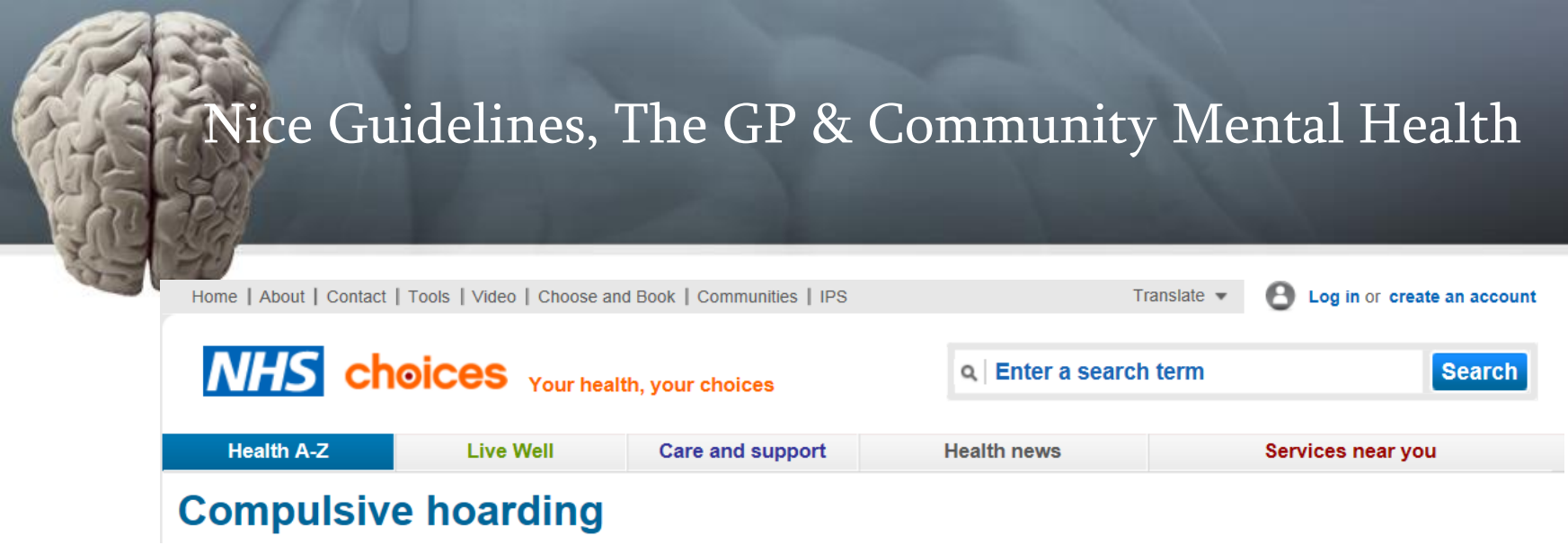
Hoarding Behaviours

Agenda

- The Human mind, Psychology & Psychiatry
- What is a ‘Disorder’;
- Hoarding Behaviours: The differential diagnoses;
- Human Rights Act, Mental Capacity Act, Mental Health Act;
- Environmental Health Legislation;
- The problems, challenges and common mistakes that most people make when working with individuals vulnerable to hoarding behaviours;
- The treatments & solutions
- Policy & multi-agency protocols

Nice Guidelines, The GP & Community Mental Health



What you can do if you suspect someone is hoarding
If a member of your family or someone you know is a compulsive hoarder, try to persuade them to come with you to see a GP. This will not be easy, as someone who compulsively hoards may not think they need help and may not want to seek treatment.

Ask your GP to refer you to your local community mental health team, which may have a health professional who specialises in OCD and is familiar with hoarding.

How compulsive hoarding is treated
It's not easy to treat compulsive hoarding, even when the person is prepared to seek help, but it can be overcome.

The main treatment is cognitive behavioural therapy (CBT). The therapist will help the person understand what makes it difficult to throw things away and the reasons why the clutter has built up.

This will be combined with practical tasks and a plan to work on. It is important that the person takes responsibility for clearing the clutter from their home. The therapist will support and encourage this.

A type of antidepressant – selective serotonin reuptake inhibitors (SSRIs) – has also been shown to help some, but not all, compulsive hoarders.

Cognitive–behavioural therapy for compulsive hoarding: principles of treatment

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Compulsive hoarding

Cognitive behavioural therapy (CBT)
CBT is a type of therapy that aims to help you manage your problems by changing how you think and act. It encourages you to talk about how you think about yourself, the world and other people, and how what you do affects your thoughts and feelings.

By talking about these things, CBT can help you to change how you think (cognitive) and what you do (behaviour), which can help you feel better about life.

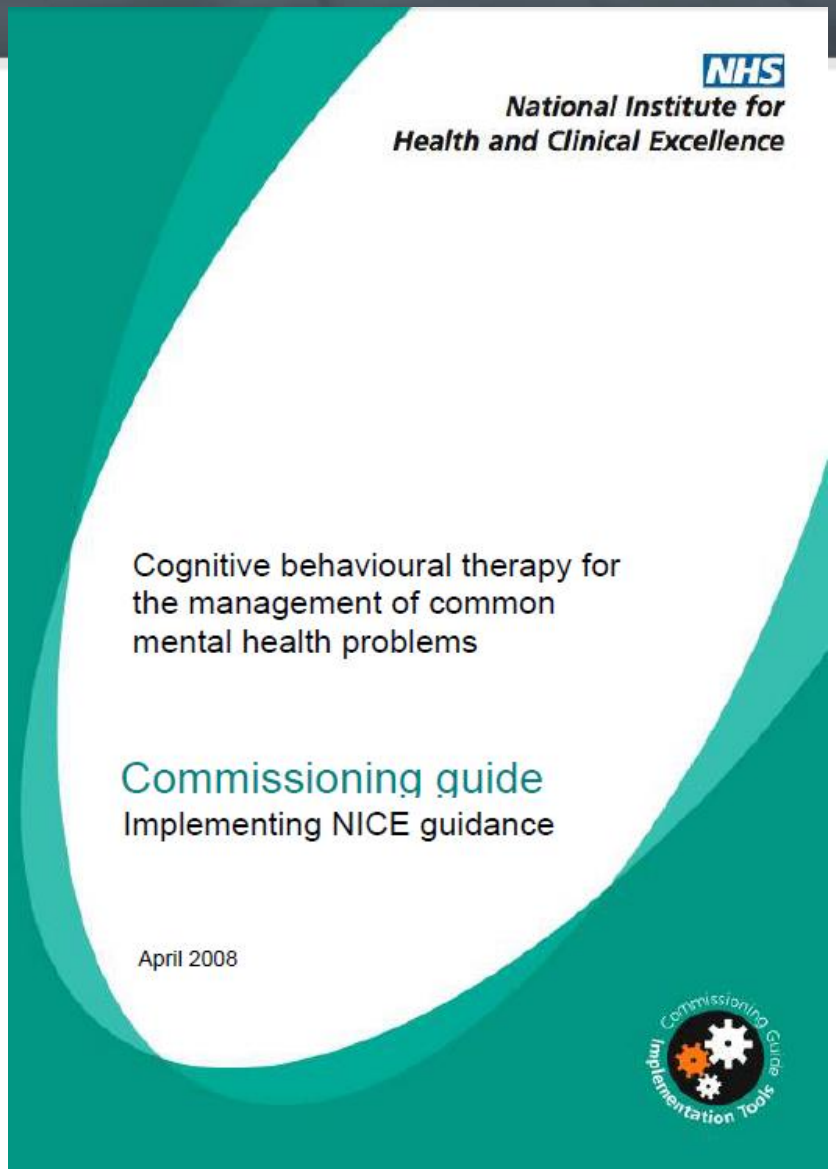
The National Institute for Health and Care Excellence (NICE) recommends that a period of cognitive behavioural therapy is considered for adults who have significant problems with hoarding.

Regular sessions of CBT over a long period of time are usually necessary and should include some home-based sessions, working directly on the clutter. This requires motivation, commitment and patience, as it can take many months to achieve the treatment goal. The goal is to improve the person's decision-making and organisational skills, help them overcome urges to save, and ultimately clear the clutter, room by room.

The therapist won't throw anything away, but will help guide and encourage the person to do so. The therapist can also help the person develop decision-making strategies, while identifying and challenging underlying beliefs that contribute to the hoarding problem. The person gradually becomes better at throwing things away, learning that nothing terrible happens when they do so, and becomes better at organising items they insist on keeping.

At the end of treatment, the person may not have cleared all their clutter, but they will have gained a better understanding of the problem. They will have a plan to help them continue to build on their successes and avoid slipping back into their old ways.

Cognitive–behavioural therapy for compulsive hoarding: principles of treatment



Human Rights Act.

Article 5. Right to Liberty and Security

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law

(a) the lawful detention of a person after conviction by a competent court;

(b) the lawful arrest or detention of a person for noncompliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;

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Human Rights Act.

Article 8. Right to private and family life

Article 8 Right to a private and family life
Everyone has the right to respect for his of her private and family life, home and correspondence. This right is subject to proportionate and lawful restrictions. Article 8 is a broad-ranging right that is often closely connected with other rights such as freedom of religion, freedom of expression, freedom of association and the right to respect for property.

The obligation on the State under Article 8 is to refrain from interfering with the right itself and also to take some positive measures, for example, to criminalise extreme breaches of the right to a private life by private individuals.

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DSM Criteria for Hoarding Disorder

The DSM 5 diagnostic criteria for hoarding disorder is:

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty discarding is due to a perceived need to save the items and distress associated with discarding them.

C. The symptoms result in the accumulation of possessions that congest and clutter active living areas and substantially compromise their intended use. If living areas are decluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

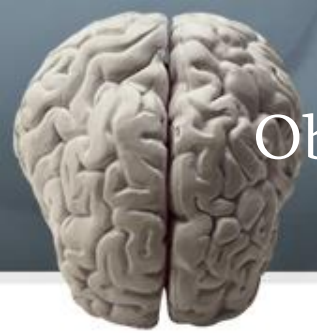
D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).

F. The hoarding symptoms is not better accounted hoarding due to obsessions in Obsessive-Compulsive Disorder, decreased energy in Major Depressive Disorder, delusions in Schizophrenia or another Psychotic Disorder, cognitive deficits in Dementia, restricted interests in Autism Spectrum Disorder)

Self Control (Impulse Control)

- **Self Control (Impulse Control)**
- The ability to evaluate and subsequently respond flexibly;
- The ability to forego an immediate reward in favour of a delayed larger reward;
- The ability to use available information to reflect on the consequences of an action;
- The ability to suppress motor responses;
- The capacity to delay reward.

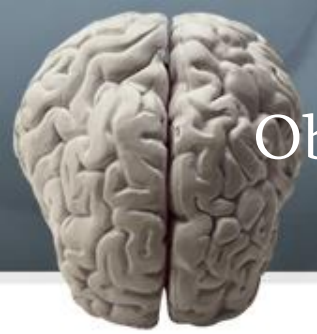


Obsessive-Compulsive Personality Disorder (Anankastic)

The World Health Organization's ICD-10 uses the term *anankastic personality disorder* (F60.5).[1] *Anankastic* is derived from the Greek word *ἀναγκαστικός* (*Anankastikos*: "compulsion").

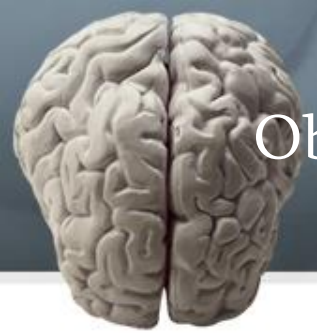
It is characterised by at least four of the following:

- feelings of excessive doubt and caution;
- preoccupation with details, rules, lists, order, organization, or schedule;
- perfectionism that interferes with task completion;
- excessive conscientiousness, scrupulousness, and undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships;
- excessive pedantry and adherence to social conventions;
- rigidity and stubbornness;
- unreasonable insistence by the individual that others submit exactly to his or her way of doing things or unreasonable reluctance to allow others to do things;



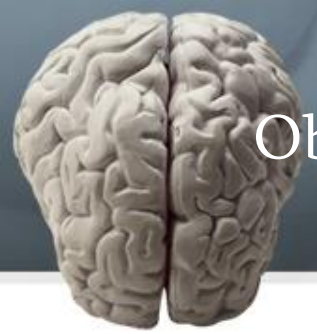
Obsessive-Compulsive Personality Disorder (Anankastic)

Symptom of OCPD	Consequences to organisations working with an individual's Hoarding problem
Feelings of excessive doubt and caution (ICD 10)	Concerns with making the wrong decision which can disable best intentions
Excessive pedantry and adherence to social conventions (ICD 10)	A determination to do things "by the book" to an extent that it overrides intuition. This naturally delays the de-cluttering process as common-sense intuition is often lacking and conflict commonly results
Rigidity and stubbornness (ICD 10) (Perception of one's own and others' actions and beliefs tend to be polarised into "right" or "wrong", with little or no margin between the two). General refusal to take someone else's Point of view	The ideas of backing down creates feelings of loss, being reduced, being humbled, and, hence, being a lesser person. So stubbornness and rigidity of view serves to maintain a fragile sense of self. Once an individual emotionally interprets a situation in such a way as to feel controlled, he or she is likely to slip into passive-aggressive resistance. In feeling forced to comply, passive-aggressive people might say to themselves, "No, I won't, and you can't make me!" They seem agreeable on the surface, but their resistance and behaviours soon exhibit the rigidity of passive non-compliance.



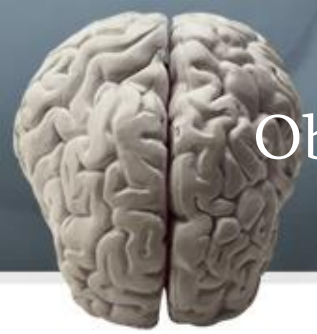
Obsessive-Compulsive Personality Disorder (Anankastic)

Symptom of OCPD	Consequences to organisations working with an individual's Hoarding problem
Unreasonable insistence by the individual that others submit exactly to his or her way of doing things or unreasonable reluctance to allow others to do things (ICD 10)	Results in constant tension and conflict and delays in any decluttering / cleansing process. Conversation fail and result in conflict before the process of decluttering / cleansing even begin.
Preoccupation with remembering past events,	Possessions serve as reminders of significant life events.
Critical of short cuts taken by others and unwilling to modify routines even though it causes problems.	Results in conflict and delays in the de-cluttering process as the individual refuses to allow anyone to make decisions that may simply or speed-up the process of decluttering / cleansing.



Obsessive-Compulsive Personality Disorder (Anankastic)

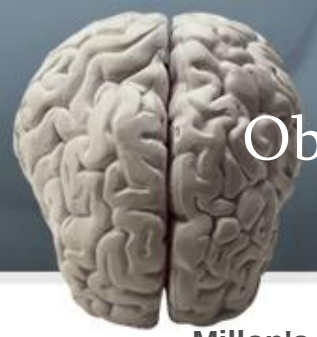
Symptom of OCPD	Consequences to organisations working with an individual's Hoarding problem
Angry outbursts when their sense of control is threatened.	The refusal to allow anyone to help functions to maintain a sense of self-worth and value. Individuals resist delegating work, immerse themselves in the work assigned to others, look at the detail instead of the big picture, discourage or refuse others to make any decisions, push aside the experience and knowledge of experts and generally focus on the wrong priorities.
Preoccupation with remembering past events and fear of making the wrong decision	Possessions serve as reminders of significant life events.



Obsessive-Compulsive Personality Disorder

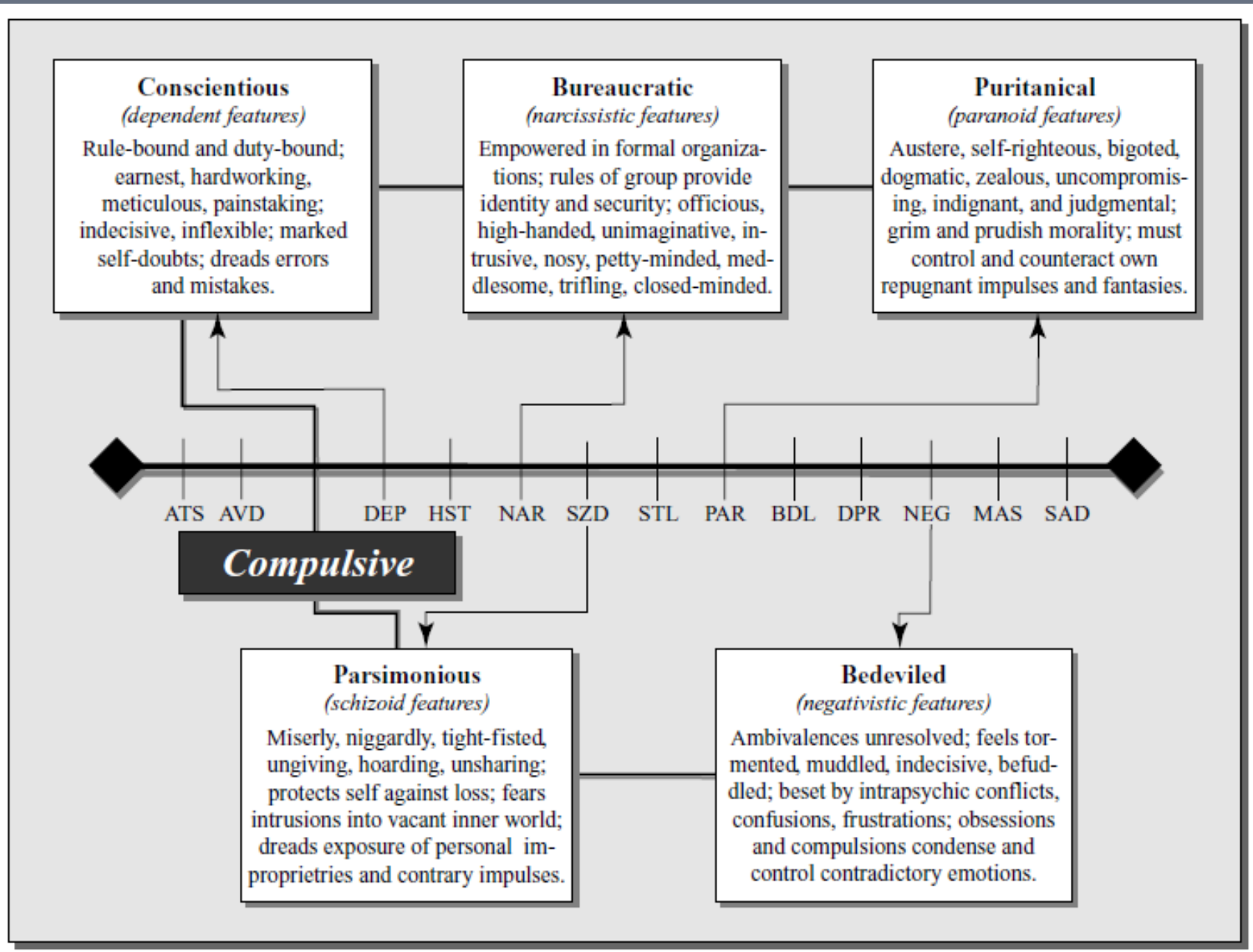
- **Obsessive–compulsive personality disorder** (**OCPD**) is a personality disorder characterized by a general pattern of concern with orderliness, perfectionism, excessive attention to details, mental and interpersonal control, and a need for control over one's environment, at the expense of flexibility, openness to experience, and efficiency.
- Workaholism and miserliness are also seen often in those with this personality disorder.
- Persons affected with this disorder may find it hard to relax, always feeling that time is running out for their activities, and that more effort is needed to achieve their goals. They may plan their activities down to the minute—a manifestation of the compulsive tendency to keep control over their environment and to dislike unpredictable events as elements beyond their control.

- The main observed symptoms of OCPD are
    - (1) preoccupation with remembering past events,
    - (2) paying attention to minor details,
    - (3) excessive compliance with rules or regulations,
    - (4) unwarranted compulsion to note-taking, or making lists and schedules, and
    - (5) rigidity of one's own beliefs, or
    - (6) showing unreasonable degree of perfectionism that could eventually interfere with completing the task at hand.
- OCPD's symptoms may cause varying level of distress for varying length of time (transient, acute, or chronic), and may interfere with the patient's occupational, social, and romantic life.
- OCPD patients might never do obsessive cleaning/organizing, as they become increasingly busy with their workload, and thus their stress turns gradually to what can be described as anxiety. Anxiety is a disorder known for excessive and unexpected worry that negatively impacts an individual's daily life, and routines.
- Perception of one's own and others' actions and beliefs tend to be polarised into "right" or "wrong", with little or no margin between the two. For people with this disorder, rigidity could place strain on interpersonal relationships, with occasional frustration turning into anger.



Obsessive-Compulsive Personality Disorder

Millon's subtypes:
Theodore Millon identified subtypes of the compulsive personality (2004). These include:-
Parsimonious compulsive: Miserly, tight-fisted, ungiving, hoarding, unsharing; protects self against loss; fears intrusions into vacant inner world; dreads exposure of personal improprieties and contrary impulses.
Bedeviled compulsive: Ambivalences unresolved; feels tormented, muddled, indecisive, befuddled; beset by intrapsychic conflicts, confusions, frustrations; obsessions and compulsions condense and control contradictory emotions.


Conscientious
(dependent features)
Rule-bound and duty-bound; earnest, hardworking, meticulous, painstaking; indecisive, inflexible; marked self-doubts; dreads errors and mistakes.
Bureaucratic
(narcissistic features)
Empowered in formal organizations; rules of group provide identity and security; officious, high-handed, unimaginative, intrusive, nosy, petty-minded, meddlesome, trifling, closed-minded.
Puritanical
(paranoid features)
Austere, self-righteous, bigoted, dogmatic, zealous, uncompromising, indignant, and judgmental; grim and prudish morality; must control and counteract own repugnant impulses and fantasies.
ATS AVD DEP HST NAR SZD STL PAR BDL DPR NEG MAS SAD
Compulsive
Parsimonious
(schizoid features)
Miserly, niggardly, tight-fisted, ungiving, hoarding, unsharing; protects self against loss; fears intrusions into vacant inner world; dreads exposure of personal improprietries and contrary impulses.
Bedeviled
(negativistic features)
Ambivalences unresolved; feels tormented, muddled, indecisive, befuddled; beset by intrapsychic conflicts, confusions, frustrations; obsessions and compulsions condense and control contradictory emotions.

Considering Anxiety in Hoarding Behaviours

- Anxiety

- Decisions;
- Making mistakes;
- Losing opportunities;
- Worries and memory;
- Losing information;
- Putting things out of sight;

Hoarding features

Table 1. Comparison of the features of collecting, hoarding and accumulation

Normal collecting	*Controlled hoarding*	*Pathological hoarding*	*Non-purposeful ('organic') accumulation*
Selective. Cohesive theme. One or a few categories.	Somewhat selective. One or a few categories.	Non-selective. Lots of different categories.	Non-selective.
Planned, organised collecting.	Purposeful, but relatively unplanned.	Purposeful, but with lack of planning or focus.	Unplanned.
Not usually excessive.	Not excessive.	Excessive.	Can become excessive.
Orderly display of collected items.	Items commonly stored in a disorganised way.	Disorganised clutter.	Unorganised.
Not distressing unless costly.	Not distressing.	Distress is very common.	Can become distressing.
Little or no social impairment; collecting enhances social life.	Little or no social impairment.	Considerable social impairment/withdrawal.	Social life may be affected.
No significant functional or work impairment.	No functional or work impairment.	Occupational + functional impairment common.	May result in functional impairment.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Outcomes?


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DSM Criteria for Schizophrenia

- According to the revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), to be diagnosed with schizophrenia, three diagnostic criteria must be met:
- Characteristic symptoms: Two or more of the following, each present for much of the time during a one-month period (or less, if symptoms remitted with treatment).
  - **Delusions**
  - **Hallucinations**
  - **Disorganised speech, which is a manifestation of formal thought disorder**
  - **Grossly disorganized behaviour (e.g. dressing inappropriately, crying frequently) or catatonic behavior**
  - **Negative symptoms: Blunted affect (lack or decline in emotional response), alogia (lack or decline in speech), or avolition (lack or decline in motivation)**
- If the delusions are judged to be bizarre, or hallucinations consist of hearing one voice participating in a running commentary of the patient's actions or of hearing two or more voices conversing with each other, only that symptom is required above. The speech disorganization criterion is only met if it is severe enough to substantially impair communication.

- Cont …

DSM Criteria for Schizophrenia

- Social or occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset.
- Significant duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less, if symptoms remitted with treatment).
- If signs of disturbance are present for more than a month but less than six months, the diagnosis of schizophreniform disorder is applied. Psychotic symptoms lasting less than a month may be diagnosed as brief psychotic disorder, and various conditions may be classed as psychotic disorder not otherwise specified. Schizophrenia cannot be diagnosed if symptoms of mood disorder are substantially present (although schizoaffective disorder could be diagnosed), or if symptoms of pervasive developmental disorder are present unless prominent delusions or hallucinations are also present, or if the symptoms are the direct physiological result of a general medical condition or a substance, such as abuse of a drug or medication.

Schizophrenia

- (a) thought echo, thought insertion or withdrawal, and thought broadcasting;
- (b)delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;
- (c)hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;
- (d)persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);
- (e)persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent
- over-valued ideas, or when occurring every day for weeks or months on end;
- (f)breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;
- (g)catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;
- (h)"negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and
- lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;
- (i)a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.


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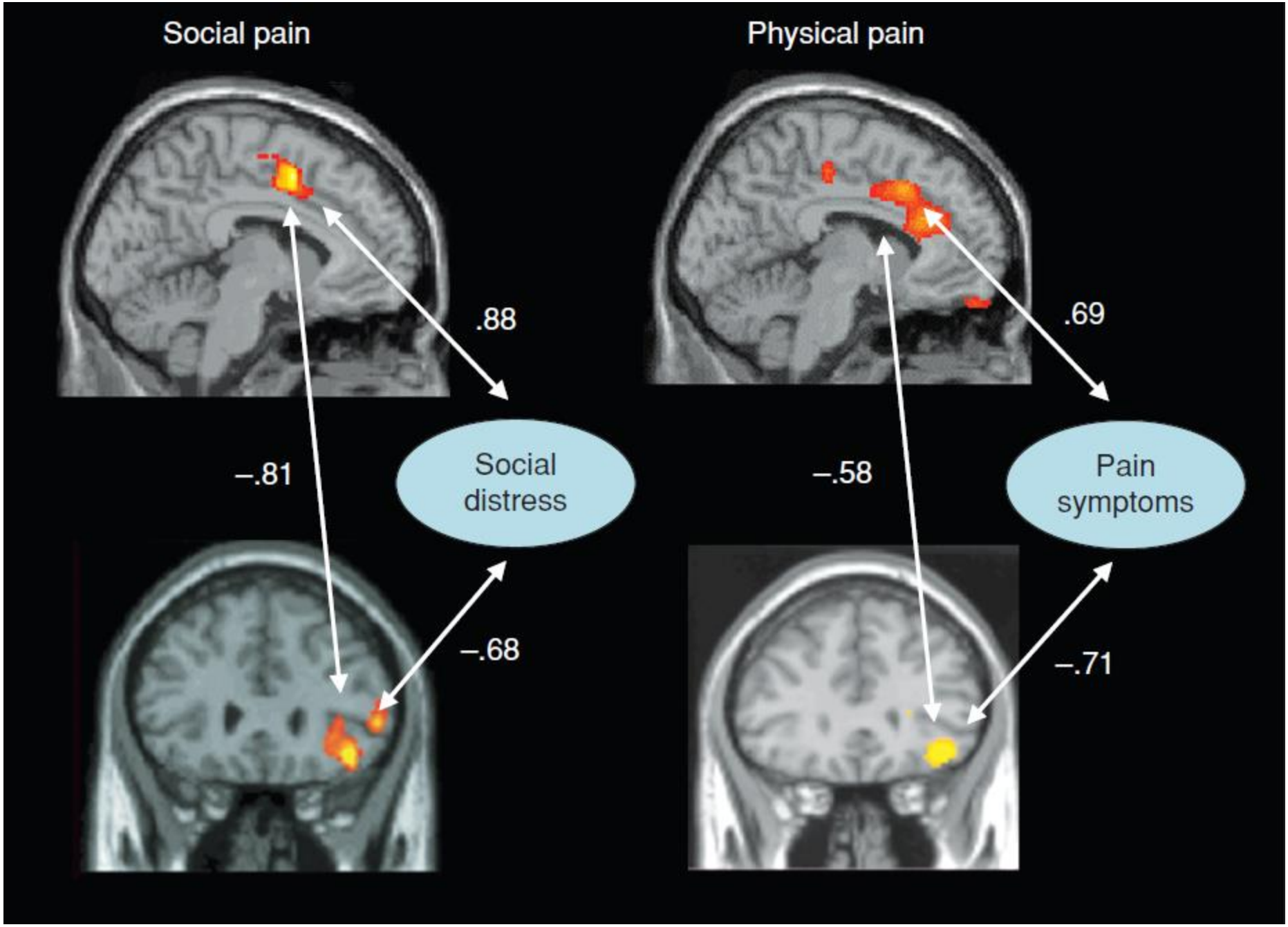
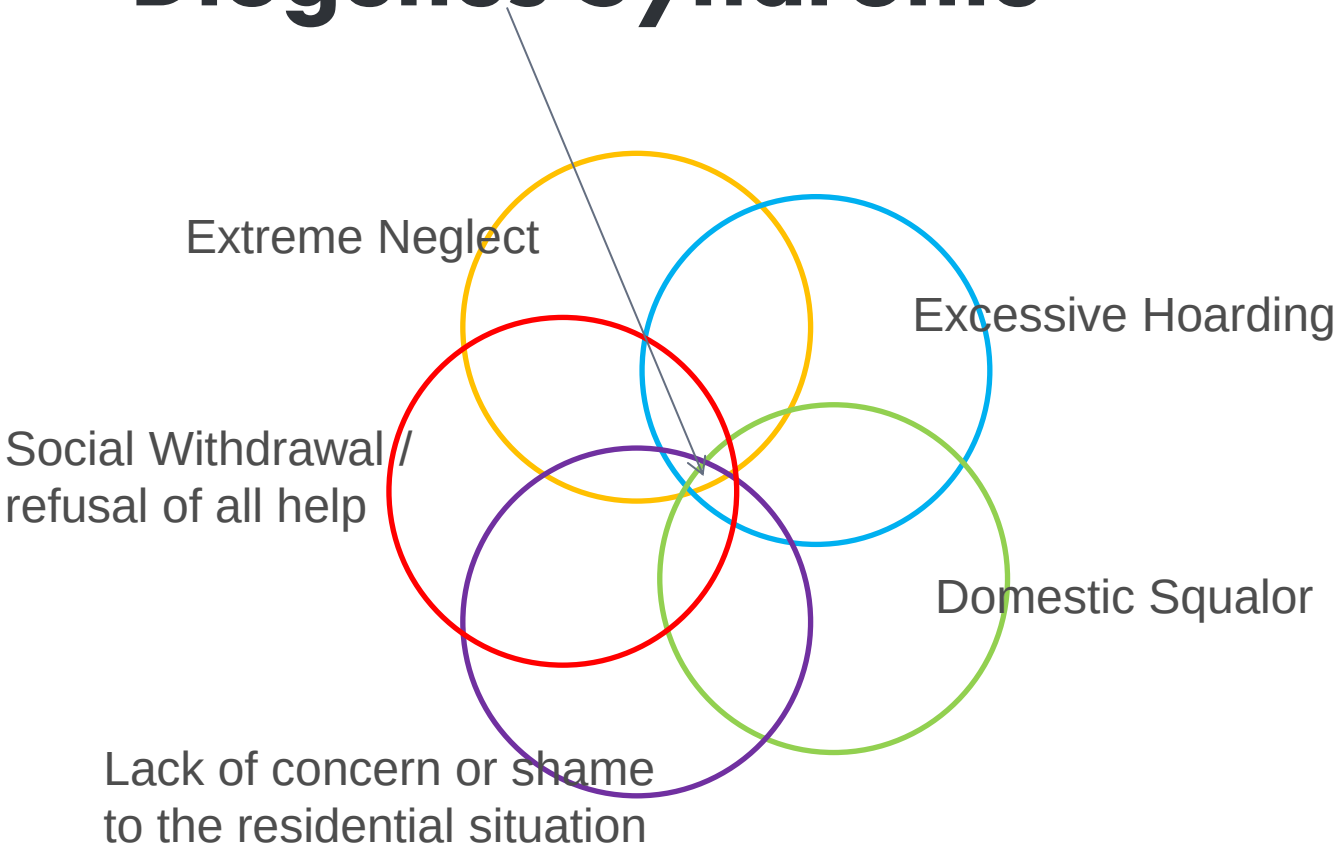

Social pain
Physical pain
.88
.69
Social distress
Pain symptoms
–.81
–.58
–.68
–.71

Diogenese Syndrome?

Diogenes Syndrome



Diogenes Syndrome

Predisposing Factors

- Pre-morbid behaviours
- Personality disorders
- Pre-morbid Personality traits

Triggers

- Mental Illness
- (Depression, Dementia)
- Medical co-morbidities (Stroke, CHF, COPD etc.)
- Psycho-social (Isolation, retirement, divorce, death of spouse)

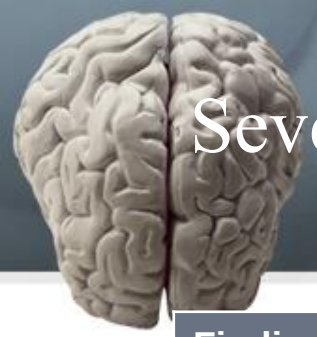
Congestive heart failure (*CHF*)
Chronic obstructive pulmonary disease (*COPD*)

Diogenes Syndrome

- **Diogenes syndrome. A clinical study of gross neglect in old age.**
- **Abstract**
- A study of elderly patients (fourteen men, sixteen women) who were admitted to hospital with acute illness and extreme self-neglect revealed common features which might be called Diogenes syndrome. All had dirty, untidy homes and a filthy personal appearance about which they showed no shame. Hoarding of rubbish (syllogomania) was sometimes seen. All except two lived alone, but poverty and poor housing standards were not a serious problem. All were known to the social-services departments and a third had persistently refused offers of help. An acute presentation with falls or collapse was common, and several physical diagnoses could be made. Multiple deficiency states were found--including iron, folate, vitamin B12, vitamin C, calcium and vitamin D, serum proteins and albumin, water, and potassium. The mortality, especially for women, was high (46%) . Half showed no evidence of psychiatric disorder and possessed higher than average intelligence. Many had led successful professional and business lives, with good family backgrounds and upbringing. Personality characteristics showed them to tend to be aloof, suspicious, emotionally labile, aggressive, group-dependent, and reality-distorting individuals. It is suggested that this syndrome may be a reaction late in life to stress in a certain type of personality.

Diogenes Syndrome

- Diogenes syndrome (DS) is a behavioural disorder of the elderly.
- The estimated annual incidence of DS is 0.5 per 1000 of the population aged 60 or over living at home.
- Symptoms include living in extreme squalor, a neglected physical state, and unhygienic conditions.
- This is accompanied by a self-imposed isolation, the refusal of external help, and a tendency to accumulate unusual objects.
- Researchers have underlined the frequent presence of DS (36%) in frontotemporal dementia (FTD).
- The eponym was first suggested in 1975 by Clark and collaborators, who described 30 geriatric patients with personalities characterized by suspiciousness, aloofness, hostility, and unfriendliness admitted to hospital in a state of severe self-neglect, and who were living in gross domestic squalor.
- The syndrome has been defined as a “failure of social and personal care,” reflecting a public health point of view, rather than a psychiatric one.
- While most reported cases have involved individuals who live alone, cases have been described in siblings and married couples.
- The loss of a close relative who was caring for the patient appears to be the most important precipitating factor, initiating the deterioration in self-care in one third of cases.
- Medical and psychiatric comorbidities such as dementia, depression, obsessive-compulsive disorder, obsessive–compulsive personality and alcoholism have been suggested as causes or contributors to the phenomenon.
- Reyes-Ortiz reviewed the literature on DS and introduced a distinction between primary and secondary DS, the latter being related to mental disorders ranging from paranoid schizophrenia to affective disorders.
- A clinical form of frontal lobe dysfunction has been postulated to explain this syndrome, so executive dysfunction may have a role in the condition. It has also been suggested that DS may be a manifestation of a subclinical personality disorder—in particularly with schizoid
- and paranoid traits unmasked by age.
- It has been stated that many persons with DS commonly display subclinical personality traits including unfriendliness, stubbornness, aggressiveness, independence, eccentricity, paranoia, aloofness, detachedness, compulsivity, narcissism, and lack of insight.
- Some authors have questioned whether extreme self-neglecting behaviour in old people is a form of indirect self-destructive, even suicidal, behaviour.
- New-onset DS in older age may be due to dementia, for instance. Most patients showing self-neglect are diagnosed with dementia within 1 or 2 years of presentation. In fact, patients with dementia invariably develop progressive inability to take care of themselves.
- It has been long observed that individuals with dementia develop inability to assess critically what is of value, and that can result in the accumulation of trash and objects.



Severe domestic squalor and psychiatry findings

Findings from a cross age study of severe squalor (needing heavy duty cleaning) in South London	
57	(70%) of 81 subjects had an ICD-10 mental disorder
17	(21%) schizophrenia, (9% plus drug and / alcohol abuse)
13	(6%) Dementia (6% plus alcohol abuse)
5	(6%) other organic mental disorder, (all 6% plus alcohol abuse)
8	(10%) drug or alcohol abuse but no other mental disorder
5	(6%) anxiety related disorder
4	(5%) mood disorder
9	(11%) developmental disability (1% plus drug abuse, 5% plus other mental disorder)
Other	14 anxious-avoidant personality, 5 paranoid/schizoid, 10 conscientious, perfectionist, house proud and 1 dissocial /antisocial personality disorder
	Reference: The Lancet 355, 2000

Diogenes Syndrome

- **Diogenes of Synope (Greek Philosopher (412 – 323 BC)**
- Scorned and rejected material wealth and possessions
- ‘Life according to nature’
- ‘Self sufficiency’
- ‘Lack of shame’
- ‘Contempt for social organisation’

- **Primary (50-70%)**
- Intentional
- Not related to mental illness

- **Secondary (30-50%)**
- Unintentional
- Related to mental illness
  - **Schizophrenia**
  - **Depression**
  - **Dementia**
  - **Alcoholism**

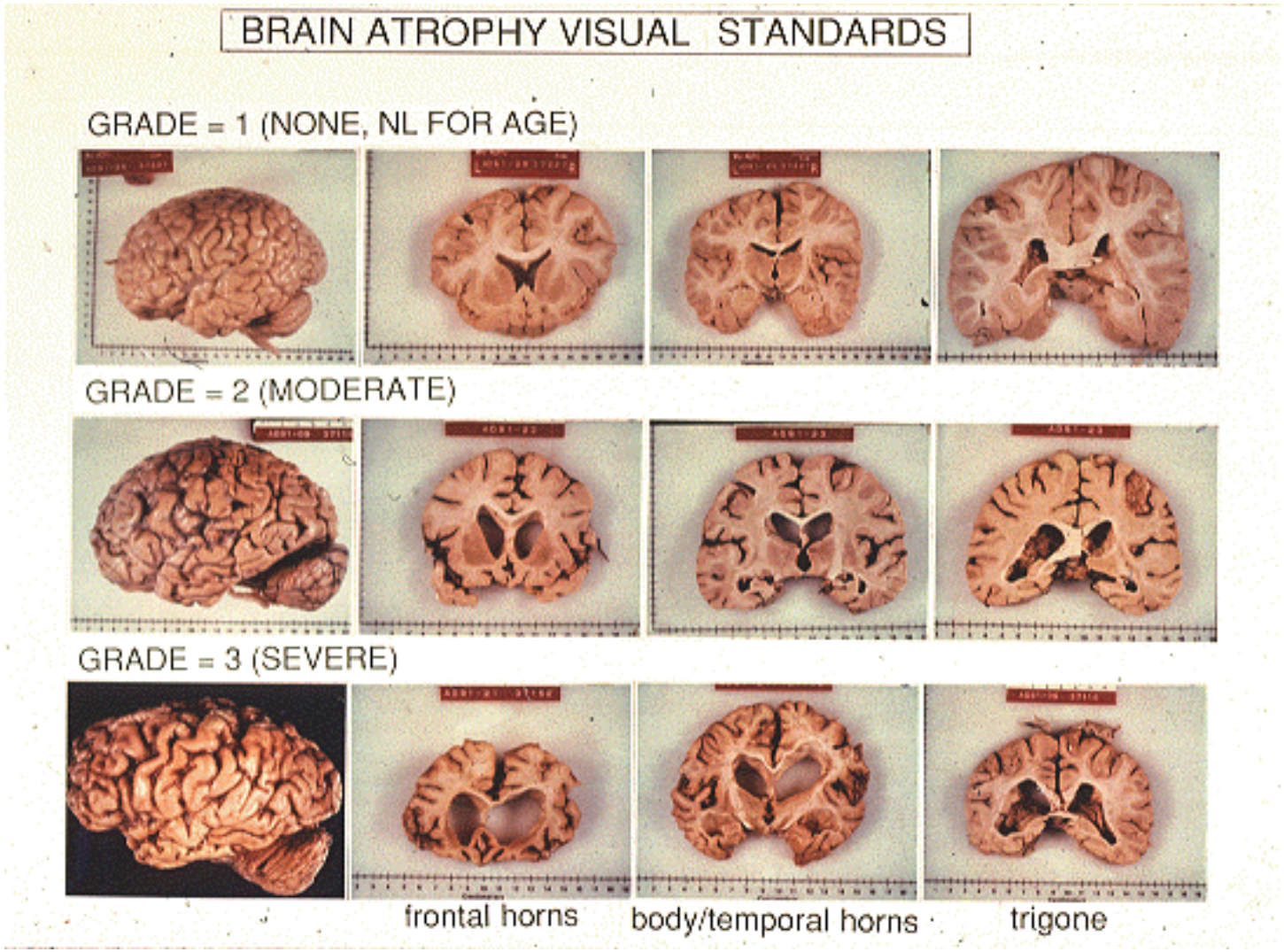
Diogenes Syndrome

Diogenes Syndrome

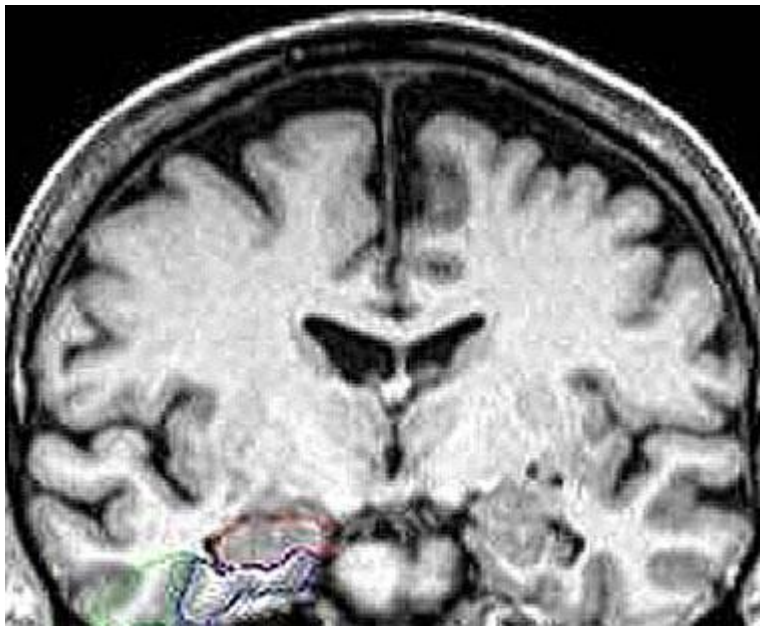
Diogenes Syndrome

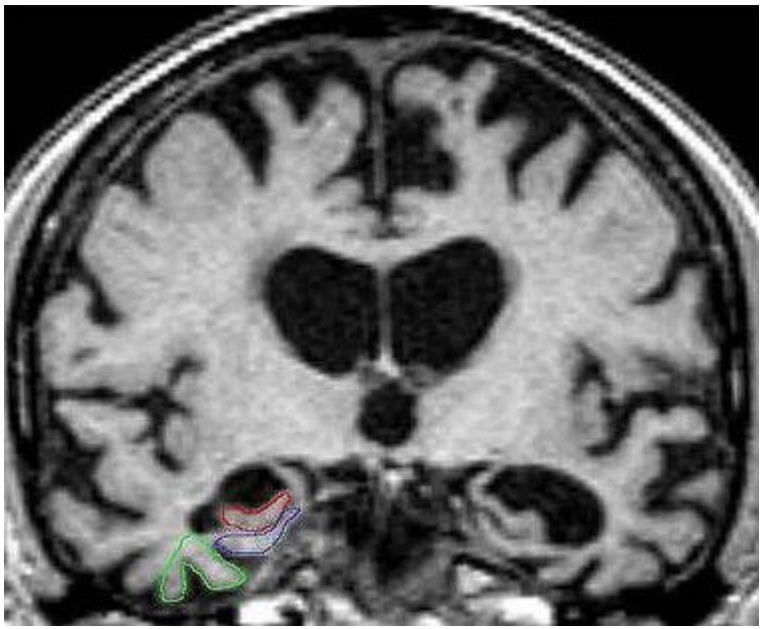
Anatomy and Functional Areas of the Brain

Organic Illness / Dementias



Organic Illness / Dementias





Considering Common Mental Health Problems

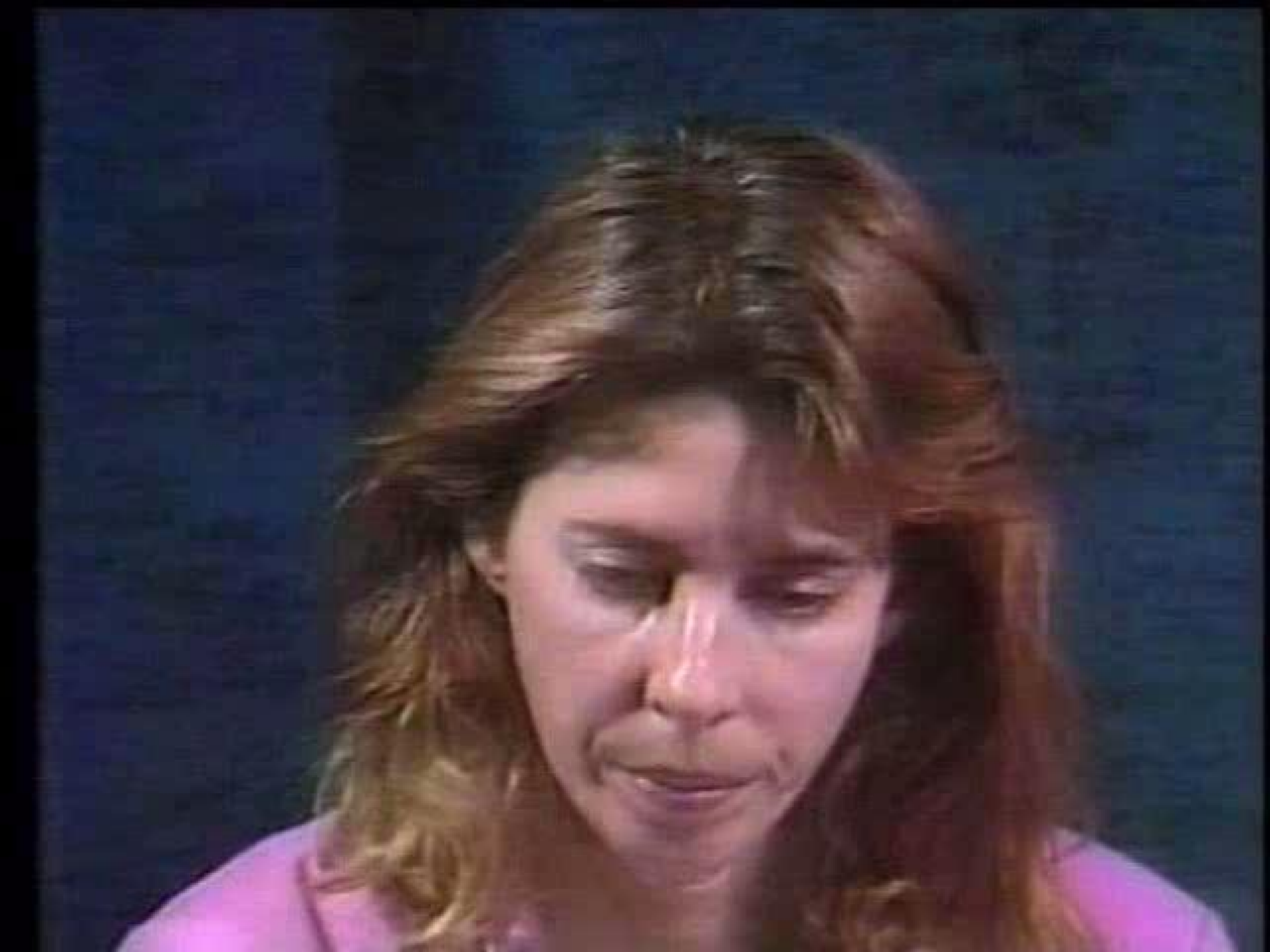
DSM Criteria for Major Depressive Disorder

Diagnostic Criteria for Major Depressive Disorder and Depressive Episodes

- Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
- Mood represents a change from the person's baseline.
- Impaired function: social, occupational, educational.

- Specific symptoms, at least 5 of these 9, present nearly every day:

1. **Depressed mood or irritable** most of the day, nearly every day, as indicated by either subjective report
(e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2. **Decreased interest or pleasure** in most activities, most of each day
3. **Significant weight change (5%) or change in appetite**
4. **Change in sleep**: Insomnia or hypersomnia
5. **Change in activity**: Psychomotor agitation or retardation
6. **Fatigue or loss of energy**
7. **Guilt/worthlessness:** Feelings of worthlessness or excessive or inappropriate guilt
8. **Concentration**: diminished ability to think or concentrate, or more indecisiveness
9. **Suicidality:** Thoughts of death or suicide, or has suicide plan



Obsessive Compulsive Disorder

Obsessive Compulsive Disorder

DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder (300.3)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2.The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

   2.The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
   ***Note**:* Young children may not be able to articulate the aims of these behaviours or mental acts.

Obsessive Compulsive Disorder

DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder (300.3)

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Obsessive Compulsive Disorder

DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder (300.3)

Specify if:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:
Tic-related: The individual has a current or past history of a tic disorder.


BBC

Obsessive Compulsive Disorder

- **What Is OCD and How is it Recognised?**
- Virtually everyone has experienced worries, doubts or fears at one time or another. It's natural to worry about life issues such as your health or the well-being of someone you love, paying bills or what the future will bring. Everyone has also an occasional intrusive thought; it's not even abnormal if you've had an intrusive "bad" thought. That's not OCD.
- OCD is diagnosed when obsessions and compulsions
- Consume excessive amounts of time (an hour or more each day)
- Cause significant distress
- Interfere with daily functioning at work or school, or with social activities, family relationships and/or normal routines.
- OCD is characterised by obsessive thoughts, impulses, or images and compulsions (overt or mental rituals) that are difficult to suppress and take a considerable amount of time and energy away from living your life, enjoying your family and friends or even doing your job or school work.
- When OCD symptoms are present, it's important to consult a mental health professional who is knowledgeable about OCD for evaluation and treatment.

Obsessive Compulsive Disorder

- **What are the Symptoms of OCD?**
- In some cases, compulsions are shaped by the nature of the obsessions. Compulsive washing, for example, is commonly performed in response to obsessive fears of contamination. Similarly, a fear of the house burning down may lead to excessive checking of the stove, oven and iron.
- In other cases, obsessions and compulsions are paired in a way that defies explanation; the compulsive behaviour is completely unrelated to the obsession. For example, a business man may feel compelled to tap his desk multiple times to prevent harm from coming to his family while he is at work..
- It's important to note that some people with OCD perform rituals not in response to a distinct obsession or fear but rather in response to certain sensory phenomena. Visual, auditory or tactile sensations may trigger a need for something to look, sound, or feel "just right." Upon seeing a tile floor, for example, a person may experience a need to trace over each of the tiles mentally in a symmetrical fashion.
- In other cases, external triggers are absent, but the individual has an inner feeling and/or perception of discomfort that causes him or her to repeat a behaviour until the feeling is relieved; the behaviour needs to be repeated until it *feels* "just right" or "complete." In still other situations, repeating behaviour is preceded neither by obsessions nor sensations but rather by a need or urge.
- Below are some examples of the more common OCD symptoms. Obsessions are shown *in italics*, and rituals that are frequently associated with those obsessions are listed beneath them

Obsessive Compulsive Disorder

- ***Fears of germs or contamination***
- Repeatedly washing hands, using anti-bacterial wipes or hand-sanitizer
- “Protecting” what is perceived as “clean” space – personal desk or locker, other personal property
- Seeking reassurance from someone in the environment that others aren’t “sick” or “dirty”
- Avoiding touching “dirty” surfaces that others may have touched, including common-area objects such as doorknobs, desks, shared supplies, computer keyboards, soap, cafeteria trays, etc.
- Avoiding contact play or sports – either because of a fear of catching a disease or fear of contaminating others
- Avoiding the use of public washrooms
- Refusing to share items or supplies with others
- Refusing to eat in a cafeteria
- Avoiding certain products or surfaces because they may contain “poison” (for example, cleaning chemicals)

Considering Obsessive Compulsive Disorder

- ***Fears that harm, illness, or death, will befall oneself or others; fear of causing harm to oneself or others, including violent or aggressive obsessions (fear of killing or injuring oneself or another person; fear of molesting a child)***
- ***Note****: Individuals with OCD who have violent/aggressive thoughts neither have a history of violence nor act upon these urges or ideas.*
- "Checking" behaviour, such as making sure doors and/or windows are locked; checking to be sure that oven, stove, coffee pot, iron, curling iron are off
- Checking light switches or turning them on and off repeatedly
- Repeatedly checking to see if a child is still breathing during the night
- Reading a paragraph over and over again to prevent harm from coming to a loved one, pet, etc.
- Seeking reassurance from someone in the environment that the person (with OCD) is "safe"
- Avoiding leaving a "safe" zone (such as a cubicle, classroom); avoiding going into certain "unsafe" zones (for example, for lunch or recess areas)
- Avoiding open spaces, such as a gymnasium
- Unreasonable avoidance of colleagues or peers, for fear of causing them harm

Obsessive Compulsive Disorder

- ***Fears/feelings/urges related to numbers, e.g., "good" numbers, "bad" numbers, "magical" numbers***
- “Counting” behaviour such as counting, touching or saying words a certain number of times (believing there is a magical significance to certain numbers and, for example, using those numbers to “magically” keep harm from coming to another); counting the number of steps between locations and having to start over if interrupted
- Touching objects a certain number of times; not being able to move on unless this touching has been accomplished
- Reading words or pages a certain number of times, causing delays in completing work, assignments
- Going back and forth through doorways a certain number of times before it’s OK to enter the room
- Avoiding using certain numbers that are "unlucky" or "not safe"; only using numbers that are "safe" or "lucky."

Obsessive Compulsive Disorder

- ***Fears/feelings/urges related to discarding something (e.g., fears that something bad will happen if something is thrown away); feelings of incompleteness if something is discarded (e.g., need to document and preserve all life experiences); fears of contamination (excessive acquisition of items that cannot be touched due to contamination fears; buying items that a person has touched to avoid contaminating other people); need to buy items in multiples of a particular number; not discarding objects to avoid repetitive rituals such as washing or checking***
- ***Note****: This form of hoarding is related to the obsessions and compulsions of OCD and is distinct from Hoarding Disorder*
- Saving useless items – scraps of paper, candy wrappers, bottle caps, broken items; being unable to part with things that are not needed any more
- Holding on to items for fear that they might be needed sometime in the future, such as books, newspapers, food, school papers
- Buying multiples of the same item (e.g., buying in multiples of 3 because its a person's magic number)
- Buying every item in a grocery store that one may have touched (and therefore "contaminated") to prevent others from being contaminated
- Accumulating items or objects in a particular area (e.g., desk drawer) because they are contaminated and cannot be touched

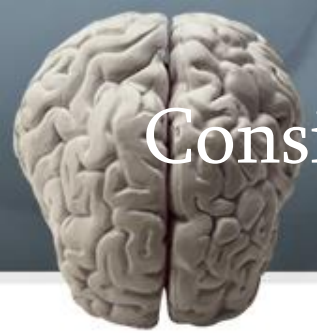
Obsessive Compulsive Disorder

- ***Excessive fear of violating religious or moral rules (scrupulosity)***
- Apologizing or confessing that something was (or is thought to have been) wrong, such as breaking rules, including religious, office, classroom rules
- Constantly seeking reassurance that a task has been completed right or perfectly; seeking affirmation that a mistake was not made
- Saying prayers a certain number of times; excessive praying to atone for being “bad”; repeatedly confessing perceived “sins” or bad behaviour
- Repetitive praying or confessing to neutralize or “undo” bad thoughts, intrusive sexual thoughts, or visions of acting badly, including cursing or blaspheming at work, school or church
- Avoiding answering questions for fear of telling a lie
- ***Fears/feelings/urges related to symmetry or order***
- Constantly “evening up” items or groups of items, such as books on a shelf or items on a desk; aligning edges to be “just right” or “even”
- Rearranging items to be in a certain order, for example, by color or alphabetical order
- Avoiding a particular room with square tiles (e.g., bathroom); seeing the tiles would necessitate tracing each of the edges with the eyes
- **'Prevention of harm' hoarding – Prevention of bad things happening, common to other forms of OCD, where a person will fear that harm will occur if they throw things away. For example dustmen will be injured by sharp edges of discarded cans or glass objects, or that someone may be contaminated from a discarded item.**

Obsessive Compulsive Disorder

- ***Fears/feelings/urges/images related to sexual content***
- Doubting one's sexual orientation, even though there is no evidence to support this concern
- Excessive praying to atone for having inappropriate sexual thoughts or images
- Avoiding TV, magazines, books, DVDs, etc., for fear of seeing something sexually-related
- ***Excessive doubting/dread of uncertainty***
- Constantly rechecking to see if everything that should be in a brief case, backpack is actually there
- Leaving one's work area to check something, e.g., to check that a car in a parking lot is actually locked
- Avoiding a school locker to prevent having to check the lock over and over again
- ***Fears/feelings/urges related to having something "just right," "just so" or "perfect"***
- Getting up and sitting down repeatedly at a desk, until the "just right" feeling has been achieved
- Repeatedly revising the way letters, words, numbers, or ones name is written to make them look "just right"; getting "stuck" writing the same letter or word over and over again
- Erasing words and rewriting over and over – sometimes until holes are rubbed in the paper
- Extreme slowness with work or school activities – making sure that everything looks "just right" or is done "just right," possibly in a certain order or pattern
- Repeating various actions over and over for no apparent reason
- Avoiding a hallway in which one must walk repeatedly until it feels "just right"

Considering OCD in the following Case Vignette



Considering OCD in the following Case Vignette

- The photographs in this article were taken in the house of Mr B, a 57-year-old single man, unemployed for more than 20 years and without previous contact with mental health services. He was referred by his GP to the local CMHT because local authorities and neighbours had raised concerns about his hoarding behaviour and hazards associated with it. Mr B showed pride in his possessions and when visited he expressed no concern about his hoarding or living conditions. Six months after these photographs were taken, Mr B was admitted to a psychiatric unit, with a diagnosis of major depressive disorder with psychotic symptoms that developed soon after a forced clean out of his possessions by local authorities.

Considering OCD in the following Case Vignette

FIG 1 The bedroom of a 57-year-old compulsive hoarder (see Case vignette). © Worcestershire County Council.

FIG 2 An almost unusable kitchen. © Worcestershire County Council.

Considering OCD in the following Case Vignette

FIG 4 When recycling is not an option. © Worcestershire County Council.

Considering OCD in the following Case Vignette

FIG 5 Compulsive buying. © Worcestershire County Council.

Behavioural Experiments

Considering Delirium

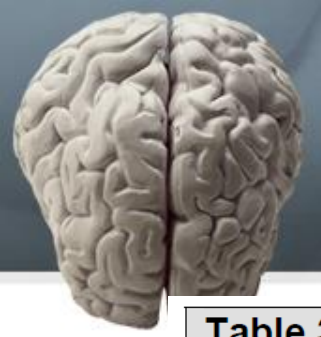
DSM Criteria for Delirium

A. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention.
___yes___no

B. A change in cognition or the development of a perceptual disturbance that is not better accounted for by a pre existing, established or evolving dementia.
___yes___no

C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day
___yes___no

D. There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.
___yes___no



Considering Delirium

Table 3.1: Common risk factors: [1-4, 7]			
Co-existing medical conditions	**Severe illness** **Current hip fracture** Significant co-morbidity Chronic renal or hepatic impairment History of stroke Infection with HIV	**Drugs**	Polypharmacy (>3 drugs) Treatment with multiple psychoactive drugs Alcohol/recreational drug dependency
Cognitive status	**Dementia** **Cognitive impairment** History of delirium Depression	**Functional status**	Functional dependence Immobility Low level of activity History of falls Incontinence
Demographics	**Age > 65 years old**	**Sensory Impairment**	Visual and hearing
Decreased oral intake	Dehydration Malnutrition	**Metabolic abnormalities**	Hepatic failure Renal failure Thiamine deficiency

Flat denial that there is a problem

Cognitive inflexibility – Fronto-temporal Dementia (Picks Disease)

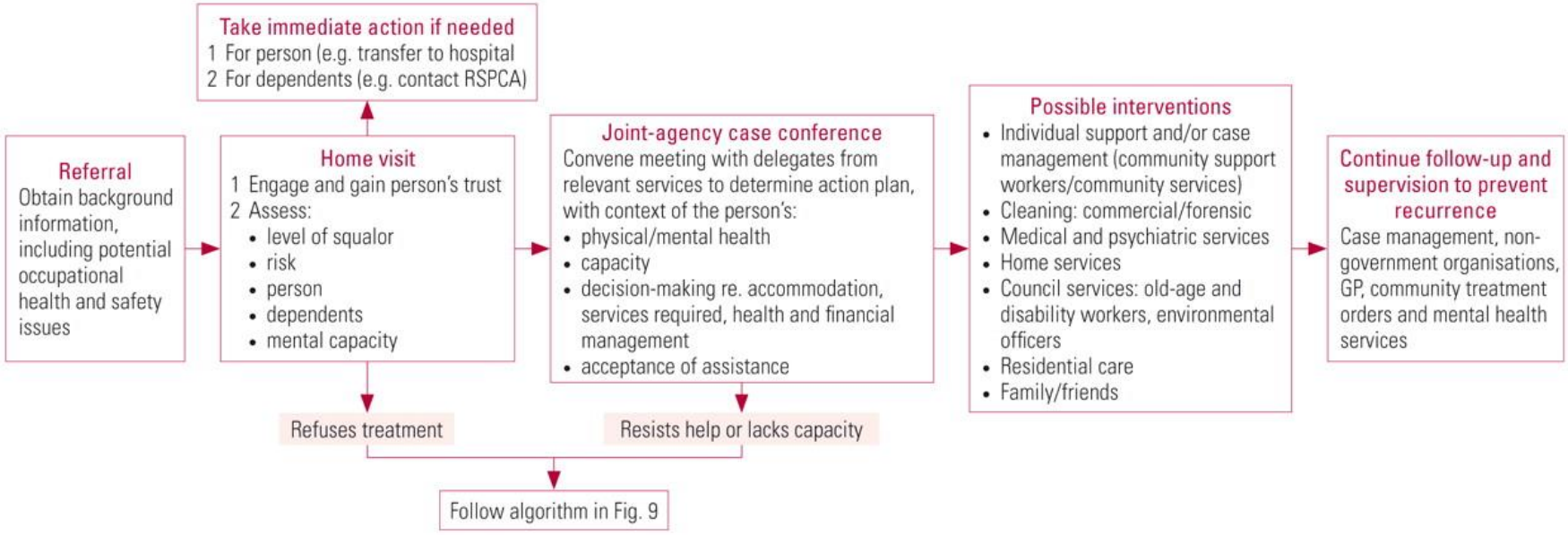
Considering Delirium

Table 3.2 Common precipitating factors: [1-4, 7]			
Environmental factors	Change of environment Loss of spectacles or hearing aid Inappropriate noise and lighting Immobility Sleep deprivation Catheters and lines Change of staff and ward Falls Physical restraint	**Drugs**	Alcohol or sedative withdrawal Sedative hypnotics Opioids Anticholinergics Antiparkinsonian drugs Antidepressants Anticonvulsants Corticosteroids Acute recreational drug toxicity or withdrawal
Fluid and electrolyte abnormality	Hypo/hypernatreamia Hypercalcaemia Renal failure Dehydration	**Infections**	Chest Urine (do urinalysis) Skin / ulcers Abdominal CNS
Neurological illness	Stroke Seizures Subdural haematoma	**Surgery**	Orthopaedic Vascular/cardiac Gastro-intestinal
Pain	Acute pain Acute on chronic pain	**Urinary and faecal retention**	Specifically examine to exclude, history is unreliable
Respiratory/ Cardiovascular	Hypoxia e.g. Pulmonary embolus, pneumonia Hypercapnia Cardiac failure Myocardial infarction Organ/tissue ischemia	**Endocrine/ metabolic**	Thiamine deficiency Hypo/hyperthyroidism Hypo/hyperglycaemia Liver failure

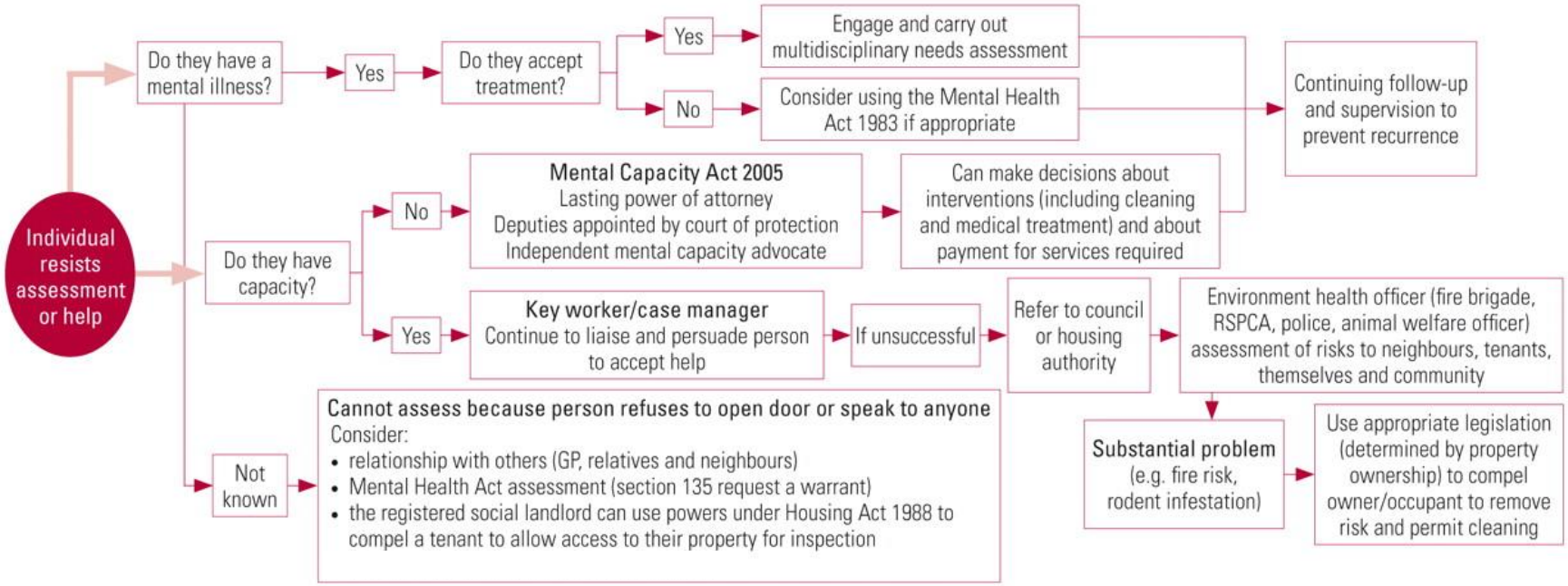
Considering Delirium

Table 4.1 Clinical Features of Delirium: [9]	
Altered cognitive function	Typically global or multiple deficits in cognition, including disorientation, memory deficits and language impairment.
Inattention	Difficulty focusing, sustaining, and shifting attention. Difficulty maintaining conversation or following commands.
Disorganised thinking	Manifested by disorganised or incoherent speech. Rambling or irrelevant conversation or an unclear or illogical flow of ideas.
Altered Perception	Illusions or hallucinations in about 30% of patients.
Altered physical function	Hyperactive: marked by agitation, restlessness, vigilance. Hypoactive: marked by lethargy, decreased mobility, reduced movement, reduced appetite.
Altered social behaviour	Common. Manifested by intermittent and labile change in mood or attitude with symptoms of fear, paranoia, anxiety, depression, irritability, apathy, anger or euphoria.
Altered level of consciousness	Clouding of consciousness, with reduced clarity of awareness of the environment and slow responses.
Altered sleep-wake cycle	Characteristic sleep-cycle disturbances. Typically daytime drowsiness, night time insomnia, fragmented sleep or complete sleep cycle reversal.
Acute onset	Occurs abruptly usually over a period of hours or days. Important to try to establish that the symptoms are a new phenomenon.
Fluctuating course	Symptoms tend to come and go or increase and decrease in Severity over a 24 hour period. There is often a characteristic lucid interval.

Interventions?

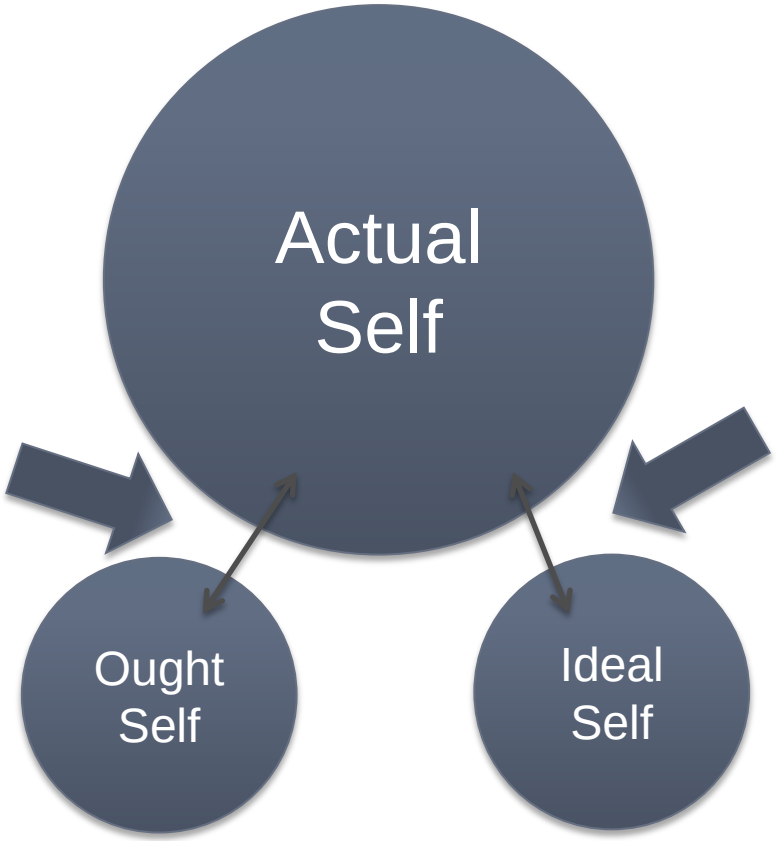


Interventions?



Self Discrepancy Theory

Higgins, E.T., Roney, C.J.R., Crowe, E., Hymes C. (1994). Ideal versus ought predilections for approach and avoidance: Distinct self-regulatory systems, Journal of Personality and Social Psychology, 66, 276-286.



Own
A discrepancy between these self-guides occurs when one's view of their actual attributes do not meet the expectations of what they think they ought to possess or believe they have transgressed a personally legitimate and accepted moral standard

- Self-dissatisfaction
- Vulnerable to guilt,
- self-contempt
- Uneasiness
- Feelings of moral worthlessness or weakness

Other
This discrepancy exists when a person's own standpoint does not match what they believe a significant other considers to be his or her duty or obligation to attain. Agitation-related emotions are associated with this discrepancy

- Violation of prescribed duties and obligations is associated with punishment
- The person is predicted to be vulnerable to fear and feeling threatened
- anxiety and apprehension over perceived negative responses from others
- May also might experience feelings of resentment (arises from the anticipated pain to be inflicted by others)

Own
An individual's *own* personal standpoint. This discrepancy is uniquely associated with depression

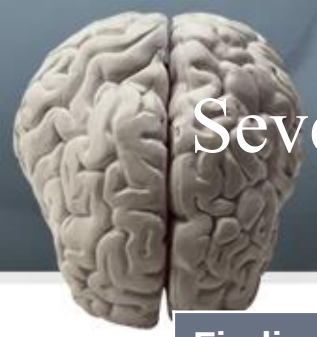
- Disappointment and dissatisfaction
- personal wishes have been unfulfilled
- Dejection from perceived lack of effectiveness or self-fulfilment
- Frustrated
- Emotions such as blameworthiness, feeling no interest in things, and not feeling effective

Other
The standpoint of some *significant other* (Here, one's view of our actual attributes do not match the ideal attributes the significant other hopes or wishes for them. This discrepancy is associated with dejection from perceived or anticipated loss of social affection or esteem

- Shame
- Embarrassment
- Shame - believing that they have lost standing or esteem in the eyes of others.

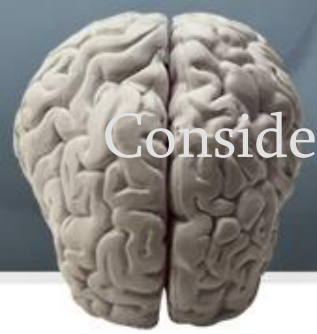
Steps to misidentification, disengagement & 'disidentification'

1) Identifies with a social group & and has aspirations to belong & sees the self as capable **(Declarative knowledge)** ;
2) Distorted cognitions:
    1) Vulnerable to developing a sense of injustice / feeling overlooked or rejected
    2) The sense of injustice and perceived rejection results in a sense of 'misrecognition', disengagement and sometimes 'subversive' behaviour.



Severe domestic squalor and psychiatry findings

Findings from a cross age study of severe squalor (needing heavy duty cleaning) in South London	
57	(70%) of 81 subjects had an ICD-10 mental disorder
17	(21%) schizophrenia, (9% plus drug and / alcohol abuse)
13	(6%) Dementia (6% plus alcohol abuse)
5	(6%) other organic mental disorder, (all 6% plus alcohol abuse)
8	(10%) drug or alcohol abuse but no other mental disorder
5	(6%) anxiety related disorder
4	(5%) mood disorder
9	(11%) developmental disability (1% plus drug abuse, 5% plus other mental disorder)
Other	14 anxious-avoidant personality, 5 paranoid/schizoid, 10 conscientious, perfectionist, house proud and 1 dissocial /antisocial personality disorder
	Reference: The Lancet 355, 2000



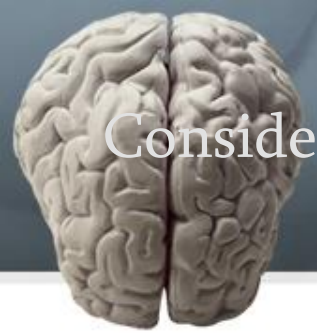
Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Self-neglect is a behavioural condition in which an individual neglects to attend to their basic needs, such as

- personal hygiene,
- appropriate clothing,
- living conditions,
- feeding,
- or tending appropriately to any medical conditions they have.

The behaviours and characteristics of living in self-neglect include

- unkempt personal appearance,
- hoarding items and pets,
- neglecting household maintenance,
- living in an unclean environment,
- and eccentric behaviours.



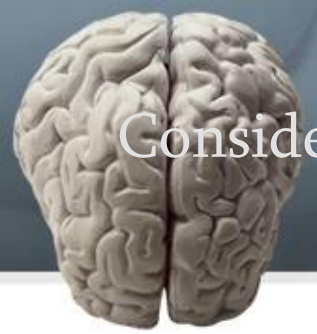
Considering the spectrum of Self Neglect Vs Hoarding Disorder.

1) **There is no clear operational definition of self-neglect - some research suggests it is not possible for a universal definition due to its complexity. Gibbons (2006) defined it as:**

"The inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecters and perhaps even to their community.“

Gibbons, S., Lauder, W. (2006) Self-neglect: a proposed new NANDA diagnosis, International Journal of Nursing Terminologies and Classifications, Jan-Mar, 17, 1

Among adults who are vulnerable to self neglect, the capacity to make decisions may remain intact. However, the capacity to identify and extract oneself from harmful situations, circumstances or relationships may be diminished

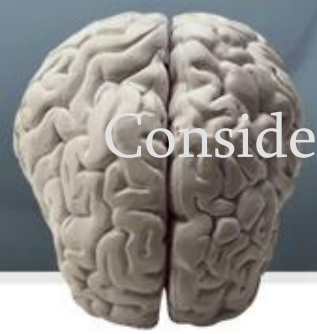


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Self neglect is better-viewed on a **continuum of severity** with low level concerns, (e.g. refusing services) potentially escalating to more troubling concerns (e.g. Living in squalor, rather than distinct categories of self-neglect type.

Staff must accept a person's autonomy and their rights to refuse services. That said, self neglect is not a decision that people have arrived at; rather it's something that has often come about by default. Most people do not, at some point in their lives, choose to live in squalor and danger.

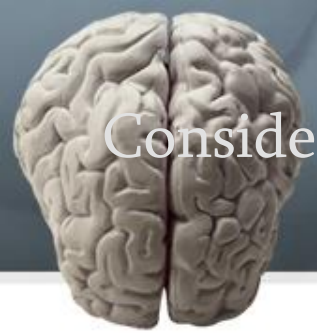
From this perspective, the concepts of 'lifestyle choice', and 'eccentric', 'reclusive' lifestyle should be questioned.



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Indicators associated with self-neglect

- Living in very unclean, sometimes verminous circumstances, such as living with a toilet completely blocked with faeces
- Neglecting household maintenance, and therefore creating hazards within and surrounding the property
- Portraying eccentric behaviour / lifestyles
- Obsessive hoarding
- Poor diet and nutrition. For example, evidenced by little or no fresh food in the fridge, or what is there, being mouldy
- Declining or refusing prescribed medication and / or other community healthcare support
- Refusing to allow access to health and / or social care staff in relation to personal hygiene and care
- Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity)
- Repeated episodes of anti-social behaviour – either as a victim or perpetrator
- Being unwilling to attend external appointments with professional staff
- whether social care, health or other organisations (such as housing)
- Poor personal hygiene, poor healing / sores, long toe nails;
- Isolation
- Failure to take medication.

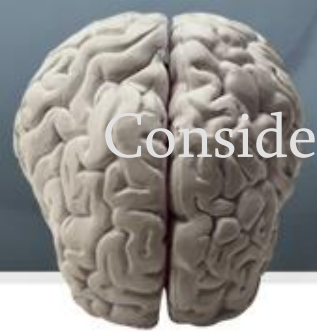


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Significant risk:

Where there are indicators that change is likely to occur in levels of risk in the short to medium term, appropriate action should be taken or planned.

- Indicators of significant risk could include:
- History of crisis incidents with life threatening consequence
- High risk to others
- High level of multi-agency referrals received
- Risk of domestic violence
- Fluctuating capacity, history of safeguarding concerns / exploitation
- Financial hardship, tenancy / home security risk
- Likely fire risks
- Public order issues; anti-social behaviour / hate crime / offences linked to petty crime
- Unpredictable/ chronic health conditions
- Significant substance misuse, self-harm
- Network presents high risk factors
- Environment presents high risks
- History of chaotic lifestyle; substance misuse issues
- The individual has little or no choice or control over vital aspects of their life, environment or financial affairs.



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Comprehensive Assessments:

The key components of the comprehensive assessment of neglect will include the following elements:

a. A detailed social and medical history;

b. Essential activities of daily living (e.g. ability to use the phone, shopping, food preparation, housekeeping, laundry, mode of transport, responsibility for own medication, ability to handle finances);

c. Environmental assessment; to include any information from neighbours

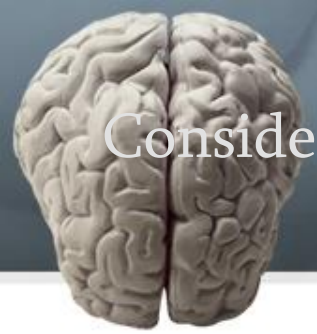
d. A description of the self-neglect;

e. A historical perspective of the situation;

f. The individual's own narrative on their situation and needs;

g. The willingness of the individual to accept support; and

h. The views of family members, healthcare professionals and other people in the individual's network.

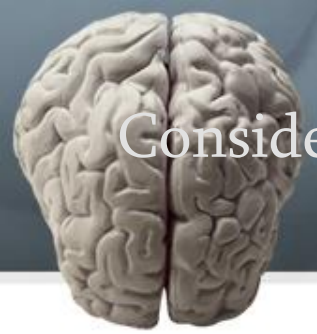


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Self-neglect is thought to be linked to impairments caused by underlying abnormal psychology, mental illnesses and neurological damage.

Risk factors include:

- Attachment Disorders & complex psychological defences;
- Advancing age;
- Psychiatric Disorder;
- Cognitive impairment / Dementia syndromes;
- Frontal lobe dysfunction or damage;
- Chronic illness;
- Nutritional deficiency;
- Alcohol and substance misuse;
- Functional and social dependency;
- Delirium.

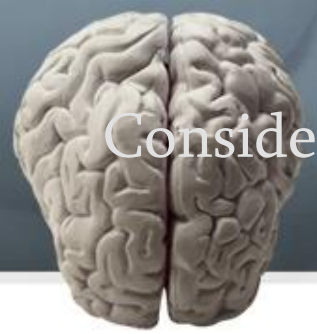


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect
- Self-neglect is included within the safeguarding definitions in the above statutory guidance and “covers a wide range of behaviour, neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding”.

(Care and Support Statutory Guidance issued under the Care Act 2014, Department of Health October 2014)



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

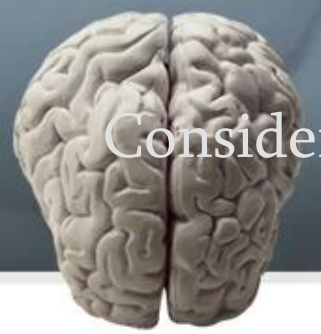
Possible agencies and professionals to engage with
You may want to consult with or invite to a multi-agency meeting:

- Environmental Health
- Housing Provider
- Community Wardens
- Care Agencies
- Community Safety
- Fire and Rescue Service
- GP
- Community Health Services
- District Nurses
- Acute Hospital Trusts
- Learning Disability Services
- Age Concern
- Ambulance Services
- Transport providers
- Community / Voluntary Sector
- Community Networks
- Legal advice / services
- Providers of utilities – gas, electricity, water, telephone

In addition, always consider the involvement of people who know the adult:

- Family members
- Carers
- Neighbours
- Power of Attorney holders

Considering the spectrum of Self Neglect Vs Hoarding Disorder.



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Metacognition is "cognition about cognition", **"thinking about thinking",** or **"knowing about knowing".**

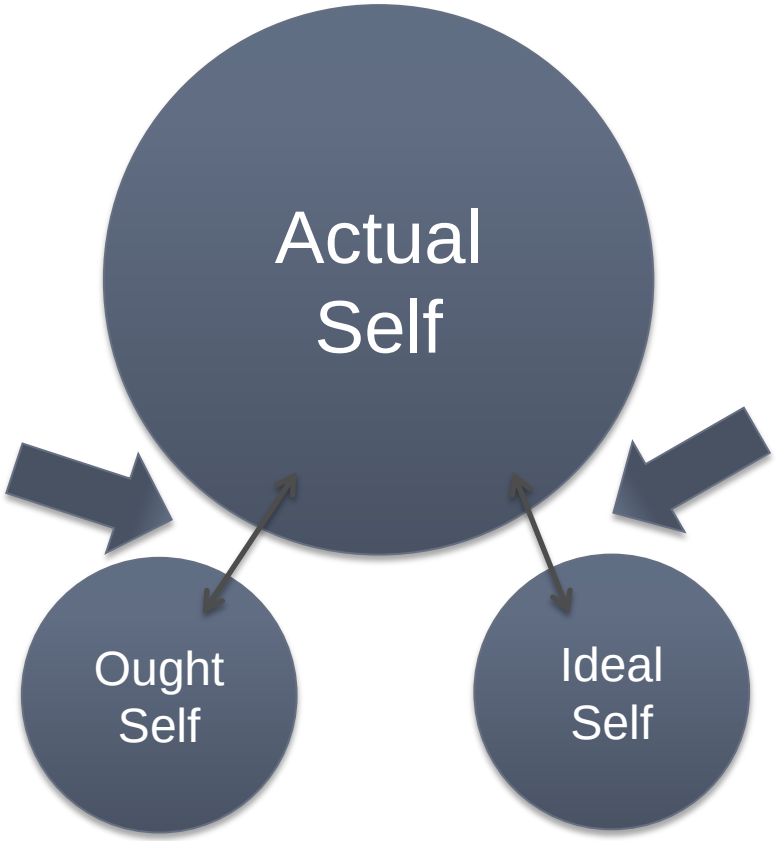
Metacognitive knowledge includes:

- **Declarative knowledge** is understanding one's own thoughts, self-concepts and capabilities;
- **Task knowledge** (procedural knowledge) which is knowing how to perform a task, or how one perceives the difficulty of a task , for example the complexity, content and length;
- Metacognition serves to correct the wandering mind, suppressing spontaneous thoughts and bringing attention back to more worthwhile tasks. It is also involved in working memory processes.

- **Problems with metacognition – particularly in the domains of declarative knowledge and task knowledge may be the cognitive foundations of self neglect.**

Self Discrepancy Theory

Higgins, E.T., Roney, C.J.R., Crowe, E., Hymes C. (1994). Ideal versus ought predilections for approach and avoidance: Distinct self-regulatory systems, Journal of Personality and Social Psychology, 66, 276-286.



Own
A discrepancy between these self-guides occurs when one's view of their actual attributes do not meet the expectations of what they think they ought to possess or believe they have transgressed a personally legitimate and accepted moral standard

- Self-dissatisfaction
- Vulnerable to guilt,
- self-contempt
- Uneasiness
- Feelings of moral worthlessness or weakness

Other
This discrepancy exists when a person's own standpoint does not match what they believe a significant other considers to be his or her duty or obligation to attain. Agitation-related emotions are associated with this discrepancy

- Violation of prescribed duties and obligations is associated with punishment
- The person is predicted to be vulnerable to fear and feeling threatened
- anxiety and apprehension over perceived negative responses from others
- May also might experience feelings of resentment (arises from the anticipated pain to be inflicted by others)

Own
An individual's *own* personal standpoint. This discrepancy is uniquely associated with depression

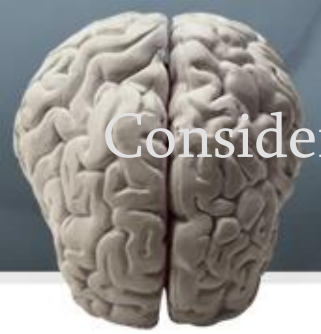
- Disappointment and dissatisfaction
- personal wishes have been unfulfilled
- Dejection from perceived lack of effectiveness or self-fulfilment
- Frustrated
- Emotions such as blameworthiness, feeling no interest in things, and not feeling effective

Other
The standpoint of some *significant other*. Here, one's view of our actual attributes do not match the ideal attributes the significant other hopes or wishes for them. This discrepancy is associated with dejection from perceived or anticipated loss of social affection or esteem

- Shame
- Embarrassment
- Shame - believing that they have lost standing or esteem in the eyes of others.

Steps to misidentification, disengagement & 'disidentification'

1) Identifies with a social group & and has aspirations to belong & sees the self as capable **(Declarative knowledge)** ;
2) Distorted cognitions:
    1) Vulnerable to developing a sense of injustice / feeling overlooked or rejected
    2) The sense of injustice and perceived rejection results in a sense of 'misrecognition', disengagement and sometimes 'subversive' behaviour.



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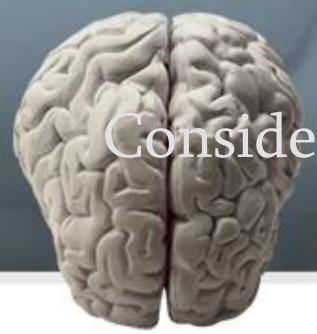
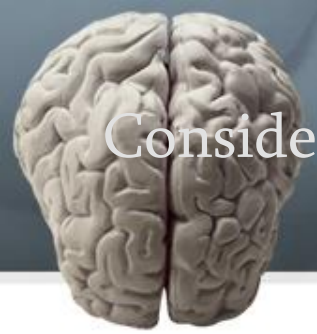


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

The ‘Self’, and the ‘Self Guides’
(Declarative knowledge) Metacognitive experience is responsible for **creating an identity that matters to an individual.** The creation of the identity with metacognitive experience is linked to the **identity-based motivation.**

Is this action / behaviour part of my identity or **‘part of the ‘self’ and so worth pursuing? Or should be abandoned**?

Here is an example: a woman who loves to play clarinet has come upon a hard piece of music. She knows that how much effort she puts into learning this piece is beneficial. The piece had difficulty so she knew the effort was needed. **The identity the woman wants to pursue is to be a good clarinet player.**



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Executive management processes involve

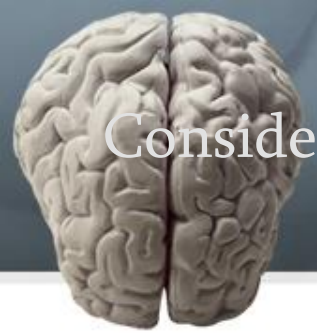
1. **Planning / organising,**
2. **monitoring,**
3. **evaluating**
4. **maintaining motivation & maintaining / regulating thinking**

(and revising one's own thinking processes).

Maintaining motivation to see a task to completion is also a metacognitive skill. The ability to become aware of **distracting stimuli – both internal and external – and sustain effort over time also involves metacognitive or executive management.**

Strategic knowledge (or procedural knowledge) involves knowing ***what***, knowing ***when and why*** and knowing ***how*****.**

For both **executive management** and **strategic knowledge** metacognition is needed to self-regulate one's own thinking and learning.

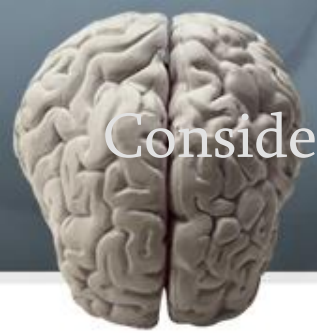


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Attachment Disorders and Self Neglect:
Disorganised attachments are characterised by episodic memories or attachment-related trauma or losses that are not integrated into semantic structures of self knowledge. Particularly if the attachment figure was both persecutor and rescuer.

Key to understanding individuals is understanding that some individuals are naturally suspicious of information that you receive from others. The unresponsiveness of individuals with psychological disturbances to change situations. It's not that they are abnormal to responding to a situation it's that they are hypervigilant to human communication and are reluctant to change in the light of their social experience – this is primed in early development.

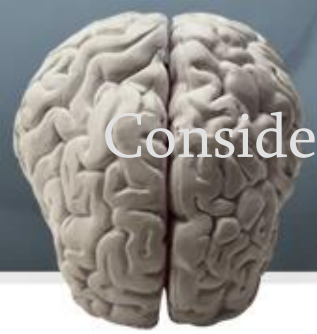
Cont …



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Ostensive Cues:
According to Csibra and Gergely's natural pedagogy theory, this certain class of social stimuli has a special meaning to young infants. That is, infants are sensitive to particular ostensive cues that communicate to them that they are being addressed and that they can expect to learn referential information.

Example:
Experimenter asks a baby for an item (hello baby, hello baby – smiles at one object, frown at another one) – then another person comes in and asks for one of the objects – 71% of the infants will pass on the object that was smiled at (transmission of cultural knowledge – only if the baby had been made contact with as an agentive being)
Second condition – no transfer of information – Baby is ignored – smiling and frowning takes place though. In this condition only 40% pass on the object that was smiled at.

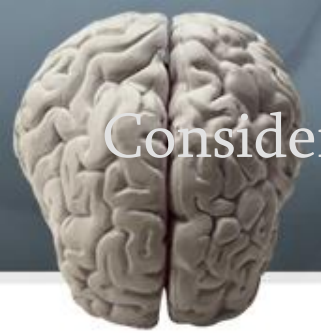


Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Attachment Disorders and Self Neglect:
Dissociation:
Discrepancies between thinking and feeling can result in dissociation - a discontinuation of thought or behaviour and metacognitive monitoring.

The collapse of the integrative functions of consciousness may create an experience of psychological equilibrium and provide a mental defence against psychological pain.

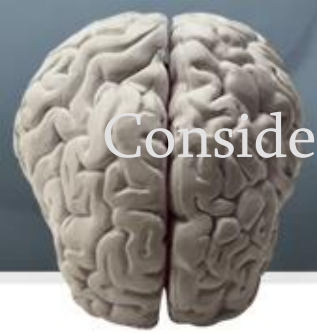
Decisions (in the interest of personal care and wellbeing) may represent an invisible source of danger and dissociation processes may protect the individual.



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

- **Attachment Disorders and Self Neglect:**
- **Learned helplessness** – exposure to uncontrollable events and situations will lead to inactivity – a person who experiences uncontrollable situations (that were punishing) does not make any attempt to improve the situation. Uncontrollability beliefs can be generalised from one context to another (Punishment results in aversive behaviour which diminishes the probability of performing an action and avoidance of, and relief from punishment reinforces the probability of performing a similar action).

- **Self-efficacy** is one's belief in one's ability to succeed in specific situations or accomplish a task. One's sense of **self-efficacy** can play a major role in how one approaches goals, tasks, and challenges



Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Key to understanding individuals is understanding that some individuals are naturally suspicious of information that you receive from others.

The unresponsiveness of individuals with psychological disturbances to change situations. It's not that they are abnormal to responding to a situation it's that they are hypervigilant to human communication and are reluctant to change in the light of their social experience – this is primed in early development.

The destruction of trust does lead to a behavioural rigidity but some individuals cannot change because they cannot trust new information as something that could take into the future – everyone is treated with mistrust.

Considering the spectrum of Self Neglect Vs Hoarding Disorder.

Relapse
Falling back into old patterns, actions and behaviours

Pre-Contemplation
Not thinking about, or has rejected Change

Contemplation
Thinking about change. Seeks out support

Planning
Planning what it could take to make change happen

Action
Taking positive steps by putting the plan into practice

Maintenance
Achieving positive and concrete developments with potentially little support

Motivational Interviewing

Crystallisation of discontent


Cottonelle

Invalidation

Invalidation

Invalidation:

- Emotional **invalidation** is when a person's thoughts , feelings and actions are rejected, ignored, or judged. Most individuals are sensitive to invalidation and the experience of invalidation can be particularly difficult for someone who emotionally or psychologically vulnerable.
- Most people (carers / friends) would deny that they invalidate the internal experience of others. Very few would purposefully invalidate someone else. But well-intentioned people may be uncomfortable with intense emotions or believe that they are helping when they are actually invalidating.
- **Carer's, therapists, and clients should remember that no one *owns* the truth. Practice looking at ALL sides of a situation /points of view.**

Invalidation

- **What is Invalidation?**
- To invalidate is to weaken, to nullify, to cancel, to reject or to dismiss.
- Invalidation negates or dismisses behavior independent of the actual validity of the behavior.
- Invalidation goes beyond mere rejection by implying not only that our feelings are disapproved of, but that we are fundamentally abnormal. This implies that there is something wrong with us because we aren't like everyone else.

- **Examples of invalidating expressions. Each is an attempt to talk you out of your feelings.**

- **Telling people to feel differently:**
- Smile.
- Be happy.
- Cheer up
- Lighten up.
- Get over it.
- Grow up
- Get a life
- Don't cry.
- Don't worry.

Invalidation

- **Telling people to feel differently (cont)**
- Don't be sad.
- Stop whining
- Stop laughing..
- Don't get angry
- Deal with it.
- Give it a rest.
- Forget about it.
- Stop complaining.
- Don't be so dramatic.
- Don't be so sensitive.
- Stop being so emotional.
- Stop feeling sorry for yourself
- Stop taking everything so personally

Invalidation

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- Stop whining
- Stop laughing..
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- Stop feeling sorry for yourself
- Stop taking everything so personally

Invalidation

- **Telling people to look differently:**
- Don't look so sad.
- Don't look so smug.
- Don't look so down.
- Don't look like that.
- Don't make that face.
- Don't look so serious.
- Don't look so proud of yourself.
- Don't look so pleased with yourself.

- **Criticising an individual's perspective of thoughts:**
- You've got it all wrong.
- But of course I respect you.
- But I do listen to you.
- That is ridiculous (nonsense, totally absurd, etc.)
- I was only kidding.
- That's not the way things are.
- That's not how things are.
- I honestly don't judge you as much as you think.

Invalidation

- **Trying to make people feel guilty:**
- I tried to help you..
- At least I .....
- At least you....
- You are making everyone else miserable.

- T**rying to isolate people**:

- You are the only one who feels that way.
- It doesn't bother anyone else, why should it bother you?

- **Minimising an individual's feelings:**
- You must be kidding.
- You can't be serious.
- It can't be that bad.
- Your life can't be that bad.
- You are just ... (being difficult; being dramatic, in a bad mood,
- tired, etc)
- It's nothing to get upset over.

Invalidation

- **Using reason:**
- There is no reason to get upset.
- You are not being rational.
- But it doesn't make any sense to feel that way.
- Let's look at the facts.
- But if you really think about it...

- **Telling people how they should feel:**
- You should be excited.
- You should be thrilled.
- You should feel guilty.
- You should feel thankful that...
- You should be happy that ....
- You should be glad that ...
- You should just drop it.
- You shouldn't worry so much.
- You shouldn't let it bother you.
- You should just forget about it.
- You should feel ashamed of yourself.

Invalidation

- **Defending the other person:**
- Maybe they were just having a bad day.
- I am sure she didn't mean it like that.
- You just took it wrong.
- I am sure she means well.

- **Negating, denial and confusion:**
- Now you know that isn't true.
- You don't mean that.
- You know you love your baby brother.
- You don't really mean that.
- You are just ... (in a bad mood today, tired, cranky)

- **Sarcasm and mocking:**
- Oh, you poor thing.
- Did I hurt your little feelings?
- What did you think?
- The world was created to serve you?
- What happened to you? Did you get out of the wrong side of bed again?

Invalidation

- **Laying guilt trips:**
- Don't you ever think of anyone but yourself ?
- What about my feelings?!
- Have you ever stopped to consider my feelings?

- **Philosophising or using clichés:**
- Time heals all wounds.
- Every cloud has a silver lining.
- Life is full of pain and pleasure.
- In time you will understand this.
- When you are older you will understand
- You are just going through a phase.
- Everything has its reasons.

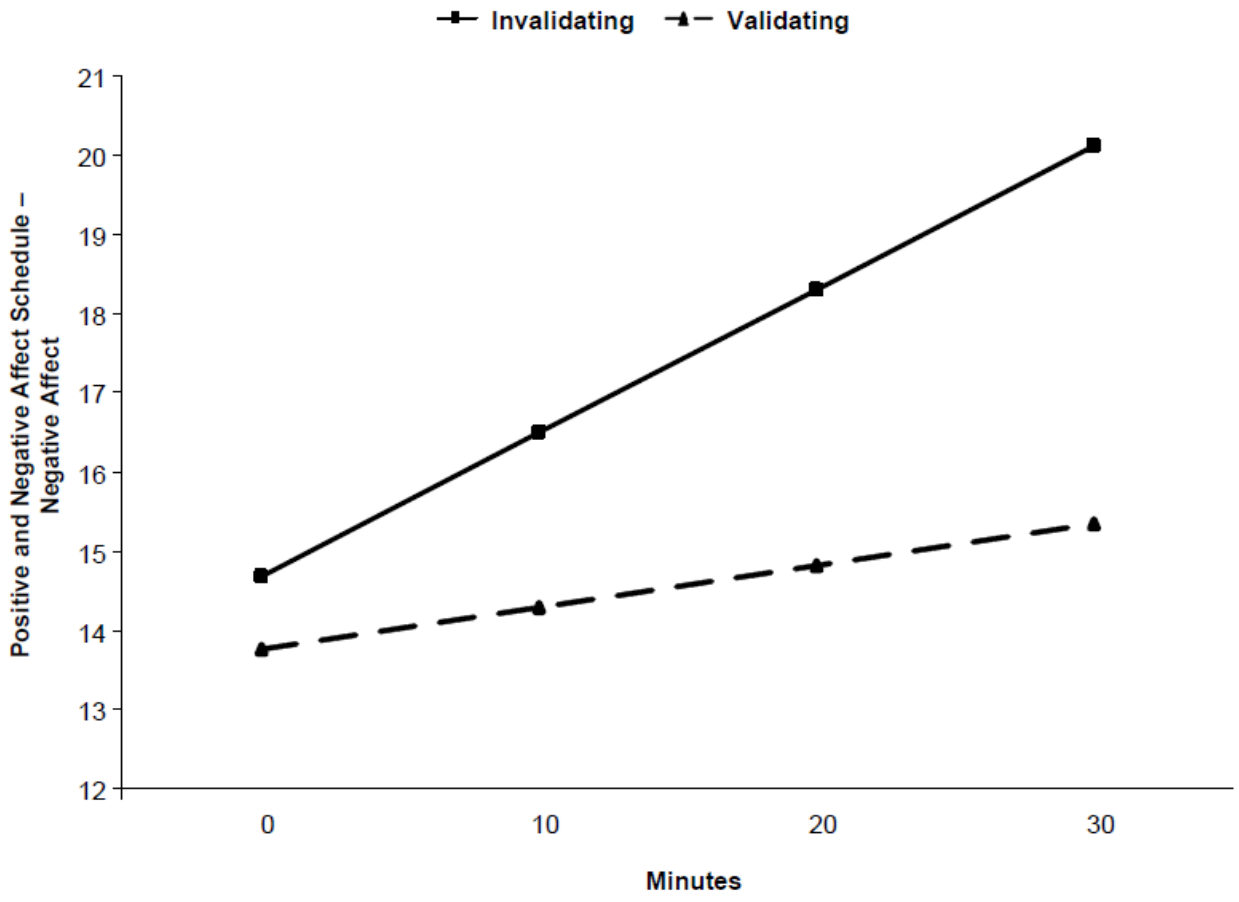
- **Showing Intolerance:**
- This is getting really old.
- This is getting really pathetic.
- I am sick of hearing about it.
- She is impossible to talk to.

Invalidation

- **Trying to control how long someone feels something for:**
- Are you still upset over that? It happened a long time ago.
- You should be over that by now.

- **Explanations:**
- Maybe it is because...
- That is because

Invalidation



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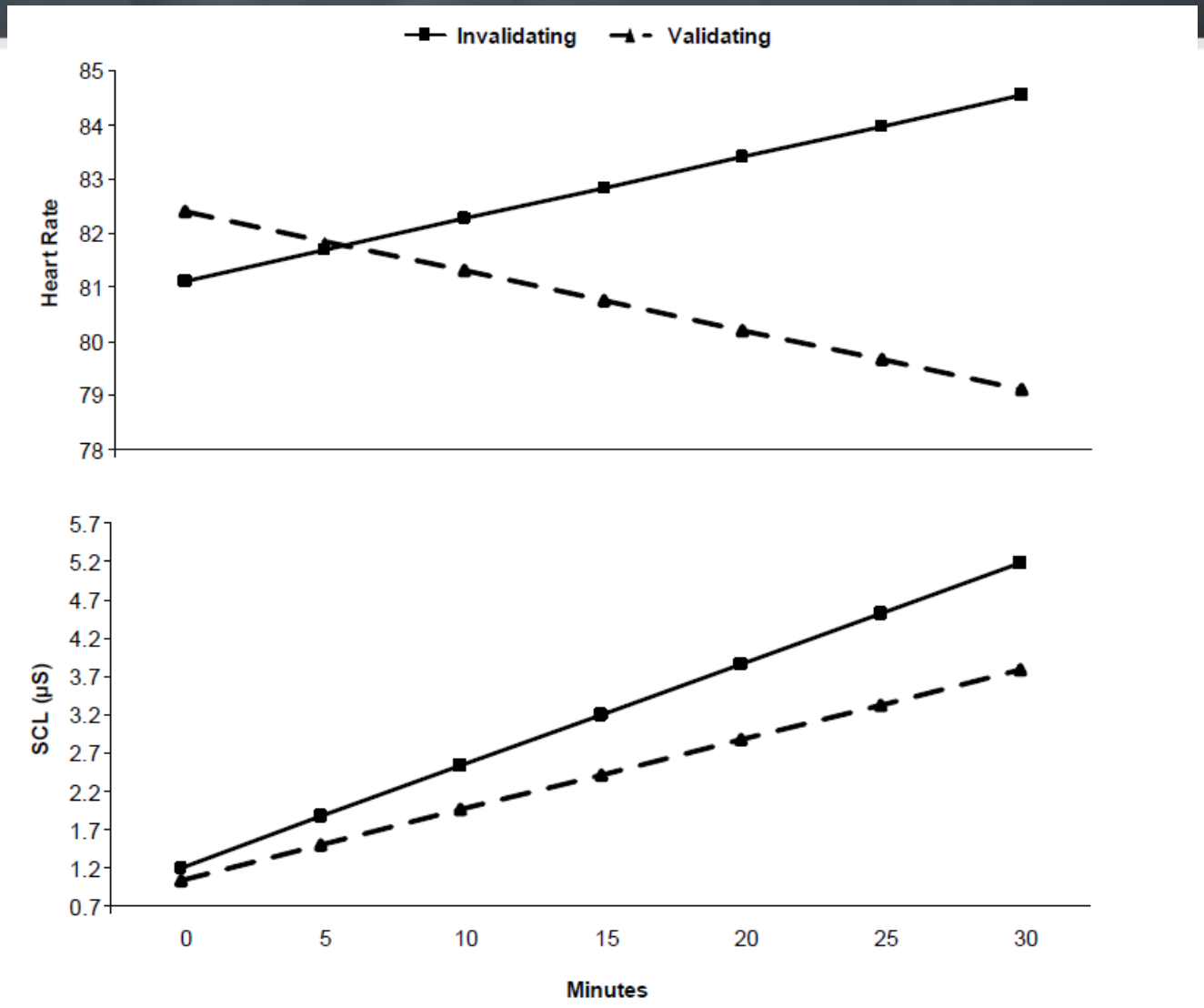
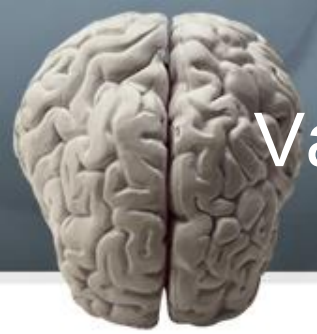


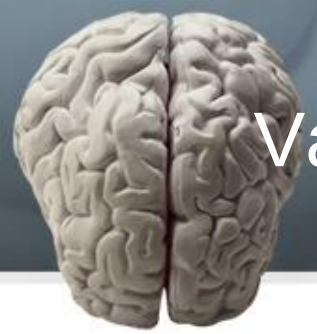


Validation

- **Validation:**
- Validation means telling someone that what they feel, think, believe (from the perspective that they have) is **logical, understandable**

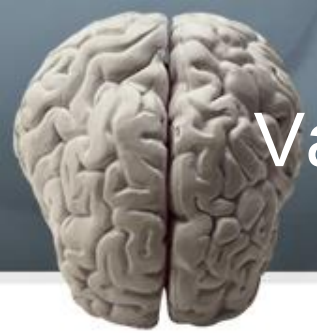
- Unfortunately there are many different reasons and ways that people who care about others (or are paid to care for them) unconsciously invalidate.

- Here are just a few.



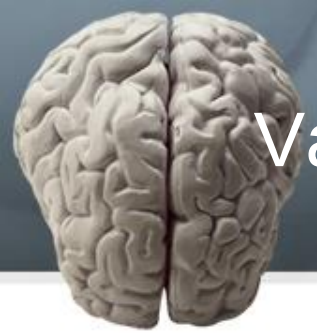
Validation

- **Misunderstanding what it means to 'Validate':** Validation is about accepting someone else's internal experience as valid and understandable.
- Validation doesn't mean agreeing or approving. Sometimes people invalidate because they believe if they validate they are agreeing.
- **A person way wish to reassure, or correct what they see as 'an error in judgement'.** The invalidation would be, *"You shouldn't think that way."* Invalidation can also be the result of a genuine desire to fix peoples' feelings: *"Come on, don't be sad, 'It's not that bad", "You'll get over it".*
- People who want to help (by describing the errors in a person's logic, feelings and behaviours) often invalidate in their efforts to resolve problem. Unfortunately this type of Judging, for example, *"You are so overreacting, it's not a dig deal"* or *"Get that thought out of your head"* are examples of invalidation.



Validation

- **Validation involves:**
- **Being present:**
- Multi-tasking while you listen to a person’s anxieties or problems is not being present. Being present means giving all your attention to the person you are validating. Just being present, paying complete attention to the person in a non-judgmental way is often the answer.
- **Accurate reflection**:
- Accurate reflection means you summarise what you have heard from someone. When done in an authentic manner, with the intent of truly understanding the experience and not judging it, accurate reflection is validating. Sometimes this type of validation helps someone sort through their thoughts and separate thoughts from emotions.
- **Expressed empathy:**
- Expressed empathy (mindreading) is guessing what another person might be feeling or thinking and reflecting it to them. "I'm guessing you must have felt pretty hurt by her comment" is an expressed empathy validation. If you guess wrong, the person will probably correct you. Accepting the correction is validating



Validation

- **Understanding the person's behaviour in terms of their history and experiences**
- Experiences typically influence our emotional reactions. If a colleague or service user was bitten by a dog a few years ago, they are not likely to value exposure to a dog in the future. Validation at this level would be saying, *"Given what happened to you, I completely understand you not wanting to be near a dog.“*

- **Normalising or recognising emotional reactions that anyone would have**.
- Understanding that our emotions, thoughts are normal is helpful. For the emotionally vulnerable person, knowing that anyone would be upset in a specific situation is validating. For example, *"Of course you're anxious. Speaking before an audience the first time is scary for anyone.“*

Motivational Interviewing

"What is Motivational Interviewing?

"A client-centered, directive intervention focused on resolving ambivalence in the direction of change."

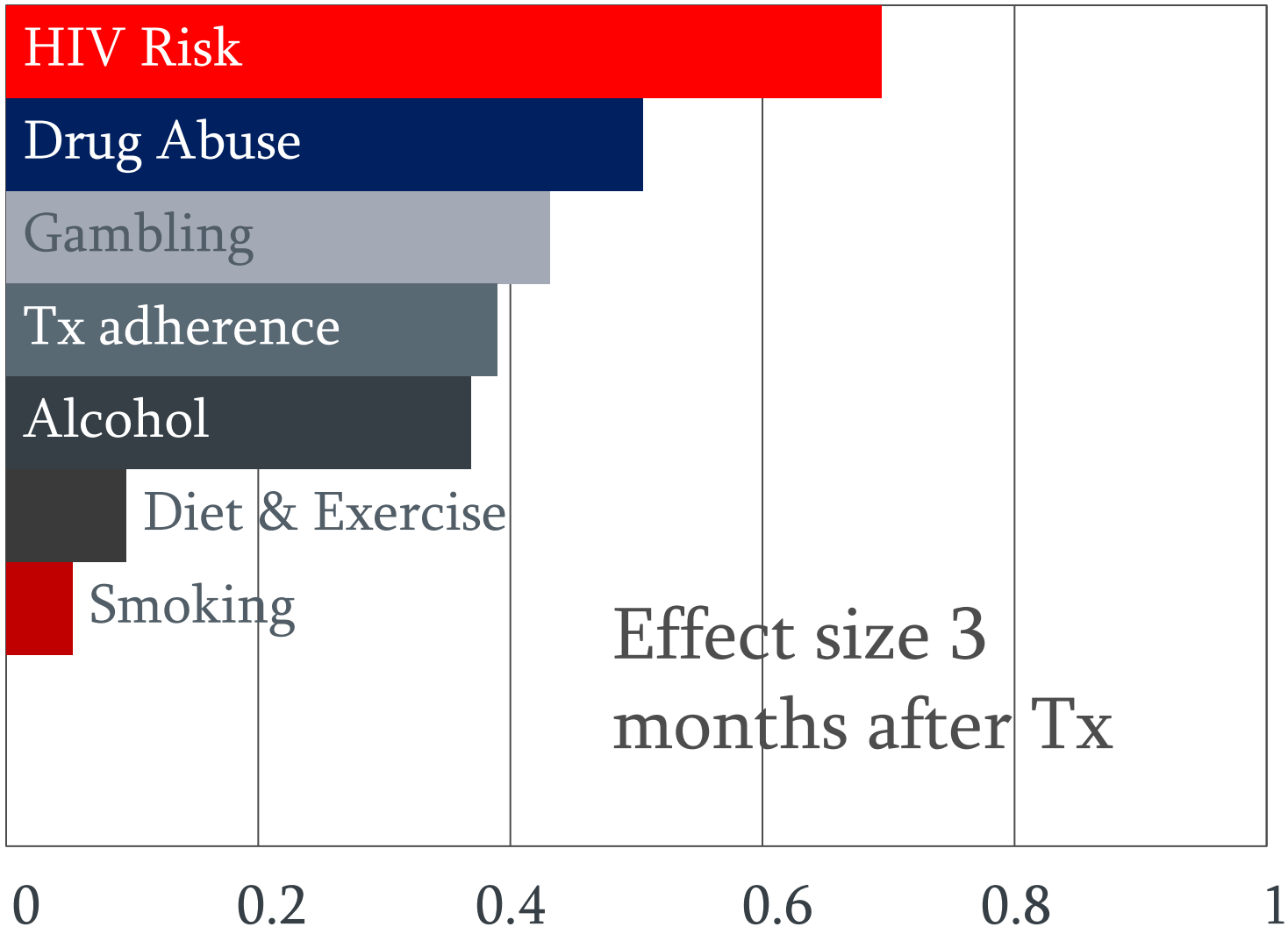
Motivational Interviewing

‘I learn what I believe as I hear myself speak’.

Crystallisation of discontent

Motivational Interviewing

Burke, B.L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. Journal of Consulting and Clinical Psychology, 71, 843–861.



Motivational Interviewing

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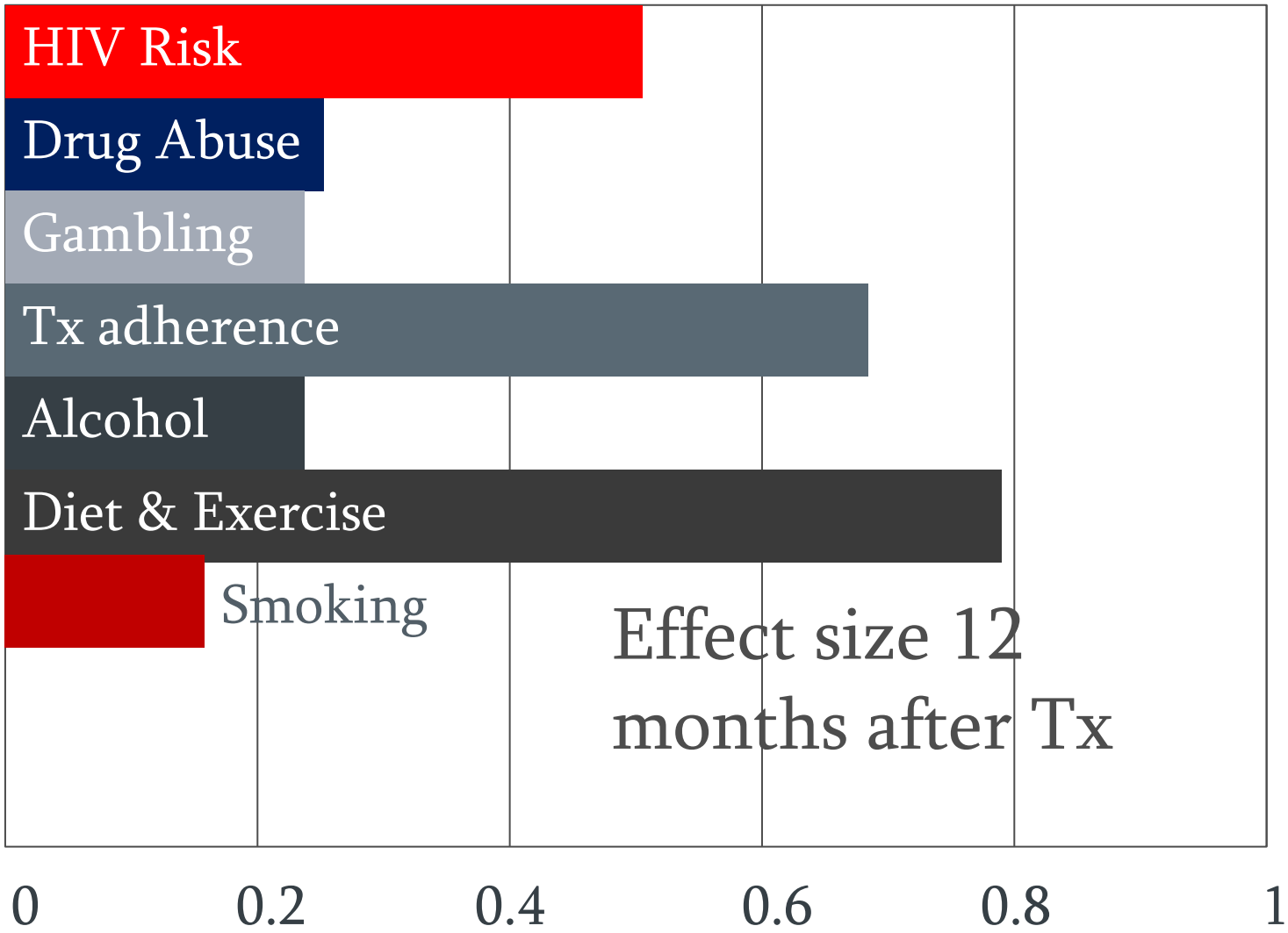


Motivational Interviewing

- The discomfort experienced when simultaneously holding two or more conflicting cognitions, ideas, beliefs or values. People may experience Dissonance when they find themselves doing things that don't fit with what they know, believe or opinions that they hold;
- Cognitive Dissonance theory proposes that people have a motivational drive to reduce the subsequent anxiety and 'disequilibrium' by altering cognitions, justifying behaviours or reducing the importance of one of the dissonant elements;
- Dissonance Reduction can be achieved by lowering the importance of one of the dissonant factors;
- Examples: 'The Fox and the Grapes'

Cognitive Dissonance

Motivational Interviewing

Reactance is an emotional reaction in direct contradiction to rules or regulations that threaten or eliminate specific behavioural freedoms. Reactance can occur when someone is heavily pressured to accept a certain view or attitude. Reactance can cause the person to adopt or strengthen a view or attitude that is contrary to what was intended, and also increases resistance to persuasion.

Psychological reactance occurs in response to threats to perceived behavioural freedoms.

This behaviour is not necessarily intentional, and can be completely outside of the reactant individual's conscious awareness.

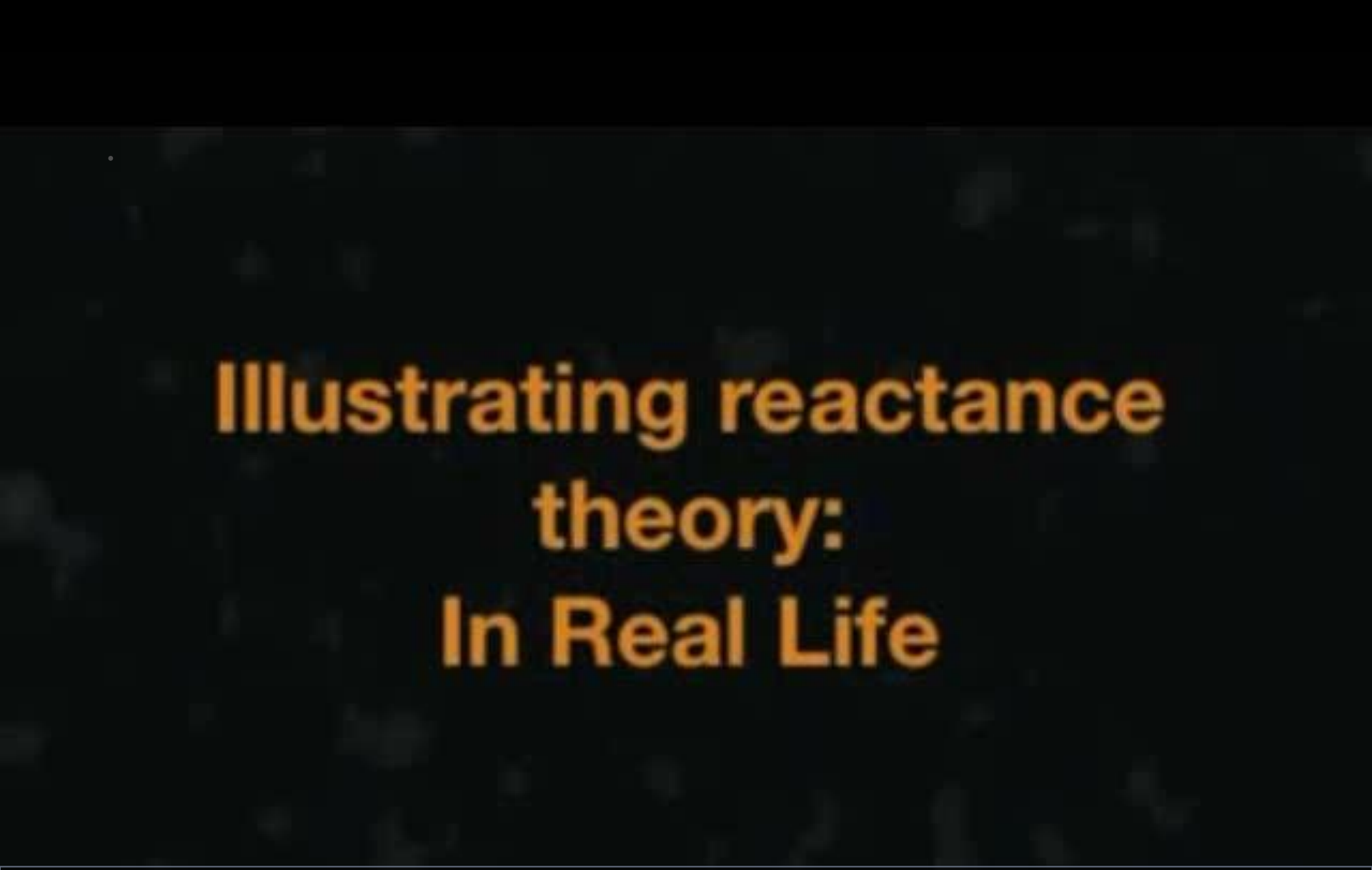
Psychological Reactance Theory

Motivational Interviewing

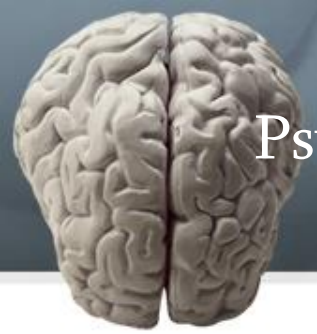
- 1- Direct **restoration** of Freedom
- 2- Increased **preference** of the eliminated option
- 3- Derogation of the **source** of threat

Effects of Reactance


SOCIAL PSYCH



Reactance Theory



Psychological Reactance

- Psychological reactance is described as resistance to persuasive messages when a threat to freedom is perceived (Brehm,1966; Brehmand Brehm, 1981). This condition brings individuals to do the contrary of what they are asked to do or to persist in a wrong behaviour even in the face of evidence.
- The key factors involved in the arousal of reactance are perceived freedom, threat to freedom, reactance and restoration of freedom. Studies have shown that reactance is the result of a combination of cognitive and affective processes, in which negative cognition and anger play a major role (Dillard and Shen, 2005; Rains and Turner, 2007).
- As far as knowledge is concerned, it seems that pure information regarding an issue, e.g., a disease, is likely to represent a threat in itself, as it sheds light on possible limitations to freedom for the individual, who in turn will experience reactance (Brehmand Brehm, 1981; Fogarty, 1997).
- With regard to persuasion, another study found that quality of argument does not impact on the degree of reactance (Rains and Turner, 2007), because it seems that perceiving a threat to freedom is enough to cause anger and negative cognitions that actually make the quality of arguments irrelevant. In other words, once certain information has been provided and reactance has been aroused, the potential benefits of persuasion are reduced by the emotional component of reactance itself, i.e., anger and negative cognition.
- It also seems that reactance is strengthened by the perception of dominance, i.e., the extent to which a message reveals that the sender believes s/he can control the receiver.
- On the other hand, when justifications for requesting a certain behaviour are provided, this softens the feeling of threat and reduces the arousal of reactance.
- Fuelling client's' perception that they are retaining some degree of control over the procedures, and that they are freely conceding something to the provider, instead of being persuaded against their will into something they did not want to do. This should decrease the perception of loss of freedom, thereby also reducing reactance.
- Offering more than one effective alternative, whenever possible, and let clients select the one that best fits their preferences and possibilities.
- This suggestion in particular is aimed at communicating the perception of the provider as someone who is willing to make concessions. A universal rule of behavior (Cialdini, 2007; Ariely, 2008) dictates that when one party is willing to make concessions, the other one will reciprocate.

Motivational Techniques: The Decisional Balance

Important Theorists

"Named must be your fear before banish it you can."

-Yoda

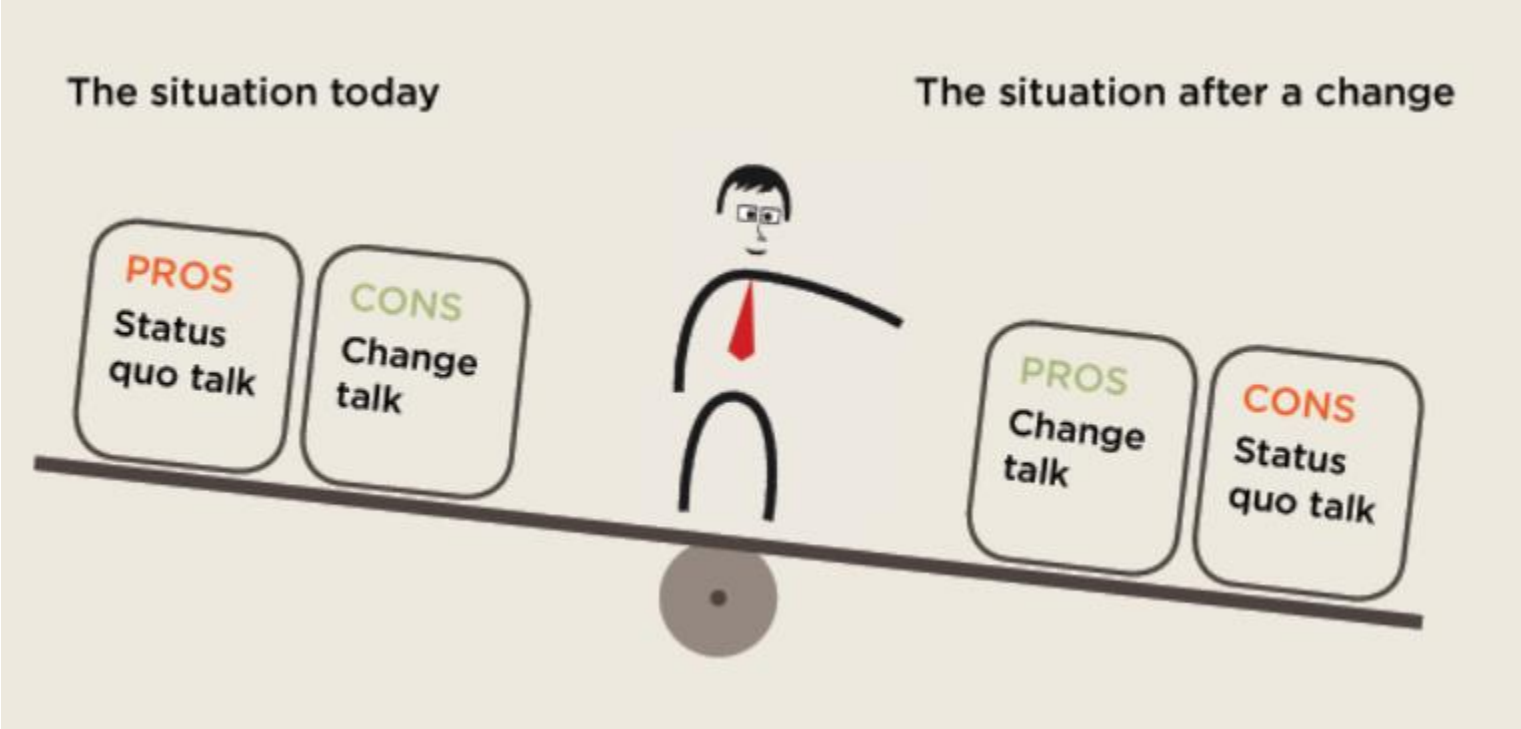
Ambivalence

Motivational Interviewing'

A collaborative conversation style for strengthening a person's own motivation and commitment to change

Ambivalence, Dissonance & Reactance. The problem …

Motivational Interviewing



Motivational Interviewing

A collaborative conversation style for strengthening a person's own motivation and commitment to change

Motivational Interviewing

1. Ambivalence normally precedes change. Candidates for change tend to be ambivalent.
2. What happens if you "confront" an ambivalent person, taking up one side of the internal argument? It elicits from the person the other side of the argument.
3. We become gradually more committed to that which we voice. (Bem's self-perception theory) Therefore, eliciting counter-change arguments would be expected to decrease likelihood of change.
4. Level of client defensiveness (taking the non-change side of the argument) is strongly influenced by the interviewer; it can be increased or decreased.

Considerations

Motivational Interviewing

5. Counsellor confront responses particularly elicit defensiveness (resistance, denial), and it only takes a few confronts to do it.
6. Client defensiveness predicts lack of behaviour change.
7. Confrontational treatment methods produce little behaviour change. Clients change least whose counsellors are high in confrontation. Low defensiveness predicts change.

Considerations

Assessment Trap – The clinical error of beginning consultation with expert information gathering at the cost of not listening to the client's concerns;

Affirmation – One of four aspects of acceptance as a component of MI spirit, by which the counsellor accentuates the positive, seeking and acknowledging a person's strengths and efforts

Autonomy Support –One of four aspects of acceptance as a component of MI spirit, by which the interviewer accepts and confirms the client's irrevocable right to self-determination and choice

Change Ruler -A rating scale, usually 0-10, used to assess a client's motivation for a particular change; see confidence ruler and importance ruler

Confidence Ruler – A scale (typically 0-10) on which clients are asked to rate their level of confidence in their ability to make a particular change

Change Talk -Any client speech that favours movement toward a particular change goal.

Closed Question -A question that asks for yes/no, a short answer, or specific information

Open Question -A question that offers the client broad latitude and choice in how to respond; compare with closed question

Commitment Language. A form of client mobilizing change talk that reflects intention or disposition to carry out change; common verbs include will, do, going to.

DARN -An acronym for four subtypes of client preparatory change talk: Desire, Ability, Reason, and Need.

Discrepancy -The distance between the status quo and one or more client change goals

Double-Sided Reflection. An interviewer reflection that includes both client sustain talk and change talk, usually with the conjunction "and".

Elaboration -An interviewer response to client change talk, asking for additional detail, clarification, or example

Emphasizing Personal Control -An interviewer statement directly expressing autonomy support, acknowledging the client's ability for choice and self-determination

Envisioning -Client speech that reflects the client imagining having made a change

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Exploring Goals and Values – A strategy for evoking change talk by having people describe their most important life goals or values

Formulation – Developing a shared picture or hypothesis regarding the client's situation and how it might be addressed

Goldilocks Principle – In order to be motivating, a discrepancy should be not too large or too Small

Importance Ruler – A scale (typically 0-10) on which clients are asked to rate the importance of making a particular change

Linking Summary – A special form of reflection that connects what the person has just said with something you remember from prior conversation;

Looking Back -A strategy for evoking client change talk, exploring a better time in the past

Looking Forward -A strategy for evoking client change talk, exploring a possible better future that the client hopes for or imagines, or anticipating the future consequences of not changing

Permission - Obtaining by the interviewer of client assent before providing advice or Information

Planning – The fundamental process of MI, which involves developing a specific change plan that the client is willing to implement

Querying Extremes – A strategy for evoking change talk by asking clients to imagine best consequences of change or worst consequences of status quo

Reactance – The natural human tendency to reassert one's freedom when it appears to be threatened

Running Head Start -A strategy for eliciting client change talk in which the interviewer first explores perceived "good things" about the status quo, in order to then query the "not so good things"

Status Quo – The current state of affairs without change

Simple Reflection -A reflection that contains little or no additional content beyond what the client has said

Complex Reflection -An interviewer reflection that adds additional or different meaning beyond what the client has just said; a guess as to what the client may have meant (**Depth of Reflection** – The extent to which a reflection contains more than the literal content of what a person has already said)