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Ethical Considerations in the Treatment of Compulsive Hoarding

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Although empirically supported treatment for compulsive hoarding is in its preliminary stages, some information has emerged regarding ethical challenges experienced in treating this population. Our aims are twofold: (a) to inform the clinical community of ethical complications when conducting treatment for hoarding clients, and (b) to provide a decision-making model for ensuring quality and ethical care of hoarding clients. The ethical challenges (boundary crossings, dual roles, privacy/confidentiality, record keeping, fees, and cultural competence in treatment) were discovered through multiple roundtable discussions, supervision, and in the course of delivering empirically supported treatment protocols. A literature search was conducted to identify research that addressed ethical concerns. A decision-making model addressing ethical challenges in treatment of compulsive hoarding was developed.

In the last 10 years, compulsive hoarding has emerged as a debilitating and often difficult-to-treat phenomenon in North America. Samuels et al. (2008) estimated the prevalence of hoarding at approximately 5%, more than twice the rate of obsessive-compulsive disorder (OCD) and five times the rate of disorders such as panic disorder and schizophrenia. In hoarding cases, clutter prevents the normal use of space for basic activities such as cooking, cleaning, moving through the house, and even sleeping. Interference with these functions can make hoarding a dangerous problem, putting people at risk for fire, falling, poor sanitation, and health risks. In a recent large-scale (N=864) website study of self-identified individuals with hoarding problems, 8% reported that they had been evicted or threatened with eviction due to hoarding, and 0.1% reported having a dependent removed from the home (Tolin, Frost, Steketee, Gray, & Fitch, 2008). Additionally, this cohort showed impairment comparable to those with psychosis and reported missing a mean of 7 work days per month due to psychiatric impairment (Tolin et al., 2008). In 2000, results from a survey of 88 Massachusetts health department officials representing about 1.79 million people found that 64% of them had received complaints about hoarding over a 5-year period (Frost, Steketee, & Williams, 2000). Health department officials noted that clutter interfered 80% of the time with food preparation; that 92% of the furniture could not be utilized for its normal uses; and that movement was obstructed 86% of the time (Frost et al., 2000). Health officials also disclosed that personal hygiene was compromised in 88% due to clutter and was acknowledged as a problem by the hoarding individual in only 50% of cases (Frost et al.). These complaints and official visits result in enormous costs to the public. For example, $16,000 or most of the budget of one small town's public health department was spent cleaning out one hoarder's house only to have the problem return almost 2 years later (Frost et al.). Often up to three repeat visits per hoarding household were necessary and in nearly half of the cases more than one official agency (fire, police, and health departments) was involved (Frost et al.). If an enduring solution is not found to help those with hoarding, this problem may continue to have an exponentially deleterious effect on society's resources as people lose control of their clutter.

Frost and Hartl (1996) formally defined compulsive hoarding as difficulty with acquisition and discarding of items, subsequent excessive clutter that impedes households' functionality, and the presence of significant distress and/or impairment. A model of compulsive hoarding has been developed which suggests that these symptoms may be the result of information processing deficits, erroneous beliefs about and excessive emotional attachment to possessions, and emotional distress and subsequent avoidance (Frost & Hartl, 1996; Frost & Steketee, 1999; Hartl & Frost, 1999; Steketee & Frost, 2003). This model of compulsive hoarding has been instrumental in developing and testing an effective treatment for this traditionally treatment refractory population.

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Treatment for Compulsive Hoarding

Preliminary research has suggested that traditional cognitive behavior therapy (CBT) and exposure and response prevention (ERP), which are effective for treating other types of OCD, may not be as helpful in treating individuals suffering from compulsive hoarding (Abramowitz, Franklin, Schwartz, & Furr, 2003; Frost & Hartl, 1996; Frost & Steketee, 1998; Steketee & Frost, 2003). This has led to efforts to develop a specialized form of CBT specifically designed for treating compulsive hoarding (Steketee & Frost, 2007). Preliminary investigation of this treatment suggests that it is effective (Tolin, Frost, & Steketee, 2007).

In this treatment protocol, patients receive 26 weekly sessions of individual CBT in addition to monthly home visits over a 9- to 12-month time period. Several features of the treatment differ from traditional CBT and present the potential for ethical difficulties. *Home visits* are an integral aspect of treatment and consist of the clinician visiting the patient's home and conducting a 1- to 2-hour therapy session. While in the home, clinicians are able to conduct accurate assessments and teach the patient various skills (e.g., sorting, categorizing, organization) aimed at reducing the problem, levels of clutter, right at the source. At this point the treatment focuses on the patient's relationship with possessions and whether or not to discard them. The types of things people value vary widely. In hoarding cases there is the potential for infusion of value judgments that may influence a patient's behavior. The home visit provides an invaluable contextual learning experience for the patient that they would otherwise be unable to gain from office sessions. *Treatment in public places* is another standard feature of this protocol that may be utilized for treatment of excessive acquisition behavior or excessive amounts of clutter located outside the home, such as in work offices or extra storage units. Other examples of public places where treatment may be conducted are retail shops, resale shops, grocery stores, dumpsters, or yard sales. Some behavior therapists conduct exposure exercises for fear-related problems in public places and face similar dilemmas in maintaining ethical guidelines. Similar to on-site home visits, non-acquisition exposures provide the patient with a real-world experience in which they attempt to resist urges to acquire and examine thought patterns that drive acquiring. In carrying out an actual exposure as opposed to in vivo, it is hoped that the exposure itself will have a stronger effect and will generalize more broadly. Finally, for many hoarding patients, the treatment incorporates the use of *coaches* who operate in similar ways to a clinician on a home visit. Coaches may include family members such as spouses, close friends, or even professional organizers. These coaches provide invaluable services by enhancing motivation, providing support, and providing manual labor; however, they introduce yet another area for ethical dilemmas to occur.

General Background for Ethics Codes and Principles

All service providers, including mental health providers, are subject to codes of ethics set forth by their field's leading institutions. This is necessary to ensure that all patients are treated equitably and ethically. For example, if the clinician is licensed as a clinical social worker, then he or she adheres to the ethics code set forth by the National Association of Social Workers. If the clinician is a pastoral psychotherapist, he or she is ethically guided by the American Association of Pastoral Counselors. If the clinician is a mental health counselor, then the American Mental Health Counseling Association sets forth the ethical standards, whereas marriage and family clinicians may reference the American Association of Marriage and Family Therapists' Ethics Code. In the field of psychology, the American Psychological Association (APA) developed ethical principles and an official code of conduct as a guideline for psychologists in 1952. Since this paper reflects the experiences of clinical work conducted primarily by psychologists and psychology graduate students, the APA Ethical Principles of Psychologists and Code of Conduct, or Ethics Code, (2002) was used as the standard by which ethical considerations in treating compulsive hoarding was examined.

In the most recent edition, the APA (2002) set forth five aspirational ethical principles for psychologists to strive for:

- "beneficence and nonmaleficence" or doing no harm to patients;
- "fidelity and responsibility" or the development and maintenance of a trusting relationship;
- "integrity or being of honorable" and accurate character;
- "justice"or being fair and equitable in all dealings with people;
- "respect for people's rights and dignity" or being aware of the effect they have on people.

The APA set forth 10 standards or obligations that provide the framework for the code of ethics. This Ethics Code includes ethical standards for resolving ethical issues, competence, human relations, privacy and confidentiality, advertising and other public statements, record keeping and fees, education and training, research and publication, assessment, and therapy. Five of the APA ethical standards were identified as particularly relevant when providing treatment to patients meeting criteria for compulsive hoarding. These ethical standards are human relations, privacy and confidentiality, record keeping and

fees, therapy, and competence. Each standard is defined and discussed in relation to compulsive hoarding treatment in the upcoming sections.

In addition to the Ethics Code set forth by APA, each state sets forth codes of ethics based on state and federal regulations. It is important for clinicians who may be treating compulsive hoarding to be aware of all of their state's rules and regulations for providing ethical treatment of their patients, particularly as they may conflict with the Ethics Codes set forth by professional institutions. For example, APA ethical standards for privacy and confidentiality may conflict with state and federal regulations for mandated reporting. Potential conflicts and implications are further discussed below.

Both ethics codes and laws/regulations are necessary as guidelines for the protection of patients yet should not be considered the absolute and only standard by which clinicians and other mental health providers should operate as interpretations and implementation of these rules and laws vary significantly. The clinician often struggles to apply one set of standards in the same manner to different patients as each patient usually presents with a unique set of problems within specific environments and circumstances, and with different values and experiences. In addition, decisions about ethical choices are influenced by several variables, such as the individual clinician's own personality and background, the nature of the ethical dilemma, the environmental characteristics in which the dilemma occurs, and external factors such as the political atmosphere, societal norms, economic status, and technology (Hadjistavropoulos & Malloy, 2000). Thus, what may be a correct and ethical behavior with one patient may not be with another.

Purpose

The distinctive features of treatment for compulsive hoarding, such as conducting treatment protocols in nontraditional settings like the patient's home, present potentially ethically challenging situations for the clinician. Although there are professionally established ethics codes and state laws/regulations protecting the ethical rights of patients, these can often be confusing and limited in scope. Additional guidelines are necessary, particularly when dealing with treatment-resistant populations such as compulsive hoarding patients. The identification of specific ethical concerns and resulting suggestions may be useful in informing clinicians who are treating this population in private practice and community settings. Thus, this article is an attempt to inform the clinical community of potential ethical complications when treating people struggling with compulsive hoarding. We conclude this article with suggestions, guidelines, and a decision-making model for dealing effectively and compassionately with these challenges.

Method

The ethical challenges discussed were mainly discovered in the course of delivering empirically supported treatment protocols at Boston University through a federally funded grant. These challenges were identified and discussed in depth in multiple roundtable discussions and supervision meetings. Boundary crossings and dual roles, privacy/ confidentiality (mandated reporting), record keeping/fees, and competent delivery of therapy were the most common ethical issues observed and experienced during the course of empirically supported treatment of compulsive hoarding patients. For example, conducting treatment sessions in the home raised the potential for latently harmful *boundary crossings* and *dual role conflict* both for the clinician and patient. *Privacy and confidentiality* standards were challenged by reporting mandates, as well as family members or friends present in the home during session or acting in the capacity as coaches. *Record keeping* became more difficult for the clinician when traveling to and from the home and *fee* arrangement for home sessions remains an undefined area. Finally, the clinician was occasionally forced to address potential treatment-interfering obstacles while in the home (i.e., the possibility of injury, insect infestation, presence of animal feces, etc.), and maintain cultural competency, which is less of an issue in the traditional office setting and more of an issue when entering a patient's home domain.

In addition, a PsychLit and Medline literature search was conducted to identify research that addressed ethical concerns, particularly as related to compulsive hoarding populations, and ethical decision-making models. Unfortunately, no literature existed that specifically discussed the ethical challenges in treating the hoarding population. However, general information addressing ethical challenges in treating elderly patients, providing home care, boundary violations, dual relationships, and mandated reporting situations were discovered and were instrumental in developing a decision-making model for guidance in ensuring ethical treatment for hoarding patients.

Potential Ethical Issues

Human Relations: Boundary Issues

Among the potential ethical dilemmas that a clinician treating compulsive hoarding in the patient's home may encounter are boundary issues, which may affect the therapeutic relationship. Boundary issues have been recognized by the APA (2002) and other regulatory organizations as one of the top two ethical complaints filed by patients—patient confidentiality being the second (Knapp & Slattery, 2004; Pope & Vetter, 1992). Common boundary issues occur in a number of different

areas: business, sexual, social, student, mentor, supervisor, relatives of the patient, and former patients (Bersoff, 2003). Zur (2007) suggested that all services provided outside of the office violate traditional therapeutic boundaries set within the office walls but proposed that the relationship stays one-natured (not dual) because it remains clinical in nature. Other researchers suggest that boundary issues fall into two categories: boundary crossings or "any deviation from the strictest professional role" and boundary violations or deviations from the professional role that could potentially harm the patient (Guthiel & Gabbard, 1993; Knapp & Slattery, 2004). Boundary violations tend to be the more explicit of the two and are generally easy to recognize. A good example of a boundary violation would be engaging in a sexual relationship with a patient while the patient is in active therapy (APA, 2002). However, boundary crossing, such as embracing patients, accepting gifts, and using self-disclosure, are more ambiguous and can be harmful or helpful depending on the situation and the patient.

In many cases, clinicians treating compulsive hoarding experience more boundary crossings than explicit boundary violations. While social norms are clear for the clinician when operating inside the clinic, outside the clinic they are not as obvious. When social norms are undefined, clinicians run the risk of engaging in boundary crossings and potentially harming the patient. For example, a graduate student trainee clinician who was treating compulsive hoarders described a situation where the patient lived quite a distance from the clinic and options for transportation were limited as the clinician did not own a car. Thus, the patient ended up personally providing transportation for the clinician. During the car ride, the clinician described not knowing what to say or how to comport herself. The undefined environment of the car may have disrupted the focus of the therapeutic relationship (e.g., the patient), causing the clinician to feel obligated to engage in "small talk," socially accepted behavior outside the office, resulting in a greater level of self-disclosure than in the clinic to pass the time. However, alternatively, in accepting a ride from the patient, the clinician may be promoting the collaborative nature of the therapeutic relationship consistent with the spirit of CBT. It should be noted that navigating boundary issues can be a challenging task for any clinician, but may be particularly difficult for mental health trainees as in this case example. Facing a variety of situations in which boundary crossings are more likely to occur (including home visiting and nonacquisition exposures), trainees may be more likely to experience higher levels of discomfort or confusion over potential ethical dilemmas due to their lack of clinical experience and fear of negative evaluation by clinical supervisors.

Other boundary crossing may occur when clinicians introduce third parties such as coaches, professional organizers, case managers, or other state officials such as public housing authorities. For example, some patients were able to afford to pay for additional help in reducing their clutter in their homes and hired professional organizers or professional de-clutter services such as 1-800-GotJunk. Many of the compulsive hoarding patients treated by the hoarding team at Boston University qualified for public assisted housing due to mental impairment or elderly status and were monitored by public housing officials. Other patients were working with Child Protective Services due to the presence of dependents in cluttered and unlivable households. In addition, some elderly patients qualified for additional services such as monthly maid service or massive clean-outs by professionals, again overseen by public state officials. The role of the clinician may be diluted by these additional relationships and subsequently the therapeutic relationship may be compromised. Additional confusion may result for the patient in identifying who is responsible for what tasks. Finally, the questions arises, Who is responsible for the ethical behavior of a group of third parties working together with a single compulsive hoarding patient?

Human Relations: Dual Roles

Related to boundary issues is the potential for the clinician to be caught in multiple relationships or dual roles with the patient. Dual relationships are an occurrence that the APA Ethics Code suggests avoiding as much as possible. The APA (2002) defines multiple relationships as:

> … occurring when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. (p. 6)

Identifying the potential for dual relationships in compulsive hoarding treatment can be complicated by the nature of the therapeutic relationship. Consistent with cognitive-behavioral treatments, treatment for compulsive hoarding is built on the assumption that the clinician and the patient are working collaboratively. This assumption, while having certain benefits, may also make it more difficult to spot ethical or social discomfort issues. When treating compulsive hoarders, the multiple relationship or dual role that the clinician encounters most frequently is the role of therapist and house guest. The power differential in the therapeutic relationship changes

when the clinician leaves the office and enters a patient's home (therapist to guest role). When therapy is conducted in an office, the clinician is in charge of the situation—but in the home, the roles can be reversed as the patient takes on the role of the host. In the role of host, the patient and the clinician may become confused about the social rules expected of them, which in turn may lead to dual relationships and potentially questionable ethics.

Privacy and Confidentiality

Another potentially sensitive ethical issue is the patient's right to privacy and confidentiality. In many cases, the patients that are treated for compulsive hoarding are elderly and their homes are so cluttered as to impede certain functions of daily living which could be construed as abuse or self-neglect by state laws. According to the APA Ethics Code, it is the responsibility of the clinician to maintain the confidentiality of the patient, reduce any infringement to privacy, and only disclose confidential information if provided with written consent from the patient or if mandated by the law (Bersoff, 2003). As of 2006, Massachusetts psychologists are mandated to break confidentiality and report suspected abuse of people over the age of 60 years (The General Laws of Massachusetts, 2008). This includes self-neglect defined as "unmet essential needs for food, clothing, safe and secure shelter, personal care, supervision and medical care that results in serious harm or in the immediate risk of serious harm and the inability of the elder to remain safely in the community." Unfortunately, reporting patients for self-neglect or abuse increases the likelihood that they may distrust future mental health providers and delay seeking assistance with their problem or knowing the potential for being reported, may choose to refuse any assistance at all, and run the risk of increased self-harm.

It is occasionally the case that compulsive hoarding patients reside with other elderly relatives, children, or disabled people. Oftentimes, the extremely cluttered condition of the home that may interfere with cooking, cleaning, laundry, etc., can also lead to situations that qualify for abuse or neglect of dependents. Again, psychologists are mandated by state law to report instances of abuse or neglect of disabled people and children. A conflict arises when the clinician needs to decide whether to protect the elders/children living in the home or protect the rights of their patient, the homeowner hoarder. In some cases, other agencies become involved independently of the clinician's influence. Clinicians need to be aware of the potential for disclosing too much of the patient's information while working with other agencies such as Child Protective Services, Elder Services, Department of Social Services, etc.

Although there are no official regulations about reporting animal abuse, it is a situation that bears some thought as clinicians may encounter instances of animal abuse or neglect, especially in the cases of people who hoard animals. Animal hoarding is a relatively understudied situation that is defined as the accumulations of a large number of animals, failure to provide adequate care or living environment, and the presence of significant impairment or distress (Patronek, 1999). Unfortunately, when animal hoarders are reported to authorities such as the police, public health officials, or the Massachusetts Society for the Prevention of Cruelty to Animals (MSPCA), they are often fined, their animals removed from their homes, and they are assigned community work at local animal shelters (Patronek & HARC, 2001). Unfortunately, these actions appear inadequate as the animal hoarder often resumes collecting animals once the authorities depart. In one study by Patronek (1999) almost 60% of animal hoarders were repeat offenders. Animal hoarders are then reluctant to seek treatment for their hoarding problem due to the fear that they will be turned in to the authorities again.

Violation of confidentiality or privacy also has the potential to occur when the clinician is conducting a nonacquisition exposure with the patient. The majority of nonacquisition exposures are typically conducted in public arenas (e.g., a store, yard sale, etc.) and are usually sites that the patient frequents. As a result, numerous risks to confidentiality/privacy can occur, such as bumping into someone known by the clinician or patient, dealing with questions from store clerks, or having conversations that may be overheard by other customers.

Another confidentiality concern may arise when the clinician is in the patient's home and encounters other family members. Other family members may have lived in the cluttered situation for many years, and by the time the hoarder seeks therapy and a clinician arrives in their home, they may be extremely frustrated and angry. Oftentimes they seek out the clinician during the home visit. Therapeutic boundaries, in addition to confidentiality, may be hard to maintain when an angry spouse demands to speak with the clinician while the clinician is in the home. In addition, it is occasionally the case that other family members contribute to the clutter in the home and need to be in treatment concurrently. It is difficult for a clinician to approach them and offer treatment when it may invade their privacy. The clinician may only be aware of this additional involvement because the behavior was observed in the patient's home. An additional conundrum exists when family members do become aware that they are part of the problem and seek assistance but are unable to get another clinician because few clinicians are currently trained to treat compulsive hoarding. Then a potentially ethically questionable situation exists where

the original clinician may need to provide couples or family therapy while still treating the individual patient.

Finally, the possibility of intruding on the patient's privacy exists when the therapist handles the patient's personal items in the home. Treatment protocol requires that the therapist only explicitly handle those items that the patient designates as acceptable. However, the clinician may accidentally stumble upon items that the patient feels uncomfortable about the clinician even viewing, not to mention touching. Additional conflict may arise when patients ask the clinician to take certain items out of the home to discard. What the discarded item is and where the item is discarded may affect the patient's confidentiality and privacy. For example, if the patient discards a bundle of junk mail and requests that the clinician take it out of the house, the clinician has to be aware of the effects of throwing away mail with identifying information on it in insecure locations. In addition, the patient may change his mind and ask for the item to be returned, or he may retrieve it himself, which may not only affect the therapeutic relationship but may place the clinician in an awkward position of having to break confidentiality to regain the item.

Record Keeping and Fees

When traveling back and forth between households and the office, the issue of correct documentation and record keeping may arise. The APA suggests that the clinician is responsible for creating accurate accountings of patient interactions, safely storing said documents, and maintaining confidentiality in accessing, storing, transferring, and disseminating patient records (APA, 2002). Clinicians would have to be careful of what they carry with them and what records are created in the patient's house. Often in the course of treatment, clinicians may want to take pictures of the patient's homes to record progress or use in the office. These pictures are potentially dangerous in that they may be misplaced in transit and discovered by others, thereby risking exposure of personal identifying patient information. In addition, the patient may decide to bring personal items into the office to sort and may ask the clinician to carry them back with them. Sometimes, the items are bulky and take up a lot if room. If the clinician decides to store the patient's personal items, how they should store them in a safe and confidential manner becomes a matter of concern, particularly if they are composed of sensitive material such as mail or personal documents.

Another area of potential sensitivity can be found during the payment for therapeutic services. Doing in vivo treatment or treatment in the home creates additional cost. For example, there is the additional cost of transportation either by car, train, bus, boat to the patient's home. If the clinician drives, there is the cost of the gas and time, depending on how far away the patient's house is. If traveling by train, bus, or boat, there is the cost of the ticket as well as the time cost. What happens if the fastest way to get to a patient's house is also the most expensive? Does the clinician take the most economical route, which may cost the clinician time? How does the clinician ethically bill for these additional practical and time costs? When does the clock start? Does it start before travel, during travel, or when the clinician gets to the house? What is reasonable to charge people for such nontraditional treatment?

Therapy

Interrupting or terminating treatment is another area for potential ethical dilemmas. Clinicians need to be aware of several situations that may contribute to interruptions or terminations in treatment. Clinicians treating compulsive hoarding and conducting home visits have encountered a number of personally hazardous situation such as insect infestation (bed bugs), mold, dust, animal feces and urine, cluttered paths, items stacked precariously, and lack of restroom facilities. Clinicians run the risk of transporting insects back to their own homes, developing physical conditions due to the unsanitary conditions, and incurring injury due to falling objects and tripping. The APA Ethics Code (2002) suggests:

> When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the client/patient. (p. 7)

However, most clinicians do not plan for potential home conditions interrupting treatment, and if they do, the question becomes: Would it be ethical to send another clinician into the same hazardous situation with the possibility of the same negative results? How much information should the clinician disclose to other treating clinicians while still maintaining the integrity and privacy of the patient? It is also often hard to prove that patients have infestations or that the condition of the house contributed to any negative outcomes experienced by the clinician. In addition, the clinician may have a dilemma if he or she is not sure which of their patients' homes are responsible.

Competency

According to the APA (2002) Code of Ethics, it is the responsibility of the clinician to maintain competence, or (2.03) "psychologists undertake ongoing efforts to develop and maintain their competence." Patients often have different rules about how visitors should behave in their

homes. For example, some Asian cultures demand that when a visitor enters their home that they remove their shoes before coming inside. This cultural rule can cause a dilemma for the clinician entering the home of a hoarder as safety and nonhygienic conditions may be present. In other cultures, it is considered impolite to reject food or drink offered and if the clinician declines what is offered it may offend the patient and negatively affect therapeutic alliance.

Additionally, clinicians and patients may end up in mixed gender pairs (based on availability, preference, or assignment). Mixed gender pairs in compulsive hoarding treatment may present certain miscommunication challenges that must be addressed. A patient might have safety concerns or preexisting issues such as sexual trauma with members of the opposite sex that interfere with their ability to have a clinician of the opposite gender in their home. See Table 1 for a summary of the specific ethical issues in the treatment of compulsive hoarding.

Recommendations

General Guidelines

Over the last 30 years, ethics researchers have expanded their research beyond the scope of ethics codes and laws/regulations and developed and implemented many additional guidelines and decision-making models for dealing with the variety of ethical issues arising in clinical practice. Several guidelines were helpful in thinking about how to approach ethical practice in the treatment of compulsive hoarding patients. One valuable source was Pope and Keith-Spiegel (2008), who suggested that "ethical awareness is a continuous, active process that involves constant questioning and personal responsibility." As such, they recommend that it is the responsibility of the clinician to:

1. Keep informed about and constantly check for updates on their profession's ethics code and their state's laws and regulations.

Table 1
Specific Ethical Issues in the Treatment of Compulsive Hoarding

Ethical Issue	Definition	Specific Clinical Examples
Boundary Issues	Boundary issues typically fall into two categories, boundary crossings (any divergence from the professional role) and boundary violations (divergence from the professional role in a way which could harm the patient) (Guthiel & Gabbard, 1993; Knapp & Slattery, 2004).	1) Accepting a ride from a patient to the patient's home 2) Conducting treatment in patient's home
Dual Roles	Defined as being in a professional role with someone at the same time as being (a) in another role with the same person, (b) being in a relationship with someone closely related to the person whom the provider is in a professional relationship with or (c) intention to enter into a future relationship with this person or a person closely related to the person (Bersoff, 2003).	1) Clinician in role of therapist and guest in patient's home 2) Patient in role of patient and host of therapist while in home
Privacy and Confidentiality	It is the responsibility of the clinician to maintain the confidentiality of the patient, reduce any infringement to privacy, and only disclose confidential information if provided with written consent from the patient or if mandated by the law (Bersoff, 2003).	1) Conducting exposures such as nonacquisition exercises in public places 2) Encountering occurrences of mandated reporting of elderly and dependent abuse due to clutter
Record Keeping and Fees	The clinician is responsible for creating accurate accountings of patient interactions, safely storing said documents, and maintaining confidentiality in accessing, storing, transferring, and disseminating patient records (APA, 2002). It is also the responsibility of the clinician to set fees for services provided and inform patient of fee structure prior to treatment.	1) Transporting files to and from patient's home may result in misplaced paperwork or exposure to other members living in the household 2) Dilemma of when the treatment hour begins and thus how much to charge
Therapy	Clinicians make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the client/patient (Bersoff, 2003).	1) Hazardous home conditions may cause delayed home visits until the situation has been addressed (e.g., insect infestations, animal feces/urine, mold and lack of restroom facilities)
Competency	It is the responsibility of professionals to continue to develop and maintain their competence (APA, 2002).	1) Patient may have different cultural expectations in home

2. Consistently and intellectually evaluate emerging research and theory.
3. Constantly evaluate and question his/her understanding and practice of ethical behavior.
4. Not only question others' ethical behavior but question his/her personal behavior.
5. Not limit his/her self observations to what s/he does not know but to closely examine what is also known for mistakes or misinterpretations.
6. Understand that confronting ethical dilemmas is unavoidable and an essential part of clinical work.
7. Never be afraid to seek consultation or ask for help.

It is important to include ethical training guidelines due to the emerging status of treatment for compulsive hoarding, which often necessitates clinical work being conducted by trainees or graduate students. In training new providers about the intricacies of ethical behavior and decision making, some researchers advocate an ethics acculturation model composed of two parts: (a) "maintenance," or the culture, beliefs, and personal experiences of the clinician, and (b) "contact and participation," or the extent to which the clinician incorporates his/her profession's values (Gottlieb, Handelsman, & Knapp, 2008). This model suggests that the goal for effective ethical decision-making is an "integration" strategy that combines both the trainee's personal values and experiences and his or her profession's values when making decisions about ethical dilemmas. To achieve this goal, the authors suggest that trainees' ethics training should incorporate the following principles:

1. Be provided in a positive, inspiring environment that fosters open discussion of how to problem-solve around ethical dilemmas, a shift away from simply using aversion techniques of avoiding disciplinary action to teach about ethical behavior.
2. Be considered a dynamic and constant learning process rather than a static and one-time event.
3. Should include actual clinical experiences and examples, thereby exposing the trainee to new ideas, values, etc., gleaned from the world around them.
4. Should be "supportive and social", thereby continuing to expose the trainee to other people's views and experiences and contributing to a positive learning environment.
5. Supervisors or trainers should take into account the trainee's cultural background and needs in an effort to help the trainee integrate more fully and effectively with their professions' values.

Specific Decision-Making Model for Compulsive Hoarding

The following ethical decision-making model for compulsive hoarding was developed to address the specific ethical dilemmas that can be encountered when working with compulsive hoarding. However, it was purposely kept sufficiently general to account for situations not foreseen or observed by the current treatment providers of compulsive hoarding. This model was significantly influenced by models developed by Pope and Keith-Spiegel (2008) for boundary violations, Tymchuk (1986) and Hadjistavropoulos and Malloy (2000) for general ethical decision-making, and Knapp and Slattery (2004) for ethical decisions in nontraditional settings. See Table 2 for summary of model.

Step 1: The Clinician Should Evaluate and Anticipate Potential Ethical Dilemmas That Could Arise for Each Patient

In 2004, Knapp and Slattery suggested that the first step should be a thorough examination and analysis of all the potential ethical pitfalls that a clinician may encounter with a particular patient. In addition, during the analysis of the situation, the clinician should account for treatment goals, potential conflicts of interest, varying levels of objectivity, presence of patient's different cultural norms, and potential interruptions to therapy. The clinician should review and/or be aware of the ethics code for his or her professional organization and be cognizant of their state and federal regulations for mandated reporting. At this point, the clinician should be able to identify at least one other professional/supervisor to be used as a consultant for potential ethical or therapeutic questions that may arise in treatment (Pope & Keith-Spiegel, 2008). In addition, this analysis should assess the patient's level of functioning as well as the patient's decision-making abilities (Younggren & Gottlieb, 2004).

Most services provided to patients in their homes are provided to elderly patients. Linzer (2002) examined the ethical dilemmas home health care aides experience while serving elderly populations. Elderly patients often refuse home services, which can create conflicts between respecting their autonomy and dignity and providing services that could make their lives better. Linzer suggests that when making the decision about whether or not to respect the patient's autonomy, the service provider should take into account the patient's decision-making capacity and constantly monitor for changing circumstances. For elderly hoarding patients, it may be important to assess the decision-making capacity before entering the patient's home.

Step 2: Develop a Pretreatment Plan for Dealing With Anticipated Ethical Dilemmas

The next step is to communicate the potential risks to the patient and set up a plan for dealing with potential ethical risks. Often the patient is aware of the rules governing behavior in the office setting. In a typical office setting the patient arrives at the office and expects to sit in a room with the clinician and discuss topics of personal

Table 2
Specific Decision-Making Model for Compulsive Hoarding

Pre-Treatment	Step 1: Evaluate and anticipate potential ethical dilemmas	a) Analyze treatment goals, potential conflicts of interest, varying levels of objectivity, presence of patient's different cultural norms, and potential interruptions to therapy. b) Evaluate and anticipate potential ethical dilemmas. c) Identify at least one other professional/supervisor to be used as a consultant for potential ethical questions that may arise in treatment.
	Step 2: Develop ethics plan	a) Consult with profession's ethics code and state laws to make sure there are no flagrant violations. b) Problem-solve for several solutions or alternative courses of action and agree on a plan with the patient. Include short-term, ongoing, and long-term risk/ benefits or pros/ cons assessment evaluating outcomes not only for the patient but for other people who may be affected such as family, other providers, etc. c) If the fit between patient and provider is not comfortable or the provider feels incompetent working with patient, refer the patient to another clinician.
	Step 3: Informed consent	Through the informed consent process, inform patient of potential ethical dilemmas and gain agreement of patient with plan.
During Treatment	Step 4: Mindful awareness/ monitoring	a) Be mindful of "gut" or inner feelings about potential ethical dilemmas. b) Gather information by carefully observing the situation, maintaining an open and honest view and keeping as objective as possible. Pay attention to the patient, both to the patient's verbal and nonverbal communication. "Attempt to see the situation from the patient's point of view."
	Step 5: If ethical dilemma occurs	c) Look to resources such as the preestablished ethical plan, ethics codes, state laws, and colleagues/supervisors. d) If not already established, work with patient to set up a plan of action. e) Implement plan of action and evaluate results. If plan does not work, try another option and repeat process.
	Step 6: Documentation	Document all interactions with the patient, paying particular attention to ethical dilemmas encountered. Include course of action, rationale for action, expected benefit to patient, and outcome.

interest. However, patients often do not know the rules for conducting therapeutic conversations in their own homes and may be confused with other rules of behavior such as social rules. It is up to the clinician to work together with the patient to set up the rules of appropriate behavior of both parties in the home (Knapp & Slattery, 2004). It would also be prudent to discuss clear guidelines about what fees are associated with treatment, when payment will be required, and consequences for failure to pay. If other parties, such as coaches or other professionals, are involved in the treatment process, they should be included in this discussion with the patient. Other parties may include other family members, friends, organizations, and service providers such as Elderly Services or Social Services. Clinicians can decrease confidentiality/privacy concerns when conducting treatment in public settings by carefully planning out with the patient how the exposure will be conducted and identifying procedures for handling confidentiality/ privacy risks. At this point in the treatment process, if the fit between patient and clinician is not comfortable or the clinician feels incompetent to handle the treatment, the clinician should refer the patient to another clinician.

Step 3: Agreement of Ethics Plan and Signed Inform Consent

Once the clinician and patient are aware of the risks and have developed a plan, it is the responsibility of the clinician to fully document the proceedings through the use of informed consent protocols. The clinician should rigorously scrutinize the plan developed, keeping in mind state and federal regulations. If necessary, the clinician should consult with their ethics committees or other professionals familiar with ethical issues (Moleski & Kiselica, 2005, Younggren & Gottlieb, 2004). Finally, both the patient and the clinician need to agree in writing on the planned course of action in case ethical issues should arise during treatment.

Step 4: Be Mindful of Gut or Inner Feelings About Potential Ethical Dilemmas During Treatment

It should be the responsibility of the clinician to constantly monitor for changes in the therapeutic relationship. The clinician should constantly gather information by carefully observing the situation, maintaining an open and honest view, and keeping as objective as possible. Special attention should be paid to the patient, both to the patient's verbal and nonverbal communication in an attempt to perceive the situation

from the patient's viewpoint (Pope & Keith-Spiegel, 2008).

Step 5: If an Ethical Dilemma Occurs During the Course of Treatment

If unforeseen ethical problems arise during the course of treatment, the clinician should consider the patient's treatment goals, short-term and long-term consequences to both the patient and others, and how harmful specific actions may be for the patient when considering how to proceed (Knapp & Slattery, 2004). In addition, the clinician should consult with supervisors or peers to rectify the situation in an expedient, effective, and ethical manner. Problem solving for alternative solutions with the patient and anyone else involved is often helpful. Once a plan or course of action has been decided on, the plan should be implemented and monitored. If the plan does not succeed, another option should be initiated and the entire process repeated until an effective and safe solution has been reached.

Step 6: Document All Interactions With the Patient, Paying Particular Attention to Ethical Dilemmas Encountered

The clinician should be documenting all interactions with the patient. If an ethical dilemma occurs, the problem should be carefully described, a course of action should be recommended, the rationale for the recommended action should be included, as well as the expected benefit to patient, and outcome (Pope & Keith-Spiegel, 2008).

Implementing the Decision-Making Model for Compulsive Hoarding

Earlier we described common potential ethical issues encountered when treating compulsive hoarding patients. Specifically, when treating compulsive hoarding in nontraditional settings such as the patient's home or work place, special attention should be paid to potential boundary crossings and/or dual relationships, conflicts in patient privacy and confidentiality, questions regarding fees and record keeping, clinician competence, and therapy issues. According to *Step 1* in the decision-making model we developed, before conducting treatment in the compulsive hoarding patient's home or other nontraditional setting, the clinician should be aware of these common ethical issues and prepare ahead of time how s/he will deal with them. For example, we discussed how special ethical dilemmas may occur with the introduction of third parties, and in these cases it is essential that all service providers involved in a case communicate with one another and the patient from the outset. It is recommended that service providers arrange at least one initial team meeting with themselves and the patient to clarify the roles of various treatment providers. Ideally, if a large number of providers is involved, it is better for the therapeutic relationship if the clinician refrains from accepting the lead role of coordinating services as it has been observed that the individual who carries out the logistics of the service plan is a frequent source of anxiety and irritability for the patient. A strong therapeutic alliance is essential to progress in the treatment; without it, patients are less likely to reach their goals. If the patient has been referred by the court and is under the care of adult or child protective services, it is often the responsibility of the case manager from these services to lead the team of providers.

In one case example, a female patient in her late 20s, with several dependents living with her, was referred for hoarding treatment through child protective services. Many service providers were involved in the case, including a child protective services case manager, housing authorities, early intervention specialists, and a clinician treating the compulsive hoarding. In this instance, the clinician assigned to the case met with and communicated with all of the other providers as part of a team. The case manager at child protective services was ultimately responsible for drafting a service plan created by everyone on the team and each team member was delegated specific responsibilities. Furthermore, it was clearly communicated to the patient what each team member's role was and what she could expect from each of them (*Steps 2–3*). Finally, frequent meetings and communications were established between the patient and all the team members to evaluate the patient's progress and problem-solve if issues were encountered (*Step 4*).

Introducing third-party members raises the issue of deciding who is responsible for the ethical behavior of other team member, which changes with differing situations and involvement of different people. It is recommended that if the therapeutic team consists of one or more licensed supervisors and mental health trainees within the same field, it is ultimately the most experienced licensed supervisor's responsibility to guide the ethical behavior of the trainees. Additional recommendations are that supervisors build time into supervision to anticipate and discuss any ethical dilemmas. The situation becomes more complex when licensed service providers from different fields form the team. In these cases, it is recommended that each service provider refer to the ethical guidelines provided for their field, for example, psychologists would follow the APA guidelines. It is essential that service providers become knowledgeable with their set of ethical guidelines and that all team members communicate between one another about the guidelines that they are referring to. When faced with an ethical dilemma in these instances, it is helpful for the various service providers to meet and come to a consensus agreement as to how to proceed. In cases where the ethical dilemma seems particularly complex, consultation

is recommended. It is suggested that team members consult with a professional who has expertise in ethics and at least some familiarity with compulsive hoarding.

Finally, it was mentioned earlier that boundary crossings and other ethical challenges may be particularly difficult for mental health trainees due to their lack of clinical experience and fear of negative evaluation by clinical supervisors. Clinicians, who supervise trainees in the treatment of hoarding, can reduce the potential for discomfort or confusion by anticipating with trainees' boundary issues that may arise. It is suggested that supervisors begin this process prior to treatment starting (*Step 1*) and foster an open and supportive environment for discussion throughout the continuation of treatment (*Step 4*). Experienced supervisors can recommend ways to decrease the potential for ethical issues, such as arranging one's own transportation to the home and setting limits surrounding self-disclosure. Supervisors may also be on hand to support the resolution of ethical issues when they do occur; help trainees to process feelings of discomfort or tension; and work to successfully address these issues with the patient in an appropriate manner.

Step 2 of our model suggests working with the patient to develop a treatment plan and identify potential barriers to progress. For example, a potential therapeutic alliance and dual role issue may occur when the clinician conducts a home visit. In entrusting the clinician to enter their house and view and handle their objects, compulsive hoarding patients are opening up a potentially vulnerable side of themselves that must be respected. The clinician can decrease the chances of the patient feeling uncomfortable and anxious by acknowledging at the outset of treatment that clinician and patient may have different value judgments around possessions but it is essential for the patient to make decisions about discarding on their own. The clinician may guide the patient by providing multiple perspectives on the value of their possessions but should always respect and never make the decision for a patient about whether to discard.

Besides identifying and discussing different values and goals, the clinician and patient should discuss other risks and set up a plan for dealing with them. For example, to discourage breaches in confidentiality and privacy, the clinician may plan with the patient to conduct nonacquisition exposures in a less-frequented store or, if in a store that the patient frequents, the therapist may find a place in the store or directly outside of the store that is out of the way. The clinician and patient may practice a script of the patient's preference to be used if they are approached by store clerks, someone the patient or clinician knows, or other customers. This script may be designed to maximize the patient's confidentiality and privacy. Another potential risk may arise when patients ask clinicians to discard items from their home. A plan can be discussed that identifies the proper place to discard the items in a confidential manner, in order to both protect the patient's privacy and maintain their wishes. Similar discussions and subsequent plans should be developed in regards to potential boundary crossings, other conflicts in confidentiality and privacy, therapy issues, and reporting and fee issues. Once a satisfactory plan is in place that has the support of both clinician and patient, it should be documented and signed by both parties during the informed consent process (*Step 3 and 6*). The clinician should carefully monitor the situation (*Step 4*) and if ethical complications should arise along the way, then the clinician should work closely with the patient to problem-solve the issues and should not be hesitant to involve other professionals (*Step 5*).

A Specific Case Example

A case that well illustrates the ethical dilemmas that can arise during the treatment of compulsive hoarding occurred while treating a 60-year-old Caucasian woman who self-referred for CBT due to severe levels of clutter in her home, which was making it significantly difficult for her to function in her home on a daily basis. At the initial intake level, the patient reported several elements that could be categorized as high risk, including relative isolation from family and friends, as well as a chronic upper respiratory condition for which she was receiving medical attention. A mental health trainee was assigned to work with the patient, under the supervision of a licensed clinician with expertise in compulsive hoarding.

Boundary issues arose early in treatment, with the first therapeutic visit conducted in the patient's home. Lacking means of transportation, the trainee relied on public transportation and then having the patient drive her the remaining distance. As a result, the trainee faced the risk of boundary crossings while in the car with the patient (i.e., excessive self-disclosure on the part of the trainee). Accepting transportation from the patient also put the trainee into the potential dilemma of dual roles. The trainee took on the role of therapist and guest both in the patient's car and home. Furthermore, due to the patient's significant isolation and the number of hours spent in treatment both in the office and at home, the trainee also faced the dual role conflict of therapist versus friend. The trainee addressed the boundary issues and dual role conflicts by minimizing the risk associated with them as much as possible. The trainee consulted on this matter with her supervisor and decided to obtain a membership with a car sharing service (Zipcar.com) to gain the ability to drive herself to the patient's house. In addition, she monitored self-disclosure at home and maintained awareness throughout the case for the potential of dual role conflict. Consequently, she sought to respect and support the patient without straying from her main role as a professional.

Perhaps the most challenging ethical issue that arose during treatment was the maintenance of the patient's privacy and confidentiality. Upon inspection of the house it became clear to the trainee that there were a number of inherent safety hazards for both the patient and the trainee. Specifically, there was a lack of a heating system, missing windows, and insect and animal infestation (e.g., mice and squirrels), resulting in the substantial presence of animal urine and feces. The trainee had serious concerns about the lack of a heating system due to the upcoming fall and winter season, as well as the quality of the air due to the infestations. The trainee was most concerned on both of these points because of the patient's age and chronic medical condition. The patient's age and poor condition of her living environment contributed to a situation of mandated reporting of elder abuse in accordance with Massachusetts state laws. This situation created a conundrum for the trainee because the trainee was concerned about how the reporting might affect the therapeutic alliance and treatment progress.

In order to address this complex situation, the trainee consulted with her supervisor, as well as a team of other professionals trained in treating hoarding. The trainee also researched and referred to the APA Ethics Code, as well as her local state mandated reporting laws. Ultimately, the trainee decided to discuss her concerns surrounding safety as well as her desire to maintain the patient's privacy with the patient. She and the patient discussed the situation in depth and developed a plan of action that included: (a) a series of massive team cleanups to improve air quality and allow professionals in the house to fix the heating system, and (b) mutually agreed upon contingencies: for example, if the temperature of the house went below a certain cutoff point, the patient would go to stay at a friend's home until it became warmer. In regards to the massive team cleanups, the trainee worked closely with the patient to plan the logistical details, such as identifying goals, deciding on supplies needed, deciding on participants and what each of their roles would be, and clearly defining limits and boundaries. Finally, they both agreed that if these recommendations were not satisfactorily followed, then the trainee would have no choice but to report the patient to elder protective services given her age and the risk involved. The patient's house was sufficiently cleared of clutter, the heating was fixed, and the patient was satisfied with the results and how they were obtained.

As for the safety of the trainee working in these conditions within the home, the trainee sought additional consultation from her supervisor and other professionals. The goal was to continue providing treatment without interruption of services due to hazardous conditions. The solution was that the trainee required that both she and the patient wear gloves and masks when working within the house to protect themselves. The trainee minimized record-keeping risks by keeping confidential information stored in prearranged locked areas at the office and updated them as soon as she returned from the home visit. The arrangement of fees did not become an issue during the course of this treatment, as it was in the context of a federally funded research study. Finally, the trainee worked to maintain competence during the course of the treatment through consultation with her supervisor as well as researching to understand the patient's cultural background and how this might influence treatment both in the office and the home. Ultimately, through mindful observation during treatment, extensive consultation with her supervisor and other experts, and by directly working with the patient to identify ethical issues and develop subsequent plans of action, the trainee was able to protect the patient's safety and privacy while actually strengthening the therapeutic relationship.

Conclusion

Treatment for compulsive hoarding is still evolving, but recent research seems to indicate that nontraditional settings such as home visits and treatment in public arenas may play an important role in successful treatment outcome. Providing treatment in a patient's home or outside of the office introduces the possibility of specific potential ethical dilemmas that may affect the therapeutic relationship, the patient's confidentiality and privacy, and other patient rights. It is the responsibility of the clinician providing treatment in nontraditional settings to be aware of the ethical pitfalls, to have knowledge of the ethical guidelines set forth by their professional organizations, and to work diligently at all times to ensure that the patient's rights are maintained and that ethical treatment is provided. Through clinical observations and experiences, multiple roundtable discussions, and thorough literature searches, several potential ethical issues were identified. Based on combined clinical experience and suggestions from researchers in the field of ethical treatment, an ethics decision-making model was developed for use during treatment of compulsive hoarding to augment standard ethics codes and laws. Although it has not yet been empirically tested, it is a preliminary attempt to help other mental health providers provide the highest quality ethical and effective treatment to the compulsive hoarding population.

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