Hoarding Interview

Client initials: ______________ Date: ______________

1. What kind of home do you live in? Who else lives there with you?

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2. Let's talk about the rooms in your home. [Use the Clutter Image Rating pictures to determine the extent of clutter in each room and also in other living spaces like the attic, basement, garage, car, etc.] How much does the clutter interfere with how you'd like to use each room and which rooms bother you most?

   Living room: ______________________________

   Dining room: ______________________________

   Kitchen: ______________________________

   Bedrooms: ______________________________

   Bathrooms: ______________________________

   Hallways: ______________________________

   Basement: ______________________________

   Attic: ______________________________

   Porch: ______________________________

   Garage: ______________________________

   Yard: ______________________________

   Car: ______________________________

   Work or office space: ______________________________

   Other: ______________________________

3. Do you keep any items in other places outside your home like a storage space, another person's home, etc? How much stuff is there and what kinds of items?

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4. What kinds of things do you save? For example, what would I mainly see in these rooms?

5. Tell me about your emotions when you look at or think about the clutter? (e.g., anxiety, guilt, sadness, pleasure, etc.)

6. How much discomfort would you feel if you had to get rid of some of your ______ (ask about each category of items identified earlier, such as books, junk mail, kitchen trash, bottle caps).

7. Which rooms would you like to work on first? Why? Which one will be easiest and which one most difficult? Why? (Discuss the pros and cons with regard to the usefulness of space if clutter is cleared, the quickest visual improvement in the space, the most pressing need to locate important items, the most reduction of distress, and so forth.)

8. Are your possessions organized in some way? How do you decide what goes where? How well does this plan work for you?

continued

9. How do you acquire new things? Tell me about the most recent things you got—how did you get them? (e.g., shopping, store sales, yard/tag sales, trash picking, free things)

10. Let's talk about the sequence of thoughts, emotions, and behaviors when you acquire new items. For example, the [most recent items acquired], how did you feel when you first got it and what were you thinking? What did you do with it once you got it home?

11. What happens if you try to avoid getting something?

12. Tell me about why you save these items. (If clients do not mention the reasons below, ask about each.)

    a. Sentimental: Do you save things because they seem sentimental or emotionally significant to you? That is, you are so emotionally attached items that you do not want to part with them? Can you give an example?

b. Instrumental/useful: Are you afraid of losing important information you might need someday when you try to throw something out? Are you concerned about being wasteful because the object may eventually be put to good use? Can you give an example?

c. Intrinsic/beauty: Do you save things just because you like them or think they are pretty? Do you think they will be valuable someday? Can you give an example?

13. Do your family members or friends help you get items or store them for you?

Do some people help you organize things you can't deal with?

What about helping you get rid of things?

Does anyone get upset by your collecting and clutter or do they mostly tolerate it?

Do you prevent others from touching your things?

Are your family members/significant others supportive of treatment? If so, would any of them be interested in coming with you to a treatment session?

continued

14. Does the clutter present a health or safety problem for you or your family? (If yes) What kinds of problems? (e.g., falling, fire hazard, hygiene, medical problems, nutrition, insect infestation) (If no) Do other people think the clutter presents a problem for you or for your health or safety?

15. Has your buying or acquiring things caused any problems? (e.g., family arguments, financial burden or debt, negative mood such as guilt, depression, anxiety) (If yes) What kinds of problems? (If no) Do family or friends think buying or acquiring items is causing any problems?

16. Has the clutter affected your social life? (avoids having visitors; avoids going to others home because can't reciprocate) Are you interested in having some people come over once the clutter is less of a problem? Who, for example?

17. Do you have any problems with washing, checking, putting things in order, repeating actions or other mental compulsions? Do these thoughts and behaviors affect the hoarding problem? (e.g., contamination fears make it difficult to put things away, checking lengthens the time it takes to put away or discard items)

18. Do other family members have hoarding problems? Who? Tell me about the saving and clutter.

19. When you were young, did you spend a lot of time in any other household (e.g., grandparents, other family members, friends) that was cluttered?

20. Did anyone in the household you grew up in acquire things excessively? Who? What types of things?

21. When you were a child, did you experience any kind of deprivation (e.g., not enough to eat, not enough clothes, too few toys, no spending money) or serious losses (e.g., death, major move)? How old were you when this occurred? Do you think it has any relationship to your hoarding problem?

22. When was the first time you noticed that you had trouble acquiring too many things, throwing things away, or had a lot of clutter in your home? How old were you? Was anything special going on in your life at that time? (e.g., traumatic experience, moving, loss of a family member, etc.)

continued

23. Have you had any previous therapy (medication, behavior therapy, psychotherapy, family efforts to help) for hoarding problems? What about for other types of problems? How long did the treatment last? Did it help? Why or why not? (Later on you will need to give a rationale for the hoarding treatment that addresses concerns the client may have because of previous treatment experiences.)

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24. Have other people tried to intervene in the hoarding problem? Have you ever been contacted by landlords, health department officials, or other officials about problems related to the hoarding. What happened? What was your reaction?

____

____

____

25. Are there other aspects of hoarding you haven't mentioned, like legal or financial problems, problems with collecting animals, special embarrassments?

____

____

____

Saving Inventory—Revised

Client initials: ________________ Date: ________________

For each question below, circle the number that corresponds most closely to your experience DURING THE PAST WEEK.

0--------------------1--------------------2--------------------3--------------------4

None	A Little	A Moderate Amount	Most/Much	Almost All/ Complete

	Question					
1.	How much of the living area in your home is cluttered with possessions? (Consider the amount of clutter in your kitchen, living room, dining room, hallways, bedrooms, bathrooms, or other rooms).	0	1	2	3	4
2.	How much control do you have over your urges to acquire possessions?	0	1	2	3	4
3.	How much of your home does clutter prevent you from using?	0	1	2	3	4
4.	How much control do you have over your urges to save possessions?	0	1	2	3	4
5.	How much of your home is difficult to walk through because of clutter?	0	1	2	3	4

For each question below, circle the number that corresponds most closely to your experience DURING THE PAST WEEK.

0--------------------1--------------------2--------------------3--------------------4

Not at all	Mild	Moderate	Considerable/Severe	Extreme

	Question					
6.	To what extent do you have difficulty throwing things away?	0	1	2	3	4
7.	How distressing do you find the task of throwing things away?	0	1	2	3	4
8.	To what extent do you have so many things that your room(s) are cluttered?	0	1	2	3	4
9.	How distressed or uncomfortable would you feel if you could not acquire something you wanted?	0	1	2	3	4
10.	How much does clutter in your home interfere with your social, work or everyday functioning? Think about things that you don't do because of clutter.	0	1	2	3	4
11.	How strong is your urge to buy or acquire free things for which you have no immediate use?	0	1	2	3	4

continued

12. To what extent does clutter in your home cause you distress?	0	1	2	3	4
13. How strong is your urge to save something you know you may never use?	0	1	2	3	4
14. How upset or distressed do you feel about your acquiring habits?	0	1	2	3	4
15. To what extent do you feel unable to control the clutter in your home?	0	1	2	3	4
16. To what extent has your saving or compulsive buying resulted in financial difficulties for you?	0	1	2	3	4

For each question below, circle the number that corresponds most closely to your experience DURING THE PAST WEEK.

0	1	2	3	4
Never	Rarely	Sometimes/ Occasionally	Frequently/ Often	Very Often

17. How often do you avoid trying to discard possessions because it is too stressful or time consuming?	0	1	2	3	4
18. How often do you feel compelled to acquire something you see, e.g., when shopping or offered free things?	0	1	2	3	4
19. How often do you decide to keep things you do not need and have little space for?	0	1	2	3	4
20. How frequently does clutter in your home prevent you from inviting people to visit?	0	1	2	3	4
21. How often do you actually buy (or acquire for free) things for which you have no immediate use or need?	0	1	2	3	4
22. To what extent does the clutter in your home prevent you from using parts of your home for their intended purpose? For example, cooking, using furniture, washing dishes, cleaning, etc.	0	1	2	3	4
23. How often are you unable to discard a possession you would like to get rid of?	0	1	2	3	4

See score key at end of appendix.

Saving Cognitions Inventory

Client initials: ______________ Date: ______________

Use the following scale to indicate the extent to which you had each thought when you were deciding whether to throw something away DURING THE PAST WEEK. (If you did not try to discard anything in the past week, indicate how you would have felt if you had tried to discard.)

1--------------2--------------3--------------4--------------5--------------6--------------7

Not at all Sometimes Very much

1.	I could not tolerate it if I were to get rid of this.	1	2	3	4	5	6	7
2.	Throwing this away means wasting a valuable opportunity.	1	2	3	4	5	6	7
3.	Throwing away this possession is like throwing away a part of me.	1	2	3	4	5	6	7
4.	Saving this means I don't have to rely on my memory.	1	2	3	4	5	6	7
5.	It upsets me when someone throws something of mine away without my permission.	1	2	3	4	5	6	7
6.	Losing this possession is like losing a friend.	1	2	3	4	5	6	7
7.	If someone touches or uses this, I will lose it or lose track of it.	1	2	3	4	5	6	7
8.	Throwing some things away would feel like abandoning a loved one.	1	2	3	4	5	6	7
9.	Throwing this away means losing a part of my life.	1	2	3	4	5	6	7
10.	I see my belongings as extensions of myself; they are part of who I am.	1	2	3	4	5	6	7
11.	I am responsible for the well-being of this possession.	1	2	3	4	5	6	7
12.	If this possession may be of use to someone else, I am responsible for saving it for them.	1	2	3	4	5	6	7
13.	This possession is equivalent to the feelings I associate with it.	1	2	3	4	5	6	7
14.	My memory is so bad I must leave this in sight or I'll forget about it.	1	2	3	4	5	6	7
15.	I am responsible for finding a use for this possession.	1	2	3	4	5	6	7
16.	Throwing some things away would feel like part of me is dying.	1	2	3	4	5	6	7
17.	If I put this into a filing system, I'll forget about it completely.	1	2	3	4	5	6	7
18.	I like to maintain sole control over my things.	1	2	3	4	5	6	7
19.	I'm ashamed when I don't have something like this when I need it.	1	2	3	4	5	6	7
20.	I must remember something about this, and I can't if I throw this away.	1	2	3	4	5	6	7
21.	If I discard this without extracting all the important information from it, I will lose something.	1	2	3	4	5	6	7
22.	This possession provides me with emotional comfort.	1	2	3	4	5	6	7
23.	I love some of my belongings the way I love some people.	1	2	3	4	5	6	7
24.	No one has the right to touch my possessions.	1	2	3	4	5	6	7

See score key at end of appendix.

Client initials: ____________ Date: ____________

A. Activities of Daily Living:

Sometimes clutter in the home can prevent you from doing ordinary activities. For each of the following activities, please circle the number that best represents the degree of difficulty you experience in doing this activity because of the clutter or hoarding problem. If you have difficulty with the activity for other reasons (for example, unable to bend or move quickly due to physical problems), do not include this in your rating. Instead, rate only how much difficulty you would have due to hoarding. If the activity is not relevant to your situation (for example, you don't have laundry facilities or animals), circle the Not Applicable (NA) box.

Activities affected by clutter or hoarding problem	Can do it easily	Can do it with a little difficulty	Can do it with moderate difficulty	Can do it with great difficulty	Unable to do	Not Applicable
1. Prepare food	1	2	3	4	5	NA
2. Use refrigerator	1	2	3	4	5	NA
3. Use stove	1	2	3	4	5	NA
4. Use kitchen sink	1	2	3	4	5	NA
5. Eat at table	1	2	3	4	5	NA
6. Move around inside the house	1	2	3	4	5	NA
7. Exit home quickly	1	2	3	4	5	NA
8. Use toilet	1	2	3	4	5	NA
9. Use bath/shower	1	2	3	4	5	NA
10. Use bathroom sink	1	2	3	4	5	NA
11. Answer door quickly	1	2	3	4	5	NA
12. Sit in sofa/chair	1	2	3	4	5	NA
13. Sleep in bed	1	2	3	4	5	NA
14. Do laundry	1	2	3	4	5	NA
15. Find important things (such as bills, tax forms, etc.)	1	2	3	4	5	NA
16. Care for animals	1	2	3	4	5	NA

B. Living Conditions:

Please circle the number below that best indicates how much of a problem you have with the following conditions in your home:

Problems in the home	None	A little	Somewhat/ moderate	Substantial	Severe
17. Structural damage (floors, walls, roof, etc.)	1	2	3	4	5
18. Presence of rotten food items	1	2	3	4	5
19. Insect infestation	1	2	3	4	5
20. Presence of human urine or feces	1	2	3	4	5
21. Presence of animal urine or feces	1	2	3	4	5
22. Water not working	1	2	3	4	5
23. Heat not working	1	2	3	4	5

C. Safety Issues:

Please indicate whether you have any concerns like those described below in your home.

Type of problem	Not at all	A little	Somewhat/ Moderate	Substantial	Severe
24. Does any part of your house pose a fire hazard? (for example, stove covered with paper, flammable objects near the furnace, etc.)	1	2	3	4	5
25. Are parts of your house unsanitary (bathrooms unclean, strong odor)?	1	2	3	4	5
26. Would medical emergency personnel have difficulty moving equipment through your home?	1	2	3	4	5
27. Are any exits from your home blocked?	1	2	3	4	5
28. Is it unsafe to move up or down the stairs or along other walkways?	1	2	3	4	5
29. Is there clutter outside your house (porch, yard, alleyway, common areas if apartment or condo)?	1	2	3	4	5

See score key at end of appendix.

Client initials: ______________ Date: ______________

Pre-Tx Sess12 Post-Tx 3-Mos. 6-Mos. 1-Yr

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes how much that experience has DISTRESSED or BOTHERED you during the PAST MONTH. Use the following scale:

0-------------------1-------------------2-------------------3-------------------4

Not at all A little Moderately A lot Extremely

1.	I have saved up so many things that they get in the way.	0	1	2	3	4
2.	I check things more often than necessary.	0	1	2	3	4
3.	I get upset if objects are not arranged properly.	0	1	2	3	4
4.	I feel compelled to count while I am doing things.	0	1	2	3	4
5.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0	1	2	3	4
6.	I find it difficult to control my own thoughts.	0	1	2	3	4
7.	I collect things I don't need.	0	1	2	3	4
8.	I repeatedly check doors, windows, drawers, etc.	0	1	2	3	4
9.	I get upset if others change the way I have arranged things.	0	1	2	3	4
10.	I feel I have to repeat certain numbers.	0	1	2	3	4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
13.	I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
15.	I need things to be arranged in a particular order.	0	1	2	3	4
16.	I feel that there are good and bad numbers.	0	1	2	3	4
17.	I wash my hands more often and longer than necessary.	0	1	2	3	4
18.	I frequently get nasty thoughts and have difficulty getting rid of them.	0	1	2	3	4

See score key at end of appendix.

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Scoring Keys

Saving Inventory–Revised Scoring

Clutter Subscale (Nine Items)

Sum items: 1, 3, 5, 8, 10, 12, 15, 20, 22

Difficulty Discarding/Saving Subscale (Seven Items)

Sum items: 4 (reverse score), 6, 7, 13, 17, 19, 23

Acquisition Subscale (Seven Items)

Sum items: 2 (reverse score), 9, 11, 14, 16, 18, 21

Total score = sum of all items

Saving Cognitions Inventory Scoring

Subscales

Emotional Attachment (10 items): 1, 3, 6, 8, 9, 10, 13, 16, 22, 23

Control (three items): 5, 18, 24

Responsibility (six items): 2, 7, 11, 12, 15, 19

Memory (five items): 4, 14, 17, 20, 21

Total score = sum of all items

Clinician Session Form

Client: ______________ Session #: ______________ Date: ______________

Basic Session Content:

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Agenda:

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Homework report:

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Degree of homework compliance (1 to 6): ______________

(1 = did not attempt; 2 = attempted but did not complete; 3 = did about 25%; 4 = did about 50%; 5 = did about 75%; 6 = did all homework)

Symptoms and topics discussed during session:

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Intervention strategies used or reviewed:

____

____

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____

Homework assigned:

Comments on client's summary and feedback:

Goals for next or future sessions: