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Mini Review Article

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The Etiopathogenesis of Diogenes Syndrome

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Abstract

Diogenes syndrome is characterised by extreme self-neglect of environment, health, and hygiene, excessive hoarding, squalor, social withdrawal, and a distinct lack of concern or shame regarding one's living condition' [1]. There have been proposals to use the term 'severe domestic squalor', and previously, the cluster of symptoms has been known as 'senile squalor syndrome'. Diogenes is not uniquely recognised in the Diagnostic and Statistical Manual of Mental Disorders (DSM); however, the closely related condition Hoarding Disorder appears in the fifth version [2]. Numerous case report studies suggest that the constellation of symptoms representative of Diogenes is distinct from other closely related disorders. This mini-review presents a brief overview of cases highlighting the complexity and diversity of patients suffering from Diogenes, underscoring the importance of diagnostic criteria and classification to treat this condition accurately.

Keywords: Diogenes Syndrome; Individual Psychotherapy; Case Report; Severe Domestic Squalor; Hoarding Disorder

Introduction

'Diogenes syndrome is characterised by extreme self-neglect of environment, health, and hygiene, excessive hoarding, squalor, social withdrawal, and a distinct lack of concern or shame regarding one's living condition' [1]. As highlighted by us in Proctor and Rahman:

> Symptoms have been noted to include the following: extreme self-neglect of environment, health, and hygiene, excessive/abnormal hoarding (syllogomania), living in squalor, social withdrawal/living reclusively, refusal of help, and a distinct lack of concern and shame regarding one's living condition [3-7].

Diogenes syndrome is named after the ancient Greek philosopher 'Diogenes of Sinope' who lived in a barrel in the 4th century BCE [4, 8]. Diogenes taught cynicism philosophy and followed ideas such as lack of shame and contempt for social organisation. However, many in the literature have argued that little evidence exists as to the appropriateness of the term 'Diogenes' to the condition and therefore suggest that the term is a misnomer – with the term 'severe domestic squalor' being a more accurate descriptor [4, 8-11]. The term Diogenes syndrome was coined by Clark et al., replacing the earlier term senile squalor syndrome [10, 12]. Nevertheless, the disorder's validity remains controversial and the literature is scattered with inconclusive arguments with regards to its etiopathogenesis [3].

The literature reveals Diogenes syndrome to be highly comorbid with various psychiatric, psychological, and somatic disorders, including depression, obsessive-compulsive disorder, personality disorder, frontotemporal dementia, executive dysfunction, and stress [3,13, 14]. There is a dearth of literature in the area, with the majority focusing primarily on case studies. The purpose of this mini-review is to present a brief overview of cases highlighting the complexity and diversity of patients suffering from Diogenes, underscoring the importance of diagnostic criteria and classification to treat this condition accurately.

Mini Literature Review

Dermatological/Physical Neglect Presentations

Biswas et al., reported an extreme case of cessation of normal skin cleansing leading to dermatitis passivata as an example of Diogenes syndrome among a young individual living in self-imposed isolation [4]. The patient, a 34-year-old male, lived alone in a filthy, crowded home and had not taken a bath for over 2 years. The authors note Diogenes as being:

> [p]rimary or pure which is not associated with mental illness and secondary or symptomatic...with at least 4 permanent symptoms: patients do not ask for any help although they possess nothing; unusually fond of objects (hoarding of rubbish, or nothing in the house); unusual behavior with other people (misanthropy) and severe self-neglect...[s]uch persons usually have above average intelligence and it is now clear that some stressful event precipitates the disease in predisposed individuals. (p. 2)

Similarly, Badr, Hossain, and Iqbal reported a case of a 72-year-old woman discovered to be in a state of gross physical neglect [15]. Mental health services visited her following being alerted by neighbours complaining of 'an intolerable smell and flies coming from her apartment' (p.1).

> On observation from the entrance, the apartment was grossly dirty with an offensive odor. The carpets were soaked with urine and moldy feces. Piles of garbage, each about 5 feet high, restricted the living space. There was no furniture in the house, no refrigerator, and among the garbage the only signs of nourishment were cracker wrappers and soda cans. (p. 1)

The woman was found to be wearing layers of dirty, urine-soaked clothes. Her exposed skin was deeply engrained in dirt, she had arthritic deformities in both hands, and neglected venous ulcers on her ankles. The authors note that psychiatric assessment revealed no evidence of dementia, affective or psychotic disorders, or difficulties with executive function, intelligence, attention, memory, language, or visual and spatial abilities.

In contrast, Reyes-Ortiz and Mulligan present a case of a 77-year-old man with a 3-year history of progressive social communication, personal hygiene, and nutritional decline [16]. The patient's history indicated he was of average intelligence with no personal or familial psychiatric illness. On examination, the man was thin and dirty, with long hair and a beard, and he refused to communicate or receive professional help. According to the authors, over the course of 3 years, 'he lost 20 pounds, fell, developed pneumonia, and died' (p. 1486).

Hoarding Presentations

Irvine and Nwachukwu present a case of a 61-year-old obese female with a history of bipolar 1 disorder and hypothyroidism who attended an outpatient psychiatric follow-up review accompanied by her Community Psychiatry Nurse [7]. The woman was found to be living in a two-story home 'crammed with filthy clothes, garbage, dirty dishes, and rotting food...it looked as if some dishes were being cleaned in the toilet...[and] any clear space on the floor was strewn with cat and dog feces' (p. 2). As noted by Irvine and Nwachukwu, Diogenes can be difficult to diagnose due to there being no established constellation of symptoms [7]. However, they suggest that keeping note of the known constellation of symptoms distinguishing Diogenes from other related conditions 'will allow for a more prompt diagnosis and initiation of management of these clients' (p. 1). Indeed, as exemplified in this case, the woman had no insight into any personal hygiene or living situation problems – lack of insight, distress, or emotional attachment distinguish Diogenes from hoarding disorder [7, 8, 17].

Similarly, Khan reported a case of a 78-year-old widowed male brought to the hospital due to concerns about worsening dysphagia, fatigue, and serosanguinous drainage from his nose [8]. While being assessed, the patient's son reported additional problems regarding his father's living condition, noting that he 'lived alone, and there had been accumulation of "waste" congesting and cluttering the living area' (p. 9). The patient did not meet criteria for hoarding disorder, 'as there was no sentimental attachment to possessions in the house nor a perceived need to necessarily keep "waste" at home. Moreover, the patient lacked insight into his situation at home and did not report distress' (p. 9). Further, Ferry describes the case of an 83-year-old woman with mild dementia whose living situation was brought to the attention of a consultant geriatrician by her nephew [5]. According to the report, upon entering the woman's house, there was a 'stench of rotting garbage... [and] [t]here was household waste all over the place, including on the floor, on furniture and in every room including the kitchen, bedroom and living room. The garden was overgrown and also contained mounds of rubbish' (p. 29). Similar to other reported cases of Diogenes, the patient had no insight into her social situation and could not understand others concern for her and is reported as being surprised upon learning of neighbours' complaints about odours and pests emanating from her house [13, 18]. Extant case studies of Diogenes suggest that the syndrome is a reaction to stress in older adults with certain personality characteristics or as the end stage of a personality disorder or following a diagnosis of a life-threatening condition [5, 13, 19]. Nevertheless, the pathological hoarding behaviour of Diogenes is distinct in the context of this specific behavioral disorder, with typical clinical features including 'poor personal hygiene, hoarding of litter, very poor surroundings with filth in or around the house, resistance to offers of help, social withdrawal and shameless attitude' [5 (p. 30), 13, 20].

Intellectual/Cognitive Disability Presentations

According to Boyd and Alexander, there is a lack of identified Diogenes' syndrome individuals with intellectual disability, which they conclude may be due to 'diagnostic overshadowing' [21]. They present a case of a 55-year-old woman with borderline intelligence admitted to mental health services twice in five years for living in conditions of extreme squalor – including hoarded rubbish, piles of wet clothing, and rotting food and excrement.

The authors note a long history of contact with mental health services and previous diagnoses of obsessive-compulsive disorder (aged 17), schizophrenia (aged 40), and frontotemporalb dementia (aged 48); however, no diagnosable psychiatric disorder present on the two most recent admissions. In contrast, Zuliani et al. describe a case of a 43-year-old man with a history of cognitive difficulties living in precarious hygienic conditions [22]. The patient's behaviour was characterised by social withdrawal, lack of insight, and hoarding of every kind of object and food from dustbins and accumulating them in the house[1]. Further, Ashworth et al., reported a case of a 53-year-old male with birth-related learning difficulties living with his younger brother in appalling conditions [3]. Concern for the pair was raised by neighbours who called emer-

[1] For further case examples highlighting the complexity and diversity of patients that may be correctly or incorrectly labelled as having Diogenes, see Lee and LoGiudice, 2012 and Zuliani et al., 2013.

gency services. The brothers were discovered to be living in extreme squalor, with 'faeces everywhere, cockroaches and rodents throughout the house, food mouldy and out of date, some dating back to the time of their mother's death [2000].Newspapers and rubbish were stacked high in every room' (p. 249). The authors note that the younger brother gave up trying to keep the house clean and tidy due to his older brother's 'hoarding and compulsive buying and refusal to throw anything away' and inability to see that there was anything wrong (p. 249). The older brother was diagnosed as having Diogenes on the basis of self-neglect and his distinct lack of concern over his living situation.

Discussion

The literature on Diogenes syndrome is scattered, inconclusive, and primarily based on case studies [3]. However, as evidenced by this mini-review, there is an identified cluster of symptoms representative of Diogenes, distinguishing it from the closely related condition hoarding disorder [1]. These include dirty home, extreme self-neglect of hygiene, health, and environment, squalid living conditions, syllogomania (i.e., compulsive accumulation or collection or acquisition of objects that have no a priori value), social withdrawal/isolation, refusal of help, denial/lack of shame/embarrassment, absence of evolving psychiatric disorder, particular personality characteristics (e.g., aggressiveness, unfriendliness, stubbornness), and domestic poverty. Reyes-Ortiz and Mulligan offer the following description of the origination and development of Diogenes [16]:

> The pathogenesis of DS is postulated to be a life-long subclinical personality disorder turned gradually into gross self-neglect and social retreat. Premorbid personality traits include a tendency to be unfriendly, obstinate, aloof, aggressive, independent, detached, stubborn, secretive, suspicious, quarrelsome, and eccentric. The social breakdown may be precipitated by a stressful life event (e.g., bereavement, retirement) and further aggravated by debilitating physical problems. The complex of personality factors, loneliness, stress, and somatic illness, forms a vicious cycle, resulting in a reclusive life-style, abandonment of social norms, and refusal of help. (p. 1486)

Indeed, there is much controversy in the literature of the etiopathogenesis of Diogenes, with many arguing that it is neurologically or psychologically based, with some suggesting that the aetiology is much more complex and a result of both [3, 14]. However, at the core of Diogenes syndrome is a lack of shame or disgust over one's living situation and a lack of concern with regards to their situation and self-neglect. As noted by Ashworth et al. [3]:

> Disgust is considered one of the six basic human emotions and has a significant evolutionary role in protecting us: for example, the smell of meat that has gone off elicits a disgust response, which prevents us from eating the meat and getting food poisoning...However, such research in DS is limited, which is interesting given that it may be central to the presentation...Further, it is reported that individuals with DS lack a sense of shame, that is, have a lack of concern about their living situation...Evidence suggests that those experiencing hoarding do experience shame, embarrassment, and guilt (p. 246-247) [23].

Therefore, further research is required into the noted central role that lack of shame and disgust play in identifying Diogenes. Furthermore, given the other cluster of characteristics, it is well documented that the management and treatment of individuals with Diogenes present many challenges and medical/legal/ethical issues. Thus, the overall challenge is to preserve the rights of the individual while at the same time protecting them from harm and reducing risk, which often brings such individuals to the attention of mental health services in the first place [3,11, 24].

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