Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

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May 2025

Word counts

Systematic Review of the Literature (SRL)	**7,342**
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Service Improvement project (SIP)	**5,098**
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Systematic Review of the Literature (SRL)

Various interpersonal factors have been considered in the understanding of hoarding disorder (HD), with three variables gaining particular attention: adult attachment, social support and loneliness. The review systematically evaluates evidence for these three variables, and how they may interrelate. Peer-reviewed studies and published dissertations that measured HD and one or more of the interpersonal factors via a validated measure were identified from EMBASE, MEDLINE, PsycINFO, PubMed and Scopus. Quality appraisal for each study was undertaken using a modified Downs and Black checklist. Twenty-six papers met inclusion criteria. The majority employed a cross-sectional design, in clinical and non-clinical samples. Fifteen studies examined attachment, showing that attachment style is relevant but not specific to hoarding disorder. Ten studies examined social support showing reduced social network with a specific difference in terms of perceived support in individuals with HD. Eight studies examined loneliness showing elevated loneliness in individuals with HD, again with some degree of specificity. Interpersonal factors are relevant to understanding HD with perceived support only showing evidence of being disorder specific. Further experimental and qualitative research is warranted to explore the nature and direction of these relationships, and how they may interrelate.

Key words: Hoarding disorder, interpersonal factors, attachment, social support, loneliness

Service Improvement Project (SIP)

The introduction of the THRIVE model across Child and Adolescent Mental Health Services (CAMHS) aims to ensure young people (YP) receive timely support based on their current psychological needs, moving fluidly between teams. Limited research has explored the experience of being transferred from a YP's perspectives. A mixed methods project (including an audit and interview) aimed to understand how internal transfers are currently documented and experienced by YP and their families who had transitioned between Getting Help and Getting More Help teams within a regional CAMH service. Twenty-seven clinical notes were audited to determine whether local Standard Operating Procedures (SOP) were being followed. Six YP and eight parents took part in semi-structured interviews. The interview data were analysed using reflexive thematic analysis. Results showed SOP guidance was inconsistently applied to document transfers. Six themes emerged from the interviews: 1) Getting Help or Getting More Help? The 5 W's 2) "Radio silence" 3) Feeling alone in the CAMHS maze 4) Various agencies: Two teams are better than one 5) One step forward, two steps back 6) CAMHS Professionals: Light at the end of the tunnel. The project generated a range of service recommendations. Findings, limitations and future research are discussed.

Keywords: internal transfers, service improvement, CAMHS, experiences of young people

Theoretically Driven Research Project (TDRP)

Mental contamination (MC) refers to internal feeling of dirtiness without contact with a physical contaminant and is prevalent in individuals with obsessive-compulsive disorder (OCD). Evidence suggests MC is linked to sensitivity to betrayal. The present study investigated if individuals experiencing high levels of MC and OCD report more betrayal events relative to those with OCD and low MC and other anxiety disorders and non-clinical controls. Additionally, we examined the role of thought-action-fusion (TAF), a type of magical thinking in MC. A cross-sectional design was used, with four groups, OCD high MC (*n* =30), OCD low MC (*n* =38), a mixed anxiety sample (*n* =41) and non-clinical controls (*n* =62). Participants were identified according to appropriate Structured Clinical Interview for the DSM (SCID-5-RV) interview modules and completed online questionnaires. All clinical groups reported more betrayal events compared to non-clinical controls, though no differences were observed between clinical groups, suggesting experience of betrayal events was not specific to diagnoses. TAF and magical thinking were significantly higher in the OCD high MC group relative to the other groups. Regression analysis identified TAF and magical thinking as the strongest predictors of MC scores. Betrayal may be a disorder-relevant, but not disorder-specific experience that occurs trans-diagnostically. TAF and magical thinking may be both disorder specific and relevant in high MC OCD.

Key words: OCD, mental contamination, betrayal, trans-diagnostic

Systematic Review of the Literature

Title: Interpersonal Factors in Hoarding Disorder: Adult attachment style, social support, and loneliness: a systematic review

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Word count: 6,963 (including tables)

Date: 23rd of May 2025

Internal Supervisors:

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Intended Journal and rationale: Journal of Obsessive- Compulsive and Related Disorder. This journal specialises in HD and OCD disorders.

Acknowledgements: Thank you to Amy Lunn for being my second reviewer.

Abstract

Various interpersonal factors have been considered in the understanding of hoarding disorder (HD), with three variables gaining particular attention: adult attachment, social support and loneliness. The review systematically evaluates evidence for these three variables, and how they may interrelate. Peer-reviewed studies and published dissertations that measured HD and one or more of the interpersonal factors via a validated measure were identified from EMBASE, MEDLINE, PsycINFO, PubMed and Scopus. Quality appraisal for each study was undertaken using a modified Downs and Black checklist. Twenty-six papers met inclusion criteria. The majority employed a cross-sectional design, in clinical and non-clinical samples. Fifteen studies examined attachment, showing that attachment style is relevant but not specific to hoarding disorder. Ten studies examined social support showing reduced social network with a specific difference in terms of perceived support in individuals with HD. Eight studies examined loneliness showing elevated loneliness in individuals with HD, again with some degree of specificity. Interpersonal factors are relevant to understanding HD with perceived support only showing evidence of being disorder specific. Further experimental and qualitative research is warranted to explore the nature and direction of these relationships, and how they may interrelate.

Key words: Hoarding disorder, interpersonal factors, attachment, social support, loneliness

Hoarding disorder (HD) is characterised by the strong urge to acquire possessions and the distress associated with discarding them, resulting in the accumulation of clutter that compromises the use of living spaces (Frost & Hartl, 1996). The estimated prevalence of HD across the population is 2.5%, with symptoms typically emerging during adolescence and becoming increasingly persistent over time (Grisham et al., 2006). Hoarding behaviours exist on a spectrum varying in severity and level of functional impairment. All individuals appear to form relationships with objects, with items reflecting aspects of identity, interests, social status or serving as an aide-memoire (Timpano & Port, 2021). A key distinguishing feature between HD and more typical object ownership is the degree of functional impairment in activities of daily living. In HD, the attachment to objects is particularly intense, which likely prevents discarding and significantly disrupts daily functioning and quality of life across multiple domains. Health risks associated with living in a cluttered home may include unsanitary living conditions, risk of falls, and an elevated risk of death from fire hazards (David et al., 2022; Postlethwaite et al., 2019). Many individuals do not seek professional support until later in life when the consequences of hoarding have become more severe.

HD was previously conceptualised as a subtype of obsessive-compulsive disorder (OCD) or as an aspect of obsessive compulsive personality disorder (OCPD); it is now recognised as a distinct disorder in the 5th edition of the Diagnosis and Statistical Manual of Mental Disorders (DSM-5)(Frost et al., 2012; Mataix-Cols et al., 2010). Three diagnostic criteria are required for a HD diagnosis 1) the acquisition of and failure to discard a number of possessions that appear useless, 2) living spaces are significantly cluttered, 3) significant distress or impairment of functioning (Frost et al., 2012).

Cognitive models are the most widely researched theoretical frameworks conceptualising HD (Frost & Hartl, 1996; Kyrios et al., 2018). Models consider vulnerability factors associated with the onset of HD such as family history, genetic influences, early childhood experiences and traumatic events. Frost and Hartl's model (1996) focuses on three key factors being central to the maintenance of HD: emotional attachments to and beliefs about possessions, maladaptive emotional responses, and information-processing difficulties.

Individuals with HD often endorse beliefs regarding the meaning and value of possessions that could drive acquisition and/or difficulty with discarding, including fears of being wasteful, missing opportunities if an item is discarded, losing connection to the past, or to others (Hare, 2015). Such individuals typically develop strong emotional attachments to items that others may view as insignificant, which can lead to difficulty discarding the possession due to the evaluation of strong intrinsic, instrumental or sentimental value of an item (Kellett & Holden, 2014). Attachment to objects may also be linked to anthropomorphism, in which, individuals perceive objects to have human-like qualities, providing a sense of comfort and security (Wan & Chen, 2021). Due to the strong emotional attachments associated with objects, the idea of discarding them results in high levels of negative emotions such as anxiety, guilt and distress. This can lead to avoidance of making discarding decisions increasing levels of accumulation (Levy et al., 2019). Individuals with HD may also have difficulties with a range of information-processing functions including, memory, attention and decision-making (Gledhill et al., 2021).

Research Gap

The cognitive model provides an empirically supported model for understanding how hoarding develops, is maintained and reinforced. Treatment informed by the cognitive model includes Cognitive Behavioural Therapy (CBT) which incorporates cognitive restructuring of hoarding-related beliefs, exposure tasks designed to reduce distress with discarding objects, and skills to support executive function (Muroff & Underwood, 2015; Steketee & Frost, 2006). Despite this, the treatment response rate for HD is poorer than CBT interventions for other psychological disorders such as anxiety and depression. Tolin et al. (2015)found that only 24-43% of individuals showed clinically significant post treatment changes in their hoarding symptoms. This poor treatment response suggests that the cognitive model may not capture all the relevant components in the formulation of HD.

Research has begun to widen its lens beyond the Frost & Hartl (1996) cognitive model, to consider the role of interpersonal factors such as attachment, early family experiences and emotional regulation in the conceptualisation of HD. A recent systematic review synthesised evidence regarding vulnerability factors in hoarding symptomatology including attachment style, early family environment and traumatic life events (Chia et al., 2021). Adult attachment, social support and loneliness have gained attention as possible interpersonal factors across analogue and non-clinical studies, yet there is not a clear link between these variables and their relationship with hoarding symptoms (Barton et al., 2021; Chen et al., 2022; Medard & Kellett, 2014; Yap et al., 2023).

1. Adult Attachment Style

Attachment theory posits that humans have an innate tendency to seek connection, security and belonging through their relationships (Bowlby, 1977). In early childhood, our first attachment is with a primary caregiver; children display behaviour (i.e. crying, cooing) to elicit care and ensure that their physical and psychological needs are met. Interactions between parent and child over time leads to the internalisation and development of an internal working model of relationships. This provides an expectation of how an individual views themselves, others and the world. It also provides the basis for internalising emotional regulation strategies (i.e. shifting from a reliance on soothing from others to self-soothing).

When a caregiver is attuned, consistent and responsive to the physical and psychological needs of the child, this results in a ‘secure attachment’ style. Individuals with a secure attachment typically have positive views about themselves and others, meaning they feel comfortable with intimacy and expressing their emotional needs in relationships. In contrast, experiences of inconsistent or inadequate caregiving where a child’s physical and emotional needs are not met, can result in an insecure attachment, either anxious or avoidant.

Insecure anxious attachment results in individuals with a heightened sense of insecurity within their relationships (e.g. being concerned about being abandoned, seeking reassurance, preoccupied with relationships), whereas an insecure avoidant attachment style tends to overvalue independence and self-sufficiency (e.g. avoiding emotional closeness in relationships, avoiding vulnerability). Adult attachment has also been suggested as impacting hoarding symptomatology, with higher levels of attachment anxiety and avoidance reported in those with HD compared to student and community controls (Medard & Kellett, 2014). Individuals with HD may use object attachment as an attempt to compensate for unmet personal or attachment needs. However, attachment to objects as a soothing strategy is unlikely to fulfil an individual’s relational needs but instead intensifies hoarding behaviours and further perpetuates hoarding symptoms (David et al., 2022; Yap & Grisham, 2021).

2. *Social Support*

Social support refers to the perception and actuality that an individual is cared for by those in their social network and is able to access tangible (e.g. financial) or intangible (e.g. emotional support when required (Taylor, 2011). Individuals with HD report feeling socially isolated and have smaller social networks relative to non-clinical samples, and may use objects for comfort and emotional security (Barton et al., 2021). Edwards et al. (2023) found that, despite comparable numbers of potential supporters, HD patients reported lower levels of perceived social support relative to individuals with OCD and healthy controls. The reduction in social networks and support may be due to interpersonal conflict with family, friends and community, perhaps driven by conflict over the accumulation of possessions.

Additionally, individuals with HD may not draw upon social support because they experience relationships as more threatening, possibly due to early childhood experience and/or trauma or experiencing higher attachment insecurity. Those with HD report higher exposure to traumatic events compared to those with OCD and non-clinical controls (Shaw et al., 2016).

3. Loneliness

Loneliness is a subjective emotional experience, whereby people feel isolated and disconnected from relationships, often even in the presence of others. This feeling may be related to the lack of depth or closeness within relationships. Loneliness is more prevalent among those that are experiencing mental health difficulties, such as depression or anxiety (Beutel et al., 2017). Recently, a small number of studies have explored loneliness and hoarding behaviours within non-clinical samples, finding strong positive correlations between experiences of loneliness and hoarding behaviours (Yap et al., 2023).

Individuals with hoarding disorder, may form emotional attachments to objects due to the lack of depth or connection to others, and to compensate for feelings of loneliness and isolation. These strong emotional attachments, however, do not meet their actual relational needs and increase the need to acquire and save objects in an attempt to fulfil this need. Much like the experience with social support, this creates a vicious cycle, whereby the greater attempts to save and protect attachments with objects, the greater the interpersonal difficulties and feelings of loneliness.

Review Aims

Hoarding disorder is a complex, debilitating condition with poorer treatment outcomes than in other mental health conditions, suggesting further components are needed to be considered within our understanding of HD from a cognitive perspective (David et al., 2022). Studies on the role of interpersonal factors in relation to hoarding symptoms have used a range of different methodological approaches across clinical and non-clinical samples, leading to some uncertainty on how these variables relate to HD and how they may fit together.

The present paper aims to synthesise the currently available evidence on the link between hoarding symptoms, attachment, social support and loneliness and their interrelationships. The aim is to identify how confident we can be in relating these interpersonal factors and hoarding symptoms and if they are *disorder specific* (differentiating HD from other diagnoses) or *disorder relevant* (relevant in other mental health disorders). Given Chia et al.'s (2021) previous systematic review investigating attachment and hoarding, this paper aims to extend and update that work whilst also investigating the role of adult attachment, social support and loneliness.

Research Questions

1) How do interpersonal factors, including adult attachment, social support, and loneliness, influence hoarding severity?
2) Are these disorder-relevant or disorder-specific variables?

Methods

The methodology for this study was pre-registered via PROSPERO (CRD42023449163) prior to undertaking searches. The structure follows that of Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher et al., 2009).

Eligibility criteria

Articles were eligible if they met the following criteria: (a) written in English (b) quantitative study design (c) were not a systematic review or meta-analysis (d) measured hoarding symptom or severity via a validated measure or diagnostic interview (e) included participants over the age of 18 (f) reported on the relationship between hoarding symptoms and adult attachment style, social support or loneliness using a validated measure (g) examined hoarding in a human population (h) examined hoarding of objects. An additional exclusion criterion was applied within the eligibility phase: papers were excluded if they measured the relevant variables exclusively in the context of treatment. This was decided as it would be challenging to disentangle the relationship between hoarding symptoms and the interpersonal factors from the treatment within this methodology.

Given that the literature on these variables is still in its early stages, a decision was made to include all quantitative study types, including papers that were not peer-reviewed. Studies including individuals from a non-clinical population were also used as subclinical hoarding behaviours are common in the population and hoarding symptoms present across a spectrum.

Search Strategies

Database searches included EMBASE, MEDLINE, PsycINFO, PubMed and Scopus in July 2024. No restrictions were placed on the date of publication.

Search terms included key words for hoarding in combination with terms related to social support, adult attachment and loneliness. These were developed through previously published reviews on hoarding and consultation with librarians at the University of Oxford. They were as followed:

Hoard* OR "Hoarding Disorder*" OR "Compulsive Hoard*" OR "Difficulty discarding" OR "Object Acquisition" OR Diogenes syndrome
AND
Attachment* OR "Adult Attachment" OR "Adult Relation*" OR "Interpersonal Attachment" OR "Romantic Attachment" OR Lone* OR Isolat* OR Lonel* OR Alone OR "Social* Isolat*" OR Connection* OR "Social* Support*" OR "Perceived Social Support*"

To ensure a comprehensive, unbiased review search terms were used to search grey literature (including Google Scholar, Open Grey). This included non-peer reviewed sources such as thesis’, which may have non-significant or less conclusive findings avoiding favouring only significant finding.

Study Selection

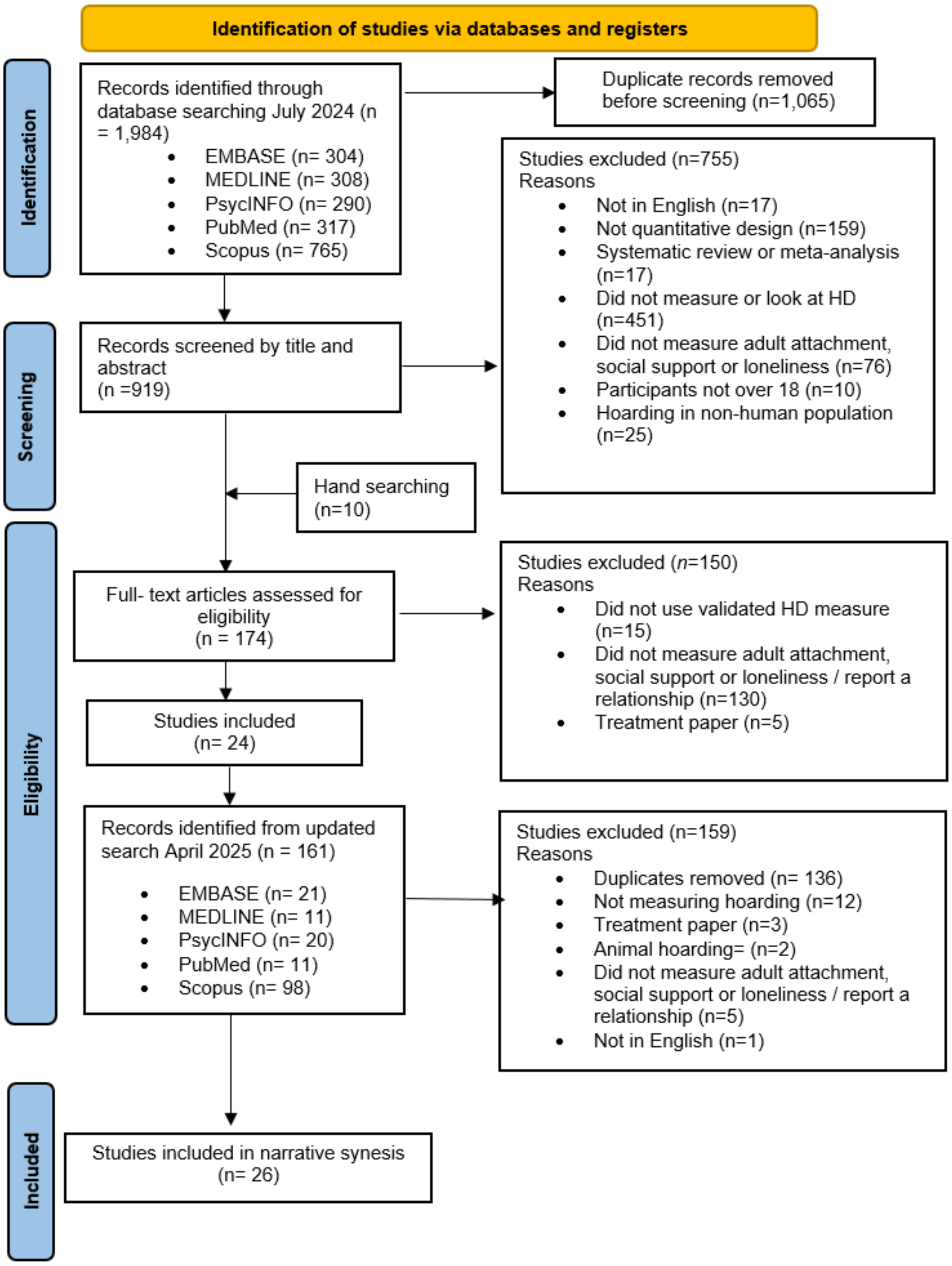
Figure 1 summarises the study selection process. The databases yielded 1,984 results, from which 1,605 were duplicates. Once removed the remaining 919 articles were assessed for inclusion using a two-step procedure 1) title and abstract screening and 2) a full text screen.

In the first stage, the primary researcher (TM) independently screened the title and abstract against the eligibility criteria listed above. A second researcher (AL) independently reviewed 20% of the papers (*n*=184). During the first stage, inter- reliability was assessed using Cohen’s Kappa (K=0.89). A near-perfect agreement was found between the reviewer, suggesting high levels of consistency in the screening process. A total of 174 papers were included for full-text review.

In the second stage, the primary researcher completed a full-text screen all of the papers using the eligibility criteria. The second researcher reviewed 50% of the texts (*n*=87). Inter-rater reliability was assessed using Cohen’s Kappa (K=.91). This resulted in a total of 24 papers within the review. The database searches were updated in April 2025 to capture newly published studies. A further 2 studies met the inclusion criteria, final paper number *n*=26.

Figure 1

Description of the study selection process using PRISMA Guidelines



Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Data Extraction

Data extracted from the included studies were: publication details (author name, year of publication, country), design (quantitative, cross-sectional, experimental), sample characteristics (sample size, age, gender, living environment/ marital status, clinical or non-clinical), study variables (hoarding symptoms, attachment, social support or loneliness, type of measure used), study findings (statistical analyses, confounders controlled for and results). These were extracted onto a standardised Excel spreadsheet to increase the reliability of extraction and support with inter-rater reliability, a second researcher (AL) independently extracted data from 50% of the included papers (*n*=12). Discrepancies that emerged: (a) errors in extraction (b) difference in quality appraisal (c) difference interpretation of study were resolved through discussion. Inter-rater reliability was K=.87

Quality Assessment

The papers were assessed for quality by combining two quality appraisal tools into a single scale: Checklist for Measuring Quality (Downs & Black, 1998) and The Quality Assessment Tool for Quantitative Studies (Effective Public Healthcare Panacea Project, 2024).This adapted quality tool has been previously used in a recent hoarding systematic review investigating emotional regulation and hoarding symptom (Barton et al., 2021).Given the similarities in the methodological approaches, this tool was suitable for the current research. Some issues were not applicable to the current studies and were removed from the appraisal tool: randomisation to treatment conditions, compliance with treatment or intervention, blinding to experimental or treatment and impact of intervention.

There were seven methodological domains that were appraised: reporting (/8), outcome measures (/2), selection bias (/2), control for confounding variables (/2), power analysis (/2), analysis (/3), and ethics and service user consultation (/2). This resulted in an overall quality score of 26, higher scores indicating better methodological quality.

Additionally, studies were assigned a categorical rating as either 'weak', 'moderate' or 'strong'. Papers were marked as weak if two or more domains were rated as weak, moderate if one weak rating had been allocated, and strong if there were no weak domains.

A further 30% of the included papers (*n*=8) were selected for a second rater to assess the methodological quality.

Findings regarding hoarding symptomology, and adult attachment, social support and loneliness were summarised via a narrative synthesis. This methodology was used due to the range of methodological and theoretical conceptualisations across the literature (Siddaway et al., 2019). To address the research question regarding relevance versus specificity, studies were also evaluated based on the strength of their design to determine these outcomes. Specifically, studies were considered to provide evidence for specificity if they employed a clinical sample compared to a clinical control group and included a non-clinical control sample. Papers that accounted for potential confounding variables through methodological controls were considered as suggestive evidence and discussed, but do not provide conclusive evidence regarding specificity. Thus, papers that could have the design to shown specificity and their outcomes are discussed across each domain are shown in Table 3. Only findings relevant to the research question are reported and discussed.

Results

Study characteristics

A total of 26 papers were identified by the search as relevant to the research question. Studies were published between 2009 to 2025. Four studies were published in the UK, six in the USA, ten in Australia, one in China, three in Canada, one in France and one in Ireland. Sample sizes ranged from 30 to 1,429 participants, were 44.7%-100% female. Twenty- two were peer-reviewed articles and four were doctoral theses. Quality rating ranged from weak to strong, with scores ranging from 14 to 23.

Table 1

Summary of Study Characteristics, Design and Demographic Information

ID	Authors	Country	Peer-reviewed/ Thesis	Sample	Design able to demonstrate specificity	Variables measured	Sample Size (n=)	% Female	Mean Age (SD)	Ethnicity	Relationship status
1	Barton et al. (2021)	United Kingdom	Peer-reviewed	HD, OCD and HC	✓	Adult attachment, social support and loneliness	Total: *n*=133 HD: *n*= 38, OCD: *n*= 46 HC: *n*=49	HD=70.3%, OCD=67.4%, HC=63.3%	HD: Median = 59.38, OCD: Median=38, HC: Median= 63.00,	Caucasian: HD=97.4%, OCD= 93.5%, HC= 91.7%	Relationship: HD= 26.3%, OCD= 47.8%, HC= 61.2%
2	Medard and Kellett (2014)	United Kingdom	Peer-reviewed	Self-identified HD (scored >41 on SI-R), SC, and HC	✗	Adult attachment and social support	Total: *n*=1426 HD: *n*=380, SC: *n*= 670; HC: *n*= 379	73.70%	31 (13.39)	Not reported	Not reported
3 3	Norberg et al. (2020)	Australia	Peer-reviewed	Self-identified HD sample above	✗	Adult attachment and loneliness	Total: *n*=180 AD: *n*=59, ADD:	80%	AD= 20.29 (3.88), ADD= 25.55 (7.18)	Caucasian: AD= 32.2%, ADD=29.8%	Not reported

				SI-R threshold			*n*=121				
4	Edwards et al. (2023)	United Kingdom	Peer-Reviewed	HD, OCD and HC	✓	Social support and loneliness	HD: *n*=37, OCD: *n*=31, HC: *n*=45	HD=30, OCD=24%, HC=36%	HD =58.76 (10.19), OCD=38.57, (11.05) HC=51.42 (19.37)	Caucasian HD= 33%, OCD=28%, HC= 40	Married or living as couple: HD=37.8%, OCD= 58.15%, HC=51.1%
5	Bedi and Woody (2025)	Canada	Peer-reviewed	HD, HC	✗	Social support and loneliness	Total: *n*=158 HD: *n*=57; HC: *n*= 60	HD= 66.7%, HC= 58.3%	46.97 (14.91)	White: HD=66.0%, HC= 58/3% Asian: HD= 19.3%, HC= 31.7% Other HD= 12.3%, HC=8.33%	Not reported
6	Chen et al., (2022)	Australia	Peer-reviewed	Non-clinical sample recruited online in USA	✗	Social support	Total: *n*= 278	47.1%	39.49 (12.26)	Caucasian=72%, African American=11%, Hispanic/Latino= 8%, Asian= 4%, Multiracial = 3%, Native American/Alaskan Native =5.2%	Not reported
	Fontenelle	Australi	Peer -	Online	✗	Social	Total:	90.5%	43.38 (12.74)	Not reported	Married= 41.4%,

7**	et al. (2021)	a	reviewed	sample from USA, UK, Australia; Self-identified HD using >39 SI-R		support	*n*=117 USA: *n*=60 Aus: *n*=25 UK: *n*= 117				Single= 38.8%, Divorced=18.1%, Widowed=1.7%
8**	Fontenelle et al. (2021)	Australia	Peer-reviewed	Self-identified HD using >39 SI-R from USA, UK, Australia	✗	Social support	Total: *n=117* USA: *n*=60 Aus: *n*=25 UK: *n*= 117	90.5%	43.38 (12.74)	Not reported	Married= 41.4%, Single= 38.8%, Divorced=18.1%, Widowed=1.7%
9 9	Yip (2015)	Canada	Thesis	Self-identified as HD and HC (used SI-R cut off) c Controlled for depression?	✗	Social support	Total: *n=78*	73.1%	42.95 (14.15)	Not reported	Alone=30.8%, Partner=20.5 %, Family=32.1% ,Housemate(s)=15.4% Other= 1.3%
10	Vorstenbo	Canada	Peer-	Self-	✗	Social	Total:	HD=	HD= 44.8	Caucasian	Not reported

	sch et al. (2015)		reviewed	identified HD and CSO (dyads)		support	*n*= 104 HD: *n* =52 CSO: *n* = 52	84.62% CSO=51.92%	(15.56), CSO= 37.45 (13.41)	HD= 66.67% CSO= 64.71%	
11	Broos et al., (2024)	USA	Peer-reviewed	Non-clinical sample, university students	✗	Social support	Total: *n*= 137	27.7%	19.52 (12.36)	White=57.7% Black =16.1% Asian=13.9% Other/Multiracial= 8.8%	Not reported
*12 a	Yap et al. (2023)	Australia	Peer-reviewed	Clinical sample (HD) and non-clinical controls (Lee et al., 2019) Matched depression non-clinical group	✗	Loneliness	Total: *n*= 379 HD: *n*= 39 CC: *n* =340	79.5%	HD=60.83 (8.69), CC= 62 (18.00)	Not reported	HD: Married= 25.6% Single= 30.8% Divorced/ separated=38.5%
*12 b	Yap et al. (2023)	Australia	Peer-reviewed	Non-clinical sample	✗	Loneliness	Total: *n*= 1514 HH: *n* =306 LH: *n* =775	HH= 55.1% LH= 50.1%	HH= 38.90 (11.95), LH= 43.23 (13.07)	HH: White=71.1%, Black= 8.9%, Asian= 8.2%, Hispanic=5.6%, Other=3.9%	HH: Married=41.0%, Widowed=2.3% Divorced=9.2% Single=47.5% LH=

										LH: White=78.6%, Black=7.0%, Asian=7.4%, Hispanic=4.9%, Other=2.2%	Married=44.4% Widowed: 2.1%, Divorced =13.2% Single=47.5%
13	Burgess et al. (2018)	USA	Peer-reviewed	Non-clinical, university students	✗	Loneliness	Total: *n*= 232	95.5%	20.00 (3.78)	White=60%, Asian=22%, African American= 6.5%, Hispanic=12%, Mixed/Other= 11%	Not reported
*14a	Yap et al. (2020)	Australia	Peer-reviewed	Non-clinical sample	✗	Loneliness	Total: *n*= 213	83.5%	44.5 (10.5)	Not reported	Not reported
*14b	Yap et al. (2020)	Australia	Peer-reviewed	Non-clinical scoring >13 on SI-R discarding, university students	✗	Loneliness	Total: *n*=91	71.1%	23.15 (5.24)	Not reported	Not reported
15	Biagas & Rockey (2014)	USA	Thesis	Self-identified hoarders	✗	Adult attachment	Total: *n*= 84 OCD:	89.3%	50.98 (10.01)	Caucasian=92.8%, African	Single= 29.8% Married= 33.3% Separated=3.6%

				with and without OCD or OCPD			*n* = 9 OCDP: *n* =3 Without OCD or OCPD: *n* = 72			American=2.4%, Hispanic=1.2%, Asian=1.2%, Mixed=1.2% Other=1.2%	Divorced=29.8% Widowed=3.6%
16	Chen et al., (2024)	Australia	Peer-reviewed	Non-clinical sample, subsample with high hoarding levels	✗		Adult attachment	Total: *n*= 235 HH: *n* =47 HC: *n*= 188	44.7 %	40.33 (12.33)	Caucasian 73.6 African American= 9.8% Asian=8.1% Hispanic=5.55 Multiracial=2.1% Other=2.1%	Not reported
17	Crone et al., (2019)	Australia	Peer-reviewed	Non-clinical sample	✗	Adult attachment	Total: *n*= 156	82.7%	21.96 (7.38)	Anglo Australian=37.2% Asian=45.5% European= 6.4% Middle Eastern= 6.4% Other= 4.4%	Not reported
18	Danet and Secouet (2018)	France	Peer-reviewed	HD (using SI-R cut off) and	✗	Adult attachment	Total: *n*= 197 HC: *n* = 173	100%	30.58 (10.74)	Not reported	Not reported

				HC			HD: *n* = 24				
19	Grisham et al., 2018)	Australia	Peer-reviewed	HD, CC and HC	✓	Adult attachment	Total: *n*= 72 HD: *n* = 24 CC: *n*=22 HC: *n* = 26	HD= 66.7% CC=63.6% HC=61.5%	HD=40.38 (15.58), CC 41 (13.29), HC= 48.31 (12.28)	Caucasian: HD=50.0% CC=77.3% HC=73.1% Asian/South Asian: HD=33.3% CC=18.2% HC=19.2 % Other: HD=16.7% CC=4.5% HC=7.7%	Single HD=66.7% CC=45.5% HC= 38% Married or de-facto HD=20.8% CC=40.9% HC=34.6% Divorced, separated or widowed HD=12.5 % CC=13.6 % HC=26.9%
20	Kehoe and Egan, (2019)	Ireland	Peer-reviewed	Non-clinical sample (HD group >41 SI-R)	✗	Adult attachment	Total: *n*= 463 HD *n*=216	84.2%	Range:35-64	Not reported	Relationship =58.7% Single, divorced or widowed= 41.3%
21	Ma et al., (2024)	China	Peer-reviewed	Non-clinical online community sample	✗	Adult attachment	Total: *n*= 662	54.2%	22.35 (4.45)	Not reported	Not Reported

22	Nagy et al., (2023)	USA	Thesis	Self-reported HD sample using SI-R and non-clinical controls	✗	Adult attachment	Total: *n*= 180 HD: *n*=73	88.3%	HD=40. 7 (13.9), HC=37.2(12.5)	Not reported	Single=20.0% Relationship living apart=15.6%, Living with partner=17.2% Married= 39.4% Divorced=6.1% Prefer not to answer =1.7%
23	Neave et al., (2016)	UK	Peer-reviewed	Non-clinical sample	✗	Adult attachment	Total: *n*= 283	74.2%	27.86 (13.94)	Not reported	Not reported
24	Sampson (2013)	USA	Thesis	Self-identified HD or FM of person with HD	✗	Adult attachment	Total: *n*= 387 HD: *n* =73 FM: *n* = 242 HD+FM: *n* = 63 Unsure: *n=6*	90.5%	Not reported Range:18-60+	Caucasian= 89.6% Other= 5.5% Hispanic= 3.4% Asian American=2.3% Black=0.8% Hawaiian= 0.3% Mixed= 2.1% Native American= 1.6%	Single, never married=23.1% Divorced= 10.2% Widowed =1.3% Married= 38.8% Married, not first marriage =13.4% Life-partnership= 4.2% Living together= 6.6% Separated= 2.4%
25	Norberg et al. (2018)	Australia	Peer-reviewe	Non-clinical	✗	Adult attachme	Total: *n*= 361	72.9%	27.86 (13.943)	Not reported	Not reported

			d	sample (score of >9 SI-R on excessive acquisition subscale)		nt					
26	Nedelisky & Steele (2009)	USA	Peer-reviewed	OCD with and without HD	✗	Adult attachment	Total: *n*= 30 OCD and HD: *n*=14 OCD: *n* = 16	46.6%	HD= 51.29 (17.06), OCD=41.55(14.24)	Not reported	HD and OCD: Single=57.1% Married=7.1% Divorced= 21.4% Widowed= 7.1% Separated= 7.1% OCD: Single=68.8% Married=31.3% Divorced=0% Widowed=0% Separated=0%

Note:* Asterisk represent one published paper that presented two separate studies. ** Represents the same sample used in two separate studies. **HD**= Hoarding Disorder, **OCD**= Obsessive Compulsive Disorder, **HC**= Healthy Controls, **SC**= Student Control, **AD**= acquiring difficulties, **ADD**= acquiring and discarding difficulties, **CSO**= Close Significant Other, **HH**= High Hoarding (≥ 14 on HRS), **LH**=Low Hoarding, **FM**= Family Member, **CC**= Clinical control

Study Findings

Table 2

Summary of study's findings between hoarding severity and interpersonal factors including quality ratings: adult attachment, social support and loneliness

ID	Study Authors	Study Design and Analysis	Hoarding Measure	Mean HD measure M (SD)	Attachment/ Loneliness or Social Support measure used	Mean Score on measure (SD)	Confounders controlled for	Main Findings	Quality Rating
1	Barton et al. (2021)	Cross-sectional between groups, One-way ANOVA	SCID; SI-R	HD Median= 64.00 OCD Median= 16.00 HC Median= 5.00	**Attachment**: RSQ **Social Support**: MOS-SSS **Loneliness**: UCLA	**RSQ Anxious:** HD= 17.50 (12.75) OCD= 20.50 (11.00) HC= 7.00 (9.75) **RSQ avoidant** HD= 11.00 (6.25) OCD= 11.00 (7.00) HC=	Not reported	**Attachment:** HD participants reported higher levels of attachment anxiety/ insecurity compared to the HC (H (2)= 43.10, $p < .001$, $\eta^2 = .34$) however there was no difference between the HD and OCD group (p=.47) **Loneliness:** OCD and HD groups reported significantly higher levels of loneliness compared to the HC ($F_{(2, 110)} = 19.41$, $p < .001$, $\eta^2 = .26$), but no difference between OCD and HD (p=.602). **Social support:** HD group reported lower perceived support compared to OCD and	Strong, 23

						7.00 (9.75) **MOSS-SS perceived support** HD=54.00 (27.0) OCD= 71.50 (25.25) HC= 84.50 (30.75) **MOSS-Number of close friends** HD=4.0 (5.00) OCD= 5.00 (5.0) HC= 7.00(7.00) **UCLA** HD= 47.10 (13.76), OCD= 48.86(12.09) HC=31.49 (15.29)		HC group ($H(2) = 25.98$, $p < .001$, η^2= 0.20). Both the HD and OCD group reported a lower total number of friendships compared to HC, however, there was no significant difference between the hoarding and OCD group (p=.350)	
2	Medard & Kellett (2014)	Cross sectional	SI-R (clinical cut off of	HD= 54.65 (11.53) SC= 21.04	**Attachment:** RQ	Not reported	Not reported	**Attachment:** *Anxious attachment:* HD group reported significantly higher level of attachment	Weak, 14

		ANOVA and regression	>41 used for HD sample)	(9.43) HC= 21.07 (10.18)	**Social support:** SPS	anxiety (*F*=37.60, *p* <.01) compared to SC and HC. *Avoidant attachment*: HD group reported significantly higher attachment avoidance (*F*=13.10, *p* <.01) compared to SC and HC. **Social support:** HD group reported lower perceived social support compared to the SC and HC (*F*=34.64, *p*<.001). This was across all subscales of the SPS: attachment, social interaction, guidance, nurturance, reliable alliance and reassurance of worth. Multiple regressions showed that attachment and social support explained 11% of the variance in SI-R score. **Social support and Attachment:** Attachment anxiety moderated the effect of social support on hoarding symptoms (*t* (329) = -2.66, *p* = .008), but attachment avoidance did not (*t* (329) = -.852, *p* = .395).	
3	Norberg et al. (2020)	Cross sectional, ANCOVA and mediation	SI-R (Cut- off of 15< for ADD group and 12< for AD group)		**Attachment:** RAAS-anxiety subscale **Loneliness:** UCLA	**Attachment:** Individuals with ADD had higher levels of attachment anxiety compared to AD ($F_{(1, 177)} = 4.63$, *p* <.05) No significant effect between anxious attachment and difficulty discarding (*b*= .29, *SE*= 0.14). **Loneliness:** No difference between levels of loneliness between the AD and ADD group ($F_{(1, 177)} = 1.13$, *p*=.29).	Weak, 17

4	Edwards et al. (2023)	Cross sectional, Chi square test, ANOVA	SCID; SI-R	HD=60.92 (15.60) OCD= 23.81 (19.47) HC=12.21 (10.7)	**Social Support:** NSSQ-R MOS-SSS **Loneliness:** UCLA	NSSQ-R: Total Support: HD=14.34 (4.44) OCD=17.08 (3.40) HC=17.30 (4.05) MOSS-SSS- Total support HD=37.73 (16.47) OCD=54.0(18.70) HC=54.84 (18.56) UCLA HD=34.65 (11.60) OCD=27.77 (14.05) HC= 19.73 (12.31)	Not reported	**Social Support:** HD and OCD groups reported reduced social networks compared to HC ($F_{(2, 110)} = 6.39$, $p=.002$). On the NSSQ-R HD group reported significantly lower perceived support. On the MOS-SSS showed the OCD and HD had similar network size, reduced from the HC. Only the HD group reported reduced perceived support across all four subscales: emotional, tangible, affection, positive ($F_{(2, 110)} = 10.91$, $p < .001$) **Loneliness:** HD group reported significantly greater loneliness compared to the OCD and HC group ($F_{(2, 110)} = 14.37$, $p < .001$)	Strong, 23
5	Bedi & Woody (2025)	Cross-sectional, Correlation, ANCOVA, Linear regression	MINI, SI-R	HD= 58.53 (12.45) HC= 17.22 (11.72)	**Social Support:** LSNS **Loneliness:** CES-D	LSNS Network Size: HD= 6.84 (2.83), HC=7.78		**Social Support:** Hoarding symptoms were significantly negatively correlated with network size (*r*= -.27), frequency of contact (*r*=- .18) family (*r*= -.29) and friends (*r*= -.19) but not neighbours (*r*= -.11). Compared to HC, HD had weaker family	Moderate, 19

					(3.06) Frequency of contact: HD= 7.75 (2.86) HC= 8.20 (2.40) Family: HD= 13.88 (5.79), HC=16.83 (6.66) Friends: HD= 14.46 (6.12) HC= 15.72 (5.61) Neighbours: HD= 7.49 (5.57) HC= 7.88 (6.74) Loneliness: HD= 1.26 (1.06) HC=0.53(0.83)		networks (*F* = 6.85, η^2 = .06, *p* = .01) but no significant difference across other friend or neighbour networks. There were no different in social network size or frequency of contact when accounting for age and depression. Linear regression shows higher hoarding severity predicted smaller social networks when controlling for depression (β= -0.27, *t*= -2.59, *p*=.001) however, hoarding did not predict frequency of contact. **Loneliness:** Compared to HC, HD had stronger feelings of loneliness when controlling for age and depression (*F* = 23.16, η^2 = .17, *p* < .001). Hoarding severity was moderately positively correlated with loneliness (*r*=.42). Linear regression found hoarding severity did not predict levels of loneliness (β = 0.13, *t*=1.42*, p*=.16) but depression did (β = 0.45, *t* = 4.99, *p* < .001).	
6	Chen et al., (2022)	Within subject cross-sectional design, Pearson's correlations	SI-R	**Social Support:** SPS	**SPS Subscales:** Guidance=12.61 (2.93) Reassurance=12.56(2.55) Social	Depression	**Social Support:** Hoarding symptoms negatively correlated with social support across all 6 subscales (*r* = -.41, *p* < .001). Within the regression analysis hoarding symptoms were predicted by social support even when controlling for depression (ΔR^2=.042*,* $\Delta F_{(4, 272)}$= 4.502, *p*=	Moderate, 19

		and Hierarchical Multiple regression				Integration=12.78(2.37) Attachment=12.38(2.92) Nurturance=12.25(2.87) Reliable Alliance=12.65(2.75)		.002). Poor social integration uniquely predicted hoarding symptoms (β= -.198, t (272) – 3.04, p= .030).	
7**	Fontenelle et al. (2021)	Spearman correlation, Poisson Regression, Linear Regression	SI-R	76.54 (14.17)	**Social Support:** MSPSS	18.26 (7.52)		**Social Support:** Perceived social support measured by MSPSS was significantly negatively correlated with SI-R Subscale: clutter (ρ= -.40, p < .001) and difficulty discarding (ρ =-.27, p=.022). No correlation with SI-R excessive acquisition (ρ= -.13, p=.15).	Moderate, 20
8**	Fontenelle et al. (2021)	Correlational, Linear regression, Poisson Regression	SI-R	76.54 (14.17)	**Social Support:** MSPSS	18.26 (7.52)		**Social Support:** No significant effect of MSPSS on hoarding severity (B = -.071, p = .439). Lower perceived social support was associated with a greater number of covid-related stressful life event (B=- .017, SE =.008, p=.038)	Moderate, 18
9	Yip (2015)	Cross sectional, between groups. Correlational and hierarchal multiple regression	SI-R	HD =53 (14) HC =23 (14)	**Social Support:** SNI ISEL ISSB	Not reported	Depression	**Social Network (SNI):** No significant correlation with network size and SI-R (r= -.17, p >.05). Hoarding severity did not significantly predict social network (β = -.17, p = .131) but were significant when accounting for depression (β= -.47, p < .001). **Perceived Support (ISEL):** There was a negative correlation between perceived support and HD symptoms (r= -.30, p <	Strong, 17

								.01). Hoarding symptoms predicted perceived support initially (β= -.30, *p*= .007) and became a stronger predictor when accounting for depression (β = -.62, *p* < .001). **Received Support (ISSB):** No significant correlation with received support (*r*= -.15, *p* >.05). Hoarding symptoms were not a significant predictor of received support (β = -.15, *p*= .20)	
10	Vorstenbosch et al. (2015)	Dyadic correlational design, Between-group comparison	MINI; HRS, SI-R above >14	SI-R HD= 55.25 (16.12) HRS= 20.98 (7.77)	**Social Support:** QRI	QRI Support= 2.31 (.57) QRI Conflict=2.10 (.54) QRI Depth= 3.46 (.43)		**Social Support:** Positive correlation between discarding difficulty on SI-R and QRI conflict for HD participants (*r*= .29, *p* <05) and their CSO (*r*=.41, *p* < .01). Positive correlation between SI-R clutter and QRI-Conflict in HD participants (*r*= .23, *p*= .05) and CSO *r*= .36, *p* < .01) No significant correlation between hoarding symptoms, relationship support (*r*= -.27, *p*=.06) or depth (*r*= -.04, *p* =.77) for HD participants or for CSO.	Moderate, 19
11	Broos et al., (2024)	Cross-sectional, ecological momentary assessment (EMA), correlation and linear regression	SI-R (no-cut-off required)	SI-R Difficulty discarding= 7.26 (5.41) Acquiring= 7.35 (4.97)	**Social support:** FSSQ	32.30 (7.47)	Depression	**Social support:** Greater difficulties discarding was correlated with lower levels of perceived support (*r* = -.32, *p* <.001) as were acquiring symptoms (*r* = -.32, *p* <.001). Within the linear regression, greater difficulties discarding (β= - .18, *t*(134) = -2.07, *p*= .04) and acquiring predicted (β= -.23, *t* (134)= -2.45, *p* =.01) lower perceived social support, even after accounting for	Weak, 15

								depression.	
12a *	Yap et al. (2023)	Chi Square, Pearson's correlations	SCID; SI-R	HD= 56.6 (7.2), HC=35.9 (10.7)	**Loneliness:** UCLA		Depression	**Loneliness:** HD group had significantly higher loneliness compared to the HC (χ^2 (1)= 70.35, *p* <.001). Hoarding severity was strongly correlated with loneliness (*r*=.62, *p*<.001*)* which remained significant even when controlling for depression (*r*=.34, *p*=.04).	Moderate, 17
12b *	Yap et al. (2023)	Cross-sectional t-test, Pearson's correlations.	HRS (Cut off of ≥13 for HH group)	HH= 19.92 (5.53) LH=1.78 (1.81)	**Loneliness:** UCLA		Age, gender, marital status and depression	**Loneliness:** HH had significantly higher levels of loneliness compared to the LH (*t* (623) =14.81, *p* < .001, *d*= .95). This difference remained significant after controlling for age. Hoarding severity was positively correlated with loneliness (*r*= .42, *p* < .001) and remained significant when controlling for age, gender, marital status and depression.	Moderate, 17
13	Burgess et al. (2018)	Cross-sectional, Pearson's correlation and linear regression	SI-R	25.93 (14.83)	**Loneliness:** UCLA	46.34 (10.99)		**Loneliness:** Higher loneliness was associated with greater hoarding severity (*r*=.40, *p* <.001) across all subscales of the SI-R: clutter *(r*=.36*, p*<.001), difficulty discarding (*r*=.36*, p*<.001), and acquisition *(r*=.35*, p*<.001). Interaction between loneliness and anthropomorphism significantly predicted clutter on the SI-R (β = .71, *t*=1.99, *p* < .05).	Weak, 15
14a *	Yap et al. (2020)	Cross-sectional, Pearsons's correlations,	SI-R	26.8 (16.2)	**Loneliness:** UCLA	43.5 (11.4)		**Loneliness:** Positive correlation between loneliness and hoarding severity (*r*=.45, *p*<.001). A total direct effect was found between loneliness and hoarding symptoms	Weak, 14

		Regression/ mediation?					(b= .64, t= 7.32, p <.001). A direct effect between loneliness and hoarding symptoms was observed (b=.38, t=5.25, p <.001) and an indirect effect of loneliness on hoarding symptoms through object attachment was significant (β=.18, SE= .04).	
14b *	Yap et al. (2020)	Cross-sectional Pearsons's correlations, Regression/ mediation	SI-R scoring above ≥13	38.4 (11.7)	**Loneliness:** UCLA	47.3 (10.0)	**Loneliness:** A moderate positive correlation between hoarding severity and loneliness (r=.35, p<.001). A significant total effect between loneliness and hoarding symptoms (b=42, t= 3.10, p=.003). The direct effect between hoarding and loneliness was not significant (b= .25, t=1.92, p= .06), however the indirect effect via object attachment was significant (β=.15, SE= .05).	Weak,16
15	Biagas and Rockey (2014)	Cross sectional, Spearman's rank correlation, ANOVA and multiple regression	SI-R	60.25 (12.02)	**Adult Attachment:** AAS	Close Attachment 3.1 (.85) Dependent Attachment= 2.43 (0.77) Anxious Attachment =2.88 (0.87) Avoidant Attachment= 3.25 (0.76)	**Adult Attachment:** A one-way ANOVA compared attachment styles (secure, preoccupied, dismissive and fearful and SI-scores, which was statistically significant ($F_{(3,80)}$= 3.53, p= .02) with a large effect size (η^2= .34). Those with a fearful attachment style scored higher on SI-R compared to secure attachment. *Anxious attachment:* There was no significant relationship between anxious attachment and hoarding symptoms (r_s =.20, p <.05). *Avoidant attachment:* There was a significant positive correlation between avoidant attachment and hoarding symptoms (r_s =.39, p <.001).	Moderate, 21

16	Chen et al., (2024)	Cross sectional, Pearson's correlation and Multiple regressions, structural equation	SI-R	24.66 (15.56) HD= 48.34 (5.67)	**Adult Attachment:** ECR		Depression	**Adult Attachment:** *Attachment Insecurity*: The regression analysis between insecure attachment measured by the ECR and hoarding symptoms was not significant (β= 0.15, p= .16). There was a significant indirect effect between insecure attachment and hoarding symptoms via anger (β=.18,b= .20, SE= .08, p= .017).	Moderate,17
17	Crone et al., (2019)	Correlational and multiple regression	SI-R	44.81 (11.20)	**Adult Attachment:** ECR	ERC-RS Avoidance= 3.38 (1.18) ECR-RS Anxiety=4.75 (1.63)		**Adult Attachment:** *Anxious Attachment*: ECR-RS anxiety subscale had a weak positive correlation with hoarding symptoms (r=.06, p< .05) but was not statistically significant. *Avoidant Attachment*: The ECR-RS avoidance subscale had almost no correlation with SI-R total (r=.01, p >.05).	Moderate, 16
18	Danet and Secouet, (2018)	Cross sectional, Pearson's correlation and Multiple regressions	SI-R	HD=50.80 (8.80) HC=21.35 (8.94)	**Adult Attachment:** RSQ	HD; Secure:14.9 (2.70) Anxious 14.33 (2.28) Avoidant= 17.33 (2.97) HC: Secure= 15.57 (2.70) Anxious=	Age and level of education	**Adult Attachment:** *Anxious attachment:* There was a significant difference between hoarders and non-hoarders in attachment anxiety (t= -3.02, p < .01). Positive statistically significant correlation between anxious attachment measured by the RSQ and SI-R (r=.35, p <.001). Regression analysis showed that anxious attachment style was the strongest predictor of total hoarding symptoms (β=0.37, p < .001).	Weak, 16

						12.65 (2.9) Avoidant= 17.26 (3.44)		*Avoidant Attachment:* There was no significant difference between avoidant attachment between hoarding and HC (*t*= -.10, *p* > .05). No significant relationship between avoidant attachment and hoarding (*r*= -.02). Not a predictor of hoarding. *Secure attachment*: A negative correlation between secure attachment and hoarding behaviours (*r*= - .15, *p* < .05).	
19	Grisham et al., (2018)	Cross sectional between-groups design, ANOVA	SI-R HRS-I, MINI	HD= 54.87 (8.40) CC= 23.23 (9.83) HC= 15.88 (6.30)	**Adult Attachment:** ECR-RS	ECR-RS: Anxiety HD=4.99 (1.72) CC=4.29 (1.81) HC=2.77 (1.56) ECR-RS: Avoidance HD=3.72 (1.18) CC=4.02 (1.15) HC=2.76 (.90)		**Adult Attachment:** *Anxious attachment:* A one-way ANOVA showed difference between ECR-RS anxious attachment and group ($F_{(2,72)}$ =11.22, *p* <.001, η^2 =.25). *Avoidant attachment*: A one-way ANOVA showed differences in the ECR-RS avoidance subscale ($F_{(2,72)=}$9.10, *p*< .001, η^2) and group. HD group report higher attachment avoidance and anxiety compared to HC, no difference from the CC.	Moderate, 18
20	Kehoe and Egan, (2019)	Cross sectional, Pearson's correlation,	SI-R	38.34 (19.56)	**Adult Attachment:** AAQ	AAQ Total 66.54 (17.46) Avoidance 33.62 (10.02)	Anxiety and depression (co-	**Adult Attachment:** *Anxious attachment:* Correlation between AAQ anxiety and hoarding (*r*= .38, *p* < .01). Attachment anxiety was significant predictor	Moderate, 17

		regression and mediation				Anxiety 32.92 (10.89)	variate)	of hoarding symptoms (*b*= .359, *t* (459) = 4.30, *p* < .001) *Avoidant Attachment*: Correlation between AAQ and avoidance (*r*= .32, *p* < .01). Avoidant attachment was a significant predictor of hoarding (*b*=.219, *t* (435) = 2.38, *p*= .018).	
21	Ma et al. (2024)	Cross sectional, Pearsons Correlational and mediation	SI-R (adapted Chinese)	2.59 (0.87)	**Adult Attachment:** ECR-R SS	ECR-R= Attachment anxiety= 4.07 (1.14) Attachment avoidance=3.39 (0.89) SS: Sense of insecurity= 2.82 (0.90)	Gender, age, siblings, city, relationship status, Childhood SES, times falling in love.	**Adult Attachment:** *Anxious attachment*: Hoarding symptoms were positively correlated with attachment anxiety (*r*= .57, *p* <.001). Attachment anxiety mediated childhood unpredictability and hoarding symptoms. *Avoidant attachment:* Hoarding symptoms were positively correlated with avoidance (*r*= .32, *p* < .01). Avoidant attachment did not mediate the role of childhood unpredictability. *Attachment insecurity:* Hoarding symptoms correlated with sense of insecurity (*r*=.58, *p* <.001).	Weak, 15
22	Nagy et al., (2023)	Cross sectional, Pearson’	SI-R	HD M= 54.7 (10.7) Total	**Adult Attachment:** ECR-RS	ERC Anxious HD M=4.56 (1.19) Total		**Adult Attachment:** *Anxious attachment***:** There was a moderate positive correlation between anxious	Strong, 22

		correlation, regression and Mediation		Sample M=38.2 SD= 17.1		sample=4.3 (1.12) ERC avoidance HD= 4.24 (1.19) Total sample= 3.39 (1.20)	attachment and hoarding symptoms. This was not significant. (*r*= .27, *p* > .05). *Avoidant attachment*: A small correlation for anxious attachment (*r*=.14, *p* >.05), that was not statistically significant.	
23	Neave et al., (2016)	Cross sectional, Pearson's correlation, Regression and mediation	SI-R	24.2 (14)	**Adult Attachment:** RAAS, ECR-RS	RAAS Avoidance= 2.9 (0.7) RAAS Anxiety= 3.2 (1.1) ECR-RS Maternal anxiety=1.9 (1.4) ECR-RS Maternal avoidance=3.4 (1.7) ECRS Paternal anxiety= 2.0 (1.50) ECR-RS Paternal avoidance=4.1(1.7)	**Adult Attachment:** *Anxious attachment:* Hoarding severity was positively associated with anxious attachment on RAAS (*r*=.42, *p* < .01) and ECR-RS for maternal anxiety (*r*= .17, *p*< .01). RAAS anxiety was a significator predictor of SI-R (β= .193, *p* < .001). *Avoidant attachment:* Hoarding severity was correlated with avoidant attachment on RAAS (*r*=.29, *p* <.01). Non-significant correlation on ECR-RS.	Weak, 15

24	Sampson (2013)	Cross sectional, Structural Equation modelling, ANOVA, Correlation and regression	SI-R	Clutter=21.6 (10.40 Discarding =17.04(6.9) Acquisition =15.2(6.1)	**Adult Attachment:** ECR-RS	Avoidance Maternal= 3.5(1.7) Avoidance Paternal=3.5 (1.79) Anxiety Maternal= 4.92(1.8) Anxiety Paternal=5. (1.8)	Psychological distress, attachment security, and family dynamic	**Adult Attachment:** *Anxious attachment:* There was a moderate positive correlation for attachment anxiety (*r*=.28, *p*< .05). *Avoidant attachment:* There was a moderate correlation for attachment avoidance (*r*= .30, *p* <.01). *Attachment security:* A negative correlation was found between total attachment security on that ECR and SI-R severity (*r*= -.35, *p* <.01).A comparisons of group differences from the hoarding group (based on severity from the SI-R) showed a significant difference between groups ($F_{(2, 3857)}$= 4.65, *p*< .01). Those with higher SI-R scores had a lower attachment security score.	Strong, 19
25	Norberg et al. (2018)	Cross sectional, Pearson's correlation and regression	SI-R	43.63 (12.25)	**Adult Attachment:** ECR-RS	ECR-RS-Avoidant= 3.37 (1.17) ECR-RS-Anxious= 4.71 (1.57)		**Adult Attachment:** *Anxious attachment:* No significant correlation between hoarding severity and attachment anxiety (*r*=.02, *p* > .05). *Avoidant attachment:* No significant correlation between hoarding severity and attachment avoidance (*r*=.03, *p* > .05).	Moderate, 18

26	Nedelisky & Steele (2009)	Cross sectional, between group differences Pearson's correlation and regression	SCID; SI-R	HD and OCD= 57.79 (12.47) OCD=22.63 (10.15)	**Adult Attachment:** RAQ	Overall attachment security HD and OCD= 47.14 (13.43) OCD=44.23(12.81)		**Adult Attachment:** Attachment security was predicted by hoarding status (β= 0.51, $p < .01$). Feared loss, proximity- seeking and secure base were also significant predictors. Compulsive care seeking was also strong predictor of hoarding (β=0.56, $p < .01$). Female participants reported a statistically significant difference in attachment insecurity compared to males ($F_{(1,26)} = 9.37$, $p = .005$), but gender was not a significant factor in predicting hoarding behaviour.	Weak, 17

Note. * Asterisk represent one published paper that presented two separate studies. ** Represents the same sample used in two separate studies**.**

SCID= Structured Clinical Interview for DSM-5 (First, 2015); **SI-R**= Savings-Inventory Revised(Frost et al., 2004a); **RSQ**= Relationship Scales Questionnaire(Griffin & Bartholomew, 1994a); **MOSS-SS**= Medical Outcomes Study Social Support Survey (Sherbourne & Stewart, 1991a); **UCLA**= UCLA Loneliness Scale (Russell, 1996); **RQ**= The Relationship Questionnaire(Bartholomew & Horowitz, 1991); **SPS**= Social Provision Scale (Cutrona & Russell, 1987); **RAAS**= Revised Adult Attachment Scale(Collins, 1996); **NSSQ-R**= Revised Norbeck Social Support Questionnaire(Norbeck et al., 1981a); **MINI**=Mini International Neuropsychiatric Interview(Lecrubier et al., 1997); **LSNS**= Lubben Social Network Scale (Lubben, 1988); **CES-D**= Centre for Epidemiological Studies Depression Scale (Radloff, 1977); **MSPSS**= Multidimensional scale of perceived social support (Zimet et al., 1988); **SNI**= Social Network Index(Berkman & Syme, 1979); **ISEL**= Interpersonal Support Evaluation List (Cohen & Hoberman, 1983); **ISSB**= Inventory of Socially Supportive Behaviours (Stokes & Wilson, 1984); **HRS**= Hoarding Rating Scale(Tolin et al., 2018); **QRI**= Quality of Relationships Inventory (Pierce, 1994);**FSSQ**= Functional Social Support Questionnaire (Broadhead et al., 1988); **AAS**= Adult Attachment Scale(Collins & Read, 1990); **ECR**= Experience of Close Relationships Scale(Brennan et al., 1998); **ECR-RS**= Modified Experiences in close relationships-Relationship Structures(Fraley et al., 2011); **AAQ**= Adult Attachment Questionnaire (Simpson et al., 1996); **SS**= Security Questionnaire(Zhong & Lijuan, 2004) **RAAS**=Revised Adult Attachment Scale (Collins & Read, 1990) **RAQ**= Reciprocal Attachment Questionnaire (West et al., 1987)

Table 3

Papers that had a design to demonstrate specificity, providing evidence for or against specificity.

Study ID	**Groups Compared**	**Diagnostic Method**	**Variables Measured**	**Variable**	**Evidence for or against specificity**	**Key Findings**
1	HD vs OCD vs HC	SCID	Attachment, social support, loneliness	*Attachment insecurity*	Against	No difference between attachment insecurity between OCD and HD.
				Perceived social support	For	HD reported lower perceived support compared to OCD suggesting specificity to HD.
				Social network size	Against	No difference between HD and OCD in relation to network size.
				Loneliness	Against	No difference between HD and OCD.
4	HD vs OCD vs HC	SCID	Social support, loneliness	*Perceived social support*	For	HD reported lower perceived support compared to OCD

						suggesting specificity to HD.
				Social network size	Against	No evidence of specificity, this is a disorder- relevant variable
				Loneliness	For	Difference between HD and OCD, suggesting evidence of specificity to HD. This is in contrast with the findings from study 1.
19	HD vs Mixed clinical vs HC	MINI	Attachment	Anxious attachment	Against	No evidence of specificity in HD, suggesting this is a disorder-relevant variable
				Avoidant attachment	Against	No evidence of specificity in HD, suggesting this is a disorder-relevant variable

Studies that included a clinical HD sample, a clinical control group and a non-clinical control group were deemed as being able to demonstrate specificity.

Assessment of quality and methodology

1. Clarity of reporting

All studies provided a clear rationale regarding the purpose of their research, indicating high clarity of reporting. Despite this, none of the paper protocols were pre-registered. Pre-registration of a study protocol is important in enhancing the transparency and credibility of research, by reducing the risk of possible bias within the methods and analysis avoiding researchers altering their hypothesis based on their findings (van den Akker et al., 2024).

2. Outcome measures

Of the papers, 24 achieved a strong rating for outcome measures indicating that psychometric measures were reliable and valid. The Saving Inventory revised (SI-R) SI-R was most frequently used as a measure of hoarding severity. This self-report questionnaire contains three subscales measuring key symptomology of hoarding: clutter, difficulty discarding and excessive acquisition. Items are scored on a 4-point Likert scale, with a score of 41 or higher indicating clinically significant hoarding behaviour. Cronbach alpha rating which measures internal consistency, ranged from $\alpha = 0.88-0.92$ which suggests high levels of internal consistency. Differences across the measures used to measure the interpersonal factors makes it challenging to compare results due to possible different constructs, scoring system and validity and reliability levels.

3. Selection bias

Several papers relied on self-reported hoarding symptoms rather than a clinical diagnosis; however, using individuals with subclinical symptoms may offer useful insights as hoarding behaviours are understood to exist on a spectrum. Recruitment methods, such as online surveys, may introduce sampling bias. These methods exclude socially isolated individuals or those with limited insight into their difficulties, who are often underrepresented in research yet highly relevant to the clinical presentation of HD.

4. *Control for confounding variables*

Several papers did not adequately control for confounding variables, such as depression and anxiety (11, moderate, 1 weak). These co-morbid mental health difficulties may be contributing to the link between interpersonal factors and hoarding.

5. *Power*

Only 5 studies (1, 4, 9, 22, 25) reported a power calculation to ensure that the sample size was sufficient to detect an effect, increasing the risk of type 2 error, so results may not be reproducible

6. *Analysis*

A range of statistical methodologies were used, including Pearson's correlation, Regression, ANOVA and T-tests. All studies utilised appropriate statistical tests for parametric and non-parametric data and provided clear data analysis plans.

7. *Ethics and Service User consultation*

Four papers (11, 14a, 14b, 26) did not explicitly report ethical approval in the main text. Two papers (1, 4) reported involvement of service users during the research process.

Narrative synthesis

Social support and hoarding

Social support has gained attention as a variable critical for psychological wellbeing, acting as a buffer against stress and contributing to overall mental health. Ten papers examined social support and hoarding symptoms (1,2,4,5, 6, 7,8, 9, 10, 11); one paper examined all three variables together (1), two papers examined social support and loneliness (4, 5) and one examined social support and adult attachment (2). Nine were peer-reviewed and varied from weak to strong in quality, plus one (strong quality) thesis (9). Both clinical and non-clinical populations were evaluated.

Are social support difficulties a disorder-relevant variable?

Two key findings emerged, individuals with HD or hoarding symptoms report smaller social networks (as indexed by number of supportive persons) and lower perceived social support. In a peer-reviewed study utilising a diagnosed HD sample, individuals with HD reported smaller social networks compared to healthy controls, suggesting less access to social support (1). A replication of this study by Edwards et al. (2023) (4) similarly found reduced social networks in those with HD compared to HC. Supporting this, a non-peer reviewed thesis (9) found a negative correlation between hoarding severity and social networks in a self-identified hoarding population. The correlational nature of the latter study means causality cannot be assumed, but these findings suggest that reduced social networks are found in individuals with HD.

Bedi and Woody, (2025) (5) extended these findings by suggesting that it may not be network size alone, but the quality of social relationships which may differ dependent on relationship (i.e. family, peers, neighbours). Individuals with HD reported weaker family networks compared to HC. They did not find a significant group difference in overall size or frequency of contact with social networks between HD and HC, but hoarding severity predicted smaller social networks. This implies that perception, and relationship type may be important for individuals with HD.

Perceived social support appears to be a more disorder-specific variable associated to HD. Two high quality peer reviewed studies (1, 4), in clinical samples, found that individuals with a diagnosis of HD reported significantly lower perceived support compared to both OCD and HC groups as measured by the MOS-SSS. Reduction in perceived support was observed across all four subscales of the MOS-SSS (emotional, tangible, affection and positive interaction) but was particularly pronounced in the emotional support subscale in Edwards et al., (4), suggesting difficulties with emotional closeness. Both these studies were of strong methodological quality, increasing confidence in these findings.

Chen et al. (2022) (6) in a peer-reviewed paper in a non-clinical sample found social support across all six subscales on the SPS was correlated with hoarding symptoms, remaining significant when controlling for depression. Notably, lower social integration, defined as the subjective sense of belonging in a community, uniquely predicted hoarding symptoms within a regression analysis. This suggests two possible processes: individuals with HD may have smaller social networks and also feel less socially integrated within them, both of which may contribute to reduced perceived support.

One study (10) comparing individuals with HD and their caregivers found relationship conflict, rather than relationship support, was correlated with clutter and difficulty discarding on the SI-R. This suggests that interpersonal conflict, rather than depth or support, may influence the experience of social support.

Two peer-reviewed, moderate-quality papers, utilising the same data set found a link between hoarding and perceived social support in a self-identified HD sample. One found (7) lower perceived support resulted in higher hoarding severity across the clutter (ρ= -.40) and difficulty discarding subscale (ρ = -.27) of the SI-R. No correlation found between the excessive acquisition subscale and perceived social support (ρ= -.13). The results of the second paper are broadly similar, as this was the same data set, the findings will not be considered further.

Are social support difficulties disorder-specific?

Two papers (1, 4) employed a design that could demonstrate specificity. From these papers, reduced social network size is not disorder specific, with individuals with OCD also reporting reduced social network (1,4). Reduced perceived social support appears to be disorder specific. Both Barton et al. (2021) (1) and Edwards et al. (2023) in a replication study (4) found those with HD reported lower perceived support relative to those with OCD and non-clinical controls, suggesting specificity to hoarding.

Three papers (6,9,11) did not include a study design capable of demonstrating specificity but provide possible insights examining the role of depression as confounding variable. For example, Yip (9) found in a self-identified hoarding sample that hoarding severity did not predict social network but became significant went account for depression; additionally, perceived social support became a stronger predictor of hoarding severity when accounting for depression. Chen et al. (6) found in a non-clinical sample, hoarding symptoms predicted social support when controlling for depression and Broo’s et al. (11) sample also found lower perceived social support even accounting for depression. Due to the absence of clinical comparators and diagnostic confirmation is not clear on the role of depression, but these findings may indicate evidence against depression being sole explanation for the link between social support and hoarding symptoms.

Currently, the evidence in this review only provides specificity for perceived social support.

Loneliness and hoarding

A total of nine papers examined loneliness and hoarding symptomatology (1,3,4,5,12a,12b,13,14a,14b). Of these, one paper examined all variables together (1), one examined loneliness and attachment (2) and two examined social support and loneliness (4,5). All nine papers were peer-reviewed. The methodological quality of these studies ranged from weak to strong, including both clinical and non-clinical populations. Eight studies utilised the UCLA Loneliness scale, a widely used psychometric tool that measures subjective feelings of loneliness and social isolation (Russell, 1996).The consistent use of the same measure allows for greater cross-study comparisons, despite using different populations. One paper (5) used CES-D which has a single item that operationalises loneliness on a scale of 0 (rarely feeling lonely) to 3 (feeling lonely most of the time). This single item has been used in other studies measuring loneliness in studies relating to social network/support in older adult population (Harasemiw et al., 2018).

Is loneliness a disorder-relevant variable?

Four peer-reviewed studies utilised a clinical HD sample, confirmed by the SCID (1, 4, 5 12a) and consistently found that individuals with HD reported higher levels of loneliness compared to HC. For example, both Yap et al. (2023)(12a) and Bedi and Woody (2025)(5) found a HD sample, self-reported significantly higher levels of loneliness compared to non-clinical controls. Hoarding severity was also strongly correlated with loneliness, which remained significant when controlling for depression (12a).

Both Barton et al. (2021) (1) and Edwards et al. (2023), found that across clinical groups (OCD and HD) there was higher loneliness compared to non-clinical controls. Interestingly, in Edwards et al. (2023) there were no significant differences in marital status between groups, implying that loneliness is not solely linked to being single or living alone.

Five studies utilised non-clinical samples with elevated hoarding symptoms (3,12b,13,14a,14b). Yap et al., 2023 (12b) study within a sample of community controls differentiated by experiencing high hoarding or low hoarding symptoms (as measured by the HRS) found individuals with higher hoarding symptoms had higher levels of loneliness compared to the low hoarding group, even when depression was accounted for. This relationship remained significant when controlling for other variables such as age, gender, and marital status. Other peer-reviewed studies within student/ community samples (13, 14a, 14b) report moderate to strong correlations ranging from r=.35 to r=.45, further supporting this relationship. However, these three papers were of weak methodological quality.

Norberg et al., (3), in a methodologically weak study, compared self-reported HD samples with either (a) acquiring and discarding difficulties (ADD) or (b) only acquiring difficulties (AD) and found no difference in loneliness between groups, with both groups reporting high levels of loneliness. This suggests that loneliness may be associated with the overall experience of hoarding, rather than specific behaviours. This paper also found attachment anxiety was higher in ADD relative to those with AD.

Taken together, despite some variance between the methodological strength of the papers, the findings suggest that loneliness is a relevant factor in hoarding, evidenced in both clinical and non-clinical populations.

Is loneliness a disorder- specific variable?

Two papers had the design to demonstrate specificity but including a OCD group and non-clinical controls (1, 4); however, their findings were inconsistent. Edwards et al. (2023) (4) found individuals with HD reported significantly higher levels of loneliness compared to individuals with OCD and HC suggesting specificity. In contrast Barton et al. (2021), the original research that Edwards et al. (2023) replicated, did not find a difference in loneliness levels between clinical groups. Edwards et al. reported a lower mean UCLA score (*M*=34.65, *SD*=11.60) than what is typically observed in HD samples across the other studies (1, 13,14a, 14b). This complicates the interpretation of whether HD is a disorder-specific variable as it was only found in a single study and both are methodically strong

Two papers (5, 12a/12b) considered the role of depression in hoarding severity in clinical and non-clinical samples. There was conflicting evidence regarding the role of depression. Yap et al., (2023)(12a) found loneliness remained highly correlated with hoarding when controlling for depression in a self-identified HD sample. Bedi and Woody (2025) (5) found in a clinical sample that once depression was accounted for hoarding severity did not predict loneliness.

Taken together, there were only two studies that could provide evidence for specificity and only one was able to demonstrate this, meaning the evidence of specificity is inconclusive. Depression appears to play an important, but possibly not exclusive role in hoarding and loneliness.

Attachment and Hoarding

A total of 15 papers examined adult attachment and hoarding (1,2,3, 15,16,17,18,19,20,21,22,23,24,25,26). One paper examined all three variables together (1), one examined attachment and social support (2) and one examined attachment and loneliness (3). Three papers were theses (15, 22, 24). Methodological quality varied across studies, ranging from strong to weak. A variety of psychometric tools were used to measure adult attachment style, including ECR, RSQ, RAQ, ECR-RS. These scales conceptualise attachment differently, mainly utilising avoidance/anxiety and secure/ insecurity as constructs. Additionally, some of these scales are more relevant to adult romantic relationships rather than family, further complicating direct comparison. Findings can be broadly divided in two categories: insecure anxious attachment and insecure avoidant attachment.

Is anxious attachment a disorder-relevant variable?

Anxious attachment style was consistently associated with higher hoarding severity across 12 of the 15 papers in clinical and non-clinical samples. Three papers did not find statistically significant results between anxious attachment and hoarding symptoms (16, 17, 22).

Across papers the strength of correlations varied from non-significant r=0.35 (18) to r= .57 (21); the stronger correlation (21) was methodologically weak within a non-clinical sample with mostly subclinical SI-R scores, limiting its generalisability to HD population. Furthermore, in two peer-reviewed papers anxious attachment style was found to be a strong predictor of hoarding symptoms in a self-identified HD sample (18) and within a clinical HD sample (20). Despite the variation in methodological strength of papers the overall pattern of findings suggest that anxious attachment is a disorder-relevant variable for HD.

Attachment insecurity may influence how individuals experience social support. Medard and Kellett's (2014) (2) peer-reviewed paper, found greater attachment anxiety and avoidance and lower perceived social support in individuals with HD compared to SC and HC. Social support accounted for 11% of the variance in SI-R scores. Differences in perceived social support may stem from attachment insecurity, influencing how relationships are experienced and perceived. Attachment anxiety was found to moderate the effects of social support on hoarding symptoms, while attachment avoidance did not. This paper was methodologically weak particularly in the domains of analysis and power.

Is anxious attachment a disorder-specific variable?

Only two papers had the methodological design to support specificity (1, 9). Barton et al. (2021) (1) and Grisham et al. (2018)(19) in methodologically strong peer reviewed papers found elevated levels of anxious attachment in individuals with HD. However, they found that these were not statistically different from those in individuals with OCD (1) or a mixed clinical control sample (19) (including PTSD, depression and anxiety) suggesting that attachment anxiety is not a disorder-specific variable but a disorder-relevant variable.

Is avoidant attachment a disorder-relevant variable?

Of the 15 studies examining attachment style, 14 assessed avoidant attachment. Findings were generally less consistent compared to anxious attachment. Five studies did not find a significant relationship between hoarding and avoidant attachment (16, 17, 18, 22, 25). These studies were primarily using the ECR-RS measure. Across the papers, correlations ranged from *r*=. 01 (17), which was not significant to *r*=.39 (15), which was statistically significant. In a peer-review paper using clinical samples, a HD group reported higher attachment avoidance relative to HC (19), there was also higher level of avoidant attachment compared to SC and HC (2).

Some of studies utilised attachment insecurity, alongside the specific anxious and avoidant scales or instead of (16, 21, 24, 26). For example, Sampson (2013) (24) in an unpublished thesis found that lower attachment security was associated with higher hoarding severity; comparison of group differences based on severity from the SI-R found those with higher SI-R scores had lower attachment security scores. Interestingly, Chen et al. (2024) did *not* find a direct relationship between insecure attachment, but there was an indirect effect via anger. Given the absence of a direct effect the meaning of this is uncertain. The inconsistencies across the literature and the range of measures used, means it is challenging to ascertain if avoidant attachment is disorder relevant as results are mixed. Overall, it is likely that avoidant attachment is relevant to HD, but this is less consistent compared to anxious attachment.

Is avoidant attachment a disorder-specific variable?

Only two papers had the methodological design to support specificity (1, 9). Both Barton et al. (2021) (1) and Grisham et al. (2018) (19) found that while avoidant attachment was elevated in those with HD there were similar levels reported across OCD and other clinical groups, suggesting that avoidance is not specific to HD. Based on this evidence avoidant attachment is not disorder-specific to HD.

Discussion

This review examined the role of three interpersonal factors: adult attachment, social support and loneliness in hoarding severity across clinical and non-clinical populations; both relevance and specificity to HD was evaluated. Only lower perceived support showed evidence of being *disorder specific* (differentiating HD from other diagnoses). Evidence was found that reduced social networks, loneliness, anxious attachment style and avoidant attachment style may be *disorder relevant* in that they may impact HD in a similar way to what can be observed in other mental health problems. Overall, there were a limited number of papers with the methodological design to demonstrate specificity. Several papers that had the ability to demonstrate specificity were not able to do so lending evidence for disorder-relevance as opposed to specificity.

Theoretical implications

Social support and hoarding

Social support is a multifaceted construct encompassing various dimensions including, perceived social support, social networks, received support, emotional depth and social integration (Schwarzer et al., 2004).The heterogeneity of this construct and therefore the psychometric measures used across the literature makes direct comparisons challenging. Within this review, two consistent findings emerged: individuals with a diagnosis of HD or those with HD symptoms, generally self-report smaller social networks and lower perceived support; however, only a reduction in perceived support was disorder specific. Individuals with HD rate their social support as less adequate than those with OCD and controls. A recent study by Dennis et al. (2024) offers a potential explanation for why this social support is perceived differently. Individuals offering support to those with HD rate their own efforts as less successful and expressed a reduced desire to continue to offer support, compared to supporters of individuals with OCD. Family members may attempt to intervene/ offer support by clearing possessions leading to conflict and distress, impacting how an individual with HD may perceive and experience support. There is likely a bi-directional relationship whereby individuals with HD perceive the support as unhelpful; (i.e. removing clutter) which may lead supporters to feed discouraged by their efforts (as suggested by Dennis et al. (2024). This may lead to further emotional withdrawal and lower perceived social support, reinforcing the reliance on possession to address deficits in personal relationships. Thus, it seems that the perception, coupled with possible differences in family relationships are key in HD, rather than network size alone.

Loneliness and hoarding

The findings suggest that loneliness is elevated in individuals with HD; however, it seems that this is likely a transdiagnostic factor across mental health difficulties. It may be that loneliness precedes hoarding, with individuals using objects to meet their unmet emotional needs. This possible link aligns with attachment theory of HD (Grossmann & Grossmann, 2006). Equally, it is possible that hoarding contributes to loneliness. The accumulation of possessions impacts living spaces, which evoke feelings of shame, leading to social withdrawal and interpersonal conflict- increasing the experience of loneliness. A reciprocal relationship may mean that loneliness and hoarding mutually reinforce each other. Contextual factors including the COVID-19 pandemic may have intensified experiences of loneliness and contributed to hoarding behaviour.

Attachment and hoarding

Attachment difficulties are found here to be relevant but not specific to HD; evidence suggest that attachment anxiety is more consistently linked with HD, whereas findings for avoidant attachment are more mixed. A key hypothesis within the cognitive and attachment models of hoarding (Frost & Hartl, 1996; Grossmann & Grossmann, 2006; Mathes et al., 2020) is that individuals with HD may compensate for reduced interpersonal closeness by forming attachment to objects that provide emotional security. Interpersonal factors such as social support and loneliness may exacerbate these difficulties and further increase the reliance on objects.

The review found evidence implicating attachment anxiety in poorer social support, whereas attachment avoidance was not. Attachment anxiety is characterised by excessive worry about interpersonal relationships; perhaps preoccupation with impaired interpersonal relationship influences the perception of social support. Individuals with avoidant attachment may be less reliant on interpersonal relationships and therefore this may influence their perception of social support.

Research implications

The review highlights the need for good quality studies to draw more definitive conclusions regarding hoarding symptoms and interpersonal factors. Clarification is needed regarding the different findings between Barton et al. (2021) and Edwards et al. (2023) in terms of the specificity of loneliness in HD. None of the reviewed studies ascertained the combined impact of attachment, social support, and loneliness on hoarding severity. Most studies were correlational, and thus, the directionality and causal relationships between these variables remain unclear. Experimental research using a clinical hoarding group may help clarify the interrelationship of these three variables. Importantly, studies should consider using both depressed and anxious control groups to determine the extent to which these factors uniquely relate to HD. Further research on how depression impacts HD and interpersonal factors is required.

Qualitative methodology, particularly across loneliness and social support may begin to guide relevant research questions into the possible directionality of these experiences. This should generate more questions that can be tested empirically.

Clinical implications

Cognitive Behavioural Therapy (CBT) treatments have the best evidence base for HD. Treatment typically focuses on challenging cognitive distortions and maladaptive behaviours associated with hoarding, such as difficulty discarding items (Steketee & Frost, 2013). Findings from this review suggest that interpersonal factors, including attachment avoidance and anxiety, social support, and loneliness, could be targeted within treatment to improve hoarding severity; this proposition needs to be evaluated.

Clinicians should utilise attachment-focused assessments, to evaluate these patterns. Additionally, exploring early attachment experiences and relational difficulties during assessment may provide valuable insights into the function of hoarding behaviours, supporting a formulation-led treatment approach.

People experiencing HD consistently report lower perceived social support compared to HC and those with OCD, despite having similar friendship networks. There is also evidence that supporters may be less inclined to provide support, perhaps due to stigma (Dennis et al., 2024). Addressing these issues to enhance interpersonal relationships and increase engagement with social support systems is an obvious implication of the present review.

Limitations of the review

The review should be considered in regard to its limitations. No restrictions were placed on the date of publication, or inclusion of clinical and non-clinical populations, and were limited to studies written in English. Findings drawn from studies recruiting individual scoring above a threshold on the SI-R may not be representative of individuals meeting criteria for HD. However, this was a necessity decision given significant stigma (Prosser et al., 2024) and difficulty in getting a diagnosis of HD. Individuals may not have insight into the severity of their difficulties or be reluctant to access support, therefore, being missed by services.

Given that social support is a multifaceted area, which was measured with a range of different instruments, it may be that the nuanced findings regarding specific elements of social support have been diluted. Taking social support as a broad construct was a pragmatic decision, due to the inclusion of other interpersonal factors and wanting to synthesise possible relationships between these variables. When reviewing the data it was clear that the conceptualisation of social support varied widely, and in the present study it was challenging to effectively comment on different aspects of social support. Research has yet to properly disentangle these dimensions and the extent of unique effects on hoarding severity, further conceptualisation is needed.

Conclusion

This review identified that loneliness, social support, and adult attachment style are likely associated with the experience of hoarding severity, but only perceived social support shows evidence of specificity. Mostly these difficulties are relevant to broader psychopathology, particularly depression and OCD.

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Service Improvement Project

Title: “Am I getting more help or am I just getting helped?”: Understanding the transition between Getting Help and Getting More Help from young people and their parents: a service improvement project

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Wordcount: 5,000

(Excluding tables and figures)

Date: 23rd of May 2025

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Intended Journal and rationale: The Association of Child and Adolescent Mental Health (ACAMH). This journal was selected as it accepts papers that are clinically relevant and empirically grounded focusing on child and adolescent mental health.

Abstract

Background: The introduction of the THRIVE model across Child and Adolescent Mental Health Services (CAMHS) aims to ensure young people (YP) receive timely support based on their current psychological needs, moving fluidly between teams. Limited research has explored the experience of being transferred from a YP's perspective.

Method: A mixed methods project (including an audit and interview) aimed to understand how internal transfers are currently documented and experienced by YP and their families who had transitioned between Getting Help and Getting More Help teams within a regional CAMH service. Twenty-six clinical notes were audited to determine whether local Standard Operating Procedures (SOP) were being followed. Six YP and eight parents took part in semi-structured interviews. The interview data was analysed using reflexive thematic analysis.

Results: Results showed SOP guidance was inconsistently applied to document transfers. Six themes emerged from the interviews: 1) Getting Help or Getting More Help? The 5 W's 2) "Radio silence" 3) Feeling alone in the CAMHS maze 4) Various agencies: Two teams are better than one 5) One step forward, two steps back 6) CAMHS Professionals: Light at the end of the tunnel.

Conclusions: The project generated a range of service recommendations. Findings, limitations and future research are discussed.

Keywords: internal transfers, service improvement, CAMHS, experiences of young people

A rising number of young people (YP) across the UK experience mental health difficulties (Belfer, 2008; Sadler et al., 2018), yet YP are not accessing the specialist support they require. Future in Mind (Department of Health, 2017) and the NHS Long Term Plan (NHS, 2019) proposed a plan to improve accessibility to timely support, ensuring YP receive treatment at the “right place, right time, right offer” (Department of Health, 2017, p. 42). The THRIVE framework (Figure 1) aligns with these wider goals and is a new tier-less service, advocating YP access support based on their current psychological needs, rather than diagnosis. The Oxfordshire Local Transformation Plan (LTP; Buckinghamshire Oxfordshire Bekrshire (BOB) Integrated Care System, 2023), which are strategic location-specific plans, adopts the THRIVE framework creating two primary pathways for YP in CAMHS: the ‘Getting Help’ (GH) and ‘Getting More Help’ teams (GMH). Alongside this, are other specialist services sitting within GMH (Table 1). Referrals are triaged through Single Point of Access (SPA); YP should ideally move fluidly between GH/GMH based on their evolving mental health need. Service data from Oxfordshire (2024) indicates a two-year wait from SPA referral to first contact. This may mean there are changes to symptom severity, requiring reassessment and possibly an internal transition from GH to GMH (or vice versa). The ‘Feeling Heard’ report found disparities in access to GH/GMH regionally, with frequent referral rejections (CQC, 2020). This raises questions about the effectiveness of THRIVE in clinical practice.

Figure 1

The THRIVE Framework (Wolpert, 2014, p.10)

Table 1

Oxford CAMHS Team Structure

Team Name	Who can this team support?	Treatment options
Single Point of Access (SPA)	All request for mental health services goes via SPA. Professionals, schools, voluntary agencies or individuals are able to refer.	An assessment of a YP's psychological needs to decide whether they need support and if so, which pathway. ○ Provide triage assessment to access correct support. ○ Assess risk and urgency of case to ascertain when a young person needs to be seen.
Getting Help (GH)	Provides brief targeted interventions for mild to moderate mental health	Evidence-based intervention that is time-limited. ○ Informed Cognitive Behavioural

	difficulties.	Therapy (CBT) o Parenting group o Psychoeducation group
Getting More Help (GMH)	Provides support for young people with moderate to severe mental health difficulties: o Anxiety disorders o Post-traumatic stress o Self-harm o Bipolar	This team offers a range of evidence-based interventions dependent on presenting difficulty. This may be working directly or indirectly with the young person. o CBT o Systemic therapy o Psychotherapy o Dialectical Behavioural Therapy (DBT) o Medication o Care Co-ordination
Neurodevelopmental conditions (NDC) Team	A specialist CAMHS provision that offers diagnostic assessment of Autism and Attention Deficit Hyperactivity Disorder (ADHD).	o Diagnostic assessment for Autism o Diagnostic assessment for ADHD o Signposting to third-sector organisations post diagnosis
Child and Adolescent Eating Disorder Team (CAEDS)	Provides support for people with eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding or eating disorder (OFSED).	Offering evidence-based interventions specifically for eating disorders. o CBT-Enhanced (CBT-E) o Family Based Therapy o Structured Clinical Management. o Care co-ordination o Systemic therapy. o Body image group.

Transitions between CAMHS and Adult Mental Health Services (AMHS) are well-studied and associated with high levels of uncertainty and reduced support, which can be anxiety-provoking for YP and their families, possibly exacerbating mental health difficulties (Hill et al., 2019; Paul et al., 2015; Singh et al., 2008). Qualitative research reveals YP "falling between the gap" and feeling "abandoned" during the transfer; parents assume a more proactive role in the absence of professional support (Appleton et al., 2021). The impact of internal CAMHS transfers is often discussed clinically, but limited research has explored this from a YP's perspective, despite evidence suggesting transitions may affect a YP's mental health(Singh et al., 2010). Adolescence is a period where psychological problems may become increasingly complex, and engagement with mental health services may fluctuate (Lamb & Murphy, 2013; Petersen & Leffert, 1995). If not carefully coordinated, transitions risk YP disengaging with services. The National Institute of Clinical Excellence (NICE) suggests transfer planning meetings, joint working and establishing relationships to ensure continuity of care, are central for successful transitions (Appendix G; NICE, 2016).

The impact of transitions can be understood through queuing theory, referred to as the 'psychological cost of waiting' (Osuna, 1985). Anxiety, lack of information and uncertainty makes waiting feel longer, possibly affecting help-seeking behaviour within CAMHS. This may lead families to seek support from multiple agencies, such as third sector organisations or private psychologists (Reid & Brown, 2008; Shanley et al., 2008). Prolonged wait times for CAMHS treatment can result in poorer outcomes as YP may feel discouraged about the support received, reducing service satisfaction and patient experience (Stallard & Sayers, 1998; Westin et al., 2014).

Furthermore, the experience of transfers may also be related to threats to psychological safety. Psychological safety refers to an individual's ability to take interpersonal risks within a team without fear of negative consequences (Edmondson, 1999).In a mental health context, psychological safety empowers YP and their families to voice their concerns and anxiety within their care team (Hunt et al., 2021). Psychological safety can be developed by clinicians adopting compassionate attitudes, collaboration with patients in decision-making regarding their care and ensuring physical safety (Vogt et al., 2024). Internal transfers may threaten psychological safety, hindering engagement with the new care team (Hill et al., 2019). Understanding the experience of internal transfers is key to meeting the LTP aims and providing a needs-led service.

Service Context:

Oxford Health Foundation Trust (OHFT) CAMHS teams are sub-divided based on locality: the North and South team. YP are referred to the GH or GMH pathway, following a SPA assessment, based on their perceived level of need. Anecdotally, clinical teams highlight YP are uncertain about which team they are under and the rationale for internal transfers. Internal transfers have been an overlooked experience, and the service is unclear on what is currently being reported on clinical notes.

Aims

i. Understand what information is currently being recorded for YP when they are transferred between GH/GMH.
ii. Understand CYP and their families experience of being transferred between teams in relation to the THRIVE model.
iii. Produce service recommendation to support with transition between GH/GMH.

Method

Design

This service improvement project employed a mixed-methods design encompassing two stages.

(1) Audit of clinical notes of the internal transfer based on Standard Operating Guidance (SOP; Appendix H)

(2) Semi-structured interviews with YP and parents to explore experiences of their transfer.

Ethics

The project was approved by the OHFT Clinical Audit Team (Appendix I) and registered on the audit system, AMAT. A Data Protection Information Assessment (DPIA) was completed (Appendix J). Participants provided informed consent via Microsoft Forms; parental consent was required for YP under 16. Additional consent for the audit was not required as accessing notes in this capacity is considered indirect care.

Procedure

Stage 1

Clinical notes of all YP aged 12-17 transferred between GH and GMH (and vice versa) across North and South Oxfordshire CAMHS between April 2023-December 2023 were reviewed. Eligible cases on RiO were identified by the OHFT Performance and Information Team. This timeframe ensured adequate documentation on the new clinical system following the move from Carenotes to RiO. Records of individuals who had declined to have their notes reviewed under the National Data Opt-Out were excluded. Transfer-related notes were extracted and compared against a pre-determined audit criterion. A 20% sample were randomly selected (*n*=5) and reviewed by the researcher's supervisor to assess inter-rater reliability.

Inter-rater agreement between coders was calculated using percentage agreement was completed early within the audit process, with both raters reviewing 5 cases. Agreement ranged from moderate (60%) to high (100%) (Appendix K; McHugh, 2012). Some elements of the criteria yielded high agreement as they relied on a simple yes/no criteria (e.g. GP letter), other items had lower agreement due to its subjective nature (e.g., formulation in notes). To improve consistency the audit tool was refined before the final cases were reviewed (*n*=21), which improved the reliability and usability of the audit tool.

Stage 2

YP aged 12-17 years, or their parents, who had been transferred between GH or GMH (or vice versa) within the previous year from July 2023- July 2024 were eligible for interviews. Clinicians within the team were sent a study pack (Appendix L) including consent to contact and a participant information sheet. A purposeful sampling approach was used; clinicians identified eligible YP, and the researcher contacted consenting families. Semi-structured interviews were conducted via Microsoft Teams by the lead researcher, audio-recorded, transcribed verbatim and checked for accuracy. Interviews ranged from 12-57 minutes. Consent and/or assent was gained prior to the interview commencing for all participants. Demographic information of the YP accessing CAMHS was recorded. YP received a financial incentive to participate, a £15.00 Amazon voucher.

Materials

Stage 1

The audit criteria (Appendix M) were based on the current GH and GMH SOP of what should be documented for internal transfers: a letter to family and GP, and a named member of staff within the new team. Collaboration with the service manager led to the inclusion of other good-practice elements (e.g., formulation, MDT discussion).

Stage 2

A semi-structured interview schedule was co-developed, in accordance with previous literature and a YP who had previously accessed CAMHS, who received financial reimbursement for their time. Questions explored participants' understanding of their transfer process and the experience associated with this (Appendix N).

Data Analysis

Stage 1

Data from clinical notes were reviewed to determine the number of cases which adhered to the SOP. A Red/Amber/Green (RAG) rating was applied to each criterion. As no pre-established benchmarks existed for this process, fixed-reference values were applied based on the RAG Rating Indicator Values Guidance (Fox & Fryers, 2017). The decided thresholds were *green* indicates ≥80% of the cases met the audit criteria, *amber* signified >50% of cases, and *red* would be fewer than < 50% of cases.

Stage 2

The anonymised transcripts were analysed in accordance with Braun and Clarke's (2006) six-phase reflexive thematic analysis.

The epistemological stance adopted in this study is constructivism, which assumes that there is no single objective truth, but rather multiple, socially constructed interpretations of reality. This informed the methodological approach- reflexive thematic analysis, which seeks to understand the experiences and realities of the participants, acknowledging that these are influenced and dependent upon the participants' social and cultural context, as well as the researcher's. Rationale for this research method are discussed in Appendix O. Both semantic (descriptive) and latent (implicit) coding were used to ensure richness within the data; codes were continually refined and developed into themes and subthemes. The primary researcher transcribed and analysed all of the data; regular research supervision discussed biases within the codes and themes. A second researcher coded a transcript of the data, to support inter-researcher consistency and synthesis of themes. A preceding bracketing interview and reflexive log helped to explore the researcher's positioning throughout the research process (Appendix P).

Self-Reflexivity Statement

The lead researcher (TM) is a White British female undertaking her doctoral training in clinical psychology, with prior experience of working in CAMHS. Both research supervisors were White British female Clinical Psychologists (JA & ER), currently working within Oxfordshire CAMHS.

Results

Stage 1: Audit

A total of 26 clinical notes were reviewed relating to an internal transfer. Demographic information regarding the transfer process can be seen in Table 2. Table 3 shows the results of the audit.

Table 2

Demographic information about the transfer

Transfer Process	Category	Number of cases (*n*=26)	Percentage (%)
Referral into CAMHS	GP	13	50.0%
	School	9	34.6%
	Self-referral	2	7.7%
	Professional	2	7.7%
Direction of Transfer	Getting Help→ Getting More Help	20	76.9%
	Getting More Help → Getting Help	0	0%
	Getting More Help North → Getting More Help South	2	7.7%
	Getting More Help South → Getting More Help North	0	0%
	MHST → GH	3	11.5%
	MHST → GMH	1	3.8%
Rationale for transfer	Risk increase (e.g., suicidal ideation, self-harm)	12	46.1%
	Outside current team's provision (e.g., OCD, substance misuse)	7	26.9%
	Unclear	7	26.9%
Stage of Transfer	Following assessment with	16	61.5%

	GH/GMH		
	Prior to assessment with first team	5	19.2%
	Mid therapy	1	3.8%
	Post completed intervention	2	7.7%
	Unclear	2	7.7%

Note. GH= Getting Help; GMH= Getting More Help; MHST= Mental Health Support Team (school-based equivalent to GH)

Table 3

Summary of audit results

Audit Element	**Percentage of notes meeting criteria** (*n*=26)	**RAG Rating**
MDT discussion regarding transfer	58%	*Amber*
Formulation within notes	73%	*Amber*
Named professional in new team *	11%	*Red*
Letter to family regarding transfer*	15%	*Red*
Letter to GP regarding transfer*	0%	*Red*

Qualitative observation noted from the audit	Several acronyms used without a clear definition (e.g. SW, MHP, GH) No label to ascertain which team or professional was authoring the note. Email chains pasted in clinical notes without providing a summary of their context. Challenging to ascertain the rationale for transfer, or to locate documentation relating to the transfer.

Note. * Asterisked items are required documentation within SOP guidance.

Green= ≥80% , Amber = >50% Red = < 50% of cases.

Overall, the key elements outlined by the SOP were not consistently documented on notes during an internal transfer, rated as ‘red’. Both researchers found it challenging to ascertain several elements of the audit, given the disjointed nature of the transfer notes, meaning some of the data set was left as ‘unclear’. Full audit data in Appendix Q.

Stage 2: Semi-structured Interviews

A total of 21 YP met the inclusion criteria across both localities. Of these, 13 parents were approached by the assistant psychologist. Five parents and two YP declined to participate. In total, six interviews were undertaken with YP (age range=13-17, *M*=15.5), and eight interviews with parents (all mothers). Primarily, interviews were of dyads (*n*=6; mothers and child), who were interviewed separately about their experiences. Some interviews involved only mothers participating without their YP (*n*=2). Demographic information is presented in Table 4.

Table 4

Demographics of participants

ID	Participant (gender, age)	Ethnicity	Presenting Difficulty	Transition stage at time of interview	Point of transfer	Open to NDC or another CAMHS Team	Accessing private support
YP1	Young person (f, 13)	Mixed White	Low mood	GH to GMH	Assessment	Waitlist for NDC	✓
P1	Mother	White British					
YP 2	Young person (f, 14)	Black Caribbean	Self-Harm	GMH to GH	Assessment	Accessing private Autism assessment	✓
P2	Mother	White British					
YP 3	Young person (f, 17)	White British	Self-harm	GH to GMH	Assessment	Wait list for NDC	✓
P3	Mother	White British					
YP4	Young person (f, 16)	White British	Anxiety/Se	GH to GMH	Assessment	Accessing private Autism assessment	✓

P4	Mother	White British	lf-harm				
YP5	Young person (m, 16)	White British	Anxiety	GH to GMH	Assessment		
P5	Mother	White British					
YP6	Young person (m, 17)	White British	Anxiety/Low Mood	GH to GMH	Unclear		
P6	Mother	White British					
P7	Mother (m,15)	White British	Anxiety/ Self-harm	GH to GMH	Assessment	Wait list for NDC	✓
P8	Mother (m,15)	White British	Anxiety/ Depression / Self-harm	GH to GMH	Assessment	Wait list for NDC Team	✓

Thematic Analysis

A total of six themes were identified in the interviews 1) Getting Help or Getting More Help? The 5 W's 2) "Radio silence" 3) Feeling alone in the CAMHS maze 4) Various agencies: Two teams are better than one 5) One step forward, two steps back 6) CAMHS Professionals: Light at the end of the tunnel. Theme and subtheme descriptions are outlined in Table 5. A thematic map and illustrative quotes can be seen in Appendix R.

Table 5

Summary of themes and subthemes

Themes	**Theme Description**	**Subtheme**
1. Getting Help or Getting More Help? The 5 W's	This theme captures the uncertainty and doubt that families experience associated with their journey through CAMHS and their transfer across teams. Parents acknowledge that the 'journey was a blur'.	1. Who have we seen? 2. Why am I being transferred? 3. Where will I end up? 4. What am I waiting for in the new team? 5. When will I be seen again?
2. "Radio silence"	This theme captures the difficulties of communication associated with the transfer. Families feeling as though they had been 'dropped' from the waiting list and were not sure when they were going to be next seen. This could also be the 'onset' of radio silence, where families went from regular CAMHS contact to waiting again.	1. The line keeps moving 2. No written communication 3. "Black hole of emails" 4. No named professional

3. Feeling alone in the CAMHS maze	This theme reflects how parents and young people are attempting to navigate the CAMHS system. Parents using their own personal resources (skills, time, money) to get the right support. Yet, there is a sense of anxiety for both young people and parents surrounding managing fluctuating mental health, worries around risk and when they will be able to access support.	1. My own knowledge 2. Anxious to get the 'right help' 3. Impact of child's mental health on parents 4. Holding the risk and fighting for help 5. They only care if I hurt myself
4. Various Agencies: Two teams are better than one	This theme encapsulates how parents and young people are open to multiple different teams whilst waiting for CAMHS support during their transfer. Without external supports parents feel they would be unable to cope with the wait. Parents felt that two teams or third-sector agencies may be able support their child faster and more effectively.	1. Paying for external support 2. Financial privilege of accessing support 3. Accessing the Neurodevelopmental Condition Team 4. Social Care bridging the CAMHS gap
5. One step forward, two steps back	This theme captures the worries associated with starting within the new team and the pre-existing narratives that influenced the experience of the CAMHS transfer.	1. Starting from scratch 2. Retelling my story 3. What support am I getting? 4. Low expectations of new team 5. Narratives of CAMHS

4. CAMHS professionals: Light at the end of the tunnel	This theme reflects the positive experiences parents and young people had with individual staff, and a feeling of hope once support had started.	1. Professionals are fantastic 2. Going above and beyond

Theme 1: Getting Help or Getting More Help: The 5 w's.

This theme encapsulates the uncertainty and doubt families experienced associated with their transfer between teams and recognition that the *"journey has been a blur'* (P4). Confusion existed across multiple layers both prior to and associated with the transfer, including who a YP had previously been seen, as to what team they were in, where they were moving too, why they were being transferred and when they could expect to be next seen.

"I'm not sure what team they are or what they are going to be doing?" (YP2).

Parents and YP commented during the transfer there was a sense of uncertainty of what they could expect:

"*It was limbo time of being stuck and not really knowing when the support is going to happen or where we sit"* (P1).

Both reflected they felt passed to other professionals without accessing any support, leading them to question the nature of the support they would be receiving next.

"Am I getting more help or am I just being helped?" (P5).

The rationale for the transfer was often unclear, and provided no timeframe leaving families wondering when they would be next seen:

*"The support just stopped, and I didn't know why or when it was going to start again" (*YP2*)*

Theme 2: Radio Silence

Parents noted challenges with communication during the transfer process could feel like "*radio silence*" (P4).

"*But literally since the referral to the new team I have heard nothing since"* (P2).

The sudden lack of communication after consistent contact with the original team felt like "radio silence", leading to anxiety and frustration for parents and YP. This was intensified as YP were often in a period of heightened mental health vulnerability, as they were being transferred due to changes in risk or mental health presentation. The lack of support during this process exacerbated levels of distress. Parents felt CAMHS kept changing what they would offer, and when the new team would see them, as though "*the line kept moving*" (P5).

"They would keep changing the time frame, it's almost like a false promise." (P1)

The parents interviewed were not informed in writing that their child's care had been transferred, meaning parents were often worried if this had happened. This appeared to negatively impact attitudes and trust towards CAMHS.

> *"I've heard nothing in writing from them ever, and they said they would. As far as I know that didn't happen which is a pity. If you say something, it needs to actually happen, that's pretty important."* (P2)

Beyond this uncertainty, there appeared to be a sense of disappointment in CAMHS' ability to meet the basic expectations previously agreed to. Consistent communication and following through on decisions, help to develop trust, and a sense of hope between the system, parent, and YP. If CAMHS were perceived as unable to perform basic administrative tasks, parents questioned the level of care they were anxiously waiting for, creating a sense of uncertainty.

> *"I had the support and then I have to wait, they've just sort of left me here." (*YP6)

When parents contacted CAMHS for an update via the administration email, as the service suggested, they reported emails often went unanswered or received a generic response in reply. This left some parents feeling as though emails were getting sent to a "*black hole*" (P8). Parents suggested this felt as though CAMHS were not aware of relevant information regarding their child.

> *"I'd get a generic email response back, I never know who to speak to, it's really hard work."* (P6)

Difficulties with communication also appeared to be related to not having a named CAMHS professional during this transition period, parents did not know who to reach out to if they were concerned about their child's safety. There was a sense of desperation and concern that no one is listening.

> *"Literally we were screaming for help, and you know we would send emails. They wouldn't be replied to. We would phone the duty team and it would be like OK, yeah fine. He's not going to kill himself this weekend. Somebody will get back in touch in the week, nobody ever would."* (P4)

Theme 3: Feeling alone in the CAMHS maze

Parents described feeling they were going beyond their role of parents to facilitate support for their children, and to get the help they required from CAMHS. Some parents utilised their "*own professional knowledge*" (P1,3) of the CAMHS system to not only navigate the transition between teams, but more broadly to understand the different teams and support on offer:

> "*I think maybe because I'm in similar area, for work, if I wasn't, it would be a bit foreign to me and I wouldn't have a clue…. I think I'd be like a rabbit in headlights."* (P1)

Irrespective of professional knowledge, all parents shared experiences of researching for further support and ensuring children had *"access to the right help, right time"* (P3) for their current mental health needs. Navigating their journey to mental health support often had a significant impact on family life:

> *"I've stopped work now just purely to support my kids through this process. That's the impact it's had. Even part time I couldn't navigate this world with all the drama and all the upheaval and the risks she was at and the lack of support we had."* (P6).

The transfer process and their child's mental health had a bi-directional relationship with parental mental health.

> *"I was not an anxious person until my son started having difficulties, when a child has a mental health crisis it affects everybody."* (P4)

Parents felt high levels of responsibility to access support from CAMHS, so they were not the only ones holding this risk.

> *"You feel like no one is listening. You feel like no one cares. We're not just a number, this is our children, were trying to protect them."* (P6)

Parents reported a conflicting sense of doing anything they could to keep their child safe and mitigate risk. Yet, the more competent parents were at this, the less they felt CAMHS would engage with them.

> *"I'm doing my own risk assessment, and I feel in a way that got us downgraded in terms of urgency, cos you know I was doing it. But yes, I was reducing his risk, but that didn't mean we were no less important to see."* (P4)

This process was sometimes described as "*fighting for help*" (P2,3,7). One YP felt CAMHS only cared when they were in crisis.

> *"They only really care if I am in a place where they genuinely think I am going to hurt myself. It's like I don't know how to say. If I'm gonna hurt myself its fine, but if I am gonna end my life it's not fine." (*YP 4)

It appeared there may be a sense amongst both YP and parents that being ‘at risk’ may encourage CAMHS to offer support. This implies a reactive system, as opposed to one which focuses on preventing difficulties.

Theme 4: Two teams are better than one.

This theme encapsulates how parents and YP are often seeking “external support” in different teams, both through CAMHS and third sector organisations (i.e. charities or private practice) during the transfer process. Most parents were accessing private support for their children whilst under CAMHS. Accessing this support was seen as essential to cope with the wait; there was a sense that two teams were better than one.

“*We have not felt abandoned, but honestly without that [private support] I would have just felt abandoned. And I think [YP] would have too.”* (P2)

YP also shared this support had been beneficial.

*“I feel like I can actually be open and honest with her, she gives me coping mechanisms that help.” (*YP4)

There was often mention of the financial privilege of parents able to access support privately, and concern for other families this may not be possible for, potentially leaving YP without crucial care.

"We couldn't have survived without it. And that is something really, quite honestly, the CAMHS, should have offered." (P3)

Parents felt referrals to the NDC were necessary, and additional team support would be beneficial to a YP's wellbeing and would mean they could access the right help:

"I'm not surprised they did both referrals, but I'm glad they're keeping both parts open as I think that the two services are actually probably a better fit for her. Yeah. It's a bit of a relief, really, that she's actually getting help." (P1)

Several families were in contact with social care and reported they provided high-quality support for YP's mental health, which was particularly needed during the transition between teams when support was reduced.

"I think without the social worker it would have been hard to wait." (YP2)

Theme 5: One step forward, two steps back.

This theme represents the frustration associated with the transfer process. Families felt they were "*Gonna have to start from scratch"* (P2) with a new team, were frustrated with the wait, and had low expectations of the new team.

YP shared frustration with having to '*retell their stories'* (YP1,2,3) in the new team. They felt disappointed about the support they were offered, question's and talking did not appear to be recognised as effective support.

"They didn't really help, they just asked questions every week." (YP 3)

Poor experiences of accessing CAMHS support previously meant some families did not have high expectations for the new team.

“I didn’t have huge hopes to be honest. We’d had no help, the school had not helped us, how could this team?” (P8)

There were several narratives surrounding CAMHS based on preconceptions.

“I think there's like a lot of negativity towards like CAMHS like just in this generation type thing.” (YP4)

Concurrently, parents also had compassion for the CAMHS system, acknowledging systemic barriers within CAMHS were beyond the professionals’ control. This emphasised a frustration towards the system as opposed to individuals.

“I am so grateful for CAMHS, I know how incredibly stressed and underfunded the entire system is.” (P7)

Theme 6: CAMHS Professionals: Light at the end of the tunnel

Both parents and YP shared some positive experiences of individual staff in CAMHS that both supported the transfer process and provided high-quality person-centred care. This appeared to instil a sense of hope for families being supported by CAMHS. YP shared practitioners were able to develop therapeutic alliances and support YP to consider their strengths and resources beyond their mental health.

"She got me to talk about myself instead of going directly into my problems." (YP 4)

Parents acknowledged how well staff were able to relate to YP and their difficulties.

""*It was lovely for [YP], although she wasn't her age, you could tell that would be able to relate to the youth."* (P2)

Discussion

Summary of main findings

This service improvement project aimed to ascertain how the GH/GMH teams documented internal transfers against local SOP guidance and to understand the experience of YP and their parents who had been transferred between teams. The audit found that SOP guidance was being inconsistently applied, resulting in unclear documentation of transfers. Notes often lacked a clear transfer rationale, making it difficult to determine which professional, or team authored them.

A parallel can be drawn between the unclear audit documentation and themes from the interviews which describes the transfer as a "blur." This uncertainty and lack of transparent communication increases anxiety for parents who are relying on clinicians' knowledge to support their child's mental wellbeing. The absence of clear communication may undermine psychological safety for YP and their families, leading to feelings of abandonment and impacting engagement with the team post-transition (Vogt et al., 2024).

Results from thematic analysis support the existing literature surrounding queuing theory; movement between teams increased the sense of waiting (Osuna, 1985). YP were typically transferred due to an increased risk, or change in mental health presentation, requiring a higher level of support. During the transfer there was a decrease in the level of support as they were placed on a waitlist, parents assumed more responsibility for their child's risk during this time (Schraeder & Reid, 2015). Transitions did not align with the THRIVE model whereby transitions were intended to be fluid.

Families often sought external support to bridge the gap during this transition period. Those without the means to pay for private services are reliant on CAMHs and have no option but to wait, creating a disparity for low-income families who may have long periods without critical mental health support. Experiences of inconsistent communication and a lack of clarity surrounding the transfer, influenced narratives surrounding CAMHS and their potential usefulness. Clinicians demonstrating compassion, providing clear communication, consistent documentation and transparent decision-making helped YP feel supported during transfers (Embrett et al., 2016).Clinician recommendations in Appendix S.

Recommendations

A set of recommendations for service development were made based on the findings (Table 6). These were primarily focused on providing clearer guidance to clinicians and families relating to internal transfer, for example, introducing a standardised note template for transfers to ensure clear, consistent communication. Findings were disseminated to the service manager, wider CAMHS team, and participants who requested the results. The team valued the transfer-note template and hearing YP perspective of the transfer process. Feedback in Appendix T.

Table 6

Recommendations for service development

Recommendation	**Evidence from findings**	**Implementation**
Standardised Transfer Note Template	*Audit* Rationale/direction of transfer not being recorded in clinical notes. Increasing transparency of decision-making surrounding transfer.	• Introduce a transfer note template document to support the documenting of internal transfers. **CAMHS- Getting Help Team/ Getting More Help Team (Team Name Psychology/ Nursing/ Care-Coordination) Transfer to internal Team** *Professional Role:* (Job role) *Transfer from*: (team moving from) *Transfer too:* (team moving to) *Transfer Rationale:* Briefly describe rationale for transfer and how this team will meet it (risk, presentation, therapy) *Risk:* Any concerns that new team should be aware of. *Family informed*: Document phone call to family/ discussion with family. *Letter:* Therapeutic Template – what professionals shared with? If not, why? **Plan:** Transfer of care- what do new team need to do, including time frame, risk management, signposting.

		• All acronyms should be typed in full within a note first, regardless of whether they had been previously used in other notes to support with clear decision making surrounding the transfer. • Clinicians to be mindful of language within emails informally discussing a transfer of care, if these will then form part of the young person’s clinical care record. Ensure clear documentation of the transfer process and rationale to be documented to ensure the new clinicians are clear on the reason for transfer.
Review of SOPs across GH/GMH	*Audit* Inconsistency from notes regarding the documentation of the transfers across teams.	• As GH/ GMH are supposed to be a shared team, a single SOP procedure on internal transfers should be synthesised from the current separate guidance. This will provide consistency across teams and within the notes regarding the documentation of the transfer.
Clinician Transfer Pack	*Audit* SOP guidance for internal transfer not being used	• Create a clinician transfer pack to support the correct documentation and communication of transfer to family. This should be integrated with the GH/GMH SOP to provide consistency across teams regarding the documentation of the transfer.

	consistently.	i) Clear information about the CAMHS structure and reasons for stepping up/down. ii) Transfer specific note template iii) Internal transfer document to upload on the clinical notes system (Appendix P) iv) Therapeutic Letter Template to be sent to young person/family. • Clear guidance of what needs to be completed within the transfer will support clinicians with communicating and documenting transfers across GH/GMH.
Therapeutic Template Letter	*Interviews:* Theme 1, 2 3,	• Development of a therapeutic letter template, sent to young people, GP, and other professionals to indicate a transfer. • This would serve as communication of the transfer and provide practical elements relating to transfer: a clear rationale of why this has happened, where the young person is moving to, what they can expect, how to contact the team and crises support. • Collaborative and sensitive language throughout the letter can provide emotional

		validation associated with waiting for support.
How to navigate a wait in CAMHS	*Interviews:* Theme 1, 3, 4	• CAMHS clinicians having a short session with a family at the point of referral to GH/GMH to discuss expectations and how to navigate CAMHS. Families will be more aware of the possibility of transfers during their journey with CAMHS and why this may happen, to reduce the uncertainty and anxiety associated with navigating CAMHS during the transfer process. i) *CAMHS Structure:* Key information about professionals' roles and different CAMHS team structure. ii) *Risk management:* Developing a safety plan for young people and how families can mitigate risk prior to a transfer from GH/GMH or vice versa. Instilling a sense of autonomy and confidence for parents and YP. iii) *Signposting*: Providing comprehensive signposting for resources that families can access while they are waiting during their transition, including parental support (e.g. third sector charities, books, webinars). iv) *Stories of hope:* Inclusion of positive experiences of CAMHS and what

		families had found useful from the support once they had been transferred. This may support families who are waiting for specific support related to their transfer and help with narratives surrounding CAMHS which could influence engagement with the new team.
Named Professional or New inbox	*Interviews* Theme 1, 2, 3	• Implementation of a clinician monitored email account for families who have been transferred between GH/GMH to answer specific mental health- related queries. • Alternatively, having a named clinician that can support with any concerns during the transfer period, as this is an increased risk vulnerability. • Planned telephone review at 6 months if a young person is still waiting to ensure families feel held in mind and maintain contact with the service. This new team holds this clinical responsibility once they are placed on this team's waitlist.
CAMHS One-page Profile (Sanderson, 2014)	*Interviews* Theme 5, 6	• One-page profile to be given to young people for them to complete, should they wish, at point of contact with service (e.g. SPA assessment or other assessment) or developed with a named CAMHS worker at the point of transfer. This will reduce the need for young people to 'retell their stories'.

	• Profile may include strengths, hobbies, family background, any support needs, goals and mental health history to support person-centred, tailored care.

Strength and Limitations

A strength of this research is the emphasis on the YP and parental voice in an under-researched area. Interview questions were developed with an individual with lived experience of CAMHS. Triangulation of themes with two research supervisors, ensured identified themes were not of a single perspective leading to a richer, nuanced understanding of themes, and enhancing the reliability of the findings. Yardley's (2000) principles of quality research were followed: sensitivity to context, commitment and rigor, transparency, coherence, impact and importance to ensure high quality methodology.

However, the small, predominately White British sample may not accurately reflect the population accessing Oxfordshire CAMHS. Only mothers participated in the interview, despite being open to all parents. Furthermore, the audit RAG rating used arbitrary values, and findings are limited to this this specific service context. Nevertheless, there are clear and meaningful recommendations relating to consistent documentation of the transfer process.

Future directions

Further research should explore paternal and staff perspectives on internal transfers. Additionally, explorations into equity of transfers across demographics (e.g., ethnicity, neurodivergence, socio-economic status) to identify gaps within the service set-up.

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Theoretically Driven Research Project (TDRP)

Title: Obsessive Compulsive Disorder (OCD) and Mental Contamination: The Role of Betrayal, Magical Thinking and Thought-Action Fusion

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Word count: 5,000 (excluding tables and key words)

Date: 23rd of May 2025

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Intended Journal and rationale: British Journal of Clinical Psychology. This journal was selected as it publishes original research within clinical psychology integrating theory-practice links.

Joint Working: Aspects of this project were completed jointly with another trainee clinical psychologist (Appendix V; Amy Lunn) to reduce participant burden. The contributions to the work presented in the thesis are as followed: Torileigh Matthews- conceptualisation, methodology, data analysis, writing. Joint working with Amy Lunn- Project administration-ethics application, recruitment and data collection

Abstract

Mental contamination (MC) refers to internal feeling of dirtiness without contact with a physical contaminant and is prevalent in individuals with obsessive-compulsive disorder (OCD). Evidence suggest MC is linked to sensitivity to betrayal. This study investigated if individuals experiencing high levels of MC and OCD report more betrayal events relative to those with OCD and low MC and other anxiety disorders and non-clinical controls. Additionally, we examined the role of thought-action-fusion (TAF) and magical thinking in MC. A cross-sectional design was used, with four groups, OCD high MC (*n* =30), OCD low MC (*n* =38), a mixed anxiety sample (*n* =41) and non-clinical controls (*n* =62). Participants were identified according to appropriate Structured Clinical Interview for the DSM (SCID-5-RV) interview modules and completed online questionnaires. All clinical groups reported more betrayal events compared to non-clinical controls, though no differences were observed between clinical groups, suggesting experience of betrayal events was not specific to diagnoses. TAF and magical thinking were significantly higher in the OCD high MC group relative to the other groups. Regression analysis identified TAF and magical thinking as the strongest predictors of MC scores. Betrayal may be a disorder-relevant, but not disorder-specific experience that occurs trans-diagnostically. TAF and magical thinking may be both disorder specific and relevant in high MC OCD.

Key words: OCD, mental contamination, betrayal, trans-diagnostic

Obsessive-Compulsive Disorder (OCD) is characterised by obsessions and compulsions, but typically the presence of both. Obsessions are recurrent, persistent thoughts, urges, or images, that individuals experience as distressing. Compulsions are mental acts or repetitive behaviours individuals perform to prevent distress or possible feared outcome (American Psychological Association [APA], 2013). Lifetime prevalence rates of OCD are estimated to be 2-2.5% (Torres et al., 2006). Symptom severity is associated with functional impairment, affecting quality of life across a range of domains, including mental health, social relationships and activities of daily living (Coluccia et al., 2016; Eisen et al., 2006).

OCD can present as a clinically heterogeneous condition, leading some to suggest distinct subtypes based on obsessional themes, such as contamination, harm, morality and scrupulosity (McKay et al., 2004;Rachman, 1998). These subtypes respond similarly to CBT (Abramowitz et al., 2003), perhaps due to similarities in their psychological mechanism suggested by the cognitive model (Salkovskis, 1985). Two sets of symptoms have been definitively noted to be less responsive to standard CBT: firstly, hoarding, which is now categorised as a distinct disorder since DSM-5, and secondly, mental contamination (MC), still categorised as OCD (APA, 2013).

Rachman (2004) described MC as the subjective internal feeling of 'dirtiness' in the absence of contact with an external contaminant. Approximately 46% of individuals with OCD experience some MC, suggesting it is a common experience (Coughtrey et al., 2012). Experiences of MC can be evoked through cognitions alone, particularly by memories of being 'humiliated, deceived, violated or degraded by those whom they trusted' (Rachman et al., 2006). MC is generally less responsive to CBT/Exposure and Response Prevention (ERP), with effect sizes moving from large ($d = .80\text{-}1.0$) when treating OCD alone (McKay et al., 2015) to moderate when OCD and MC are both present ($d = .40\text{-} .60$; Warnock-Parkes et al., 2012). Thus treatment for OCD and MC may require adaptations, including an idiosyncratic formulation to include MC, experiences of betrayal (where relevant), cognitive elements including imagery rescripting for betrayal experiences, behavioural experiments focused around moral standards, and misattribution of anxiety as evidence of being contaminated (Warnock-Parkes et al., 2012; Coughtrey et al., 2013). Sensitivity to betrayal has been implicated as a likely causal factor issue in MC (Howkins et al., 2022). This may be because of experiences of actual betrayal, but this has not been established.

Role of Betrayal

Betrayal, defined as "*the sense of being harmed by the intentional actions or omissions of a trusted person"* is prevalent across mental health conditions (Rachman, 2010) including PTSD, anxiety and depression (Freyd et al., 2005; Platt & Freyd, 2012) , and particularly in the development of MC in the context of OCD (Rachman, 2006).One hypothesised mechanism linking betrayal and MC is the associations between betrayal experiences and feelings of humiliation and worthlessness, meaning individuals may avoid people or objects associated with the betrayal (Rachman et al., 2012). MC may stem from memories of past betrayal linking to feelings of internal dirtiness and contamination (Nielsen et al., 2024). Two strands of research have examined the link between MC and betrayal events: analogue studies in non-clinical samples and clinical studies.

Analogue Studies:

Analogue studies take a sample from the general population and induce the experience of MC using hypothetical imagery. For example, the "Dirty Kiss" paradigm had students imagine giving or receiving a consensual or non-consensual kiss to examine increased MC and the urge to wash (Elliott & Radomsky, 2013; Rachman et al., 2012). The non-consensual imagery resulted in higher levels of MC and stronger washing behaviours compared to the consensual kiss. Further manipulations involved imagining the perpetrator as moral or immoral (i.e., violated their trust); the immoral perpetrator led to high MC and washing urges. Results suggest betrayal experiences may contribute to feelings of MC. However, the ‘dirty kiss’ paradigm confounds physical contaminant (exchange of saliva) with betrayal aspect (non-consensual kiss), making unclear what triggers MC.

Millar et al. (2016) disentangled physical contamination from betrayal by using a non-consensual kiss or theft of a sentimental item by a friend (betrayal) or stranger. Betrayal levels were comparable, and only the imagined kiss evoked MC and the urge to wash, suggesting the physical contamination, not betrayal evoked MC in such studies.

Clinical Studies:

Although the experimental evidence for MC in student participants is called into doubt, questionnaire studies in clinical populations may indicate the importance of *sensitivity to betrayal*. Sensitivity to betrayal refers to heightened awareness of emotional response to the experiences of betrayal in interpersonal relationships. This variable is a predictor of MC and is disorder-specific to OCD when compared across individuals with depression, other anxiety disorders and non-clinical controls (Pagdin et al., 2021). Howkins, Millar, and Salkovskis (2022) found individuals with OCD and high MC report greater sensitivity to both *being betrayed* and *betraying others*, compared to those with low MC and OCD, depression and non-clinical controls. Individuals with high MC and OCD reported higher rumination and responsibility beliefs relative to all groups, suggesting a link between MC, betrayal sensitivity and their responsibility of betraying others. Similarly, French, Salkovskis, and Bream (2023) found increased levels of state MC and anxiety upon recalling autobiographical memories of betraying others and of being betrayed. This increase was greater in an OCD group relative to non-clinical controls. Although in clinical samples, evidence highlights the likely significance of *sensitivity* to betrayal and experiences of MC, we do not know whether individuals with high MC and OCD have experienced more *actual* betrayal events compared to those with low MC and OCD, and whether this is a key factor in the experience of sensitivity to betrayal.

The Howkins et al. (2022) and French et al. (2023) studies suggest a mechanism linking MC and betrayal, whereby the experience of being betrayed sensitises the vulnerable person to concerns about betraying others; they understand how betrayal feels and may not risk being responsible for doing this to others. An alternative possibility is a tendency towards “magical thinking” and/or thought-action fusion (TAF).

Magical thinking and thought-action fusion

Magical thinking refers to the belief that thoughts or actions can influence the world in ways that defy scientific laws; it is a significant predictor of OCD severity (Einstein & Menzies, 2004). TAF, a specific type of magical thinking, is prevalent in OCD. It refers to the belief that merely thinking about an event makes it more likely to occur (TAF-likelihood) or that thoughts are morally equivalent to actions (TAF- moral) (Shafran et al., 1996). In a non-clinical sample, TAF was associated with the experience of MC (Fergus & Rowatt, 2018). TAF may contribute to the maintence of MC, as individuals may believe thinking about experience of betrayal increases the likelihood of reoccurrence or makes them more likely to betray others, creating a heightened sense of responsibility (Rachman, 2006). Thus, the present study aims to evaluate the role of TAF and magical thinking in MC in a clinical sample.

Aims and hypotheses

The aim is to establish whether individuals with OCD and high levels of MC are more sensitive to being betrayed because of their experience of past betrayals. We address the prevalence of betrayal experiences across clinical populations (OCD and anxiety) and non-clinical controls to evaluate the *relevance* and *specificity* of perceived past betrayal in OCD and evaluate two other cognitive variables to the experience of MC: magical thinking and TAF.

Primary hypothesis

1. The OCD high MC group will report higher frequency of betrayal, particularly abusive betrayal types, compared to OCD low MC, other anxiety disorders and a non-clinical control.
2. The OCD high MC group will report greater lifetime impact of betrayal events relative to the other groups

Secondary hypothesis

1. The OCD high MC group will report higher levels of magical thinking and TAF relative to the other groups.

Method

Design

A cross-sectional between groups design was employed with four groups: OCD low MC, OCD high MC, mixed anxiety group (generalised anxiety and panic), and non-clinical control group. High and low MC grouping was determined by an enhanced VOCI-MC median split one standard error (SE) above or below.

Sample size

An a priori power calculation using G*Power was undertaken to determine sample size. There was no previous study to inform our effect size, therefore, we chose to ensure there was a small to moderate effect ($f = 0.2$), whilst ensuring significant power suitable for group-level analysis (.90). To ensure the sample was adequately powered for the planned regression analysis, we recruited 171 participants.

Participants

Participants were aged 18 years and above (no upper limit) based in the United Kingdom. Inclusion for the clinical groups required self-identification with one of three primary mental health concerns: OCD, generalised anxiety or panic disorder. Diagnosis was assessed using only the relevant sections of the SCID-5-RV module (subsection E and F), with brief screening questions regarding co-morbidity. Participants who reported that both OCD and another anxiety disorder were equally impactful were not invited to participate. The OCD group were specifically selected to ensure that they did not meet the criteria for Post-Traumatic Stress Disorder (PTSD); this was assessed during pre-screening by asking whether participants identified as having PTSD or reported related symptoms. Non-clinical controls were required to self-report having no current mental health difficulties and did not undertake a screening call. All participants required the capacity to consent to the study and ability to read the materials presented.

Exclusion criteria, irrespective of mental health difficulties, were participants unable to read or write English, a significant cognitive impairment, or moderate to severe learning disability.

Procedure

Expert by experience involvement

Key measures were piloted with an individual with lived experience of OCD. Feedback was obtained which resulted in improvements to the usability of the questionnaires.

Recruitment and procedure

Participants were recruited via mental health charities (OCD-UK, OCD Action, Anxiety UK, Triumph over Phobia, Maternal OCD), Facebook, X, Instagram and existing participant pools. Interested participants emailed the primary researchers (AL or TM) where a participant information sheet was provided. Potentially eligible participants undertook a screening call to establish the presence/absence of diagnostic criteria for clinical grouping. Oral consent was sought. Interviews were conducted with the researchers who were collecting data jointly, trainee clinical psychologists, TM or AL, who were trained to use the SCID-5-RV by an experienced researcher and clinical psychologist (PS).

Participants were assigned participant identification numbers and emailed a self-report demographic and psychological measures on Qualtrics (November 2024). All participants completed an online consent form at the beginning of the questionnaire and taken to a debrief/ signposting page at the end. The battery took approximately 30-40 minutes to complete.

Measures

Table 1

Questionnaire sequenced in order of use

Measures	Description
Structured Clinical Interview for the DSM- Research Version (SCID-5-RV; First, 2015)	The OCD, Panic Disorder and Generalised Anxiety Disorder (GAD) models of the SCID-5-RV was used to confirm diagnoses of OCD, Panic Disorder, and GAD, respectively based on DSM-5 criteria (yes/no).
The Patient Health Questionnaire-8 (PHQ-8;Kroenke et al., 2001)	An 8-item questionnaire measuring depression symptoms over the last two weeks. Items are scored on a 5-point rating scale (*0= not at all to 4= nearly every day*). Maximum score is 21, minimum score is 0. Higher scores indicated greater levels of depression. Optimal cut-off for identifying depression is >10. This measure has found to be valid with high levels of internal consistency (α = .83; Kroenke et al., 2001). Within this study internal consistency was found to be excellent α = .90.
The Generalised Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006)	A 7-item questionnaire measuring symptoms of generalised anxiety disorder over the last two weeks. Items are scored on a 4-point Likert scale from (*0= Not at all to 3= nearly every day*). Maximum score is 21, minimum score is 0. Higher scores indicate greater GAD scores. Optimal cut-off for identifying GAD is a score of >10. The GAD-7 has good internal consistency (α = .89) and test-

	retest reliability (Löwe et al., 2008). Within this study internal consistency was excellent α = .92.
The Work and Social Adjustment Scale (WSAS;Mundt et al., 2002)	A 5-item self-report measure, measuring functioning across work, home management, social and private leisure, and personal or family relations. Items are scored on a 9-point rating scale (*0= not at all to 8=very severely*). Maximum score is 40, minimum score is 0. Higher scores indicate a greater level of impairment. The WSAS has been found to has excellent internal consistency (α = .94;Mundt et al., 2002). Within this study the internal consistency was good α = .83.
Panic Disorder Severity Scale (PDSS; Shear et al., 1997)	A 7-Item questionnaire that rates the severity of panic symptoms over the past week. Items are scored on a 5-point Likert scale (*0= no interference to 4= extreme impairment*). Maximum score is 28, minimum score is 0. Optimal cut-off for identifying panic disorder is a score of > 9. The PDSS demonstrate good reliability, validity and internal consistency (Houck et al., 2002).Within this study the internal consistency was excellent α = .94

Obsessive-compulsive Inventory-Revised (OCI-R; Foa et al., 1998)	An 18-item self-report measure that assess OCD symptomatology and severity over the past month. There are six subscales: checking, washing, ordering, obsessing, hording, counting and neutralising. Items are scored on a 5-point Likert scale (*0=not at all to 4= extremely*). Maximum score is 72, minimum score is 0. Higher scores indicate greater OCD severity. Optimal cut-off for identifying OCD is a score of ≥21. The OCI has excellent internal consistency (α = .92), test-retest reliability and convergent validity (Foa et al., 2002).Within this study the internal consistency was excellent α = .93.
Hypothesis Measures	
Betrayal Screening Measure (BSM-Self; Millar & Salkovskis, in prep)	A 21-item self-report questionnaire which asks participants to rate if they have been a victim of a betrayal on a yes/no scale. Seven betrayal types are included: acts of infidelity, disloyalty, disclosure of confidential information, deceptions, sexually inappropriate behaviour, aggressive/threaten behaviour and failure to be helped. There are two subscales based on the types of betrayals: *dismissive* (disclosure of confidential information, disloyalty and deception) and *abusive* (infidelity, aggression, failure to be helped, sexually inappropriate behaviour). It measures total occurrence, age of event, and the impact of this betrayal at the time that it occurred and over the course of their life measured on a scale *0= no impact to 100= strong impact.*

The Vancouver Obsessional Compulsive Inventory- Mental Contamination (VOCI-MC; Rachman, 2005)	A 20-item scale used to assess mental contamination. Items are scored on a five-point Likert scale (*0=not at all to 4= very much*). Maximum score is 80, minimum score is 0. No diagnostic cut-offs are currently utilised. Higher scores on the VOCI-MC indicate higher experiences of mental contamination. The VOCI-MC demonstrates excellent internal consistency (α =0.94; Rachman, 2006). Within this study, there was also excellent internal consistency α = .97.
Thought- Action Fusion Scale (TAFS; Shafran et al., 1996)	A 19-item questionnaire that measures thought-action fusion. Three subscales: TAF- likelihood self, TAF- likelihood others and TAF moral. Items are rated on a 5-point scale (*0= strongly disagree to 4= strongly agree*) Maximum score 76, minimum score 0. Higher scores indicate a stronger tendency towards thought-action-fusion like cognition. The TAFS shows high levels on internal consistency and reliability (α = .92; Shafran et al., 1996). Within this study there was excellent internal consistency α = .95.
Magical Ideation Scale (MIS; Eckblad & Chapman, 1983)	A 30-item true-false questionnaire exploring a number of magical influences such as thought transmission, spirit influences, astrology, good luck charms, and psychic energy.

	Total score ranges from 0 to 30 with higher scores indicating greater levels of magical ideation. The MIS demonstrates good internal consistency (α = .84, Eckblad & Chapman, 1983). Within this study, internal consistency was slightly lower than other questionnaires but still acceptable α = .72.

Ethical Considerations

Ethical approval was obtained from The University of Oxford Research Ethics Committee (R89339/RE001). Participants provided informed consent and were reminded of their right to withdraw.

No adverse consequences were noted throughout the study. Regular research supervision with two qualified psychologists (PS & SF) allowed for discussion of concerns regarding group membership or risk concerns.

Results

Data analysis

Demographic and descriptive data were analysed to characterise the sample, followed by analysis of the primary and secondary hypotheses. All analyses were performed using IBM SPSS Statistics V30. Significance thresholds were set to <=.05.

The number of participants in each analysis varied slightly due to different data, particularly within the secondary analysis. Thus, the degrees of freedom (*df*) differ based on the number of participants who completed all relevant measures.

Treatment of data

Data was normally distributed therefore parametric tests were used. A number of non-clinical controls did not complete all the questionnaires (*n* =18). Participants were included within the primary analysis if they completed the BSM questionnaire (*N*=171) to ensure sufficient power. For the regression analysis, only participants who completed all questionnaires were included (*n*=153).

One participant from the OCD group, despite meeting clinical criteria for OCD, scored only 3 on the OCI and below the clinical threshold for the GAD and PHQ-9. This participant was considered subclinical and was removed prior to analyses.

It was decided *a priori* that low and high MC would be differentiated by the VOCI-MC scores using an enhanced median split to create two groups. The median score within the data set was 30 and therefore the division between the high MC and low MC were the SE above and below this, individuals with OCD scoring between < 28 and > 31 were removed (*n* =2).

The main analyses were conducted using a 4X2 mixed model ANOVA; between subject factor (group membership: OCD high MC, OCD low MC, anxiety and non-clinical controls); within subject factors (BSM: abusive vs dismissive betrayal events).

Final Sample

The final sample consists of 171 participants: OCD high MC (*n* =30), OCD low MC group (*n* =38), anxiety (*n* =41) and non-clinical controls (*n* = 62).

Sample Characteristics

Demographic information of participants based on group is shown in Table 2. A one-way analysis of variance (ANOVA) with appropriate post hoc comparisons was employed for comparisons between groups with age as the dependent variable.

The ANOVA revealed a significant main effect of group on age ($F_{(3,167)} = 4.12$, p=.008). Levene's test indicated unequal homogeneity of variance ($F_{(3, 167)} = 4.92$, $p = .003$) and therefore Dunnet T3 was used for pairwise comparisons. Post hoc analysis revealed the anxiety sample was significantly younger than the non-clinical controls (p=. 019). The non-clinical controls were also significantly older than the OCD high MC group (p= .038). No other pairwise comparisons were statistically significant.

Chi-square analyses were used to examine difference in demographic variables between group membership (OCD high MC, OCD low MC, anxiety and non-clinical controls). There were no significant differences between the groups based on employment status ($\chi^2_{(4)} = 5.33$, p=.255), relationship status ($\chi^2_{(4)}$= 4.50, p=.343), ethnicity ($\chi^2_{(4)} = 1.09$, p=.90). There was a significant difference in level of education ($\chi^2_{(4)} = 21.98$, p=.005). Partitioned Chi-square analyses, revealed that the anxiety group were more likely to have only completed up to primary school compared to the high OCD MC group ($\chi^2_{(2)} = 6.19$, p = .045), low OCD MC group ($\chi^2_{(2)} = 7.12$, p = .028) and non-clinical controls ($\chi^2_{(2)} = 5.79$, p = .055). No significant association were found between education and any other clinical group ($p < .05$).

Table 2

Sample characteristics of participants

	†† OCD high MC Group Total: *n*= 30 *N* (%)	†† OCD low MC Group Total: *n*= 38 *N* (%)	Anxiety Group Total: *n*=41 *N* (%)	Non-clinical Controls Total: *n*= 62 *N* (%)
Age *M (SD*)	38.13 (11.64) ^{a}	44.05 (15.01) $^{a, b}$	37.27 (13.97) ^{a}	47.00 (18.56) ^{b}
Sex at birth				
Female	24 (80.00%)	29 (76.3%)	34 (82.9%)	51 (82.3%)
Male	6 (20.00%)	9 (23.7%)	7 (17.1%)	11 (17.7%)
Ethnicity†				
White British	26 (88.7%)	32 (84.2%)	32 (78.0%)	51 (82.3%)
Any other white background	2 (6.7%)	3 (7.9%)	4 (9.8%)	6 (9.7%)
Mixed/multiple ethnic groups	0 (0%)	3 (7.9%)	1(2.4%)	0 (0%)
Asian/Asian British	2 (6.7%)	0 (0%)	3 (7.3%)	3 (4.8%)

Black/ African. Caribbean/ Black British	0 (0%)	0 (0%)	1 (2.4%)	0 (0%)
Other ethnic group	0 (0%)	0 (0%)	0 (0%)	2 (3.2%)
Highest level of education †				
Primary school	0 (0%)	0 (0%)	2 (4.9%)	0 (0%)
Secondary school	7 (23.3%)	9 (23.7%)	19 (46.3%)	20 (32.3%)
University degree	12 (40.0%)	14 (36.8%)	11 (26.8%)	19 (30.6%)
Postgraduate degree	11 (36.7%)	15 (39.5%)	9 (22.0%)	23 (37.1%)
Work status †				
Unemployed	6 (20.0%)	2 (5.3%)	7 (17.1%)	1 (1.6%)
Employed full-time	16 (53.3%)	18 (47.4%)	18 (43.9%)	28 (45.2%)
Employed part-time	6 (20.0%)	13 (34.2%)	8 (19.5%)	10 (16.1%)
Retired	1 (3.3%)	3 (7.9%)	1 (2.4%)	14 (22.6%)
Choose not to be employed	0 (0.0%)	0 (0.0%)	2 (4.9%)	4 (6.5%)
Student	1 (3.3%)	5 (5.3%)	5 (12.2%)	5 (8.1%)
Civic status †				

Single	12 (40.0%)	11 (28.9%)	20 (48.8%)	15 (24.2%)
Living with partner	8 (26.7%)	7 (18.4%)	10 (24.4%)	15 (24.2%)
Married	8 (26.7%)	13 (34.2%)	9 (22.0%)	26 (41.9%)
Divorced or separated	2 (6.7%)	6 (15.8%)	2 (4.9%)	4 (6.5%)
Widowed	0 (0.0%)	1 (2.6%)	0 (0.0%)	2 (3.2%)

Note. ^{abc} Groups with different letters are significantly different from each other ($p < .05$).

†Due to small cell sizes a chi-squared analysis could not be computed for *work status* (groups as employed, not in employment,), *ethnicity* (grouped as White/ Mixed White and Other ethnic minority group) and *civic status* (married/ living with partner and single/divorced/ widowed) *education* (up to primary education, secondary education completed, university/postgraduate completed)
††Does not include two excluded participants from the OCD sample (n =2)

Descriptive psychopathology

One-way analyses of variance (ANOVA) compared the groups across the descriptive psychopathology measures shown in Table 3, with post hoc comparisons exploring group differences. A significant main effect of group was found in GAD-7 ($F_{(3,167)} = 50.36, p < .001$), PHQ ($F_{(3, 167)} = 34.92, p < .001$), PDSS ($F_{(3,167)} = 21.20, p < .001$). Appropriate post-hoc tests were undertaken and showed non-clinical controls were significantly different from all clinical groups ($p < .001$). A significant main effect of group was found in WSAS ($F_{(2, 106)} = 9.91, p < .001$), which was accounted for by higher scores in the OCD MC group.

A mixed-model ANOVA was conducted for the OCI subscales (Washing, Checking, Neutralising, Ordering, Obsessing) across the four groups. The ANOVA showed a main effect off subscale type ($F_{(4, 668)} = 35.84, p < .001$), and for group ($F_{(3,167)} = 5.014, p = .002$). These were modified by an interaction between OCI subscale and diagnostic group ($F_{(12, 668)} = 4.78$, $p < .001$) indicating patterns of symptoms differed across each diagnostic group; see table 3.

Table 3

Descriptive measures scores by group

	OCD high MC Group *n*=30 M (SD)	OCD low MC Group *n*=38 M (SD)	Anxiety Group *n*=41 M (SD)	Non-clinical Controls *n*=62 M (SD)
PHQ-9	14.30 (5.53) ^{a}	8.95 (5.31) ^{b}	12.27 (5.69) ^{a,b}	4.27 (4.09) ^{c}
GAD-7	15.36 (4.73) ^{a}	9.76 (4.76) ^{b}	11.78 (5.23) ^{b}	3.60 (4.31) ^{c}
PDSS	15.86 (6.20) ^{a}	11.92 (5.14) ^{b}	15.02 (6.20) $^{a, b}$	7.48 (3.67) ^{c}
WSAS	25.13 (9.36) ^{a}	15.61(7.61) ^{b}	20.07 (9.30) ^{b}	N/A
VOCI-MC†	50.8 (11.86)	10.38 (8.55)	13.19 (15.11)	5.32 (10.81)
OCI Total	41.43 (13.76)	27.47(11.92)	19.9 (13.68)	9.5 (10.98)
OCI subscales				
Washing	7.96 (3.55) ^{a}	4.09 (4.23) ^{b}	2.66 (3.58) $^{b, c}$	1.05(2.34) ^{c}
Checking	6.66 (3.52) ^{a}	5.55 (3.46) ^{a}	3.12 (2.69) ^{b}	1.25 (1.86) ^{c}
Neutralising	5.63 (4.39) ^{a}	3.24 (3.61) ^{a}	1.51 (2.47) ^{b}	.9 (1.95) ^{c}
Ordering	6.80 (3.38) ^{a}	4.13 (3.47) ^{b}	3.51 (3.68) $^{b, c}$	2.32 (2.44) ^{c}
Obsessing	9.87 (2.93) ^{a}	7.32 (3.21) ^{b}	5.78 (3.60) ^{b}	1.82 (3.05) ^{c}

Note. ^{abc} Groups with different superscripts horizontally are significantly different on multiple comparison ($p < .05$).
†VOCI-MC available for *n* =49 in non-clinical controls. OCD subgroups were separated on this variable a priori.

Main analysis

Experience of Betrayal

A betrayal score was calculated for each of the respective betrayal types, abusive and dismissive, to ascertain if a person had experienced this, or not, creating a total score of 1 for each betrayal. The main effect of mean *occurrence* of betrayal *type* (abusive vs dismissive) is significant ($F_{(1,167)}$= 47.06, $p < .001$), as was the main effect of group ($F_{(3, 167)} = 6.84$, $p < .001$) however the interaction between betrayal type and group was not significant ($F_{(3,167)}$=.03, p=.992), suggesting the effect of betrayal type is not dependent on group. Homogeneity of variance was not violated ($F_{(3, 167)} = 1.09$, $p = .355$). Tukey post hoc comparisons showed non-clinical controls reported significantly lower betrayal occurrence compared to the high MC anxiety group (p= .004) and the anxiety group ($p <.001$). There was no significant difference found between the low OCD MC group and any other group ($p >.05$). No significant difference between the anxiety group and high MC group (p =.999). Overall, participants in anxiety and OCD high MC groups reported a significantly higher total betrayal occurrence. There was a significant difference between the high OCD MC group than non-clinical control, but no difference from OCD low MC.

Betrayal total occurrences

A mixed model ANOVA was conducted, with betrayal type (abusive vs dismissive) as the within subject variable and group as between-subjects factor. The main effect of betrayal type was significant ($F_{(3, 166)}$= 49.01, p < .001) as was the main effect of group ($F_{(3,166)}$=8.45, $p <.001$). There was no significant interaction effect ($F_{(3, 166)}$= 1.75, p=.159). Levene test of homogeneity was significant indicating violation of the assumption of equal variance ($F_{(3, 166)} = 6.35$, $p < .001$). Therefore, Dunnet T3 post hoc comparisons showed non-clinical controls were significantly different to OCD low MC (p =.048), high MC (p=.004) and anxiety group ($p < .001$). No significant differences were observed between clinical groups ($p >.05$).

Betrayal impact at time of occurrence

The main effect of mean betrayal impact at time of occurrence was significant ($F_{(1, 167)} = 38.73, p < .001$) as was the main effect of group ($F_{(3, 167)} = 7.79, p < .001$). The interaction effect predicted by the hypothesis was not ($F_{(3, 167)} = 0.49, p = .688$). Homogeneity of variance was not violated $F_{(3, 166)} = .305, p=.822$. Tukey post-hoc comparisons revealed a significant difference between the OCD high MC ($p <.001$) and anxiety groups ($p <.001$) compared to the non-clinical controls, but no significant difference between these groups and the low MC, or between the non-clinical control and low MC ($p=.059$).

Betrayal impact across lifetime

The main effect of betrayal lifetime impact was significant ($F_{(1, 167)} = 35.34, p < .001$) as was the main effect of group ($F_{(3, 167)} = 12.25, p < .001$); the interaction effect was not significant ($F_{(3, 167)} = 2.52, p= .059$) . Homogeneity of variance was not violated ($F_{(3, 167)} = 1.783, p=.152$). Tukey HSD post hoc comparisons found non-clinical controls were significantly different than OCD low MC ($p=.026$), anxiety ($p <.001$) and OCD high MC ($p < .001$). There was no significant difference in lifetime betrayal impact across the clinical groups ($p >.05$)

Table 4

Betrayal Screening measure by group

	OCD high MC Group	OCD low MC Group *n*= 38	Anxiety Group *n*= 41	Non-clinical Controls *n*= 62

	n=30			
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*
Experience of Betrayal †				
Dismissive	.66 (.36)	.57 (.36)	.67 (.35)	.42 (.38)
Abusive	.48 (.35)	.40 (.37)	.49 (.33)	.25 (.31)
Total mean experience of betrayal	1.15 (.62) ^{a}	.97 (.67) $^{a, b}$	1.17 (.59) ^{a}	.67 (.61) ^{b}
Betrayal total occurrence				
Dismissive	7.33 (6.28)	6.05 (6.14)	8.15 (7.02)	3.03 (4.33)
Abusive	4.15 (4.65)	3.36 (3.96)	4.88 (4.73)	1.66 (3.05)
Total mean betrayal occurrence	11.48 (9.10) ^{a}	9.37 (9.26) ^{a}	13.03 (11.16) ^{a}	4.68 (6.47) ^{b}
Betrayal impact at the time				
Dismissive:	54.67 (30.96)	45.79 (31.92)	53.17 (33.23)	28.58 (29.22)
Abusive	41.08 (29.44)	31.71 (28.74)	40.37 (28.69)	20.50 (26.86)
Total mean impact at time	95.75 ^{a} (53.87)	77.5 (56.75) ^{a,b}	93.54 (55.08) ^{a}	49.45 (51.04)^{b}
Betrayal lifetime impact				
Dismissive	52. (41.10)	35.61 (30.19)	47.80 (30.58)	19.34 (22.98)

Abusive	34.08 (26.16)	27.24 (28.01)	36.89 (27.04)	15.16 (21.30)
Total mean lifetime impact	86.08 ^{a} (49.16)	62.85 (55.39) ^{a}	84.70 (50.11) ^{a}	34.76 (40.52) ^{b}

Note. †Experience of betrayal was calculated to create a score of 1 for each respective type (abusive and dismissive), indicating whether this had occurred or not.
^{abc} Groups with different superscripts horizontally are significantly different on multiple comparison ($p < .05$).

Secondary Analysis: Magical thinking and Thought-Action-Fusion

A one-way ANOVA between groups was conducted to examine the effect of group on magical thinking. Results show a significant main effect of group ($F_{(3,148)}$=8.41, p <.001). Levene’s test indicated violation of the assumption of homogeneity of variance $F_{(3, 148)} = 4.36$ p=.006. Tukey post hoc comparisons revealed the OCD high MC group had significantly higher magical ideation scores relative to all other groups (p <.001). No significant different were found between other groups (p >.05).

A mixed-model ANOVA was conducted to examine the effects of the TAF subscales (moral, likelihood-other, likelihood-self) x group. To do this each subscale was totalled and then divided by the number of items to provide comparability. Mauchly test indicated the assumption of sphericity was violated for the TAF subscale ($\chi^2_{(2)}$=13.005, p=.001). Greenhouse- Geisser correction was applied. The main effect of subscale was not significant ($F_{(1.85, 276.86)} = 2.71$, $p = .072$), nor was the interaction effect ($F_{(5.54, 276.86)} = 1.22$, $p = .300$). The main effect of group was however significant ($F_{(3,150)} = 19.944$, $p < .001$). Homogeneity of variance was not violated ($F_{(3,\ 150)}$ =2.62, p=.053), Tukey post hoc comparisons again found significant difference between OCD high MC (p <.001) and all other groups, and no significant different across those groups.

Table 5

Magical thinking and TAF scores by group

Measure	OCD high MC Group *n*=30 *M (SD)*	OCD low MC Group *n*=33 *M (SD)*	Anxiety Group *n*=41 *M (SD)*	Non-clinical Controls *n*=49 *M (SD)*
Magical Ideation Scale	11.20 (6.03) [a]	6.91 (3.34) [b]	7.37 (4.03) [b]	6.21 (4.30) [b]
TAF-moral	2.37 (.92)	1.60 (.74)	1.29 (1.08)	1.06 (.89)
TAF-likelihood self	2.39 (1.13)	1.33 (1.25)	1.15 (1.26)	.82(1.08)
TAF-likelihood others	2.48 (1.22)	1.46 (.85)	.85 (1.07)	.71(1.03)
TAF total mean	45.50 (17.17) [a]	29.08 (16.27) [b]	22.34 (27.14) [b,c]	17.96 (13.35) [b,c]

Note. TAF=Thought-action Fusion. Subscale mean presented to provide comparability.
[abc] Groups with different letters are significantly different (p < .05)

Hierarchical multiple regression analysis was used with MC as the dependent variable, and experience of betrayal, lifetime impact of betrayal, magical thinking and TAF (Table 6). Data met collinearity requirements. At step 1, experience of betrayal significantly contributed to the regression model ($F_{(2,\ 148)}$=9.28, p=.001), initially accounting for 11.1% of the variance in MC scores (R^2=.111). Experience of dismissive betrayal events were significantly associated with MC (β =.28, t = 2.80, p=.006). At step 2, inclusion of lifetime betrayal impact contributed an additional 8.1% of the variance ($F_{(2, 146)}$=8.69, p=.001). Lifetime impact of dismissive betrayal events scores was a significator predictor, β =.39, t = 3.05, p <0.01. Finally, at step 3, magical thinking (β =.20, t = 2.64, p=.009) and TAF (β =.39, t = 5.18, p=.001) were significantly associated with MC scores. The model remained significant ($F_{(2, 144)}$=18.90, p=.001), contributing an additional 24.8% amount of variance (ΔR^2=.248.) The full model accounted for 44.1% of the variance in MC scores, but with magical thinking and TAF being the only remaining significant independent variables.

Table 6

Multiple regression results for betrayal events, impact of betrayal events, TAF and magical thinking predicting VOCI-MC scores

	Variable	β	t	R	R^2	ΔR^2	R^2 Change	p
Step 1	Experience of Betrayal: abusive	.07	.70	.33	.11	-	.111	0.49
	Experience of Betrayal: dismissive	.28	2.80**					0.006
Step 2	Experience of Betrayal: abusive	-.04	-.31	.44	.19	.08	.08	.76
	Experience of Betrayal: dismissive	.03	.26					.80
	Lifetime impact: abusive	.06	.50					.62

	Lifetime impact: dismissive	.39	3.05**					.003
Step 3	Experience of Betrayal: abusive	-.10	-1.01	.66	.44	.25	.25	.314
	Experience of Betrayal: dismissive	.11	1.04					.30
	Lifetime impact: abusive	.19	.94					.36
	Lifetime impact: dismissive	.20	1.73					.08
	Magical Thinking	.20	2.64**					.009
	TAF	.39	5.18***					<0.001

Note. *N*=151, **p* <.05, ***p* <.01, ****p* <.001

Discussion

The study aimed to examine whether high levels of MC in OCD are linked to the self-reported occurrence of historical betrayal events and ascertain the possible contribution of magical thinking and TAF within the experience of MC. We also wanted to make a comparison with people who meet clinical criteria for non-OCD anxiety disorders to understand the relative contribution of betrayal experiences to MC. The results indicated all clinical groups reported higher levels of betrayal experiences relative to non-clinical controls, but this was not specific to OCD high MC or OCD itself. Contrary to expectations, there were no differences in the relative occurrence of betrayal type dependent on group. OCD participants with high levels of MC were significantly more likely to endorse magical thinking and thought-action-fusion. In an exploratory analysis both magical thinking and thought-action-fusion were better predictors of MC than the betrayal experience variables.

The findings generally align with previous literature regarding the relevance of the experience of betrayal events (French et al., 2023; Millar et al., 2016) but do not indicate diagnostic specificity. Previous literature suggests individuals with high MC report higher sensitivity to betrayal, which is relevant to the experience of MC (Howkins et al., 2022). We hypothesised that betrayal -particularly abusive forms- would be more prevalent in individuals with OCD and high MC.

Experiences of dismissive betrayal were reported more frequently across all clinical groups compared to non-clinical controls. Severe interpersonal traumas such as sexual and physical assault, categorised as abusive betrayal within the BSM, are considered to be associated with more severe mental health consequences (i.e. PTSD, OCD, substance misuse)(Dugal et al., 2016; Jordan et al., 2010; Rioli et al., 2017).The current findings show experiences of dismissive, rather than abusive betrayal events, predicting MC scores in the regression analysis. Perhaps, the cumulative impact of exposure to these dismissive betrayals, may impact the ability to form trusting relationships, creating a possible preoccupation with betrayal.

These findings suggest the experience of MC is not simply a product of more betrayal experiences, but that a range of psychological factors are relevant, particularly magical thinking and TAF. TAF is a well-documented cognitive distortion in OCD (Berle & Starcevic, 2005; Shafran et al., 1996); in the present study, individuals with OCD with high MC reported high levels of TAF relative to non-clinical control and the other clinical groups. Findings suggest the experience of TAF may be important in the development/maintenance of

MC; clinically, this suggests targeting cognitive distortions could improve treatment for those experiencing MC.

Limitations

The use of retrospective self-report measures of betrayal, such as the BSM, introduces the possibility of recall bias, as emotional states can distort recall and interpretation of past betrayal events (Brewin et al., 1993; Hardt & Rutter, 2004). Individuals with OCD and anxiety may be prone to perceiving past events, particularly those associated with responsibility, as distressing and threatening (Sookman & Pinard, 2002). Longitudinal research would help mitigate recall bias. The validation of the BSM has been carried out but is not yet published.

Furthermore, the VOCI-MC has not undergone a factor analysis as part of its validation, which raises concerns about the extent to which its specifically assesses the construct of mental contamination. This ambiguity limits the scales construct validity. The high VOCI-MC scores were associated with more severe OCD symptomatology, which could indicate that the higher MC group may reflect those within more severe OCD rather than identifying those with high MC. A factorial analysis would clarify the interpretability of the VOCI-MC.

Research Implications

This study highlights options for future research. Experience of betrayal is likely *disorder-relevant* but not *disorder-specific* for OCD involving MC. Understanding the moderating impact of betrayal events to sensitivity to betrayal and MC is needed. Qualitative research with individuals with OCD and MC who have experienced varying degrees of betrayal may provide more nuanced understanding of the meanings attributed to betrayal. This should generate further hypotheses for quantitative investigation.

TAF and magical thinking were particularly strongly related to MC scores compared to betrayal events; this variable should be investigated as a possible driver of the impact of betrayal events. For example, utilising thought-action fusion induction tasks with general vs betrayal content.

Clinical implications

Experiences of betrayal are present across mental health difficulties and may impact abilities to form trusting relationships in CBT. Ensuring that betrayal issues and MC are addressed within the formulation may enhance the effectiveness of such treatment.

TAF and magical thinking are key cognitive distortions highly present within individuals with MC and an important target for treatment. Therapy may test the idea that thoughts are causally linked with actions via behavioural experiments specifically considering MC.

Conclusion

Betrayal events are universally experienced but may be particularly prevalent in individuals with mental health difficulties. Those with high levels of MC did not report more betrayal events, suggesting it is not the frequency of betrayal events *per se* that determines the experience of MC. There appears to be a strong association between MC and TAF.

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Executive summary

Word count: 505

Background: Mental contamination (MC) is a subjective feeling of internal dirtiness without contact with a physical contaminant; meaning, thoughts can induce the feeling of MC. MC is well documented across individuals with obsessive-compulsive disorder (OCD), with approximately 46% of individuals with OCD experiencing it. When MC and OCD co-occur, treatment outcomes are typically poorer than standard Cognitive Behavioural Therapy (CBT) treatment for OCD. Previous research has suggested that the experience of betrayal and sensitivity to betrayal may play a role in MC. It remains unclear whether individuals with high MC and OCD have experienced more betrayal events compared to other clinical groups and if this may be contributing to the MC symptoms.

Aims: This study aimed to investigate whether individuals with OCD and high levels of MC self-report more betrayal events (abusive and dismissive events as categorised by the Betrayal Screening Measure), compared to those with OCD and low MC, individuals with other anxiety disorders, and non-clinical controls. We were also interested to see if they had experienced more 'abusive' betrayal events compared to the other groups and to understand the impact of such events. Finally, we examined whether Thought-Action-Fusion (TAF) and magical thinking, which are commonly observed cognitive distortions in OCD, may contribute to MC symptoms.

Methods: A cross-sectional online study was used with a sample of 171 participants across four groups: OCD with high MC (*n* = 30), OCD with low MC (*n* = 38), other anxiety disorders *(n* = 41), and non-clinical controls (*n* = 62). Participants were recruited via social media, charities and existing research pools. Before taking part, individuals completed the Structured Clinical Interview with one of the primary researchers to check they met the diagnostic criteria for the clinical group, then completed online measures.

Findings: Betrayal experiences were significantly higher across all clinical groups compared to the non-clinical controls, however, there were no differences in frequency of events across the groups. Dismissive betrayal, rather than abusive betrayals, was more common across all groups. There was no difference in the lifetime impact of these betrayal events between clinical groups. Individuals with OCD and high MC reported significantly higher levels of TAF and magical thinking relative to all groups. These two variables were also the strongest predictors of MC, compared to experience of betrayal and lifetime betrayal impact.

Conclusion: The results suggest that betrayal experiences are present across clinical populations; they are not specific to MC or OCD, suggesting betrayal events are disorder-relevant, not disorder-specific. It also implies that it is not the frequency of betrayal events that is relevant to MC. The novel finding is the role of TAF and magical thinking, which was significantly higher in the high MC group relative to the others. This suggests that it may be cognitive mechanisms that are more closely tied to the experience of MC. This research has important implications for therapy, highlighting treatment targets for clinicians, such as addressing TAF and magical thinking. Future research is needed to understand the mechanism underpinning MC and the role of TAF and magical thinking.

Connecting narrative

Word Count: 974

All three projects span across areas of my clinical interest and allowed the opportunity to utilise a range of methodological approaches. A common thread that draws these projects together is the consideration of individuals who have complex mental health difficulties and therefore may not fit into a single diagnostic criterion. These individuals are frequently underrepresented clinically and within research. Contributing to the evidence-base across these domains has highlighted the need for formulation-led interventions that not only consider the individual but also the wider systemic context in which they are situated.

My SRL and TDRP examine OCD and hoarding (HD); these are linked by their classification under the obsessive-compulsive related disorders within the DSM-5. Previously, hoarding was conceptualised as a form of OCD, but more recently has been redefined as a distinct disorder. Both the presence of OCD with mental contamination (MC) and hoarding disorder have poorer treatment outcomes in Cognitive Behavioural Therapy (CBT). Further evidence is required to understand what adaptation to typical treatment is needed to improve treatment outcomes. Both papers begin to understand the mechanisms underpinning MC and HD supporting with possible treatment targets.

Each project has developed different skills, which have contributed to my ability to design, conduct and synthesise research. Clinical psychologists utilise these research skills to improve existing evidence-based treatments. These projects have highlighted how psychologists can support individuals who may present with co-morbid mental health difficulties and have a range of systemic or interpersonal factors that are maintaining their difficulties. Clinically, this raises questions about which difficulty should be prioritised within treatment, and how psychologists work when problems are multifaceted. Two projects, the SRL and TDRP, also discuss transdiagnostic factors across OCD and HD and ascertain if a variable is disorder-*relevant* or *disorder-specific*, helping to understand the specificity of certain variables and their relevance within formulations.

These projects also have parallels to the clinical experience I have gained while training. In particular my final year placement in a service for young people who do not meet criteria for CAMHS due to high levels of complexity, and co-morbid mental health presentations. This draws together theory and practice and the need for clinicians to be flexible, adapting treatment in order to translate research into clinical practice.

SRL

For my systematic review, I aimed to understand HD which is often portrayed within the media but is associated with high levels of stigma and taboo. I had limited understanding of the psychological theory underpinning the disorder but was drawn to the idea of social context, and how interpersonal factors may '*keep problems going'* but also be '*part of the solution'*.

The SRL was particularly challenging as I was drawing evidence from three different interpersonal variables, with a large variation within each construct. For example, the variable social support is conceptualised by received support, perceived support and network size. Synthetising the data into a clear narrative whilst acknowledging the range of measures used was difficult. Reading and extracting data from different papers utilising different data analytic plans, enhanced my understanding of research methodology and my ability to critically appraise evidence.

SIP

The idea for my SIP stemmed from observations prior to training: young people within CAMHS are frequently moved between teams and often are unclear regarding which team they are under, and what support they are waiting to receive. When discussing this with an internal supervisor and a service manager in a regional CAMH service, they too shared this clinical observation. Nationally, there is a focus on increasing access to CYP mental health services, leading to a transformation in CAMHS structure. It was crucial to hear the voice of YP and their families to understand their experience of transitions, to further support changes within the wider service.

The service was supportive of the project's aims, providing vouchers for YP to participate. Recruiting YP was challenging. I reflected that parents and CYP with mental health difficulties, navigating a transition, may have found engaging in research too overwhelming. Despite the initial difficulties with recruitment, I met my recruitment target, the results produced clear, meaningful service recommendations.

TDRP

OCD had been a strong clinical interest prior to training; I was keen to pursue research in this area. OCD is a relatively well-studied disorder; however, I had been introduced to the concept of mental contamination (MC), which significantly impacts treatment yet was relatively misunderstood. I became particularly interested in how other variables, such as TAF and magical thinking, which are highly prevalent in OCD, may relate to MC.

To support recruitment, I partnered with several OCD charities and advertised on social media. Initially, I was apprehensive that individuals would not be interested in participating in research due to its time-consuming nature. However, individuals with both anxiety and OCD were keen to share their experience and participate, despite not receiving any compensation. This reflects the OCD's/ anxiety community's dedication to working alongside researchers to help develop the evidence-base by sharing their lived experience.

Conclusions

My three projects focus on populations with limited research, representing individuals who do not fit within typical diagnostic criteria. These projects reflect my clinical experience within the NHS. Increasingly, we are supporting people with complex mental health difficulties where the evidence-base may be limited, or only just emerging. These projects highlight the necessity for clinicians to take a formulation-led approach and to understand the meaning of experiences for a client. Understanding how individuals interpret, process, and make meaning from their experiences is central to the therapeutic process.

Furthermore, it raises the importance of comprehensive assessments and formulations to consider wider transdiagnostic variables that may be maintaining difficulties. These projects have supported my journey as an evidence-based clinical psychologist and provided a wealth of experience in understanding research methodology which will improve my clinical practice. I hope that these findings make relevant contributions to the growing evidence-base. I look forward to disseminating these results.

Acknowledgements

I would like to express my gratitude to my supervisors, Professor Paul Salkovskis, Dr Joanna Adams, Dr Emily Reeves, Dr Neil Carrigan and Dr Sam French, for their unwavering support over the past three years. I've appreciated your thoughtful comments and clinical, expertise which have helped grow my research skills. A special thanks to Professor Paul for supporting me with two projects and always being willing to read another draft! And to Dr Joanna Adams, my course tutor, thanks for all your guidance, time and support throughout training.

To Amy Lunn, my research partner and friend, it has been a joy working alongside you on these projects. Thanks for always being there, no matter the time! To my cohort, it has been a pleasure working alongside a group of passionate trainees. I'm especially grateful for all the wonderful friendships I've made along the way.

I would like to thank all the participants who kindly gave their time and effort to for these research projects. This research would not have been possible without you, and I'm grateful that you shared your experiences with me.

To my placement supervisors, thank you for helping to shape me into the psychologist I am today. I've learnt so much from each of you, and it has been a privilege to work within your teams.

To Brandon, my partner, thank you for being you. Your constant love, encouragement and knowing how to make me laugh when I need it most has meant so much to me.

To my family, Orlea, Flynn, and Dad, for your support over the last three years and cheering me on no matter how stressed I've been! And finally, to my Mum, I wouldn't be

here without your love and unfaltering belief in me. Thank you for always being a listening ear, chief proofreader and my biggest supporter. I hope I’ve made you all proud.

Appendices

Appendix A: SRL: Journal Guidelines

For full journal guidance, please see: https://www.sciencedirect.com/journal/journal-of-obsessive-compulsive-and-related-disorders/publish/guide-for-authors

Aims and scope

Journal of Obsessive-Compulsive and Related Disorders (JOCRD) is an international journal that publishes high quality research and clinically-oriented articles dealing with all aspects of **obsessive-compulsive disorder** (OCD) and related conditions (**OC spectrum disorders**; e.g., **trichotillomania**, **hoarding**, **body dysmorphic disorder**). The journal invites studies of clinical and non-clinical (i.e., student) samples of all age groups from the fields of psychiatry, psychology, neuroscience, and other medical and health sciences. The journal's broad focus encompasses **classification**, **assessment**, **psychological** and **psychiatric treatment**, **prevention**, **psychopathology**, **neurobiology** and **genetics**. Clinical reports (descriptions of innovative treatment methods) and book reviews on all aspects of OCD-related disorders will be considered, as will theoretical and review articles that make valuable contributions.

Suitable topics for manuscripts include:

- The boundaries of OCD and relationships with OC spectrum disorders
- Validation of assessments of obsessive-compulsive and related phenomena
- OCD symptoms in diverse social and cultural contexts
- Studies of neurobiological and genetic factors in OCD and related conditions
- Experimental and descriptive psychopathology and epidemiological studies
- Studies on relationships among cognitive and behavioral variables in OCD and related disorders

- Interpersonal aspects of OCD and related disorders
- Evaluation of psychological and psychiatric treatment and prevention programs, and predictors of outcome.

Article types

Research paper:

Clinical and non-clinical research dealing with all aspects of obsessive-compulsive disorder (OCD) and related conditions (OC spectrum disorders; e.g., trichotillomania, hoarding, body dysmorphic disorder)

Review:

The journal welcomes systematic reviews and meta-analysis that make valuable contributions on all aspects of OCD-related disorders.

Viewpoint:

These are concise discussion papers on important topics in obsessive-compulsive and related disorders. For example, they may include new research developments, emerging innovations, critical challenges, and debates in the field. They are a platform for author(s) perspective with the aim to generate discourse on important issues. Viewpoint articles are by invitation only. Potential authors who wish to be considered may email the Editor for approval (cougle@psy.fsu.edu)

Viewpoints should have a maximum 1,000 words (not including references), no more than 10 references, up to 1 figure or table and no abstract.

Short communication:

A condensed paper with a brief scientific message. This option is designed to allow publication of research reports that are not suitable for publication as regular articles. Shorter Communications or Brief Reports are appropriate for articles with a specialized focus or of particular didactic value. Manuscripts should be between 3000-5000 words, and must not exceed the upper word limit. This limit includes the abstract, text, and references, but not the title page, tables and figures.

Correspondence:

Letters in response to papers published in journal.

Brief Review:

These are concise review articles on new and emerging topics, summarizing current information and advances in the field. The review should be approximately 2000 words (not including references or reference notes), with up to 50 references.

Peer review

This journal follows a double anonymized review process. Your submission will initially be assessed by our editors to determine suitability for publication in this journal. If your submission is deemed suitable, it will typically be sent to a minimum of one reviewer for an independent expert assessment of the scientific quality. The decision as to whether your article is accepted or rejected will be taken by our editors.

Read more about peer review.

Our editors are not involved in making decisions about papers which:

- they have written themselves.
- have been written by family members or colleagues.
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Any such submissions will be subject to the journal's usual procedures and peer review will be handled independently of the editor involved and their research group. Read more about editor duties.

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Appendix B: SRL: Acknowledgements for Journal

Authorship: Torileigh Matthews- conceptualisation, methodology, formal analysis (data extraction and quality appraisal) ,writing- original draft, writing- reviewing and editing, **Amy Lunn**- second reviewer- Data extraction (data extraction and quality appraisal), **Neil Carrigan** - methodology, supervision, methodology, writing- reviewing and editing, **Paul Salkovskis** - supervision, methodology, writing – reviewing and editing.

Conflicts of interests: There are no conflicts of interest to declare.

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Generative AI: No AI was used within the writing process of this report.

Appendix C: SRL: Quality Appraisal Tool

Study ID	Reporting (/8)	Outcome measures (/2)	Selection bias (/7)	Control for confounding variables (/2)	Power (/2)	Analysis (/3)	Ethics and SU consultation (/2)	Overall quality (/26)
1	S (7)	S (2)	S (6)	M (1)	S (2)	S (3)	S (2)	Strong 23/ 26
2	M (5)	S (2)	M (4)	M (1)	W (0)	W (1)	M (1)	Weak, 14/26
3	S (7)	S (2)	W (3)	M (1)	W (0)	M (2)	M (1)	Weak, 17
4	S (7)	S (2)	S (6)	M (1)	S (2)	S (3)	S (2)	Strong, 23
5	S (7)	M (1)	S (6)	S (2)	W (0)	S (2)	M (1)	Moderate, 19
6	S (6)	S (2)	S (5)	S (2)	W (0)	S (3)	M (1)	Moderate, 19
7	S (6)	S (2)	S (6)	S (2)	W (0)	S (3)	M (1)	Moderate, 20
8	S (6)	S (2)	S (5)	S (2)	W (0)	M (2)	M (1)	Moderate, 18
9	S (7)	S (2)	S (6)	M (1)	S (2)	S (3)	M (1)	Strong, 21
10	S (7)	S (2)	S (5)	S (2)	W (0)	M (2)	M (1)	Moderate, 19
11	S (7)	S (2)	W (3)	M (1)	W (0)	S (3)	W (0)	Weak, 15
12a	S (7)	S (2)	M (3)	S (2)	W (0)	M (2)	M (1)	Moderate, 17
12b	S (7)	S (2)	M (3)	S (2)	W (0)	M (2)	M (1)	Moderate, 17
13	S (7)	S (2)	W (1)	M (1)	W (0)	S (3)	M (1)	Weak, 15
14a	S (6)	S (2)	W (2)	M (1)	W (0)	S (3)	W (0)	Weak, 14
14b	S (6)	S (2)	M (4)	M (1)	W (0)	S (3)	W (0)	Weak, 16
15	S (7)	S (2)	S (6)	W (0)	S (2)	S (3)	M (1)	Moderate, 21
16	M (5)	S (2)	M (4)	S (2)	W (0)	S (3)	M (1)	Moderate,17
17	S (6)	M (1)	S (5)	M (1)	W (0)	M (2)	M (1)	Moderate, 16
18	S (6)	S (2)	M (4)	W (1)	W (0)	S (3)	M (1)	Weak, 16
19	S (7)	S (2)	S (5)	M (1)	W (0)	M (2)	M (1)	Moderate, 18

20	S (7)	S (2)	M (4)	M (1)	W (0)	M (2)	M (1)	Moderate, 17
21	S (6)	S (2)	W (2)	S (2)	W (0)	M (2)	M (1)	Weak, 15
22	S (7)	S (2)	S (6)	M (1)	S (2)	S (3)	M (1)	Strong. 22
23	S (7)	S (2)	W (2)	M (1)	W (0)	M (2)	M (1)	Weak, 15
24	S (7)	S (2)	M (4)	M (1)	M (1)	S (3)	M (1)	Strong, 19
25	S (7)	S (2)	M (4)	W (0)	S (2)	M (2)	M (1)	Moderate, 18
26	S (7)	S (2)	M (5)	M (1)	W (0)	M (2)	W (0)	Weak, 17

GLOBAL RATING FOR PAPER
Strong (no *weak* ratings)
Moderate (one *weak* rating)
Weak (two or more *weak* ratings)
For each of the seven domains, the following descriptions were used as a guide:

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Strong: assigned to studies adequately describing the scientific rationale, hypotheses, aims, and objectives, and where main outcomes to be measured are clearly described in introduction and/or methods (score 6+)
Moderate: assigned to studies that adequately describe at least three main areas of reporting (score 3–5)
Weak: assigned to studies not providing sufficient descriptions of background, aims, and findings (score of 2 or less)

2) OUTCOME MEASURES

Strong: assigned to studies that used measures established psychometric properties, i.e., SI-R (2)
Medium: assigned to studies using at least one measure with established psychometric properties (score of 1)
Weak: assigned to studies that solely rely on a interpersonal measure with poorly established psychometric properties (1)

3) SELECTION BIAS

Strong: assigned to studies where the selected participants are likely to be representative of the target population and use validated and reliable diagnostic tools to identify hoarding symptoms (scores of 5+)
Moderate: assigned to studies where the participants are somewhat likely to be representative of the target population, and/ or use validated and reliable self-report measures to identify hoarding symptoms (scores of 3–4)
Weak: assigned to studies where the participants are not likely to be representative of the target population (scores of 2 or below)

4) CONTROLLING FOR CONFOUNDING VARIABLES

The following are examples of confounders: race, sex, age, mental health symptoms (anxiety/depression)
Strong: assigned to studies that controlled for most confounders and/ or compared scores to a matched clinical control group (score of 2)
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5) POWER

Strong: assigned to studies that report power calculations and have an adequate sample size (score of 2)
Moderate: assigned to studies reporting power calculation but have not reached power (score of 1)
Weak: no power calculation or comment on whether their data reached power (score of 0)

6) ANAYLSIS

Strong: assigned to studies reporting a clear data analytic plan and where statistical tests used to analyse main outcomes were appropriate (e.g., nonparametric statistics being used for small sample sizes, estimates used to describe data appropriate) (score of 3)
Moderate: assigned to studies where the statistical tests used to analyse the main outcomes were appropriate and/ or where any analysis based on “data dredging” is made clear, but do not meet other criteria (score of 1 or 2)
Weak: assigned to studies who do not describe a missing data plan and where statistical tests were not appropriate (score of 0)

7) ETHICS AND SERVICE USER CONSULTATION

Strong: assigned to studies that report obtaining ethical approval and where service users were consulted at any stage during the project (score of 2)
Moderate: assigned to studies reporting ethical approval but where service user involvement is not reported (score of 1)
Weak: assigned to studies that fail to describe the above two criteria (score of 0)

Appendix D: Description of measures

Measure	**Acronym**	**Measure Description**
Hoarding		
Structured Clinical interview for DSM-5 (First, 2015)	SCID	A semi-structured, clinician- administered diagnostic interview for psychiatric disorders using DSM criteria.
Saving Inventory-Revised (Frost et al., 2004)	SI-R	This is a 23-item self-report measure of hoarding severity with three subscales: difficulty discarding, clutter and acquisition. A score of >41 indicated clinical level of hoarding.
Mini-international Neuropsychiatric Interview (Lecrubier et al., 1997)	MINI	A brief structured interview for clinicians for major Axis 1 psychiatric disorders on the DSM/ ICD.
Hoarding Rating Scale-Self-report (Tolin et al., 2010)	HRS-SR	This is a 5-item measuring hoarding severity across clutter, difficulties in discarding, acquisition, hoarding related emotional distress and impairment. Total scores range from 0-40. Scores of >14 used as a clinical cut off to indicate hoarding symptoms.
Social support		
Multidimensional scale of perceived support(Zimet et al., 1988)	MSPSS	This is a 12-item self-report scale that measures perceived social support from three different sources: friends, family and significant others. Higher scores indicate higher levels of perceived support.
Medical Outcomes Study	MOS-SS	A 20-item self-report questionnaire that measures social

Social Support Survey (Sherbourne & Stewart, 1991)		support. Items are across four subscales: perceived adequacy of tangible support, emotional support, affectionate support and positive social interaction. Items are rated on a 5-point Likert scale. Additionally, one question asks participants the number of close friends and relatives.
Social Provision scale (Cutrona & Russell, 1987)	SPS	This is a self-report questionnaire measuring social support across six subscales: Attachment, social interaction, reassurance of worth, reliable alliance, guidance and opportunity for nurturance.
Revised Norbeck Social Support Questionnaire (Norbeck et al., 1981)	NSSQ-R	Participant self-report significant relationships in their life and rate them on various categories. There are two subscales: total network and total support. Total network comprises of 1) number of supporters, 2) duration of relationship and 3) frequency of contact. Total support comprises of 1) affect (how much they feel liked) 2) affirmation (can they confide in supporters) 3) aid (immediate and long-term help).
Interpersonal Support Evaluation List (Cohen & Hoberman, 1983)	ISEL	This is a 40-item measure of perceived social support. There are four subscales: tangible support, belonging support, self-esteem support and appraisal support. Items are scored on a 4-point Likert scale.
Inventory of Socially Supportive Behaviours (Stokes & Wilson, 1984)	ISSB	This is a 40-item measure of received support that assess the quality of support individuals have received in the last month. Questions ask how often others did activities with

		them, for them, or to them in the past 4 weeks.
Duke-UNC Functional social support questionnaire (Broadhead et al., 1988)	FSSQ	This is an 8-item self-report scale that measures perceived social support. Items are scored on a 5-point Likert scale. Higher scores indicate greater perceived social support.
Social Network Index (Berkman & Syme, 1979)	SNI	This is an 11-item self-report questionnaire that measures social interactions/ network size. It measures the type size, closeness and frequency of contacts in a person's current social network.
Lubben Social Network Scale (Lubben, 1988)	LSNS	The LSNS is an 18-item self-report measure of social support, including social network size and frequency of contact. Total scores range from 0-90 with higher scores indicating strong social networks.
Loneliness		
UCLA Loneliness scale (Russell, 1996)	UCLA	This is a 20-item self-report measure of loneliness. Items are rated on a 4-point Likert scale.
Centre for Epidemiological Studies Depression Scale (Radloff, 1977)	CED-S	This is a 10-item scale that measures depression. There is one question that measures loneliness on a scale of 0 (rarely feeling lonely) to 3 (feeling loneliness most of the time)
Attachment		
Relationship Scales Questionnaire(Griffin & Bartholomew, 1994b)	RSQ	This is a 30-item self-report measure relating to attachments in close relationships. Items are score on a 5-point Likert scale across four different subscales: secure, fearful, preoccupied and dismissing.
The Relationship	RQ	This is a 4-item questionnaire designed to measure adult

Questionnaire(Bartholomew & Horowitz, 1991)		attachment style. Items are scored on a seven-point Likert scale/
Revised Adult Attachment Scale(Collins, 1996)	RAAS	This is an 18-item self-report measure of attachment style in close relationships. It has two subscales: anxious and avoidant.
Adult Attachment Scale (Collins & Read, 1990)	AAS	This is an 18-item self-report measure for attachment styles. Item responses are score on a five-pint Likert scale.
Experiences in Close Relationships (Brennan et al., 1998)	ECR	This is a 36- item self-report questionnaire that measures adult interpersonal attachment. It consists of two dimensions: avoidance and anxiety. Items are rated on a 7-point Likert scale.
Experience of Close Relationships- Relationship Structure (Fraley et al., 2011)	ECR-RS	This is 9-item measure to assess attachment patterns. This gives a score for attachment avoidance and anxiety for maternal and paternal figures.
Adult Attachment Questionnaire (Simpson et al., 1996)	AAQ	This is a 17-item-self report measure that assess romantic relationships. Each item is rated on a seven-point Likert scale. There are two subscales: avoidance and anxiety.
Security Questionnaire (Zhong & Lijuan, 2004)	SS	This is a 16-item self-report measure of attachment insecurity. There are two subscales interpersonal security and uncertainty of control. Items are scored on a 5-point Likert Scale. Higher scores indicate a greater sense of attachment insecurity.
Reciprocal Attachment Questionnaire (West et al.,	RAQ	This is a 75-item self-report measure of attachment security, attachment patterns and features. This measures

1987)	attachment across security and insecurity.

Appendix E: SIP: Author guidelines

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See **http://authorservices.wiley.com/bauthor/illustration.asp** for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Data Sharing and Supporting Information

CAMH encourages authors to share the data and other artefacts supporting the results in the paper by archiving them by uploading it upon submission or in an appropriate public repository. Examples of possible supporting material include intervention manuals, statistical analysis syntax, and experimental materials and qualitative transcripts.
1. If uploading with your manuscript please call the file 'supporting information' and reference it in the manuscript.
2. Please note supporting files are uploaded with the final published manuscript as supplied, they are not typeset.
3. On publication your supporting information will be available alongside the final version of the manuscript online.
4. If uploading to a public repository please provide a link to supporting material and reference it in the manuscript. The materials must be original and not previously published. If previously published, please provide the necessary permissions. You may also display your supporting information on your own or institutional website. Such posting is not subject to

the journal's embargo date as specified in the copyright agreement. Supporting information is made free to access on publication.

Appendix F: SIP: Acknowledgements for journal

Study funding: Oxford Health Foundation Trust (OHFT) CAMHs Team provided funding for participants, this was in the form of a £15.00 Amazon voucher.

Contributorships: TM - design of study, data collection, data analysis and writing of manuscript. JA & ER supervised TM and was involved in design of the study, data analysis and manuscript review. MD, a service lead, from Oxfordshire CAMHS. supported with recruitment. Thank you to all the young people and parents from the Oxford GH/GMH team who took their time to participate in this research.

Ethics: The study followed the *r*elevant local audit procedures. The project was registered on OHFT clinical audit system AMAT. A relevant data protection impact assessment (DPIA) was completed regarding the processing of personal information. Informed consent was collected for young people and parents who completed interviews.

Data availability: Data will be made available upon request.

Conflicts of interest: The authors declare no conflict of interest.

Key Practitioner Message

What is known?

- The THRIVE model has recently been introduced within CAMHS to support with young people accessing timely, needs-based mental health support. This translates to the 'Getting Help and Getting More Help' Teams.
- Young people are expected to move between teams fluidly based on their mental health need, rather than a diagnosis.
- At present, there is limited understanding regarding what this experience is like for YP and their families.

What is new?

- Transitions typically occur due to an increase in risk, or a presentation not meeting the current team's pathway. It is a period of increased mental health vulnerability.
- Families and young people share the transition process makes them feel isolated. They often turn to external services (i.e., social care, private support) in the absence of mental health support.
- Families are having to manage risk alone with limited contact from CAMHS during the transition period.

What is significant for clinical practice?

- Clinicians need to document the transfer process consistently and be clear about how and what they are communicating to families.
- Young people perceive CAMHS only being responsive in a crisis, clear safety planning and risk management is needed during the transition process to prevent escalation of risk. A named professional during the transition period would aid with communication.
- Tools such as the 'One page profile' may reduce the need for young people to retell their stories and support with relationship building in the new team, preventing disengagement during the transfer.

Key words: CAMHS, transition, mental health, vulnerability, engagement, lived experience

Appendix G: SIP: Summary of NICE Guidance (2016): transition from children to adult services for young people using health or social care services

Summary of NICE Guidance (2016): transition from children to adult services for young people using health or social care services

Overarching Principles	Involve young people and their carers in service design, delivery and evaluation related to transition by: • co-producing transition policies and strategies with them o planning, co-producing and piloting materials and tools o asking them if the services helped them achieve agreed outcomes o feeding back to them about the effect their involvement has had. Ensure transition support is developmentally appropriate, considering the person's: o maturity o cognitive abilities o psychological status o needs in respect of long-term conditions o social and personal circumstances Check that the young person is registered with a GP. Consider ensuring the young person has a named GP.
Timing and Review	For groups not covered by health, social care and education legislation, practitioners should start planning for adulthood from year 9 (age 13 or 14) at the latest. For young people entering the service close to the point of transfer, planning should start immediately
A named worker	Help the young person to identify a single practitioner – who should act as a 'named worker' – to coordinate their transition care and support. This person could be supported by an administrator. The named worker: o a nurse, youth worker or another health, social care or education practitioner o an allied health professional o the named GP (see recommendation 1.1.9) an existing keyworker, o transition worker or personal adviser should be someone with whom the young person has a meaningful relationship. The named worker should: o oversee, coordinate or deliver transition support, depending on the nature of their role o be the link between the young person and the various practitioners involved in their support, including the named GP

Involving young people	Offer young people help to become involved in their transition planning. This may be through: peer support o coaching and mentoring o advocacy o the use of mobile technology. Service managers should ensure a range of tools is available, and used, to help young people communicate effectively with practitioners. These may include, for example: o ways to produce a written record of how a young person communicates, for example, communication passports or 1-page profiles o ways to help the young person communicate, for example, communication boards and digital communication tools.
Building independence	Include information about how young people will be supported to develop and sustain social, leisure and recreational networks in the transition plan. o Include information and signposting to alternative non-statutory services, including condition-specific support services, in transition planning. This may be particularly important for people who do not meet the criteria for statutory adult services. o Put young people in touch with peer support groups if they want such contacts. This type of support: o may be provided by voluntary- and community-sector organisations, such as specific support groups or charities o should be provided in a way that ensures the safety and wellbeing of the young people involved.
Involving parents and carers	Ask the young person regularly how they would like their parents or carers to be involved throughout their transition, including when they have moved to adults' services. Discuss the transition with the young person's parents or carers to understand their expectations about transition. This should include: recognising that the young person's preferences about their parents' involvement may be different and should be respected considering the young person's capacity, following the principles of the Mental Capacity Act and other relevant legislation, as necessary. Help young people develop confidence in working with adults' services by giving them the chance to raise any concerns and queries separately from their parents or carers.

Appendix H: SIP: Getting Help SOP Guidance: May 2022

Internal Transfers and Discharges

- It may become apparent during the assessment or during the course of treatment the young person's needs are not matched entirely to the intervention being offered.
- If a GH worker believes the young person they are treating requires longer term intervention, they will **refer on at the earliest opportunity**. Following discussion with the Countywide lead, the identified worker will email the appropriate team manager to request transfer of care. Uploaded to care notes with the agreed plan and timescales.
- **All documentation needs to be updated at the point of transfer**, Risk Assessment and Care Plan.
- The GH worker will then continue to give the agreed GH intervention while waiting for the care coordinator to be identified.

Getting More Help SOP Guidance: May 2022

Transfer between teams

The transfer of Care is a potentially vulnerable time for children and Young People who have developed therapeutic relationships with the clinicians and the CAMHS team.

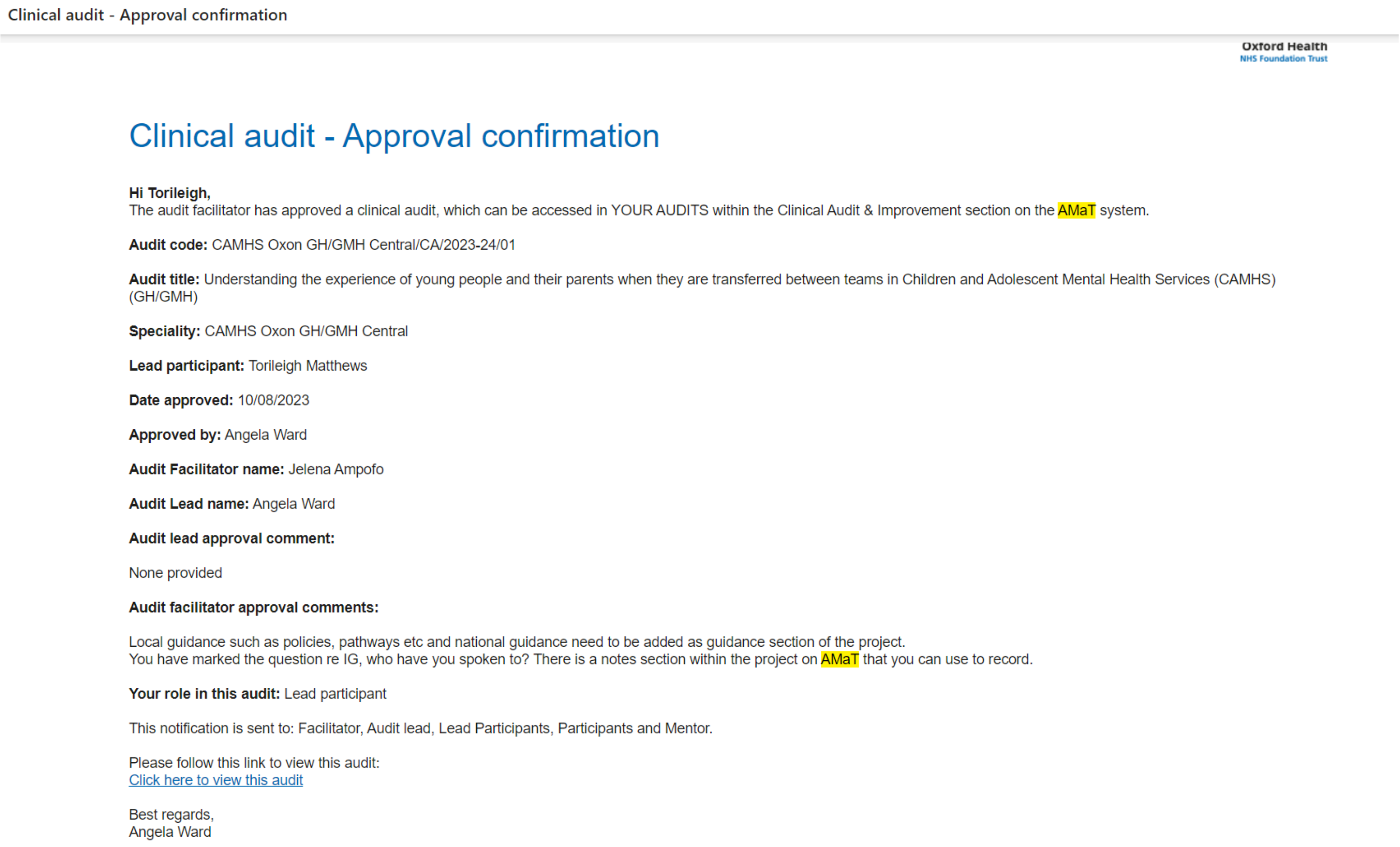
Transfer of care can be initiated by:

- A change of Care Coordinator within the team (i.e. a clinician moving on)
- Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Assessment and Treatment Teams as per protocol
- Child being brought into care and moved away
- Custodial sentence with the young person to another region
- Transfer to specialist service for example inpatient team, the forensic team

OHFT CAMHS places a significant importance on care continuity and will ensure that the Care Coordinator maintains their involvement until the young person is safely within the new environment of care provision. If this is not possible (in extreme situations such as staff sickness etc.) whilst the responsibility for managing any transfer of care lies with the Care Coordinator (CC) if they remain available, they can also get support from their Team Manager (TM). The TM and CC (or TM on behalf of CC) can negotiate with other colleagues, and where practicable should involve a period of joint working with colleagues in the ongoing team to ensure stability for the young person at this vulnerable time.

Care should be transferred at a CPA review meeting, with all relevant agencies represented, followed promptly **by a letter confirming the agreed transition and naming the key staff responsible in each team, and copied to the Young Person, their Parents or Carers and the GP.**

Appendix I: SIP: AMAT Approval Email from Research and Development



Clinical audit - Approval confirmation

Clinical audit - Approval confirmation

Hi Torileigh,
The audit facilitator has approved a clinical audit, which can be accessed in YOUR AUDITS within the Clinical Audit & Improvement section on the AMaT system.

Audit code: CAMHS Oxon GH/GMH Central/CA/2023-24/01

Audit title: Understanding the experience of young people and their parents when they are transferred between teams in Children and Adolescent Mental Health Services (CAMHS) (GH/GMH)

Speciality: CAMHS Oxon GH/GMH Central

Lead participant: Torileigh Matthews

Date approved: 10/08/2023

Approved by: Angela Ward

Audit Facilitator name: Jelena Ampofo

Audit Lead name: Angela Ward

Audit lead approval comment:

None provided

Audit facilitator approval comments:

Local guidance such as policies, pathways etc and national guidance need to be added as guidance section of the project.
You have marked the question re IG, who have you spoken to? There is a notes section within the project on AMaT that you can use to record.

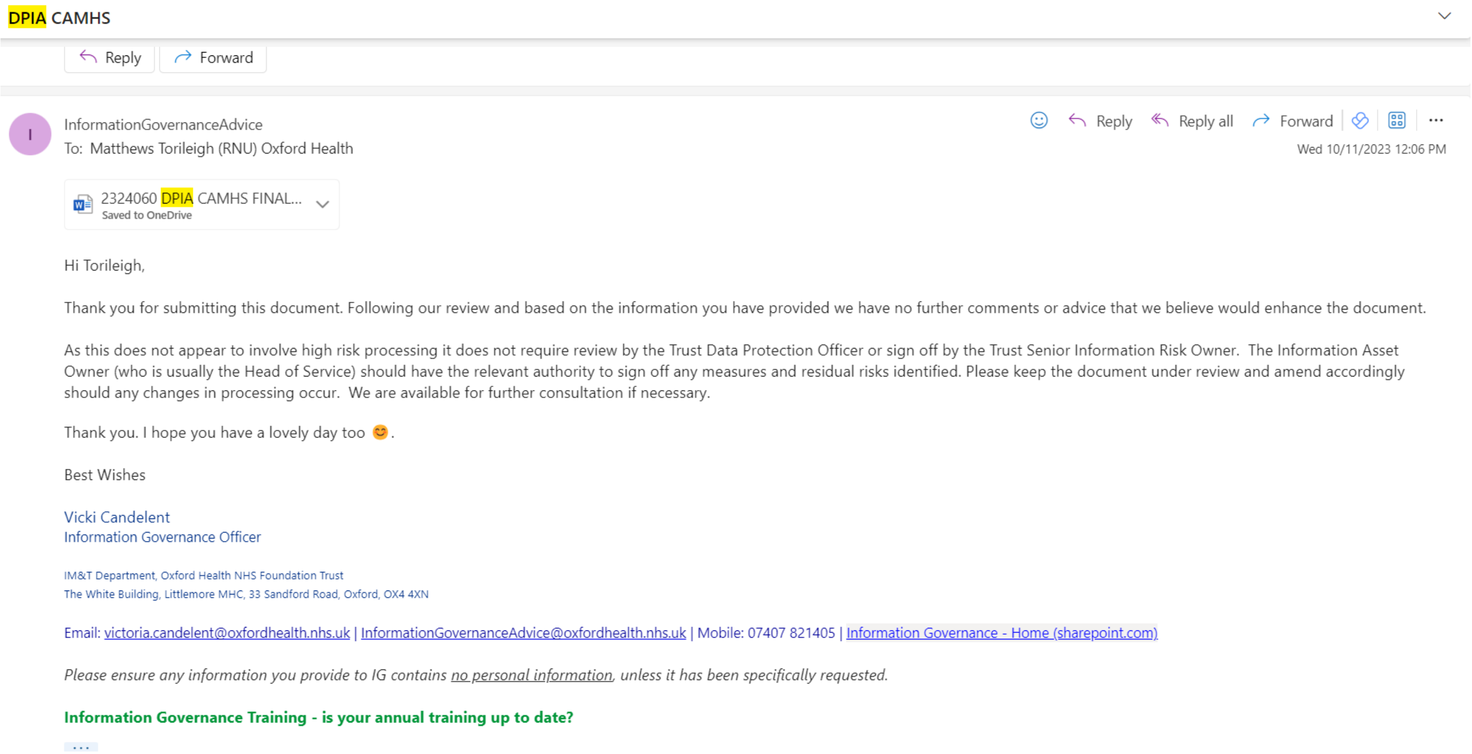
Your role in this audit: Lead participant

This notification is sent to: Facilitator, Audit lead, Lead Participants, Participants and Mentor.

Please follow this link to view this audit:
Click here to view this audit

Best regards,
Angela Ward

Appendix J: SIP: DPIA Email Confirmation



DPIA CAMHS

InformationGovernanceAdvice
To: Matthews Torileigh (RNU) Oxford Health

Wed 10/11/2023 12:06 PM

2324060 DPIA CAMHS FINAL...
Saved to OneDrive

Hi Torileigh,

Thank you for submitting this document. Following our review and based on the information you have provided we have no further comments or advice that we believe would enhance the document.

As this does not appear to involve high risk processing it does not require review by the Trust Data Protection Officer or sign off by the Trust Senior Information Risk Owner. The Information Asset Owner (who is usually the Head of Service) should have the relevant authority to sign off any measures and residual risks identified. Please keep the document under review and amend accordingly should any changes in processing occur. We are available for further consultation if necessary.

Thank you. I hope you have a lovely day too 😊.

Best Wishes

Vicki Candelent
Information Governance Officer

IM&T Department, Oxford Health NHS Foundation Trust
The White Building, Littlemore MHC, 33 Sandford Road, Oxford, OX4 4XN

Email: victoria.candelent@oxfordhealth.nhs.uk | InformationGovernanceAdvice@oxfordhealth.nhs.uk | Mobile: 07407 821405 | Information Governance - Home (sharepoint.com)

Please ensure any information you provide to IG contains no personal information, unless it has been specifically requested.

Information Governance Training - is your annual training up to date?

Appendix K: SIP: Cohen Kappa and Percentage Agreement

Coding Category	**Cohen's Kappa (K)**	**Percentage agreement (%)**	**Agreement interpretation**
MDT discussion regarding transfer		100%	High Agreement
Formulation within their notes	1.00	100%	High Agreement
Named Professional in new team *		100%	High Agreement
Letter to family regarding transfer*		60%	Moderate Agreement
Letter to GP regarding transfer*		60%	Moderate Agreement

It was challenging to calculate Cohen Kappa's across all of the coding categories. This was because, in most of the categories, there was no variability in the coding (i.e. they answered the same in each item). As there was no variability from the coder, it is not possible to determine if the agreements are due to coders actual agreement or just the lack of variation. Therefore, percentage agreement was reported when this was not possible. A high percentage agreement is considered above 80%, moderate is between 60%-80% and low would be below

60%. Overall, there was moderate to high levels of agreement across the audit. This seems to mirror the difficulties with ascertaining the information from the clinical notes.

Appendix L: SIP: Clinician Pack (Participant Information, Consent and recruitment poster)

Participant Information Sheet

Understanding the experience of young people and their families when they are transferred between teams in CAMHS

1. **Background and aims of the project**

The current service improvement project is focused on trying to better understand what it is like for young people and their families when they have been moved between teams within Child and Adolescent Mental Health Services (CAMHS), specifically between the Getting Help (GH) or Getting More Help Team (GMH) or vice versa. We hope that hearing about your experience of being transferred between teams in CAMHS will help us to improve transition processes and support other young people.

We are particularly interested in understanding what information was shared with you to explain why you were being transitioned to another team. We also hope to understand how this was communicated to you, how you felt throughout the transfer process, and what information will help the service understand the barriers families face when being transferred to different teams. This can help the service create changes that will enable smoother transition between teams for young people whilst they are under CAMHS.

2. **Why have I been invited to take part?**

You have been invited to take part because you or your child's care has been transferred from one CAMHS team to another. We hope to interview both young people aged 12-17 and their parent/carer to be able to capture the range of experiences that occur in the transition process.

3. **Do I have to take part?**

No. Your participation is completely voluntary, and you are free to ask questions about the study before deciding whether to take part. If you do agree to participate, you may withdraw at any time, without giving a reason by emailing Torileigh Matthews (Torileigh.matthews@oxfordhealth.nhs.uk) to advise them of this decision. Once the interview has been undertaken, information will be made anonymous a week after your interview, and therefore you will not be able to withdraw your information after this date. Choosing not to take part in these interviews or choosing to withdraw will not have any adverse effects on the care you/your child receives.

4. **What will happen in these interviews?**

Firstly, if you would like to take part in this project, we will ask you to complete a consent form. If you would still be happy to take part, you will be invited to a 30–45-minute interview on Microsoft Teams. Questions will focus on your/your child's experience of being moved between teams in CAMHS, how you felt about the transition, what information was helpful and how this process could be improved. The interview will be audio- recorded and transcribed as part of the research process; however, your responses will be anonymised.

5. **Are there any potential risks to taking part?**

We do not anticipate any harm to come to you because of taking part in this study. However, should you have any concerns, please contact Torileigh Matthews (torileigh.matthews@oxfordhealth.nhs.uk). If during the interview the researcher has any concerns about your/ your child's safety this information may be shared with their current CAMHS team.

6. **Are there any benefits to taking part?**

Young people will be given a £15.00 voucher as compensation of their participation. For parents there will be no direct benefit to you from taking part in this research. However, we hope that the responses you provide will enable the service to be able to make improvements that will benefit future families referred for support.

7. **What happens to the data provided?**

All study data will be anonymised and held securely in accordance with local and national governance procedures regarding confidentiality and data management. All data will be stored for a minimum period of 3 years after publication or public release of the work. Any personally identifiable data provided (i.e. names, email addresses, telephone numbers) will be held solely for the purposes you agree to in the consent form (e.g. completing a video-call interview to gather further information regarding your experiences). Any personally identifiable data provided will be stored separately from study data and deleted once data collection is complete.

8. **Will the research be published?**

The results of the study will be written up in a thesis as part of the dissertation portfolio for the lead investigators' Doctorate in Clinical Psychology. The University of Oxford is committed to the dissemination of its academic work for the benefit of society and the economy and, in support of this commitment, has established an online archive of materials. This archive includes digital copies of student theses successfully submitted as part of a University of Oxford postgraduate degree programme. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in the future. The thesis will be published open access, and the results of the study may also be published in an academic journal. Data that is published is anonymous.

9. **Who has reviewed this study?**

This study has been reviewed by and received approval to proceed by the Oxford Health NHS Foundation Trust Quality & Audit Team.

10. **Who do I contact if I have a concern about the study or wish to complain?**

If you have a concern about any aspect of this study, please speak to the lead investigator Torileigh Matthews (torileigh.matthews@oxfordhealth.nhs.uk). Alternatively, you can contact their supervisor's Dr Emily Reeves (Emily.reeves@hmc.ox.ac.uk) or Dr Joanna Adams (joanna.adams@hmc.ox.ac.uk) who are Clinical Psychologist working in CAMHS. We will do our best to answer your query. Your concern will be acknowledged within 10 working days, and they will give you an indication of how they intend to deal with it. If you remain unhappy or wish to make a formal complaint, please contact the Patient Advice and Liaison Service (PALS@oxfordhealth.nhs.uk/0800 328 7971).

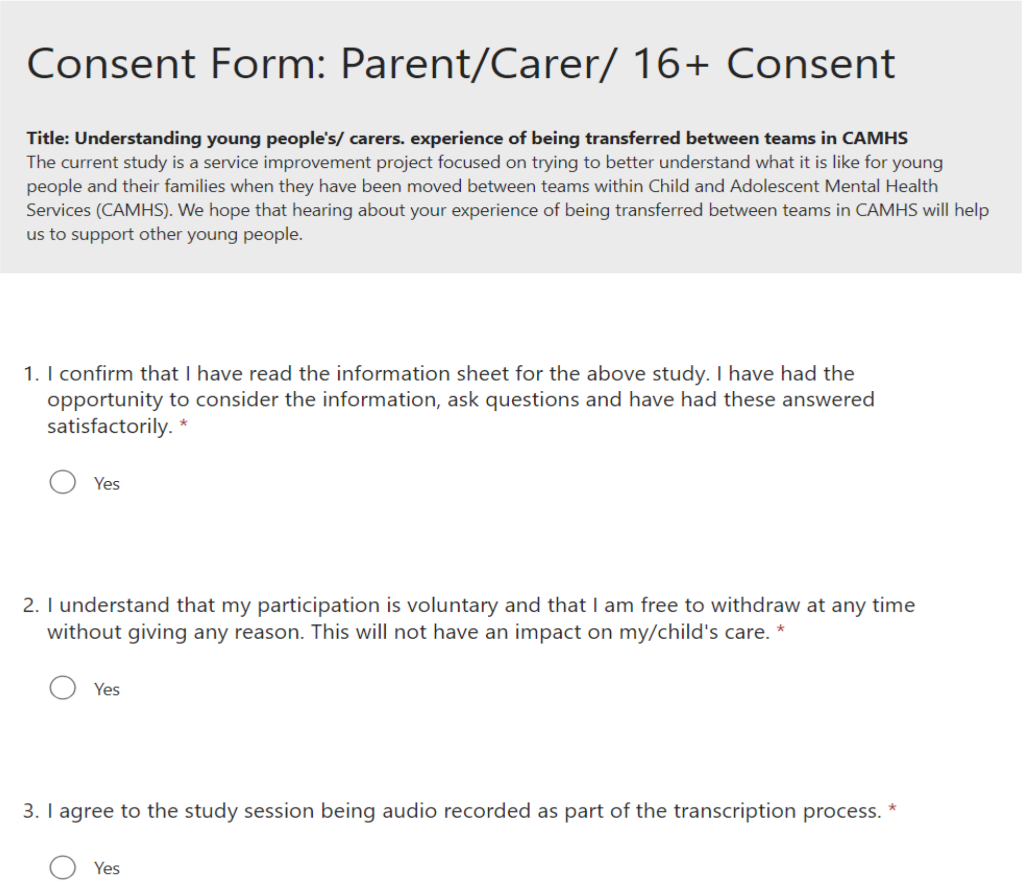
11. **Further Information and Contact Details**

If you would like to discuss the study with someone beforehand (or if you have questions afterwards), please contact: Torileigh Matthews Trainee Clinical Psychologist (torileigh.matthews@oxfordhealth.nhs.uk)

12. What to do if I am interested?

If you are interested in participating in this study, please complete a consent form and a short questionnaire and then email torileigh.matthews@oxfordhealth.nhs.uk to book an interview.

Thank you.



Consent Form: Parent/Carer/ 16+ Consent

Title: Understanding young people's/ carers. experience of being transferred between teams in CAMHS
The current study is a service improvement project focused on trying to better understand what it is like for young people and their families when they have been moved between teams within Child and Adolescent Mental Health Services (CAMHS). We hope that hearing about your experience of being transferred between teams in CAMHS will help us to support other young people.

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. *

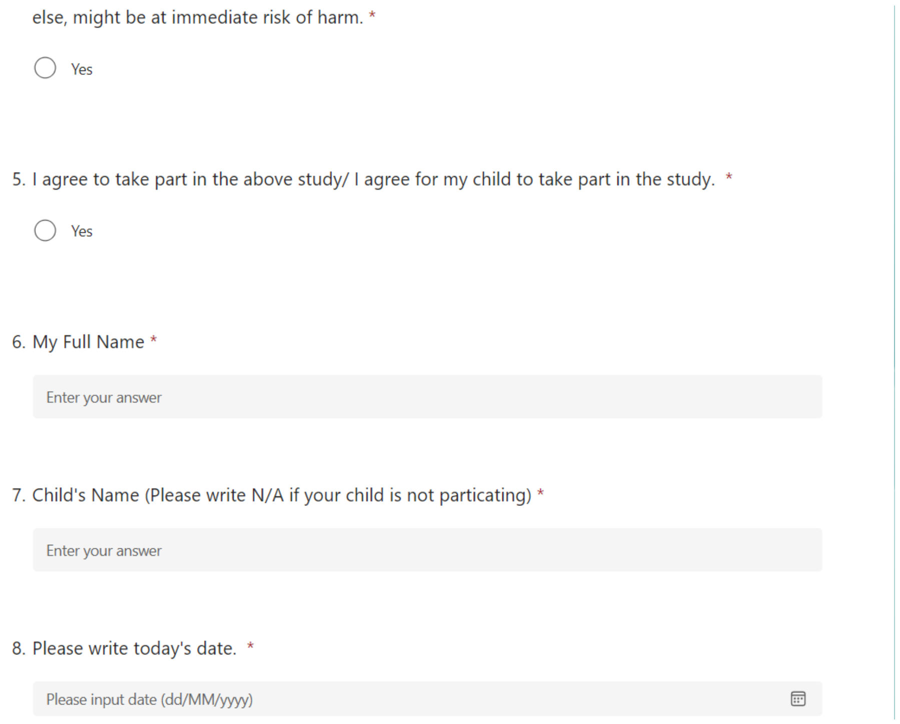
○ Yes

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. This will not have an impact on my/child's care. *

○ Yes

3. I agree to the study session being audio recorded as part of the transcription process. *

○ Yes



else, might be at immediate risk of harm. *

○ Yes

5. I agree to take part in the above study/ I agree for my child to take part in the study. *

○ Yes

6. My Full Name *

Enter your answer

7. Child's Name (Please write N/A if your child is not particating) *

Enter your answer

8. Please write today's date. *

Please input date (dd/MM/yyyy)

Have you been transferred between Getting Help or Getting More help whilst in CAMHS?

Can you help us to improve our CAMHS Service?

We are looking for young people aged between 12-17 and/or their parents/ carers to take part in a short online interview to help us understand their experience of being transferred between teams within CAMHS.

SCAN ME

FOR MORE INFORMATION

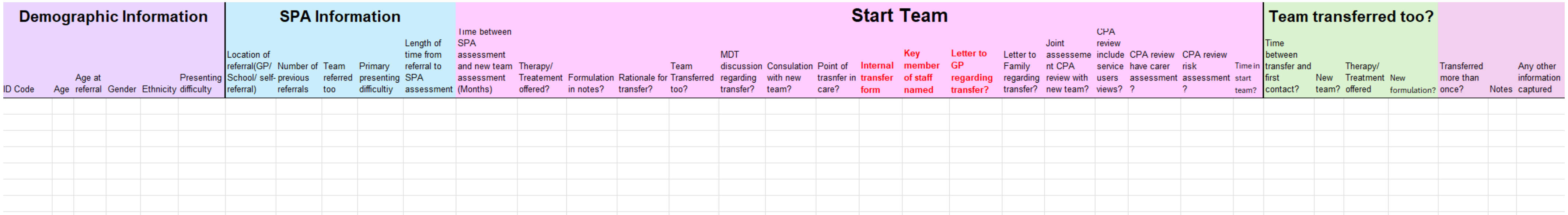
If you are interested and would like to participate please contact Torileigh Matthews (Trainee Clinical Psychologist- torileigh.matthews@oxfordhealth.nhs.uk). You can get more information about the study by scanning the QR code above. There is no obligation to take part.

Taking part will not impact on your care in any way.

Young people will be given a £15.00 Amazon Voucher for their time!!

Help improve CAMHS services!!

Appendix M: SIP: Audit Criteria



Demographic Information						SPA Information					Start Team																	Team transferred too?						
ID Code	Age	Age at referral	Gender	Ethnicity	Presenting difficulty	Location of referral(GP/ School/ self-referral)	Number of previous referrals	Team referred too	Primary presenting difficultiy	Length of time from referral to SPA assessment	Time between SPA assessment and new team assessment (Months)	Therapy/ Treatement offered?	Formulation in notes?	Rationale for transfer?	Team Transferred too?	MDT discussion regarding transfer?	Consulation with new team?	Point of trasnfer in care?	**Internal transfer form**	**Key member of staff named**	**Letter to GP regarding transfer?**	Letter to Family regarding transfer?	Joint assessement CPA review with new team?	CPA review include service users views?	CPA review have carer assessment ?	CPA review risk assessment ?	Time in start team?	Time between transfer and first contact?	New team?	Therapy/ Treatment offered	New formulation?	Transferred more than once?	Notes	Any other information captured

Appendix N: SIP: Interview Schedule

- Introduce self
- Check consent and details
- Explain rationale
- Talking about talking- anything that you do not want to talk about let me know.

Interview Schedule

1. How did you first come into CAMHS? *Who referred you? What was going on for you/your child?*
2. What team were you first referred to in CAMHS? *(e.g. name, what they did?) Did you get any support from them?*
3. When was it first suggested that your care might be transferred? *How did you feel when this was mentioned?*
4. Had you received any treatment/ therapy at this point?
5. What was your understanding for the reason for being transferred?
6. Who in your team suggested that you should be transferred? (Psychologist? Care-co?
7. Did you agree/ disagree with this decision to be moved to another team?
8. How did they share that you were being transferred?
9. Did you receive a letter with this information?
10. If you were given a letter, what was the reason you were given for being transferred?
11. How did you feel about being transferred?
12. What team were you transferred too? How do you feel about being under this team?
13. What did CAMHS do that was helpful during this transfer process?
14. What did CAMHS do that was not helpful during this process?

15. What information would it be useful for the new team to have about you/ your care?
16. Was there any you did not passed on passed on?
17. Were there were any specific worries that you had?
18. Have you had a second assessment when you were transferred by team?
19. Involvement with other services?

Key elements to capture:

- Point of care
- Journey through CAMHS- start/transfer
- What they understood of it
- Emotions/ understanding – what
- Areas of good practice
- Areas of improvement

Appendix O: SIP: Rationale for Reflexive Thematic Analysis

Reflexive thematic analysis was chosen due to the incorporation of the researcher's subjectivity and reflexivity that influence the data collection and analysis process. Data analysis took a primary inductive approach; therefore, data analysis was data driven rather than from the researchers' preconceptions or a pre-determined coding framework. However, analysis was not exclusively inductive, due to the research question and aims that had been derived from literature associated with this domain. Reflexive TA has theoretical and methodological flexibility, which recognises that inductive and deductive positioning are not mutually exclusive allowing for the research to explore the meaning of multiple perspectives whilst still holding a theoretical framework surrounding previous research regarding transitions.

Appendix P: SIP: Bracketing Interview

Bracketing Interview

Why am I interested in this topic?

I had a personal connection to CAMHS, with a family member accessing mental health support during my adolescence and having a poor experience. From this, I have always had an interest in working with children and young people, and pre-training worked in CAMHS. Given these experiences, I am mindful that my assumptions and narratives about this topic. CAMHS is challenging to navigate, and there are several negative experiences due to lack of funding and waiting times. I am expecting this to be reflected within the interviews. However, I am also hoping that there may be areas where CAMHS are providing good quality care, as within a professional context I have seen first-hand how well CAMHS are able to communicate with parents/young people and other professionals. which may indicate that transfers may be effective.

Any difficulties I am expecting?

I am concerned about holding a ‘research’ and ‘trainee’ position. Recognising the need to have validity by maintaining consistent research questions yet, a sense of wanting to empathise and validate the experience of a YP/ family. I hope that by spending 5-10 minutes to ‘talk about talking’ may help to develop a rapport and then support my ability to complete the semi-structured interview. Using this style of interview approach, I hope will allow me to integrate my therapeutic skills to support engagement.

Coding Data (Bracketing)

As I begin to think about coding the data, I thought I would take time again to reflect on my positioning, and standpoint before fully immersing myself within the data. I have noticed a sense of apprehension as I begin to embark on TA, and a sense of 'doing it right' and 'capturing the experience properly'; I have spent time making sure I am familiar with the research process to ensure that I understand the data. My research approach is inductive in nature; as I am unable to separate my own experiences from the data, yet I am still grounded within the theory. My own background as a White British female undertaking doctoral training in clinical psychology, shapes how I view the world. Previously working within CAMHS and viewing the complexities of navigating complex pathways means I may have preconceptions about the findings within the data. I feel that I may hold some polarising views regarding CAMHS, for example that the wait-time is problematic and increases mental health problems, and CAMHS can provide timely support that can be beneficial for young people. I am mindful of my own pre-conceptions whilst looking at the data, that my disciplinary context and training has influenced how I may perceive the data.

Developing themes and codes

As I have begun to develop my themes, from my codes, I am mindful about the themes that are already emerging. It has been interesting to see how separate interviews, that all were so different, have come together to create several meaningful themes which tells a story about the data, and the participants experience. I mindful about what parts of the data I was drawn to, and I tried to ensure that I took several days to code the data. This allowed me to pay attention to where I had already coded- and where I may have missed. Spending this time to go back over these codes over several days meant that I had rich data, with layers of experiences.

As I was developing my themes, I used a range of different methods to collate them- this included organising the codes digitally and trying to draw these as a thematic map to see how these codes fitted together. Using both these approaches meant that I was able to review codes and create themes that worked with the data. I tried to be mindful of not just being drawn to the volume of codes but also trying to capture the meaning. The use of both semantic and latent coding really added depth to the themes. I also noticed how, as I was developing the themes, they were quite 'problem-saturated', yet there were clear themes of individual staff being fantastic. I was reflecting on how this may be received by staff who I would be disseminating the research to. Being mindful of my position situated outside of the team, and the implication that these findings could have on CAMHS staff's attitudes, meant I may have been more explicitly trying to find positive themes to balance these themes. Whilst this is not negative, it is important to be aware of how I was drawn to offering something 'useful' and 'positive' to the service.

Appendix Q: SIP: Full copy of Audit Data

ID	Age	Gender	Ethnicity	Presenting difficulty	Location of referral (GP/ School/ self-referral)	Team referred too	Team Transferred too	Treatment offered	Point of transfer in care?	Rationale for transfer	Formulation in notes	Consultation with new team?	Key member of staff named	Letter to GP regarding transfer?	Internal Transfer Document
1	12	Male	Asian	Low mood and suicidal ideation	Self-referral	GH	GMH	No	Assessment	Unclear	No	No	No	No	No
2	13	Male	Mixed-any other background	Enuresis/ School anxiety.	Paediatrician	MHST	GH	Yes	Assessment	Unclear	No	No	No	No	No
3	13	Female	White	Low mood and self-harm,	GP	GH	GMH	No	Pre-assessment	Risk Increase	Yes	Yes	No	No	No
4	13	Female	White	Self-Harm	GP	GH	GMH	Yes	Assessment	Unclear	No	No	No	No	Yes
5	13	Male	White	Self-harm and depression	GP	GH	GMH	Yes	Unclear	Unclear	Yes	No	No	No	Yes
6	14	Male	Unknown	Anxiety/ Depression with Psychosis	GP	GH	GMH	No	Assessment	Presentation change	Yes	Yes	No	No	Yes
7	15	Male	White	Anxiety	School	GH	GMH	No	Assessment	Risk Increase	Yes	Yes	Yes	No	No

			British												
8	15	Female	White British	Anxiety,	GP	GH	GMH	No	Assessment	Unclear	No	No	No	No	No
9	16	Female	White British	Anxiety and low mood	Clinical Psychologist in Paediatrics	GMH (N)	GMH (S)	Yes (Helios)	Post therapy	Presentation	Yes	No	No	No	Yes
10	17	Female	White British	Depression	School	GH	GMH	No	Assessment	Risk increase	Yes	Yes	Yes	No	no
11	16	Female	White British	Depression	GP	GH	GMH	No	Unclear	Risk Increase	Yes	Yes	No	No	No
12	17	Female	White British	Depression/ Gender identity	School	GH	GMH	Yes	Post therapy	Presentation	Yes	No	Yes	No	Yes
13	12	Male	White British	Poor school attendance	School	MHST	GH	No	Assessment	Presentation	No	No	No	No	No
14	12	Female	White British	Self-Harm	GP	GH	GMH	Yes	Pre-assessment	Unclear	No	No	No	No	Yes
15	12	Male	White British	Anxiety	GP	GH	GMH	No	Assessment	Presentation	Yes	Yes	Yes	No	no
16	13	Female	White British	OCD	GP	MHST	GMH	Yes	Mid therapy	Presentation	Yes	Yes	No	No	No
17	13	Male	White-Any other	Substance misuse	School	GH	GMH	Yes	Assessment	Presentation	Yes	No	No	No	No
18	14	Female	White British	Anxiety/ Suicidal Ideation	GP	GH	GMH	No	Assessment	Risk Increase	Yes	No	No	No	No
19	14	Male	White British	Depression	GP	GH	GMH	No	Assessment	Risk increase	Yes	No	No	No	Yes
20	15	Male	Unknown	Trichotillomania	GP	GH	GMH	No	Assessment	Risk Increase	Yes	No	No	No	Yes

21	14	Female	White British	Anxiety	School	GH	GMH	No	Assessment	Risk increase	Yes	No	No	No	Yes
22	15	Male	White British	Anxiety	School	MHST	GH	Yes	Pre assessment	Unclear	Yes	Yes	No	No	No
23	15	Female	White British	Self-harm	School	GH	GMH	No	Pre-assessment	Risk Increase	Yes	Yes	No	No	No
24	15	Female	White British	Depression	School	GH	GMH	Yes	Pre assessment	Risk Increase	Yes	Yes	No	No	No
25	16	Female	White British	Low mood/ anxiety	GP	GH	GMH	No	Assessment	Risk Increase	Yes	Yes	No	No	No
26	16	Female	Not Known	Low mood	Self-referral	GMH (N)	GMH (S)	Yes	Assessment	Risk Increase	No	Yes	No	No	No

Appendix R: SIP: Thematic Map and Illustrative Quotes

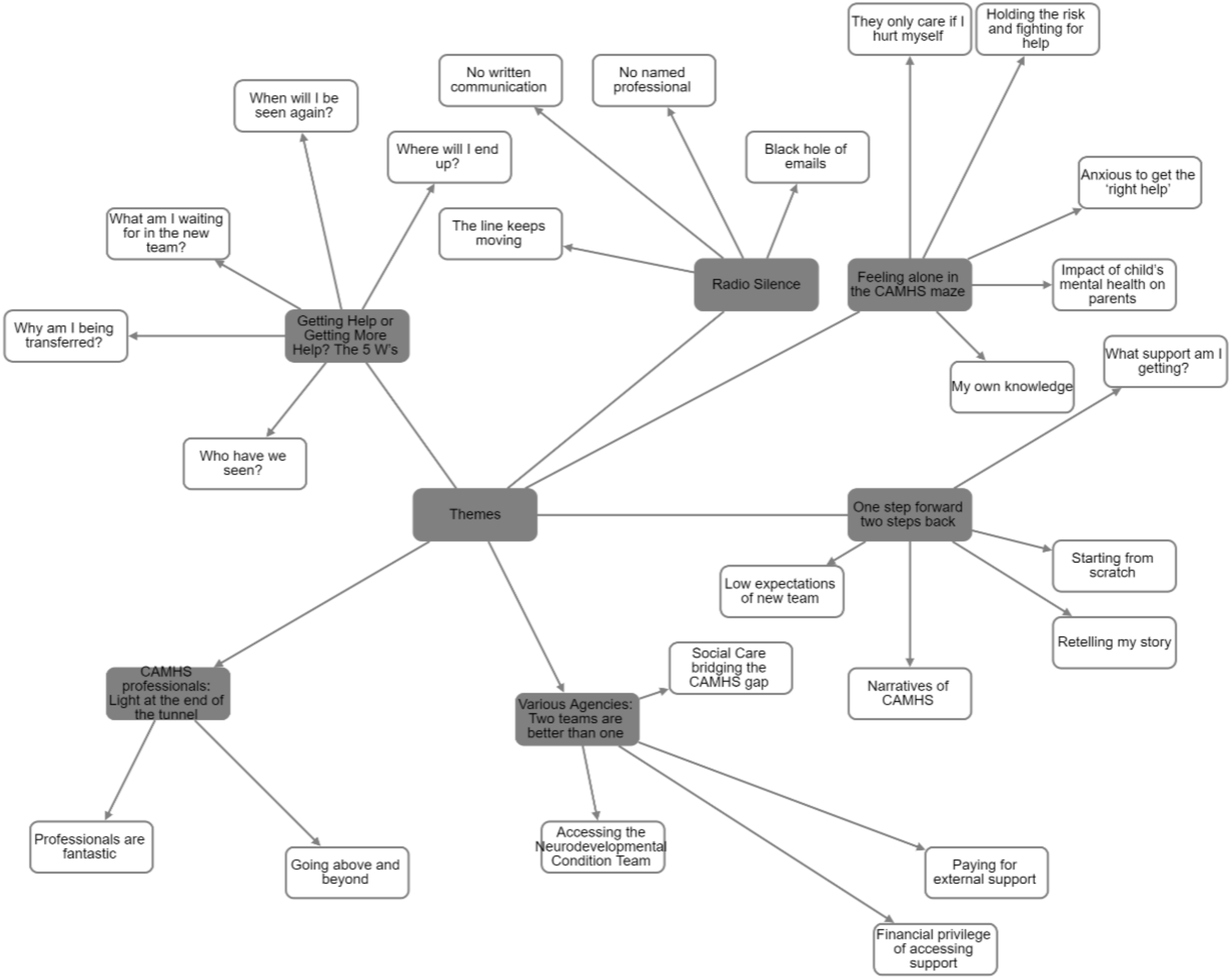
Themes	Subthemes
1.Getting Help or Getting More Help? The 5 W's	*Who have I seen?* "Nobody said we are going to be part of the Getting Help Team or who they were" (P1) "I can't remember the lady or the team. I wasn't quite sure what team I was in" (P2) "There was no mention of what team we were in" (P3) "I don't know which team it was all a blur" (P4) "I don't remember seeing anyone in that team, and I get confused on who I have seen." (YP 1) "I think she was a nurse or something I don't know." (YP2) "Sorry, I do not remember which team I was in" (YP5) "The language can be really confusing, your asking yourself what the difference is" (between GH and GMH)" (P5)
	Why am I being transferred? "My mum just told me that I have been moved to getting more help, I don't know why" (YP1) "We started meeting and then they just stopped, and you don't know why" (YP2) "I don't know what else to say. I have been good at paying attention. I don't think to what he has been saying or at the very least it went in one ear and out the other." (YP5) "I wasn't aware that I had been moved teams" (YP6)
	What am I waiting for? "Are they going to be able to do anything useful?" (P1) "I'm not sure what team they are or what they are going to be doing?" (YP2) "I wasn't really feeling much about it because. I've been waiting for tots of times before so it just felt like the same. " (YP 3) "I don't know if that is happening or not really[support]" (YP5)
	Where will I end up? "When is the help coming" (P1) "This was the first time that I saw the getting more help team come up, before that I am not sure where we were" (P3)

	“It all irrelevant really {what team we are in} as long as we are getting the care” (P3) “I didn’t know that it was two different places, I just thought it was one big list” (YP 3)
	When will I be seen again? “Right help, right time” (P3) “The main thing is that the support just supported, and I didn’t know when it was going to start again or what the plan was” (YP2) “I just felt a bit left, like what is going on” (P5)
2.“Radio silence”	*The line keeps moving* “As far as I know, that didn't happen, which is a pity. So, you know that's pretty important when you're working with teenagers. If you say something, it needs to happen.” (P2) “I had the support and then I have to wait, well they’re just sort of left me here, if that makes sense” (YP6) “We’ve literally done this assessment before; she doesn’t need another assessment she needs help” (P5) “In my head, she should have been having this therapy almost a year ago” (P5)
	No written communication “There has been no letter to say that [young person] is waiting for another team, or what we might get” (P1) “I’ve had nothing in writing from them ever” (P2)
	Black hole of emails “Black hole of emails” “Since then, it’s been quiet, we haven’t heard anything. It’s been months and months” (P2) “We just were getting increasingly frustrated as nobody was speaking to us” (P4) “Obviously, no direct contact but I can email the office, but no one will actually help you” (P5)
	No named professional “While you are waiting you are alone, who do you contact?” (P1)
3.Feeling alone in the CAMHS maze	*My own knowledge* “I’ve done a lot of like looking on the internet’” (P1) “I’ve accessed all sort of things, but they’ve been under my own steam rather than through CAMHS” (P3)

	“It ties to my practice in teaching” (P3) “At this point I’d already put most of it in place myself, through my own research” (P6)
	Anxious to get the ‘right help’ “It was unsettling when we had to wait” (P2) “I think if we hadn’t had the external support I would have badgered her more” (Parent 2) “It didn’t materialise. I didn’t push for it because we didn’t feel he was ready.” (P3) “She's a child in distress. So, you know, you need to make sure that, you know, she does get the CAMHS support, as soon as it's available” (P2) “It would be good to know a time frame” (YP 4)
	Impact of child’s mental health on parents “I cut down on my work in order to do the research” (P3) “I was not an anxious person until my son started to have difficulties” (P4) “I kept chasing them in on the phone in tears and I would just say please someone help us” (P5)
	Holding the risk and fighting for help “I feel like if I spoke up more maybe that would have sped things along, and if I asked or shouted for help that would of helped” (P2) “I had to fight and argue and say no hold on a moment, just because he is on the ASD pathway doesn’t mean we don’t need help”(P3) “You know, what support? Unless it was an emergency there really wasn’t anything.” (P3) “I’m not a shouty kind of person but sometimes it helps and CAMHS will actually listen” (P5) “I’m there to fight for her. I am giving them all the information they need to get her the right help” (P7).
	They only care if I hurt myself “The first team we had were the crises team as she ended up in hospital as she had hurt herself “*(P5)* “Then she self-harmed so badly that the crises team stepped in and then CAMHS suddenly started calling us weekly and took it seriously. It literally took her being hospitalised before anything was done.” (P6)
4.Various Agencies: Two teams are better	*Paying for external support* “Also seeing someone outside of CAMHS, I think without them we would have really struggled as we are just in the limbo phase”

than one	(P1) “I have a counsellor that I can be open and honest with. She gives me coping mechanisms” (YP 4)
	Financial privilege of accessing support “Unless you can pay for it you know there is very little. But you also have to have the means and the time to do so” (P3) “We are lucky we have the means financially” (P3) “We started paying privately, and we’re not well off, but we are in a situation that we could do that. There are millions of families that cant and that’s where I feel bad” (P5)
	Accessing the Neurodevelopmental condition team “We’ve also been pursuing a NDC referral through social care” “Getting my Autism diagnosis was really useful2 (YP6) “We were then sent to the ASD screening referral and knew the wait for that was around 4 years” (P3)
	Social Care bridging the CAMHS gap “We were in conversations with various agencies, and we had been referred to CAMHS” (P2) “A lovely social worker who is still supporting us” (P2) “I think without the social worker it would have been hard to wait” (YP2) “I had two social workers that were supporting me with my wellbeing, one at school one at home” (YP 4) “Social workers were always checking in and they told us how we were doing everything right” (P6) “Social care were great, she helped link up school and CAMHS so that we all knew what was going on” (P6)
5.One step forward, two steps back	*Starting from scratch* “Waiting gets longer and longer every time I have to wait” (YP1) “It was different people every time” (YP 3) “They rebuild a whole profile about me if they don't share” (YP 4) “It was so frustrating to keep going over and over why we were here- like asking ‘Why do you need help?’” (P5)
	Retelling my story “I don’t like retelling my story over and over again. A lot of stuff changes and I can’t remember things” (YP 1) (YP2) “I feel nervous as I don’t like talking to new people and not sure when I am meeting with them” (YP2) “They just asked the same questions they already asked and I felt like I had to repeat myself” (YP 3) “It was a bit off putting as once I have built that trust I don’t really like letting it go”(PY6)
	Low expectations of new team

	“What am I actually waiting for?” (YP1) “I don’t see what the difference is now, cause I haven’t seen anyone before, what are they going to do?” (YP1)
	What support am I getting? “I didn’t really know what was happening” (YP 1) “It would be helpful to have support while you are waiting for support” (YP2) “I had a couple of meetings, but I don’t think they were the actual support” (YP2) “I guess I just wanted some support, but I don’t really know what that would be” (YP 2) “They didn’t really help, they just asked questions every week” (YP 3) “All CAMHS would do is sit with their checklist maybe once a month and ask ‘is she alive?’. We were breathing, great, move on, it was literally that impersonal” (P6)
	Narratives of CAMHS “I think there's like a lot of negativities towards like CAMHS like just in this generation type thing.” (YP4) “I think a log of the time the media and the press influence what you think about CAMHS, you think that you are going to have to wait along time” (P5)
6.CAMHS professionals: Light at the end of the tunnel	*Professionals are fantastic* “CAMHS was very quick to be fair, the first lady was fantastic” (P2) “She did gel with actually did gel with [CAMHS worker]. She got on well with her, which was great” (P2) “I liked [CAMHS Practitioner]. She's very nice. I wish I could of kept seeing her” (YP2) “The assistant psychologist |I am seeing is really good” (YP 3) “He gets me just to talk about myself instead of going directly into what's going on and all the problems. “They gave me space to talk about how I feel and gave me ideas on how to cope” (YP6) “She was really good. She was very experienced” (P3)
	Going above and beyond “The talking therapy I’ve had has been really good” (YP6) “They have been really good at building this connection, it’s not like a friendship but it’s like trust” (YP6) “That was a great document that she sent to us off her own back” (P3) “The family therapy sessions we have had have been good. The support has been consistent” (P6)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CAMHS professionals: Light at the end of the tunnel
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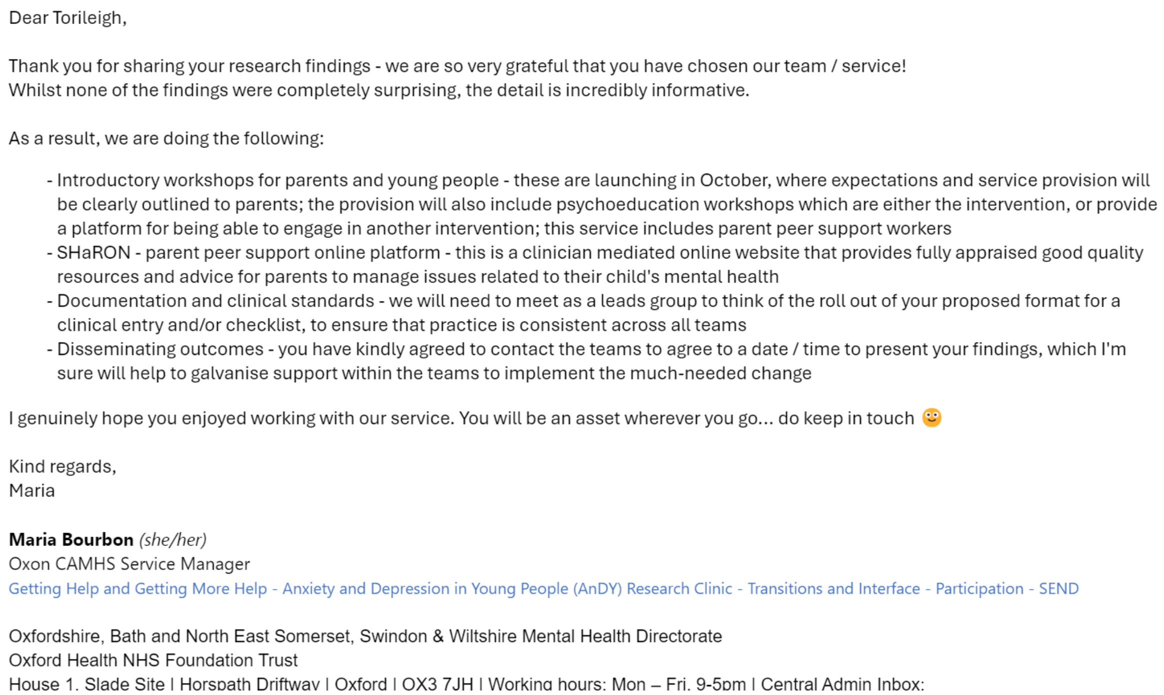
Going above and beyond

Appendix S: SIP: Key Clinician Messages

Key clinician messages:

- Clear, concise notes regarding the transfer process should be documented on the clinical notes. Clinicians should reduce the use of acronyms and ensure that it is clear the team’s name, locality, and professional role from which they are writing. Transfer between teams should use a standardised notes template.
- The transfer process is a time of increased risk, and vulnerability for both young people and parents. Clear communication about expectations and care plan is important to reduce risk and support engagement with CAMHS. This may include regular phone check ins, providing interim support via psychoeducation groups, access to a named professional or providing an update on wait times.
- Parents are often anxious during this period to due to the lack of clarity; they are likely to reach out more to reduce this. Clinicians spending time explain the transfer process/ CAMHS structure at the point of contact to service may mitigate this and increase parents’ capacity to cope.
- Young people often feel overlooked, and as though CAMHs does not care. Taking the time to write to young people in a more therapeutic manner can support engagement in the future.

Appendix T: SIP: Feedback from service



Dear Torileigh,

Thank you for sharing your research findings - we are so very grateful that you have chosen our team / service!
Whilst none of the findings were completely surprising, the detail is incredibly informative.

As a result, we are doing the following:

- Introductory workshops for parents and young people - these are launching in October, where expectations and service provision will be clearly outlined to parents; the provision will also include psychoeducation workshops which are either the intervention, or provide a platform for being able to engage in another intervention; this service includes parent peer support workers
- SHaRON - parent peer support online platform - this is a clinician mediated online website that provides fully appraised good quality resources and advice for parents to manage issues related to their child's mental health
- Documentation and clinical standards - we will need to meet as a leads group to think of the roll out of your proposed format for a clinical entry and/or checklist, to ensure that practice is consistent across all teams
- Disseminating outcomes - you have kindly agreed to contact the teams to agree to a date / time to present your findings, which I'm sure will help to galvanise support within the teams to implement the much-needed change

I genuinely hope you enjoyed working with our service. You will be an asset wherever you go... do keep in touch 🙂

Kind regards,
Maria

Maria Bourbon *(she/her)*
Oxon CAMHS Service Manager
Getting Help and Getting More Help - Anxiety and Depression in Young People (AnDY) Research Clinic - Transitions and Interface - Participation - SEND

Oxfordshire, Bath and North East Somerset, Swindon & Wiltshire Mental Health Directorate
Oxford Health NHS Foundation Trust
House 1, Slade Site | Horspath Driftway | Oxford | OX3 7JH | Working hours: Mon – Fri, 9-5pm | Central Admin Inbox:

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https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448295/homepage/forauthors.html

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You may like to use **this template** for your title page. The title page should contain**:**

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- Keywords;

- Data availability statement (see Data Sharing and Data Accessibility Policy);
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For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

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Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

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Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡,

§, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Finally, if submitting authors have any questions about the data sharing policy, please access the **FAQs** for additional detail.

Open Research initiatives.

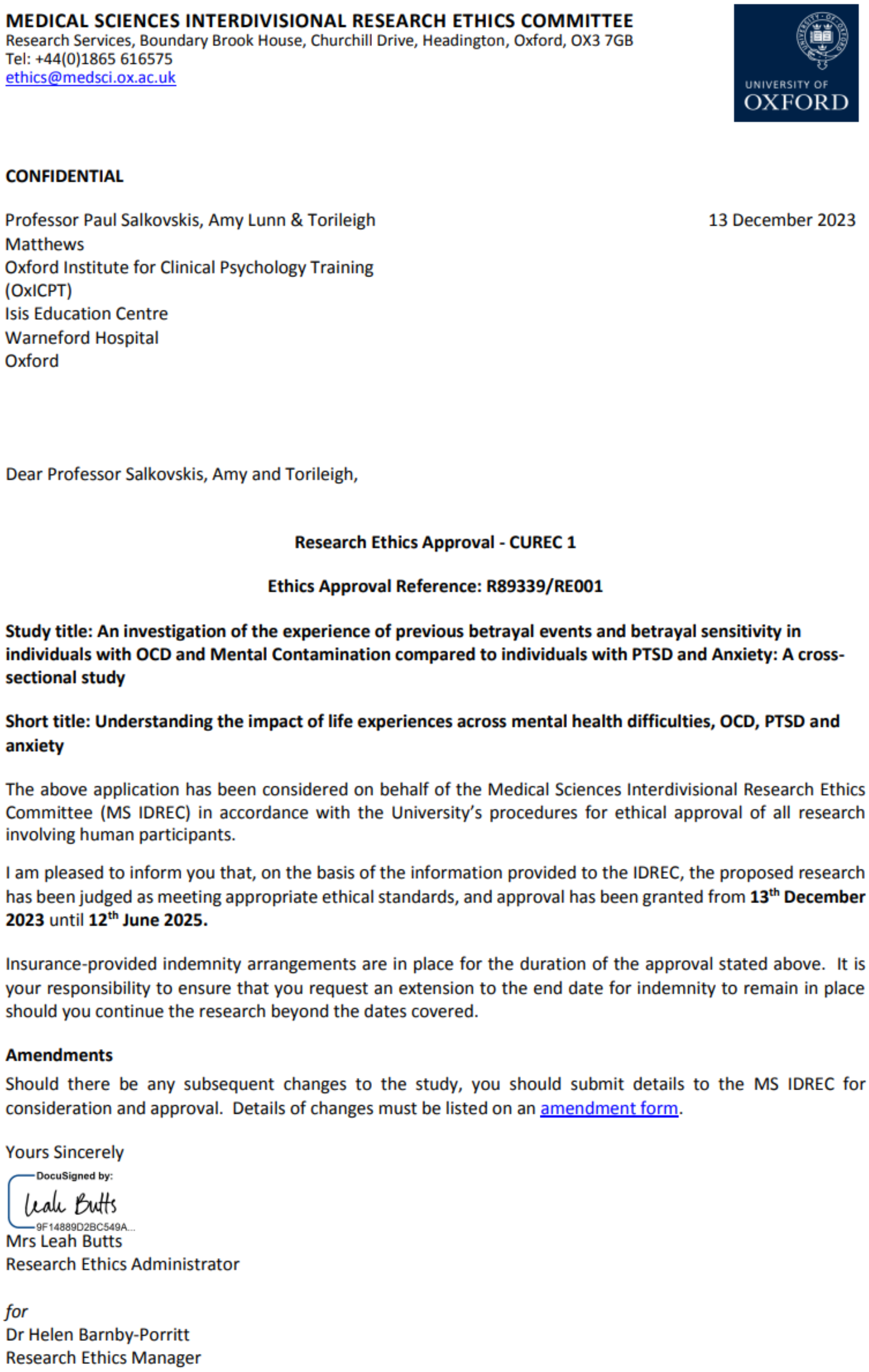
Recognizing the importance of research transparency and data sharing to cumulative research, *British Journal of Psychology* encourages the following Open Research practices. *Sharing of data, materials, research instruments and their accessibility. British Journal of Psychology* encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (**http://www.re3data.org**). Personal websites and most departmental websites do not qualify as repositories.

Appendix V: TDRP: Joint working statement with Amy Lunn (Trainee Clinical Psychologist)

This statement was written collaboratively with Amy Lunn.

This project was completed jointly with another Trainee Clinical Psychologist, Amy Lunn, who's research is in a similar area. Each project had different theoretical justifications, for example this project examined mental contamination in relation to betrayal type or frequency across OCD and anxiety groups. Whereas the other project focused on betrayal sensitivity, mental contamination and sensitivity to betraying others across OCD and PTSD groups. Both trainees shared the same internal and external supervisor. Projects were developed independently, however, due to the similar methodological approach and sample it was decided with the research team on the Oxford Doctorate in Clinical Psychology that the trainees should work jointly on certain areas of the project. This included a joint ethic application (CUREC) and preparation of study material, data collection (use of the SCID and self-report measure). This approach was taken to reduce participant burden and maximise recruitment efforts. Data analysis and write up were undertaken separately. As recognition of the separate and joint contributions towards each project, co-authorship was agreed to.

Appendix W: TDRP: Ethical Approval



MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

UNIVERSITY OF
OXFORD

CONFIDENTIAL

13 December 2023

Professor Paul Salkovskis, Amy Lunn & Torileigh
Matthews
Oxford Institute for Clinical Psychology Training
(OxICPT)
Isis Education Centre
Warneford Hospital
Oxford

Dear Professor Salkovskis, Amy and Torileigh,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R89339/RE001

Study title: An investigation of the experience of previous betrayal events and betrayal sensitivity in individuals with OCD and Mental Contamination compared to individuals with PTSD and Anxiety: A cross-sectional study

Short title: Understanding the impact of life experiences across mental health difficulties, OCD, PTSD and anxiety

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **13th December 2023** until **12th June 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments

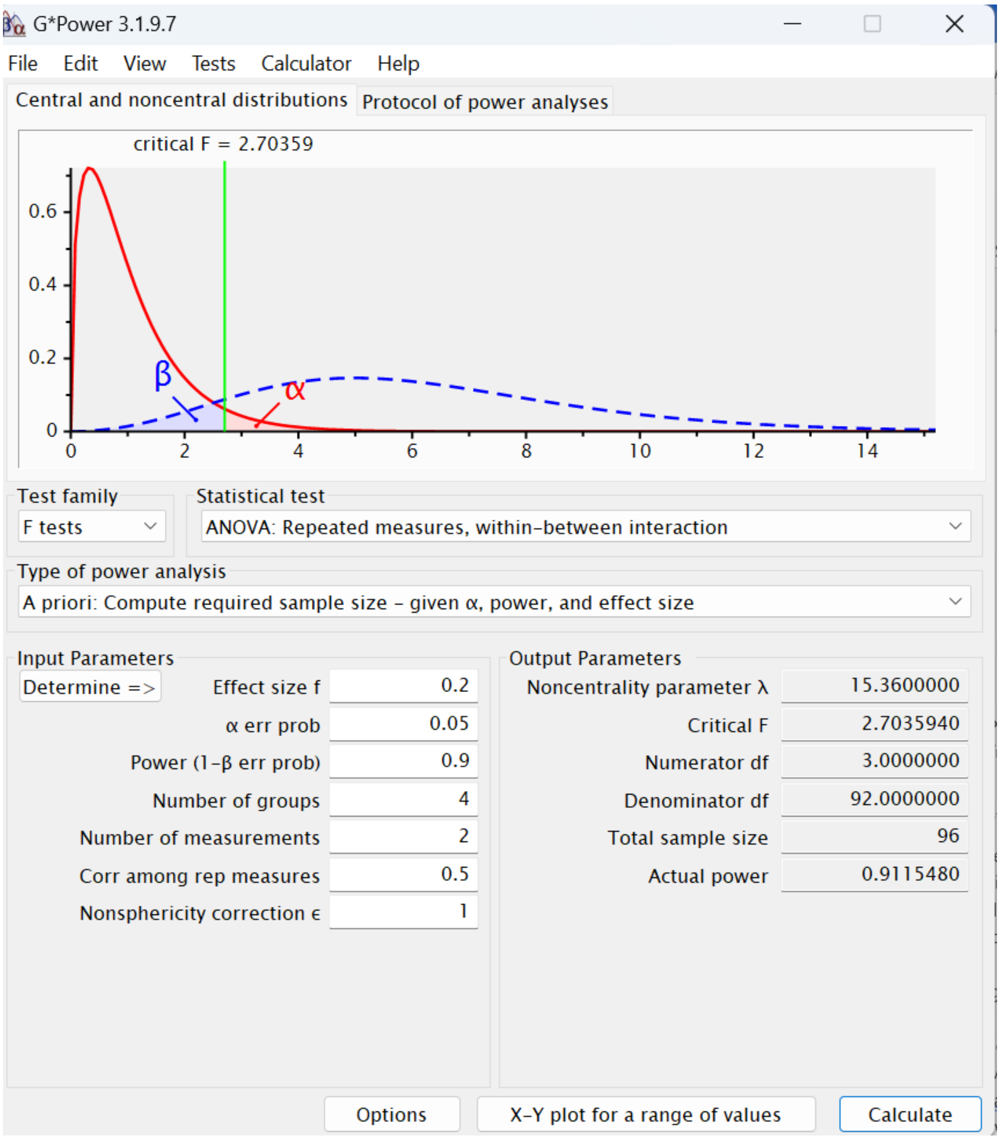
Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...
Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix X: TDRP: G-Power* calculation



Test family: F tests

Statistical test: ANOVA: Repeated measures, within-between interaction

Type of power analysis: A priori: Compute required sample size – given α, power, and effect size

Input Parameters

Effect size f	0.2
α err prob	0.05
Power (1-β err prob)	0.9
Number of groups	4
Number of measurements	2
Corr among rep measures	0.5
Nonsphericity correction ϵ	1

Output Parameters

Noncentrality parameter λ	15.3600000
Critical F	2.7035940
Numerator df	3.0000000
Denominator df	92.0000000
Total sample size	96
Actual power	0.9115480

Appendix Y: TDRP: Non-standard measures (BSM, TAF, MIS)

The Betrayal Screening Measure (BSM)

This questionnaire will ask you some questions about betrayal.

Betrayal is when **someone you trust** does something **on purpose** that causes you **emotional harm**. The most common forms of betrayal are:

1. Disloyalty
2. Infidelity
3. Dishonesty or deception
4. Disclosing confidential information
5. Sexually inappropriate behaviour
6. Aggressive or threatening behaviour and/or physical harm and/or assault by someone you know and trusted
7. Someone failing to help when you needed help

The following questions are about times when ***you yourself*** have been betrayed. You will be asked if you have experienced the different types of betrayals as listed above.

Thinking about the acts of betrayal that **you** have experienced **that have had the biggest impact** on you, please answer the questions below:

Have you experienced the following by a person you trusted?	
1. Disclosure of confidential information (*One of many possible examples would be:* if someone you trusted told other people information that you asked them to keep secret).	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened? Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc) Please select how many times this has happened to you If this has happened more than once, please list	Age drop down Open text response Drop down with number Open text response

who did this to you?	
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*). 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
2. Infidelity (*For example,* if you were in a trusting relationship and your partner had an affair with someone else).	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened? Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc) Please select how many times this has happened to you If this has happened more than once, please list who did this to you?	Age drop down Open text response Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source*	

of distress, the extent to which you still have distressing memories of this). 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
3. **Disloyalty** (e.g. being humiliated by someone you trusted) (*One of many possible examples would be;* if someone you trust is cruel or laughs about you to others behind your back.	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened? Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc) Please select how many times this has happened to you If this has happened more than once, please list who did this to you?	Age drop down Open text response Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*). 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
4. Dishonesty or deception (*One of many possible examples would be*; if someone you trusted lied to you about something important).	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened? Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc)	Age drop down Open text response

Please select how many times this has happened to you If this has happened more than once, please list who did this to you?	Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*). 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
5. Aggressive or threatening behaviour and/or Physical harm and/or assault by someone you know and trusted (*One of many possible examples would be;* if someone you know and trusted tried to/ or did do something to physically harm you)	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened? Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc) Please select how many times this has happened to you If this has happened more than once, please list who did this to you?	Age drop down Open text response Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source*	

of distress, the extent to which you still have distressing memories of this).

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong impact

6. Sexually inappropriate behaviour (*One of many possible examples would be;* if someone you know and trusted tried to/ or did do something to you in a sexual way that you did not consent to)	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened?	Age drop down
Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc)	Open text response
Please select how many times this has happened to you	Drop down with number
If this has happened more than once, please list who did this to you?	Open text response

At the time that this was ***happening***, how strongly did it impact on you?

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong impact

Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*).

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong impact

7. Failure of a trusted person to offer you help/ support when you asked for it (*One of many possible examples would be*; if you were in a situation where you needed help and someone you trusted had the capacity to help you, but they chose not to, even though they could).	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened?	Age drop down

Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc) Please select how many times this has happened to you If this has happened more than once, please list who did this to you?	Open text response Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*). 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	
8. **Other form of Betrayal:** Please briefly describe	**Yes / No** (If yes- directed to next Q or this act of betrayal)
How old were you when this first happened? Please state who did this to you (e.g. mum, dad, sister, friend, aunt, colleague, husband, wife, partner, etc) Please select how many times this has happened to you If this has happened more than once, please list who did this to you?	Age drop down Open text response Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong impact	

Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*).

0 20 30 40 50 60 70 80 90 100

not at all impact | slightly | moderately | a lot | extremely strong

Betrayal Screening Measure-others (BSM-other)

This questionnaire is going to ask you further questions about betrayal, but this time the questions are about times that **you** feel ***you might have betrayed others***.

The following questions will ask about those experiences where you may have betrayed another.

Thinking about the acts of betrayal that **you have carried** out, that have had the biggest impact on you, please answer the following:

Have you had an experienced of:	
1. **Infidelity** (*One possible example would be:* if you were in a relationship and you had an affair with someone else)	Yes/ No (if yes, participants will be directed to specifiers below- if no, they will directed to next form of betrayal)
How old were you when this first happened?	Age drop down
Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc)	Open text response
Please select how many times this has happened	Drop down with number
If this has happened more than once, please list who you did this to?	Open text response

At the time that this was ***happening***, how strongly did it impact on you?

0 20 30 40 50 60 70 80 90 100

not at all | slightly | moderately | a lot | extremely strong

Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*).

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

2. Disclosure of confidential information (*One of many possible examples would be*, if you told other people information that you had been asked to keep secret).	Yes / No
How old were you when this first happened? Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc) Please select how many times this has happened If this has happened more than once, please list who you did this to?	Age drop down Open text response Drop down with number Open text response

At the time that this was ***happening***, how strongly did it impact on you?

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*).

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

3. Disloyalty (*One of many possible examples would be;* if you were cruel or humiliated someone who trusted you behind their back).	Yes / No
How old were you when this first happened? Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc)	Age drop down Open text response Drop down with number

Please select how many times this has happened If this has happened more than once, please list who you did this to?	Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*). 0 20 30 40 50 60 70 80 90 100 not at all slightly moderately a lot extremely strong	
4. Dishonesty or deception (*One of many possible examples would be*: if you lied to someone who trusted you about something important).	Yes / No
How old were you when this first happened? Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc) Please select how many times this has happened If this has happened more than once, please list who you did this to?	Age drop down Open text response Drop down with number Open text response
At the time that this was ***happening***, how strongly did it impact on you? 0 20 30 40 50 60 70 80 90 100 not at all impact slightly moderately a lot extremely strong	
Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*). 0 20 30 40 50 60 70 80 90 100 not at all impact slightly moderately a lot extremely strong	
5. Aggressive or threatening behaviour	Yes / No

Physical harm and/or assault of someone you know (*One of many possible examples would be:* if you tried to/ or did do something to physically harm someone who you knew and trusted)	
How old were you when this first happened?	Age drop down
Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc)	Open text response
Please select how many times this has happened	Drop down with number
If this has happened more than once, please list who you did this to you?	Open text response

At the time that this was ***happening***, how strongly did it impact on you?

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*).

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

6. **Sexually inappropriate behaviour** (*One of many possible examples would be*: if you tried to /or you did do something sexually inappropriate to someone you know)	Yes / No
How old were you when this first happened?	Age drop down
Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc)	Open text response
Please select how many times this has happened	Drop down with number
If this has happened more than once, please list who you did this to?	Open text response

At the time that this was ***happening***, how strongly did it impact on you?

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

<table>
<tr><td colspan="2">Looking back <i>over your life</i> how much do you think this event has impacted on you since it happened? (<i>For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this</i>).
0 20 30 40 50 60 70 80 90 100
not at all slightly moderately a lot extremely strong</td></tr>
<tr><td>7. Failure to offer help/ support to someone who asked you for it, even though you could have
(<i>One of many possible examples would be:</i> if you were in a situation where someone you knew and trusted needed your help and you had the capacity to give it, but you chose not to).</td><td>Yes / No</td></tr>
<tr><td>How old were you when this first happened?
Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner etc)
Please select how many times this has happened
If this has happened more than once, please list who you did this to?</td><td>Age drop down
Open text response
Drop down with number
Open text response</td></tr>
<tr><td colspan="2">At the time that this was <i>happening</i>, how strongly did it impact on you?
0 20 30 40 50 60 70 80 90 100
not at all slightly moderately a lot extremely strong</td></tr>
<tr><td colspan="2">Looking back <i>over your life</i> how much do you think this event has impacted on you since it happened? (<i>For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this</i>).
0 20 30 40 50 60 70 80 90 100
not at all slightly moderately a lot extremely strong</td></tr>
<tr><td>8. Other: Please describe</td><td>Yes / No</td></tr>
<tr><td>How old were you when this first happened?
Please indicate who you did this to (e.g. mum, dad, sister, friend, aunt, colleague, partner, etc)
Please select how many times this has happened
If this has happened more than once, please</td><td>Age drop down
Open text response
Drop down with number</td></tr>
</table>

list who you did this to?	Open text response

At the time that this was ***happening***, how strongly did it impact on you?

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

Looking back ***over your life*** how much do you think this event has impacted on you since it happened? (*For example, impacted on your ability to form trusting relationships, has been a source of distress, the extent to which you still have distressing memories of this*).

0 20 30 40 50 60 70 80 90 100

not at all slightly moderately a lot extremely strong

Thought-Action-Fusion Scale

Do you disagree or agree with the following statements?	Disagree Strongly	Disagree	Neutral	Agree	Agree Strongly
1. Thinking of making an extremely critical remark to a friend is almost as unacceptable to me as actually saying it……….	0	1	2	3	4
2. If I think of a relative/friend losing their job, this increases the risk that they will lose their job………………………..	0	1	2	3	4
3. Having a blasphemous thought is almost as sinful to me as a blasphemous action……………………………………………	0	1	2	3	4
4. Thinking about swearing at someone else is almost as unacceptable to me as actually swearing………………….	0	1	2	3	4
5. If I think of a relative/friend being in a car accident, this increases the risk that he/she will have a car accident…….	0	1	2	3	4
6. When I have a nasty thought about someone else, it is almost as bad as carrying out a nasty action……………………….	0	1	2	3	4
7. If I think of a friend/relative being injured in	0	1	2	3	4

	a fall, this increases the risk that he/she will have a fall and be injured.					
8.	Having violent thoughts is almost as unacceptable to me as violent acts………………………………………………………	0	1	2	3	4
9.	If I think of a relative/friend falling ill this increases the risk that he/she will fall ill……………………………………..	0	1	2	3	4
10.	When I think about making an obscene remark or gesture in church, it is almost as sinful as actually doing it……………	0	1	2	3	4
11.	If I wish harm on someone, it is almost as bad as doing harm.	0	1	2	3	4
12.	If I think of myself being injured in a fall, this increases the risk that I will have a fall and be injured…………………….	0	1	2	3	4
13.	When I think unkindly about a friend, it is almost as disloyal as doing an unkind act……………………………………….	0	1	2	3	4
14.	If I think of myself being in a car accident, this increases the risk that I will have a car accident……………………………	0	1	2	3	4
15.	If I think about making an obscene gesture to someone else, it is almost as bad as doing it……………………………………	0	1	2	3	4
16.	If I think of myself falling ill, this increases the risk that I will fall ill………………………………………………………..	0	1	2	3	4
17.	If I have a jealous thought, it is almost the same as making a jealous remark………………………………………………...	0	1	2	3	4
18.	Thinking of cheating in a personal relationship is almost as immoral to me as actually cheating…………………………..	0	1	2	3	4
19.	Having obscene thoughts in a church is unacceptable to me…	0	1	2	3	4

VOCI - MC Scale

	Do you *agree* or *disagree* with the following statements?	**Not at all**	**A little**	**Some**	**Much**	**Very much**
1.	Often I look clean but feel dirty.	0	1	2	3	4

2.	Having an unpleasant image or memory can make me feel dirty inside.	0	1	2	3	4
3.	Often I cannot get clean no matter how thoroughly I wash myself.	0	1	2	3	4
4.	If someone says something nasty to me it can make me feel dirty.	0	1	2	3	4
5.	Certain people make me feel dirty or contaminated even without any direct contact.	0	1	2	3	4
6.	I often feel dirty under my skin.	0	1	2	3	4
7.	Some people look clean, but feel dirty.	0	1	2	3	4
8.	I often feel dirty or contaminated even though I haven’t touched anything dirty.	0	1	2	3	4
9.	Often when I feel dirty or contaminated, I also feel guilty or ashamed.	0	1	2	3	4
10.	I often experience unwanted and upsetting thoughts about dirtiness.	0	1	2	3	4
11.	Some objects look clean, but feel dirty.	0	1	2	3	4
12.	I often feel dirty or contaminated without knowing why.	0	1	2	3	4
13.	Often when I feel dirty or contaminated, I also feel angry.	0	1	2	3	4
14.	Unwanted and repugnant thoughts often make me feel contaminated or dirty.	0	1	2	3	4
15.	Standing close to certain people makes me feel dirty and/or contaminated.	0	1	2	3	4
16.	I often feel dirty inside my body.	0	1	2	3	4
17.	If I experience certain unwanted repugnant thoughts, I need to wash myself.	0	1	2	3	4
18.	Certain people or places that make me feel dirty or contaminated leave everyone else completely unaffected.	0	1	2	3	4
19.	The possibility that my head will be filled with worries about contamination makes me very anxious.	0	1	2	3	4
20.	I often feel the need to cleanse my mind.	0	1	2	3	4
21.	I can catch ‘mind germs’ from people who are mentally ill.	0	1	2	3	4
22.	I often feel dirty or contaminated when someone has humiliated me.	0	1	2	3	4
23.	If someone betrays me, it leaves me feeling dirty.	0	1	2	3	4
24.	People who are immoral can make me feel dirty.	0	1	2	3	4
25.	My own thoughts, memories or images can make me feel dirty or contaminated.	0	1	2	3	4

26. I can catch people’s undesirable characteristics.	0	1	2	3	4
27. I worry that I might pick up ‘mental germs’ or ‘mind germs’.	0	1	2	3	4

Magical Ideation Scale (MIS)

1. I have occasionally had the silly feeling that a TV or radio broadcaster knew I was listening to him.	True	False
2. I have felt that there were messages for me in the way things were arranged, like in a store window.	True	False
3. Things sometimes seem to be in different places when I get home, even though no one has been there.	True	False
4. I have never doubted that my dreams are the products of my own mind.	True	False
5. I have noticed sounds on my records that are not there at other times.	True	False
6. I have had the momentary feeling that someone's place has been taken by a look-alike.	True	False
7. I have never had the feeling that certain thoughts of mine really belonged to someone else.	True	False
8. I have wondered whether the spirits of the dead can influence the living.	True	False
9. At times I perform certain little rituals to ward off negative influences.	True	False
10. I have felt that I might cause something to happen just by thinking too much about it.	True	False
11. At times, I have felt that a professor's lecture was meant especially for me.	True	False
12. I have sometimes felt that strangers were reading my mind.	True	False
13. If reincarnation were true, it would explain some unusual experiences I have had.	True	False
14. I sometimes have a feeling of gaining or losing energy when certain people look at me or touch me.	True	False
15. It is not possible to harm others merely by thinking bad thoughts about them.	True	False
16. I have sometimes sensed an evil presence around me,	True	False

although I could not see it.

17. People often behave so strangely that one wonders if they are part of an experiment. True False

18. The government refuses to tell us the truth about flying saucers. True False

19. I almost never dream about things before they happen. True False

20. I have sometimes had the passing thought that strangers are in love with me. True False

21. The hand motions that strangers make seem to influence me at times. True False

22. Good luck charms don't work. True False

23. I have sometimes been fearful of stepping on sidewalk cracks. True False

24. Numbers like 13 and 7 have no special powers. True False

25. I have had the momentary feeling that I might not be human. True False

26. I think I could learn to read others' minds if I wanted to. True False

27. Horoscopes are right too often for it to be a coincidence. True False

28. Some people can make me aware of them just by thinking about me. True False

29. I have worried that people on other planets may be influencing what happens on Earth. True False

30. When introduced to strangers, I rarely wonder whether I have known them before. True False