Case report

Diogenes syndrome and autistic spectrum disorder

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Abstract

Diogenes syndrome or senile squalor syndrome has been described in the psychiatric literature with an associated mental illness in between one half and two thirds of the cases cited. The occurrence of the syndrome in the absence of a psychiatric disorder has received much attention with many hypotheses proposed. We present the case of a 72-year-old man living for many years in domestic squalor whose presentation, neuropsychological profile and history suggest an underlying autistic spectrum disorder. We are not aware of any similar case in an older adult reported in the medical literature. The co-occurrence of these two conditions is an intriguing one as certain key features of autistic spectrum disorder may predispose to Diogenes syndrome.

Key words: Diogenes syndrome; Autistic spectrum disorder; Senile squalor syndrome.

Introduction

Despite being first described over 50 years ago, by Shaw[1] there remains uncertainty regarding the exact nosology of domestic squalor syndromes. There appear to be two bodies of literature on the subject, one focussed upon domestic or personal neglect and another focussed on the symptom of hoarding.[2] Terms such as 'Diogenes syndrome', 'social breakdown of the elderly' and 'domestic squalor' have all been used to describe cases where the features of domestic squalor, personal neglect and/or hoarding have occurred either collectively or separately.[3] However due to the lack of diagnostic consensus it has been suggested that squalor should be treated as a state which requires assessment and treatment rather then a specific syndrome.[4] In those aged 65 and over domestic squalor has been reported as having an incidence of between 1 and 0.5 per thousand.[2,5]

The syndrome has also previously been reported in association with a number of medical and psychiatric conditions. A number of studies have shown an association between squalor syndromes and the presence of mental disorder.[1,4,7,8] Halliday et al,[4] in a study of senile squalor in a deprived inner London borough found that 70% had a mental disorder at interview as defined by the SCAN[20] which generates ICD-10 diagnoses. The commonest diagnoses were organic mental disorders (22%) and schizophrenia, schizotypal and delusional disorders (21%). However, a significant percentage of those living in squalor do not appear to have an identifiable psychiatric disorder.[9] This finding has been replicated in Irish studies of Diogenes syndrome.[8,10] In cases without comorbid frank mental illness a number of hypotheses have been proposed including the possibility that some cases may represent the reaction of a particular personality type to stress[7] or indicate dysexecutive syndrome secondary to frontal lobe syndrome.[11]

Recent prevalence studies of autistic spectrum disorder – which include classic autism, Asperger syndrome, pervasive developmental disorder [unspecified], and atypical autism – indicate that they affect up to 1% of children. This represents a 30-fold increase in less than 30 years.[12] Grouped under the category of pervasive developmental disorders the core characteristics of autistic spectrum disorders (ASDs) are: impairment in social interaction and in communication; an inflexible adherence to repetitive routines and activities; and a restricted range of interests. Clumsiness may also be present.

The phenomenal interest in disorders at the high-functioning end of the autistic spectrum which followed Wing's seminal paper[13] on Asperger syndrome in 1981 has focussed almost exclusively on children and younger adults.[6] There is very little published research on these disorders in later life. James et al[6] describe a case series of five patients referred to their service with affective symptoms whom they identified as having Asperger's. They postulate that due to the relatively recent identification of this syndrome there may remain an undiagnosed cohort of elderly patients with a similar disorder, a query also raised by a correspondent, following publication of a case history of senile squalor syndrome.[23]

Case report

Mr K is a 72-year-old man referred to the Dublin South East Psychiatry of Old Age service while he was an inpatient in a general hospital receiving treatment for a head injury sustained in a recent assault. He had confronted several youths he believed to be loitering in the vicinity of his local tennis club and had sustained a serious head injury from which he made a remarkable recovery. The referral was prompted by his siblings who were concerned about his longstanding history of hoarding and domestic squalor which had preceded his current admission by many years. He had been referred previously to his local psychiatric services for

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this problem but had refused to attend.

During initial assessment he reported that he did not feel that his home was in an unhygienic state. He described a daily routine of purchasing five newspapers each day which he stored in his house. He expressed dissatisfaction with previous attempts by his family and others to clean his house despite being aware that his local council was threatening legal action due to its seriously unkempt appearance.

Assessment of his mental state was unremarkable except that he seemed quite guarded. On a number of occasions he checked the environment to see if he was being overheard. He was reluctant to reveal personal information. No psychotic symptoms were elicited and he displayed no cognitive deficits on MMSE.

Collateral history from his family members revealed that he had exhibited hoarding behaviour, particularly for newspapers, and had lived in domestic squalor dating back to early adulthood. His family had recently arranged, during his admission to hospital, to have his house cleaned. They described that prior to this it was in a particularly unhygienic state with no running water and a broken toilet. The house was filled with various items including a large number of newspapers as well as containers of his own faeces. They also described how he had not moved his car for such a long period of time that a tree had begun to grow through it. Despite this he had kept the car tax and insurance up to date.

The eldest of seven children, the consensus among his siblings was that he gave no cause for concern in childhood although he himself recalled having few friends and being 'a loner' in boarding school from age seven. However, from his late teens into adulthood he was described as being 'on the periphery': although a 'fearless fullback' on the senior rugby team, who sustained a series of concussions – in contrast to his two brothers who were not on the team – he was not "one of the lads". An application to join a seminary at age 18 was not successful due to his being considered 'indecisive'.

In his 20s he led a somewhat 'nomadic' existence changing accommodation frequently due to communication problems with his landlords whom he regarded as unreasonable. Rigid in his thinking and concise in his speech he could say embarrassing things in company. He had comprehension difficulties unless communication was made clear and simple. His low tolerance for people who broke rules coupled with a failure to read social situations led to his intervening, as in the episode preceding this admission, at considerable risk to himself.

He spent most of his career in the bank where he had significant difficulty with organisation and completing tasks and he had a history of procrastination both at work and in his roles in the various clubs to which he belonged. An examination paper for a bank promotion in his 40s was so overinclusive, overwritten and underlined that his superior did not submit it lest it damage his prospects. He retired not long afterwards.

His siblings regarded him as a likeable person who had 'many acquaintances rather than friends' but he had no close friends or intimate relationships. His closest bond was with his mother, also described as a hoarder. His reaction to her death when he was 43 was catastrophic – he seemed 'distraught and lost'. In the years after her death his father had great difficulty living with him.

Apart from his routine of getting five newspapers each day he had some unusual behaviour, eg. writing the days of the week in French and registering his name in Irish on the register of electors. Although apologetic he was invariably over half an hour late for appointments. He had an amazing facility for remembering numbers and dates and the temporal sequencing of events.

Psychological assessment

Mr K was referred for a psychological assessment and among the tests administered where the Wechsler Adult Intelligence Scale, the Autism Spectrum Quotient and the Frontal Systems Behaviour (Family) rating form.

On the WAIS III his current overall intellectual functioning was in the 'superior' range with a discrepancy in favour of verbal over performance subtests. His profile was scattered with relatively low scores on the 'coding' and 'picture arrangement' subtests and on the 'processing score index' with high scores on the 'block design' subtest. This neuropsychological profile is similar to that described in many studies on patients with Asperger syndrome[14] and high functioning autism.[15]

On the Autism Spectrum Quotient, a screening questionnaire which has a score range of 0-50, Mr K had a score of 25. In a clinical study of adults suspected of having Asperger syndrome a cut-off of 25 on the AQ correctly classified 81% of adults who were subsequently given the diagnosis.[21] The results of the Frontal Systems Behaviour rating completed by Mr K's brother indicated a statistically significant score in executive dysfunction. This finding of frontal lobe compromise was in the opinion of the assessing psychologist more consistent with a longstanding problem than a traumatic brain injury. Numerous studies have identified executive function problems such as time management and organisational ability in subjects with Asperger syndrome.

Conclusion

Mr K's clinical presentation, taken in conjunction with his history and neuropsychological profile, is consistent with an underlying autism spectrum disorder. In early childhood and adolescence his superior intelligence may have enabled him to compensate for some of his deficits.

In view of the lack of information on his early developmental history, and given that, unlike most people with Asperger syndrome, he is not physically clumsy, he is best placed in the diagnostic category of pervasive development disorder-unspecified (ICD-10).

Discussion

Autistic spectrum disorders are increasingly diagnosed in early and late childhood years and less often in adulthood. Although it was described by Asperger in 1944 it was not until 1993 that diagnostic criteria for high functioning autism were established.

In our case the patient's high IQ probably masked other features of the condition in childhood, but the emergence of problems in adolescence and later employment difficulties and housing problems reflect the increasing demands of life on his coping strategies.

Both ASDs (especially Asperger's syndrome) and domestic squalor syndromes have been reported as co-existing with other psychiatric diagnoses. We believe we are presenting the first case which identifies a patient over 65 years of age with both conditions. Hoarding and repetitive behaviours have

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been commonly described in younger patients with ASD[16,17] but never in the elderly. It is likely that increasing awareness of the condition in later life will lead to greater recognition of the condition.

It has been reported that children with autistic spectrum disorder have higher frequencies of obsessive-compulsive symptoms clustering around hoarding behaviours[18] and it has been recommended that OCD with comorbid ASD should be recognised as a valid OCD type.[16]

Mr K's lack of awareness of societal norms and socially appropriate behaviour and a history of significant disorganisation and procrastination may explain his lapse into squalor and his failure to address the environmental issues associated with this. The finding of dysexecutive syndrome (a commonly reported feature of ASDs) in this case supports this explanation. It seems reasonable to suggest that some older patients who present with squalor syndromes may have an underlying autistic spectrum disorder. Social isolation and some of the personality features often described in Diogenes syndrome literature, such as aloofness, detachedness, eccentricity, unfriendliness, and lack of insight,[19] may arise from the core features of this disorder.

Given the heritability of autistic traits, a history of an autism spectrum disorder in a younger family member should alert the clinician while conversely a late diagnosis may shed light on hitherto undiagnosed autistic traits in the extended family. The importance of assessing premorbid functioning and assessing the lifelong interpersonal perspective by collateral history, to avoid incorrect diagnoses and inappropriate treatments,[6] cannot be overstated.

In view of the dearth of literature on autistic spectrum disorder in older adults there are no clear guidelines for managing this condition as it occurs in later life. However, as squalor syndromes have a range of associated physical and mental health problems a multi-dimensional approach to treatment is required,[4] and a comprehensive needs assessment should be the cornerstone of management in this situation. Further recognition of these disorders in older people should help to provide a clinical evidence base for helping these patients appropriately.

Declaration of Interest: None.

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