Correspondence

Diogenes' syndrome and intellectual disability: An uncommon association or under diagnosed?

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Diogenes' syndrome, a term first suggested by Clarke *et al*. [1], is characterised by marked self-neglect, domestic squalor, social withdrawal, apathy, lack of shame and hoarding of rubbish (syllogomania) [2]. This syndrome has been reported in association with several other psychiatric conditions including dementia, obsessive-compulsive disorder (OCD), psychosis, affective disorders, personality disorders, substance abuse, autism and frontal lobe impairment. These authors were able to find only one other instance of a reported association with intellectual disability [3].

We report the case of a 55-year-old woman, MM with borderline intelligence who has been admitted twice in the last 5 years for living in conditions of extreme squalor. On both these occasions no other psychiatric disorder was diagnosable. Ms MM has a long history of contact with mental health services. At 17 she developed symptoms of OCD characterised by thoughts of contamination with cleaning rituals following a sexual assault. She experienced these symptoms for 20 years following which she was able to overcome problems with medication and cognitive behavioural therapy. She had a brief de facto relationship and separated to live with her son when she was 21. Her stringent standards of obsessive cleaning led to estrangement from her son. MM received a diagnosis of schizophrenia when she was 40 and had two extended admissions in hospital. She has been off antipsychotic medication for the last 2 years without a relapse of psychotic symptoms. A review of past notes did not reveal positive symptoms for a significant period of the illness. She received a diagnosis of fronto-temporal dementia at 48 without any significant cognitive decline since or evidence of degenerative changes on neuroimaging. No symptoms of any of these disorders were elicited in the last two admissions apart from a decline in living standards and hygiene precipitating contact with mental health services. During both these admissions her accommodation was described as littered with hoarded rubbish, piles of wet clothing, rotting food and excrement that had been left in saucepans for weeks. During both these admissions, standards of personal and environmental hygiene responded to behavioural prompts by staff. Community management was problematic, as neither disability services nor mental health services were easily convinced about their role in owning responsibility towards providing follow-up services.

There was a family history of intellectual disability in the absence of any other psychiatric morbidity. MM did not have a history of substance abuse. Difficulties with financial management had resulted in petty theft but had not recurred in the last 4 years.

MM fits the description of individual's likely to be at risk of lapsing into such squalor – 'old people of the independent and domineering type living alone, with poor or non-existent social links with their local community' [4]. The only exception to this conformity being her relatively young age and borderline intelligence although significant breakdowns in standards of personal and environmental hygiene have been described in younger individuals [2,5,6]. Adults with intellectual disability are as prone to mental illness as other normal individuals, if not more as evidenced by MM's own varied response to stressful life situations. The paucity of identified Diogenes' syndrome in individuals with intellectual disability is therefore puzzling. This may be secondary to one of several reasons. It could be reflective of 'diagnostic overshadowing', which refers to the presence of an intellectual disability decreasing the diagnostic significance of an accompanying behavioural problem [3,7]. The more severely intellectually disabled are often in supported accommodation or residential facilities where a decline in standards of hygiene is identified earlier preventing progression to a state where diagnosis of Diogenes' syndrome might be made. A lack of familiarity with this condition could possibly contribute to poor identification and diagnosis in atypical circumstances such as MM's-younger age at onset and intellectual disability.

An awareness of Diogenes' syndrome, risk factors that contribute to causation and familiarity with systemic difficulties in management are therefore important in appropriate recognition and management.

References

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