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Acceptance and Commitment Therapy for Hoarding Disorder in an Older Adult - Pilot Study

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Abstract

Forming connections with objects can be a part of normal development; however, difficulties occur when this accumulation of items grows excessive or when the person finds it difficult to part with the collected items. Hoarding disorder (HD) can be characterised as an enduring difficulty to part with objects or items because of a need to collect them, coupled with considerable distress associated with disposing of them. Hoarding problems come under the clinical guidelines for obsessive-compulsive disorder (OCD), which recommend psychological intervention at the individual's home. Cognitive-Behavioural Therapy (CBT) is the most widely used psychological therapy in treating HD currently. With dropout rates high and problems persisting for more than 50% of this population, there is a need for perhaps a different psychotherapeutic approach. Acceptance and Commitment Therapy (ACT) is based on mindful and values-guided action but has received very little attention in terms of the efficacy for treating HD in older adults. Exploring different therapy modalities for the treatment of HD in this population could provide useful insights in understanding, conceptualising and treating HD. This case study describes the use of ACT to treat "Emily," a 69-year-old woman with HD. The case also explores the strengths of using ACT in HD, possible adaptations to the model moving forward and suggestions for future research.

Keywords

hoarding disorder, older adult, treatment efficacy, acceptance and commitment therapy

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Theoretical and Research Basis for Treatment

Attaching meaning to several different possessions is common and can even provide comfort for individuals (Yap & Grisham, 2021). The collection of and attachment to these items becomes excessive when there is a reluctance to part with a substantial number of these possessions. Hoarding disorder (HD) is defined as a mental health condition characterised by a persistent difficulty in discarding possessions coupled with considerable distress associated with discarding them (American Psychiatric Association [APA], 2022).

To be defined as HD, the hoarding should not be better explained by different mental health disorder or another medical condition. The Diagnostic and Statistical Manual of Mental Disorders Text Revised (DSM-5-TR) recommends identifying whether an excessive level of collecting items is present and if the individual has an awareness of the hoarding-related cognitions and behaviours causing a problem (APA, 2022). Cath et al. (2017) have reported that the prevalence of HD among 15–97-year-olds is 2.12% in a large population-based sample, which increases linearly by 20% with every 5 years of age, indicating a significantly higher prevalence amongst older adults.

Research suggests that HD develops during adolescence with hoarding difficulties often increasing over time without treatment (Dozier et al., 2016; Morris et al., 2016). In a recent review, Stelis et al. (2022) highlight that common symptoms associated with HD in older adults include social isolation; leading to a lack of support when it comes to decluttering, low mood and other comorbidities such as anxiety and PTSD, which disrupts managing the household. Hoarding can have an enormous effect on the daily lives of individuals and others close to them. There are risk implications such as fires (Dozier & Porter, 2020), poor sanitation and falling (Larkin et al., 2024) which consequently impacts activities of daily living (ADLs) (Archer et al., 2019).

Research has shown that perceived stigma is a common barrier to mental health help-seeking in many populations (Koutra et al., 2024). Chasson et al. (2018) highlight that that self-stigma negatively correlates with treatment seeking behaviour in individuals with HD. Using qualitative methodology, Clark et al. (2025) have further reported that patients with HD regularly attribute a delay and/or avoidance of help-seeking due to perceived stigma. Although stigma is not specific to older adults, they are reported to be particularly vulnerable to HD as they are more susceptible to hazards (Hombali et al., 2019), with Ayers, Castriotta, et al. (2014) also reporting on the associated cognitive deficits that often presents with HD.

Dozier et al. (2024) have also investigated individual differences in older adults in relation to HD, specifically personality profiles. They reported that older adults in their sample had disproportionately high levels of extraversion and agreeableness and low conscientiousness scores, possibly impacting treatment outcomes. Older adults have also been shown to report significantly lower distress ratings in response to a sorting task compared to working age adults (Dozier et al., 2021). The common factors and individual differences in older adults with HD must, therefore, be taken into consideration at the point of assessment, formulation and intervention (Segal et al., 2018).

Typically categorised as a form of obsessive-compulsive disorder (OCD), HD is, however, recognised as a disorder itself in the DSM-5-TR (APA, 2022). Current interventions include cognitive-behavioural therapy (CBT) (Farquhar & Caiazza, 2020; Rodgers et al., 2021), self-help (Timpano et al., 2016), psychopharmacology interventions such as serotonin reuptake inhibitors (SSRIs) (Piacentino et al., 2019) and family therapy (Thompson et al., 2017). In a recent systematic review and meta-analysis looking at the efficacy of current treatment, O'Brien and Laws (2025) concluded that whilst there appears to be some efficacy for psychological interventions in reducing hoarding symptoms, symptoms often persist above clinical cut-offs at therapy completion and follow-up.

In the United Kingdom (UK), the National Institute for Health and Care Excellence (NICE), a regulatory body which provides evidence-based recommendations to guide health and social care professionals to improve treatment and service provision, do not report specific treatment guidelines for HD. Instead, HD treatment guidelines fall within the clinical guidelines for OCD (NICE, 2005), which advises psychological therapy at the individual's home where there is a substantial impact on the persons quality of life. Critically, there is some research which suggests that the use of home visits may enhance clinical outcomes for HD patients (Crone & Norberg, 2018). More recently, however, utilising meta-analytic methodology, O'Brien and Laws (2025) compared the treatment efficacy for psychological interventions in the treatment of HD when delivered at home vs without home visits. The researchers reported no significant difference in treatment outcome between the two groups, which also supports the conclusions drawn by Rodgers et al. (2021) meta-analysis on the same topic.

At present, the treatment modality with the largest evidence-base is individual CBT. Traditionally, CBT for HD involves psychoeducation and skill-building for patients to facilitate organisation of items (Frost & Hartl, 1996). Behavioural exposure is also used to help patients overcome patterns of avoidance in relation to facilitating the sorting and discarding items in conjunction with cognitive restructuring to target maladaptive beliefs about them (Frost & Hartl, 1996). In a recent meta-analysis, Tolin et al. (2021) concluded that CBT appears to be a promising treatment for HD, but suggested significant improvement in treatment modalities could be made, particularly on post-intervention efficacy, with Fang et al. (2023) purporting how third wave therapy models could support with HD treatment.

In a critical review of CBT for HD, David et al. (2022) have recently reported that approximately 25% of patients who engage with CBT interventions report improvement of symptoms. David et al. (2022) go on to conclude that despite some promising evidence, there are a number of limitations in achieving clinically significant change, specifically with older adult populations, for example, higher prevalence of executive dysfunction. Due to this increased prevalence, tailored CBT-HD interventions have been piloted by Ayers et al. (2014b, 2018) that also incorporate cognitive rehabilitation. Although Ayers et al. (2014b, 2018) reported promising results from this work, tailored intervention may not be possible in all services, largely due to service demand.

More recently, Nix et al. (2025) have explored the efficacy of in-home motivational interviewing (MI) techniques to enhance behavioural change in an older adult with HD. They reported that over the course of 16 sessions, the patient demonstrated an increased level of readiness for change and lower levels of object attachment. These gains persisted at a 3-month follow-up, providing some utility to MI as a psychological intervention for HD where CBT may have been ineffective. In the larger pilot study, Dozier and Nix (2025) also reported significant reductions in hoarding symptoms were evident after only six at home sessions utilising the brief MI intervention, further suggesting this type of intervention may be a viable treatment option for symptom reduction.

Acceptance and Commitment Therapy (ACT) seeks to encourage clients to a place of "psychological flexibility," where they can engage with their difficult thoughts and feelings with a view to living congruent to their identified values. Krafft and Ong (2025) argue that ACT uses a functional contextual model to conceptualise hoarding, viewing HD as a narrowed behavioural repertoire caused by psychological inflexibility. The objective of any ACT protocol is to bolster psychological flexibility such that individuals can live congruent to their identified values. Krafft and Ong (2025) argue that from an ACT perspective, engaging in repetitive behavioural actions which are not value-congruent perpetuates the problem. With respect to HD, ACT conceptualises the inflexibility as trusted rigid responses to both internal and external stimuli, for example, avoiding fear that comes with routinely ignoring clutter.

Previous research has indicated a correlation between psychological inflexibility and symptoms of HD (Ayers, Castriotta, et al., 2014). In recent years, Jennifer Krafft and colleagues have investigated the role of ACT in treating HD across different contexts, including online self-help (Krafft et al., 2023a, 2023b) and in person vs online interventions (Ong et al., 2021). Their findings provide preliminary support for ACT across platforms. Krafft et al. (2023a, 2023b) have also investigated the processes of change within the ACT model in the treatment of HD. Their research suggests that psychological inflexibility, self-stigma and mindful awareness are indeed related to hoarding symptoms but were unable to conclude that they are central mechanisms of change within the ACT model for hoarding.

Eppingstall et al. (2020) sets out a practical guide for ACT in treating HD, which details psychoeducation around values, acceptance and attention shifting before any decluttering begins. This is different to CBT which focuses on organisational work. With CBT addressing the veracity of individuals thought patters, an ACT approach observes and notices in the first instance. Given the greater focus on psychoeducation that HD-specific ACT provides, internal conflicts that form part of a patient's life holistically can be addressed, whereas HD-specific CBT targets individual problems (Eppingstall et al., 2020). This distinction is crucial, as some research suggests that this variation could mean that ACT could be more successful in reducing symptoms in the longer-term (Ong et al., 2021). In their baseline study, Ong et al. (2021) concluded that their findings revealed preliminary support for the efficacy of ACT for HD, especially in reducing treatment severity at both immediately after therapy and at follow-up. They also report however, that the reliability of the effect on other outcome measures, such as quality of life and psychological inflexibility remain unclear.

There remains a dearth of evidence utilising and incorporating the ACT model in the psychological treatment for HD, especially in older adult populations, where the prevalence of HD is higher than in working age adults. What follows is a case study describing, conceptualising and treating HD in an older adult utilising an ACT framework.

Case Introduction

The patient ("Emily") was a 69-year-old woman who was referred to the Psychology team within a secondary care mental health service for older adults in the UK. The referral detailed that Emily presented with hoarding behaviours and a diagnosis of bipolar disorder, alongside past trauma relating to family loss and workplace bullying. Emily said that she wanted the intervention to mainly support her with the hoarding behaviours, as she felt that this was having the biggest impact on her life.

Presenting Complaints

For the purposes of this case study, the patient is referred to as Emily throughout: this is not her real name. Other details that do not need to be disclosed have also been changed or omitted to preserve confidentiality.

The death of Queen Elizabeth in September 2022 brought back a lot of memories for Emily as of her own losses and reinforced the guilt she felt for her mother's death which she feels responsible for. At this time, Emily started self-harming. Emily also displayed some obsessive-compulsive behaviours, such as feeling the need to touch a light switch several times. She also made task lists for basic tasks and events to confirm that it is planned out.

Emily's hoarding behaviours were causing conflict with her sister, rooms were cluttered in her home, and this impacted her physical health. Due to bouts of Irritable Bowel Syndrome/diverticulitis, Emily had to plan days around her meals and the toilet which led to an increase

in planning. Emily experienced a procrastination-guilt cycle in relation to her home and as a result, she felt shame due to the clutter within the home and did not let other people inside. Many of the rooms in the home contained boxes full of items. Much of the surfaces in her home were taken up by mounds of paperwork amongst other personal effects. This meant that these rooms could not be used for their intended purpose. Due to the sheer number of possessions in her home, this also posed a significant fire risk. Emily also described that feeling a lack of control had also contributed to her hoarding behaviours.

Emily had good insight into her hoarding behaviours. She realised this was having a negative impact on many areas in her life and was keen to engage in therapy to address them.

History

Growing up, Emily was considered "reliable" in comparison to her siblings and took on a motherly role at times. She achieved high grades despite not feeling she was "academically minded" and worked hard to achieve this. At this time, she began extensively writing lists when having to do lots of schoolwork and feeling she had little time to do it in. This was an ongoing compulsive behaviour at point of referral to Psychology.

Emily experienced a persistent episode of workplace bullying in her earlier life which included emotional victimisation, manipulation and controlling behaviours. The perpetrator would tell her that there had been complaints about her, observe and ridiculed her when completing work tasks and limited her work freedom. She was also physically discriminated against, after suffering from an achilles injury and not being allowed access to a walking stick at work. Locks on doors were changed without her consent or awareness, creating a very controlling work atmosphere.

During the time period that followed this workplace bullying, Emily suffered the bereavements of both parents and a friend all within 6 months. More specifically, her mother was diagnosed with cancer and passed way within 4 weeks, whilst she witnessed the passing of her father directly. She expressed an overwhelming guilt surrounding her mother's death as they were very close. Emily was later able to identify that "the death of the queen, despite not being a royalist, triggered thoughts and feelings around the deaths of my parents, with issues escalating from there." Around this time, Emily accumulated a large amount of debt whilst her pension was stopped, and she faced the threat of eviction.

Emily recognised her hoarding behaviours as an issue, and feelings of shame and fear led her to not allow people into her home, increasing social isolation. As a result of the collecting and accumulation of items, Emily's home was cluttered to an unmanageable state. This, coupled with self-harm, suicidal ideation and leaving her previous job, led to Emily describing herself as "on the verge of a nervous breakdown" prior to psychological input. At this time, Emily was diagnosed with bipolar disorder, which she has difficulty identifying with.

Assessment

The assessment lasted three sessions across visits to a hospital clinic and at Emily's home. The first session was a general assessment of current difficulties, what Emily would like to work on, goal setting and to explain what psychological input would look like. The following two sessions centred around the hoarding behaviours, guided by treatment guidelines, see Holmes et al. (2015) and Steketee and Frost (2014). During assessment, Emily completed a general measure of psychological well-being, the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM; Evans et al., 2000), which demonstrated a moderate level of psychological distress. A series of HD-specific measures were also carried out, including the Hoarding Rating Scale

(HRS; Tolin et al., 2010), the Saving Inventory Revised (SI-R; Frost et al., 2004) and the Clutter Image Rating (CIR; Frost et al., 2008).

Scores across HD specific measures demonstrated that Emily exhibited clinically significant hoarding behaviours that were impacting her daily life (See Table 1). More specifically, she reported greater difficulties with the Clutter subscale, compared to the Saving and Acquisition subscales.

- The CORE (Evans et al., 2000): The CORE is an evaluation of global distress, containing 34 questions ranked on a 5-point Likert-type scale. It is comprised of four subscales including Risk, Subjective Wellbeing, Functioning and Problems/Symptoms.
- The HRS is a short measure of the main features of HD. It contains five items, which measure, Distress, Difficulty Discarding, Interference, Clutter and Acquisition.
- The SI-R is a measure of compulsive hoarding, comprised of 23 items. The scale consists of three subscales, including Clutter, Acquiring, and Difficulty Discarding.
- The CIR is a measure of how cluttered specific rooms are, rated from 1 (no clutter) to 9 (severe clutter). Images are presented for each room, for example, a bedroom, and the person is asked to say which picture most reflects the corresponding room in their home.

Emily provided written informed consent for purposes of publishing the study in a scientific journal, including the results and scores of outcome measures completed.

Table 1. Outcome Measure Scores

Outcome measure	Assessment	Final session	HD cut-off
CORE			
Total	58 (moderate level)	22 (low level)	
HRS			
Total clutter	27[a]	24[a]	14
Difficulty discarding		4[a]	4
Acquisition distress		6[a]	4
Interference		4[a]	4
SI-R			
Total	65[a]	53[a]	41
Clutter	32[a]	26[a]	17
Difficulty discarding	20[a]	17[a]	12
Excessive acquisition	13[a]	10[a]	10
CIR			
Kitchen	3	3	4
Bedroom 1	4[a]	5[a]	4
Bedroom 2	5[a]	7[a]	4
Bedroom 3	4[a]	2	4
Living room	4[a]	6[a]	4
Bathroom	3	5[a]	4
Loft			—
Garage			—
Shed			—

Note. HD = hoarding disorder; CORE = clinical outcomes in routine evaluation; HRS = hoarding rating scale; SI-R = saving inventory revised; CIR = clutter image rating.
[a]Denotes score that meets HD cut-off.

Case Conceptualisation

Both Emily's psychometric scores and qualitative information ascertained at assessment were consistent with the diagnostic criteria for HD. Following guidance, two formulation models were used, both a HD specific formulation model (see Steketee & Frost, 2014) and an ACT informed formulation. A model tailored to HD was used to create a shared understanding of Emily's challenges, informing planned intervention work, see Figure 1.

The HD-specific model argues that hoarding is a complex behaviour stemming from various factors, including issues with processing information, individual and family challenges, unhelpful thoughts about belongings, emotional responses and reinforced behaviours.

Individual/Family Vulnerability Dynamics

It is possible that Emily may be more predisposed to hoarding due to the difficulties she has faced in her life. For example, she was considered reliable within the immediate family and as a result, took on a motherly role with her siblings. This may have had a knock-on effect with her school life, as she began extensive list writing when feeling she had little time to do her schoolwork in. She worked incredibly hard to achieve good grades, despite feeling that she wasn't academically minded. Research has shown that adversity in childhood can disrupt relationships in later life, whilst increasing the likelihood of someone engaging in hoarding (Medard & Kellett, 2014). Comorbidity is frequently observed in HD, with 84% of individuals reporting a medical co-morbidity and 63% experiencing at least one additional psychiatric disorder (Tolin et al., 2008). Emily's comorbid bipolar disorder, a diagnosis she has had difficulties identifying with, contributed towards fluctuations in mood and subsequent engagement with support.

Information Processing

Despite no clinical concerns regarding executive functioning, Emily reported challenges with organising and implementing plans. She also experienced difficulties with throwing away items, which may stem from the significant loss of both friends and family members in her life, as well as experiencing controlling behaviours and emotional victimisation at work. These factors may have contributed to her difficulties with "losing" or parting with items, as well as means of keeping herself safe from others through not allowing them in her home.

Meaning of Possessions

Throughout therapy, it became apparent that Emily held certain beliefs that made it difficult for her to part with items in her home. Stemming from her traumatic experiences of loss and workplace bullying, her cluttered home environment "kept her safe from others" and therefore possessions reminded and allowed her to feel safe.

Emotional Responses

When Emily tackled the task of decluttering, she often felt shame, anxious and overwhelmed, which led to cognitions around "feeling like a failure."

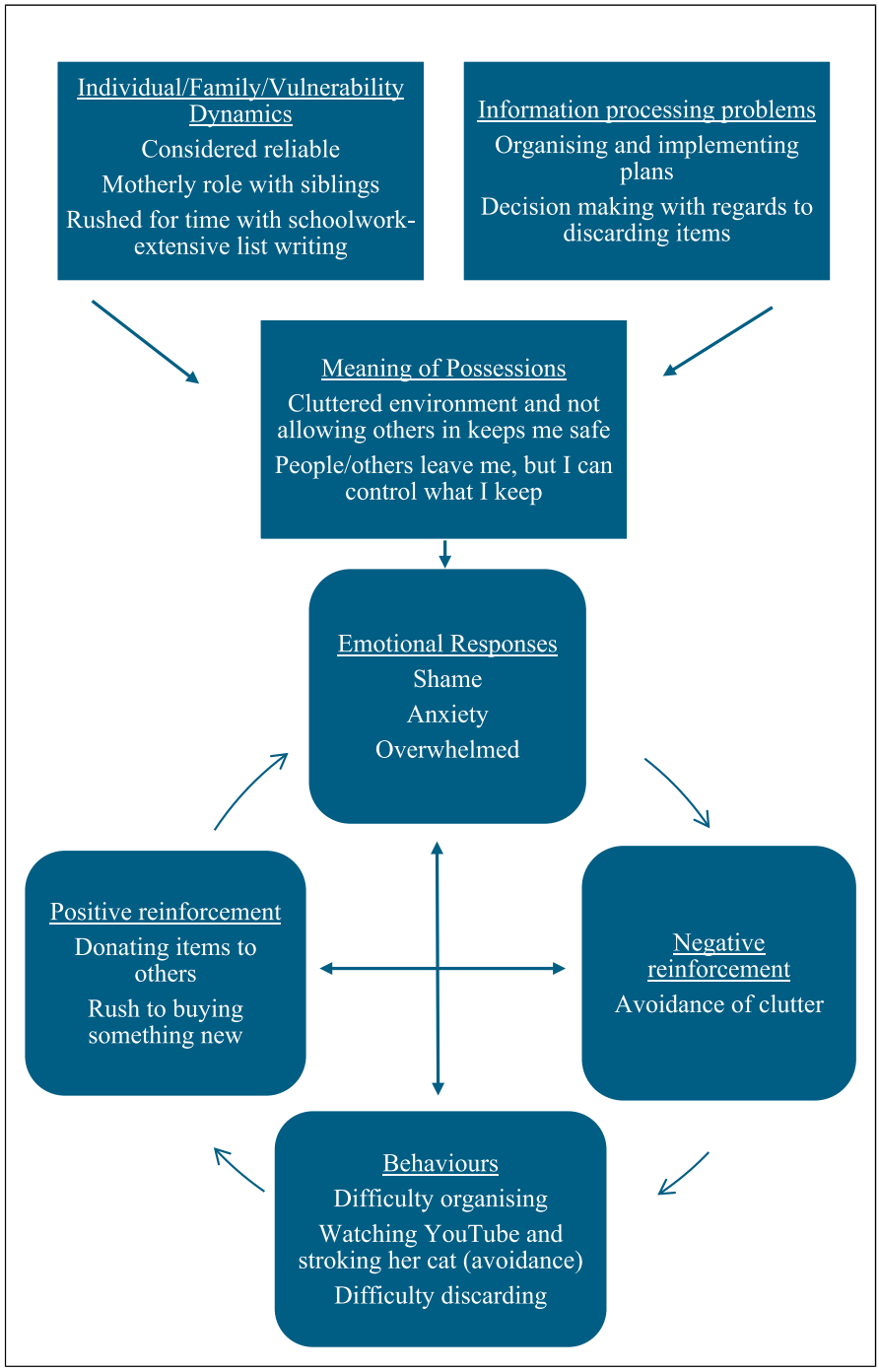

Figure 1. Emily's formulation model of hoarding, adapted from (Steketee & Frost, 2014)

Behaviours

To minimise these unwanted internal experiences Emily would exhibit avoidant behaviours, such as stroking her cat and spending time distracting herself on YouTube.

Negative Reinforcement

By avoiding the clutter, Emily alleviated the unpleasant emotions, which in turn reinforced this maladaptive coping strategy.

Positive Reinforcement

Emily found it rewarding to give items to others, and this sense of satisfaction acted as a positive reinforcer, making it harder for her to dispose of items until she had identified the ideal person to give them to. She also found excitement in purchasing new, nice things. Although she had significantly reduced the number of items she bought, the pre-existing accumulation of possessions she had was impacting her day-to-day functioning.

The ACT Model

The ACT Hexaflex is a core model within ACT that outlines six interrelated therapeutic processes aimed at increasing psychological flexibility, the mechanism of change within ACT. The Hexaflex describes how individuals can be more adaptable and responsive to difficult thoughts, feelings, and situations, enabling them to pursue meaningful actions aligned with their values. The six components of the Hexaflex are:

Cognitive Defusion. This process involves distancing oneself from thoughts and viewing them as mental events rather than truths. It helps individuals to reduce the impact of negative or unhelpful thoughts by changing their relationship with them (Hayes, 2004). Emily sometimes fused with the thought "I'm a failure," particularly when not completing tasks she had set herself.

Acceptance. Acceptance refers to embracing difficult internal events without trying to avoid or control them. This process encourages individuals to experience emotional pain without struggling against it, fostering psychological flexibility (Hayes et al., 2012). Emily commented that despite looking forward to spending Christmas with family, this time of year was upsetting as it reminded her of the death of her parents. Therapy in this way encouraged Emily to accept she had these understandable feelings, but at the same time still behaving congruently to her identified values and what was important to her, in this case, spending time with family.

Present Moment. Also called mindfulness, this process involves focusing on the present moment rather than getting caught up in past regrets or future worries. It encourages individuals to engage fully with their current experiences (Hayes et al., 2012). Emily often worried about the sheer size of the task of decluttering her home, with other factors such as the fire service doing a safety assessment of her home causing her anxiety. Mindfulness was encouraged to help shift Emily's attention to the present moment when her thoughts would spiral.

Self-as-Context. This component refers to the perspective of the self as an observer of internal events, separate from one's thoughts, feelings, and experiences. It helps individuals recognise that their sense of self is not dictated by their mental experiences, they are not simply the content of

their thoughts, allowing people to take an "observer" perspective on their own internal events (Hayes et al., 2012).

Values. Identifying and clarifying personal values is a central process in ACT. Values guide behaviour and provide meaning and motivation in life, helping individuals make decisions that align with what is important to them (Wilson & Murrell, 2004). Through values exploration, Emily identified spirituality, love, compassion, kindness and honesty as core personal values. With support, Emily could see that she had not been living congruent to these values as much as she could, which contributed to her ill-mental health.

Committed Action. This involves setting goals based on values and taking persistent, effective actions, even in the face of obstacles or discomfort. It encourages individuals to act in a way that moves them toward their values, fostering a sense of purpose and fulfilment (Hayes et al., 2012). Throughout therapy, certain goals emerged for Emily which included minimising her self-harming behaviour, spending time with family, going to church and taking measurable and achievable steps towards decluttering her home.

Together, these six processes promote a flexible, value-driven approach to life, encouraging individuals to accept and engage with their internal experiences while taking committed action towards their goals. This framework enables individuals to cultivate psychological flexibility, enhancing their ability to live more fully and in line with their values.

Course of Treatment and Assessment of Progress

Weekly ACT sessions and trauma-informed work were offered by an assistant psychologist, under the supervision of a qualified clinical psychologist. The sessions followed components from the treatment manual "Treatment for Hoarding Disorder" (Steketee & Frost, 2014), which utilises cognitive and behavioural strategies to target challenges related to acquiring and discarding items. Emily's therapy goals were to organise clutter and allow the space to feel like "home," reduce the fire risk and to feel better in herself. To facilitate this, we planned to address trauma and mood issues, identify ways to live by her values, gain a good understanding of her emotions and behaviour, reduce the hoarding behaviours and support in decluttering one room.

At the beginning of therapy, the focus was on the identification of therapy goals, psychoeducation to the ACT model and HD. There was a strong focus to create a collaborative formulation, which would indicate potential treatment intervention. Specific trauma-focused work was not undertaken, however, the impact of Emily's past traumas were captured throughout her formulation and constantly informed the intervention.

The intervention phase then shifted to beginning emotional regulation work and bolstering Emily's mindfulness skills, working to shift her attention away from the past and to live in the present moment. To ensure Emily was able to be present during sessions, mindfulness and grounding-based strategies were utilised. In early sessions these tended to be guided exercises to orientate her awareness both to the own mental events but also to bring her awareness to the present. In later sessions, after much practice, Emily developed her own repertoire of mindfulness exercises and was encouraged to regularly practice between sessions. Overall, these appeared to be particularly effective during sorting and discarding items as they allowed Emily to regulate her emotional response. Emily was able to reduce experiential avoidance as she was able to recognise her automatic urge to retain possessions which in turn supported her ability to consider the self-as-context, rather than content; distancing herself form feelings of shame and self-criticisms linked to her hoarding behaviours.

The aim of the sessions was to ultimately increase Emily's psychological flexibility. The decluttering sessions were based on problem-solving and goal setting utilising value-congruent committed actions the ACT framework. We were also able to incorporate specific creative hopelessness interventions to identify how 'workable' Emily's previous behaviour was in allowing her to live a value-congruent life.

The use of these methods was differentiated from a traditional CBT approach as the aim was not to challenge Emily's thoughts but instead to allow her to develop awareness of the existing thoughts, begin to "defuse" or "unhook" from them, bringing in an element of acceptance. Emily was then able to identify key values and decide on how not to feel "stuck." For example, when Emily would voice distress and inability to engage in the decluttering process, we didn't focus on disputing her beliefs, instead we focused on allowing Emily to be aware and notice the existing thoughts as internal events, consequently allow her to experience the emotional discomfort associated with these thoughts, and ultimately choose whether to engage or not in the decluttering activity aligned with her identified values.

The underlaying principle of our intervention was values driven. Through the ACT Choice point, Emily was able to reflect on the impact of her choices and associated unwanted internal events, resulting in either away or towards moves congruent to her identified values of safety, compassion, faith and family. Decluttering activities as well as development of a structured routine and engagement in meaningful activities were conceptualised as committed actions and not as problem solving techniques purely to reduce Emily's anxiety or distress.

Improving these skills, meant that Emily could better understand the link between her thoughts, feelings, behaviours and how automatic our responses are when we feel stressed. There was an emphasis given to values, often utilising techniques and metaphors aligned to the 'choice point' from the ACT model.

On the goal of decluttering one room, organising her house had been a task Emily had avoided since moving in, and it was hypothesised that starting with a smaller, more manageable area would reduce feelings of anxiety by gradually exposing her to the task she had been avoiding. She previously expressed a desire to complete everything quickly, but the slow progress, or "failure" to meet her expectations, had further diminished her motivation. Smaller, manageable tasks were identified together to prevent the organising process from becoming too exhausting.

Sessions remained fluid, sticking to the core principles of the ACT model, utilising elements from the hexaflex as necessary. Generally, sessions incorporated elements of psychoeducation, assessing psychological flexibility or "stuckness," re-emphasising values and actions that took her towards and away from her values, setting achievable goals in between sessions, behavioural interventions, problem solving worksheets and re-formulation where necessary.

Brief example dialogue between the clinician and Emily to help illustrate the ACT approach was as follows:

Cognitive Defusion and Acceptance

Emily: "I can't bear the feeling of throwing these papers away. I'll regret it."

Therapist: "let's try and notice that thought—I'll regret it.'

"Maybe let's think about what matters to you while you let that feeling of regret be there, how workable is that thought, how well has it served you in the past?"

Values and Committed Action

Therapist: "when you stay away from your living room, what do you think are you keeping away from you?"

Emily: "Feeling safe in my home and being able to spend time with my family in my own house."

Therapist: "what if we take a little step and just clear that spot on the sofa, how would that help you towards being able to spend time with your family?"

Self-As-Context

Emily: "The mess makes me feel so ashamed and I feel that it represents who I am."

Therapist: "I notice you're having a thought that the mess defines who you are. How about we try and step back and notice that you are noticing that thought but in fact that thought is just a thought and doesn't represent who you are?"

After 10–15 sessions, Emily reported improvement with her routine and living congruently to her identified values. She had begun washing more regularly, eating better, and reconnecting with family. She began to manage her anxiety in social settings and acknowledged her efforts reflected her core values like family and compassion. Whilst she found it hard to maintain these insights alone, she was open to support and continuing her progress.

At times, Emily struggled with energy levels, and her physical health (especially fatigue) had impacted her mood and ability to engage in planned activities. Despite these challenges, she remained motivated to engage with her committed actions.

Towards the end of therapy and when Emily felt that her goals had been met, psychometric assessments were readministered. These revealed a considerable decrease in psychological distress, from 58 (*moderate*) to 22 (*low level*) on the CORE-OM. Emily commented that this was a true reflection. She shared that her mood had improved, thoughts to self-harm had reduced, and she was finding more enjoyment in life. Emily had even taken up a new hobby in horse riding, something that she would not have considered or felt the confidence to do previously. Emily believed that the progress she had made with decluttering was the key to this positive change.

Most of the HD-specific psychometrics remained consistent (see Table 1), with some even increasing. On reflection, Emily believed this wasn't due to a worsening of HD symptoms, but instead she had gained a deeper understanding of the full scope of the problem.

At this point in therapy, Emily felt well enough to return to work as her mood had stabilised. She had now reached a long-term goal of wanting to be independent in terms of managing her household clutter and was eager to continue decluttering, aware of how she can tackle this herself. Emily also reflected that she felt comfortable enough to raise concerns with professionals if she needed additional support in the future.

Complicating Factors

Although Emily personally stated that therapy was beneficial, several complicating factors, often seen in older adults, may have influenced the overall effectiveness of the intervention.

As previously mentioned, Emily faced physical health challenges that were often triggers for mood fluctuations, including acute anterior uveitis, diverticulitis and UTIs. This could sometimes affect her motivation, cognition and energy levels during therapy sessions.

Emily's challenges with emotional regulation cannot be underestimated. After disagreements with her sister, the emotional aftermath often lasted several days, which appeared to often be a significant stressor. During this time, Emily would either stay in bed or avoid tasks because she felt too upset and overwhelmed to focus. Learning and managing her emotional distress to a tolerable level was a key focus of the intervention.

Emily's previous complex trauma also acted as a significant complicating factor. This may have affected progress with decluttering, particularly when Emily came across items that were triggering for past traumatic events. Emily also struggled with organising and implementing plans, although did not demonstrate significant cognitive decline which may have indicated further assessment of those issues were necessary. This difficulty contributed to her challenges with decluttering and likely added to her sense of being overwhelmed.

Finally, the use of outcome measures presented a complicating factor. Although there are several outcome measures for HD, none are specifically designed for older adults. Only two measures, the CORE-OM (Barkham et al., 2005) and the CIR (Dozier & Ayers, 2015), had been validated for this population, whilst the SI-R does, however, demonstrate strong psychometric properties for older adults (Ayers et al., 2017). Although the scores from the outcome measures aligned with Emily's self-reports, it's possible that the other measures were not sensitive enough to detect change.

Access and Barriers to Care

The intervention was delivered by a Consultant Psychologist and Assistant Psychologist working with the Psychology service of a Community Mental Health Team (CMHT). As a result, sessions were held at Emily's home, with no associated costs for these visits. In addition, Emily received support from a Community Psychiatric Nurse (CPN) from the CMHT, who also made home visits. This arrangement made it easier for Emily to access and engage in care.

Follow-Up

A follow-up session was conducted one month after the intervention. As previously mentioned however, a limitation of the current case study was the lack of more in depth follow-up provision and the administration of psychometric measures to assess for longer-term change. Nonetheless, Emily qualitatively reported that she flet empowered and knowledgeable on how to tackle her HD, recognised the need to be kinder to herself and that her overall "mindset" was one of acceptance. She recognised the dangers of experiential avoidance and was keen to maintain positive mental health moving forward. She acknowledged that she had gained insight into her interpersonal dynamics, particularly her trauma history and how this linked to her formulation. Although Emily could benefit from further psychological therapy to address previous trauma and bereavements, her treatment goals were achieved through this intervention, and she attributed many of those gains to techniques learnt in therapy.

Treatment Implications of the Case

The strengths of this case included following best practice guidelines by working with the patient in her home, focusing on her personal values and goals, and using a shared formulation-driven, evidence-based intervention (Holmes et al., 2015; Steketee & Frost, 2014). A multidisciplinary approach was also used, with CPN and psychiatry input where necessary to manage pharmacological intervention.

Although Emily commented that the intervention had been beneficial, there was concern about the slow pace of progress. There were indications that avoidance was more prevalent than Emily realised—such as when struggling to practice strategies in between sessions and procrastinating. Although this was raised with Emily, she always provided a reason for the slow progress, including physical health issues causing fatigue and illness or feeling too upset after arguing with her sister. As previously noted, comorbidity is common in older adults with HD, and a slower pace of progress may, therefore, be expected.

Based on existing research, outcomes might have improved if Emily had access to additional family support (Steketee & Frost, 2014). The intervention had been carried out over a 27-month period, without specifically working to tackle previous trauma and bereavement. The guidance for treatment for CBT-HD is 26 sessions over 12 months (Steketee & Frost, 2014) however, there is currently no recommendation for number of specific ACT sessions with HD due to the limited literature available.

CBT has the largest evidence base in treating HD, and therefore incorporating further strategies from this intervention may have improved outcomes. Despite the lack of evidence for ACT in treating HD, it is clear to see where it could possibly benefit such individuals. Those with HD are more likely to experience difficulties in emotional regulation (Tolin et al., 2018), which was a factor in Emily's case. Teaching skills such as mindfulness to help tolerate difficult emotions was clearly beneficial, allowing her to engage in decluttering even when feeling overwhelmed. In addition, HD symptoms are often linked to a high emotional attachment to objects, so integrating a therapy with a relational focus, such as Cognitive Analytic Therapy (Denman, 2001), may have helped Emily gain a deeper understanding of these attachments.

Recommendations to Clinicians and Students

It was crucial to adapt ACT to address the complexities often seen in older adults. Given the high comorbidity in HD, there is a need for therapists' to recognise additional mental health and physical challenges, consider how these factors could impact patient abilities and the pace of sessions.

Emily's therapeutic journey underscores the importance of holistic approaches that address both emotional regulation and practical tasks such as decluttering. The combination of ACT, mindfulness, and self-efficacy techniques helped Emily achieve greater psychological flexibility and a stronger alignment with her personal values.

This case also highlighted that clinicians should carefully select appropriate outcome measures for each individual. As noted, only one hoarding-related measure has been validated for older adults (CIR). Additionally, difficulties occasionally found in older adults with HD, such as overall cognition, should be considered when determining whether widely used HD measures are suitable.

In conclusion, Emily's case highlights the potential for ACT to bring about significant change for someone with HD, even in the face of complex emotional and external challenges. Future research could explore how ACT and other third wave therapies can be further refined and adapted for individuals facing similar struggles.

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Ethical Considerations

Our institution does not require formal ethical approval for reporting individual cases or case series.

Consent to Participate

Written informed consent was obtained from the patient to complete a case study manuscript prior to any data collection.

Consent for Publication

Written informed consent was obtained from the patient for publication purposes.

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Data reported on within the article and in supplementary material is available by contacting the corresponding author.

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