

Hoarding Disorder: New Horizons

Satwant Singh, RN, MSc

**Middlesex University & Metanoia Institute
Doctorate of Psychotherapy by Public Works**

2017

Contents

PART 1: INTRODUCTION.....	2
1.1 Abstract.....	2
Part 3 contains examples of the Public Works and supporting evidence.....	4
1.2 Timeline	5
Figure 1. Timeline	7
1.3 Hoarding Disorder.....	8
1.4 Development of my interest in Hoarding Disorder	9
Reflection in action.....	14
Figure 2. Schon’s (1983) reflection in action	14
Figure 3. My reflexivity in action based on Schon’s (1983) reflection in action.....	16
Figure 4. Development of Hoarding Disorder.....	25
1.5 DSM 5.....	34
PART 2: PERSONAL AND PROFESSIONAL BACKGROUND TO THE THEME OF HOARDING DISORDER: NEW HORIZON.....	40
2.1 Overview of Part 2	40
2.2 Raising awareness and understanding	40
2.3 Research collaboration	48
2.4 Dissemination	66
2.5 Treatment model	69
2.6 Concluding comments.....	76
APPENDIX I: Time line: 1971-2016.....	90
APPENDIX II- OVERCOMING HOARDING LHTG TREATMENT MODEL ..	114
APPENDIX III- OVERCOMING HOARDING LHTG MODEL	115
APPENDIX IV- OVERCOMING HOARDING Case Study	117
APPENDIX V- Reclaim your space and life APP	131
PART 3: EXAMPLES OF THE PUBLIC WORKS	151
3.0 COLLABORATION.....	152
3.1 RAISING AWARENESS AND UNDERSTANDING.....	155
3.2 DISSEMINATION.....	156
3.3 SUPPORT	158
3.4 PROFESSIONAL APPRAISAL	160

PART 1: INTRODUCTION

1.1 Abstract

The theme of this contextual statement is Hoarding Disorder (HD), which can be defined as a failure to discard possessions, which may be useless or of little value, resulting in excessive clutter that precludes activities for which the living space was originally intended. Individuals with HD have a strong emotional and sentimental attachment to these items resulting in the experience or perceived high levels of distress at the thought of discarding them.

Hoarding disorder is a relatively new disorder. Within this contextual statement, I will demonstrate how I contributed to the increased awareness and understanding of this disorder in the United Kingdom in four key areas outlined below which is the basis of the public works that are being presented for consideration of the award Doctorate in Psychotherapy by Public Works:

- **RAISING AWARENESS AND UNDERSTANDING**

As a relatively new disorder, there has been a lack of understanding and awareness of this condition across the professional domains. I have been involved in raising the understanding and awareness of HD and its impact on the individuals, community, environment and professions through radio interviews, teaching and training and providing consultations to individuals, professionals and organisations. This has also influenced and contributed to the development of protocols for engaging those who have hoarding issues.

- **RESEARCH COLLABORATION**

My personal experiences of providing therapy, observations, reflections and reflexivity led me to undertake private and collaborative research with a range of professionals and variety of fields to improve understanding of the disorder. This collaborative work has helped develop innovative and creative

interventions that led to the development of the London Hoarding Treatment Group model.

- **DISSEMINATION**

As part of good practice and to improve the quality of life for individuals who engage in hoarding behaviours I have been actively disseminating research findings, treatment practices through teaching and training, while presenting at national and international conferences and peer review journal publications. I have contributing to the field by offering expertise, knowledge and skills by undertaking professional reviews for professional journals for academic articles submitted for publications.

- **TREATMENT MODEL**

The impact of my personal experiences of providing treatment, undertaking both private and collaborative research, developing creative and innovative interventions has led to the development of the London Hoarding Treatment Group model. There have been a number of self-help books published on HD. This treatment model has been published as the UK's first self-help book titled *Overcoming Hoarding* and led to the development of the smart phone app titled *Reclaim your space and life*.

Part 1 contains a summary of the Public Works, a timeline, an introduction to HD, and the practice of engagement in narrative inquiry and reflexivity on which I based my personal and professional development in relation to my professional practice and in the development of my interest in HD.

Part 2 describes the Public Works, the knowledge and skills, collaborative work and challenges faced and achievements in the development of the works, and how I have applied them in the development of my influence in increasing the awareness and treatment of HD and the impact it has had on the field. I will draw on the work I have produced in relation to HD between the periods of **2011 to 2016**. I will refer to my earlier works in Part 1 between **2004 and 2010** to set the context, demonstrate my interest in HD and the journey of my personal and professional development in this field. I will conclude with a critical reflection on the development of awareness, understanding, and treatment for HD and outline future development in this area.

Part 3 contains examples of the Public Works and supporting evidence.

1.2 Timeline

I provide a summary of my journey in becoming a hoarding disorder specialist. I completed my primary and secondary education in the Far East. The journey in my professional development as hoarding disorder specialist began with my initial training as a Registered General Nurse. It was during this period I realised that the training ill equipped me to understand the nature of psychological issues whilst working with individuals with physical health problems. This led me to undertake further training in mental health to become a Registered Mental Health Nurse. As part of my professional development, I undertook a number of health related courses to enhance my skills and ability as a nurse. Whilst on placement during my training, I had the opportunity to gain clinical experience of Behavioural Therapy while working on an in-patient treatment unit. This experience was instrumental in directing my career progression and development as a Cognitive Behavioural Therapist. During this period I engaged and completed a certificate course in CBT, Masters in Mental Health Interventions and other continuing professional development courses.

Whilst working as a sessional Cognitive Behavioural Therapist at the Priory Hospital North London, I first encountered individuals referred for the treatment of hoarding issues and developed my interest in this field. I completed the Post Graduate Diploma in CBT at Oxford University in 1999 and Masters in Psychotherapy (CBT) at Derby University in 2013. I left the Priory Hospital to develop a Primary Care CBT service in East London in 2001, which was the precursor and contributed to the creation of the current Improving Access to Psychological Interventions (IAPT) national programme. In 2003, I was appointed as a Nurse Consultant in Cognitive Behavioural Therapy and Mental Health. From 2004 onwards my interest in the field of HD further developed with my involvement in raising the awareness and understanding by providing teaching and training and facilitating a national treatment group (LHTG). In 2008 I began my initial engagement in collaborative research contributing to the understanding and treatment of HD, disseminating findings and facilitating workshops and training at conferences

both nationally and internationally. From 2012 onwards I began contributing to the academic community through the peer review of academic journal articles and influencing the development of multi-agency protocols to manage and support those with hoarding issues. My engagement in all these activities has raised my profile as a Hoarding Disorder specialist in the United Kingdom. A fuller description of this progression will be discussed later in this document which is referenced in appendix I a summary of my professional development and some of the key public works are illustrated below in figure 1:

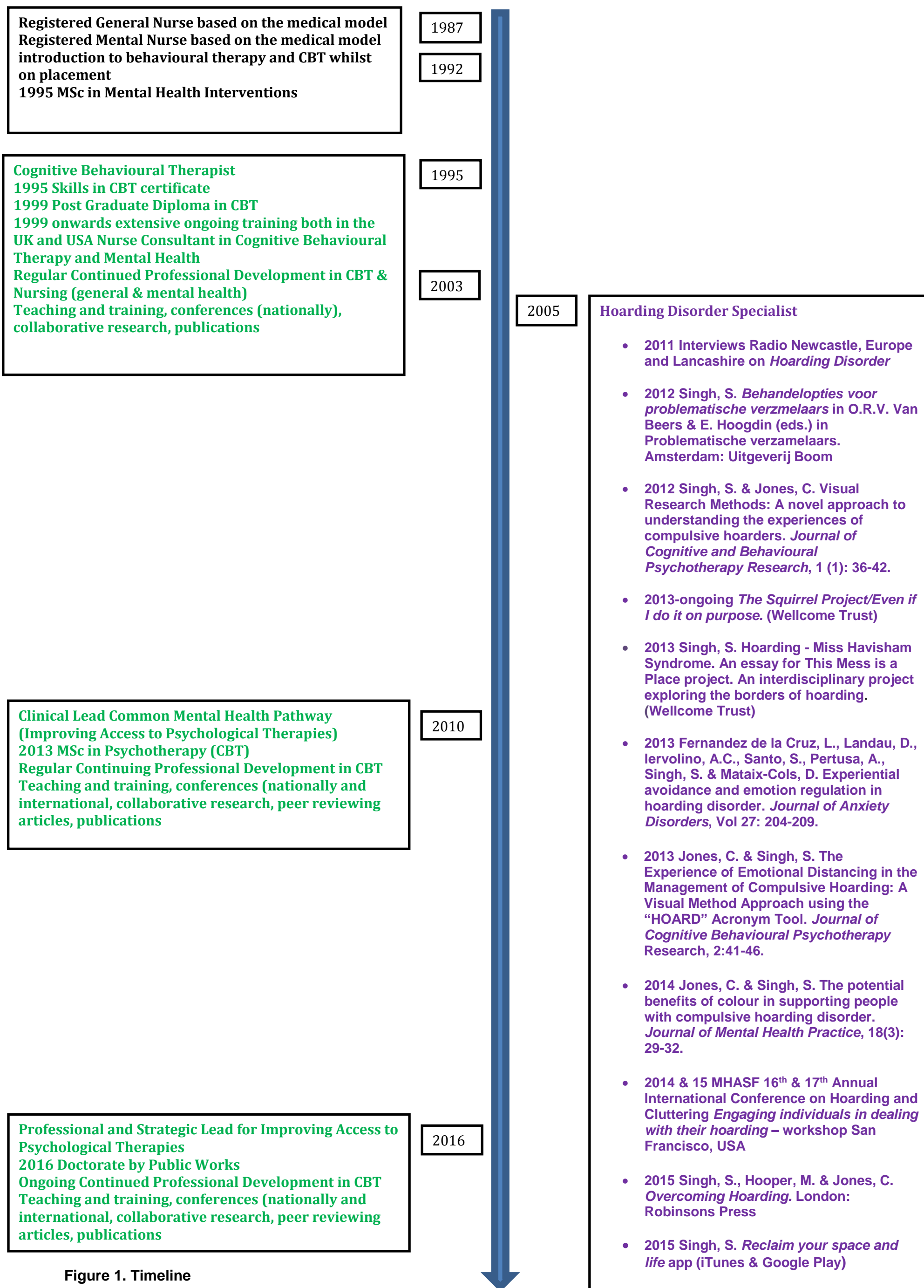


Figure 1. Timeline

1.3 Hoarding Disorder

The human desire to collect and save is not uncommon and from an evolutionary perspective, the tendency to collect and save items could be seen as an adaptive feature for survival when resources are scarce (Grisham & Barlow, 2005). Collecting and saving is a normal human activity especially in the context of food during the time of plenty to ensure there is adequate supplies for leaner times, especially when food production is dependent on the seasons and weather. However, the patterns and habit of acquiring and keeping items over the generations has changed in recent times influenced by our economic status, availability of supplies and beliefs about need. This is apparent in the modern concept of the consumerist society driven by the association between wealth and happiness. Wealth is often demonstrated by the ability to purchase, acquire and collect items and with an excess of the required need.

Hoarding Disorder or *compulsive hoarding*, as it was previously known, can be defined by:

- Pervasive difficulties with acquisition
- Failure to discard possessions which may be useless or of little value
- Excessive clutter that precludes activities for which the living space was originally intended
- Having excessive emotional and sentimental attachments (value) to the items saved
- Experiencing or being perceived to experience distress at the thought of discarding their items (Frost & Hartl, 1996; Frost & Gross, 1993, American Psychiatric Association (APA), 2013).

The key definitions have been the cornerstone of understanding this condition by providing the basis of its conceptualisation as a phenomenon. However, HD is not a new presentation. The earliest printed record in modern history is the story of the Collyer brothers who were found dead entombed by their

hoard in 1947. In classic literature the character of Miss Havisham is portrayed as a decaying old woman living with the hoard of her failed wedding. The story recounts how Miss Havisham, who is now old, is still dressed in her wedding dress and is surrounded by the spoils of the celebration feast after being jilted on her wedding day. This story highlights the beliefs and meanings that individuals place on events and possessions.

In recent clinical history, HD was seen as a presentation within the OCD spectrum. In the then DSM 3-R (1997), it was described as a symptom of Obsessive Compulsive Personality Disorder (OCPD). Hoarding behaviours were first observed by Frost & Hartl (1993) and Frost & Gross (1996) in their OCD outpatient clinic, where they noticed some of their patients presenting with hoarding issues. Until recently, little research has been undertaken in this field. Some of the possible explanations for this are related to a lack of understanding of this presentation: hoarding behaviours were seen as a symptom of either OCD or OCPD and were assumed to have a low prevalence rate. The association of hoarding behaviours with OCD or OCPD resulted in people often being offered Cognitive Behavioural Therapy (CBT)-based treatments for OCD which were ineffective and often resulted in a poor prognosis.

1.4 Development of my interest in Hoarding Disorder

I will be using narrative inquiry as the basis of my epistemological approach gaining insights through reflexivity (Etherington, 2004; Willig, 2001) – an active and engaging process helping me explore and make sense of my professional and personal journey in the development of my interest in relation to HD. I adopt Etherington's (2004: 32) definition of researcher reflexivity as *the capacity of the researcher to acknowledge how their own experiences and context...might inform the process of outcomes of inquiry*, and Finlay and Gough's (2003) *five variants* of reflexivity in undertaking this narrative inquiry. Finlay and Gough's (2003) *five variants* of reflexivity are:

- Reflexivity on introspection relates to the reflexive stance of the self dialogue and discovery, to yield insights to formulate a generalised understanding and interpretation.
- Reflexivity of intersubjective reflections relates to the self in relation to others both focus and the object of focus.
- Reflexivity of mutual collaboration relates to taking into account the multiple perspectives and conflicting positions to help shift the preconceived theories and subjective understanding.
- Reflexivity as social critique relates to acknowledging the tensions that arise from the different social positions.
- Reflexivity as ironic deconstruction relates to identifying underlying weakness, any ambiguity of meanings, the language used and how it impacts on the modes of presentation.

Over the last few decades, researchers have taken a narrative approach to understanding experience leading to the development of a research methodology called narrative inquiry. Clandinin and Connelly (2000) describe narrative inquiry as follows:

Narrative inquiry is an umbrella term that captures the personal and human dimension of experience over time, takes into account the relationship between individual, experience and cultural.

Narrative inquiry is a way of understanding experience; it is a view of the phenomenon of experience over time and within a specific context. In psychotherapy, narrative inquiry is the whole process of therapy. It involves individuals telling their story as an attempt to make sense of their situation. The creation of the personal narrative can provide individuals with a sense of their lives having cohesion and purpose (McAdams, 1985; 2006; Singer,

2004). The whole process of psychotherapy relies on the therapist's reflexivity in responding to the patient's narrative to help create cohesion and purpose as described by McAdams (1985; 2006) and Singer (2004). Likewise, narrative inquiry can create a new sense of meaning and significance for a therapist's experience, bringing a new significance and meaning for the therapist within their clinical work. Therapists deal with their patients' stories by facilitating the development of meaning and their stance in the world. Narrative inquiry can be seen as a mode of thinking especially in the representation of the richness of the human experience (Bruner, 1996). On a personal level, I have employed narrative inquiry by telling my story to make sense of a situation which aids my reflexivity by allowing the process of reflection within that moment. The story has a voice and a language that is in many ways familiar, the voice and language of my childhood where I learned about life. The telling of my story is not confined to me but sharing with my peers enabled the creation of multiple perspectives and challenged my preconceived ideas, concepts, and beliefs. This led to change in the way a situation is understood (Josselson, 2004; Singer 2005). The changes that I have encountered have resulted in the development of the treatment model for the LHTG and *Overcoming Hoarding* (2015) (PW 3.01), a self-help book.

Narrative inquiry conceptualised within Dewey's (1916; 1920; 1930) educational philosophy argues that reflection on experience, confronting the unknown, developing an understanding and then taking action is part of the development process. Narrative is diverse in the changes it seeks to create, such as personal and professional growth and empowerment to change the situation (Johnson & Golombek, 2002). In the case of therapists, this can lead to an epistemological shift (the way knowledge is gained), a change between the therapist, research, and theory. Cognitive Behavioural Therapy research is steeped in the positivist tradition and my shifting to post-positivist (interpretative) stance in relation to HD.

Narrative inquiry requires reflexivity throughout to help contextualise experiences (Etherington, 2004). My first experience of reflection and reflexivity was as a teenager when I first read Jane Austen's *Northanger*

Abbey (1817/1995, 85):

Catherine listened with astonishment; she knew not how to reconcile two such very different accounts of the same thing; for she had not been brought up to understand the propensities of a rattle, nor to know to how many idle assertions and impudent falsehoods the excess of vanity will lead. Her own family were plain, matter-of-fact people who seldom aimed at wit of any kind; her father, at the utmost, being contented with a pun, and her mother with a proverb; they were not in the habit therefore of telling lies to increase their importance, or of asserting at one moment what they would contradict the next. She reflected on the affair for some time in much perplexity, and was more than once on the point of requesting from Mr. Thorpe a clearer insight into his real opinion on the subject; but she checked herself, because it appeared to her that he did not excel in giving those clearer insights, in making those things plain which he had before made ambiguous; and, joining to this, the consideration that he would not really suffer his sister and his friend to be exposed to a danger from which he might easily preserve them, she concluded at last that he must know the carriage to be in fact perfectly safe, and therefore would alarm herself no longer.

I started my journey in my early nursing career by cultivating the practice of reflection. Reflective nursing practice where nurses were encouraged to reflect on their practice to improve and develop became prominent in the early 1990s by the introduction of evidence-based practice. There is a logical relationship between practice and the generation of knowledge and evidence. Thus the introduction of reflection in nursing was seen as a means of exploring and learning from practice as part of the process of generating knowledge, which is a research methodology in its own right (Rolfe, 1998; Kim, 1999). As a trainee nurse, I was actively encouraged by my mentors on the different wards to reflect on each intervention I carried out to help me consolidate my learning (theory to practice) and development as a practitioner. Reflection can be basically defined as the practice of returning back to an event, evaluating it in relation to an individual's experience.

Reflection is personal, focused and purposive. These are important qualities as they enable practitioners to intervene in specific aspects of their own conduct (Klien, 1998). The feedback is the first firm evidence the individual has about the interaction with the unique situation, which is used to affirm or disconfirm the initial action which in turn influences the subsequent interactions. The practice of evidence-based practice is embedded in the reflective/reflexive where one modifies one's behaviour and responses from the feedback received. This is a process referred to as *reflection in action* (Schon, 1983) and *action research* (McNiff, 1993; Rolfe, 1998). Reflection in action is similar to Kolb's (1984) hermeneutic learning cycle which is based on learning theory. It works on two levels: a four state cycle of learning and four separate learning cycles. The theory is concerned about the practitioner's internal cognitive process, which is part of reflexivity. The model is about gathering abstract concepts that can be applied to a range of situations and the learning of new concepts occurs from the new experiences. Kolb states 'Learning is the process whereby knowledge is created through the transformation of experience' (Kolb, 1984: 38). The diagram below illustrates reflection in action:

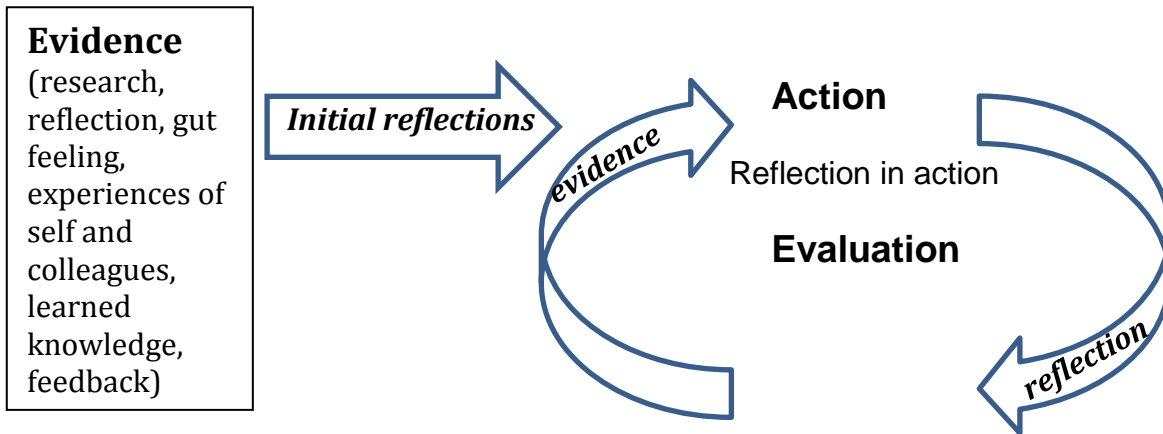


Figure 2. Schon's (1983) reflection in action

In the reflection of my practice as a general nurse, I realised that the training I received did not provide me with an adequate level of understanding of psychological problems. The training was lacking in helping us recognise psychological distress and equipping us with the appropriate skills in supporting inpatients. This prompted me to undertake further training in mental health. It subsequently led me on to the path to train and develop as a Cognitive Behavioural Therapist. A requirement of the mental health nurse training that I underwent was to attend a bi-monthly psychoanalytical group that formally facilitated my practice of reflexivity over the duration of the training.

Reflexivity can be understood as critically thinking about one's practice, which is made explicit by expressing an acute sense of self-awareness. Willig (2001: 10) uses the term *personal reflexivity* to describe the process of *reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims of life and social identities have spaced the research...and possibility changed us as people and as researchers*. As a Cognitive Behavioural Therapist, this is a constant process that occurs within each observation of the interplay between thoughts, feelings, and behaviours as I interact with the internal and external world. In contrast to reflection, reflexivity refers to an individual's capacity to monitor and affect events,

conduct, and context in the moment. In order to practice reflexivity, an individual has to have the capacity to be reflective. Often these terms are used interchangeably: however, they refer to two different processes that occur simultaneously. These simultaneous processes only occur through the conscious practice of reflection and reflexivity. Reflexivity at a certain level resembles Schon's (1983) reflection in action. However, unlike reflection which is about past situations or events, reflexivity is collaborative, diffuse in focus, open-ended in its purpose and immediate in effect. Reflection and reflexivity are not singular processes but occur concurrently, but the key principle in reflexivity is the ability to step back and reflect and review and react within the current situation. The diagram below describes my personal reflexive process.

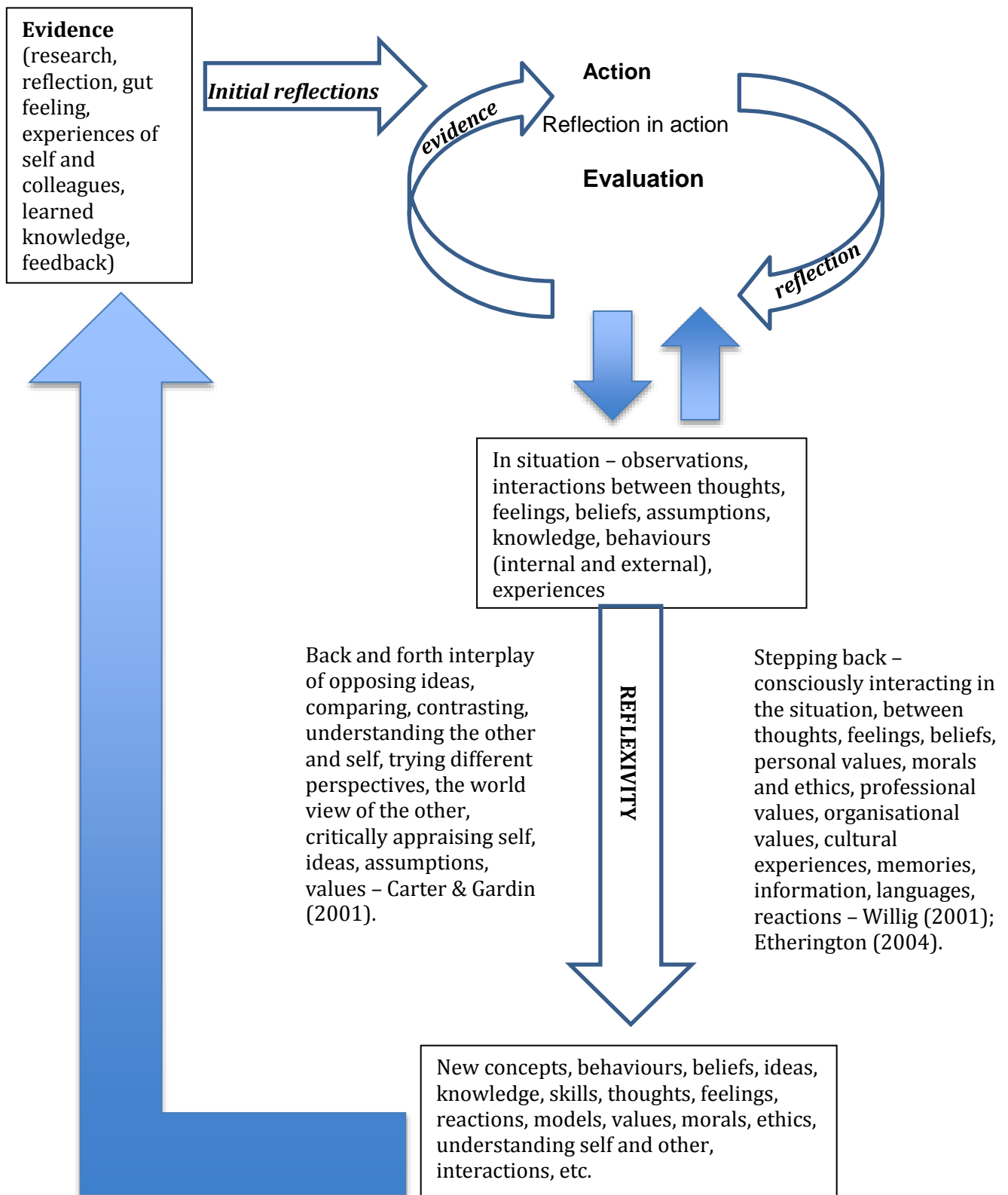


Figure 3. My reflexivity in action based on Schon's (1983) reflection in action

Life experiences play a crucial role in reflexivity as these experiences shape an individual's views, values, beliefs, and assumptions. The process of reflexivity is the interaction between what is observed and experienced with our thoughts, feelings, beliefs, values, experiences, prior knowledge, morals and ethics amongst others. It is extremely difficult to quantify this process of reflexivity as there are subtle triggers, such as memories (positive and negative), smells, and touch that influence our reactions and responses in any given situations. Qualley (1997: 11) describes it as:

Reflexivity is a response triggered by a dialectical engagement with the other – another idea, person, culture, text or even another part of one's self e.g. past life.

Reflexivity is a dynamic process of interaction within ourselves, others, and information that informs our decisions. Actions and interpretation at all stages, therefore, operate at several different levels at the same time. Lang (in Hedges, 2010: 11) describes the process of 'self-other reflexivity' as involving a to and fro, back and forth process of response-invitation-response. Lang (in Hedges, 2010: 118) goes further to state that everything that is done and said is simultaneously a communication, an invitation, an ongoing, to and fro communication process of responding to the other's invitation and issuing invitations to them. As a therapist, this is more pertinent as I work within specific boundaries to help maintain the safety of both the individual and therapist. There are responsibilities in dealing with issues that arise and reflexivity enables that to occur by allowing the synthesis of new ideas, concepts, and reactions that could be both empowering and productive. Additionally, reflexivity helps the therapist within an interaction to monitor the appropriateness of his/her responses, interventions or actions. Lang (in Hedges, 2010: 11) discusses the concept that the therapist develops a 'third eye' perspective to help the therapist shift between the client's position and the therapist. Reflexivity can help generate research ideas through the experience of shifting perspectives. An individual's personal and professional morals and ethics play a crucial role in this process as they set the parameters of what is acceptable or unacceptable. Often for individuals, their

responses occur automatically when they react to situations, but as a therapist, this process becomes more conscious and there is an awareness of that process. My multiple cultural experiences have an important role to play in my engagement in reflexivity as they have provided me with a particular cultural and spiritual lens in how I perceive and understand HD. An example is my beliefs about the negative/bad energy of cluttered environments, especially the keeping of old and damaged items.

I was born and grew up in the Far East: I am of North Indian Sikh extraction. We lived within a diverse Chinese community. The first language I remember speaking was Cantonese and I still speak it fluently even though my mother tongue is Punjabi. To this day, I still think in Cantonese. I had both the Sikh and Chinese values instilled in me by my family and the community in which I lived. The Sikh values are the belief in the brotherhood of man, equality, the connection between people and supporting a strong community spirit. The Chinese community held specific beliefs surrounding damaged or old items. It is believed that damaged or old items contained *bad or negative energy*. Culturally it was considered not a good practice to retain these items as it was perceived that the *bad or negative energy* would have a negative impact on the individual and their family. It was common practice to regularly purge items such as clothes, furniture or crockery. In the event of a death, often the deceased person's belongings would be thrown away or burnt rather than be kept, as it is also common practice in some other cultures. For instance, it is a common tradition to replace one's crockery for the New Year to signify a new beginning and bring in *positive energy*. Personally, I consider old furniture or antiques that do not belong to my immediate family as items that hold *negative energy* and place no value on them. For years, I challenged myself to wear clothes that may have a slight defect rather than throw them out. Additionally, cluttered environments impede the flow of energy, the energy needed for growth and prosperity, which maintains my personal habit to de-clutter my environment of excessive items and maintain clear space. On my first visit to the United States, I was shocked by the number of items people bought, kept and rarely used. The homes were filled with things that appeared to be out of place. In discussions with my family and friends whilst there, I

learned that they held beliefs about property, and their happiness was driven by the quantity of things that they owned. They shared a common belief that the more one earned the more one bought and the happier one was.

My interest in this area developed as a result of my previous work in treating individuals with Obsessive Compulsive Disorder (OCD) who presented compulsive hoarding, whilst working at the Priory Hospital North London in the mid-1990s. The Priory Hospital North London at that time provided a specialist treatment group programme for those suffering from OCD. During that period we received a number of referrals, often from family members referring individuals with hoarding issues for treatment. These individuals received therapy at the request of their family and lacked personal volition to deal with their underlying issues. The lack of awareness, understanding of the disorder and low motivation for change resulted in poor treatment outcomes.

I had little or no experience of working with individuals with saving tendencies. I found engaging therapeutically with these individuals fascinating as the rigid behaviours of saving items opposed my personal values of discarding items that were no longer of benefit. My cultural beliefs and values of *negative/bad energy* have been a powerful force in my work in this field as I strive to create a clear space for positive energy for personal and spiritual growth.

Recollecting that early period, there was little published literature available on HD. Whilst working with individuals with hoarding issues as a Cognitive Behavioural Therapist, I attempted to understand the underlying mechanisms that drove these behaviours to enable me to work effectively with them. In my reflexive practice I asked myself these key questions: “What drives this behaviour?”, “What is the way these individuals see the world that is different from others?”, “What value do the possession hold for them?”. These questions also led me to question myself in relation to my behaviours of discarding and the value of possessions. These questions helped me identify the beliefs, emotions, and behaviours that led these individuals to hoard items and live within a cluttered environment. My reflexive practice helped me appreciate the importance of understanding and respecting the significance

and value of possessions to the individual when engaging with my patients. It also helped me deconstruct my personal values of discarding based on the values instilled in me as part of my upbringing and the importance of keeping this in check when working with these individuals. Gaining this understanding was crucial in conceptualising the individual's problem and in identifying interventions to deal with their presenting issues. As mentioned previously, treatment outcomes were poor as individuals with hoarding problems were treated using the evidence-based cognitive behavioural OCD treatment model which did not target their motivation, perpetuating factors and underlying beliefs. My transcultural beliefs about positive and negative energy helped conceptualise HD differently. My reflexive practice helped me distinguish them as individuals with difficulties rather than relating them to a diagnosis, through personal questioning and reflecting on the drivers of the hoarding problem. Most importantly, reflexivity helped me gain the understanding of short-term and long-term costs and benefits (the yin and yang) for the individual when they engage in their hoarding behaviours. This understanding has been the core in helping me develop an individualised conceptualisation of their presenting problems related to their hoarding issues. In essence, through reflexivity I gained the appreciation that with any behaviour that individuals engaged with there is both a positive and a negative consequence. It provided a more holistic view of the individuals' difficulties rather than a diagnosis of or a symptom of OCD. It also enabled me to understand their anxieties in relation to their being, roles and function in relation to the world around them. Through the process of reflexivity I have had a constant reminder that the most important focus is on the individual, not on their presenting behaviours, and of the need to be curious about their presenting problems. The process of curiosity led to questions – “What do I need to do here to engage with the individual in helping them deal with their problem?”, “What is about me or I am doing that is helping with the engagement?”, “How am I engaging differently?”, “What interventions can I use with this individual in this moment?”, “What skills do I have that I can employ in this moment?” – which have been instrumental in helping me to be reflexive in being creative and testing out my initial thoughts and ideas to aid engagement. This enabled me to engage with these individuals at the many different levels they presented

with. It enabled me to work with them therapeutically and experientially, moving away from the pure cognitive behavioural approach, which I have found to be more effective.

The development of the treatment of HD in the UK began after I was involved in an interview on the BBC's *All in the Mind* (Singh, 2004) programme on HD. My participation in the programme prompted a host of queries for the treatment of HD or *compulsive hoarding* as it was known then by individuals who felt that they had hoarding issues. Prior to this, there was little or no treatment available as HD was not a recognised condition even within the mental health field. As a clinician and therapist, I faced a dilemma, as there appeared to be individuals experiencing emotional difficulties in relation to their hoarding behaviours and a lack of support or help available. Some of my reflexive thoughts at this time were: "What can I do to support these individuals?", "I am a single practitioner, what can I do?", "What resources that I can tap into to help?". This dilemma helped me focus on how to help these individuals which led me to contact OCDAction (a national charity for those who suffer from OCD). In September 2005, this helped develop the first support group for those suffering from compulsive hoarding. OCDAction (PW 3.15) supported this group by locating a venue and advertising the group nationally on their website. It highlights the importance of the need for collaboration with other agencies for the benefit of those who have hoarding issues. It is a challenge to create a treatment group without the support of other agencies, to be able to increase access and also to be able to increase the awareness of the existence of the treatment group.

The key feature of the group is to provide access for individuals with hoarding issues and their family members: to provide a supportive space to discuss their difficulties with no cost to the individuals. Both my colleague and I would facilitate the group in our own time. There were a number of reasons why my colleague and I offered to facilitate the treatment group. Firstly, there was a lack of services available for these individuals, and by contributing a few hours a month, we could make a difference to individuals. Secondly, one of my core values in being a Sikh is the belief in supporting the community.

Thirdly, it is a personal challenge that I can in some way provide some help to these individuals and to make a difference by improving the quality of their lives. The motivation to continue with facilitating the group has been the improvement in the quality of lives and the positive changes that have been achieved by the group participants.

In the first group session that was held, I faced ethical dilemmas as a therapist. I did not feel that I would be providing the appropriate level of support or help to these individuals by providing a space to discuss difficulties. I felt that I had to intervene or provide therapeutic interventions to enable individuals with hoarding issues to deal with their underlying issues and reduce their clutter. As a therapist, I felt my function was to bring about change, and within the CBT tradition, there is a clear definition of identified problems and goals. These were in contradiction to the function of a support group. Additionally, as a therapist, I wanted to reduce and make better the element of human suffering that individuals experienced. Through reflexivity, I was able to step back and understand this dilemma within a wider context and reflect as to how the group initially came into being. It helped me deconstruct the reasons the group came into existence which was driven by individuals seeking treatment and help in dealing with their hoarding issues. This led to the development of the London Hoarding Treatment Group (LHTG), a free monthly therapy group that has been in existence for over ten years.

One of the most important lessons that I learned through reflection during my employment with the Priory Hospital North London was the need for individuals attending the group to show motivation and willingness to engage in therapy. Having considered a number of proposals, I felt the most effective route was for individuals to self-refer for therapy as it ensured that individuals had made a conscious decision that they needed help, demonstrated a level of motivation and were willing to engage in changing their behaviours. In the case of referrals made by a professional, they were usually sent back with information for the clients. The information enabled them to make an informed choice of whether they wanted to participate. In reviewing the last ten years of the existence of the group, I have found the participants have benefited from

the therapy they have received and helped develop the current therapy model based on the research I have collaboratively undertaken. The treatment model developed as a result of the reflexivity exercised in the group session, where at each stage I questioned: “What is working?”, “How are individuals relating to the interventions?”, “What is missing?”, “How effective are we in the work we are doing?” . Each intervention has to be considered for a number of individuals ensuring that it can be of benefit to others. Through reflection about the process, the learning I gained is the importance of involving participants in the development of a treatment model, testing it and receiving feedback. This is in line with Kolb’s (1984) model of experiential learning, and it is a constant cycle of ongoing evaluation and development.

As mentioned earlier, compulsive hoarding or HD was little known within the mental health field or within the wider community. The housing professionals encountered individuals with clutter issues within the social housing scheme. However, these professionals’ understanding of HD was limited. I was invited to be interviewed by Tina Bexson, a journalist who was interested in compulsive hoarding, and I considered that this would be an excellent way to raise awareness for the public and professionals within the housing and environmental health sectors. Through reflexivity, I was able to formulate in my mind key messages that I wanted to impart, with the aims to raise awareness of the presentation of hoarding, develop the idea that it is not a life choice but an actual mental health issue, reduce stigma, and the need to consider alternative ways of dealing with individuals with hoarding issues. The interview was published in *Guardian Society* (Bexson, 2005) and *Environmental Health Journal* (Bexson, 2005). These interviews led to engagement with a few housing providers and some local authorities in order to develop their understanding of HD. Housing providers and local authorities had been experiencing an increase in individuals presenting with cluttered homes and an increased financial cost and emotional distress. The latter affected both housing providers and the individuals when they had to confront these issues. The raising of awareness in the published press resulted in the request for training of housing support officers, support workers, social workers and environmental health officers to develop their understanding of

HD and engagement issues. The challenge in dealing with these requests was about gauging the level at which the training was to be provided and meeting the multiple agendas. The training was, after all, offered to a wide range of professionals who had a wealth of professional experience in dealing with clutter. The key guiding principle that I focused on was to validate their experience. This structured the training sessions that facilitated discussions with the aims firstly to share experiences, secondly to create an awareness of the wealth of experiences within the teams, and thirdly to develop joint working practices. This is crucial when dealing with individuals with hoarding problems as it impacts on individuals at multiple levels. Services within local authorities and housing departments are fragmented and the lack of coordination has often resulted in these individuals not receiving appropriate support, and interventions often left negative beliefs about professionals and an experience of trauma.

My first collaborative study with the researchers at King's College London on HD looked at whether HD was a separate condition or a symptom of OCD, using brain imaging techniques (Pertusa et al., 2008) (PW 3.05). The research idea was conceived through my work with individuals. In offering group therapy in the LHTG, I noticed that there were different presentations of hoarding behaviours with other comorbid psychological problems. Some had rigid beliefs surrounding their acquisition and discarding behaviours whilst others held less rigid beliefs, highlighting a difference between the two. These observations within the group led me, through reflexivity, to question: "What is different between these individuals who appear to have the same problem?", "What makes it more difficult for some to discard?", "What values do they have in relation to their belongings?". Personally, I learned that it is necessary to develop an individualised conceptualisation for each person to facilitate a better understanding of their presentation. This was the first study on the understanding of HD. For the first time it was recognised that individuals presented with hoarding symptoms without comorbid OCD. This was a significant study as it prompted a debate within the OCD clinical field over two main issues: firstly, whether HD should be classified as a separate disorder, and secondly, the implications on treatment offered. This study was

instrumental as it propelled the debate into the direction where it was considered as a separate diagnostic category in the new *Diagnostic and Statistical Manual 5* (DSM-5) (APA, 2013).

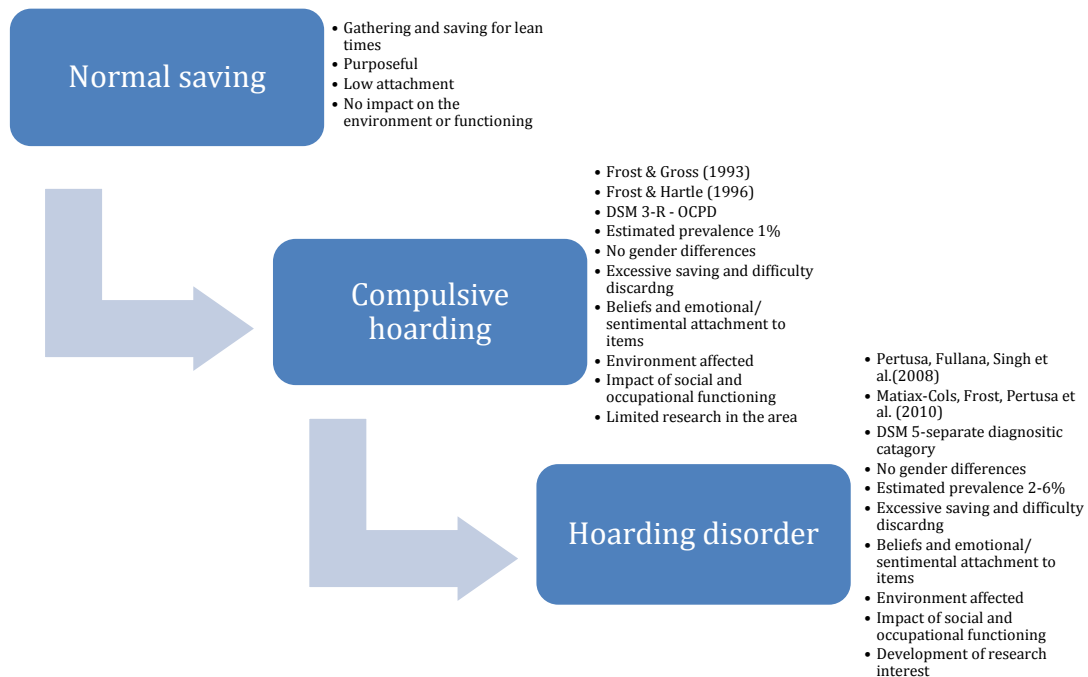


Figure 4. Development of Hoarding Disorder

The first five years (2005-2010) of the LHTG helped me develop a greater insight into HD. The participants of the group provided me with the opportunity to observe closely the hoarding behaviours individuals engaged in. I observed that individuals tended to hoard a range of different items: normal items such as newspapers, books, clothes or bizarre items such as hair, faeces, and urine, amongst others. Through reflection and discussion with my colleague and co-facilitator of LHTG, I was motivated to critically consider whether these individuals experienced other comorbid psychological presentations. The key question that challenged me was: *what is it that makes these individuals collect and save differently?* It is not uncommon for individuals to have other comorbid conditions but with HD it was always assumed to be within the OCD spectrum of disorders. I started to identify these differences using the Socratic

questioning style about their hoarding issues in the group. My observations were that there were different levels of severity. Through my reflexive practice, I learned that I needed to ensure that the assessments that I undertake are more in depth and to identify any symptoms of OCD that would impact the treatment process within the group. Those on the severe end of the condition appeared to be suffering from comorbid OCD, and tended to hoard different items from those without OCD. Additionally, these findings highlighted the need to be sensitive when working with individuals within the group. Some of the items hoarded can be revolting to others, leading to them being labelled and stigmatised by other group participants. These observations led to my collaboration with Pertusa et al. (2008) (PW 3.05) in the very first study to identify HD with and without OCD.

Whilst working with these individuals, I experienced that those who presented with OCD features with their hoarding issues were more challenging to engage in therapy. Their OCD symptoms appeared to interfere with the therapy process. This presented a challenge for me as the facilitator as this often interfered with the group processes and impacted on other participants. It also highlighted that the group therapy model based on the *Buried in Treasures* (Tolin et al., 2007) treatment manual was not effective in engaging and dealing with these presentations. This treatment manual focuses on the individual's beliefs and behaviours but fails to deal with the presenting emotions. As a practitioner-researcher, and through reflexivity of my experiences of working with individuals in the group, I have come to understand the hoarding phenomenon in more detail and am able to discriminate between different presentations. Those who suffered from comorbid OCD engaged in a range of compulsions or rituals which are absent in those without OCD. This meant that individuals had to have different treatment interventions. In attempting to overcome this challenge through reflection and reflexivity, I critically examined the specific aspects of their presentation that interfered with their therapy. This led to liaison with other experienced colleagues who specialised in the treatment of OCD. Their expert advice, which was welcomed, highlighted the need to treat the OCD presentation separately from the hoarding issues (e.g., addressing the

obsessions and the associated compulsions (rituals)). This led me to consider a similar approach of getting participants to separate the two conditions and develop a new formulation as to how their OCD interferes with dealing with their hoarding issues and rigidly held beliefs. Incorporating this within a therapy group was demanding and challenging; through reflexivity during the group interactions, especially when introducing and explaining about HD, I developed a way of introducing this as psychoeducation about the condition, which worked effectively over time.

The group therapy programme provided me with the privilege to appreciate the participants' narratives about their lives and the impact hoarding has had on them. Their personal stories are filled with challenges, meaningful moments that reflect their resilience and resolve in wanting to deal with their hoarding problems. Their stories have been moving as they recount the impact and implications of their hoarding issues on their lives. One of the most salient aspects in these individuals' lives was a lack of support, and that they were treated negatively by professionals and by their community. In reflection, these personal and emotive stories formed my resolve to increase the awareness of HD amongst professionals to offer support to those who present with hoarding issues. I have offered my clinical expertise on a *pro bono* basis to a range of professionals, such as environmental officers, housing officers, social workers, mental health practitioners, therapists, solicitors and non-statutory agencies locally and nationally over a broad range of platforms from providing information on HD, advice on management and support, attending case conferences or writing letters of support. Often I have had joint sessions with the individuals with hoarding issues and the professionals involved in their care to help facilitate the dialogue and develop a plan of action to reduce the negative impact of the clutter, such as forced clearance, with the aim to support the individual and reduce the risk of trauma. It is very much a part of my upbringing, familial and cultural values, morals, ethics and the value of sharing that drives me to provide whatever support I can to be of benefit to another. The lack of awareness and understanding of HD amongst the professional community has led to these individuals being labelled, marginalised and discriminated against, and by providing my clinical expertise

to the professionals, I have been able to increase the awareness and understanding of HD, instil change in attitudes, policies, development of protocols and working practices. Most important are changes in the way these individuals are considered as *people who engage in hoarding behaviours* rather than as *hoarders*. The term hoarder is negative and conjures up images of problematic clutter. Through my reflexive practice, I questioned the use of the term hoarder and how individuals with hoarding issues labelled themselves, as well as the emotional reactions I experienced when they labelled themselves. This raised additional questions for me: “What do individuals gain when they use the term hoarder?”, “Is it a way to excuse the situation they are in?”, “What impact does the term hoarder have on them?”, “Are they affected by it?” “Does it help them deal with their hoarding issues?”. As part of the process, I considered removing the person from the condition recognising the engagement in hoarding behaviours as the problem, and not the person themselves as the problem. Reflecting on my contribution over the years has resulted in the positive movement towards developing HD related services within local authorities. As a result, some local authorities have created specific roles to engage and support individuals with HD, improving their quality of life and social inclusion. I have worked alongside these professionals in supporting them develop their role by providing guidance and supervision when dealing with complex and difficult cases (PW 3.54, 3.55,3.56,3.57, 3.58,3.59 3.60, 3.61, 3.62,3.63, 3.64, 3.65,3.66,3.67,3.68, 3.69,3.70). I have been honoured by being invited to be part of the Chief Fire Officers Network’s HD Working Group, a national organisation to support fire officers and services, where I have a role in providing guidance, advice, and expertise in the development of protocols and working practices (PW 3.79).

The first project that I collaborated on as an expert in HD, was a short film called *Possessed* (Hampton, 2009) (PW 3.16). This was part of a dissertation for Martin Hampton’s Master’s degree in Anthropology and raised awareness of HD both for sufferers and professionals. The producer of the short film approached the group with various ideas as to the context of the project, based on my experiences as a practitioner-researcher and reflections on the narratives from the group. In our discussions and my reflexive practice, we

decided on taking the approach of participants narrating their personal stories about their hoarding, telling their story as to how they understood it and the impact it had on them. Considering it reflexively at that time, I felt that it was important that individuals are able to tell their story; it was not about the therapist or producer, as information gets distorted when described through the lens of another. It was important for individuals to convey the meaning of their individual journey in relation to their hoarding issues. The story had the personal voice of the narrator connecting with individuals who watch the DVD. In analysing their narratives and helping the producer to draw the key themes from the individual personal stories using my clinical knowledge and experience of HD, we were able to identify the themes that others with hoarding issues could relate to and make sense of their own personal underlying issues. I felt that the key feature of this film was that it did not portray any stigma or prejudice by incorporating a professional commentary, but just the voice of the storyteller, which was powerful and evocative. In addition, as a clinician with expertise in HD, during the process of developing this project and having thought reflexively about it, I felt that it was important that those who watched the DVD were aware that treatment was available for their condition, and ensured that there was a separate short segment in the DVD demonstrating the group process, increasing their motivation and reducing anxieties about therapy, should they decide to seek help. This short film has won a number of international awards and has been used extensively in teaching and training and by professionals to help individuals understand about HD and engage with services. When teaching and training professionals, I use this DVD to help them access their thoughts, feelings, and reactions, and to help them recognise how their covert reactions (thoughts and feelings) impact on their overt behaviours (expression and interactions). During these training sessions, I introduce and demonstrate the concept of personal reflexivity to the participants, by helping them to learn to step back and become aware of their own beliefs, prejudices, and personal, professional and organisational values, amongst others, to help enable them to start to develop an awareness of their personal processes when dealing with individuals with hoarding issues.

An important aspect that I learned by being reflexive whilst facilitating LHTG was the value of group therapy. In my work I observed the level of isolation that individuals experienced for a variety of reasons, such as shame, fear of being criticised, labelled, rejected and stigmatised. In reflecting on the experiences of the group, participants are able to share their experiences without the fear of being judged, labelled or stigmatised due to the supportive nature of the group. In addition, one of the most important aspects is the normalising of the experience and that there are others who have similar issues. Many participants, when they first engage in therapy, often state that they are the only individuals who suffer from such difficulties. By being reflexive, I learned to gauge when not to intervene, to enable the group to lead the process. This is helpful as, firstly, they have a common experience and issues, and secondly, it develops their skills and confidence to deal with their own difficulties. Through reflexivity, I learned the value of not trivialising individuals' difficulties, which I had done in the past as a means to help reduce their level of hopelessness, and the value of incorporating humour in the group to help with the engagement and normalisation process. I truly value the experiences that individuals share in the group therapy. This has enabled me to develop a better understanding of the hoarding phenomenon and allowed me to be a practitioner-researcher by developing creative and innovative interventions within the group. For example, one important creative and innovative intervention that I developed is the concept of *buddying*, which was conceived by being reflexive in the group when considering additional support/resources that individuals could utilise. Buddying is where two participants develop a therapeutic relationship with each other based on trust and mutual respect. They develop their relationship based on their shared experience of hoarding issues and with the common purpose of dealing with them. It is a relationship in which the participants are committed and accountable to each other, and also feel confident to challenge each other when dealing with their hoarding issues. Through my practitioner-researcher role, and through reflection and reflexivity, I have gained the knowledge and experience that when individuals have a common condition, they feel safer and more confident in challenging each other, as they are aware of their similar and shared personal experiences.

One of my observations from the group was the impact of stress on the participants' hoarding behaviours. As a practitioner-researcher, I observed that when individuals experienced higher levels of stress there was also an increase of their hoarding behaviours and, through reflexive questioning and engagement, I learned that engaging in the hoarding behaviours helped them cope with their stress and provided a sense of security as it was familiar, tried and tested, and worked for them. Some of my reflexive questions were: "What is the driving force for the increase in hoarding behaviours?", "How do the hoarding behaviours help?", "What do these behaviours parallel with?". I also observed that individuals who were deprived in childhood had a higher rate of collecting and saving items that were perceived as valuable to them. Engaging with my reflexive thinking, I attempted to understand the connection between a deprived childhood and collecting. Some of my personal questions were: "In what way does deprivation increase collecting and saving?", "What is the significance of items collected/saved?", "What do individuals gain when they collect and save?". I collaborated in a research study to understand the role of stress and material deprivation in the development of HD (Landau et al., 2011) (PW 3.06). My collaboration in this study included sharing my observations, recruitment of participants, data analysis, contributing to the findings and discussion. The findings of this study have been useful in my teaching and training sessions in helping professionals recognise the impact their interventions have on these individuals. The increase in their emotional distress results in the increase in hoarding behaviours as a coping mechanism for many individuals. Reflexively, I have used this to help shape professionals' attitudes and behaviour when working with these individuals by attempting to develop a sense of curiosity leading them to develop innovative ways of engagement that is not threatening for the individuals. Additionally, I help them recognise that engaging and working with individuals is a long-term process.

The increased awareness of LHTG by a range of activities such as feedback from participants, promotional work by OCDAction (PW 3.15), the *Possessed* DVD (PW 3.16), and the publication and dissemination of our research

studies (PW 3.05, 3.06, 3.07, 3.09, 3.10, 3.11), has led to an increase in consultations by professionals (PW 3.54, 3.55, 3.56, 3.57, 3.58,3.59 3.60, 3.61, 3.62, 3.63, 3.64, 3.65, 3.66, 3.67, 3.68, 3.69, 3.70). I capitalise on these opportunities to help increase awareness and understanding of HD and provide on the spot teaching and training where possible. My reflexive practice has helped me develop the style of using constructive language within the Socratic dialogue, which I train professionals to use. Some of my reflexive observations were that when using the “why” questioning style, individuals disengage. Upon personal questioning, I found that the “why” questioning style tends to be blaming, taking on an assumption that they had done something wrong or made mistakes. It helped me consider the different ways of questioning that would facilitate engagement and, most importantly, enable individuals to further elaborate, which is a helpful process in helping them make sense of their issues. This led me to consider the use of constructive language in my therapeutic questioning and interactions, such as “what?”, “how?”, ‘in what way?’. This line of questioning fosters a sense of curiosity, which I feel is crucial in engaging individuals with hoarding issues in treatment, as it reduces stigma, encourages disclosure and helps develop a shared understanding of their problems. This has also helped me gain an understanding of how professionals’ attitudes, values and ethics impact on their engagement with individuals. As an example of constructive language, the reader will find throughout this document that the word hoarder is not mentioned as it is labelling, stigmatising, and devalues the person. Instead, I have used the term individuals with *hoarding issues* or who *engage in hoarding behaviours*. This also helps to externalise the problem from the individual rather than the individual is the problem. Being reflexive has helped me to understand there is a difference between a problem and a person. The individual is not a problem but has positive attributes; however, they may have a problem when they engage with problematic behaviours. Recognising the hoarding behaviour as the problem rather than the person facilitates the engagement process. The process of engaging in reflexivity over the years has made me believe that individuals are inherently good but may engage in unhelpful behaviours. I observed that a large majority of professionals have negative and unhelpful attitudes (resentment, labelling) towards those who

have hoarding issues. These negative attitudes impact on their engagement and treatment of their clients, which is not productive when working with these individuals and often leads to experiences of high stress levels for both parties. My reflections on the responses from the professionals and being reflexive enabled me to formulate the purpose of the consultations. The aim was to change the professionals' attitudes towards individuals with hoarding problems.

I was involved in raising awareness of HD within the housing communities in 2010 when I was invited to present at the Housing Quality Network Conference on health and housing focusing on HD. I collaborated with the organisers as to their purpose, aims, and objectives of the event, to formulate jointly the presentations and the adaptations that may be needed for each location. This event was replicated in three locations: London, Manchester, and York. This event provided an opportunity to disseminate information on HD widely across the country. I had to be reflexive in undertaking these presentations by assessing the needs of the participants of the events as there was a wide range of participants with varying needs. Reflexivity enabled me to step back and consider their specific needs and adapt each presentation for the audience to ensure that they got the appropriate information, which would enrich their understanding of HD. During this period my reflexive thinking was: "I need to adapt the examples that will relate to the audience and participants", "I need to facilitate the audience to ask questions as this will allow their specific needs to be addressed". In addition, the reflexivity process enabled me to choose the best method of engaging with the participants and the best way to engage with them in the presentations. The key message has been collaboration with others to meet the needs of others.

There is an international awareness of LHTG. There has been interest from clinicians from the Netherlands and Australia, who have participated as observers of the group. In the Netherlands, HD is a problem that is still not recognised. It is important to collaborate with other professionals to share information and good practice with the aim to develop greater access to

support and treatment. Being sensitive to the group's needs and the ethical implications for allowing an observer to the group, I consulted the group and gained consent for the observation request. The feedback from the observer was complimentary on the way the group was facilitated, ensuring the participants engaged in the group, and the way tensions were dealt with. Reflexivity has helped me to manage and deal with the tensions that arise during the group therapy sessions.

The clinician's visit resulted in the raising of awareness of HD in the Netherlands. I feel proud to have been able to exert an influence on that process. The impact of the visit was the organisation of the first conference on HD in the Netherlands. It was organised by *Cure and Care*, a health care organisation, and was held in Utrecht with over 200 professionals from across the country attending. It was my first international presentation on HD. My presentation was on HD, and the LHGT group therapy model that has been replicated in the Netherlands. This highlights that sharing good practice benefits society in general. I am proud to be a part of the process of raising awareness and understanding in the Netherlands, indicating that achievement goes beyond the national to the international.

This is the outline of my initial involvement in HD, which was at that time little known and not recognised as a disorder in the UK. My influence and work in the field has led to the increased awareness and understanding of this disorder. Being a reflexive practitioner has been instrumental to this development. My experiences, observations, thoughts, assumptions and collaboration in research with other researchers has led to the recognition as a disorder in its own right and to be included in the DSM-5 (APA, 2013).

1.5 DSM 5

The DSM is the diagnostic manual used by psychologists, psychiatrists and therapists to guide their diagnostic and treatment decision making and has been in existence since 1952 with revisions over the years. The DSM 5 (APA, 2013), the fifth revision, was released in 2013 after several years in

development. The initial concerns about the Task Force identified for the development of the DSM 5 was that the key decisions were made behind closed doors (Ledford, 2009; Spitzer, 2009). The substance of this manual has been reviewed, debated and released online for scrutiny for contestations and critiques resulting in over 30, 000 responses reviewed by the Task Force. As a clinician specialising in the treatment of HD, I engaged in the consultation process and contributed to some of these critiques. The resulting changes in the DSM 5 include the removal of the multi-axial systems which is not supported by research data in the instance of personality disorders are no longer an Axis II disorder but a general diagnosis. This has also led to the combination of many disorders in one single diagnostic criteria and the introduction of 15 new disorders of which HD is one. These additions and removals from the DSM 5 have been influenced by social pressure exerted by special interest groups. As a clinician, I have found these changes to be unhelpful as there are implications for the treatments being offered. This has led to the questioning of the manual's diagnostic criteria validity as some of these changes are not based on research findings, which I feel goes against the purpose of the DSM as diagnostic manual based on research findings. On the other hand, a large number of clinicians argue that that the DSM is only useful in the context of research in defining psychological conditions. The instrument of choice for diagnostic purposes is the International Classification of Diseases 10 (ICD 10) (WHO, 1992) and currently, HD is not within its classification.

In general, there has been a great deal of criticism of the DSM 5. Greenberg (2013) state that the diagnosis of mental disorders is too subjective. The manual is based on the medical model and assumes that mental disorders are medical. Experts attempt to define mental conditions that may not exist in nature in pure forms and there is no clear distinction between normal or abnormal. The diagnosis of mental disorders is subjective but that is the state of the art of psychodiagnosis at the current time (Morrison, 2014). I think that it is important to acknowledge the fact that diagnosing a psychological presentation is subjective rather than factual and it is important that that

manual is able to provide the appropriate research based guidance and algorithms to help make the diagnosis which I feel it is now lacking.

Another criticism is that the DSM 5 is based on the symptoms and not the causes, without knowing the causes it makes it difficult to treat it. In most cases the specific causes of mental disorders are unknown (Dziegielewski, 2015). Psychological treatments have been shown to be effective even though the causes are unknown (Lebow, 2008). Diagnostic labels are powerful and can force individuals to be stigmatised and treated differently. However, having a diagnostic label is not always negative it can promote understanding and consideration of treatment choices. In my experience some individuals have found that having a diagnosis and a label helpful in understanding their condition and offers access to treatment. By being reflexive it has helped me decide as to which intervention would be more helpful to the individual whether to discuss the diagnosis or to view it as a psychological or behavioural presentation. Personally, as a clinician, the key objective is to help the individual develop an understanding of their problem with the intention to deal with their hoarding issues. Being reflexive during the therapeutic process in deciding on intervention is instrumental in achieving this.

However, there have been reservations about the DSM 5's role in medicalisation of normality. In a *British Medical Journal* editorial, Frances (2010) writes that the DSM 5 would 'expand the territory of mental health and the thin ranks of normal'. In my experience the dangers of medicalisation of normality will lead to normal reactions being pathologised as a mental health issue, for instance, the normal grief reaction, which in the DSM 5 is medicalised as major depression after 2 months by the removal of the bereavement exclusion period of 6 months (Stetka, & Correll, 2013; Pickergill, 2014). Grief is an adjustment issue and the period of adjustment varies for individuals depending on their personal and cultural context. The reduction in exclusion period medicalises grief without allowing the individual an adequate period of time to adjust to the loss naturally, often resulting in psychological or medical interventions. This medicalisation is often deemed to promote the role

of medication in mental health (Jutel, 2009; Pickergill, 2012). The funding of the development of the manual has been heavily sponsored by pharmaceutical companies with the aim to promote the use of medication to treat mental health problems. There were new policies introduced by the American Psychiatric Association to minimize the influence of the pharmaceutical industry in the development of the DSM 5. I am uncertain to the degree of effectiveness with the introduction of these policies to reduce the influence of the pharmaceutical companies in the development of this manual. Pharmaceutical companies tend to engage with clinicians at many different levels directly (sponsorship) or indirectly (service development or educational programmes), thus effecting influence on clinicians which is difficult to monitor or contain.

On balance the introduction of HD as a separate diagnosis from OCD or OCPD spectrum of disorders is welcomed as it recognises it as a disorder and no longer a symptom of OCPD or the OCD spectrum of disorders. In the past HD as a symptom of OCPD or the OCD spectrum of disorders did not receive adequate attention. This has resulted in the lack of understanding of the disorder and development of effective treatment models. In my experience, as discussed previously, treatment options were based on the evidence-based treatment of model for OCD which yielded poor outcomes when treating HD. The positive aspect of the inclusion of HD will drive more research into the disorder for the development of treatment interventions and collection of data to inform for evidence-based treatment options for these individuals. In the longer term, there is potential for the DSM 5 to benefit individuals with HD by the development of disorder specific services and evidence-based treatment pathways.

However, I feel the danger of inclusion of this disorder may lead to the potential of misdiagnosis of those who collect as a hobby as suffering from HD. There has been a debate between collecting and HD. In my experience those who collect as a hobby can also present with a cluttered environment. According to Mataix-Col & Fernandez de la Cruz (2015) collecting is a pleasurable activity and up to 30% of children and adults own collections.

There are key similarities and differences between collecting and HD which I feel need to be defined in the DSM 5 to reduce the risk of misdiagnosis. A positive aspect of the diagnostic criteria in the DSM 5 is that they are specific and clear that those with other mental health disorders (dementia, autism, OCD) or brain injury are excluded from being diagnosed with HD. I have found this helpful as it provides clinicians with guidance to those who would benefit most from the current evidence-based psychological interventions and those with organic causes of their hoarding issues to be offered medication based treatments.

In my opinion there is still a lack of clarity as to what defines hoarding disorder as a mental disorder. The criterion offered in the manual is generally a basic description of the presentation and impact of the hoarding and saving behaviours rather than a mental health issue in comparison to other psychological conditions. In relation to HD there is a need for greater clarity to help clinicians differentiate between the presentation of hoarding tendencies and what constitutes it as a mental health disorder. This lack of clarity manifests itself in the wider community that HD is often perceived as a choice in the way an individual chooses to live their life rather than a mental health issue requiring treated by health care professionals. In my experience under the current DSM 5, diagnostic criteria individuals would be more likely be identified as having a hoarding problem or tendencies rather than suffering from hoarding disorder. The benefits of this I feel reduce the negative labelling and stigma attached to HD and it would improve engagement in dealing with their issues. On the other hand, it could prevent individuals accessing evidence-based treatments or specialist services as they do not meet the criteria of HD.

As a clinician, I am aware there is a tension between diagnosing and offering treatment. In some cases having a clear diagnosis can be useful, however for some, it can be a negative experience leading to fear of being labelled, stigmatised, and feel discriminated against. Being reflexive in my practice has led me to be aware of the tension that exists. When working with individuals, my reflexive practice has helped me develop a constructive approach of

steering away from using the diagnostic term of hoarding disorder to a more neutral one of “an individual who engages in hoarding behaviours”. Based on my experience, individuals have found it helpful and constructive when working with the term of “an individual who engages in hoarding behaviours”. The use of this term depersonalises the problem from the individual and places the focus on their behaviour. In my experience, this has shown to enhance the engagement process in dealing with their hoarding issues.

Despite the criticisms of the DSM 5, I feel that the constructive role DSM has played over the years in the development of treatment and therapy models for psychological conditions needs to be given consideration. Namely the systematic collection of data which has led to research being undertaken which I feel will continue with the DSM 5. The data collection and research into the disorder will help with future developments of especially better diagnostic tools. It is important to recognise the manual is dynamic, further revisions and adaptations will occur over the next few years with on-going research in the field of mental health contributing to the evidence pool and treatment options. In view that the ICD 11 is not yet in existence, for the current moment the DSM 5 is the only diagnostic manual that is available to clinicians to help with identifying and diagnosing HD.

In Part 2, I will discuss how my observations of the emerging themes whilst working with individuals with HD has led to further research being undertaken.

PART 2: PERSONAL AND PROFESSIONAL BACKGROUND TO THE THEME OF HOARDING DISORDER: NEW HORIZONS

2.1 Overview of Part 2

In Part 2 of the context statement, I will describe the personal and professional background to my interest in hoarding disorder, and my reflections arising out of the writing of this statement. The process of reflection and being reflexive whilst treating individuals suffering from HD will be demonstrated through my personal experiences. There are four main areas that I will focus on. Firstly, raising awareness and understanding of this disorder amongst the wider multi-professional community, through consultations and providing support to those who have sought my professional expertise. Secondly, my contributions as a practitioner researcher, working collaboratively with researchers and professional artists interested in the field to improve our understanding of HD and engagement issues. Thirdly, the dissemination of the research findings, expertise, and practice articles through publication in peer-reviewed journals, presenting at conferences, facilitating workshops for multi-professionals and contributing to the professional journals through peer reviews. Finally, developing the treatment protocol for the London Hoarding Treatment Group leading to the publication of *Overcoming Hoarding*, a self-help book based on cognitive behavioural techniques (PW 3.01), and *Reclaim your space and life*, a smart phone application (PW 3.02). I will be presenting the relevant works in each section.

2.2 Raising awareness and understanding

The lack of mental health and psychological services to support and treat individuals with HD has been appalling. These individuals are often left untreated for their presenting hoarding issues, which have an underlying mental health origin, usually considered as a social problem. This raises the tension between understanding and acceptance of HD as a mental health problem by the psychological community and the need for a psychological provision to support these individuals. The lack of awareness and understanding of HD as a mental health issue has led individuals to be

marginalised, and has enforced interventions that attend to the consequences of their hoarding behaviours rather than dealing with the underlying factors that have contributed to the development of this problem in the first place. These enforced interventions cause unnecessary trauma and distress leading to an increased engagement in hoarding behaviours and clutter as a coping mechanism for those individuals.

As there is a lack of service provisions both in the mental health and social care arenas, it has meant those identified individuals affected do not receive the help and support to deal with their hoarding issues. It is often assumed that those suffering from HD are perceived to have a lack of awareness and understanding of their condition however, it can be argued that the professionals are those who lack the understanding of the problems experienced by these individuals. This leads to the on-going conflict between individuals with hoarding issues and professionals.

The lack of understanding and awareness has led to a culture of considering individuals with hoarding issues to be problematic. This has had led to labelling of these individuals as *hoarders* associated with the accumulation of clutter which is stigmatising. This unhelpful label of *hoarder* conjures up images of extreme clutter where the individual is no longer recognised as a person but as a mounting disorganised pile of rubbish. In reflection of my engagement with the professionals when dealing with issues of clutter and hoarding, I have experienced professionals expressing feelings of disgust and repulsion towards these individuals. This has had a profound impact on me as it contravenes my personal and professional beliefs on respect and acceptance, which have developed over the years working within the mental health field. The expression of such powerful negative feelings has led to the stigmatisation and marginalisation of these individuals, treating them in a derogatory and punitive way; for example, in the case of forced clearing of a person's home. Personally, I can accept professionals as individuals who feel these feelings. However, as professionals who deal with the public, they need to be able to take a *step back* and maintain their personal feelings separately from their professional responsibilities. This is an inherent problem as a result

of lack of awareness, knowledge and understanding of HD, or other conditions for that matter.

When faced with these situations, being a reflective and reflexive practitioner has helped me be aware of my own personal reactions towards these professionals. The awareness of my personal reactions, and my reflexive practice, have helped me react in a non-confrontational manner but instead with an attitude of compassion and understanding. As part of my reflexive practice I remind myself that each individual has their own personal experiences which influence the way they feel and react to situations. This has helped me to develop strategies as to how to help them deal with their reactions. These strategies include acceptance of their feelings, normalising and then externalising their sense of awareness of their feelings and reactions, which has helped them to review the way they react in those situations. According to Scaife (2001: 60), as strong feelings will inevitably be evoked, it is important to acknowledge and understand these emotions and utilise them to the best advantage of the individuals. My reflexive practice has helped me deal with a challenge that I often face, of attempting to remain non-judgemental and react in a defensive manner in response to their attitudes affecting the consultative relationship. During my interactions with professionals, I often take the opportunity to help them differentiate between the person and the problem. This has been done by challenging professionals in a safe manner using a Socratic questioning style to enable exploration whilst not jeopardising our relationship and engagement to the detriment of the individual they are dealing with. I feel I have a duty of care towards both the professional and the individual. This is because I am seen as the *expert in the field* and there is an assumed implicit expectation to support both the professional and the individual. Through reflexivity I have been able to maintain these boundaries and ensure there is a degree of fairness in the way I respond to them. I attempt at every stage to model the way I work as a demonstration to them that it is possible to be supportive and fair by validating the difficulties experienced by both parties.

My reflective and reflexive practice has helped me develop a personal model of engagement based on the social systems that I encounter. Steier (1991) suggests that we gain knowledge through a modelling process through experience and our own constructing process. This is in line with Kolb's (1984) learning cycle.

When we make descriptions of social systems, or of biological organisms for example, the categories and standards that we apply in order to make sense of our constructed worlds are necessarily immersed in models that we have also participated in constructing, whether by our own explicit invention (as in creating new distinction) or, in using and by the use, sustaining categories and tacit conventions of the language of our research communities (Steier, 1991: 2)

The synthesis of our interactions depends on developing an understanding of the social systems and the factors associated (reflexive practice) which is considered new learning and practice (Kolb, 1984).

Stigma plays a major role in the persistent suffering, disability and economic loss as a result of mental illness. Individuals with mental health issues are often victimised for their illness and face unfair discrimination such as difficulties in accessing appropriate services and support. Often they are mistreated by their family, friends and the community (Thornicroft, 2006; Sartorius, 2007; Stuart & Sartorius, 2005). In the case of hoarding disorder, there is a general lack of awareness and understanding about it. A study by Wibram, Kellett & Beail (2008) found that family and carers lacked an understanding of their family member's hoarding. Until recently, individuals who suffer from HD and living in a cluttered environment have been subjected to the Anti-Social Behaviour Order (ASBO), which when enforced has the authority to restrict behaviours. ASBOs were introduced through the Crime and Disorder Act 1998, which came into force in 1999, to help target those who behaved inappropriately causing concern or harm to others to a degree that did not necessarily warrant criminal proceedings. The issuing of ASBOs to individuals with clutter and hoarding issues is a form of institutional stigma

and victimisation through the lack of understanding that HD is a mental health disorder.

My first priority had been to raise awareness about HD, through engagement and management of individuals within the housing community, local authorities and the emergency services (fire department) (PW 3.25, 3.26, 3.27, 3.28, 3.29, 3.30, 3.31,3.32,3.33, 3.34, 3.35, 3.36, 3.37, 3.38, 3.39, 3.40, 3.41). The engagement with these organisations allowed me the opportunity to assess the target audience, level of understanding, training needs and mode of training to be offered. The target audience identified a range of professionals such as housing officers, support workers, emergency staff, social workers, and environmental health officers, amongst others. Tailoring the training was a challenge as each professional group had different training needs. My reflexive practice helped me consider the training format and formulate the key aims for the training to be offered (PW 3.40). The key questions that I asked myself as part of the process were: “What is it they are wanting to know?”, “What is their understanding/awareness of the problem?”, “What are their needs and what are they hoping to gain?”, “What is the common theme for this group of participants?” “What is it that I am aiming to impart?”, “How would it benefit them and improve the way they engage those with hoarding issues?”, “How can this training influence the way they work?”. Their training needs were met through a series of presentations, workshops and training sessions (PW 3.25, 3.26, 3.27, 3.28, 3.29, 3.30, 3.31, 3.32, 3.33, 3.34, 3.35, 3.36, 3.37, 3.38, 3.39, 3.40, 3.41). The aims were firstly, to raise awareness and understanding HD as a psychological condition, skills in engagement, and considering interventions for each professional group. Secondly, for participants to feedback to their organisations the need to develop appropriate referral pathways and joint multi-agency working (PW 3.32, 3.71, 3.74).

One of the biggest challenges that I face is having a full understanding of the individual professional roles and their level of engagement and the material to help them develop their skills. It is difficult to utilise clinical material such as video recordings of sessions or interventions for non-clinical staff as they are

not able to relate to the process of therapy. To overcome this problem, participants were requested to present cases which were more relevant to the training, which generated discussion and the full participation of the attendees. In reflection the discussion of cases provided me with the opportunity to fully understand their roles and their professional links. My reflective and reflexive practice helps me to take the stance of focusing on the identification of the professionals' beliefs, attitudes, feelings and reactions that affect their engagement processes. I demonstrated to them during the training session the potential impact of their conscious or unconscious display of their negative attitudes on the individual they are dealing with. Here, "conscious" referred to their overt behaviours, such as their use of language, and "unconscious" to their covert behaviours, such as expressions. As mentioned previously, the negative reactions expressed (e.g. repulsion and disgust) impact on the engagement process and development of a collaborative working relationship between the professional and the individual with hoarding issues.

Services are disjointed, as there is little or no communication between professionals, which impacts the individual's management and treatment. In meeting the second aim as part of the teaching and training sessions, I encourage the participants to begin by considering, when dealing with an individual, the need for joint work as they all are involved at different stages. I highlight the importance and need to develop a local strategy, protocol and pathways for hoarding disorder (PW 3.25, 3.26, 3.27, 3.28, 3.29, 3.30, 3.31, 3.32, 3.33, 3.34, 3.35, 3.36, 3.37, 3.38, 3.39, 3.40, 3.41, 3.32, 3.71, 3.74). This is to ensure that individuals identified with hoarding issues are supported appropriately. In addition, the strategy, protocols and pathways provide clear guidelines, which reduce the risk of individuals being treated inconsistently or victimised. The impact of the training in Nottinghamshire, for example, has resulted in the development of the Nottingham Protocol and Strategy for HD (Nottingham County Council, 2015) (PW 3.64). The development of these protocols has been a positive and progressive step forward in recognising, supporting and managing individuals with hoarding issues. Through my reflective and reflexive practice, I developed these skills over a course of a

number of training sessions, which enabled me to learn and to develop my teaching and training of non-clinical professionals incorporating my values and enthusiasm of working with individuals with hoarding issues. Through reflexivity, I have gained the skill to recognise patterns that professionals engage in and respond to them in a supportive and facilitative manner to help change unhelpful working practices.

Additional opportunities were presented to me to highlight and raise awareness of HD. I was interviewed by a number of radio stations where I was able to inform a wide audience about HD as a psychological condition, to reduce the stigma and victimisation of individuals, and the support that could be offered. Three opportunities arose between 2011 and 2013 for Radio Newcastle (PW 3.25), Europe (PW 3.27) and Lancaster (PW 3.28). Prior to each interview I reflexively considered the best approach to engage the listeners whereby I would be able to raise awareness, understanding and reduce stigmatisation by openly discussing hoarding issues. In May 2016, a podcast and a clip on YouTube discussing HD (PW 3.30) and the use of the *Reclaiming your space and life* app (Singh, 2015) (PW 3.02) were published. A great number of television programmes have capitalised on hoarding disorder over the past few years. These programmes have been a *double edged sword*, on one hand raising the awareness of HD and on the other sensationalising the disorder and negative connotations by increasing the negative beliefs surrounding this disorder, stigma and repulsion by the general public. I have been approached on a number of occasions to participate in these television programmes but I declined to participate based on my reflections and reflexive practice on the programmes. My reflexive practice raised the ethical issues and the potential harm it could contribute for the participants in the longer term. Some of the questions raised for me were: “What is the impact of participating in the programme for the individual?”, “How helpful is this to them?”, “What are the potential negative experiences they might experience?”, “What support mechanisms are in place?”. I participated in the *National Geographic’s Taboo Series* (2011) (PW 3.17) on HD demonstrating a treatment session at a participant’s home. Randy Frost, the world’s expert on hoarding disorder, provided a commentary on my

interventions. The key motivations for my participation in this programme were, firstly, it followed clear and sound ethical principles and secondly, it conveyed the message of hope and that individuals with HD could be helped with treatment.

Over the years, with the teaching and training that I have provided, I have come to be considered as a resource for local authorities, emergency services and individuals with HD. Because of the lack of services and clinicians working in this field, I have had the added responsibility of supporting individuals with HD in issues relating to evictions, environmental and housing orders. It has been demanding on my time but I have striven to support them the best I can by writing letters to inform the authorities about HD and the impact on the individual. Over the years, it has led me to develop professional relationships with other non-health professionals (PW 3.54, 3.55, 3.56, 3.57, 3.58, 3.59 3.60, 3.61, 3.61a, 3.62, 3.63, 3.64, 3.65, 3.66, 3.67, 3.68, 3.69, 3.70). This has also contributed to my reputation in the field of HD. Professionals such as environmental health officers, fire and housing officers and health care professionals often contact me for consultation when dealing with complex cases especially on engagement issues and interventions (PW 3.54, 3.55, 3.56, 3.57, 3.58, 3.59 3.60, 3.61, 3.61a, 3.62, 3.63, 3.64, 3.65, 3.66, 3.67, 3.68, 3.69, 3.70). I have also been called to act as an expert witness for local councils' community safety committees to inform and advise them on HD, which reflects the acknowledgement within the wider community of my knowledge, skills and contribution in the field of HD. I am a member of the Chief Fire Officers Network's hoarding working group (PW 3.78, 3.79). This group has a national representation from fire officers, professionals and other services dealing with individuals with hoarding issues. It has provided me with the opportunity to influence the development and implementation of protocols (PW 3.64). My main area of focus is raising the awareness, understanding and accepting of HD as a psychological condition and the need for support systems for professionals who work with individuals with HD (PW 3.25, 3.26, 3.27, 3.28, 3.29, 3.30, 3.31, 3.32, 3.33, 3.34, 3.35, 3.36, 3.37, 3.38, 3.39, 3.40, 3.41). Reflexive practice on my personal work has highlighted the demands and the impact of working with these individuals; I

have had to ensure that I practised good time management to balance professional demands and personal needs. The need to develop support mechanisms for professionals is often challenging, demanding, draining and requiring intense intervention to safeguard their physical and mental well-being.

2.3 Research collaboration

Collaborating in research has been a significant part of my personal and professional development (PW 3.04, 3.08). As a practitioner researcher, I am constantly undertaking informal or private research based on my observations, interactions between my patients and me, interactions between theory and practice, and therapeutic relationship processes, amongst others. In CBT the collaborative relationship enables the practice of constant interplay of the research process between the therapist and patient in testing out and challenging assumptions, beliefs, and predictions resulting from the individual's experiences and how they make sense of the world. Morris and Chenail's (1994) simple distinction of private and public research helps contextualise what a therapist basically does. Private research can be understood as researching our interactions with our patients on an everyday basis including our observations which happen on a moment-to-moment basis, through reflection (Schon, 1983), during and post-sessions, during supervision, peer support and continued continual professional development. Morris and Chenail (1994: 2) write:

By private research we mean the type of inquiry which is done everyday by reflecting practitioners in the course of their daily practice and they can re-search their interactions both during conversations with their clients and afterwards. The purpose of this research is to share the inquiry with practitioners and clients. These studies are usually conducted informally and their results are used to make decisions in and about treatment.

Public research can be understood as the more formal intent, structure, rigour and execution. Morris and Chenail (1994: 3) state:

By public research, we mean those studies that are more formal in intent, structure and execution. These are types of research that are presented at professional conferences and that are published in professional journals. The methods are clearly articulated, contexts of talk are analysed in intricate detail and descriptions of clinical moments are rich and exhaustive.

It is our private research that develops ideas for public research. In the course of my work facilitating LHTG, my observations found a number of group participants who presented with trauma, stressful early life events, emotional and material deprivation. My reflexive practice helped me to recognise this through questioning my observations: “What is it that I am noticing?”, “What are the common features these individuals are presenting with”, “Is there a link with their hoarding behaviours?”, “What do the hoarding behaviours represent?”. This observation is a good example of private research. Research can be defined in its simplest form as *getting a better understanding of the reality* (Wengraf, 2001: 4). As therapists, it is part and parcel of our daily work to attempt to understand or make sense of our patients’ reality in order to be able to understand the world they live within. These findings were discussed with the researchers at King’s College London, which led to my collaboration in their ethics-approved quantitative study conducted by Laundau et al. (2011) to understand the link between the onset and worsening of hoarding behaviours, and the connection between the level of material deprivation and HD (PW 3.04, 3.06) controlling for OCD. This study made use of a range of standardised clinician-administered measures, such as the *Mini International Interview* (M.I.N.I.; Sheehan et al., 1998), *Structured Clinical Interview for DSM IV* (SCID-II; First, Gibbon, William et al., 1994), and the *Dimensional Yale-Brown Obsessive Compulsive Scale* (DY-BOCS; Rosario-Campos et al., 2006). Self-administered measures included the *Saving Inventory-Revised* (SI-R; Frost et al., 2004), *Obsessive-Compulsive Inventory-Revised* (OCI-R, Foa et al., 2002), *Beck’s Depression Inventory* (BDI; Beck et al., 1961) and *Trauma History Questionnaire* (THQ; Green, 1996). Two semi-structured interviews, first for the *temporal relation between life events and*

symptoms onset was developed for this study and the second material deprivation an extension of the range of questions asked by Frost and Gross (1993) were used to obtain data that either supported or disputed the two main hypotheses. This study was conducted after obtaining ethical approval. Researchers can have different roles within a study. I facilitated the recruitment of participants for this study, and contributed to the findings, discussions, and conclusion. A challenge that I faced in this study was that a number of participants attended the LHTG and were known to me. Reflecting on past experiences, I am aware that there is a possibility that researchers could “contaminate” or influence their study. Through reflexivity, I ensured that I did not contaminate the research and reduced researcher bias by limiting my interactions and discussions about the study with the participants. In relation to the collaborative researchers, I did not discuss the participants and the prior knowledge that I had of them with the aim of reducing researcher bias. The key learning that I gained from this study are the challenges that researchers face and the importance of peer supervision and discussions to help overcome them. Through my reflexive practice, I made the decision to be involved in the analysis of data that was anonymised, contributing to the discussion and conclusion of the study.

Statistical analyses such as the Shapiro-Wilk Test, ANOVA, Tukey’s post hoc test to account for multiple testing, non-parametric (Mann-Whitney and Kruskal-Wallis and Spearman’s rho (two-tailed) tests were used to analyse the data. In addition to this, Pearson’s chi-square and Fisher’s exact test were used for the categorical data. The results from the analyses of the data from this study suggest that the total number of traumatic life events correlated with the severity of the participants’ hoarding issues but not of obsessive-compulsive symptoms (Landau et al., 2011) (PW 3.06). This study also found that half of the participants with HD linked the onset of their hoarding issues to stressful life events which were not the case for those who had a childhood onset of the disorder. As a clinician, it is very important to understand the link between traumatic life events and the onset and development of the disorder. This may help develop the clinical formulation of HD and the application of

more effective treatments to target and deal with the underlying issues that maintain and perpetuate the disorder.

It is important to consider the strengths of this study. The data obtained through the use of standardised measures provide reliability. The results were able to elucidate some key features and risk factors associated with HD, with a particular focus on the role of trauma, stressful life events and material deprivation. However, the weaknesses of the study are that the sample size is small and the results are underpowered. There were also other factors that were difficult to control, such as the dependence on the participants' recall of their time lines as a result of memory biases, lack of understanding, and their full participation. Longitudinal studies should be considered to overcome these limitations. Larger-scale studies in the future will be needed to confirm these findings.

Experiential avoidance is a key feature of many emotional disorders such as OCD, generalised anxiety disorder, post-traumatic stress disorder, and trichotillomania and skin picking (Abramowitz et al., 2009; Begota et al., 2004; Chawla & Ostaffin, 2007; Flessner & Woods, 2006; Kashdan & Kane, 2011; Newman & Llera, 2011). Experiential avoidance can be defined as a tendency to avoid contact with specific unwanted internal experiences such as bodily sensations, emotions, thoughts and memories (Hayes et al., 1999). The current existing model of pathological hoarding behaviour appears to be consistent with the experiential avoidance model (Frost & Hartl, 1996; Steketee & Frost, 2003). For example, the model suggests that saving possessions as opposed to discarding them enables an individual to avoid distressing feelings associated with the action or thought of discarding, such as loss or a fear or having made a mistake. My reflective thought in relation to this issue is: "This certainly is consistent with the presentation I have seen". In my reflexive practice, my questions are: "What is the individual saying to themselves when they experience these emotions?", "What is the role of their self-talk in maintaining their anxiety?". A study by Wheaton et al. (2011) found that experiential avoidance significantly correlated with hoarding symptoms

when measured using the Savings Inventory-Revised (SI-R; Frost, Steketee & Grisham, 2004).

My reflections of the work that I have undertaken with individuals highlighted that experiential avoidance is a factor that needs to be considered in the treatment of HD. The perceived or actual negative emotions experienced by individuals often lead them to avoid or engage in behaviours that perpetuate and maintain their hoarding problems which I observed to be the case when working with these individuals. My reflexive thoughts are: “The avoidance of emotions/distress is the maintaining factor in the behaviours”, “It is often recognised as avoidance; however, we need to help them recognise the function of the behaviours”, “This may be beneficial to help them recognise the link between their avoidance and maintenance of their hoarding issues”. Barlow (1991) suggests that emotional deregulation may be a predisposing factor for the development of a wide range of emotional disorders. I have found it a challenge in dealing with experiential avoidance when working with individuals with HD which affects their treatment and outcomes. In an attempt to understand fully about this phenomenon, I collaborated in a quantitative study by Fernandez de la Cruz et al. (2013), which had ethical approval from Kings College London Ethics Committee, to understand the role of experiential avoidance and emotional regulation difficulties for individuals with HD (PW 3.04, 3.07) controlling for OCD. This was the very first study that had been undertaken to examine the role of experiential avoidance and the broader difficulties in emotion regulation in individuals suffering from HD. The data were collated through the use of standardised clinician assessments such as the *Mini International Neuropsychiatry Interview* (M.I.N.I.; Lecrubier et al., 1997), and standardised self-report measures such as the *Saving Inventory-Revised* (SI-R; Frost et al., 2004), *Obsessive-Compulsive Inventory-Revised* (OCI-R; Foa et al., 2002), *Acceptance Action Questionnaires* (AAQ-II; Bond et al., 2011), and *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004). The clinician-administered and self-reported measures have good reliability (test and retest) and validity. My role within this study was to recruit participants suffering from HD, HD with comorbid OCD and healthy controls. The participants recruited for the study were provided

with the opportunity to ask questions before consent was sought. Statistical analysis was applied to the data collected using the Shapiro-Wilk test, independent t-test or one-way analysis of variance (ANOVA), Tukey B post hoc to correct for multiple testing, and non-parametric tests such as Mann-Whitney and Kruskal-Wallis were also used for the analysis. I contributed to the analysis of the findings, the discussion, and conclusion. I found it a challenge to ensure that I did not influence or coerce individuals to participate in the study as this proved to be an ethical dilemma. Reflexivity helped me to deal with this, to consider the best way to proceed, as the knowledge gained would be for the greater good, promoting understanding and an opportunity to provide the appropriate treatments. Robson (2002: 11) states:

The research relationship is between two equals and is not exploitative: the client organisation is merely 'used' to develop academic theory or careers, nor is the academic community being 'used' (brains being picked). There is a genuine exchange. The research is being negotiated.

Personally working within the specific roles, parameters and through reflexivity enabled me to deal with these challenges and having a clear vision of the aims of the study rather than focusing on the outcomes.

The results found that individuals with HD reported a higher level of experiential avoidance and difficulties in emotional regulation compared to healthy individuals but not to those with comorbid OCD, raising some interesting and useful clinical implications for the treatment of HD. This study prompted me as a clinician to start considering and developing novel methods of engaging individuals with HD as the standard treatment model could not be applied across the range of HD presentations. Through reflexivity, I was able to develop creative and innovative novel methods of engaging with individuals (PW 3.09, 3.10, 3.11), which will be discussed later in this section.

The strengths of this study are that it is the first study on the subject of experiential avoidance in relation to HD, and will promote further studies

employing multiple methods (observational and experimental) to further develop the hypotheses. The use of standardised measures ensured that the data were consistent and reliable. The weakness of this study is that the cross-sectional design did not allow for a better understanding of the causal relationships of the studied variables. The four study groups were carefully selected, but the numbers remain small and the analyses may have been underpowered. Participants from the study group were not perfectly matched. The findings were exclusively based on the use of self-report measures, which may be significant as many individuals with HD have limited insight into their problems and so may not have responded accurately.

The majority of the published research on HD is quantitative, little or no qualitative research has been undertaken in this area. The limited qualitative published research has focused on the experiences of family members and professionals working with those with hoarding issues (Kellet et al., 2010; Tolin et al., 2012; Tolin et al., 2010; Wilbram et al., 2008). My experiences and observations in providing group therapy based on the multimodal therapy model identified a number of deficits when working with patients. On reflection, one of the main deficits identified with this model was to do with engagement in therapy, which has been a challenge for me as a therapist, as engagement is a key feature of therapy. The level of engagement has been variable and demonstrated by not undertaking the homework task or action points discussed in the group session.

This led me, together with my colleagues, to explore avenues as to how to improve the engagement of individuals in their therapy to help them achieve their goals in dealing with their hoarding issues (PW 3.01a, 3.08). My reflexive practice led me to conclude that challenging their behaviours has not been helpful and to question: "What is it that we are doing that is not working?", "What is it that is wrong?", "What else can we try?", "What do we need to do differently?". Each consideration had to be balanced with the potential benefits and within the ethical bounds of therapy. Frost et al. (2008) developed the *Clutter Image Rating Scale* as a tool to rate the severity of clutter in each of the main rooms (e.g. living room, bedroom, kitchen). The

use of this tool highlighted to me the impact of using visual images. As part of the therapy intervention, patients are encouraged to take photographs of their cluttered environment firstly, to provide an opportunity to assess the severity of the problem and secondly, to serve as a record to measure any change that may have taken place. To potentiate the value of these photographs my co-facilitator and I encouraged patients attending the group therapy session to measure the severity of their clutter using their photographs against the *Clutter Image Rating Scale* (Frost et al., 2008). This is an example of practice-based private research (Morris & Chenail, 1994). My observations were that the patients not only related well to this scale using photographs of their environment but they also used it as an interpretative element enabling further exploration of their hoarding issues. My reflexive practice helped me to consider the use of photographs as a means of engagement as a result of their response to the use of the *Clutter Image Rating Scale* (Frost et al., 2008). My observations led me to critically consider the use of photographs as a visual tool for individuals to understand their hoarding phenomenon as it enables subjective (personal) interpretation of their condition.

I considered the research question based on my experience of using the *Clutter Image Rating Scale* (Frost et al., 2008) would enable exploration and understanding of the individuals' experience of hoarding disorder. Identifying the research question is one of the most difficult stages in the research process (Moule & Hek, 2011: 78). Finlay and Ballinger (2006: 34) state:

The research question is the most important statement we have to make about our subject matter and the mode of investigation. It is also the most difficult. It is easy for the novice researcher to drift into method, deciding strategies for data collection without determining what they want to study, why and with what epistemological perspective.

The research question provides the vehicle for how the question will be answered. Farhady (2013: 1) outlines three terms that define research: a question, a systemic approach, and an answer.

In my study involving the patients attending the LHTG, to answer the research question I considered the epistemological underpinnings leading to the use of visual research methodology, essentially a qualitative research design which developed from the use of photographs in therapy (PW 3.09, 3.10, 3.11). Visual methods can broadly be defined as the use of photographs and video material as the main component of data collection. The inception of this research methodology was a deliberate attempt to balance the power between the researcher and the participant (Stanz, 1979). The use of visual images is powerful in engaging individuals in the research process and could explain the reasons for its increasing acceptance in the health and social science field (Warren, 2005; Knoblauch et al., 2008).

This study was constructed to understand the experiences of individuals with hoarding behaviour by using a participatory photographic method (PW 3.09). This methodology is a hybridisation from *Photovoice* (Wang, 1999) and *Photo Elicitation Method* (Harper, 2002). *Photovoice* allows the participant to take photographs of salient points in their life experiences – in this case, their cluttered environment – and to present them with a detailed narrative in either a group or individual interview situation. The benefits of this approach are that it incorporates empowerment and reflection and attends to the balance of power between the researcher and the participant. In reflection, I learned that it is important to be open to different methodologies to help understand the phenomena presented.

I collaborated in this study with a researcher from an academic institution who had the experience and knowledge of visual methodology (PW 3.08). Undertaking research requires careful negotiation with all parties and to clarify specific roles to ensure that the research is to function as planned. My reflexive thinking at this point was: “How do we explore the meaning of the images?”, “What are the key questions that can be asked that would facilitate an understanding?”, “How can these questions relate to the hoarding issues?”, “What could make it accessible and engage the person?”. “What have other studies done in this area and what was helpful or unhelpful?”. To

be able to explore fully the potential of the research question using visual methodology we developed the H.O.A.R.D Acronym Tool to help the participants use photographs to narrate their story (Singh & Jones, 2012) (PW 3.09). This tool was developed as part of my observations, reflections and reflexive practice whilst engaging individuals (patients and professionals) to use the *Clutter Image Rating Scale* (Frost et al., 2008). I observed that individuals related well to photographs and there is the potential to enable exploration through their narration of the photographs. The H.O.A.R.D Acronym Tool (Singh & Jones, 2012) uses exploration through description of the participants' photographs, motivational interviewing (Rollnick & Miller, 1995) through the impact of hoarding issues on their space, life and relationship, the potential for change, and developing steps to deal with their clutter (PW 3.09).

The participants were invited to take photographs of their environment and were later asked to answer the questions as outlined in the tool in both a neutral place and their own environment. In engaging with the participants of the research there needs to be honesty, trust, respect, and empathy. Josselson (2011: 46) writes:

...in order to obtain rich and meaningful material in the interview, we enter a relationship of trust, respect and empathy with our participant – an I-Thou relationship in Buber's terms.

Reflexivity plays an integral part in research regardless of the epistemological stance. Fox, et al., (2007: 157-8) refer reflexivity as a process to help the researcher to habitually consider the researcher's impact on the research:

Reflexivity means at every stage...the practitioner has influence, consciously or unconsciously, the process and has been influenced in turn by the research process....Practitioner researcher should habitually stand back from the activities and examine reflexivity at every stage of decision making in relation to the operation of research.

One of the challenges I faced in undertaking this piece of research was the impact of my personal interest in the study and the potential of this to influence the results. Josselson (2011: 46), discussing the relationship between the researcher and participant in relation to this, adds:

We hold this doubleness at all levels. The ethical problems here ensue from the fact that, in order to obtain rich and meaningful material in the interview, we enter a relationship of trust, respect, and empathy... We then take ourselves out of this relationship to communicate about the conceptual matter with our peers, making use of the interview material in an I-it manner.

This is a challenge that I faced whilst interviewing participants as there were a number of levels of engagement: firstly, I have a relationship with them as the treating clinician; secondly, as the researcher. Josselson (2011: 46) highlights the importance of the process of reflexivity in helping the researcher step back, removing his personal views, concerns, and knowledge of participants to reduce the bias driven by the personal interest of the researcher. Receiving peer supervision prior to the interviews and the data analysis process helped me develop a stance of being an external observer yet still immersed in the study, reducing the risk of bias, a constant tension that had to be negotiated. Within my reflexive practice, I questioned myself: “What is my interest in this study?”, “What is my knowledge and how am I relating it to the study?”, “What are my values, ideas, and understanding?”, “Am I am influencing the study with my values, ideas, and understanding?”, “How are the findings related to my research ideas?”, “Do they fit?”. I ensured that the interviews were audio recorded, transcribed by another clinician and, after the analysis of content, checked by an experienced clinician not related to the research to check for validity. This process helped me develop the skill of dealing with the *doubleness* as described by Josselson (2011: 46) which enables me to step back when dealing with other situations, e.g. when dealing with the individual and their external agencies.

Reflexivity played a critical role to help me distance myself to ensure that during the data gathering and data analysis my personal process did not influence the data. The framework analysis (Ritchie et al., 2013) approach was employed. The rationale for using this approach is that it is case- and theme-based, uses a matrix display, reduces data through summarisation and synthesis, retains links to the original data, and the output facilitates comprehensive and transparent data analysis. Working collaboratively with my colleague research collaborator provided me with the additional stance for reflexivity in our discussions and in peer supervision during the process. This process worked both ways for us. In undertaking the data analysis we identified seven key themes related to the participants' experiences of their hoarding behaviours. The study demonstrated that the participants related to the hoarding issues and did not trivialise or deny the problem. The study concluded that the participants experienced a variety of distressing limitations to their lifestyles with potential negative impact on their mental health. The use of visual methods in the study proved to be encouraging due to their potential in facilitating individuals to engage with their hoarding problem. An interesting finding from this study is that visual methods methodology is also an intervention in therapy.

Fernandez et al.'s (2013) (PW 3.07) study examined the role of experiential avoidance and the broader difficulties in emotion regulation in individuals suffering from HD. One of the resulting effects of experiential avoidance is that individuals do not deal with their hoarding issues as they assume that it will be emotionally distressing. In another study, my collaborator and I (Jones & Singh, 2013) (PW 3.10) used the H.O.A.R.D. Acronym Tool (Singh & Jones, 2012) (PW 3.09) as an emotionally distancing mechanism, which enabled the participants to deal with their hoarding behaviours (PW 3.08). In this novel technique, participants were asked to take photographs of their environment and as in the previous study were asked to answer the questions in the tool in both a neutral place and their home environment (PW, 3.09, 3.10). Again, as previously discussed, my reflexive practice helped me to be aware of my biases and of the potential of these biases influencing the findings. The framework analysis (Ritchie, et al., 2013) approach was used. The benefits of

this approach are that it allows data analysis in two approaches: data management and congruent or sequential interpretation. It also allows for a second approach, which orders the data to facilitate interpretation via thematic analysis, typologies and explanatory analysis. We analysed the data and five key themes were identified. It was found that when outside their home environment, the participants experienced an emotional distancing facilitating an entirely different reflection and subsequent understanding of their hoarding issues (PW 3.09). Additionally, participants were surprised to have rediscovered aspects of the environment lost beneath their hoard. An interesting and unexpected finding from the study was that participants noticed a loss of vibrancy and environmental colour (PW 3.09). Participants identified their environment as dark, dull, drab and colourless, lacking vibrancy (PW 3.09). The use of emotional distancing as a technique to enable individuals with hoarding issues to step back, reflect and envision how they would like the environment to look can be a motivational factor for them in dealing with their hoarding issues (PW 3.09, 3.10). By reflecting and being reflexive (“What is the impact of colour for these individuals”, “Can colour provide motivation?”, “Can colour help keep the individual focused?”, “Should they use a colour the relate to?”) I was able to consider how to use these findings in the work that I undertake with the participants of the group.

There has been previous research in the physical and psychological aspects of colour and its application to illness and healthcare (Carruthers et al., 2010). However, there has been no prior research in colour and HD. In a study on colour in waiting areas, it was found that using the right colour combinations in hospital waiting areas had an impact on user motivation and stress levels (Zraati, 2012). Colour choice has been identified as an important variable in the design of healthcare environments that strive to create a calming and relaxing ambience for those using services (Zraati, 2013). The accumulation of clutter leading to the covering of all the available space and occluding the light results in an environment that are dull, drab and lacking in colour. The identification of the lack of vibrancy and emotional colour in the participants’ environment led my collaborator and I to consider another research project involving colour prompts to be used by individuals when dealing with their

clutter (PW 3.08, 3.09, 3.10 3.11). The purpose of the study was to understand the psychological benefits of colour and the potential benefits it could have on the environment for those with hoarding problems (Jones & Singh, 2014). Participants in the study were invited to choose a colour of their liking (A4 card) to be used in their home environment. Giving individuals a choice of colour may also be of benefit as the colours chosen may have some significance for them thus motivating them to deal with their hoarding issues (PW 3.11).

The framework analysis (Ritchie et al., 2013) allowed the data to be separated by themes and case or by a combination of themes and case. This study identified three main themes for individuals using the colour card: practical motivator, clarifying intentions, and metaphorical connection (Jones & Singh, 2014) (PW 3.11). The exercise of selecting the colour card could have rekindled an awareness of colour in improving their mood and influencing their motivation to deal with their hoarding issues (PW 3.11). Colour appeared to have a role in creating an ambiance within their home. The simple use of the bright colour card appeared to serve as a reminder of the colour that is hidden and concealed by the clutter and items hoarded (PW 3.11). The rediscovery of the colour within the environment (walls, floor, furniture, etc.) appears to motivate individuals in a positive way and as items are cleared the introduction of light within their environment influences the colour vibrancy (PW 3.11). Considering these findings critically led me to consider the importance of the use of colour in the treatment and further research is needed in this area. These three qualitative exploratory studies demonstrate the need to be creative, using visual methods which have been beneficial in engaging individuals to deal with their hoarding issues (PW 3.09, 3.10, 3.11).

My collaborator and I also conducted an online survey targeted at a range of professionals such as CBT therapists, housing officers, environmental health officers, and support workers on their views of working with individuals with HD (Singh & Jones, 2015) (PW 3.08, 3.14). Through reflexivity (“How can we involve a range of professionals in a study?”, “What would be the easiest way to reach them?”, “What are the current survey methods?”), we decided on this

method due to the variety of professionals involved, in diverse geographical locations, and assured anonymity. Wright (2005) outlined the advantages, disadvantages, and limitations of internet-based research; however, it has gained popularity over the last ten years (Convery & Cox, 2012). The study contained eight short questions with free text boxes to allow elaboration (PW 3.14). The framework analysis (Ritchie, et al., 2013) was employed as with the online survey the data were organised and could be reduced, retaining the link to the data and themes identified. The data analysis in this study identified four themes: difficulties in engagement, coping with complexity, building trust and rapport, and lack of support and training (PW 3.14). We recommended that professionals working with these individuals needed training in HD and have better defined job roles outlining their involvement with these issues (Singh & Jones, 2015) (PW 3.14). Online studies pose the challenge of trusting the respondents to be the professional target as there is no mechanism built in to check the reliability and validity of this. However, the survey was only sent to professional email addresses which provided the safeguard that it was potentially the selected professional group who responded.

The benefits of using framework analysis are not tied to any specific epistemological position, and it renders flexible, straightforward teasing out and organisation of the data (Gale et al., (2013). It enables the researcher to be fully immersed in the data. The strong emphasis on data management improves the transparency and audit trail of where the interpretations have come from, making it possible for reviewers to trace findings back to the raw data. This is useful when research is being undertaken by a team, as it allows the process to be logged and for the work of individual members to be systematically reviewed.

However, there are limitations, such as the potential for the researcher to engage in the data mechanically and treat the five stages as mechanical steps to follow. There is the potential to shift away from the research question, especially when there is a large data set to be managed. Indexing subjective data is complex, as it is not easy to summarise, and researchers need to keep

in focus the research aims and question to help manage this process. It is also labour- and time-intensive.

The strengths of qualitative research are that issues can be examined in detail and depth. Data based on human experience can be more powerful than quantitative data, and the direction of research can be revised as new information emerges. Data are collected from fewer cases. Interviews are not restricted to specific questions and can be guided/redirected by the researcher for clarity. It also allows for subtleties and complexities about the research participants to be discovered, which are often missed or overlooked in quantitative research.

The limitations of qualitative research are that the quality of the research is dependent on the skills of the researcher and can be easily influenced by the researcher's biases and idiosyncrasies. Additionally, the presence of the researcher can affect the participant's responses. Findings from qualitative studies are usually based on smaller numbers of participants and cannot be generalised to the wider population. Rigour is more difficult to maintain, assess and demonstrate, and requires good record-keeping and journaling of the process of research. The process is also time-consuming in terms of data collection, analysis and interpretation. The scientific community can be critical of qualitative research. The results are more difficult and time-consuming to present in a visual format, and often tend to be presented in verbal format.

Collaborating in these quantitative and qualitative research projects has developed my understanding, capability, and ability to engage in the research process. I have been able to appreciate the different epistemological stances and associated paradigms that can be engaged to help investigate the research questions and hypotheses for the studies. The collaborative nature of these studies enabled me to contribute to each of the projects within the parameters of my role. I appreciate the role of the statistician in assisting in the data analysis and report the findings. Being involved in the task of transcribing the qualitative data (interviews) helped me to be immersed in the data, facilitating the data management and analysis within framework

analysis. It has enriched my understanding of hoarding disorder from the different epistemological approaches.

I was invited to be one of the contributors to a project titled *This Mess is a Place* (Mendelson, 2013) as a recognised specialist in the field of HD. This interdisciplinary project, funded by the Wellcome Trust, explored the boundaries of hoarding (inability to discard) and collecting (PW 3.19). It also allowed a cross-disciplinary project to develop in parallel to contemporary interest in archives and collections. Placing collection and compulsion together in theory and practice combines psychiatric research into hoarding (a new area in the UK with little support for sufferers) with current debates within contemporary art and archival practices (PW 3.19). The project produced *This Mess is a Place: A Collapsible Anthology of Collections and Clutter* to which I contributed a chapter titled Hoarding – Miss Havisham Syndrome (Singh, 2013) based on Miss Havisham, a character in decay, surrounded by her hoard, who had underlying loss issues, in Charles Dickens's novel *Great Expectations* which is well-read and with which people are familiar (PW 3.19). I developed the idea for my contribution to this project through reflections of my past reading and reflexively ("What have I read that has issues of hoarding?", "How was Miss Havisham portrayed?", "What was Miss Havisham representing?", "How does this relate to or parallel hoarding?") considering the character of Miss Havisham and the relationship to hoarding disorder. It was a rewarding project to contribute to as it challenged my concept of hoarding being a modern-day induced problem (PW 3.19).

I was invited to be involved in another on-going project on HD funded by the Wellcome Trust titled *The Squirrel Project/Even if I do it on purpose* (Hampton & Hewitt, on-going) in recognition of my expertise in the field (PW, 3.18). This project focused on discarding hoarded items by selling them on eBay, exploring the individual's experiences, challenges and resilience. I advised on and supported the application for funding from the Wellcome Trust (PW 3.18). My contribution to the application was in my discussions with the researchers as to how the project could add to the body of knowledge and qualitative aspects of the project on the lived experiences of both the subject and

researchers (PW 3.18). The project team employed me in a consultancy role, drawing on my expertise in dealing with hoarding issues (PW 3.18).

It has been a rewarding experience to engage in collaborative work, and I have developed both personally and professionally (PW 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.16, 3.18). Research is complex especially when applying for ethics permission and collaboration provide the support and mechanisms to deal with issues that arise. Research ethics are in place to safeguard the interest of the participant. Even though I am engaged in reflexive practice it is difficult to consider all the potential areas that could compromise the participant. Research ethics provide clear guidance on the format, language and acceptability parameters. The collaboration with others enabled me to fully engage in the process as it reduced the intimidation of the whole exercise (PW 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.16, 3.18). Being involved in the application for a research grant from the Wellcome Trust was valuable experience in understanding the complexities in making an application for funding and the need for collaboration with others in the process (PW 3.18). The invitation to collaborate in research on a personal level demonstrated the recognition and value of my contribution to the field. As a collaborator in the research, the discussions, exchange of ideas and views, synthesis of hypothesis, and agreements and disagreements provided me with validation of my knowledge and developed my confidence to test out my assumptions and ideas (PW 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.16, 3.18). From my experience, I have found that collaborative work is very different from undertaking research as a lone researcher. Undertaking research as a lone researcher is stressful and complicates reflexivity, as it is difficult to gauge the degree of immersion in the study and can lead to biased results. The experience of collaborative work has provided me with confidence and courage to be creative and innovative in the development of the LHGT treatment protocol in the form of the self-help book *Overcoming Hoarding* (Singh et al., 2015) challenging the current CBT model of treatment (PW 3.01). It has also helped me realise my resilience in dealing with the challenges that arise when dealing with issues as they develop. I have gained

a sense of belonging in a world of improving treatments and gone far from my initial trajectory of progression. I never assumed that I would have engaged in research and contributed to the body of knowledge as I have done, which challenges the assumptions I held.

2.4 Dissemination

HD has recently been identified and included in the *DSM 5* (APA, 2013) as a condition in its own right, yet there are little or no mental health or psychological services available for the treatment of this condition. It has been my experience that there is a gap in information, research outcomes and sharing of good practice for HD. Although there are some demonstrable outcomes of research findings there still a reluctance to put research findings into practice. There are many possible reasons for this, such as lack of available resources, access to peer-reviewed professional journals, training or interest from practitioners. This has been a major challenge for me in terms of disseminating research outcomes and sharing of good practice. There are numerous ways information can be disseminated, however, it is important to identify and select the most appropriate method that would be most effective in reaching the widest audience. In consultation and discussion with colleagues and peers in the field, it was suggested to disseminate information through peer-reviewed journals, which allows for a wider range of clinicians, facilitating clinical skills workshops and master classes for clinicians (PW 3.01a, 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.15a, 3.25, 3.26, 3.27, 3.28, 3.29, 3.30, 3.31, 3.32, 3.33, 3.34, 3.35, 3.36, 3.37, 3.38, 3.39, 3.40, 3.41, 3.42, 3.43, 3.44, 3.45, 3.46, 3.47, 3.48, 3.49, 3.50, 3.51, 3.52). The challenges faced included identifying the journals that would have the maximum impact by reaching the right audience. To publish articles and research findings is a lengthy process. I learned the importance of having conversations with the editors of the journals to discuss the suitability of my articles for their journal. In addition, it is important to follow the author guidelines for the presentation of the paper. This helps increase the likelihood for the article to be published within a shorter time frame. I found the rejection of articles intended for publication by the journal editors difficult but it has

taught me to appreciate the feedback, which has helped me improve my academic writing style and accept that some of my work may not be of the required standard.

The LHTG has received attention as a pioneering treatment group. I was invited to contribute a chapter in a book on HD in the Netherlands (PW 3.03). Through reflexivity, I decided that the book chapter titled *Behandelopties voor problematische verzmelaars (Group therapy for individuals with hoarding disorder)* (Singh, 2012) would be another avenue to raise awareness, understanding of the disorder, and the application of group therapy as a treatment option (PW 3.03). I developed an online learning module, *Engaging with individuals who hoard* (Singh, 2014), for those who work within the social care sector (PW 3.15a). Engagement in treatment with individuals with hoarding issues has been an area clinicians have found difficult (PW 3.09, 3.10, 3.11, 3.13, 3.14, 3.15a). This has limited the support and treatment individuals could receive. I felt it was an important aspect of therapy that needed to be addressed. I published two practice articles in mental health and CBT academic peer-reviewed journals: *Engaging in treatment sufferers of compulsive hoarding disorder* (Singh & Jones, 2013a) and *Novel method in engaging compulsive hoarders in treatment* (Singh & Jones, 2013b) to help clinicians develop skills in engagement (PW 3.12, 3.13).

I have been invited to facilitate workshops and present at conferences. Conferences are an ideal venue to present research findings, to generate interest and promote discussion among professionals working in the specific field (PW 3.42, 3.43, 3.44, 3.45, 3.46, 3.47, 3.48, 3.49, 3.50, 3.51, 3.52). I have presented at a number of national and international conferences, including at the Mental Health Association of San Francisco's annual *International Clutter and Hoarding Conference* (PW 3.42, 3.43, 3.44, 3.45, 3.46, 3.47, 3.48, 3.49, 3.50, 3.51, 3.52). Presenting at conferences has provided the opportunities to network with other professionals and develop professional links: an example of this was the invitation to present a full-day post-conference workshop on HD at the *Institute for Challenging Disorganisation, 2016* in Portland, Oregon (PW 3.42, 3.43, 3.44, 3.45, 3.46,

3.47, 3.48, 3.49, 3.50, 3.51, 3.52). The outcome of the networking has been positive, affording me greater opportunities to share good working practices. My reflexive practice (“What are the issues presented here?”, “What are they doing differently?”, “How can I contribute to what is already known?”) has helped me engage with others by attending to the specific issues and by being focused.

My publications have gained interest in the clinical field (PW 3.75, 3.76, 3.79, 3.80, 3.81). I have been invited to facilitate workshops on the treatment of HD for therapists (PW 3.41). This is encouraging as there are now more therapists who are showing an interest in the field of HD. It is a complex disorder requiring additional training to be able to engage and work therapeutically with affected individuals. It is to be hoped that with the increased interest there will be opportunities for more individuals to access therapy for the presenting issues.

I have been invited to undertake scientific academic reviews on HD as a testament to my knowledge, skills, and contribution to the body of knowledge in this field by a range of therapy journals (CBT and psychotherapy) (PW 3.20, 3.21, 3.22, 3.23, 3.24). Scientific academic reviews require practitioners to have a wealth of experience and recognition within the therapeutic community as an expert in the field. The process is both engaging and challenging. Each review has provided me with the opportunity to have a deeper understanding of and insights into the assumptions and ideas of other researchers in the field (PW 3.20, 3.21, 3.22, 3.23, 3.24). It enriches my reflexivity process when I am working with individuals as I have a greater wealth of information and understanding to help me deal with issues as they arise.

My reflexive practice (“How can I reach the greatest number of individuals?”, “How can I share good practice and findings to improve engagement and the interventions offered?”) has enabled me to consider the route to disseminate the research findings and information about the disorder. It is challenging to present at conferences as it is difficult to gauge the information that needs to

be presented. Being reflexive in the moment (“What is happening here?”, “How do I deal with it?”) has enabled me to react and deal with these challenges by considering them to be an opportunity to engage others, for example involving others in discussions. The process of dissemination has been a steep learning curve for me as it has made me push my safety boundaries and take risks that have helped me to develop both personally and professionally (PW 3.01, 3.03,3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.42, 3.43, 3.44, 3.45, 3.46, 3.47, 3.48, 3.49, 3.50, 3.51, 3.52). It has also enabled me to value the knowledge that I contribute to the field and body of knowledge (PW 3.01, 3.02, 3.03, 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.42, 3.43, 3.44, 3.45, 3.46, 3.47, 3.48, 3.49, 3.50, 3.51, 3.52). The ability to personally recognise this contribution has shifted my perspective of how I engage with others about HD as an expert and leader in the field. It is rewarding to observe the increased interest that therapists are showing in this disorder and makes me feel encouraged that services will improve over time to be accessible to those with hoarding issues (PW 3.64, 3.73, 3.74, 3.79,3.80).

2.5 Treatment model

Theory and treatment models guide practitioners in implementing treatment and day-to-day and minute-to-minute clinical decisions (Stiles 2010: 91). Stiles (2010: 91) goes on to say theories are ideas about the world conveyed in words, numbers, diagrams or other signs offer a distinctive set of assumptions and principles about nature and sources of (for instance) psychological problems and about approaches and interventions to address them. My personal experience of treating individuals with HD using the current published CBT model of treatment based on *Buried in Treasures* (Tolin et al., 2007), a book for the treatment of HD, led me to critically critique its utility in the treatment of individuals engaging in hoarding behaviours. The manual is based heavily on CBT principles, which does not allow the flexibility to attend to the emotional and experiential elements of the individuals’ experiences. It appears very technical and despite the formulation, it still lacks the personal element within. Being a practitioner-researcher has enabled me to observe,

implement and evaluate outcomes of the treatment model (PW 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.16, 3.18).

Engaging in the critical critique reflexively has made me consider the shortcomings of the treatment model. Challenging my views, beliefs and limitations of CBT as experienced during my work with these individuals. It is challenging to implement a treatment model through the use of a manual, as individuals are unique beings. Being a reflexive practitioner, there is a constant awareness of the individual need, enabling the synthesis of innovative and creative ways to engage and work therapeutically. I pushed the boundaries as a practitioner-researcher to engage in ethical private research with the patients in therapy by being creative and developing innovative interventions to deal with their underlying issues that perpetuate their hoarding behaviours, which I found engaging and effective. Creative and innovative interventions include the use of visual methods (Wang, 1999), both as a research methodology and intervention in the form of the *Clutter Image Rating Scale* (Frost et al., 2008) in therapy, and the H.O.A.R.D. Acronym Tool (Singh & Jones, 2012) which led to public research being undertaken to assess the utility of these interventions in helping individuals with HD to develop an understanding, motivation and engagement in therapy (PW 3.09, 3.10, 3.11). Many individuals with HD disorder express a lack of motivation of dealing with their clutter and hoarding behaviours. The H.O.A.R.D Acronym Tool (Singh & Jones, 2012) has elements of motivational interviewing (Rollnick & Miller, 1995), which helps individuals to reach the point of engaging in therapy to deal with their issues as demonstrated in the case study (appendix IV). I learned in this process the importance of engaging the individual to let them guide me as to what worked best for them (PW 3.09, 3.10, 3.11).

One of the challenges that I faced in therapy with individuals with hoarding issues has been accessing their emotions and beliefs. Through reflexivity I questioned (“What is about images that engages them?”, “Can it work with their own imagery?”, “Images are emotive”) the use of visual methods, which led me to consider using imagery (Singer, 2006) as a means to access

emotions and beliefs, which individuals found easier to engage in compared to the use of the downward arrow. The use of imagery in the sessions helped individuals to make the link between their emotions and beliefs without excessive interventions from the therapist. This process of guided discovery (Padesky, 1993) enables individuals to make the connections between their beliefs and emotions rather than an interpretation from the therapist. The Cognitive Behavioural model does not lend itself heavily into dealing with past related issues, e.g. childhood issues. It was observed that the treatment group participants expressed an expectation to understand where these beliefs and emotions originated from.

The practice of CBT traditionally focuses on the problems and goals. In my experience of working with individuals with hoarding issues often lead to a sense of failure when the goals are not achieved. One of the reasons for this is often due to non-accomplishment of tasks reduction of clutter as a result of the unrealistic goals that they had set themselves. The unrealistic goals are often related to their personal perfectionistic traits and high standards which is a common trait for those with hoarding issues. Through reflection and reflexivity, I concluded that the use of imagery (Singer, 2006) to access positive emotions could be a more beneficial way of identifying goals. The use of imagery to identify their goals through the use of the Vision (Singh et al., 2015) is demonstrated in the case study of Brigit, a participant in the group (appendix IV). The Vision encompasses the visual (imagery), emotions and beliefs for the change. The added advantage of using imagery aids the individual's motivation to change with the desire to experience the positive emotions that they had originally identified.

Through reflexivity ("What other ways can I use to access emotions and beliefs?", "What have I used in the past?") and discussion with my colleagues, I introduced the affect bridge technique (Watkins, 1971) a hypnotherapy/psychoanalysis tool to bridge the emotion experienced and the earliest memory associated with it. It was observed within the group that this technique helped them make sense of their hoarding experiences and develop a compassionate conceptualisation of their difficulties. Having a

compassionate understanding of their difficulties enables individuals to address their problems rather than casting blame onto others or themselves.

Part of the group therapy process is helping individuals develop an understanding as to the origins of their hoarding issues. Often individuals found it difficult to recall events from their past with regards to the trigger of the onset of their hoarding issues. Having had previous experience in using narrative writing (Epson & White, 1990) and therapeutic writing (Jolly, 2011), it was incorporated into the group programme and set as a homework task. I found that the impact of this intervention was interesting as individuals who completed it were able to make develop an understanding of the development of their hoarding behaviours, impact on their life and losses (relationships) they have had experienced as described in the case study (appendix IV).

As described in the case study the impact of implementing these creative and novel interventions within the group has been positive and benefited the individual (PW 3.09, 3.10, 3.11, 3.12, 3.13, 3.14 appendix IV). My observations of this process of engagement and change excited me as it was energising to see the positive developments for the group participants. Considering the wider issues reflexively, such as the limited access to help and treatment, led me to consider consolidating these experiences as a self-help book, using the model of treatment for the LHTG.

Self-help resources such as books are based upon many conventional psychological therapies especially Cognitive Behavioural Therapy or problem-solving approaches (Williams, 2002; Williams, 2003). Reflecting on my experiences of the group, my reflexive practice (“What is not working with *Buried in Treasures?*”, “What is missing?”, “What have I learned from the research undertaken and how can I introduce it into therapy?”) critically challenged the way the group functioned and the need to develop a treatment model that was based on the research I have collaborated in (evidence-based practice) (PW 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12, 3.13, 3.14, 3.16, 3.18). My reflective discussions with my co-facilitator (“What interventions we are using are working?”, “What creative ways have we

engaged the participants in?”, “What has not worked?”, “What has been challenging for us?”) helped me consider how best to develop the model. In group therapy sessions, as the facilitator, I was constantly engaged in reflexive practice to guide my interventions and contributions to the group. I kept a record of my observations and thoughts. The first step was considering the concepts of the therapy process, which led me to develop innovative and creative experiential interventions for the group; for example, the shift from goals to vision, from syntax to imagery, which is emotional and has a meaning attached to it (PW 3.01). As a Cognitive Behavioural Therapist, it was important to incorporate the CBT model and principles of therapy, including emotive and experiential interventions (PW 3.01). My reflexive practice guided me to consider other approaches such as narrative therapy to help individuals tell their story, externalise their hoarding problem and help them make sense of their issue (PW 3.01). These are some of the interventions amongst others that were considered. Undertaking private research with the participants as part of the group therapy, and feedback from the participants about their experiences of using some of these novel techniques being developed, contextualised the model for me (PW 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11). The outcomes of collaborative research that I participated in provided other aspects of the model.

I decided to write a self-help book with the intention of enabling more individuals suffering from HD to access the novel interventions that we developed through our therapeutic group work and research to deal with their hoarding behaviours (Singh & Jones, 2012; Jones & Singh, 2013; Jones & Singh, 2014) (PW 3.09, 3.10, 3.11). Writing a book was a challenge, as I had never written a book before. I reflected on my experiences over the past nine years in the group process to help structure the book and the sequencing of the interventions that were introduced in therapy. It was also an exciting time as it formalised the interventions both my co-facilitator and I had been implementing over this period of time and evaluating the outcomes of the group (PW 3.01a). Through my reflections and reflexive practice, I identified the key topics that I felt would be of most benefit to the participants.

I was the main author for this collaborative book project, *Overcoming Hoarding* (Singh et al., 2015) (PW 3.01, appendix I, II, III & IV). The timescale stipulated by the publisher was short. I felt that it would not do the book justice to be forced to write over such a short time (three months). I negotiated with the publishers to extend the timescale to facilitate the consolidation of the work we had done over the years. I discussed with my co-authors their specific roles based on their expertise, the sections that they were to write, and the style and layout of each chapter. Margaret Hooper was responsible for each chapter of the Friends and Family section and providing an overview that reflected our work within the group (PW 3.01a). Colin Jones was responsible for the narrative chapters and the editing of the book (PW 3.08). In reflecting my experiences and through my reflexive practice on my therapeutic style I decided to write the book in a supportive dialogical style as it engaged the participants in the group. It was my intention that the book would be able to connect with the reader. Each chapter was designed to be self-contained and can be used by professionals as additional tools within their therapeutic work. I felt that it was important that the exercises in the book were relevant and engaging and, most importantly, individuals were able to relate to them (PW 3.76).

The majority of the book was written during my holiday in the Far East, an environment that resonates with my beliefs, language, culture and my way of being in this world. It reconnected me with my roots and my cultural beliefs. The environment provided me with the space to reflect and engage in reflexivity (through observation of how others engage with their belongings and the relationship they have with objects, as well as reengagement with my values and valued directions) with my ideas and thoughts, enthusiasm and energy to complete the book earlier than planned. Having completed the book has given me a sense of personal achievement as it is the first self-help book on hoarding disorder to be published in the UK (PW 3.01). The book was reviewed by Professor Peter Cooper, the series editor. His feedback was highly complimentary as he considered it to be a sound book and did not recommend any changes to be made (PW 3.76). In my personal communication to the editor, it appears *Overcoming Hoarding* (Singh et al.,

2015) is the only book in their series that did not require any changes made prior to publication (PW 3.01, 3.76).

Smartphones have revolutionised the way people access information and the ability to run third party applications such as apps. There have been thousands of apps developed and more recently these have been developed for clinical and health care situations. Health related apps are actively researched for their applicability in clinical and health care. Recent studies have shown the potential for apps in patient self-monitoring (Rao et al., 2010; Rosser & Eccleston, 2011) and behaviour change to improve health care outcomes (Abroms et al., 2011; Cohn et al., 2011). In addition to the self-help book, I developed a mobile application that can be accessed via smartphones and other handheld devices to help those with hoarding issues as these devices are commonly used. This idea was developed through my reflective and reflexive observations of individuals' relationships with their mobile phones. In this day and age, mobile phones have become an extension of individuals. Mobile phones are utilised by individuals from all age ranges. Research has shown that individuals had an interest in using apps to support change in the health related behaviour (Dennison et al., 2013). Smartphones and handheld devices are portable, provide easy access and less likely to be lost in the clutter. In an interview on the BBC's *You and Yours* (James, 2016) radio programme, Seb James, CEO of Dixons Carphone, stated '*the smartphone is the remote control of your life*'. My observations of group participants, patients, clinicians, professionals and most people are dependent on their phones. As part of my reflexive practice, during my interactions with patients and other clinicians, I consider the topic of discussion carefully with the aim of using creative and innovative ways in dealing with issues presented. One such idea was developing an application for smartphones. I collaborated with an application developer in India and developed the app titled *Reclaim your space and life* (Singh, 2015, appendix V) which provides information and selected innovative interventions from the LHTG and *Overcoming Hoarding* book (Singh et al., 2015) (PW 3.01, 3.02, 3.05, 3.06, 3.07, 3.09, 3.10, 3.11, appendix I, II & III). As discussed earlier, the innovative use of visual methods has been central to developing the treatment

model, and this application has the capability of capturing photographs of specific rooms (bathroom, bedroom, hallway, living room, kitchen, and staircase) at regular intervals to monitor and measure progress. Uses of the application can also access the H.O.A.R.D. Acronym Tool (Singh & Jones, 2012) to help individuals understand their hoarding issues and develop motivation (PW 3.09). Due to its portability individuals, family, carers and health care professionals can access interventions to deal with an individual's hoarding problems within their environment. The advances in technology offered me the opportunity to bridge the gap between research and practice to enable effective tools to be accessed by those who need them.

2.6 Concluding comments

The journey of developing this contextual statement has been an enriching and rewarding one for me. It has helped me recognise my personal and professional development, especially the impact that I have made in the field of HD. In addition, it has been a therapeutic process for me, as it has enabled me to recognise and reflect on what it is about me that makes me a part of this world and the role I play in it. I have been able to demonstrate professional entrepreneurialism by the changes that have taken place in the landscape of hoarding disorder (PW 3.71, 3.72, 3.73, 3.74, 3.75, 3.76, 3.77, 3.77a, 3.78, 3.79, 3.80, 3.81). Leadbeater (1997) says social entrepreneurialism parallels professional entrepreneurialism and formulates social entrepreneurs as:

Entrepreneurial: they take under-utilised, discarded resources and spot ways to satisfy unmet needs.

Innovative: they create new services and products, new ways of dealing with problems, often by bringing together approaches that have been traditionally kept separate.

Transformatory: they transform the institutions they are in charge of... Most importantly, they can transform neighbourhoods and communities they serve by opening up possibilities for self-development.

(Leadbeater, 1997: 53)

The challenges that I have experienced over the years have enabled me to develop resilience in dealing with them, as well as being able to approach others for support and guidance and skills in managing these situations. There is no one model of reflexivity, but it is based on principles postulated by individual ideas and theories (Etherington, 2004; Finlay and Gough, 2003; Fox, et. al., 2007; Qualley, 1997; Willig, 2001), which over the years I have adopted through my reading and practice. For me, reflexivity has been one of the most important tools in this process and is best described by Carter and Gardin (2001: 4-5):

Reflexivity... involves a back and forth interplay of opposing ideas [so] that differing assumptions, representations, ways of seeing, and ideas are pitted against each other. This kind of engagement leads to an understanding of opposing points of view without losing our own... Reflexivity, then, involves trying on perspectives, the worldview of 'other' for long enough to look back critically at ourselves, our ideas, our assumptions, our values.

Finlay and Gough's (2003) *five variants* of reflexivity can be used to best describe the whole process of my reflexive practice:

- Reflexivity on introspection can be understood as my inner dialogue in situations, which has led me to discover, generate, interpret and develop my ideas, especially for interventions and potential research ideas.
- Reflexivity of intersubjective reflections can be understood as the interplay of me and the other, and the other and me, on the way we interact and negotiate the course and process of active and passive interactions.

- Reflexivity of mutual collaboration can be understood as relating to my taking into account the multiple perspectives and conflicting positions to help shift preconceived theories and subjective understanding, especially in relation to the collaborative work and research undertaken.
- Reflexivity as social critique relates to my acknowledging the tensions that arise from the different social positions, such as the clinician, practitioner researcher, and researcher, and power imbalances between researcher and participants.
- Reflexivity as ironic deconstruction relates my ability to identify underlying weakness, ambiguity of meanings, and language used (deconstructive and constructive) and how it impacts on the modes of presentation and engagement.

Through the process of reflexivity, based on the principles and ideas postulated by individuals such as Etherington (2004), Finlay and Gough (2003), Fox et. al. (2007), Qualley (1997), and Willig (2001), amongst others, I have been able to stand back, to utilise my lifelong experiences, learning and knowledge, and to view and reflect on situations through my transcultural lens to enhance and develop my clinical work, leadership style and influence in the wider arena in the field of HD. I have benefited enormously from the manner in which I have constructed the engagement process with individuals (patients and professionals), organisations, and research, enabling me to influence a change in culture in relation to our understanding of hoarding disorder, innovative treatment strategies and development of support systems.

References

- Abramowitz, J.S., Lackey, G.R. & Wheaton, M.G. (2009). Obsessive-compulsive symptoms: the contribution of obsessional beliefs and experiential avoidance. *Journal of Anxiety Disorders*, **23**: 160-166.
- Abroms, L.C., Padmanbhan, N., Thaweethai, L. & Philips, T. (2011). iPhone apps for smoking cessation: a content analysis. *American Journal of Preventative Medicine*, **40**: 279-285.
- American Psychological Association (2013). *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM V)*. Washington (DC): American Psychiatric Association.
- Austen, J. (1818). *Northanger Abbey*. 1995. New York: Penguin Books.
- Barlow, D.H. (1991). Disorders of emotion. *Psychological Inquiry*, **2**: 58-71.
- Begota, A.M., Woods, D.W. & Wetterneck, C.T. (2004). The relationship between experiential avoidance and the severity of trichotillomania in nonreferred sample. *Journal of Behaviour Therapy and Experimental Psychiatry*, **35**: 17-24.
- Bexson, T. (2005). Compulsive Behaviour. *Environmental Health Journal*, **1**: 12-14.
- Bexson, T. (2005). 'Grass Roots'. *Guardian Society*, 26th January.
- Bond, F.W., Hayes, S.C., Baer, R.A., Carpenter, K.M., Guenole, N., Orcutt, H.K., Waltz, T., Zettle, Q.D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire-II: a revised measure for psychological inflexibility and experiential avoidance. *Behaviour Therapy*, **42**: 676-688.
- Stetka, B.S & Correll, C.U. (2013). A Guide to DSM-5. *Medscape*, May 21st
- Bruner, J. (1996). *The narrative construction of reality*. Boston: Harvard University Press.
- Carruthers, H., Morris, J., Tarrier, N. & Whorwell, P. (2010). The Manchester Colour Wheel: the development of a novel way of identifying colour choice and validation in healthy, anxious and depressed individuals. *BMC Medical Research Methodology*, **10**: 12.
- Dickens, C. (1861). *Great Expectations*. Ed. E. Rosenberg. New York: W.W. Norton, 1999.
- Chawla, N. & Ostafin, B. (2007). Experiential avoidance as a functional dimensional approach to psychopathology: an empirical review. *Journal of Clinical Psychology*, **63**: 871-890.

Clandinin, D.J. & Connelly, F.M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.
"The Crime and Disorder Act 1998". Her Majesty's Stationery Office.
Retrieved 21 January 2007.

Cohn, A.M., Hunter-Reel, D., Hagman, B.T. & Mitchell, J. (2011). Promoting behavior change from alcohol use through mobile technology: the future of ecological momentary assessment. *Alcoholism: Clinical Experimental Research*, **35**: 2209-2215.

Convery, I. & Cox, D. (2012). A review of research ethics in internet-based research. *Practitioner Research in Higher Education*, **6(1)**: 50-57.

Cunliffe, A.L. (2009) Reflexivity, learning and reflexive practice. In S. Armstrong and C. Fukami (eds.), *Handbook in Management Learning, Education and Development* (Chapter 23). London: Sage.

Dennison, L., Morrison, L., Conway, G. & Yardley, L. (2013). Opportunities and Challenges for Smartphone Applications in Supporting Health Behaviour Change: Qualitative Study. *Journal of Medical Internet Research*, **15(4)**: e86.
Doi: 10.2196/jmir2583

Dewey, J. (1916). *Democracy and Education: An Introduction to the philosophy of education*. New York: McMillan.

Dewey, J. (1920). *Reconstruction and philosophy*. Boston: Beacon, reprint 1962.

Dewey, J. (1933). *How we think*. Chicago: Henry Regnery.

Dziegielewski, S.F. (2015). *DSM-5 in action*. Hoboken, N.J.: Wesley.

Etherington, K. (2004). *Becoming a Reflexive Researcher*, London: Jessica Kingsley.

Epston, D. & White, M. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

Farhady, H. (2013). Quantitative Methods. In C.A. Chapelle (ed.), *The Encyclopaedia of Applied Linguistics* (pp. 1-8). Oxford: Wiley-Blackwell.

Fernandez de la Cruz, L., Landau, D., Iervolino, A.C., Santo, S., Pertusa, A., Singh, S. & Mataix-Cols, D. (2013). Experiential avoidance and emotion regulation in hoarding disorder. *Journal of Anxiety Disorders*, **27**: 204-209.

Finlay, L. & Ballinger, C. (2006). *Qualitative Research for Allied Health Professionals*. Chichester: Wiley.

Finlay, L. & Gough, B. (2003). *Reflexivity: A Practical Guide*. London: Blackwell.

First, M.B., Gibbon, M., Wiliam, J.B.W. & Spitzer, R. (1994). *Structured clinical interview for DSM-IV Personality Disorders (SCID-II) Version 2.0*. New York Biometrics Department. New York State Psychiatric Institute.

Flessner, C.A. & Woods, D.W. (2006). Phenomenological characteristics, social problems, and the economic impact associated with chronic skin picking. *Behaviour Modification*, **30**: 944-963.

Foa, E.B., Huppert, J.D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., Salkovskis, P.M. (2002). The Obsessive-Compulsive Inventory: development and validation of a short version. *Psychological Assessment*, **14**: 485-496.

Frances, A. (2010). The first draft of DSM-V if accepted will fan flames of false positive diagnosis. *British Medical Journal*, 340-492.

Frost, R.O. & Gross, R.C. (1993). The hoarding of possessions. *Behaviour Research and Therapy*, **31**: 367-81.

Frost, R.O. & Hartl, T. (1996). A cognitive-behavioural model for compulsive hoarding. *Behavioural Research and Therapy*, **34**: 341-350.

Frost, R.O. & Steketee, G. (2003). *Compulsive Hoarding and Acquiring: Therapist Guide*. Cambridge University Press: Cambridge UK.

Frost, R.O., Steketee, G., Grisham, J. (2004). Measurement of compulsive hoarding: saving inventory revised. *Behaviour Research and Therapy*, **42**: 1163-1182.

Frost, R.O., Steketee, G., Tolin, D. & Renaud, S. (2008). Development and validation of the clutter image rating. *Journal of Psychopathology and Behavioural Assessment*, **30(3)**: 193-203.

Gale, N.K., Heath, G., Cameron, E., Rashid, S., Redwood, S. (2013). Using framework method for the data analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, **13**: 117.
<https://bmcmmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-13-117> (accessed 12 December 16).

Graz, K.L. & Roemer, L. (2004). Multidimensional assessment of emotional regulation and dysregulation: development, factor structure and initial validation of the difficulties in emotional regulation scale. *Journal of Psychopathology and Behavioural Assessment*, **26**: 41-54.

Greenberg, G. (2013). *The book of woe*. New York: Penguin Group.

Hampton, M. (2009). *Possessed*.
http://www.martinhampton.com/MPH_FILMS_films_POSSESSED.html

Harper, D. (2002). Talking about pictures: a case for photo-elicitation. *Visual Studies*, **17**: 13-26.

Hedges, F. (2010) *Reflexivity in Therapeutic Practice* (basic text in Counselling and Psychotherapy). Basingstoke: Palgrave MacMillan.

Ings-Chambers, E. (2005). 'Drowning in Clutter'. *Style Magazine, Sunday Times*, 1st November pp 40-41

James, S. (2016). Interview by Samantha Fenwick on BBC *You and Yours: Radio 4's consumer programme*. *Dixons Carphone*. <http://www.bbc.co.uk/programmes/b075mdy3>

Jolly, M. (2011). What I never wanted to tell you: therapeutic letter writing in cultural context. *Journal of Medical Humanities*, **32**: 47-59.

Jones, P., Singh, S. & Aquino, P. (2003). Cognitive Behavioural Therapy in Practice. *British Medical Journal*. 326: 181-2

Jones, C. & Singh, S. (2014). The potential benefits of colour in supporting people with compulsive hoarding disorder. *Journal of Mental Health Practice*, **18(3)**: 29-32.

Johnson, K.E. & Golombek, P.R. (2002). *Teachers' Narrative Inquiry as Professional Development*. Cambridge: Cambridge University Press.

Josselson, R. (2004). On becoming the narrator of one's own life. In A. Lieblich, D.P. McAdams & R. Josselson (eds.), *Healing plots: The narrative basis of psychotherapy* (pp. 111-127). Washington DC: American Psychological Association.

Josselson, R. (2011). *Bet you think this song is about you: whose narrative is it in narrative research?* Fielding Graduate University, 1(1). Available at: Journals.hil.unb.ca/index.php/NW/article/download/18472/99971 (accessed 21 November 2012).

Jutel, A. (2009). Sociology of diagnosis: a preliminary review. *Social Health Illness*, **31**: 278-299.

Kashdan, T.B. & Kane, J.Q. (2011). Post-traumatic distress and the presence of post-traumatic growth and meaning in life: experiential avoidance as a moderator. *Personality and Individual Differences*, **50**: 84-89.

Kellett, S., Greenhalgh, R., Beail, N. & Ridgway, N. (2010). Compulsive Hoarding: An Interpretive Phenomenological Analysis. *Behavioural and Cognitive Psychotherapy*, **38(2)**: 141-155.

Kim, H.S. (1999). Critical reflective inquiry for knowledge development in nursing practice. *Journal of Advance Nursing*, **29(5)**: 1205-1212.

Kolb, D.A. (1984). *Experiential learning: Experience as the source of learning and development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall.

Knoblauch, H., Baer, A., Laurier, E. et al. (2008). Visual analysis: New developments in the analysis of video and photography, *Forum Qualitative Research* 9: Article 14.

Lang, P. (2003). Personal communication. In F. Hedges (2010) *Reflexivity in Therapeutic Practice* (basic text in Counselling and Psychotherapy). Basingstoke: Palgrave MacMillan.

Landau, D., Iervolino, A.C., Pertusa, A., Santo, S., Singh, S. & Mataix-Cols, D. (2011). Stressful life events and material deprivation in hoarding disorder. *Journal of Anxiety Disorders*, **25(2)**: 192–202.
doi:10.1016/j.janxdis.2010.09.002

Leadbeater, C. (1997). *The Rise of the Social Entrepreneur*. London: Demos.

Lebow, J.L. (2008). *Twenty-first century psychotherapies*. Hoboken, NJ: Wiley.

Lecrubier, Y., Sheehan, D.V., Weiller, E., Amorim, P., Bonora, I., Harnett-Sheehan, K., Janavs, J., Dunbar, G.C. (1997). The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: reliability and validity according to the CIDI. *European Psychiatry*, **12**:221-231.

Ledford, H. (2009). Psychiatry manual revisions spark now. *Nature*, 460-445.

Mataix-Col, D. & Fernandez de la Cruz, L. (2015). Hoarding Disorder. In Robin L Cautin & Scott O. Lilienfeld (eds.) *The Encyclopedia of Clinical Psychology*. New York: Wiley-Blackwell.

McAdams, D.P. (1985). *Power, intimacy, and the life story: Personological inquiries into identity*. New York: Oxford University Press.

McAdams, D.P. (2006). *The redemptive self: Stories Americans live by*. New York: Oxford University Press.

McNiff, J. (1993). *Teaching as Learning*. London: Routledge.

Mendelson, Z. (2013). *This Mess is a Place*. <http://thismessisaplace.co.uk>

Moule, P. & Hek, G. (2011). *Making Sense of Research*. London: Sage.

Newman, M.G. & Llera, S.J. (2011). A novel theory of experiential avoidance in generalized anxiety disorder: a review and synthesis of research supporting a contrast avoidance model of worry. *Clinical Psychology Review*, **31**: 371-382.

- Morris, G.H. & Chenail, R.J. (1994). *The Talk Clinic: Explorations in the Analysis of Medical and Therapeutic Discourse*. Abingdon: Routledge.
- Padesky, C.A. (1993). *Socratic Questioning: Changing Minds or Guided Discovery?* Keynote speech presented at the European Congress of Cognitive Therapies, London, September 24.
- Pertusa, A., Fullana, M.A., Singh, S., Alonso, P., Menchón, J.M. & Mataix-Cols, D. (2008). Compulsive hoarding: OCD symptom, distinct clinical syndrome, or both? *American Journal of Psychiatry*, **165**: 1289-1298.
- Pickersgill, M. (2012). What is psychiatry? Co-producing complexity in mental health. *Social Theory Health*, **10**: 328-47.
- Pickersgill, M. (2014). Debating the DSM-5: diagnosis and sociology of critique. *Journal of Medical Ethics*, **40**: 521-525.
- Qualley, D. (1997). *Turns of Thought*. Portsmouth: Boyton/Cook Heinemann.
- Ritchie, J., Lewis, J., McNaughton Nicholls, C., Ormston, R. (2013). *Qualitative Research Practice: A Guide for Social Sciences Students and Researchers*. London: Sage.
- Robson, C. (2002). *Real World Research* (2nd edition). Oxford: Blackwell.
- Rolfe, G. (1998). *Expanding Nursing Knowledge*. Oxford: Butterworth Heinemann.
- Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, **23**: 325-334.
- Rao, A., Hou, P., Golnik, T., Flaherty, J. & Vu, S. (2010). Evolutions of data management tools for managing self-monitoring of blood glucose results: a survey of iPhone applications. *Journal of Diabetes Science and Technology*, **4**: 949-957.
- Rosario-Campos, M.C., Miguel, E.C., Quattrano, S., Chacon, P., Ferrao, Y., Findley, D., [Katsovich, L.](#), [Scahill, L.](#), [King, R.A.](#), [Woody, S.R.](#), [Tolin, D.](#), [Hollander, E.](#), [Kano, Y.](#), [Leckman, J.F.](#) (2006). The Dimensional Yale-Brown obsessive-compulsive Scale (DY-BOCS): an instrument for assessing Obsessive Compulsive dimensions. *Molecular Psychiatry*, **11**: 495-504.
- Rosser, B.A. & Eccleston, C. (2011). Smartphone application for pain management. *Journal of Telemedicine and Telecare*, **17**: 308-312.
- Scaife, J. (1991) "The contracting process and the supervisory relationship". In J. Scaife (ed.), *In Supervision in Mental Health Professions: A Practitioner's Guide* (Chapter 4, pp. 52-69). Hove: Routledge.
- Sartorius, N. (2007). Stigma and mental health. *Lancet*, **8**: 370(9590): 810-1.

Schon, D. (1983). *The Reflective Practitioner: How Professionals Think in Action*. New York: Basic Books.

Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janvas, J., Weiller, E., Hergueta, T, Baker, R, Dunba, G.C. (1998). The Mini International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, **59**: 22-33.

Singer, J.A. (2004). Narrative identity and meaning making across the lifespan: An introduction. *Journal of Personality*, **72**: 437-459.

Singer, J.A. (2005). *Personality and psychotherapy: Treating the whole person*. New York: Guilford Press.

Singer, J.A. (2006). *Imagery in Psychotherapy*. Washington DC: APA.

Singh, S. (2016). Participants' experiences of exploration in their first language whilst having Cognitive Behavioural Therapy in their second language (English). (accepted). *Journal of Mental Health Practice*

Singh, S. (2015). *Reclaim your space and life*. A smartphone application.

Singh, S. (2015). Delivering group CBT: competencies and group processes. *Journal of Cognitive Behavioural Psychotherapy Research*, 3: 150-155.

Singh, S. (2013). Interviewed by Jacquie Jones on *Radio BBC Lancashire*, 6th May.

Singh, S. (2013). Hoarding - Miss Havisham Syndrome. An essay for This Mess is a Place project. An interdisciplinary project exploring the borders of hoarding.

Singh, S. (2012). Behandelopties voor problematische verzmelaars. In O.R.V. Van Beers & E. Hoogdin (eds.), *Problematische verzame laars*. Amsterdam: Uitgeverij Boom.

Singh, S. (2012). Language and Cognitive Behavioural Therapy Practice Paper - Literature Review and Case Example. *Journal of Cognitive and Behavioural Psychotherapy Research* 1(3): 138-144.

Singh S. (2011). Interviewed by Hannah Murray. Radio Europe. 29th August.

Singh, S. (2011). Interviewed on the *Breakfast Show*. BBC Radio Newcastle, 21st February.

Singh, S. (2004). Interviewed by Raj Persaud on *All in the Mind*. BBC Radio 4 28th October.

- Singh, S. (2004). Using cognitive-behavioural therapy techniques in general practice. *British Medical Journal* E learning module.
- Singh, S. (2003). Advocates and Cognitive Therapy. *Cognitive Therapy*, 5(2): 6.
- Singh, S. (2001). Impact of Major Incidents on Patients: Field Report. *Cognitive Therapy*, 3(4): 3,6.
- Singh, S. (2013). Interviewed by Jacquie Jones on the *Breakfast Show*. BBC Radio Lancashire. 5th July.
- Singh, S. (2014). Engaging with individuals who hoard. *Social Care Information and Learning Services* (online learning module).
- Singh, S., Hooper, M. & Jones, C. (2015) *Overcoming Hoarding*. London: Robinsons Press.
- Singh, S. & Jones, C. (2016). The challenges of working with hoarders: a survey of professional groups. (under review *Journal of Mental Health*).
- Singh, S. & Jones, C. (2013a). Engaging in treatment sufferers of compulsive hoarding disorder. *Journal of Mental Health*, **17(4)**: 16-20.
- Singh, S. & Jones, C. (2013b). Novel method in engaging compulsive hoarders in treatment. *Advances in Cognitive Therapy*, **14(2)**: 8-11.
- Singh, S. & Jones, C. (2012). Visual Research Methods: A novel approach to understanding the experiences of compulsive hoarders. *Journal of Cognitive and Behavioural Psychotherapy Research*, **1(1)**: 36-42.
- Spitzer, R.L. (2009). DSM-V transparency: fact of rhetoric? *Psychiatric Times*. <http://www.psychiatrictimes.com/articles/dsm-v-transparency-fact-or-rhetoric> (accessed 20 June 2016).
- Stasz, C. (1979). The early history of visual sociology. In J. Wagner (ed.), *Images of Information: Still Photography in Social Sciences*. Beverly Hills: Sage.
- Steier, F. (1991). *Research and Reflexivity*. London: Sage.
- Steketee, G. & Frost, R.O. (2003). Compulsive hoarding: current status of the research. *Clinical Psychology Review*, **23**: 905-927.
- Stiles, W.B. (2010). Theory building case studies as practice based evidence. In M. Barkham, G. Hardy & J. Mellor-Clark (eds.), *Developing and Delivering Practice Based Evidence: A Guide for Psychological Therapies* (pp. 91-109). Chichester: Wiley-Blackwell.

Stuart, H. & Sartorius, N. (2005). Fighting Stigma and Discrimination Because of Mental Health Disorders. In G.N. Christodolous (ed.), *Advances in Psychiatry*, 2nd volume, pp. 79-86. World Psychiatric Association.

Taboo Series (2011): *Hoarding Therapy*. National Geographic
<http://channel.nationalgeographic.com/taboo/videos/hoarding-therapy/>

Thornicroft, G. (2006). *Shunned: discrimination against people with mental illness*. Oxford: Oxford University Press.

Tolin, D., Fitch, K.E., Frost, R.O. & Steketee, G. (2010). Family Informants' Perceptions of Insight in Compulsive Hoarding. *Cognitive Therapy and Research*, **34**: 69-81.

Tolin, D. Frost, R.O. & Steketee, G. (2007). *Buried in Treasures: Help for compulsive acquiring, saving and hoarding*. United States: Oxford University Press.

Tolin, D., Frost, R.O. & Steketee, G. (2012). Working with hoarding vs. non-hoarding clients: A survey of professionals' attitudes and experience. *Journal of Obsessive-Compulsive and Related Disorders*, **1(1)**: 48-53.

Wang, C.C. (1999). Photovoice: A Participation Action Research Strategy Applied to Women's Health. *Journal of Women's Health*. **8(2)**: 185-192.

Warren, S. (2005). Photography and voice in critical qualitative management research. *Accounting, Auditing & Accountability Journal*, **18**: 861-882.

Watkin, J.G. (1971). The affect bridge: A hypnoanalytical technique. *International Journal of Clinical and Experimental Hypnosis*. **19 (11)**: 21-27.

Wengraf, T. (2001). *Qualitative Research Interviewing*. London: Sage.

Wheaton, M.G., Abramowitz, J.S., Franklin, J.C., Berman, N.C. & Fabricant, L.E. (2011). Experiential avoidance and saving cognitions in the prediction of hoarding symptoms. *Cognitive Therapy and Research*, **35**: 511-516.

Wibram, M., Kellett, S. & Beail, N. (2008). Compulsive hoarding: A qualitative investigation of partner and carer perspectives. *British Journal of Clinical Psychology*, **47**: 59-73.

Williams, C. (2002). *Overcoming Depression: a five areas approach*. London: Arnold.

Williams, C. (2003). *Overcoming Anxiety: a five areas approach*. London: Arnold.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method*. Buckingham: Open University.

WORLD HEALTH ORGANIZATION. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

Wright, K.B. (2005). Researching Internet-Based Populations: Advantages and Disadvantages of Online Survey Research, Online Questionnaire Authoring Software Packages, and Web Survey Services. *Journal of Computer-Mediated Communication*, **10**: 00. doi: 10.1111/j.1083-6101.2005.tb00259.

Yalom, I.D. & Leszcz, M. (2005). *The theory of group psychotherapy* (5th ed.). New York: Harper Collins.

Zraati, P. (2012). Colour Consideration for Waiting Areas in Hospitals. *International Journal of Advancement in Research & Technology*, **1(3)**: 1-5.

Zraati, P. (2013). *Colour Consideration for Waiting Areas in Hospitals*. Conference paper: International Conference on Research into Design. Indian Institute of Technology, Madras, 7-9 January 2013.

APPENDIX I: Time line: 1971-2016

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
<p>1971-1984 <i>Primary & secondary school education</i></p> <p>1987-1990 Enfield and Haringey School of Nursing: <i>Registered General Nursing</i></p> <p>1991-1992 Bloomsbury & Islington College of Nursing & Midwifery: Registration <i>Registered Mental Health Nurse</i></p> <p>1995 Institute of Psychiatry: <i>Certificate in Cognitive Behavioural Therapy</i></p>	<p>1992-1996 <i>Staff Nurse</i> St Luke's Woodside Hospital, London</p> <p>1996-1998 <i>Honorary Cognitive Behavioural Therapist</i> City and Hackney NHS Trust</p>	<p>1994 Bloomsbury & Islington College of Nursing & Midwifery: <i>ENB 934 Care and Management of Persons with AIDS and HIV</i></p> <p><i>ENB 998 Teaching and Assessing</i></p>		

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
<p>1997 Middlesex University: <i>MSc In Mental Health Interventions</i></p> <p>1999 University of Oxford Warneford Hospital: <i>Postgraduate Diploma in CBT</i></p>	<p>1996-1998 <i>Charge Nurse</i> St Luke's Woodside Hospital, London</p> <p>1998-2001 <i>Cognitive Behavioural Therapist</i> The Priory Hospital North London</p> <p>2001-2003 <i>Cognitive Behavioural Nurse Therapist</i> Wordsworth Health Centre</p>	<p>1998 BABCP: <i>Anger Management with Assaultive and Resistant Patients -</i> Raymond W Novoco</p> <p>2000 Christine Padesky (USA): <i>Camp Cognitive Therapy</i> 1996-1998</p>	<p>1998-2001 Developed the Group CBT programme at the Priory Hospital North London</p> <p>2001 BABCP Annual Conference, Glasgow <i>Group Cognitive Behavioural Therapy</i></p> <p>2001 Developed the first primary care CBT service at the Wordsworth Health Centre, Newham</p>	

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
	<p data-bbox="566 914 909 1166">2003-Present Nurse Consultant in Cognitive Behavioural Therapy and Mental Health Wordsworth Health Centre</p>	<p data-bbox="943 435 1249 683">2001 BABCP: <i>Supervision Moving Beyond the Mere Transmission of CBT Techniques</i> - Claudia Herbert</p> <p data-bbox="943 730 1205 906">2002 Christine Padesky (USA): <i>Camp Cognitive Therapy</i></p> <p data-bbox="943 954 1279 1201">2002 University of Southampton: <i>Cognitive Therapy Supervision: Principles and Practice</i> - Christine Padesky</p>	<p data-bbox="1319 986 1671 1166">2003 New Practice Nurse Conference <i>Cognitive Behavioural Therapy in Primary Care</i></p>	<p data-bbox="1695 435 2047 611">Singh, S. (2001). Impact of Major Incidents on Patients: Field Report. <i>Cognitive Therapy</i>, 3(4): 3,6.</p> <p data-bbox="1695 770 2047 946">2003 Singh, S. Advocates and Cognitive Therapy. <i>Cognitive Therapy</i>, 5(2): 6.</p> <p data-bbox="1695 994 2047 1201">2003 Jones, P., Singh, S. & Aquino, P. Cognitive Behavioural Therapy in Practice. <i>British Medical Journal</i>. 326: 181-2.</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
		<p>2004 Christine Padesky (USA): <i>Camp Cognitive Therapy</i></p> <p>2004 Newcastle Centre for CBT: <i>Supervision: Integrating Practical Skill within a Conceptual Framework</i> Mark Freeston Peter Armstrong Vivien Twaddle</p> <p>2004 City University <i>Independent prescribing (nurse prescribing)</i></p>	<p>2005 Newham Practice Nurse Conference <i>Identifying and managing depression in Primary Care</i></p> <p>2005 London Hoarding Treatment Group established in collaboration with Obsessive Action</p>	<p>Singh, S. (2004). Using cognitive-behavioural therapy techniques in general practice. <i>British Medical Journal E</i> learning module.</p> <p>2004 BBC Radio 4 All in the Mind interview: Hoarding Disorder</p> <p>2005 Guardian Society Grass Roots Interview by Tina Bexson</p> <p>2005 Environmental Health Journal Compulsive Hoarding-Interview by Tina Bexson</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
	<p data-bbox="566 951 916 1278">2006-2010 Deputy Clinical Lead Newham Improving Access to Psychological Therapies demonstration site (The City and Hackney Mental Health Trust)</p>	<p data-bbox="943 472 1267 683">2005 BACBP: <i>Mindfulness based Cognitive Therapy: An Introduction - Melanie Fennell</i></p> <p data-bbox="943 727 1216 906">2005 Oxford Centre of Cognitive Therapy: <i>Mindfulness based Cognitive Therapy</i></p> <p data-bbox="943 951 1245 1161">2006 BACBP: <i>Working with Shame and Developing Self- Compassion - Paul Gilbert</i></p>		

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
		<p>2007 Compassionate Mind Foundation <i>Compassionate Mind</i> Paul Gilbert</p> <p>2007 World Congress of Behavioural and Cognitive Therapies: <i>Schema Therapy: New Strategies for Difficult Personalities</i> - Jeff Young</p> <p>2007 BABCP: <i>Treatment Resistant Anxiety Disorders</i> - Robert Leahy</p>		

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
		<p>2008 International Congress of Cognitive Psychotherapy: <i>Schema Mismatch in the Therapeutic Relationship: using Roadblock as Opportunity for Change</i>- Robert Leahy</p> <p>2009 East London and the City Mental Health Trust: <i>CBT for Health Anxiety</i> - Alicia Deale</p> <p>2009 Oxford Centre for Cognitive Therapy: <i>Cognitive Therapy for Chronic Worry</i> - Robert Leahy</p>	<p>2009 Challenging Healthcare Accessing Psychological Therapies <i>Developing Healthcare: Accessing Psychological Therapies</i> Workshop, Belfast, UK.</p>	<p>2008 Pertusa, A., Fullana, M.A., Singh, S., Alonso, P., Menchon, J.M. & Mataix-Cols, D. Compulsive hoarding: OCD symptom, distinct clinical syndrome or both? <i>American Journal of Psychiatry</i>, 165: 1289-1298. PW 3.05</p> <p>2009 <i>Hampton, M. DVD: Possessed</i> PW 3.16</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
	<p data-bbox="566 472 887 687">2010-Present Clinical Lead Waltham Forest Improving Access to Psychological Therapies (NELFT)</p> <p data-bbox="566 727 887 831">2010-Present BABCP course accreditation panel member</p> <p data-bbox="566 871 920 1054">2010-2014 University of Essex External examiner for the IAPT HI PG Diploma Course</p>	<p data-bbox="943 472 1234 576">2010 MDS Workshops: <i>EMDR levels I, II, III</i></p> <p data-bbox="943 616 1285 943">2010 Oxford Centre for Cognitive Therapy: <i>Recurrent Cognitions in the Anxiety Disorders: Alternative Approaches to Standard Cognitive Therapy</i> - David A Clark</p> <p data-bbox="943 983 1290 1198">2010 Oxford Centre for Cognitive Therapy: <i>Mindfulness in Medicine and Psychology</i> - Jon Kabat Zinn</p>	<p data-bbox="1319 472 1671 687">2010 Queens University Belfast <i>Supervision in Cognitive Behavioural Therapy - Masterclass</i></p> <p data-bbox="1319 727 1637 1054">2010 Housing Quality Network Housing and Health: New Perspectives - Hoarding Disorder London Manchester York</p>	<p data-bbox="1695 472 2047 871">2010 Laudau, D., Iervolino, A.C., Pertusa, A., Santo, S., Singh, S. & Mataix-Cols, D. Stress life events and materials deprivation in hoarding disorder. <i>Journal of Anxiety Disorders</i>, 25(2): 192-202. PW 3.06</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
			<p data-bbox="1314 434 1637 687">2010 Turkish Psychiatric Congress <i>Cognitive Behavioural Therapy for Social Phobia - Workshop, Istanbul, Turkey</i></p> <p data-bbox="1314 730 1637 984">2010 GGD Zuid-Holland- Zuid Hoarding <i>Group Therapy for Hoarding - Presentation Utrecht, Netherlands</i></p>	

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
		<p>2011 BABCP <i>Psychological Interventions in managing long-term conditions with and without depression - Katrina Lovell & Chris Dickens</i></p> <p>2011 BABCP <i>Cognitive Behavioural Therapy in the Treatment and Provision of therapy for Depression - Steve Hollon</i></p>	<p>2011 Age UK Conference <i>Working with Hoarders – Workshop, Nottingham, UK</i></p> <p>2011-2015 Nottingham Fire Service Training on Hoarding Disorder PW3.31, 3.37</p> <p>2011 GGD Zuid-Holland Zuid <i>Problematische versamelaars: Mijn spullen mijn kinderen</i> Engagement issues with Hoarders – Workshop, Utrecht, Netherlands PW 3.42</p>	<p>2011 <i>National Geographic Taboo series: Hoarding Therapy Worldwide PW 3.17</i></p> <p>2011 <i>Interview Radio Newcastle on Hoarding Disorder PW 3.25</i></p> <p>2011 <i>Interview Radio Europe on Hoarding Disorder PW 3.27</i></p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
<p>2013 University of Derby <i>MSc in Psychotherapy (Cognitive Behavioural)</i></p> <p>2013 Anna Freud Centre <i>Postgraduate Diploma in CBT Group Approaches</i></p> <p>2014 Royal Holloway University <i>Postgraduate Certificate in Behavioural Couples Therapy - Enhanced Cognitive Therapy - Don Boucom, Sara Corrie, Michael Worrell</i></p>		<p>2012 Royal Holloway University <i>Improving Access to Psychological Therapy Supervision Model - Michael Worrell and Sara Corrie</i></p> <p>2015 Royal Holloway University <i>Behavioural Couples Therapy Enhanced Cognitive Therapy for Long Term conditions and Infidelity - Don Boucom</i></p>	<p>2012 East Midlands Council Public Health Conference <i>Recognising hoarding in the community</i> Chesterfield, UK PW 3.44</p> <p>2012 NZIEH Conference <i>Jacks and Jackies of All Trades - Hoarders</i> Recognising Hoarding Issues (SKYPE presentation) Hamilton, New Zealand PW 3.43</p>	<p>2012 Singh, S. & Jones, C. <i>Visual Research Methods: A novel approach to understanding the experiences of compulsive hoarders. Journal of Cognitive and Behavioural Psychotherapy Research, 1 (1): 36-42</i> PW 3.09</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
			<p>2012 CCD GGD Zuid Holland Zuid <i>Waar bae bemoijje eigenlijke mee? Cognitieve gedragstherapie voor hoarders in the praktijk</i> H.O.A.R.D. Acronym workshop Utrecht, Netherlands PW3.45</p> <p>2013-ongoing <i>The Squirrel Project/ Even if I do it on purpose</i> A case study using eBay in dealing with hoarding issues Surrey, UK PW 3.18</p>	<p>2012 Singh, S. <i>Language and Cognitive Behavioural Therapy Practice Paper - Literature Review and Case Example.</i> Journal of Cognitive and Behavioural Psychotherapy Research 1(3): 138-144</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
			<p data-bbox="1314 434 1673 906"> 2014 6th International Congress on Psychopharmacology & 2nd International Symposium on Child and Adolescent Psychopharmacology <i>CBT for children and adolescents with anxiety disorders</i> Part I, II, III - workshops Antalya, Turkey </p> <p data-bbox="1314 954 1637 1276"> 2014 NBPO International Seminar in Chronic Disorganisation <i>Engaging those with hoarding issues</i> - whole day workshop Breukelen, Holland 2015 PW 3.46 </p>	<p data-bbox="1691 434 2047 833"> 2012 Singh, S. <i>Behandelopties voor problematische verzamelaars</i> in O.R.V. Van Beers & E. Hoogdin (eds.) in <i>Problematische verzamelaars</i>. Amsterdam: Uitgeverij Boom PW 3.03 </p> <p data-bbox="1691 880 2024 1313"> 2012 Invitation to peer review for <i>Journal of Behavioural and Cognitive Psychotherapy</i> Manuscript ID: BCP 00638-12 Hoarding Behaviours in an Italian Community Sample PW 3.20 </p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
				<p data-bbox="1697 432 2042 906"> 2012 Invitation to peer review for <i>Journal of Behavioural and Cognitive Psychotherapy</i> Manuscript ID: BCP 00721-12 The Role of Adult Attachment and Social Support in Hoarding Behaviour PW3.21 </p> <p data-bbox="1697 975 2042 1155"> 2013 <i>Interview Radio Lancashire on Hoarding Disorder</i> PW 3.28 </p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
	<p>2014-2017 University of Coventry External examiner for the IAPT HI PG Diploma Course & MSc Research Methods</p>		<p>2013 Thurrock District Council <i>Engaging with those with hoarding issues</i> - 6 workshops Thurrock, UK PW 3.34</p> <p>2014 MHASF 16th Annual International Conference on Hoarding and Cluttering <i>Engaging individuals in dealing with their hoarding</i> - workshop San Francisco, USA PW 3.47</p>	<p>2013 Fernandez de la Cruz, L., Landau, D., Iervolino, A.C., Santo, S., Pertusa, A., Singh, S. & Mataix-Cols, D. Experiential avoidance and emotion regulation in hoarding disorder. <i>Journal of Anxiety Disorders</i>, Vol 27: 204-209 PW 3.07</p> <p>2013 Singh, S. Hoarding - Miss Havisham Syndrome. An essay for This Mess is a Place project. An interdisciplinary project exploring the borders of hoarding.</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
				<p>2013</p> <p>Jones, C. & Singh, S. (2013). The Experience of Emotional Distancing in the Management of Compulsive Hoarding: A Visual Method Approach using the “HOARD” Acronym Tool. <i>Journal of Cognitive Behavioural Psychotherapy Research</i>, 2:41-46.</p> <p>PW 3.10</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
		<p>2015 Royal Holloway University Supervision training for <i>Behavioural Couples Therapy</i> - Don Boucom, Sara Corrie, Michael Worrell</p>	<p>2015 National Housing Federation <i>Engaging those with hoarding behaviours</i> Birmingham, Halifax, London, Manchester PW 3.39</p> <p>2015 CCC Ltd. Hoarding behaviour: taking steps to tackle a hidden problem <i>Hoarding as mental health disorder: current developments and research in psychology</i> Nottingham, UK PW 3.49</p>	<p>2015 Singh, S. <i>Delivering group CBT: competencies and group processes.</i> Journal of Cognitive Behavioural Psychotherapy Research, 3: 150-155</p> <p>2015 Invitation to peer review for <i>Journal of Contemporary Psychotherapy</i>: Manuscript ID: JOCP-D-15-0001 A Struggle with Contents: Towards an Understanding of the Dynamics of Hoarding PW 3.23</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
			<p>2015 Richmond Fellowship: Pulling together - co-producing housing management services <i>Hoarding and housing</i> London, UK PW 3.50</p> <p>2015 Epping Forest District Council <i>Engaging with those with hoarding issues - 2 workshops</i> Epping, UK PW 3.38</p>	<p>2015 Invitation to peer review for <i>Journal of Mental Health</i>: Manuscript ID: CJMH2015-0254 The Experiences of Those Working with Hoarders A Q Sort Exploration PW 3.24</p> <p>2015 <i>Edwina Ings-Chambers</i> <i>Drowning in Clutter</i> <i>Style Magazine, Sunday Times, 1st November, 2015</i> PW 3.77</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
			<p>2015 SITRA Cotman Housing Association <i>Hoarding Disorder - workshop</i> Norwich, UK PW 3.35</p> <p>2015 SITRA Thirteen Care and Support Housing Association <i>Hoarding Disorder - workshop</i> Middlesbrough, UK PW 3.36</p>	<p>2015 Singh, S., Hooper, M. & Jones, C. <i>Overcoming Hoarding.</i> London: Robinsons Press PW 3.01</p> <p>2015 Singh, S. <i>Reclaim your space and life app</i> (iTunes & Google Play) PW 3.02</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
			<p>2015 Ulusai Psikoloji Ogrencileri Kongresi: <i>Fundamentals of CBT</i> (presentation) <i>Conceptualisation</i> (workshop) Gaziantep, Turkey</p> <p>2015 Association for Cognitive and Behavioural Psychotherapies (Turkey): <i>Mindfulness Based Cognitive Therapy -</i> 2-day masterclass Ankara, Turkey</p>	

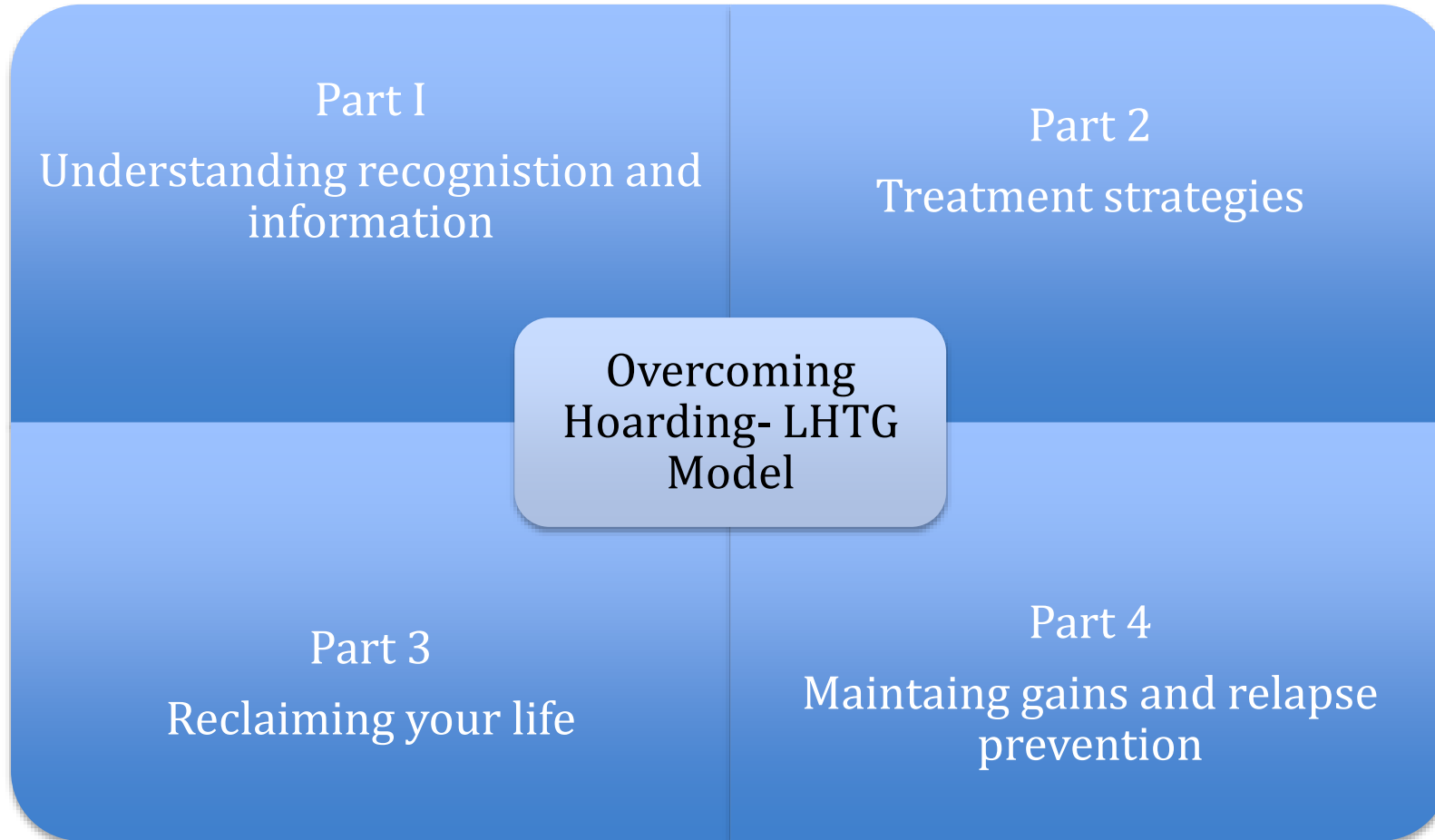
ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
			<p>2015 MHASF 17th Annual International Conference on Hoarding and Cluttering: <i>Overcoming Hoarding Reclaiming your Space and Life</i> - featured presentation San Francisco, USA PW 3.51</p> <p>2015 University of Coventry <i>Treatment of hoarding disorder</i> - Masterclass Coventry, UK PW 3.41</p>	

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
			<p>2016 University of East London <i>Treatment of hoarding disorder - Masterclass</i> London, UK PW 3.41</p>	<p>2016 Singh, S. Participants' experiences of exploration in their first language whilst having Cognitive Behavioural Therapy in a second language. <i>Journal of Mental Health Practice</i>, 20(3):23-29.</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & <i>RAISING AWARENESS OF HD</i>
			<p>2016 Hoarding Disorder and Self Neglect Workshop London Borough of Hillingdon Hillingdon, UK PW 3.41a</p>	<p>2016 Singh, S. & Jones, C. The challenges of working with hoarders: a survey of professional groups (online survey - under review, <i>Journal of Mental Health</i>) PW 3.14</p> <p>2016 Invitation to peer review for <i>Journal of Mental Health Practice</i>: Manuscript ID: MHP1161 An exploration of the utility of a tool for investigating the presence of Borderline Personality Disorder in a clinical population.</p>

ACADEMIC STUDIES	PROFESSIONAL ROLES	ADDITIONAL TRAINING	SERVICE DEVELOPMENT TRAINING PROVIDED PRESENTATIONS	KEY PUBLICATIONS PEER REVIEWS & RAISING AWARENESS OF HD
	<p>2016 BABCP Fellow</p> <p>2016 Professional and Strategic Lead (Improving Access to Psychological Therapies)</p>		<p>2016 Institute of Challenging Disorganisation Annual Conference: Blazing a trail <i>Reclaiming space and life - engaging and working collaboratively with individuals with hoarding issues</i> (mini workshop) <i>Reclaiming space and life - engaging and working collaboratively with individuals with hoarding issues: a cognitive behavioural perspective</i> (post conference workshop) - Portland, Oregon PW3.52</p>	<p>2016 <i>Reclaiming your space and life - Podcast and Youtube (1st May 2016)</i> PW 3.30</p> <p>2016 Invitation to peer review for <i>Journal of Mental Health Practice</i>: Manuscript ID: MHP1172 Describing CBT-trained mental health professionals' views towards motivation for BABCP accreditation: a generic qualitative study.</p>

APPENDIX II - OVERCOMING HOARDING LHTG TREATMENT MODEL



APPENDIX III - OVERCOMING HOARDING LHTG MODEL

PART I

Understanding hoarding disorder

Recognising hoarding disorder

Understanding therapy

Information for family and friends

PART II

Introduction to the basics

Vision

Motivation

Scheduling

Hoarding flower I - behavior

Hoarding flower II - beliefs

Hoarding flower III - emotions and tying it together

Taking control of my problem - reclaiming my flower

Telling my story

The grid method

Clutter image Rating scale

Yes No Maybe

Self talking

Questioning and beliefs

Go with the flow - staying with feelings

Round and round - ruminations

To do or not to do - procrastination

Back to the beginning - review

Traps

Keep going

PART III

Reclaiming your life

PART IV

Maintain your gains and prevent relapses

APPENDIX IV - OVERCOMING HOARDING Case Study

Case study

This brief case study has been written on an individual attending the London Hoarding Treatment Group (LHTG) and receiving group-based therapy based on the CBT treatment model in the *Overcoming Hoarding* (Singh, Hooper & Jones, 2015) book. The *Overcoming Hoarding* is a self-help book using cognitive behavioural techniques and is based on the LHTG treatment model. The LHTG is a monthly open group and between 30 and 35 individuals attend each session. The names and any identifying information have been changed to ensure to maintain the individual's confidentiality.

Introduction

The LHTG was formed in September 2005 and is currently in its 11th year. It was developed following a BBC radio 4's *All in the Mind* programme interview (Singh, 2004) in 2004. The interview generated a high number of queries from individuals seeking treatment for hoarding issues. This resulted in the collaboration between OCDAction a charity for individuals suffering from OCD and myself to provide group-based treatment for those with hoarding issues. The group format was decided to be the best option as it provided access to a larger number of individuals to receive help. OCDAction supports the group by providing a space and hosting the group sessions details on its website. The group initially based its treatment model on *Buried in Treasure* (Tolin, Frost & Steketee, 2007) a treatment manual for compulsive hoarding. Whilst providing treatment based on this model it was observed that there were limitations in the model, as it did not address the emotional aspects of individuals with hoarding issues. As a result of our observations, reflections and reflexivity we developed the LHTG CBT treatment model that is innovative and creative using experiential interventions.

The case

Brigit is a 56 years old, employed, single woman living alone, who self-referred to the group after a chance meeting of a fellow group participant at a bus stop. Whilst at the bus stop, she started chatting with the fellow

passenger, who explained to her that she was en route to attend a group for the treatment of her hoarding issues. In their conversations, Brigit disclosed that she may have a hoarding problem, which prompted her fellow passenger to invite her to attend the group with her. She accompanied her fellow passenger to the group on the understanding that she could leave should she not feel comfortable with the group. Following her attendance, Brigit was offered to attend a brief assessment with the group facilitator.

Assessment

A brief assessment was carried out to help understand her hoarding issues and the impact it was having on her life. During the assessment, Brigit disclosed that her home has always been cluttered as long as she can remember. The situation appeared to have got worse after her parents died as she inherited their belongings, which she found difficult to discard. She works full time in an office and socialises with friends at the weekends. My reflexive thoughts were: “Is this an avoidance behavior?”, “Is she finding it uncomfortable in her environment?”. These are some common features of HD. Brigit described that she has a tendency to acquire newspapers and books, which are the bulk of her clutter, in addition to clothes and furniture to a lesser degree. Her fascination with newspapers and books is based on her love of reading and the desire to acquire new knowledge. Brigit held strong beliefs about progression in life through knowledge.

She has never been in a relationship and could not describe the reasons why she had never had a relationship. She has a number of close friends who she meets regularly but they have never visited her at home. My reflexive thoughts were: “Is she ashamed of her home?”, “How does she make sense of this?”, “What are her thoughts on what do other people do?”. On questioning further Brigit disclosed that she has never invited friends to her home and usually meets them in cafes.

Brigit was born in London and is an only child. Both of her parents are dead and she described them as loving and hard working. She recollects that her family was poor and they struggled financially. She did not feel that she was

deprived as her parents tried to give her the best they could. Brigit remembers being verbally bullied in school, as her parents could not afford new clothes for her. Her clothes were often old and of poor quality. My reflexive thoughts were: “This is a common feature for some individuals who have hoarding issues”, “How does Brigit makes sense of her past experiences and her present situation?”. Brigit completed secondary school and started working as a typist, and later became a secretary.

During the assessment, Brigit could not describe the meaning and did not have an understanding of her hoarding behaviours or the reasons for her clutter. She felt that perhaps she was lazy and should be cleaning more often. After the assessment, I reflected whether I should have used the Socratic questioning style to help Brigit to make sense of her hoarding behaviours and clutter.

Group

Brigit was welcomed to the group. At every group session, the ground rules and structure of the group were explained, as it was an open group. There are no expectations for the new participants to contribute to the group at their first attendance; however, they do have an option to speak in the group if they choose to do so. The aim of this is to ensure that individuals do not feel pressurised to participate and one of the aims of the group is to engage individuals into treatment. Another feature of the group is to move away from using the term hoarding disorder and to instead talk about hoarding behaviours, as it was seen to be labelling and stigmatising. The media attention on hoarding disorder has been a double edged sword as, whilst highlighting the condition, it has also been exposing, stigmatising and discriminating for individuals with hoarding issues. The group processes of universality, normalising and supportive (Singh, 2015) helps individuals engage and feel supported whilst attending the treatment group.

All new group participants are provided with *The Basics* (Singh, et al., 2015), which provides information for individuals and their family and friends and solutions to some of the common obstacles that individuals may experience.

The Basics provides advice on how to prepare to start dealing with their hoarding issues.

In each group session, participants are invited to engage with their Vision (Singh, et al., 2015). The Vision is a process where individuals are invited to visualise (Singer, 2006) how they would like to see their environment without the clutter. The use of the Vision has moved away from the traditional identification of problems and goals. It was found that identification of these was pressurising and often led to a feeling of failure when the goals were not met. The Vision use of imagery is both visual and experiential. My reflexive thoughts were: "Participants need to be offered the choice whether to engage in the intervention suggested in the group. It is about active participation and taking responsibility in dealing with their hoarding issues". Individuals are invited to engage with their emotional responses that aid their engagement in dealing with their cluttered environment.

Brigit's Vision was having a cleared living room where she could move freely without the fear of knocking things over. Her emotional experience was one of liberation. In the session, she was asked to link in with the feeling and describe in detail as to the location in her body and what it meant to her using the affect bridge technique (Watkin, 1971). Whilst linking with the feeling, Brigit was asked to work out the steps she would need to take to reach her Vision. This was her first homework task to be completed at home in preparation for the next session.

Motivation is a major issue for individuals with hoarding issues. Whilst working with Brigit in the session, my reflexivity identified the most appropriate approach to help develop her motivation. Brigit was spending vast amounts of time outside her environment, which could be an avoidance, and having photographs of the cluttered rooms could be a way to help her confront her hoarding issue. Another homework task for Brigit discussed in the first group was taking photographs of her environment with the intention to keep a record of her current situation, to be utilised to work on the next piece of work and measure change. In the subsequent session, Brigit was asked to engage with

the H.O.A.R.D acronym tool (Singh & Jones, 2012). This tool was designed to help individuals develop their motivation to deal with their clutter and hoarding behaviours. This tool was developed from the visual methodology and is a hybridisation from *Photovoice* (Wang, 1999) and *Photo Elicitation Method* (Harper, 2002). *Photovoice* allows the participant to take photographs of salient points in their life experiences, in this case, their cluttered environment, to develop a detailed narrative of the situation. This tool has elements of motivation interviewing (Rollnick & Miller, 1995) and emotional distancing (Jones & Singh, 2013).

Brigit was set the task of answering the five questions relating to the H.O.A.R.D acronym tool in a neutral environment and then within her home. She was asked to select a photograph of her environment that she had taken and to answer the questions. Brigit was surprised with the responses that she had when undertaking the task in a neutral environment. She was shocked to look at the photographs and, with the emotional distancing, she found that for the first time she saw her environment as it actually was. My reflexive thought was: "She has engaged and realises what her environment actually looks like. There is a degree of clutter blindness that individuals experience as the environment is familiar and they are not able to see the impact of the clutter. Brigit found that the degree of emotional distancing she experienced helped her reach a point where she wanted to clear that space.

H.O.A.R.D. Acronym Tool

H What **HAPPENED** in this picture?

I have lost control of my environment, it has been taken over by my books and newspapers. I have no control as the things that I am keeping have taken the space and I am at their mercy. I don't feel that I am free and sometimes trapped.

O What would I like to **OVERCOME** and what is my **VISION** as how I would like to my space and life to be?

My Vision is to have a living area where I can walk with ease and not worry about knocking things over. A place where I can sit and read and feel comfortable. At the moment I have no place to sit and have to be careful when I walk so that I don't trip or knock things over resulting in more time trying to restack. To feel free.

A Can I imagine my life without **ALL** this stuff?

It is hard for me to imagine not having my books, papers and clothes but on the other hand, I have been in places where I have not had my stuff and managed well. Those times were comfortable and I did not feel stressed.

R How is my life and **RELATIONSHIP** affected by this problem?

My friends have never visited my home and I have visited them in their home. Those times are very special for me as it makes me feel part of someone's life. I have never been in a close personal relationship. I am not sure what is like to be close with someone. I guess I have lost out.

D What would I like to **DO** about it?

I would like to have comfort in my life and I need some space for me. I would like to have a clear room for once and experience that feeling of being free. I need to take the step and be strong to start getting rid of things that I don't need. I am not sure where to start.

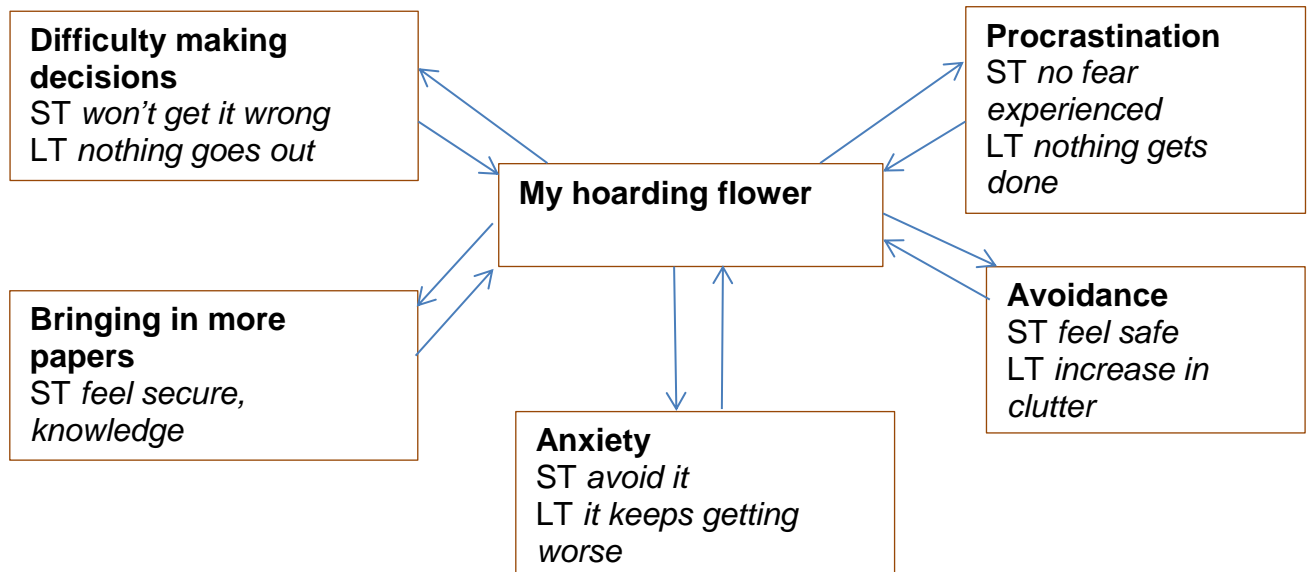
Her task was to write down the steps that she needed to take in order to clear her living area. Whilst in her home environment, Brigit felt overwhelmed in trying to deal with the clutter. In the group, we had discussed using the grid technique (Singh, et al., 2015) of dividing the room into smaller sections and only dealing with one section at a time. It is common that, when dealing with their clutter and feeling overwhelmed, that individuals distract themselves by engaging in other activities. Another intervention is the use of the colour card (Jones & Singh, 2014) to help them focus on the specific space or grid they have identified to work on.

Brigit was given a colour card, of a colour that was significant for her. She chose green as it was fresh and reminded her of spring and of her happier days. My reflexive thoughts were: "Green is an interesting colour, how can I utilise this to help engage Brigit in reducing her clutter?". In reflection, I could have explored further her happier days and gain a sense of what they were and the potential to use this in therapy. Brigit was instructed to place the colour card on the wall in the area that she is working on. It is intended to help draw attention to the area to be worked on and had some significant experience, e.g. happier times. Brigit was advised once completing a section, to move the colour card to another area that she intended to work on. She found the colour card helped her as it helped her focus her attention on that

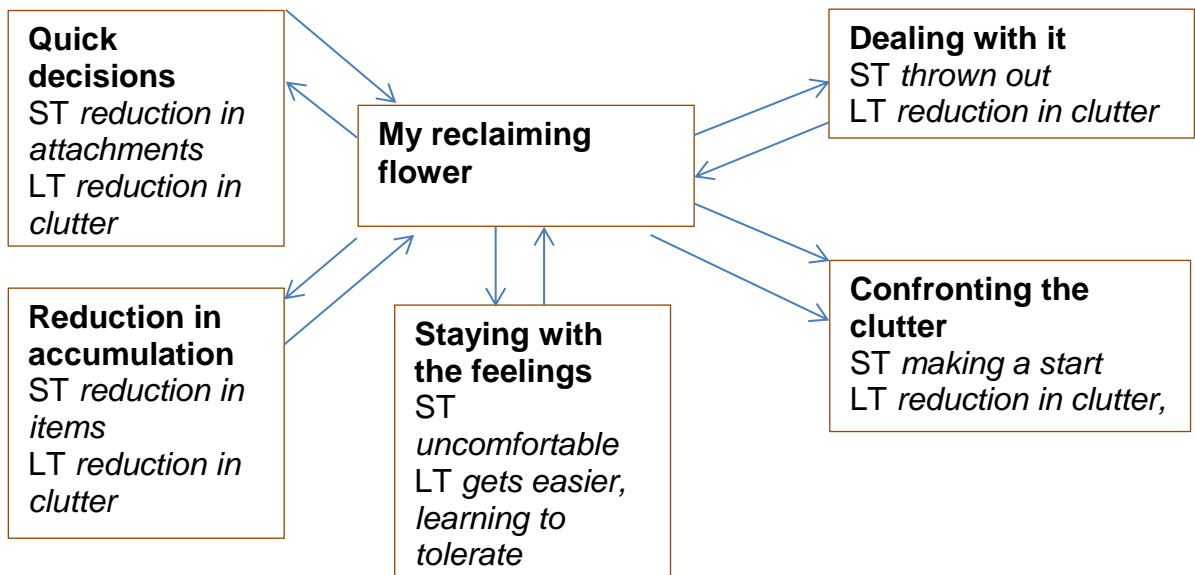
area and reduced her time procrastinating about engaging with the activity of decluttering. Brigit wrote on the card the words “focus here” with a downward arrow, which she felt helped her.

At each stage of her work, Brigit was reminded to take photographs and to use them to measure her progress and also as a motivating aid to chart her progress and observe the changes that were taking place. Brigit found it challenging emotionally to deal with her clutter and was encouraged to engage with her buddy, who she had linked in with, from the group. On reflection, I could have explored further what was emotionally challenging for her. I perhaps over-relied on the group to undertake this exploration. She found this helpful, as her buddy was challenging but understanding and she felt accountable to her buddy to ensure that she worked on her issues.

The next stage of Brigit’s treatment in the group therapy was making sense of her problem. She was asked to complete the *My hoarding flower* (Singh, et al., 2015), a formulation based on the vicious flower, that incorporates her beliefs, emotions and behaviours that maintain and perpetuate her hoarding behaviours. The group helped Brigit to identify her beliefs by the use of Socratic questioning, as well as her behaviours and emotions. They also helped her identify the short- and long-term consequences. The short- and long-term consequences are important factors to consider when dealing with beliefs, emotions and behaviours. These consequences maintain the hoarding behaviours. Brigit found this extremely helpful in understanding the role of the short and long term consequences, and how they maintain her hoarding issues. In reflection, I have considered whether developing the hoarding flower formulation could have been done earlier to help her make sense of her hoarding issues.



Following her formulation using the My hoarding flower, Brigit was asked in the group to consider developing the *My reclaiming flower* formulation (Singh et al., 2015). This is another formulation to help her to identify new behaviours, beliefs and emotions to help work with her hoarding problem. As with the hoarding flower, the reclaiming flower also focused on the short- and long-term consequences to help reinforce the helpful behaviours, emotions and behaviours.



Despite having completed both her hoarding and reclaiming formulations, Brigit still felt that she needed to understand the reasons why she had started engaging in hoarding behaviours in the first place. My reflexive thoughts at this point were: “What is she needing to understand?”, “In what way is the hoarding flower not able to answer her questions?” “What other techniques can be used to help her find the reasons for her hoarding issues?”. In one of the groups she attended, it was suggested that she could undertake narrative work (Epson & White, 1990) and therapeutic letter writing (Jolly, 2011) to help her develop a deeper and longitudinal understanding of her problems. Brigit decided to write a letter to her hoarding and the impact that it has had on her life. My reflexive thoughts were: “This could be a painful process, what safeguards are in place for her?”, “What additional support she may require during this process?”, “Encourage others to share their experiences – how did they deal with their strong emotions?”. She described it being a powerful experience for her as it was emotional, as it opened a channel to her past, which was painful, but it helped her to understand how the hoarding behaviours became a coping mechanism for her.

Dear Hoarding

I am writing this letter to you as you have taken over my life, I have lived a life of being alone and in my own world. You have kept the world out from my inner being... Writing this letter has made me realise I have lost out in my life of having a close relationship with someone. I have used you as a way of keeping others out of my life and feeling secure by keeping things. I have always been afraid of what people thought of me and you have kept people away and made me safe. I never had much in my life and having you around me makes me feel that I have something... I think it is too late for me now and I have been deprived of having a person in my life. I am now old and will be alone for the rest of my life.

The writing of the letter was helpful for Brigit as she was able to work through her past experiences and underlying issues to deal with her hoarding problems. As she uncovered some of her past issues, she sought counselling to help her come to terms and help her progress with her life.

The philosophy of the treatment group is reclaiming your space and life (Singh, et al., 2015). At every group therapy session, individuals are reminded to start engaging with life by undertaking activities that they have put off. One of the most important aspects is to share with family and close friends about their hoarding issues. The greatest fear that individuals experience is that they will be rejected by their loved ones. My reflexive thoughts were: "How will Brigit engage with this?", "How can she be supported in this process?", "How great a risk is it for her?", "Engage those who have done this to reduce her fears.". Brigit was asked to consider telling a friend who she felt comfortable with about her hoarding issues. She spent a considerable of time considering this proposal. After three months of consideration, she decided to speak about her hoarding issues with one of her close friends. To her surprise, her friend did not reject her but instead offered to help her. Brigit felt that it was too big a step to invite her friend over at this point, but it provided the motivation to clear her living area to a sufficient level so that her friend can visit.

One of her regrets, as she describes it, was that the hoarding has prevented her having a meaningful and close personal relationship in her life. My reflexive thoughts were: "Given that this opportunity has arisen, how can the group utilise this as a way to help her reclaim her life and develop meaningful

relationships?”. In the group therapy sessions the group explored ways of helping her to achieve this. As Brigit enjoyed reading, one suggestion offered was to join a reading group where she would have the opportunity to meet new likeminded people. This is still work in progress but she has developed close friendships with her fellow group participants and her personal buddy.

As part of the group therapy process, individuals are helped to develop the skills to identify their underlying beliefs and to challenge them as to the validity and conviction of their beliefs. Brigit started to challenge her beliefs by taking small risks and using self-talk (Singh et al., 2015) to question herself. Self-talk is the engagement that a person has with any situation that they are faced with. An example of self-talk for Brigit is that when she needs to discard an item, she has a dialogue in her mind about the meaning of and the reasons why she needs to keep it. My reflexive thoughts were: “To make it effective, this has to come from the group rather than me.” “I will need to encourage others who have used this technique to share their experiences and demonstrate it”. The group helped her to develop the skill of using self-talk in a positive way to help her to discard by changing the way she engages with situations to help her to reach her Vision. An example is of a book that Brigit brought to the group to discard:

Looking and holding the book, Brigit engaged with this self-talk:

It has been with me for so many years.

It is like a friend and I have not had the chance of reading it as yet. I have always wanted to read it.

I will need it in the future.

The group helped Brigit with her self-talk.

Yes, I have had it for so many years but I have not read it.

It is not likely I will read it now. If it was significant I would have read it then.

Having it does not help me reach my Vision and adds to the clutter.

Someone else could benefit from this book as it has been lying here all these years untouched.

In addition to the self-talk, Brigit found the 10-second rule (Singh et al., 2015) at looking at items when discarding helpful. The longer an individual spends looking at or checking an item, the less likely the item would be discarded. The self-talk that occurs when looking at an item places significance on it.

With the increase in significance and value on the item, the individual finds it more difficult to discard, resulting in items being kept and contributing to the hoarding issues.

Brigit has made good progress and has achieved her Vision of having a cleared living room. She has invited her friend to whom she disclosed that she had a hoarding issue. Her friend has continued to be a support to her and has offered Brigit help in dealing with the clutter in her bedroom. My reflexive thoughts were: “What is it about Brigit that her friend has been supportive towards her?”, “How can I capitalise on this to help her recognise her as a person who has so much to offer?”.

Throughout the group therapy, relapse prevention (Singh et al., 2015) is a key intervention to help participants maintain the gains they have made and deal with situations that are likely to make them vulnerable to start collecting items again. Relapse prevention is crucial in dealing with the ongoing issues. The group participants are asked to share their tips and ways they have been maintaining their gains. My reflexive thoughts were: “Individuals need to share their experiences, which will help them recognise what they have done to get this far.”. This helps consolidate their progress and also provides a sense of ability and accomplishment in dealing with their long-term problem that they have faced. It reinforces their resolve and resilience in dealing with a difficulty that has impacted on their life.

Brigit continues to attend the group less frequently than she did in the past. She averages a group every 2 months, which she finds helpful, and it benefits the group participants, especially those new to the group, as it instils hope that change can occur. My reflexive thoughts were: “The importance to highlight progress, resilience and ability to cope”, “The need to have follow up”, “Brigit’s attendance instils hope for others, especially sharing her experiences and contributing to the group”. She has been using both the *Overcoming Hoarding* (Singh et al., 2015) self-help book and the *Reclaiming your space and life* (Singh, 2015) App, which she has found helpful in dealing with her ongoing hoarding issues. She has been working on her underlying

issues of low self-esteem that she conceptualised as being a reason for engaging in hoarding behaviours.

References

Epston, D. & White, M. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

Harper, D. (2002). Talking about pictures: a case for photo-elicitation. *Visual Studies*, **17**: 13-26.

Jolly, M. (2011). What I never wanted to tell you: therapeutic letter writing in cultural context. *Journal of Medical Humanities*, **32**: 47-59.

Jones, C. & Singh, S. (2013). The Experience of Emotional Distancing in the Management of Compulsive Hoarding: A Visual Method Approach using the "HOARD" Acronym Tool. *Journal of Cognitive Behavioural Psychotherapy Research*, **2**: 41-46.

Jones, C. & Singh, S. (2014). The potential benefits of colour in supporting people with compulsive hoarding disorder. *Journal of Mental Health Practice*, **18(3)**: 29-32.

Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, **23**: 325-334.

Singer, J.A. (2006). *Imagery in Psychotherapy*. Washington DC: APA.

Singh, S. (2004). Interviewed by Raj Persaud on *All in the Mind*. BBC Radio 4 28th October.

Singh, S. (2015). Delivering group CBT: competencies and group processes. *Journal of Cognitive and Behavioural Research*.

Singh, S. (2015). *Reclaim your space and life*. A smartphone application. *Behavioural Psychotherapy Research*, **3**: 150-155.

Singh, S., Hooper, M. & Jones, C. (2015) *Overcoming Hoarding*. London: Robinsons Press.

Singh, S. & Jones, C. (2012). Visual Research Methods: A novel approach to understanding the experiences of compulsive hoarders. *Journal of Cognitive and Behavioural Psychotherapy Research*, **1(1)**: 36-42.

Tolin, D. Frost, R.O. & Steketee, G. (2007). *Buried in Treasures: Help for compulsive acquiring, saving and hoarding*. United States: Oxford University Press.

Wang, C.C. (1999). Photovoice: A Participation Action Research Strategy Applied to Women's Health. *Journal of Women's Health*. **8(2)**: 185-192.

Watkin, J.G. (1971). The affect bridge: A hypnoanalytical technique. *International Journal of Clinical and Experimental Hypnosis*. **19 (11)**: 21-27.

APPENDIX V - Reclaim your space and life APP

Reclaim your space and life

BEHAVIOURS?

HOW DO I KNOW THAT I HAVE A
HOARDING PROBLEM?

WHAT IS MY CURRENT SITUATION?

MY RECLAMING TOOL KIT

WHAT IS MY LEVEL OF DISCOMFORT AT
THIS PRESENT MOMENT?

GOLDEN RULES

RECLAIMING MY SPACE AND MY LIFE

MY TIPS

CONTACT US



Why do people engage in hoarding behaviours?

There is no one single reason as to why someone engages in hoarding behaviour. However, research has shown that there may be a genetic link, a reaction to a trauma, loss or bereavement, material deprivation, needing control, feeling safe and so forth. Additionally, individuals have strong emotional and sentimental attachments to their belongings and beliefs about the significance and value of those items.

The important issue is recognising that it is a problem for you and wanting to do something about it.

Some of the most common items saved and hoarded are newspapers, magazines, books, clothes amongst other things.

This app has been designed based on the self help model. It is an introduction to help you deal with your hoarding issues using self help as part of your journey in reclaiming your space and your life. If using this app raises difficult issues or you feel you need more help or support please seek professional help or speak to

< How do I know that I have a hoarding problem?

- Difficulty discarding items that you save and the thought of having to get rid of things cause you to feel distressed
- Disrupting your daily routines including work
- Actively buying or bringing items that are not readily used e.g. multiple copies of newspapers, clothes
- Affecting your relationships and not being able to invite others to your home
- Most importantly, your environment or space is not functioning for what it was designed for e.g. the kitchen is no longer functioning as a kitchen

If you answer to yes to any of those then you may probably have a hoarding problem





What is my current situation?

The first step is taking photographs of your environment. These photographs can be used for some of the interventions and serve a record and monitor your progress.

To upload your photograph of your environment, tap on the upload your photograph link, choose the category and then tap the square and take the photograph. Select use and press save.

To review your photograph and progress go to the main page tap of the area and you will be able to access your photographs and move across the pages to see all the photographs you have saved which can be used to monitor your progress.

Living room >

Bedroom >

Kitchen >

Bathroom >

Hallway >



My reclaiming tool kit

H.O.A.R.D acronym tool

Thoughts, feelings behaviours

The grid (select a room)

Colour card

Yes No Maybe

10 second rule

Key questions





H.O.A.R.D acronym tool



You need to be motivated to deal with your hoarding problem and its associated behaviours.

The **H.O.A.R.D.** acronym tool can be used to help understand that you have a problem and motivate you do deal with it.

Select a photograph that you have uploaded and go to a neutral environment such as a café, library or a friends house and ask yourself these five questions:

H What has **HAPPENED** in this picture?

O What would I like to **OVERCOME** and what is my vision as to how I would like my space and life to be?



Thoughts, feelings behaviours

Save

Trigger



Thoughts



Behaviours



Feelings





The grid (select a room)

Next select a room or area that is significant to you for example your bedroom so that you have a space where you can sleep and rest (living room, bedroom, kitchen, bathroom, hallway, stairway)

Break the area into small sections using a grid. You can either draw small square or place a transparent grid over the photograph to help you break the area into smaller sections. It is easier to work in a smaller area rather than the whole area.

When you start working on your selected area, it may be useful to have three piles. Use the **YES** **NO** **MAYBE** tool.

Select room:

Living room >

Bedroom >

Kitchen >



Colour card

Living in an environment can sometimes make it difficult for anyone to focus on the area they intend to work on. Using a colour card can be helpful to keep you focused on the area you are working on.

Select a colour card- a colour that is significant to you. Place this card on the area that you have selected to work on for example on the wall above the clutter. The colour card will draw your attention and attention to the area you need to work on.

Back

Living room

Select colour card





YES NO MAYBE

When you start working on your selected area, it may be useful to have three piles.

The **YES** pile- items that are definitely going out

The **NO** pile- items that are definitely staying

The **MAYBE** pile- items that you are unsure of.

Return to the **MAYBE** pile later to sort out using the **YES** **NO** piles again.

Repeat this until you have completely sorted out the **MAYBE** pile. It could be helpful using the Key questions to help you sort out your things.

Once your bag is filled place it in the area where it will be collected. Be careful that you do not go and bring in back in.





10 second rule

Use the 10 second checking golden rule. Do not spend more than 10 seconds looking at each item. The longer you spend checking the less likely it will go out. The longer you look at the item you tend to place more significance on it and attach more feelings and find more difficult to discard.

Use the 10 second rule when you are using the **YES** **NO** **MAYBE** tool.





Key questions

Save

When was the last time I used it?

If it has been more than 6 months how likely I will need it?

If I had not seen it would I have needed it?

How likely I am going to need it?

What difference would it make to my life?

< What is my level of discomfort at this present moment? Save

When decluttering and dealing with items that appear to be significant to you, you may feel discomfort and anxiety. Stay with these feelings and try not to get rid of them, let them pass gradually. The more you try to fight these feelings the more significant they become resulting them affecting you longer.

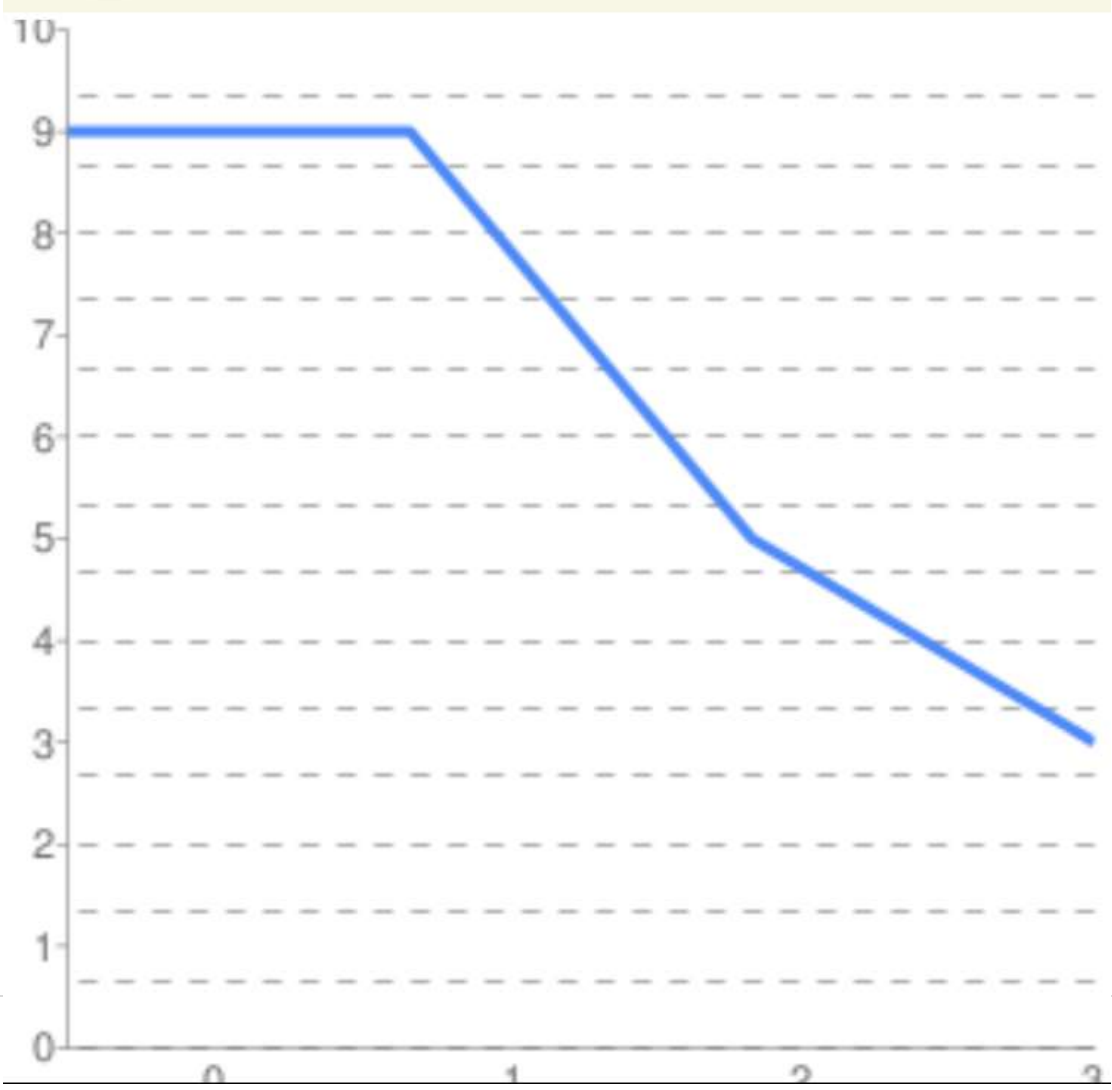
Sometimes you may find that find the level of distress is not reducing. If that is the case then question yourself as to how you may be engaging with your distress, for example by focussing on it, monitoring the level of discomfort, concentrating on these feelings and talking about them, trying to find ways of reducing it quickly (the quick fix). Remember short-term gain long term pain. Going through the discomfort in the short term will bring longer-term gain.

As you are staying with these feelings and riding them out, re-rate them at regular intervals and observe what you find.

What is my level of discomfort at this present moment? Save

As you are staying with these feelings and riding them out, re-rate them at regular intervals and observe what you find.

Rate your feelings from a scale 0 to 10 (most uncomfortable)





Golden rules

- Build into your daily routine a specific time deal with your clutter or hoard.
- Start from as little as 15 minutes a day and gradually build it up.
- Tell a family member, carer or a friend of your intention for the day (what your plans are in relation to dealing with your clutter) being accountable and having to report back to them will help with your motivation.
- Be consistent when dealing with your clutter and addressing your hoarding behaviours.
- Ensure you work in the one area that you have chosen. Use the colour card to mark the area as it will help you focus.
- Move the colour card when you are ready to deal with another section.
- If you find yourself getting distracted by other areas, issues use the colour card to refocus on the area that you need to work on.

Reclaiming my space and my life

As you work on your clutter and hoarding behaviours it is important to start incorporating new activities into your life. Keeping a record of the activities that you are engaging in and how they are added to the quality of your life will help improve your motivation to deal with your hoarding problems. Keep a record as to what you need to be doing continually to maintain your progress for the longer term and the obstacles that could interfere with the work you are undertaking. Problem solve these obstacles so that you have a plan as to how to overcome them and not let them interfere with the progress you are making.

The new activities that I have engaging in are:

In what way are these new activities adding to my life?



Reclaiming my space and my life



The new activities that I have engaging in are:

In what way are these new activities adding to my life?

The people I have invited to my home are:

What does it feel like having family and friends in my home?

What do I need to do to keep on top of my clutter and hoarding behaviours?



My tips



Write down your personal tips that you have found useful to serve as a reminder and help you in your ongoing work or if someone had a hoarding problem what advice would you give them?

You can save this information and send it to us share your tips with other who have hoarding issues. Just press share and send the email.





Contact us

Get in Touch

We would love to hear from you and receive your feedback.

Web Address:

www.lifemattersconsultancy.com

Email Us:

reclaimyourspaceandlife@gmail.com

Additional resource:

Overcoming Hoarding: A self-help guide using Cognitive Behavioural Techniques

Published by Robinson.

PART 3: EXAMPLES OF THE PUBLIC WORKS

Part 3 will contain a selection of public works.

Due to issues of confidentiality, I have not been able to provide the clinical supervision notes for the therapist on their clinical work with individuals with hoarding behaviours.

3.0 COLLABORATION

- PW 3.01 Singh, S., Hooper, M. & Jones, C. (2015) *Overcoming Hoarding*. London: Robinsons Press.
- PW 3.01a Letter of collaboration from Margaret Hooper.
- PW 3.02 Singh, S. (2015). *Reclaim your space and life* a smartphone application- iTunes and Google Play page printouts.
- PW 3.03 Singh, S. (2012). Behandelopties voor problematische verzmelaars in O.R.V. Van Beers & E. Hoogdin (Eds.) in *Problematische verzame laars*. Amsterdam: Uitgeverij Boom.
- PW 3.04 Email from research supervisor on collaborative work.
- PW 3 05 Pertusa A, Fullana MA, Singh S, Alonso P, Menchón JM, Mataix-Cols D (2008). Compulsive hoarding: OCD symptom, distinct clinical syndrome, or both? *American Journal of Psychiatry*, **165**: 1289-1298.
- PW 3 06 Landau, D., Iervolino, A. C., Pertusa, A., Santo, S., Singh, S., & Mataix-Cols, D. (2011). Stressful life events and material deprivation in hoarding disorder. *Journal of Anxiety Disorders*, **25(2)**: 192–202. doi:10.1016/j.janxdis.2010.09.002
- PW 3.07 Fernandez de la Cruz, L., Landau, D., Iervolino, A.C., Santo, S., Pertusa, A., Singh, S., Mataix-Cols, D. (2013). Experiential avoidance and emotion regulation in hoarding disorder. *Journal of Anxiety Disorders*, Vol (27): 204-209.
- PW 3.08 Letter from research colleague Colin Jones on collaborative work.
- PW 3.09 Singh, S. & Jones, C. (2012). Visual Research Methods: A novel approach to understanding the experiences of compulsive hoarders. *Journal of Cognitive and Behavioural Psychotherapy Research*, **1 (1)**: 36-42.
- PW 3. 10 Jones, C. & Singh, S. (2013). The Experience of Emotional Distancing in the Management of Compulsive Hoarding: A Visual Method Approach using the “HOARD” Acronym Tool. *Journal of Cognitive Behavioural Psychotherapy Research*, **2**:41-46.
- PW 3.11 Jones, C. & Singh, S. (2014). The potential benefits of colour in supporting people with compulsive hoarding disorder. *Journal of Mental Health Practice*, **18(3)**: 29-32.

- PW 3. 12 Singh, S. & Jones, C. (2013a). Engaging in treatment sufferers of compulsive hoarding disorder. *Journal of Mental Health* **17(4)**: 16-20.
- PW 3.13 Singh, S. & Jones, C. (2013b). Novel method in engaging compulsive hoarders in treatment. *Advances in Cognitive Therapy* **14 (2)**: 8-11.
- PW. 3.14 Singh, S. & Jones, C. (2016). The challenges of working with hoarders: a survey of professional groups. (under review *Journal of Mental Health*).
- PW 3.15 London Hoarding Treatment Group- OCD Action.
- PW 3.15a Singh, S. (2014). Engaging with individual who hoard. *Social Care Information and Learning Services* (online learning module).
- PW 3.16 Hampton, M. (2009). *Possessed*. http://www.martinhampton.com/MPH_FILMS_films_POSSESSED.html (DVD)
- PW 3.17 [Taboo Series \(2011\): *Hoarding Therapy*. National Geographic](http://channel.nationalgeographic.com/taboo/videos/hoarding-therapy/)
- PW 3.18 Wellcome Trust small arts awards application for the The Squirrel Project/Even if I do it on purpose and email about my role.
- PW 3.19 Singh, S. (2013). Hoarding- Miss Havisham Syndrome. An essay for This Mess is a Place project. An interdisciplinary project exploring the borders of hoarding. in Mendelson, Z. (2013). *This Mess is a Place*. <http://thismessisaplace.co.uk>
- PW 3.20 Hoarding in an Italian community sample. (*Journal of Behavioural and Cognitive Psychotherapy*) - peer review.
- PW 3.21 The Role of Adult Attachment and Social Support in Hoarding Disorder. (*Journal of Behavioural and Cognitive Psychotherapy*) - peer review.
- PW 3.22 To hold or let go?: Loss and Substitution in the Process of Hoarding. (*European Journal of Psychotherapy & Counselling*)-peer review.
- PW 3.23 A Struggle with Contents Towards an Understanding of the Dynamics of Hoarding. (*Journal of Contemporary Psychotherapy*)- peer review.
- PW 3.24 The Experience of Working with Hoarders: A Q-Sort Exploration.

(Journal of Mental Health)- peer review.

3.1 RAISING AWARENESS AND UNDERSTANDING

- PW 3.25 Email request to speak on BBC Radio Newcastle.
- PW 3.26 Email request to speak on Radio Notts.
- PW 3.27 Email request to speak on Talk Radio Europe.
- PW 3.28 Email request to speak on BBC Radio Lancashire.
- PW 3.29 Email request for filming on BBC Hoarding documentary.
- PW 3.30 Email request for Podcast Interview.
- PW 3.31 Email request for hoarding disorder training for Notts Fire Service.
- PW 3.32 Email feedback on the training and service development. Presentation attached
- PW 3.33 Email from OCDAction for request for Q&A session on hoarding disorder and feedback of session.
- PW 3.34 Email for Thurrock Borough Council for training and providing feedback.
- PW 3.35 Email from Cotman Housing on hoarding disorder training needs objectives and feedback.
- PW 3.36 Email confirming and feedback training on hoarding disorder for Thirteen Care and Support.
- PW 3.37 Email request from Nottingham Fire service for training on hoarding disorder.
- PW 3.38 Email request from Epping Forest District Council for training on hoarding disorder and presentation attached.
- PW 3.39 Email confirming venue for hoarding disorder awareness sessions for the National Housing Federation with agendas attached.
- PW 3.40 Selection of training presentations for housing.
- PW 3.41 Masterclass presentations on hoarding disorder for University of Coventry and University of East London with training evaluation forms attached.
- PW 3.41a Email requesting training on hoarding disorder and self-neglect with presentation and feedback.

3.2 DISSEMINATION

- PW 3.42 Email invitation to present at the Compulsive Hoarding II in the Netherlands organized by Cure & Care Developments including presentation.
- PW 3.43 Email invitation to attend and present at the International Squalor and Hoarding Conference in Sydney, Australia.
- PW 3.43 Email from Environmental Health Officer, Manawatu District Council, Fielding, New Zealand for a SKYPE presentation for their 'Jacks and Jackies of All Trades' conference includes agenda.
- PW 3.44 Email of thanks for presenting at the East Midlands Environmental Health conference, feedback and agenda
- PW 3.45 Agenda for Cure and Care 'Problematistische Verzamelaars: Waar bermoei jij je eigenlijk mee?' conference including presentation.
- PW 3.46 Email from NBPO to present a full day seminar on engaging those with hoarding issues in the Netherlands includes the presentation.
- PW 3.47 Email confirming acceptance of proposal to present a workshop on engaging individuals in dealing with their hoarding at the 16th annual International Conference on Hoarding and Cluttering in San Francisco, USA.
- PW 3.48 Invitation to submit research abstracts for Institute of Challenging Disorganisation, Cleveland, Ohio includes the published abstracts.
- PW 3.49 Email confirming presentation at the 'Hoarding behavior: taking steps to tackle a hidden problem in Nottingham, UK organized by Central Conference Consultants LTD includes flyer and presentation.
- PW 3.50 Agenda for Richmond Fellowship housing management conference. 'Pulling Together: co-producing housing management services, London, UK includes presentation.
- PW 3.51 17th Annual International Conference on Hoarding and Cluttering, San Francisco, USA conference abstract book including presentation and evaluation.
- PW 3.52 Email invitation to present at the Institute of Chronic Disorganisation conference in September 2016 in Portland,

Oregon includes, bio aims, objectives and emails discussing the contents of the presentation. Includes both presentations.

3.3 SUPPORT

- PW 3.53 Email requesting a visit from a Dutch nurse specialist to discuss her interest in hoarding disorder.
- PW 3.54 Email from nurse psychotherapist for advice on a patient and response attached.
- PW 3.55 Email from student social worker and therapist for information on hoarding disorder and advice and supervision on a case.
- PW 3.56 Email for invitation and to attend the Lewisham's protocol on hoarding disorder later to be developed as the Pan London Hoarding Protocol.
- PW 3.57 Email for information on psychological issues around empty property 'the inheritance taboo and buffers' and formal letter to write a paper on this topic.
- PW 3.58 Email to invite to attend a meeting and present the paper Psychological issues around empty property 'the inheritance taboo and buffers'.
- PW 3.59 Email for information on hoarding disorder to develop a resource in Cumbria, UK.
- PW 3.60 Email to discuss a case and training and update on the case.
- PW 3.61 Email from social services for support for an individual.
- PW 3.61a Email to discussion and potentially contribute to the development of a course for dealing with hoarding disorder.
- PW 3.62 Email from a professional to accompany a client to attend the group.
- PW 3.63 Email from social services for information and resources on hoarding disorder.
- PW 3.64 Email on feedback and development including the Nottingham Multi-Agency Hoarding Framework.
- PW 3.65 Email from the Sun Woman request to attend the group.
- PW 3.66 Email from the National Housing Federation for contribution to NHF briefing on hoarding disorder includes contribution.
- PW 3.67 Email from National Housing Federation on the publication of the report on hoarding and copy attached.

- PW 3.68 Email from London Borough of Hillingdon to attend the Residents and Environmental Health Committee Meeting as a specialist on hoarding issues.
- PW 3.68 London Borough of Hillingdon Residents and Environmental Health Policy Overview Committee minutes with contribution on hoarding disorder.
- PW 3.68a Email invitation to attend the Greenwich Hoarding Panel and feedback.
- PW 3.69 Email from hoarding and self neglect practitioner on advice to engage with the mental health teams and response.
- PW 3.70 Email from academic research facilitation on hoarding disorder.

3.4 PROFESSIONAL APPRAISAL

- PW 3.71 Email providing reference on training and impact of the training.
- PW 3.72 Journal of Cognitive and Behavioural Psychotherapy and Research denoting my involvement as a member of the International Advisory Board.
- PW 3.73 Email providing feedback and impact of training offered in the Netherlands.
- PW 3.74 Email providing feedback on project and impact of training offered.
- PW 3.75 Email with invitation to join the editorial board of the Journal of Contemporary Behavioural Health Care.
- PW 3.76 Email with feedback from Professor Cooper on reviewing the draft of *Overcoming Hoarding*.
- PW 3.77 Sunday Times Style Magazine article *Drowning in Clutter* by Edwina Ings-Chambers on her experiences working with *Overcoming Hoarding* book.
- PW 3.77a Email of recommendation to present at the ICD conference.
- PW 3.78 Email providing feedback on observations of the group therapy session by a professional.
- PW 3.79 Email invitation to be part of the Chief Fire Officers Network for the hoarding working group and mental health group.
- PW 3.80 Research Gate profile recording of citations.
- PW 3.81 LinkedIn profile
- PW 3.82 Metanoia dissertation presentation