизофренических расстройств.

Ключевые слова: *хординг, патологическое накопительство, шизотипическое расстройство, обсессивно-компульсивное расстройство, расстройства аутистического спектра, психиатрическая диагностика, МКБ-11, DSM-5*.

Для цитирования:
Менделевич В.Д., Габутдинов К.А., Руженкова В.В. Хординг (патологическое накопительство): новый диагноз против традиционной интерпретации. Случай Артёма Л. // Неврологический вестник. 2023. Т. LV. Вып. 1. С. 65–78. DOI: https://doi.org/10.17816/nb262939.

Рукопись получена: 21.02.2023 **Рукопись одобрена**: 01.03.2023 **Опубликована**: 30.03.2023

©Эко-Вектор, 2023

DOI: https://doi.org/10.17816/nb262939

Hoarding: a new diagnosis against the traditional interpretation. Case of Artem L.

Vladimir D. Mendelevich[1, 2], Kamil A. Gabutdinov[1], Viktoria V. Ruzhenkova[2]

[1]Kazan State Medical University, Kazan, Russia
[2]Belgorod National Research University, Belgorod, Russia

Corresponding author: Vladimir D. Mendelevich, mendelevich_vl@mail.ru

ABSTRACT

The article presents the case of twenty-year-old Artem L., whose clinical picture of the disease was dominated by an overvalued hobby in the form of pathological hoarding. The case was analyzed from the standpoint of highlighting a new diagnosis — hording — in international psychiatric classifications. Differential diagnosis of hording with schizotypal and obsessive-compulsive disorder, as well as with autism spectrum disorders was carried out. It is concluded that the emergence of a new diagnosis of hoarding requires the formation of new algorithms of diagnostic thinking in psychiatrists and the rejection of interpretations of paradoxical, seemingly pretentious behavior as belonging to the circle of schizophrenic disorders.

Keywords: *hoarding, schizotypal disorder, obsessive-compulsive disorder, autism spectrum disorders, psychiatric diagnosis, ICD-11, DSM-5*.

For citation:
Mendelevich VD, Gabutdinov KA, Ruzhenkova VV. Hoarding: a new diagnosis against the traditional interpretation. Case of Artem L. *Neurology Bulletin*. 2023;LV(1):65–78. DOI: https://doi.org/10.17816/nb262939.

Received: 21.02.2023 **Accepted**: 01.03.2023 **Published**: 30.03.2023

©Eco-Vector, 2023

Several factors contribute to the discovery of new diagnoses in the classifications of mental and behavioral disorders. First, this may be because, due to societal changes and the emergence of new forms of activity, some of them acquire pathological expression. Internet addictive gaming behavior is one example of a new diagnosis. Second, the emergence of a previously nonexistent diagnosis may result from a known maladaptive form of behavior beyond the clinical records of mental disorders described when prior classifications cannot fully reflect the essence of psychogenesis. Pathological hoarding is one of these disorders, as defined by the International Classification of Diseases, 11th revision (ICD-11), and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V) [12].

Traditionally, hoarding was viewed as a paradoxical form of obsessive–compulsive disorder (OCD) in the schizophrenic process, in the structure of dementia, as an overvalued hobby in autism spectrum disorders, or as a type of emerging personality disorder [3–18]. This maladaptive form of behavior has long been considered a secondary psychopathological symptom. Traditionally, when a doctor encounters a case of pathological collecting (hoarding) in a modern psychiatric clinic, the diagnostic process is incorrectly focused on old (previous) diagnostic algorithms and the search for traditional ways of interpreting the phenomenon observed.

In connection with the above, it is interesting to analyze the clinical case of Artyom L., a 20-year-old young man who built his own life for several years by hoarding rituals, resulting in a conflict situation in his family and hospitalization in a psychiatric hospital.

Artyom L., 20 years old, was transported by an ambulance team to the in-patient department of a psychiatric hospital with the accompanying diagnosis of schizophrenia (onset). According to relatives, Artyom grew aggressive, cursed at them, and threatened suicide after they threw out the garbage that had gathered in his room. He did not get out of bed for 3 days, refused food and water in protest, and expressed suicidal thoughts. He made no complaints upon admission; he was preoccupied with the predicament, which he perceived as unbearable and irreparable. He signed an informed consent form for hospitalization.

Upon admission to the hospital, he looked unkempt, with his long hair greasy and uncombed, his fingernails long and uncut for a long time, he was dressed in old and wrinkled clothes, and he smelled like an unwashed body. Tension, irritation, and anxiousness were observed in him as he fiddled with his hair, was restless, and often changed his position. Simultaneously, he maintained an adequate distance from the doctor, was not arrogant or aggressive, listened carefully to the interlocutor, and described the situation in detail, prompting the relatives to call an ambulance.

He spoke reluctantly about the events that led to his hospitalization, but the essence of the family conflict was clear. When he remembered what had happened, he would occasionally cry. He did not blame his close relatives for insisting on hospitalization; he acknowledged the reasons. He stated that he would continue living with his grandparents after being discharged from the hospital. When asked about the reasons for tearfulness (“Why are you crying? Do you feel sorry for yourself?”), he agreed (“perhaps, it is true”).

The background mood has reduced slightly. The speech is quiet, at a moderate pace, and the facial expression is more contemplative. He describes himself as calm, unenthusiastic, and conflict-free. He is appropriately oriented in terms of place, time, and personality. He admits that he had suicidal thoughts after a scandal with his relatives and wanted to die, but he claims that he made no attempts and did not even consider how to do it. Simultaneously, he states that for 3 days after the tragic event, he was extremely upset, laid in his bed, did not eat or drink, and believed that “it would be nice to die from dehydration.”

The thinking was consistent upon admission to the hospital, with no signs of paralogy, discontinuity, or other qualitative thinking disorders. The intellectual level was high, and mnestic functions were not impaired. There were no perceptual deceptions, delusions, or other psychotic symptoms observed.

Case history (according to the patient, his mother, and classmates). Heredity was burdened, as the maternal grandmother was registered with a psychiatrist with a schizophrenia diagnosis and committed suicide, and the paternal grandfather was registered with a narcologist due to alcohol abuse and attempted suicide.

Artyom’s parents have been divorced since he was 13 years old. He has a younger sister, who is 10

years old. Because his relationship with his father was complicated, the patient said he withstood his parents' divorce calmly and without deep emotions.

The patient was born as the first child of a second pregnancy, the first term birth (birth weight of 2,970 g, height of 51 cm, and discharged on Day 5). His early development was unremarkable; he began holding his head at the age of 2 months, sat up at 6.5 months, and walked at 1 yr and 1 month.

He attended preschool institutions enthusiastically from the age of 3 yr, without any adaptation difficulties, and communicated effectively with other children. He began attending a comprehensive school at the age of 7 yr, where he excelled until the seventh grade when he started skipping classes because no one supervised his studies after his parent's divorce. He deceived his mother about attending school, claiming he had the second shift study. Instead of going to school, he went to see his grandparents, where he informed them that he had already completed his first shift.

He had few friends at school, yet he did not keep aloof from his peers. He was neither a leader nor an activist at the same time. In his free time, he attended a folk dance club and participated in concerts and performances. He ceased this activity in high school.

He finished high school in the ninth grade with satisfactory academic performance and enrolled in college. He decided to live with his grandparents (on his father's side) from that point on, citing that he felt cramped in his parents' one-room apartment, which also housed his mother and younger sister. He refused to live with his father's new family, and his relationship with him remained terrible. He described the father as a rude, tough, and aggressive man who was prone to criticizing his son. However, at his father's request, he occasionally helped him with housework.

At his grandmother's request, he could spend his free time studying and doing household chores, such as washing dishes and gardening, but he chose to stay in his room and work on his computer. He used social media to interact, was interested in news, particularly political events, and regularly visited social communities with nationalistic content. He loved "scary" content on YouTube, particularly videos showing murder and violence. He idolized the patriot Tesak, who "fought pedophilia," but grew dissatisfied with him over time. Another pastime was watching pornographic videos.

He often skipped classes in college while studying computer science and computer competence. He completed his studies until year 4 but was unable to graduate because he did not prepare and submit his term thesis. He was expelled 6 months before being sent to the hospital. He did not work, lived on his grandparents' funds, and spent most of his time at home, periodically meeting with classmates at cafés and on the street. He enjoyed these gatherings because they allowed him to discuss various topics. He was not bothered by socializing with friends but tolerated loneliness easily.

Classmates describe Artyom as "a friendly, sociable, calm, humorous boy who did not study well and was willing to receive satisfactory rather than good grades on tests and exams, without being upset about it." He often helped others, such as with lectures ("helped others even more than to himself," according to classmates). Those around him noted that he had a penchant for energy drinks, which he often bought and discussed about them. According to his groupmates, Artyom was not reserved; he occasionally spoke tragically about his family, family problems, and relationships with his father. He "stopped communicating and answering calls" after being expelled from college.

He describes himself as a cheerful person who can easily meet new people without feeling embarrassed, is prone to joint activities with peers ("the guys jokingly called me a clown") and can fool around, have fun, often jokes with his peers, and rhymed texts on various indecent topics. At the same time, he did not feel any discomfort when he was left alone ("I calmly think about my affairs, and I don't need anyone"). He assesses his communication needs to be low. He considers himself frugal; for example, when brushing his teeth, he switches the water tap on and off to avoid wasting water. He is not a fan of neatness, and things were often mixed up in his closet or briefcase.

He maintains formal communication with his relatives and has no solid sentiments for them, particularly after they began to criticize his lifestyle. Her mother is described as an understanding, sensitive woman by her daughter. He did not actively show interest in females or males. His sexual behavior is restricted to masturbation. He claimed to have repeated intimate (anal) relations with a peer female

when he was 14 years old. He had no experience with sexual relations after that.

He is ineligible for military service due to severe myopia. The medical history revealed that when he was 13 years old, he was hospitalized twice a year at the coloproctology department and had paraproctitis surgery.

Case history. He had never been examined by a psychiatrist before hospitalization, and none of his relatives raised the question of the need for a psychiatric examination. He had obsessions with regular and thorough hand washing (20–30 min, many hundred times a day) when he was 13–14 years old. "If I touch my clothes, I need to wash my hands; if I touch the refrigerator handle, I must wash my hands. It seemed that any touch made my hands dirty." There was no notion that he could become infected with anything. He did everything nearly instinctively. However, he perceived this as bothersome, preventing him from living peacefully, and that he could not cope with through willpower. This condition lasted approximately a year and then disappeared spontaneously. Hand washing obsessions reappeared after worries about the possibility of mobilization (in September 2022) but also disappeared spontaneously after 4 months.

There was a period when he collected dried secretions from the nasal mucosa and cut nails. He put them in a bag or a desk drawer. His economy explained why he did not throw away napkins with nasal discharge, believing using them several times was more appropriate. He did not explain why he kept his cut nails ("I just did not want to throw them away, like many other items").

Since the summer of 2019 (3 yr before his hospitalization in a psychiatric hospital), the number of items that Artyom began storing in his room has increased significantly. After some time, when there was no more place left in the room for all the things Artyom had saved, he moved them to the attic.

Artyom associated the change in his behavior and the emergence of a passion for "collecting" used things with the stress that he had experienced shortly before. He reported receiving the news and did not want to discuss it in detail but was concerned about global changes. At this time, he felt "deprived of safety, and in an attempt to hide, he began to collect garbage… and wanted to take refuge in this little world."

He began collecting empty energy drink cans and juice boxes that he had used, which after some time exceeded 200 pieces. He also collected packages of chips, nuggets, and other food. He stored garbage and inorganic products in his room that he used personally or by the people he lived with (grandparents). He occasionally took bottles, old clothes, and rags from a garbage bag prepared for disposal.

Organic waste with inscriptions and a description of its composition was thrown away as soon as possible ("so as not to spoil"). After some time, inorganic garbage (bottles, chip packets, bags, old clothes, and rags) could also be thrown out, but only after repeated requests or demands from relatives. To perform this task, he had to take a photograph of the packaging first, read the ingredients of the products, study the description, and remember the smell and taste. He transferred the photos to his computer and saved them in a particular folder, which he opened and reviewed the photos several times a month. On his phone, he has about 6,000 similar photos stored.

He left a small amount of liquid at the bottom of each bottle to prevent the collected bottles from falling and making noise, which would remind the grandfather of the disorder in his grandson's room. In addition, this content was used to remember the taste and smell of the drink. He bought new products, such as energy drinks, based on novelty, variety, and collection expansion.

In addition to drink bottles and empty bags, he collected receipts from stores and the change. He sometimes looked at these receipts, checking the amount spent and the change. If he did not know where the change came from (coins and small denomination notes), he saved it and did not use it. If the amounts matched, he could put the coins and banknotes together with his other money. He did not have cash for purchases because he did not work or study anywhere; he relied on funds given to him by his grandfather.

He also collected seminal fluid that was discharged during masturbation. He claimed he "had a period when he was sick, and there were a lot of used paper napkins left, and he reused them so they wouldn't just be kept there." He placed the napkins with seminal fluid on the shelf next to other items (earplugs and earsticks).

Over the course of 2.5 yr, his entire room gradually turned into a garbage warehouse, but Artyom refused

to let anybody clean it. He threw away some of the accumulated things extremely reluctantly and infrequently. In this regard, there were family scandals when his grandparents insisted on removing the rubbish, throwing away empty bottles, and cleaning the room. In cases where part of his "collection" was thrown out or dusted off without his consent, he could "throw a temper tantrum," use obscene language (which was atypical for him), and threaten suicide. During the quarrels, the grandfather called Artyom a "freeloader" ("he who does not work neither shall he eat"). Because of these reproaches, Artyom began to limit his food intake ("he ate everything with bread, jam, drank water, tried not to eat much, but sometimes he got up at night to eat crackers").

Relatives highlighted Artyom's reluctance to change his appearance and home environment, among other behavioral features. He could not wash for over a month because "he did not want to wash in the new bathhouse that had recently been built, but was only ready to wash in the familiar old bathhouse, which had already been demolished."

Three days before hospitalization, he locked himself in the room, cried, and refused to communicate and eat after his relatives threw out all the rubbish in his room without his consent. He stated that he wanted to die "from dehydration or throw himself off the ninth floor" but did not take any active action, in particular, because he believed that in case of falling from a high-rise building roof, he would most likely survive. Considering Artyom's severe mental condition, his mother recommended seeing a psychiatrist or psychologist, but he refused.

Artyom's mother was concerned about his condition, so she called an ambulance and sent him to a psychiatric hospital.

Mental status. Artyom swiftly adapted to the department. He got acquainted with his roommates and began communicating with his peers on various topics. He did not show irritability, aggressiveness, or mood changes. He watched TV shows and walked along the corridor. He did not refuse food and had a healthy appetite. He could sit on someone else's bed while interacting with other patients, enabling his peers to sit on his bed.

Other patients asked him about the reasons for his hospitalization, his passion for hoarding, and why he did this, but Artyom replied that he did not know the answer.

He started a particular ritual of arranging things on the bedside table almost from the first days of his stay in the hospital. He always placed the paper on the right, bottles of water on the left, and a toothbrush and soap dishes in the center. He felt discomfort with a different order of things and tried to return everything to its place as soon as possible.

From the first days of hospitalization, he put candy wrappers in a bag, but he did not collect bottle packaging from drinks and food and instead threw them away. Before removing an unnecessary item, he carefully studied the information on the packaging and wrote it down in a notebook. In this way, he compensated for his phone's inability to photograph thrown garbage. In the notebook, in particular, it is written that "12.01—water "Pilgrim," small, still, brought, made 07.01 or earlier, 1 L; 31.01—cracker cookies, "classic," made by "Sladial," in yellow–red packaging, 400 g; and "Chernogolovka" water, delicious, artesian, still, 2.5 L." Considering that the department personnel controls periodically the contents of bedside tables and asks patients to throw out unnecessary things, Artyom recorded the basic information about the donated items in advance in a notebook ("one patient left a bottle of water, which I want to take it with me upon discharge, as well as the donated drawing").

In addition, he created a rule that he only took off his glasses while standing. If he were already in bed and wearing glasses, he would have to get up and take off his glasses in line with the established rule. He merely undressed while lying in bed. He had no problems with hygiene routines, began to appear neater, washed his hair several times a week, combed it, cut his nails, and changed his clothes.

One and a half months after his hospitalization, he was presented for consultation and a multidisciplinary team meeting. Considering the preliminary diagnosis of schizophrenia obtained during his hospitalization, he was given atypical antipsychotics (cariprazine of 1.5 mg and then 3 mg) during his stay. There were no changes in mental status recorded.

During a consultation, he readily makes contact, speaks quietly, and periodically cries, particularly when the conversation drifts to a scandal at home. He is upset because he now has nowhere to go because his home has been "scorched earth." He explains that he means that all the objects he had been collecting

for several years, without which he feels lonely, have been thrown out of his room. In this aspect, he believes that living in a psychiatric hospital for as long as possible is preferable because he does not feel burdened by his presence. He is ashamed of his actions and "did not justify his parents' hopes."

He cannot explain the motives for collecting empty bottles, bags, and other unnecessary things. At the same time, he acknowledges that such a collection is abnormal and would be glad to get rid of it. He accepts the doctor's opinion cautiously and without much hopes that this condition can be treated with medications. He reports that he never attempted to cope on his own because hoarding was not burdensome ("it even made him happy") and that the best thing would be if his relatives "left him alone."

He believes that he has all the signs of an obsessive–compulsive hoarding. When comparing the collecting process with an obsessive desire to wash his hands, he notices significant differences, particularly that the former was done almost automatically, without thinking about whether it was right or wrong, whereas the latter was always accompanied by a painful feeling of the uselessness of such actions. He considers the rules for organizing things on his bedside table that he developed in the hospital to calm down and organize his life.

He thoroughly discusses his mental state and clarifies the details of the conversation. His thinking is consistent at a moderate pace; he answers questions clearly and explains his answer if necessary. There was no intellectual–mnestic disorders found. Suicidal thoughts and intentions were not reported during the stay in the department. There are no hallucinatory–delusional symptoms. When saying goodbye to the doctor, he responded with embarrassment to the hand extended to shake hands and, before shaking hands, wiped his sweaty palm on the hem of his T-shirt.

Experimental psychological research. During the examination, the subject was contactable, answered questions asked, and showed concentration on subjectively significant topics. He understood the instructions for the proposed methods sufficiently. He worked at a steady pace, without any interest.

During testing, no violations of mechanical memorization of mediated memory were identified (6-7-8-10 out of 10 words; he correctly reproduced 9 out of 10 images). Concentration and attention stability (according to Schulte tables 55-46-44-45) showed minor instability and delayed growth. Individually significant ideas, a tendency to detailed elaboration, stereotypies, and signs of emotional instability were dominant in the pictogram.

In the methodology for discriminating the properties of concepts, a slight increase in the number of attracted features was observed for all three keys, indicating a decrease in selective focus in thinking associated with weakening discrimination of attributes based on the degree of significance. In the Wechsler test subtests "comprehensibility" and "similarity," the patient showed a distortion of generalization processes, relying in isolated cases on particular and unimportant signs. Thinking had elements of subjectivity, vagueness, and instability of motivational orientation.

Results of projective testing. The color selection method indicated a mixed type of response, with the contradictory position being active–passive and associated with the opposition of multidirectional positions. In a significant situation, sthenic tendencies predominate, and increased emotiveness manifests. These characteristics range from a cheerful, exalted mood to a melancholy one in a socially significant case. There was a pronounced dependence on environmental influences and situations of success and failure. Code 89 (74-68 T) of the abbreviated multifactor questionnaire for personality study revealed irrationality, originality of behavior and statements, perceptions, and judgments. Adaptation difficulties were also mentioned.

Thus, an experimental psychological examination revealed signs of subjectivity in judgments, instability in the level of generalizations, a decrease in focus in thinking, the originality of motives for behavior and statements, and difficulties in adaptation.

Neurologist. Residual encephalopathy is characterized by bilateral microfocal symptoms. Vegetative lability.

Therapist. Stage 1 malnutrition.

Electroencephalography. The bioelectrical activity of the brain was within the age norm variability. The estimated response to afferent stimuli was sufficient. There was no focal slow-wave activity or significant interhemispheric asymmetry. During the recording, no epileptiform activity was recorded.

DISCUSSION

The clinical case of Artyom L. appears to be complex in terms of nosological and syndromic psychopathological diagnostics. Doctors' diagnosis of schizophrenia upon Artyom's admission to the hospital reflects the traditional interpretation of cases with incomprehensible and unexplained symptoms, characterized by the terms "absurdity" and "pretentiousness."

In such cases, psychiatrists often use the concept of "verschroben" [19], which includes the patient's behavior, characterized by strangeness, emotional paradox, and eccentricity. Most studies classify this phenomenon as a schizotypal disorder; in Russian reality, it is known as "sluggish schizophrenia." However, due to the ambiguity of the concept of "verschroben," it is inappropriate to associate it exclusively with the schizophrenic spectrum of disorders or a schizophrenic defect. The need to reduce its boundaries and seek clearer criteria for its differentiation from schizophrenia is now being debated [20].

Upon admission to the hospital, psychiatrists determined that Artyom's mental state met the diagnostic criteria for neurosis-like schizophrenia or schizotypal disorder. Doctors observed signs of alienation, emotional coldness, and "exhaustion" in the clinical presentation of the disease with depleted contacts and a tendency toward social withdrawal. There were signs of "obsessive rumination without internal resistance" and contradictory interests. Artyom was given antipsychotic therapy as a result of this.

Subsequently, a psychopathological analysis of the syndromes detected in Artyom L. showed that we dealt with distinct and diverse symptom complexes that did not meet the diagnostic criteria for schizophrenia spectrum disorders.

The analysis of Artyom's super valuable hobbies was of particular interest, as they are seen as manifestations of schizophrenic obsessions by the psychiatrists who examined him upon admission to the hospital. The behavior, which may rightly be called pathological hoarding, differed in its main parameters from traditional views about obsessions. The clinical presentation, in particular, lacked the typical "struggle of motives" for obsessions, in which the patient, realizing the alienness of obsessions, strives to fight them and refrain from performing ritual actions but surrender unconditionally to anancasms. Furthermore, obsessive–compulsive symptoms are typically based on manifestations of anxiety, and rituals serve as a mechanism to compensate for expressed anxiety.

Because Artyom's "collecting" activity was not accompanied by a "struggle of motives," the patient performed these actions without internal resistance and did not experience unpleasant emotional experiences due to his predisposition to rubbish preservation and systemization. Thus, this phenomenon should be classified as an overvalued psychopathological hobby [21, 22] based on overvalued ideas rather than obsessions.

It is believed that overvalued (abnormal) hobbies or pathological hobbies can occur in adolescents and young people as part of various mental disorders, including the development of personality pathology, autism spectrum disorders, the structure of schizophrenia, and schizotypal disorder [23]. It is argued that this clinical phenomenon is manifested by the unilateral nature of hobbies, the dominance of collecting ideas in patients' minds, and their excessive affective overtones, unproductivity, persistence, and rigidity [24].

According to Malinochka [25], dominance in consciousness and activity pronounced emotional intensity and resilience, insufficient criticality with limited possibility of correction, unusualness, pretentiousness, inconsistency of the hobby with the person's previous life experience, insufficient, narrowly focused productivity, close relationship with other mental disorders, chronological coincidence of their appearance with the onset of schizophrenia spectrum disorders, and a tendency to progressive dynamics and distinct social maladjustment are typical for pathological hobbies of patients with schizophrenia spectrum disorders.

When the identified diagnostic criteria for pathological (abnormal) hobbies in schizophrenia are compared with the clinical manifestations of Artyom's overvalued hobbies (collecting garbage), we must recognize that they do not correlate in many respects. The main aspect should be the absence of any "other schizophrenia spectrum disorders." Artyom's behavior cannot be classified as pretentious,

mainly because the concept of "pretentiousness" is not "semantically clear" [22]. Artyom's behavior was unusual but was within the traditional ideas of paradoxicality.

Overvalued pathological collecting may appear counterintuitive on the surface, but this is its characteristic. Artyom's passion for refusing to throw away (keeping) napkins containing discharge from the nose and seminal fluid could only be seen as pretentiousness. However, Artyom L. explained this behavior by the need to save paper napkins and not by paralogical delusional interpretations.

From our perspective, Artyom L. did not and does not have any compelling clinical grounds for a schizotypal disorder because he has no qualitative thinking disorders, amorphousness, diversity, or tangentiality. Furthermore, there was no evidence of classic social withdrawal, emotional coldness, and exhaustion.

In his conversation with the psychiatrist and his interactions with patients in the department, he demonstrated courtesy and a keen understanding of the nuances of relationships. The latter phenomenon manifested itself at the end of the conversation with the doctor when Artyom L. delicately wiped the sweat from his palm before shaking the hand extended to him. This gesture revealed at least two features: active vegetative accompaniment of emotions and an understanding of the nuances of human relationships.

Patients with schizotypal disorder, characterized by a reduced level of emotional response (coldness and exhaustion), are believed to partially lose their understanding of the nuances of interpersonal relationships and decency. Additionally, the repertoire of their autonomic reactions is becoming more limited [26].

Thus, we rejected the diagnosis of a schizotypal disorder or another schizophrenia spectrum disorder in Artyom L. The main challenge of differential diagnosis turned out to be the challenge of distinguishing between OCD and overvalued hobbies within other mental disorders.

It was noted that Artyom's disease's clinical presentation included apparent psychopathological phenomena that reflected the obsessive–compulsive spectrum, including periods of compulsive hand washing that occurred immediately after experiencing psychological trauma and lasted for 6 months.

In addition, we identified particular fixed forms of behavior that did not correspond to overvalued hobbies or an obsessive–compulsive symptom complex. These are the so-called motivational rigidity that Artyom manifested in his resistance to altering his habitual household environment, particularly his unwillingness to use a different bathroom or cut his nails and hair.

Based on the predominance in the clinical presentation of Artyom L.'s disease of overvalued hobbies that determined the young man's lifestyle, we diagnosed pathological hoarding, which was included in ICD-11 as an independent diagnosis in the category "Obsessive–compulsive and similar disorders" [1]. According to ICD-11, "Pathological hoarding" (6B24) is diagnosed when a person acquires various objects to the point where their home becomes cluttered and unsafe. Hoarding is characterized by repeated urges and actions related to collecting or accumulating multiple things, trouble getting rid of accumulated property due to the need to preserve it, and distress when parting with it. Psychopathological symptoms result in significant distress or impairment in personal, familial, social, academic, occupational, or other functional fields.

This diagnosis was shown as distinguishing the mental state of patients from the schizophrenic spectrum of disorders, on the one hand, and from classic OCD, on the other hand. This implies that hoarding can represent a new independent diagnosis and be a secondary psychopathological syndrome as part of other mental and behavioral disorders.

According to Albert et al. [4], hoarding can be combined with or be a manifestation of such mental disorders as moderate or severe dementia (15%–25%), schizophrenia (5%–40%), social phobia (15%), generalized anxiety disorder (29%), compulsive shopping (62%), and Prader–Willi syndrome (37%–58%).

Patients with autism spectrum disorders [11, 27], particularly those with Asperger's syndrome, typically hoard as a hobby for strange types of collecting. The lifelong collecting and hoarding behavior of patients with Asperger's syndrome appears to serve the function of creating and maintaining their sense of self, sense of continuity, and freedom of action, according to the authors of an article with the grand title "I collect, therefore I exist" [28]. Some people's

Table 1. Differentiation of hoarding as an independent diagnosis and hoarding as a dimension of obsessive–compulsive disorder [4]

Diagnostic criteria	Hoarding	Hoarding as a dimension of OCD
Association of hoarding with obsessions and compulsions	Has no association with obsessions and compulsions	Mainly due to prototypical obsessions or the result of constant avoidance of burdensome compulsions
Screening for hoarding behavior	Rare	Frequent and severe
Obsessions related to hoarding (such as catastrophic consequences or magical thinking)	No	Yes
Mental compulsions associated with hoarding (e.g., the need to remember and reminisce discarded objects)	No	Yes
Ego-syntony/ego-dystonia	Usually ego-syntony: the existence of thoughts associated with pleasant feelings of safety	Usually ego-dystonia: intrusive or unwanted, repetitive thoughts
Presence of obsessive–compulsive symptoms other than hoarding	No	Yes
Distress	Originates from disorder	Consequence of compulsions
Main cause of hoarding	Internal, related to subjective value	Other obsessive matters
Hoarding type		
General items	Yes	Yes
Strange objects	No	Yes
Overacquisition	Usually present	Usually absent
Age of onset	Up to 30 years old	Approximately 20 years old
Understanding (realization)	Poor or absent	Usually good
Hoarding course	Tendency to aggravate when getting older	Usually does not aggravate when getting older
Global impact on adaptation	Usually moderate	Usually severe

collecting and hoarding behaviors may reflect inner struggles rather than symptoms of a comorbid mental illness.

Signs similar to those that appear with Asperger's syndrome could be detected in the behavior of Artyom L. He mainly showed what is referred to as "motivational rigidity," refusing to change anything in his lifestyle (washing in a new bathhouse and cutting his nails and hair). He was prone to hoarding and collecting strange things (discharge from the nose and during masturbation). However, Artyom L. did not meet the fundamental diagnostic criteria for Asperger's syndrome.

Although in the ICD-11, hoarding is discussed in the section "Obsessive–compulsive and similar disorders," differentiation between these conditions is significant (Table 1).

We can conclude that hoarding is an independent disorder and not a dimension of OCD based on the correlation of the listed differential diagnostic criteria with Artyom's clinical manifestations. At the same time, we must note that Artyom also had clinical manifestations of OCD in addition to hoarding, indicating the comorbidity of these disorders.

According to Petruso et al. [8], 15%–40% of OCD patients also exhibit symptoms of hoarding. Conversely, approximately half of the patients with hoarding have comorbid OCD (Figure 1). Most patients with hoarding combined with OCD are phenomenologically comparable with those without

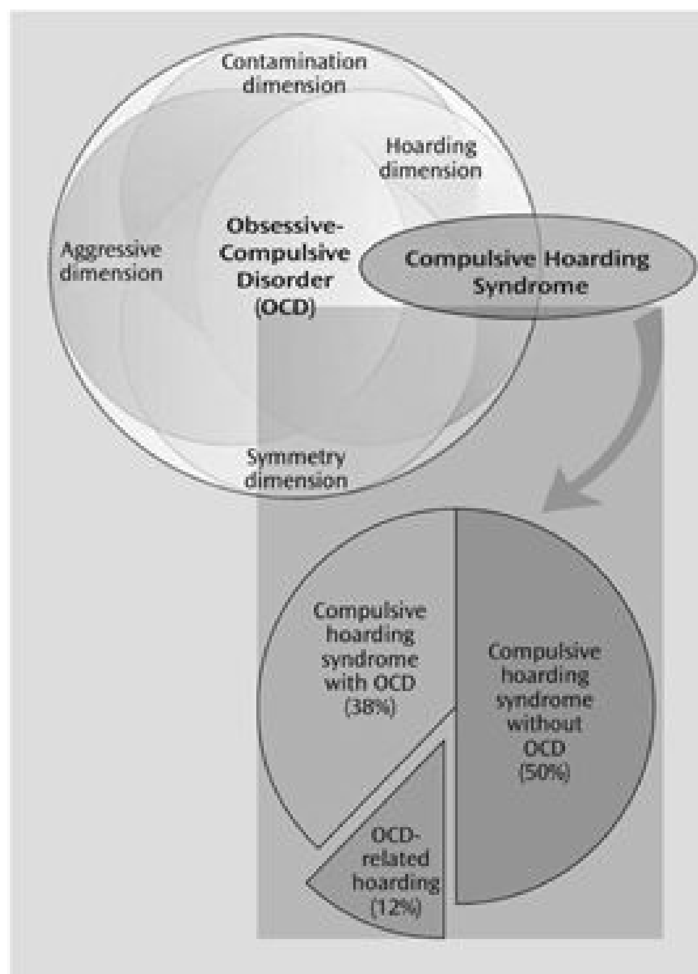


Figure 1. Ratio of the incidence of comorbidity of hoarding and obsessive–compulsive disorder [8]

comorbid OCD. However, in a small group of patients with hoarding in OCD, hoarding behavior may have distinct characteristics and associations with obsessive themes.

It is currently unclear whether hoarding behavior in these cases should be considered a primary symptom of OCD or a behavior secondary to other parameters of OCD symptoms. It is still debatable whether the definitions for OCD symptom parameters should be established based on particular behaviors, such as hoarding, or the motivations driving these behaviors, such as fear of damage and losing things.

The presented clinical case of 20-year-old Artyom L. shows typical manifestations of the diagnosis of hoarding (pathological collecting), a new diagnosis for modern psychiatry, in relation to which psychiatrists should develop new diagnostic thinking algorithms and stop interpreting paradoxical, pretentious behavior to the range of schizophrenic disorders.

Hoarding therapy, like any other disorder on the obsessive–compulsive spectrum, is not an easy task. The main treatment methods include cognitive behavioral therapy and selective serotonin reuptake inhibitors [29]. Prescribing one of the antidepressants that belonged to this group of inhibitors (fluvoxamine at a dose of 150 mg) to Artyom L. for 3 weeks resulted in some mitigation of psychopathological symptoms. Further follow-up of changes in Artyom's mental state will enable to clarify the possibilities of correcting the hoarding registered in him during therapy.

ДОПОЛНИТЕЛЬНО

Финансирование. Исследование не имело спонсорской поддержки.

Конфликт интересов. Авторы заявляют об отсутствии конфликта интересов.

Вклад авторов. *Менделевич В.Д.* — обследование пациента, обзор литературы, анализ клинического случая; *Габутдинов К.А.* — обследование пациента; *Руженкова В.В.* — обзор литературы, анализ клинического случая.
Funding. This publication was not supported by any external sources of funding.

Conflict of interests. The author declare no conflicts of interests.
Contribution of the authors. *V.D. Mendelevich* — examination of the patient, literature review, analysis of the clinical case; *K.A. Gabutdinov* — examination of the patient; *V.V. Ruzhenkova* — literature review, analysis of a clinical case.

СПИСОК ИСТОЧНИКОВ

1. МКБ-11. Глава 06. Психические и поведенческие расстройства и нарушения нейропсихического развития. Статистическая классификация. 2-е издание, переработанное и дополненное. М.: КДУ, Университетская книга; 2022. 432 с. DOI: 10.31453/kdu.ru.91304.0172.
2. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA, American Psychiatric Publishing; 2013. https://doi.org/10.1176/appi.books.9780890425596 (access date: 19.02.2023).
3. Kanat B.B., Altunöz U., Kırıcı S. et al. Hoarding behaviour in three different types of dementia cases // Turk. Psikiyatri. Derg. 2016. Vol. 27. N. 2. P. 1–5. DOI: 10.5080/u7992.
4. Albert U., De Cori D., Barbaro F. et al. Hoarding disorder: A new obsessive-compulsive related disorder in DSM-5 // Journal of Psychopathology. 2015. Vol. 21. P. 354–364.
5. Mataix-Cols D., Fernández de la Cruz L. Hoarding disorder has finally arrived, but many challenges lie ahead // World Psychiatry. 2018. Vol. 17. N. 2. P. 224–225. DOI: 10.1002/wps.20531.
6. Schou M.L., Urfer-Parnas A., Parnas J. The hoarding phenomenon in schizophrenia spectrum disorders // Psychopathology. 2020. Vol. 53. P. 111–117. DOI: 10.1159/000508453.
7. Pertusa A., Bejerot S., Eriksson J. et al. Do patients with hoarding disorder have autistic traits? // Depress. Anxiety. 2012. Vol. 29. N. 3. P. 210–218. DOI: 10.1002/da.20902.
8. Pertusa A., Fullana M.A., Singh S. et al. Compulsive hoarding: OCD symptom, distinct clinical syndrome, or both? // Am. J. Psychiatry. 2008. Vol. 165. P. 1289–1298.
9. Bratiotis Ch., Muroff J., Lin N.X.Y. Hoarding disorder: Development in conceptualization, intervention, and evaluation // Focus. 2021. Vol. 19. P. 392–404. DOI: 10.1176/appi.focus.20210016.
10. Postlethwaite A., Kellett S., Mataix-Cols D. Prevalence of hoarding disorder: A systematic review and meta-analysis // Journal of Affective Disorders. 2019. Vol. 256. P. 309–316. DOI: 10.1016/j.jad.2019.06.004.
11. Pertusa A., Bejerot S., Eriksson J. et al. Do patients with hoarding disorder have autistic traits? // Depression and Anxiety. 2012. Vol. 29. P. 210–218. DOI: 10.1002/da.20902.
12. Ivanov V.Z., Mataix-Cols D., Serlachius E. et al. Prevalence, comorbidity and heritability of hoarding symptoms in adolescence: A population based twin study in 15-year olds // PLoS ONE. 2013. Vol. 8. N. 7. P. e69140. DOI: 10.1371/journal.pone.0069140.
13. Lin N., Bacala L., Martin S. et al. Hoarding disorder: The current evidence in conceptualization, intervention, and evaluation // Psychiatr. Clin. North Am. 2023. Vol. 46. N. 1. P. 181–196. DOI: 10.1016/j.psc.2022.10.007.
14. Pertusa A., Frost R.O., Mataix-Cols D. When hoarding is a symptom of OCD: A case series and implications for DSM-V // Behav. Res. Ther. 2010. Vol. 48. P. 1012–1020.
15. Novara C., Bottesi G., Dorz S., Sanavio E. Hoarding symptoms are not exclusive to hoarders // Front. Psychol. 2016. Vol. 7. P. 1742. DOI: 10.3389/fpsyg.2016.01742.
16. Frank H., Stewart E., Walther M. et al. Hoarding behavior among young children with obsessive-compulsive disorder // J. Obsessive Compuls. Relat. Disord. 2014. Vol. 3. N. 1. P. 6–11. DOI: 10.1016/j.jocrd.2013.11.001.
17. Worden B.L., Tolin D.F. Co-occurring obsessive-compulsive disorder and hoarding disorder: A review of the current literature // J. Cogn. Psychother. 2022. Vol. 36. N. 4. P. 271–286. DOI: 10.1891/jcp-2021-0010.
18. Sordo Vieira L., Guastello A., Nguyen B. et al. Identifying psychiatric and neurological comorbidities associated with hoarding disorder through network analysis // J. Psychiatr. Res. 2022. Vol. 156. P. 16–24. DOI: 10.1016/j.jpsychires.2022.09.037.
19. Смулевич А.Б., Романов Д.В., Мухорина А.К., Атаджыкова Ю.А. Феномен фершробен при шизофрении и расстройствах шизофренического спектра (типологическая дифференциация) // Журнал неврологии и психиатрии им. С.С. Корсакова. 2017. Т. 117. №1. С. 5–16.
20. Атаджыкова Ю.А., Ениколопов С.Н. От феномена шизотипии к синдрому «фершробен»: историческая перспектива и актуальные проблемы // Клиническая и медицинская психология: исследования, обучение, практика. 2016. Т. 4. №14. http://medpsy.ru/climp (дата обращения: 19.02.2023).
21. Менделевич В.Д. Терминологические основы феноменологической диагностики в психиатрии. М.: Городец; 2016. 128 с.
22. Менделевич В.Д. Психология девиантного поведения. М.: Городец; 2016. 386 с.
23. Дейч Р.В. Клинико-динамические аспекты феномена аномальных увлечений у детей и подростков // Социальная и клиническая психиатрия. 2011. Т. 6. С. 16–21.
24. Сергеев И.И., Малиночка С.А. Патологические интересы и увлечения при шизофрении // Журнал неврологии и психиатрии им. С.С. Корсакова. 2008. Т. 5 . С. 54–67.
25. Малиночка С.А. Патологические увлечения у больных с расстройствами шизофренического спектра и их влияние на социальное функционирование больных. Автореф. дис. … канд. мед наук. М.; 2009. 26 с.
26. Алфимова М.В., Мельникова Т.С. Психофизиология эмоциональных реакций при шизофрении // Журнал неврологии и психиатрии им. С.С. Корсакова. 2012. Т. 112. №1. С. 106–113.
27. Ребер М.Е. Расстройства аутистического спектра. Научные подходы к терапии. М.: Бином; 2017. 424 с.
28. Skirrow P., Jackson P., Perry E., Hare D.J. I collect therefore I am — Autonoetic consciousness and hoarding in Asperger

syndrome // Clin. Psychol. Psychother. 2015. Vol. 22. N. 3. P. 278–284. DOI: 10.1002/cpp.1889.
29. Van Roessel P.J., Grassi G., Aboujaoude E.N. et al. Treatment-resistant OCD: Pharmacotherapies in adults // Compr. Psychiatry. 2023. Vol. 120. P. 152352. DOI: 10.1016/j.comppsych.2022.152352.

REFERENCES

1. *MKB-11*. Glava 06. Psihicheskie i povedencheskie rasstrojstva i narusheniya nejropsihicheskogo razvitiya. Statisticheskaya klassifikaciya. 2-e izdanie, pererabotannoe i dopolnennoe. M.: KDU, Universitetskaya kniga; 2022. 432 p. DOI: 10.31453/kdu.ru.91304.0172.

2. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA, American Psychiatric Publishing, 2013. https://doi.org/10.1176/appi.books.9780890425596 (access date: 19.02.2023).

3. Kanat BB, Altunöz U, Kırıcı S et al. Hoarding behaviour in three different types of dementia cases. *Turk Psikiyatri Derg*. 2016;27(2):1–5.

4. Albert U, De Cori D, Barbaro F et al. Hoarding disorder: A new obsessive-compulsive related disorder in DSM-5. *Journal of Psychopathology*. 2015;21:354–364.

5. Mataix-Cols D, Fernández de la Cruz L. Hoarding disorder has finally arrived, but many challenges lie ahead. *World Psychiatry*. 2018;17(2):224–225. DOI: 10.1002/wps.20531.

6. Schou ML, Urfer-Parnas A, Parnas J. The hoarding phenomenon in schizophrenia spectrum disorders. *Psychopathology*. 2020;53:111–117. DOI: 10.1159/000508453.

7. Pertusa A, Bejerot S, Eriksson J et al. Do patients with hoarding disorder have autistic traits? *Depress Anxiety*. 2012;29(3):210–218. DOI: 10.1002/da.20902.

8. Pertusa A, Fullana MA, Singh S et al. Compulsive hoarding: OCD symptom, distinct clinical syndrome, or both? *Am J Psychiatry*. 2008;165:1289–1298.

9. Bratiotis Ch, Muroff J, Lin NXY. Hoarding disorder: Development in conceptualization, intervention, and evaluation. *Focus*. 2021;19:392–404. DOI: 10.1176/appi.focus.20210016.

10. Postlethwaite A, Kellett S, Mataix-Cols D. Prevalence of hoarding disorder: A systematic review and meta-analysis. *Journal of Affective Disorders*. 2019;256:309–316. DOI: 10.1016/j.jad.2019.06.004.

11. Pertusa A, Bejerot S, Eriksson J et al. Do patients with hoarding disorder have autistic traits? *Depression and Anxiety*. 2012;29:210–218. DOI: 10.1002/da.20902.

12. Ivanov VZ, Mataix-Cols D, Serlachius E et al. Prevalence, comorbidity and heritability of hoarding symptoms in adolescence: A population based twin study in 15-year olds. *PLoS ONE*. 2013;8(7):e69140. DOI: 10.1371/journal.pone.0069140.

13. Lin N, Bacala L, Martin S et al. Hoarding disorder: The current evidence in conceptualization, intervention, and evaluation. *Psychiatr Clin North Am*. 2023;46(1):181–196. DOI: 10.1016/j.psc.2022.10.007.

14. Pertusa A, Frost RO, Mataix-Cols D. When hoarding is a symptom of OCD: A case series and implications for DSM-V. *Behav Res Ther*. 2010;48:1012–1020.

15. Novara C, Bottesi G, Dorz S, Sanavio E. Hoarding symptoms are not exclusive to hoarders. *Front Psychol*. 2016;7:1742. DOI: 10.3389/fpsyg.2016.01742.

16. Frank H, Stewart E, Walther M et al. Hoarding behavior among young children with obsessive-compulsive disorder. *J Obsessive Compuls Relat Disord*. 2014;3(1):6–11. DOI: 10.1016/j.jocrd.2013.11.001.

17. Worden BL, Tolin DF. Co-occurring obsessive-compulsive disorder and hoarding disorder: A review of the current literature. *J Cogn Psychother*. 2022;36(4):271–286. DOI: 10.1891/jcp-2021-0010.

18. Sordo Vieira L, Guastello A, Nguyen B et al. Identifying psychiatric and neurological comorbidities associated with hoarding disorder through network analysis. *J Psychiatr Res*. 2022;156:16–24. DOI: 10.1016/j.jpsychires.2022.09.037.

19. Smulevich AB, Romanov DV, Muhorina AK, Atadzhykova YuA. Fenomen fershroben pri shizofrenii i rasstrojstvah shizofrenicheskogo spektra (tipologicheskaya differenciaciya). *Zhurnal nevrologii i psihiatrii im SS Korsakova*. 2017;117(1):5–16. (In Russ.)

20. Atadzhykova YuA, Enikolopov SN. Ot fenomena shizotipii k sindromu “fershroben”: istoricheskaya perspektiva i aktual’nye problemy. *Klinicheskaya i medicinskaya psihologiya: issledovaniya, obuchenie, praktika*. 2016;4(14). (In Russ.) http://medpsy.ru/climp (access date: 19.02.2023).

21. Mendelevich VD. *Terminologicheskie osnovy fenomenologicheskoj diagnostiki v psihiatrii*. M.: Gorodec; 2016. 128 p. (In Russ.)

22. Mendelevich VD. *Psihologiya deviantnogo povedeniya*. M.: Gorodec; 2016. 386 p. (In Russ.)

23. Dejch RV. Kliniko-dinamicheskie aspekty fenomena anomal’nyh uvlecheniĭ u deteĭ i podrostkov. *Social’naya i klinicheskaya psihiatriya*. 2011;6:16–21. (In Russ.)

24. Sergeev II, Malinochka SA. Patologicheskie interesy i uvlecheniya pri shizofrenii. *Zhurnal nevrologii i psihiatrii im SS Korsakova*. 2008;5:54–67. (In Russ.)

25. Malinochka SA. *Patologicheskie uvlecheniya u bol’nyh s rasstroĭstvami shizofrenicheskogo spektra i ih vliyanie na social’noe funkcionirovanie bol’nyh*. Avtoref. dis. … kand. med. nauk. M.; 2009. 26 p. (In Russ.)

26. Alfimova MV, Mel’nikova TS. Psihofiziologiya emocional’nyh reakcij pri shizofrenii. *Zhurnal nevrologii i psihiatrii im SS Korsakova*. 2012;112(1):106–113. (In Russ.)

27. Reber ME. *Rasstrojstva autisticheskogo spektra. Nauchnye podhody k terapii*. M.: Binom; 2017. 424 p. (In Russ.)

28. Skirrow P, Jackson P, Perry E et al. I collect therefore I am — Autonoetic consciousness and hoarding in Asperger syndrome. *Clin Psychol Psychother*. 2015;22(3):278–284. DOI: 10.1002/cpp.1889.

29. Van Roessel PJ, Grassi G, Aboujaoude EN et al. Treatment-resistant OCD: Pharmacotherapies in adults. *Compr Psychiatry*. 2023;120:152352. DOI: 10.1016/j.comppsych.2022.152352.

ОБ АВТОРАХ

Менделевич Владимир Давыдович, докт. мед. наук, проф., зав. каф., каф. психиатрии и медицинской психологии;
ORCID: http://orcid.org/0000-0002-8476-6083;
eLibrary SPIN: 2302-2590;
e-mail: mendelevich_vl@mail.ru

Габутдинов Камиль Айратович, ординатор;
ORCID: http://orcid.org/0000-0003-0253-0622;
e-mail: gabkamil1997@gmail.com

Руженкова Виктория Викторовна, докт. мед. наук, зав. каф., каф. психиатрии, наркологии и клинической психологии;
ORCID: http://orcid.org/0000-0002-1740-4904;
eLibrary SPIN: 8424-7632;
e-mail: ruzhenkova@yandex.ru

AUTHOR'S INFO

Vladimir D. Mendelevich, M.D., D. Sci. (Med.), Prof., Head of the Depart., Depart. of Psychiatry and Medical Psychology;
ORCID: http://orcid.org/0000-0002-8476-6083;
eLibrary SPIN: 2302-2590;
e-mail: mendelevich_vl@mail.ru

Kamil A. Gabutdinov, Resident;
ORCID: http://orcid.org/0000-0003-0253-0622;
e-mail: gabkamil1997@gmail.com

Viktoria V. Ruzhenkova, M.D., D. Sci. (Med.), Head of *Depart.,* Depart. of Psychiatry, Narcology and Clinical Psychology;
ORCID: http://orcid.org/0000-0002-1740-4904;
eLibrary SPIN: 8424-7632;
e-mail: ruzhenkova@yandex.ru