

# TRAUMA MATTERS

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## The Role of Trauma in Hoarding Disorder

Most people enjoy the experience of acquiring something new. Many of us struggle to organize our belongings at times. We may also have a difficult time making decisions about discarding possessions we no longer want or need. We ask ourselves questions like, "What if I need this in the future?" We consider the sentimental value of some items we own. Eventually, though, in spite of some distress, most of us are able to part with possessions that we no longer need or that have little value. However, this process of acquiring, organizing, and discarding belongings becomes quite maladaptive for individuals who are living with Hoarding Disorder (HD).

The clinical and empirical understanding of HD is in its early stages since HD was introduced as a unique diagnosis in 2013 with the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5™)*; American Psychological Association [APA], 2013). The new diagnostic criteria for HD include three key symptoms: (a) excessive acquisition of possessions, (b) clutter in the home such that rooms or areas cannot be used for their intended purposes, and (c) difficulty discarding items regardless of their objective value. It has been estimated that HD affects between 2% and 5% of the population (Lervolino et al., 2009; Samuels et al., 2008). The addition of HD as a standalone diagnosis should enhance understanding and identification of clinical hoarding symptoms and encourage the development of treatments specific to hoarding problems. Importantly, the addition of HD to the DSM-5™ should stimulate more research on the disorder.

Before the DSM-5™, hoarding behavior was conceptualized as a feature of obsessive-compulsive disorder (OCD). Thus, earlier research on hoarding largely drew participants from populations seeking treatment for OCD. Recent research has demonstrated that OCD and HD are distinct diagnoses. For example, only 18% of individuals who have significant hoarding symptoms also meet criteria for an OCD diagnosis (Frost, Steketee, & Tolin, 2011). Other important differences between HD and OCD samples exist, including greater incidence of attention deficit hyperactivity disorder (ADHD) symptoms with hoarding and more trauma exposure among individuals with hoarding problems.

Emerging research points out a few key factors that contribute to the onset of pathological hoarding. Results of a large twin study, with 2,537 female twin pairs, suggested significant genetic heritability of clinical hoarding problems (Lervolino et al., 2009). In early environments parents may model hoarding behavior so children learn not to be wasteful or that certain items should be cherished. Similar to other mental health disorders, biological factors likely interact with environmental factors (e.g., chronic life stressors, traumatic life events), contributing to the onset, course, and severity of hoarding behavior.

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Some researchers have investigated the link between hoarding symptoms and traumatic experiences. As many as 50% of hoarding individuals report experiencing at least one traumatic life event, and 33% report a traumatic event that occurred during childhood (Frost et al., 2011). Individuals with hoarding symptoms report significantly more experiences of physical and sexual maltreatment compared to healthy controls (Hartl, Duffany, Allen, Steketee, & Frost, 2005). Other specific events that have been associated with hoarding include interpersonal violence, home burglaries, relationship disruptions, and harsh discipline. Traumatic life experiences contribute to greater severity of hoarding symptoms. In terms of the expression of HD, trauma appears to be particularly linked to clutter in the home and is less associated with acquisition or difficulty discarding (Cromer, Schmidt, & Murphy, 2007). Despite the emerging evidence that people with hoarding problems experience more traumatic life stressors compared to other populations, the link between trauma and hoarding is not well understood.

There are a few reasons why trauma could contribute to the onset and course of hoarding problems. From a diathesis stress perspective, traumatic stressors may activate a biological vulnerability to hoarding problems. From an evolutionary perspective, collecting and saving possessions may have been adaptive in times of crisis. From a cognitive perspective, people with trauma histories may develop particular beliefs about possessions. For example, possessions serve as a source of comfort and control when one's environment is unstable and chaotic. Objects may create a sense of safety when one's relationships are threatening. From a behavioral perspective, emotionally attaching to items may serve as a form of avoidance. Hoarding may be a coping strategy, and emotionally attaching to possessions following a traumatic experience could buffer against the clinical symptoms of post-traumatic stress.

Whatever the link between trauma and hoarding, this combination is clinically significant because both HD and trauma are linked to poor functioning, isolation, and low social support. With research on the treatment of HD still in its early stages, tailored cognitive-behavioral therapy (CBT) approaches show some promise for hoarding symptoms (Tolin, 2011). It is important to take a detailed history, thoroughly assessing hoarding symptoms as well as potential comorbidities (e.g., anxiety, OCD, depression, trauma, maladaptive personality traits). Cognitive limitations, including attention deficits and impulsivity should be accounted for in assessment and treatment. When tailoring a CBT approach to hoarding problems, clinicians can help individuals with histories of trauma identify cognitions that link possessions to feelings of safety, security, comfort, and control. Individuals presenting with trauma histories may benefit from engaging in therapeutic trauma work in conjunction with a CBT program. Processing traumatic experiences may help people connect their emotions to the experience rather than to items.

The relationship between hoarding and trauma is complex, and we are still learning about these associations as a field. Hoarding individuals who have experienced traumatic life events are at risk for more severe hoarding problems. Thorough assessment of hoarding symptoms and other mental health problems is important in designing a treatment approach. Clinicians can help individuals identify and challenge maladaptive beliefs associated with possessions to support them in working toward decluttering and discarding goals. Consideration should be given to establishing a home environment that can feel safe without clutter and accumulation of belongings.

*Submitted by Kaylee Burnham, M.A.*

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About the Author: Kaylee Burnham, M.A. is a doctoral candidate in clinical psychology at the University of Connecticut. Her research interests focus on trauma and its influence on social and interpersonal outcomes as well as health behaviors. She is currently receiving her predoctoral clinical practicum training at the Anxiety Disorders Center / Center for Cognitive Behavioral Therapy at the Institute of Living at Hartford Hospital.

For a complete list of references for this article please visit: [www.womensconsortium.org/references\\_Trauma\\_Matters.cfm](http://www.womensconsortium.org/references_Trauma_Matters.cfm).

## Self-Compassion

Much has been written about the benefits of compassion. Compassion is the emotion that we feel in response to the suffering of others that motivates us to help. Its derivation comes from Latin, and it literally means *to suffer together with*. It is considered to be an adaptively evolved trait as it is essential for human survival ("survival of the kindest") and has been linked to enhanced physical as well as emotional well-being. Self-compassion is no different except that the recipient is oneself. Instead of reacting to our mistakes, imperfections, and disappointments by castigating ourselves, it involves giving ourselves the kindness, understanding, and compassion that we would instinctively give a loved one who was in pain. While pain is an inevitable part of life, suffering is characterized by pain and resistance to pain, in other words, fighting versus accepting reality.

Kristen Neff, PhD, research psychologist and pioneer in this field, has identified three components of self-compassion. The first is *mindfulness*, which involves being aware of our experiences, in the present moment, without

judgment. Instead of being hijacked by our emotions, mindfulness allows us to be curious and open to them (in Dialectic Behavior Therapy (DBT)-speak, “wise mind”). It means paying attention to “self-talk,” that is, what we are actually saying to ourselves. The second component is *common humanity*, which is an acknowledgement of the imperfections of being human. Whereas unfavorable comparisons with others tend to result in feelings of isolation and estrangement, the recognition that all human beings are fallible helps foster social interaction and connection with others. Lastly, self-compassion involves *self-kindness, acceptance, and comfort* in response to painful emotions as opposed to self-criticism and judgment.

Self-esteem has long been regarded as the key to personal well-being. However, it is inherently unstable because it is based on social comparisons and fleeting accomplishments (i.e., the “Lake Wobegan effect” where all the children are above average). Many people believe that self-criticism is an effective motivator, but it is actually correlated with depression. Whatever motivation that derives from it tends to emanate from a fear of being worthless. Motivation with self-compassion comes from a desire for health and well-being. Personal goals and standards are just as high, but the greater acceptance of falling short increases the likelihood of trying again.

Preliminary research with regard to the relationship between self-compassion and trauma symptoms suggests that self-compassion is associated with greater resilience and willingness to engage painful thoughts, emotions, and physical sensations. In contrast, experiential avoidance maintains trauma symptoms over time. Self-compassion is negatively related to emotion regulation difficulties, anxiety, depression, rumination, dissociation, negative affect, and psychopathology, all symptoms of post-traumatic stress disorder. It has also been found to mediate the relationship between childhood maltreatment and subsequent emotion dysregulation by providing a buffer against negative self-feelings following distressing events. Conversely, it has been associated with increases in life satisfaction, happiness, self-confidence, optimism, curiosity, creativity, and gratitude.

In May 2011, I attended a two-day training on self-compassion, conducted by Kristen Neff, PhD and Christopher Germer, PhD, both authors of books on the subject. It was a powerful experience, not only because of its relevance to my work with male addicts and alcoholics, but also to my personal sense of well-being (or lack thereof). I had always been self-critical and perfectionistic but had never reflected on this as something that I could change. In response to my relentless self-blame, guilt, and criticism, my former husband once commented that it was a good thing that I didn’t live in prehistoric times because I would have blamed myself for the extinction of the dinosaurs.

Two weeks after attending the conference, I flew to Baltimore for a family wedding. After being picked up at the airport, I looked for my prescription sunglasses, which I knew that I had with me on the plane. They were nowhere to be found. My self-critical voice activated immediately,

saying, “I can’t believe that I lost them. I’m such an idiot! I lose things all the time! I’m such a hypocrite! I teach mindfulness but I am totally mindless.”

You get the idea. Then, I suddenly became aware of how harshly I was treating myself. I took a few deep breaths and said to myself, “I know that it is painful for me when I lose things, but beating myself up will not bring back the sunglasses. It will just make me feel miserable. I will call the airline when I get to the hotel and see if anyone found them. I need to forgive myself because I’m human and everyone makes mistakes.” The “old self-critical me” would have spent the entire weekend ruminating about the sunglasses, berating myself repeatedly, and feeling upset with myself. Acknowledging the emotional pain and challenging my inner critic enabled me to be more present and enjoy the weekend.

Several months later, I fell while running. I was holding my phone in my left hand so I could check my progress on my running app. My entire weight fell on my right hand, and I smashed my pinky finger. According to the hand surgeon who relegated it to “Humpty Dumpty,” it was the worst possible injury that I could sustain, and even with painful surgery followed by months of physical therapy, it will never be the same.

Old me: “This is all my fault. I should have been paying more attention. I shouldn’t have been holding the phone. If I had both hands free, this never would have happened.” (This would be triggered whenever I was in a lot of pain, which was most of the time for months.)

New me: “This is painful both physically and emotionally, so I need to practice self-compassion. I have learned a lesson: I will always keep both hands free when running and pay more attention to where I am going. It could have been much worse, and I am grateful that it was only my finger.”

I have been facilitating a self-compassion group on my unit for clients who struggle with addiction. When I share my personal stories of human frailty with them, the “common humanity” factor can be awesome, in part because it levels the playing field. One man shared that he had bought his son a cell phone, and while in jail, he learned that his son was murdered over it. Since then, he had been tormented by self-blame, which he believed he deserved. It had never occurred to him that he could choose to be comforting and kind to himself. Another man, whose mother had been stabbed to death, asked, “How am I supposed to get over that?” The answer was, “You are not. This is about acknowledging the pain and giving you the kindness and compassion you need because it is so painful.”

When I make mistakes now, my self-critical voice still tends to be my default mode, but it is no longer on autopilot. Sometimes I am my own coach or cheerleader, validating my painful feelings rather than intensifying them with a harsh diatribe. I have become a self-compassion zealot with my clients, friends, and family members because I want them to reap the benefits as I have. If you struggle with a relentless inner critic, I hope that you can as well.

*Submitted by Lisa Berzins, PhD*

## **Book Review:** *The Body Keeps the Score* by Bessel van der Kolk (2014), Viking: New York

Bessel van der Kolk, MD, is a visionary of contemporary trauma studies. Since the early 1990s, van der Kolk, with many collaborators, has argued for the recognition of the complex consequences of trauma. Essential to van der Kolk's contribution is his insistence on maintaining the broad picture: that the consequences of trauma impact the entire person, in all areas of functioning, and that many types of interventions may be necessary to recover from trauma. His 2014 book, *The Body Keeps the Score*, is a comprehensive review of the work of trauma clinicians and researchers over the past 25 years.

In clear language, van der Kolk reviews the literature of neuroscience, developmental psychopathology, and interpersonal neurobiology research to describe the complex consequences of trauma. He relates how experience shapes brain development—that traumatic experiences in early childhood have long-term consequences demonstrated in problems of self-regulation of body, thought, and feelings. He illuminates the inadequacy of the DSM-5™ PTSD diagnosis for most people with traumatic childhood histories because the consequences of these histories manifest in problems of self-regulation as well as memory, knowing the self, the capacity to hope, and the ability to trust, in addition to the reliving/numbing/avoidance symptoms of PTSD. These problems often lead to dysregulated behaviors (dissociation, self-harm, substance abuse, troubled relationships) and chronic feelings of emptiness and depression that present in the clinic.

Van der Kolk reviews the multimodal treatment approaches used in his clinic. He highlights that treatment interventions that are useful for some types of trauma (adult onset, single episode events), may not be helpful for people with histories of chronic childhood trauma. He describes both “top down” (talk therapies) and “bottom up” (body focused) approaches to healing, including Internal Family Systems approach, EMDR, yoga, neurofeedback, social ritual, and theater, as well as medications. Overall, *The Body Keeps the Score* is an important, impactful and passionately written book by a groundbreaking leader in the field of trauma treatment.

*Submitted by Ellen Nasper, PhD*

## **Love Soup**

On December 16, 2014, I attended the required annual training needed to continue as a member of the Disaster Behavioral Health Response Network (DBHRN). This time the training was not about “what if” but about “what was.” The topic was Mass Trauma and Violence with lessons learned from Sandy Hook and Boston. This was a tough topic, and at times my attention drifted until I heard Jeff Montague (Southeastern Mental Health Authority) talk about hope. I was reminded about love soup.

I was deployed to the Monroe school being readied for the Sandy Hook children during the first open house for parents and children. Volunteers from the Newtown community had made meals for the parents to take home to ease the burden of cooking after such an emotional day. When I say a room was filled with food, it is an understatement.

At the end of the day as I was leaving, one of the school staff told me to take a meal. I said thank you but declined, explaining that I was not a Newtown parent. The staff said, “No matter; you have been working here all day. Please take something.” I hesitated and then looked down and saw a bowl marked “Root vegetable soup (vegetarian).” As someone who is primarily vegetarian, I am used to traveling with food because I can never be sure what food will be available. I was particularly moved that someone thought to make and mark a meal as vegetarian.

At one point during the training, Jim Siemianowski (DMHAS) said that the fear and anxiety following mass trauma is palpable. Jim is correct: emotion is palpable—all emotion, including love. When I arrived home that night and opened the bowl of soup, I could feel the love. I thought about how much time it took to make that soup the right way: roast the vegetables, puree, add the spices, and simmer. I also thought that perhaps the person who made the soup wished that he or she could do more. I often have the same wish, that I could do more. Then I remembered a quote from Mother Theresa: “We cannot do great things on this Earth, only small things with great love.” I named my meal “Love Soup.” I still have the empty bowl, and each time I use it I remember the time and care it took to create what perhaps is a small thing with great love.

I believe that each of you do this every day in the face of helping others solve difficult problems or working in an environment of diminishing resources. You serve the world your own version of love soup.

*Submitted by Eileen M. Russo*

# Ask the Experts:

## A Conversation with Frank Putnam, M.D.

By Cheryl Kenn, LCSW

**F**rank W. Putnam, M.D., is a professor of psychiatry at the University of North Carolina, Chapel Hill and professor emeritus of pediatrics and psychiatry at Cincinnati Children's Hospital National Medical Center, the University of Cincinnati College of Medicine. He was formerly chief of Developmental Traumatology at the National Institute of Mental Health in Bethesda, MD. The author of over 200 scientific papers and chapters and two books on dissociative disorders, he is one of the foremost authorities on trauma and child maltreatment in the world.

### **Q: Why did you enter the trauma field?**

**A:** Accidentally. I was primed to see trauma. In the '70s I trained at Yale and the West Haven VA Hospital. There were Vietnam veterans who were called schizophrenic, hysterical, sociopathic, and borderline. Everybody disagreed about their diagnoses. PTSD did not yet exist as a diagnosis. Robert Jay Lifton and Arthur Blank were two of my supervisors. They greatly influenced the creation of PTSD in the DSM-III. I treated my first Dissociative Identity Disorder case at the NIMH in Bethesda, MD. Once your eyes are open to this diagnosis, you start to see things differently. By my tenth DID case, all my patients had told me that they were dissociative since childhood. If that were true, I reasoned that I needed to look for children with DID. I ended up seeing a lot of abused children.

This compelled me to get child psychiatry training at George Washington University and to start a longitudinal study about child maltreatment and abuse. A seminal paper published in 2011 basically covers most of that study. Penelope Trickett and I started it in 1986. We were not allowed to run it at NIH and ended up renting offices off campus. We struggled for funding. We went through six waves of evaluations following a group of sexually abused girls aged 6 to 15 years matched with a control group. By wave 6, 96% were in their late 20s and early 30s. We are now seeing them and their children in waves 7 and 8.

I also grew interested in the link between trauma and parenting. It has been shown that if a mom is depressed there are higher rates of child maltreatment in her children. Investing in mothers is the key to breaking the generational cycle of family violence.

I co-developed a home visiting program, *Every Child Succeeds*, to reach first-time mothers. We found that many suffered severe depression and developed a treatment delivered in their homes. Eighty-five percent

of the depressed mothers suffered childhood abuse. That's devastating for their children. Connecticut was the first of now six states to adopt our maternal depression treatment statewide.

I have been working in the field for over 30 years. There is still enormous stigma (to the diagnosis of DID). A recent review of psychology textbooks found that 80% list DID as a factitious disorder. Students taking graduate psychology courses say, "This is fake." They then get their first DID case and say, "Oh my gosh, look what I found."

Trauma impacts physical health, mental health, education, what a person can accomplish in life, and what is passed on to the next generation. The calculated human suffering is astounding. Every new victim of child maltreatment in 2014 will cost an extra \$1.8 million over the person's lifetime. The total cost will be \$5.9 trillion dollars for just the 2014 victims alone. These costs are preventable. Even if you are not a victim you are impacted. Society doesn't want to see that. It's the most preventable cause of mental health problems such as depression. It is also a leading cause of death, and health-risk behaviors related to HIV and AIDS, diabetes, and substance abuse – all traceable to childhood abuse.

### **Q: What do you consider to be the most helpful stabilization skill or tool one can teach to a trauma survivor?**

**A:** First and foremost, the client must be safe and feel safe, or no treatment will be effective. That's true of sexual, physical, and emotional abuse and domestic violence. There's no point in trying to treat people until they are and feel safe.

### **Q: What is something you think all trauma-focused clinicians should know?**

**A:** You need to be comfortable asking your clients about trauma. You can't look at someone and intuit whether or not they were abused. The therapist must understand how early trauma plays out in so many different ways. You shouldn't just see your client as having major depression and not ask about possible PTSD. Our home visitors were worried that asking about trauma would cause the mother to freak out or be hospitalized. That's never happened; instead, the moms often say, "No one ever cared about that before, and it has affected me in so many different ways."

## **Featured Resource: Gift From Within**

**G**ift From Within is an organization “dedicated to those who suffer post-traumatic stress disorder (PTSD), those at risk for PTSD, and those who care for traumatized individuals.” Through its website ([www.giftfromwithin.org](http://www.giftfromwithin.org)), it “develops and disseminates educational material” in both on- and off-line formats. It also provides peer support for survivors on an international scale.

This serviceable and supportive website has an extensive amount of content including articles on traumatic stress as well as PTSD and DVDs and webcasts concerning PTSD, trauma, and other topics. It provides trauma support, such as connections to support groups and pen pal networks, suggestions for PTSD etiquette, and “support pals” who share stories on topics ranging from Q&A to tips from survivors and doctors to information about retreats, conferences, workshops, and seminars. The website also has a PTSD and trauma online bookstore and product catalog; art, poetry, and music; and a section entitled “Who is Gift From Within” that provides space for people’s comments, members’ bios, etc. The site’s educational webcasts for survivors and therapists cover multiple topics from exposure therapy and cognitive behavioral therapy to de-stigmatization and

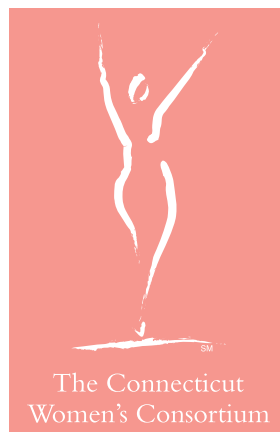
the exploration of Moral Injury and Survivor Guilt. The extensive index of articles incorporates an array of topics such as addiction, childhood and adult sexual victimization, domestic violence, and sexual assault. The index touches upon PTSD treatment and recovery, health and workplace issues, self-help, and resiliency.

Those who meditate or believe in prayer may find the Survivor Psalm, words of strength for survivors, helpful. Beyond all this are dozens and dozens of helpful links. Some are for men who’ve experienced sexual assault, physical abuse, and trauma to remind them that they, too, are not alone. Links lead to Mental Health Net for further resources and a section on PTS injury, which highlights the desire of many living with PTSD to focus on the fact that post-traumatic stress comes from injury. Gift From Within’s extensive website is geared toward the many survivors of trauma in their various stages of dealing with its effects, along with their therapists, those who care about and for them, and anyone with an interest in learning more about PTSD.

*Submitted by Aiden Kent*

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