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Compulsive Hoarding in Children: Six Case Studies

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Semi-structured interviews were conducted with the parents of six children who showed signs of compulsive hoarding. The cases revealed a wide variety of hoarding behaviors. Hoarding manifested in difficulties in discarding and maintaining control over possessions. Few cases had problems with clutter or excessive acquisition. In three cases hoarding was episodic and stress-related. Most of the cases showed overlapping ADHD symptoms and a majority demonstrated problems with perfectionism. Only two had clear obsessive-compulsive disorder, although concerns about others touching or moving possessions, which was present in all of the cases, may represent a form of ordering and arranging compulsions. None of the cases demonstrated clear insight, and several showed abnormal personification of inanimate objects and exaggerated “essentialism.”

Frost and Hartl (1996) defined compulsive hoarding as (a) the acquisition of, and failure to discard, a large number of possessions; (b) resulting clutter that precludes activities for which the living spaces were designed, and (c) significant distress or impairment in functioning caused by the hoarding. It has emerged as a serious mental and public health problem (Frost, Steketee, & Williams, 2000; Tolin, Frost, Steketee, Gray, & Fitch, 2008) and has been closely associated with problems among the elderly (Frost, Steketee, & Williams, 2000; Steketee, Frost, & Kim, 2001; Thomas, 1997). Recently Samuels et al. (2008) reported the prevalence of hoarding in a community based sample to be 5% (weighted prevalence). While hoarding is typically thought of as a subtype of obsessive compulsive disorder (OCD), its distinctiveness sets it apart and has raised questions about whether it should be considered a separate disorder (Saxena, 2007). Among adults, hoarding has been the subject of a great deal of recent research (Steketee & Frost, 2003), while there has been relatively little study of this phenomenon in children.

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Despite the focus on hoarding in adult and elderly populations (Steketee & Frost, 2003), retrospective studies of adults with hoarding problems have consistently found hoarding to begin in childhood. Seedat and Stein (2002) found an average age of reported onset of 13 among 15 individuals who displayed hoarding behaviors. Samuels et al. (2007) found onset of hoarding symptoms at 14 years among a large sample of OCD hoarders. A retrospective study of 51 individuals with compulsive hoarding indicated that 60% reported hoarding behaviors occurring by age 12, which then increased to 80% by age 18 (Grisham, Frost, Steketee, Kim, & Hood, 2006). Despite the apparent early age of onset, few studies of hoarding in children exist.

The prevalence of hoarding in children has been evaluated among those being treated in specialty clinics for OCD. Leonard, Goldberger, Rapoport, Cheslow, & Swedo (1990) reported hoarding in ten of 24 childhood OCD cases in a study of childhood rituals. Storch et al. (2007) found that 26% of their sample of 80 children with OCD had hoarding as their primary symptom. Stewart et al. (2007) found hoarding in 34% of a sample of 231 children with OCD, while Mataix-Col, Nakatani, Micali, and Heyman (2008) found hoarding symptoms in over 50% of the girls and 36% of the boys in this study of 238 children with OCD. Hoarding outside the context of OCD has not been well-studied, although hoarding also occurs in Prader-Willi syndrome (Dykens, Leckman, & Cassidy, 1996), a genetic disorder that results in mild mental retardation, intense food-seeking behavior, and hoarding.

Several factor analyses of children with OCD using the checklist from the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) have identified hoarding as a separate factor (Stewart et al., 2007, 2008), as a factor combined with checking compulsions (Mataix-Cols et al., 2008), or as a factor with ordering and arranging compulsions (McKay et al., 2006). Delorme et al. (2006) found that the four symptom dimensions that have been identified with adults (e.g., symmetry/ordering, obsessive contamination/cleaning, and hoarding) were also found with children and that over a four-year period these dimensions remained stable. Hanna et al. (2002) found childhood hoarding more common in non-tic-related OCD (>45%) compared to tic-related OCD (<15%). Storch et al. (2007) found more somatic complaints, ordering and arranging compulsions, magical thinking, more externalizing behavior, and less insight in OCD-hoarding children than OCD non-hoarding children.

Unfortunately, none of these studies address the question of whether hoarding in children manifests in the same way as hoarding in adults. No case descriptions of hoarding in children have appeared in the published literature. Descriptive case series can be especially useful in detailing the scope and complexity of a problem and elucidating the way it manifests in everyday life. In the case of childhood hoarding this is important since there are several reasons to suggest that hoarding in children may manifest differently than hoarding in adults. In adults, the primary features of hoarding (and the definition) include problems with acquisition, difficulty discarding, and clutter (Steketee & Frost, 2003). However, some evidence suggests these features may vary in importance in childhood hoarding. Grisham et al. (2006) found acquisition to develop later than difficulty discarding and clutter, and suggested that it may be less relevant for children since they lack the financial independence and transportation resources of adults.

Clutter is the most readily apparent manifestation of hoarding in adults. However, children often do not exercise complete control over their living space. Consequently, clutter may be less problematic for children who hoard, or the problem may get expressed in a different form. For example, management and organization of possessions

may be more of a problem for children who hoard. Adults who hoard express strong beliefs about maintaining control over their possessions, but this control seldom gets challenged since others are often kept out of their living space. Such concerns about control over possessions may be more apparent in children as parents attempt to manage clutter for them. Storch et al. (2007) suggested that this may be responsible for the association between hoarding and externalizing behavior observed in their hoarding sample. The intensity of control concerns may also reflect a form of ordering and arranging compulsions, also found to be associated with childhood hoarding (McKay et al., 2006; Storch et al., 2007) and in some studies of adult hoarding (Samuels et al., 2002).

Difficulty discarding in adults who hoard is associated with a variety of reasons for saving, including: beliefs about future use, responsibility, and waste, memory, emotional attachment, and identity. Occasionally adults who hoard demonstrate a tendency to ascribe human-like qualities to objects (Steketee, Frost, & Kyrios, 2003). Stage theorists suggest there is a normative phase in child development during which children attribute feelings to inanimate objects (Inhelder & Piaget, 1958). The relationship between this clinical concept and normal developmental tendency to personify objects may be relevant in childhood hoarding.

In addition, it is possible that hoarding may represent a clinical variant of a normal cognitive bias to make attributions that objects have a unique property or "essence" (Gelman, 2003). In a recent study, Hood and Bloom (2008) demonstrated that, when the appearance of an object was held constant, children preferred objects they perceived to hold some attribute or essence. Thus an object that was believed to have been touched by the Queen of England was given more importance than an identical object that had not. The categorization of objects involved the appreciation of some quality that could not be seen. Hoarding may represent a clinical variant on the normal process of psychological "essentialism." Similarly, Kellett and Knight (2003) have proposed that a type of cognitive distortion termed Object-Affect Fusion occurs in hoarding, "...in which the individual appears to pair and fuse emotions associated with the objects, to the object themselves" (Kellett & Knight, 2003). This type of cognitive distortion may be more apparent in children who hoard.

Other features of hoarding may also vary in children versus adults. Storch et al. (2007) reported insight problems in their sample of hoarding children, though a subsequent study failed to show any differences in hoarding between children with and without insight regarding their OCD (Storch et al., 2008). Perfectionism is thought to be part of the hoarding syndrome (Frost & Gross, 1993), but there are no reports of its association with hoarding in children.

The purpose of this study was to provide case descriptions of hoarding that may be helpful in identifying the defining features of hoarding in children and aiding in the direction of future research.

METHOD

Participants

Participants in this study were parents who had a child with an easily identifiable problem discarding (or letting go of) possessions that other children relinquish easily. They were recruited from local clinicians who specialized in anxiety disorders. The criterion

for inclusion was the parents' report that their child showed marked distress during everyday life when asked to discard trash, damaged toys, or other items. The children did not have to be diagnosed with any disorder, though most were since they were recruited from clinicians. To be included, the behaviors had to be intrusive enough that parents had to make the discarding of objects a frequent issue in their parenting of their child. These criteria were purposefully broad to capture as much of the range of hoarding in children as possible. The parents of six children were interviewed. Four of the children were boys and two were girls, and they ranged in age from six to 22 at the time of the interview. The parents and children were Caucasian and one was also Hispanic. One child in the study was adopted and others were biological offspring. The focus of the interview for the 22-year-old was her childhood years. Two additional families were interviewed but excluded because their children's behavior did not clearly represent difficulties in discarding objects.

The present study was approved by the Institutional Review Board at Smith College and participants signed informed consent to participate.

Procedures

A semi-structured parent interview was developed to assess the range and type of hoarding behaviors in children. The interview questions were developed based on the investigators' clinical experience on hoarding behaviors. Questions focused on the manifestation of hoarding behavior, the effects it had, onset and fluctuations in the behavior, associated problems such as ADHD and perfectionism, explanations the child offered for their behavior, and family history of hoarding and OCD (See Appendix A). To protect patient confidentiality, no information was collected from the referring clinicians.

Interviews were conducted in the subjects' home or investigators' offices and lasted about one hour. No compensation was offered for the interviews. It would have been desirable to interview the children as well as the parents. However, for reasons specific to each family, the children were unavailable for interview.

RESULTS

Case 1

Sam was a ten-year-old boy whose mother was in treatment for OCD. Sam's mother reported that when he was about eight years old, he began having great difficulty throwing away certain objects. The first thing she noticed was his inability to get rid of two empty soda bottles that he kept on the floor in the middle of his room. Not only did he refuse to get rid of them, but he became agitated and tearful whenever she suggested he do so. His explanation conveyed little information about the nature of his attachment to the bottles. His mother remembers him saying, "They're mine. They're in my room. I should be able to keep what I want in my room."

Another difficult item his mother described was an old napkin sitting on the desk in Sam's room. When she threw it away, he became angry and retrieved it from the trash, insisting that he liked it because it was old. He also saved magazines because

they might contain things he wanted to read. Sam's room was never overly cluttered, and his mother was less concerned about that than with his difficulty in discarding these unusual things. Even Sam expressed puzzlement about his not wanting to get rid of things. He said it made him feel weird and strange.

Sam showed no tendency to actively acquire possessions and no problems with clutter, but did show some rigid and unusual behavior related to the organization and storage of his possessions. In addition to the bottles and napkin, Sam's magazines and CD player resided in specified locations in his room. If someone moved them, he knew as soon as he walked into his room. He remained agitated until he moved the items back to their proper locations. He kept a glass of water on his desk, along with the old napkin, and insisted that his mother not move or replace it. His bedcovers had to be arranged a certain way as well or he became agitated.

His mother described Sam as perfectionistic and very concerned about meeting others' expectations. He had other elements of social phobia as well. In school, for instance, his teachers noted to his parents how difficult it was for him to give a presentation in front of the class. Sam's relationship to his possessions extended to how he imagined others might perceive him. He was concerned that if things were too neat in his room he might be perceived as being too much of a "fancy boy," a term that had personal significance to him, though his mother was not clear just what was significant about it. The wires to his electronic devices had to be tangled so that he did not appear to be too neat. Other objects had to be casually placed, such as a hat on the floor, to avoid the appearance of being too "fancy." Thus, certain parts of his room had to be very deliberately organized. Other than this distinct form of arranging his possessions, there were no other behaviors suggestive of OCD.

There was a family history of anxiety not only in Sam's mother but in his maternal grandmother as well. Also, Sam's maternal grandmother lived with significant clutter from magazines she collected and was unable to get rid of. Sam's father was described as having a temper which Sam found frightening. His mother believed that Sam's father "seemed to have unrealistic expectations of what's expected of a child at different developmental stages." It was during the period of greatest conflict between Sam and his father that the hoarding problems appeared. At the time, Sam and his father fought a lot, mostly over Sam's doing chores and not cooperating with other aspects of his household. The conflict coincided with the separation and divorce of Sam's parents. When the situation with the father calmed down, Sam was able to throw away the bottles on his own initiative. In fact, the hoarding behaviors disappeared shortly after the divorce, though what appeared to be discrete arranging compulsions have persisted.

Case 2

Sally was a ten-year-old girl who began having difficulty discarding at eight years old, when her parents began divorce proceedings. The difficulties began with a pumpkin Sally's mother had given her for Halloween. She became so attached to it that she wouldn't let it out of her sight. She even insisted on sleeping with it. According to her mother, Sally treated the pumpkin as though it were a person, even ascribing emotions to it, saying on some occasions that it was sad. When it fell off a table, she cried because it was both hurt and sad. Sally's mother said it was not unusual for her to do

this with some of her dolls and stuffed animals, but her attachment to the pumpkin was different somehow, almost as though the pumpkin was an extension of her.

When the pumpkin began to rot, Sally's mother made her get rid of it, and Sally reacted as though she was losing a piece of herself. With the pumpkin gone, Sally shifted her attention to a balloon with a similar kind of attachment. Sally's attachments soon spread to almost everything she owned, and her mother began having difficulty managing the behavior. Sally wanted to save everything, even scraps of paper, and became upset when her mother discarded them. Frequently she dug through the trash to rescue things. Her mother began to discard things clandestinely in order to keep their house from being overrun with junk. In addition to ascribing feelings to these objects, Sally insisted they were important to her and could be put to use, though she couldn't say how. During the worst of it, Sally's mother reported, "There wasn't very much she could throw away, and if I threw it away, it would bring great stress. I'd often have to hide it or put it beneath the garbage so she wouldn't see it." The divorce and subsequent move required getting rid of some furniture that would not fit into the new living space. Sally became upset when informed that one of their two couches would have to be sold. After the sale, Sally hid the pillows from the remaining couch with the hope that it would prevent its sale. Not long after the move Sally began actively collecting things—candy wrappers, stones, and other small items. These things piled up on the floor of her room.

Sally had relatively little clutter in her room during her hoarding problems because her mother clandestinely discarded things from Sally's room. Her mother reported no ADHD or attention related problems and no difficulties with symmetry or arrangement of objects. Nor did Sally display any other significant OCD symptoms. She had been in treatment for social phobia, which had markedly interfered with her ability to participate in the classroom. Sally was concerned with being a "perfect" student and did not want to risk saying anything wrong. There was also a family history of social phobia, but not of hoarding behavior.

The hoarding got progressively worse over a period of two years, which led Sally's mother to seek help for the problem. A combination of cognitive behavior therapy and a resolution of the parental divorce appears to have resolved the hoarding. No signs of hoarding behaviors had occurred in the year prior to our interview.

Case 3

Nine-year-old Julian was described by his parents as always being a sensitive and somewhat anxious child. He was very engaged with his stuffed animals and would personify them all in his play. As his parents explained, "He always took his toys very seriously, and broken toys were always an issue, as they are with most kids, but he was never one to say 'oh, it's broken' and throw it over his shoulder. He always wanted to know whether it could be fixed, and even if it couldn't he would still want to hold on to it." In retrospect, they can recall that Julian would hesitate before throwing anything away, and would need a prompt such as, "Julian that is trash, you can throw it away." Though noticeable, none of these behaviors seemed especially remarkable. However, when he was seven years old, Julian broke his arm, and the hoarding behaviors became pronounced. When he went to the bathroom, his parents began noticing that he saved the paper towels he used for drying his hands. When they confronted him about it he began to hide things in his pockets and under his bed. He didn't want to eat a Valentine Hershey's Kiss because it came in a red foil. He asked, "What if Hershey's

doesn't come out with it again?" He began holding onto all sorts of trash — paper plates, dirty napkins, soda bottles, empty potato chip bags — virtually anything with which he came in contact. On bad days, he even saved the lint from his clothing. In the therapist's office, Julian had difficulty recycling a piece of paper on which he had just drawn. At school his teacher observed him struggle as he approached the trashcan with scraps from a class project. When asked about why these items couldn't be thrown out, Julian was quick to offer a suggestion about a possible future use of the object at hand. When a toy of his was thrown out because it was damaged beyond repair, his parents would hear him report at bedtime that he had a sad feeling. In contrast to Sally, there was no personification of these objects; their utility and fear of waste seemed to drive the behaviors. Also, there were no OCD symptoms. Julian seldom went out of his way to collect things. His saving was limited to things that passed through his home or classroom naturally. There was little clutter in his room during this time since his parents helped Julian get rid of things.

Julian's parents had seen some distractibility or attention problems, but they thought they might be due to his cautiousness. They described Julian as "deliberate" in whatever he does, "like he doubts his answer." This often resulted in him having to stay in at recess to finish his work. He also displayed significant problems in making decisions; "he's worried about making the wrong decision in his own mind," described his father. But his perfectionistic concerns centered on only a few areas of his life. His father observed that decisions were hardest for Julian when they involved spending money. "He has trouble because he's thinking of all the different possibilities," his father said.

His parents sought therapy for Julian to address his anxiety and hoarding behaviors. A very brief cognitive behavior therapy in which the hoarding problem was personified as a "brain bug" and exercises in discarding items were employed appeared helpful. The therapy, along with his cast being removed, seemed to work together, and his hoarding behaviors disappeared for several months. Then one day Julian told his parents he was having "that sadness feeling" again, especially in math class where he worried he would cry over things he had thrown away. Shortly before this episode Julian had been moved to a more advanced math class, one requiring more rapid problem solving. The overly deliberate young man worried about his ability to succeed. In a few weeks it was clear to him that he could do the work, and that sadness feeling went away.

Nevertheless, the parents reported that discarding things continued to be hard for Julian. Popsicle wrappers deliberately perched on the edge of the trash can and clearly not placed in it led them to believe the problem still existed. Julian has remained very sensitive to the idea of recycling, frequently reminding his teacher to recycle trash. His father noted ironically that Julian received a good citizenship award in his school for his sensitivity to recycling. As long as things are recycled he can tolerate discarding them, but not if they are just treated as waste.

Case 4

Amy was in her early twenties at the time we interviewed her adoptive mother. The first five years of her life were marked by neglect and disruption. Her biological mother, who struggled with drug addiction, OCD and eventually AIDS, was not able to care for Amy, and she was placed in an adoptive home. Subsequently, her younger

sister, who also had OCD, joined this same family. At the time Amy arrived, her hoarding behaviors were evident. She and her sister hid food under their beds and elsewhere in their rooms. At first it was primarily food, and the new parents attributed it to having been deprived. They were careful to make sure the girls had plenty of food available. Gradually the food hoarding subsided, but for Amy other hoarding behavior escalated. At first her parents noticed that she never discarded any school papers. Piles of them accumulated under her bed and in her closet. The papers were a mixture of important and unimportant ones, like year-old reminders to bring mittens to school. According to her mother, Amy made no distinctions. If the paper belonged to her, she kept it. Her collection spread to other things — clothes, toys, ticket stubs, books, CDs —virtually anything imaginable, and all of it in her room. By an early age her side of the room became a cluttered sea of things and contrasted sharply with her symmetry-obsessed sister's half of the room.

As a young child Amy began actively acquiring things. When she went to other kids' homes to play, she always came home with things. Usually they were things she didn't need or already owned—clothes, DVDs, flashlights, scissors. She convinced her friends to "loan" them to her. Once they entered her room, however, they became hers and getting them back to their rightful owner was difficult. Amy's mother described numerous embarrassing phone calls from the parents of Amy's friends asking for the return of clothes, cameras, and much more. When confronted with this, Amy became infuriated that other people would insinuate she was taking things that didn't belong to her. "I'm a nice person. I don't steal things," she said. With her family, Amy often didn't cajole a loan, but simply took things. Trying to get them back resulted in an angry exchange. "But it's not stealing if it's your family," Amy insisted to her mother. Even now, when Amy comes home for a visit, her younger sister hides her favorite things so they won't leave with Amy.

Amy did not suffer from social anxiety or general perfectionism, although her mother described her as perfectionistic about her appearance. In addition to her hoarding, Amy had contamination fears and significant avoidance rituals to deal with them. Her mother explained that Amy "didn't touch a doorknob for eight years." In addition, though she was never diagnosed, Amy displayed many symptoms of ADHD which have continued into her adulthood. She had always had difficulty sustaining concentration and effort, particularly on tasks that were difficult or bored her. Throughout her childhood and into adulthood Amy lost things—cell phones, car keys, ATM cards, driver's licenses, and more. She even lost her Life Book—a compilation of her birth family history and information on her adoption.

Although Amy did not assign emotion to her possessions in the same way as Sally, she did view her possessions as part of her personal history and identity. According to her mother, Amy also had a peculiar understanding of ownership of possessions. "If she ever owned it, it's hers; if she wished she owned it, it's hers; if in the future she might own it, it's hers; if it belongs to anyone she loves and who loves her, it's hers." Her mother said that as she got older Amy could acknowledge her problem with hoarding, but only if she was having a good day.

Case 5

Eric was 12 when we interviewed his mother and father and in treatment for OCD, which began at nine-years old when a classmate vomited during a school Halloween

party. Since the episode, anything related to school was contaminated for Eric, as was anything blue, which was the color of his classmate's shirt on the day of the party. Every day after school, just inside the back door, Eric dumped his backpack and school papers and changed his clothes in order not to contaminate the rest of the house. He did his homework as close to that spot as possible.

Eric's difficulty parting with and managing possessions, while not as troublesome as his contamination fears, first appeared when he was eight. It began with saving boxes and packing materials from toys he was given as presents. It escalated when the contamination fears began. Part of his difficulty parting with things was due to his contamination fears. He let his school papers pile up just inside the door because he didn't like to handle them and get contaminated with school germs while at home. His Lego collection accumulated because once he created something he did not like dismantling it, despite seldom playing with any of his creations once they were finished. Nor could he tolerate anyone touching them. Once he physically attacked a neighbor girl who had come over to play because he thought she had knocked over one of his Lego creations. Since the incident no friends have come over to play with Eric, and they send him to visit his grandparents when his brother's friends come over. Eric's collections lined the perimeter of the family's living room. When his parents decided the clutter had crept too far into the middle, they insisted on a cleanup. Since Eric did not allow anyone to touch his things, he had to do all of the cleaning by himself. The cleanups took weeks of emotional preparation and invariably were accompanied by a great deal of crying and screaming that his parents described as "major melt-downs."

In addition to these difficulties was what his mother called Eric's "special event" hoarding. A bathrobe he received for Christmas was worn only once on that day and never again. Eric explained that the bathrobe was special because it reminded him of how he felt when he got it. Wearing it on any other day would ruin the special feeling he got from it. Similar reasoning applied to other things he received on special occasions including clothes, books, and even balloons. These items remained on a chair in the living room until his parents insisted on a cleanup. When his parents had to replace the dishwasher, Eric begged them to let him keep several pieces of metal from it. He explained that the dishwasher reminded him of that special feeling he had on summer mornings after breakfast watching his mother doing the dishes. Even though his parents agreed to let him keep several pieces of the dishwasher, Eric secretly hid other pieces of it in the yard. He suffered another emotional melt-down when his father found and discarded them. Eric's parents reported little difficulty with acquisition.

Eric displayed significant ADHD symptoms. His mother described a common scenario, "I'll ask him to go brush his teeth, and he'll go from here, maybe five feet, pet the cat, another five feet, turn around, come back in, straighten out his Legos. You get the picture. And even if we're going to Toys R Us to buy a new Lego set, it's the same thing." Eric's need to do things perfectly also contributed to his difficulties.

Both sides of Eric's family have histories of OCD as well as hoarding. His paternal grandmother accumulated so much stuff in her car that no one could ride with her. His maternal great-grandmother was described as a "world-class hoarder" who hid cash and bonds among the pages of the thousands of magazines she accumulated over the years.

Case 6

According to six-year-old James' mother, he "craved clutter" from the time he was two or three years old. To her, he seemed happy only surrounded by things and unhappy when things were cleaned up or moved. If any of his toys were moved even an inch he "became mournful" and, according to his mother, seemed to experience actual pain. His mournful periods could last all day, and there was little that comforted him. He seemed most concerned that he was no longer sure where the object was located. Similar problems occurred at school with any possessions he brought with him. His parents managed to limit the amount of clutter in his room, but his mother complained that there were bags full of broken toys that she wouldn't throw out, fearing how it would affect James.

There were a few things that came into James' possession that he could let go of, but any object that entered his fantasy world seemed to take on a life of its own. His mother stated that this "puts him into a world with this object." These objects became as important to him as a human being and, like Sally, he gave them emotional characteristics. During the summer before our visit, James spilled his fruit drink on the driveway and cried because it was getting burned by the hot pavement. Earlier in the year he stopped eating for a time because he thought it would hurt the feelings of the food. His intense attachment to and personification of objects extended beyond the things he owned. Play dates at other children's houses posed difficulties because he often became attached to their toys. Sometimes parents sent home their child's toy to ease the burden. James' mother often had to buy the child a replacement since James wouldn't part with the one he acquired. She avoided taking James shopping because if he saw or touched something, it became a part of his world and he was inconsolable unless he got it.

James was an anxious child who became frustrated easily, especially when he made mistakes. His mother reported that if he couldn't do something perfectly on the first try, he felt like a failure. His attempt at participating in team sports ended with his first missed shot in basketball. She had to carry the crying James off the basketball court. His mother's impression was that James fell somewhere on the spectrum from ADHD to Pervasive Developmental Disorder, although no professionals had diagnosed him yet. He suffered from speech delays and physical coordination issues for which he was receiving intervention. He also had pronounced sensory sensitivities, making bathing and grooming difficult.

There was no history of OCD in James' family. However, his paternal grandmother hoarded for most of her life. Forty years worth of accumulated magazines and canned food made much of her house unusable. James' parents were worried that the condition of her home posed a serious threat.

DISCUSSION

Hoarding Behavior

Many children collect, and sometimes collect unusual things (Olmstead, 1991). Distinguishing normal collecting behavior in children from problematic hoarding behaviors is crucial to understanding hoarding in childhood. In all six of the cases described

here, the children's struggles with possessions were easily identified by their parents as unusual and troublesome. In addition to not wanting to get rid of unusual things (e.g., trash, paper, parts of appliances, and lint), the intense emotional reactions to attempts by others to touch, move, or discard objects clearly differentiated these children from normal collectors. In addition, the hoarding behavior interfered with social (e.g., not being able to have other children over to play) and school functioning. For adults with hoarding problems, clutter causes the most disruption and interference (Frost, Steketee, & Williams, 2000; Steketee & Frost, 2003). Among these children, however, only Amy had significant clutter. This may have been due to parents who prevented the buildup of clutter. The other children described here may well have had significant clutter if not for their parents' efforts. Most of the parents set limits on where possessions could be left, and consequently few spaces were usable. In contrast to adults, clutter may not be a clear indication of hoarding for children. Problems with the arrangement and management of possessions (i.e., not allowing family members to touch or move possessions) characterized all these children and may be a better indication of childhood hoarding. This issue deserves more research.

All six children showed clear distress at the prospect of having to discard an item that had no functional use (e.g., old napkin, damaged pumpkin, candy wrappers, etc.). In addition, however, these children also showed clear distress at losing control of possessions that had utility and value (e.g., bathrobe, Legos, couch, etc.). While all the children were reported to experience distress when parents or others touched their things, several children were reported to experience dysphoria (James, Julian) and two became angry or aggressive (Amy, Eric). As is the case with adults who hoard, the difficulty discarding and problem managing possessions extended to all objects, not just worthless ones.

Acquisition problems do not appear to be as apparent in these children as they are in adults who hoard (Frost et al., 1998). Some of the children actively acquired objects (Sally, Amy, James) while the others struggled only with items they already owned. It is possible that some of these children didn't yet have the resources to acquire. Grisham et al. (2006) found the onset of acquisition in hoarding to occur later than the onset of difficulty discarding and clutter, and speculated that acquisition problems may not surface until the individual has independent resources. More research is needed on when and how acquisition problems develop in hoarding.

For most of these children, hoarding was not their most significant problem, and instead was something the parents managed on their own. Only in two cases did parents seek professional help for the hoarding. Nonetheless, all the parents reported that hoarding posed a significant problem, though for some it was only temporary.

Onset and Course

For all six cases hoarding appeared by age eight. In one case, unusual attachments to possessions appeared before the age of three (James). For another (Amy) the behaviors were apparent by age five, and it's uncertain how much earlier.

Three of the children experienced hoarding for a limited period of time (Sam, Sally, Julian), and for these cases situational stress appeared to play a role. For Sam and Sally, no residual hoarding was apparent. For Julian there were residual indications of continued struggles with discarding, but not serious enough to be considered clinically significant. For the remaining three cases (Amy, Eric, James), hoarding remained

relatively constant. Reports by adults with hoarding problems suggest that it is chronic with increasing severity over time (Grisham et al., 2004; Rufer, Grothusen, & Maß, Peter, and Hand, 2005). However, memoirs of adults with OCD (Traig, 2004; Wilensky, 1999) report transient episodes of hoarding that played relatively minor roles in their struggles with OCD. The implications of transient hoarding in childhood are unclear. To understand the development of hoarding, it may be valuable to compare people with time-limited hoarding episodes with those for whom it is chronic. Reports from adults suffering from hoarding described relatively mild symptoms until age 30-35. Perhaps Julian's lingering concerns about discarding waste will escalate as he moves into adulthood. Sam and Sally's hoarding seemed more clearly situational. In both cases the situation concerned the separation and divorce of their parents. The tendency to cling to physical objects during this period may reflect attachment related fears.

Perfectionism was apparent in most of these children. For some, like Amy, it was limited to one domain (appearance), while for others like James, any mistake or less than perfect performance caused great emotional turmoil. Adults who hoard have been found to be highly perfectionistic (Frost & Gross, 1993). Perfectionism in hoarding may be related to symmetry obsessions or arranging compulsions and the need to maintain absolute control over possessions.

Comorbidity

Two of the cases had significant contamination-related OCD (Amy and Eric), and were the only children who had been diagnosed with OCD. Several of the cases demonstrated what appeared to be arranging compulsions (Sam, James), although the intense dismay among all of these children at the prospect of other people touching or moving their things may reflect something similar. A number of studies of hoarding in adults and children have reported an association between hoarding and symmetry/arranging forms of OCD (Baer, 1994; Samuels et al., 2002; Storch et al., 2007). The dramatic fears about other people touching possessions may be a manifestation of ordering/arranging compulsions.

Sam and Sally both displayed social anxiety, while Julian, Eric, and James were described as anxious children. James may have had a mild form of pervasive developmental disorder. Four of the cases (Julian, Amy, Eric, and James) had heightened levels of distractibility and/or ADHD symptoms. Research on hoarding adults has found heightened ADHD symptoms as well as retrospective reports of childhood ADHD symptoms (Hartl, Duffany, Allen, Steketee, & Frost, 2005). In addition, Moll et al. (2000) found higher rates of hoarding among ADHD children compared to healthy controls. It may be worth noting that the most chronic and serious of these cases (Amy, Eric, James) were the ones who also suffered from what appeared to be ADHD and OCD (Amy, Eric). Two cases involved problems with social anxiety (Sam, Sally). Studies with adults have also found a high frequency of social phobia in hoarding (Samuels et al., 2002).

Attachments

Most of the children reported sentimental attachments to their possessions. Two cases (Sally, James) personified nonrepresentational objects (i.e., gave humanlike attributes to objects other than dolls or stuffed animals). While this behavior is not unusual in children (Inhelder & Piaget, 1958), the inflexibility and intensity of these attachments and the items involved (e.g., fruit drink) were unusual enough in these children for their parents to notice. However, abnormal personification only occurred in two of the children and does not appear to be a universal feature of hoarding in children.

Both Eric and Amy's attachments to objects appeared to reflect essentialism, or the attribution to objects of unique qualities that are not apparent from their physical properties (Gelman, 2003). For Amy, possessions carried part of her personal history and thus became part of her identity. For Eric, his bathrobe (and other objects) contained a special essence (his good feelings) because of their association with a special day. Eric's attachment is what Kellett and Knight (2003) have called "object-affect fusion"—the fusion of an object and the emotions associated with it. Amy's attachments, however, were not a fusion of an object with an affect, but rather an object with her identity, an "object-identity fusion." While possessions become extensions of the self for most people (Belk, 1988), among people who hoard the connection is more intense and closely tied to the self (Frost, Kyrios, McCarthy, & Matthews, 2007). Both types of fusion appear to be variants of essentialism, a construct that deserves more research regarding its role in hoarding problems.

Essentialism may be a form of sympathetic magic, which has been suggested to play a role in contamination-related OCD (Tolin, Worhunsky, & Maltby, 2004). In the context of hoarding, the nature of the contamination may be positive instead of negative. In the same way that anything connected with Eric's school was contaminated with "school germs", his bathrobe was "contaminated" with the good feeling he had when he received it. Ironically, anything contaminated with school germs could spread the contamination by contact, but the same was not true for things contaminated with good feelings. Instead of spreading the good feelings, the object (bathrobe) would be de-contaminated if it was used on a regular day. This process is similar to connecting contamination and bad events. However, objects contaminated with bad things spread the contamination, while objects contaminated with good feelings are de-contaminated by contact with other things or by use.

For these children, hoarding seemed closely tied to the concept of ownership. For James, incorporating an object into fantasy play established ownership, while for Amy crossing the threshold of her room did so. The intensity of attempts to maintain control over their possessions may be related to a sense of ownership. Establishing control over an object is a central feature of ownership (Furby, 1978).

Insight and Family History

Few of these children understood their behavior to be a problem, and most gave explanations for what they saved. For several, the explanations contained little information. Sam simply insisted that the things were "mine" and no one should bother him. Sally said the things she saved were important to her and might be useful in the future. Julian described a concern over waste. Amy had difficulty recognizing the boundary

between what was hers and not hers. Neither Eric nor James could articulate much other than the emotions they experienced when their possessions were threatened. Storch et al. (2007) similarly reported limited insight in their sample of children with OCD who hoarded, though a subsequent study failed to show such a relationship (Storch et al., 2008).

Recent evidence has suggested that hoarding is familial (Frost & Gross, 1993; Samuels et al., 2002) and possibly genetic (Samuels et al., 2007). Three of the six children had family histories of OCD, and two had family histories of hoarding. Only one of the children did not have a family history of hoarding or anxiety (Julian).

Implications for Assessment and Treatment

These findings have implications for the assessment and treatment of hoarding in children. Measures of hoarding in adults contain items or subscales for excessive acquisition, clutter, and difficulty discarding (Frost, Steketee, & Grisham, 2004; Tolin, Frost & Steketee, 2008). Since excessive acquisition and clutter appear to manifest differently in children who hoard, direct adaptation of such measures for children poses problems. Measures of hoarding in children should focus more closely on difficulty discarding, attachments to possessions, and on reactions to parents managing the child's possessions. In addition, treatment programs designed for adults who hoard focus heavily on acquisition and clutter (Steketee & Frost, 2007) and may need adaptation to focus more exclusively on difficulty discarding and attachment. Also, as Storch et al. (2007) have pointed out, there may be a need for more guidance and emphasis on child management strategies in the treatment of children who hoard because of their sometimes intense reactions to having items discarded.

There are potential implications for a more nuanced approach to the treatment of OCD. In the treatment of childhood OCD, the externalization or personification of the problem is a recommended strategy to help the child obtain some psychological distance from intrusive thoughts (March, 2007; Wagner, 2005; Chansky, 2000). Thus, OCD is relabeled with terms such as "Brain Bug" or "Worry Monster." However, this strategy may need to be modified in some cases in which children display OCD that includes hoarding, as some of these children personify things to an excess. As one parent of a hoarding child explained, "He personifies everything, that is why he hoards." For such children, the way in which the problem is framed may require some careful consideration.

The limitations of this study arise from the use of a semi-structured interview to provide information, the absence of standardized assessment measures, and the use of a small sample of convenience. Another limitation was the absence of interview information from the children. These factors potentially limit the conclusions we can draw. However, even though the small sample limits the generalizability, we were impressed by the heterogeneity of cases.

More research on hoarding in children is needed to understand the environment in which it develops and whether hoarding in childhood predicts hoarding in adulthood.

Appendix A. Compulsive Hoarding in Children: Semi-Structured Interview

1. When did your child's hoarding begin? How old is your child now?
 2. During the initial stages of obsessive collecting, did the child tend to have the most trouble with (A) acquiring items, (B) discarding items, or (C) an inability to organize items he/she already owned?
 3. What can you recall from the initial stages of your child's hoarding? Were there any important events or changes in his/her life at that time that you can remember?
 4. Did your child's hoarding fluctuate over time? If so, how?
If it is episodic, how long are the episodes? How frequent?
 5. Did/does the types of things the child saved, sought to acquire, or had difficulty discarding change over time? If yes, how so? If it's gone away, when? And why?
 6. What types of items does/did your child collect?
 7. What does your child say about the items that are collected?
 8. Do you find that your child tends to personify objects, giving them feelings, desires, or even personalities more so than the average child?
 9. Does your child feel that his/her things are a part of them, almost like a part of their body?
 10. Did your child act as though touching something make it more likely that your child would become attached to an object it or want to keep it?
 11. Does your child save things as reminders or souvenirs?
 12. Does your child save things because they contain information he/she wants to retain?
 13. What types of things can your child successfully throw away?
 14. Does your child become upset if an item is moved or thrown away?
 15. Does your child seek out certain objects to comfort him/her when upset?
 16. Is there anything you've noticed that influences what your child collects and won't get rid of.
 17. Does your child leave presents wrapped up long after he/she was given them?
 18. Does your child fixate or focus all of their attention on one activity, object, or idea for an extended period of time?
 19. Does your child hide odd items (e.g., boxes, paper or pencils)?
 20. How did you deal with your child when acquiring or discarding?
 21. Does your child collect outside of the house (ie. at school)? If so, did it create problems there?
 22. Is your child perfectionistic? (e.g., excessively concerned over minor mistakes)
 23. Does your child react emotionally to minor frustrations? (Anxiety sensitivity?)
 24. Compared to other problems your child has, how serious is the hoarding?
 25. Does your child recognize that his/her collecting was a problem?
 26. Has your child ever been diagnosed with any of the following? Please indicate all that apply.
 - ADHD
 - Depression
 - Developmental Disorders
 - Autism
 - Aspergers'
 - Learning Disabilities
 - Generalized Anxiety disorder
 - Obsessive Compulsive Disorder
 - What obsessions & compulsions? (ordering or arranging?)
 - Separation Anxiety
 27. Does your child have problems with aggressive behaviors?
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