Ask the Geriatrician

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HOARDING

DIOGENES SYNDROME
“Loner dies buried under self made trash tunnels.”

Daily Mail 7 January 2009
OUTLINE

1) Case studies
2) Definition
3) History
4) Epidemiology
5) Differential diagnosis
6) Treatment
7) Conclusions
CASE STUDY

MS. X IS A 96 Y/O FEMALE WITH POOR VISION WHO LIVED ALONE WITH DOZENS OF CATS, DOGS, AND PARROTS. IN ADDITION SOME DEAD CATS WERE FOUND IN THE FREEZER. THE HOUSE WAS FILTHY AND FOUL SMELLING. EVALUATION REVEALED MS. X SUFFERED FROM ISOLATION, SIGNIFICANT DEPRESSION, AND MODERATE MEMORY LOSS. OVER TIME AN INTERVENTION PLAN WAS DEVELOPED AND MS. X AGREED TO HAVE HER HOUSE PROFESSIONALLY CLEANED AND IN KEEPING WITH CITY ORDINANCE SHE KEPT 8 ANIMALS.
Case study

Mr. Y was an 82 y/o widower living at a friend’s house. He began collecting and hoarding tools, parts, and equipment. The living space became so limited they slept on chairs. The family called police for assistance. Eventually, several agencies became involved however lack of collaboration allowed the family to order dumpsters and discard items. After his possessions were thrown away Mr Y was arrested because of the rage, anxiety, and delusions he developed.
DEFINITION

HOARDING is the excessive collection and retention of things or animals until they interfere with day-to-day functions such as home, health, family, work and social life. Severe hoarding causes safety and health hazards.

COLLECTING is an organized activity and others can appreciate that which is collected.
DEFINITION

DIOGENES SYNDROME is a behavioral disorder of the elderly manifest by extreme self-neglect, domestic squalor, social withdrawal/refusal of help, lack of concern/shame at residential situation, and a tendency to hoard excessively (syllogomania). Also known as:

- SENILE/SOCIAL BREAKDOWN
- SENILE SQUALOR SYNDROME
- MESSY HOUSE SYNDROME.
DIOGENES SYNDROME

1) Extreme self neglect
2) Domestic squalor
3) Social withdrawal/refusal of help
4) Lack of concern/shame, indifference
5) Hoards rubbish excessively
DIOGENES SYNDROME
DIFFERENTIAL DIAGNOSIS

Depression
Dementia/apathy
  Frontal lobe syndrome
Substance abuse/dependency
Obsessive-compulsive disorder
Personality disorder: schizoid, avoidant, paranoid types
Paranoid psychosis
Delusional disorder
Mental retardation
DIOGENES SYNDROME
DIAGNOSIS

At present DS does not fit clearly into the diagnostic criteria for any distinct mental illness in the DSM IV.

Without a specific diagnosis APS does not have a distinct protocol for managing DS. Instead DS is treated primarily as a dementia. APS is notified in all cases where adults are suspected of suffering from self-neglect or caretaker neglect.
DIOGENES SYNDROME

First described in 1966 by Dr. Duncan McMillan:
Case series of 72 persons ages 60-92.
All living in deplorable circumstances, rejecting society, denying problems and resisting help.
50% had psychiatric diagnosis/
50% DID NOT have psychiatric diagnosis.
DIOGENES SYNDROME

Second case series Drs Clark and Mankikar (Lancet 1975):
Patients similar to previous case series but excessive hoarding noted.
High mortality (>45%).
AGAIN 50% with no psychiatric diagnosis.
WHY DIOGENES?

Diogenes of Synope: Greek philosopher 412-323 BC

Scorned and rejected material wealth and possessions. The ultimate minimalist. Precepts:

“Life according to nature”

“Self-sufficiency”

“Lack of shame”

“Contempt for social organization”

Paradoxically, he did not hoard and daily sought the company of others.
WHY DIOGENES?

Named after Diogenes because of the way he lived: slept in a barrel, often begged, engaged in forbidden public habits, initiated the practice of showing displeasure by displaying his middle finger to detractors and foes.
DIOGENES SYNDROME: SUBTYPES

Primary (50-70%): Intentional; not related to mental illness.

Secondary (30-50%): Unintentional; related to mental illness.
DIOGENES SYNDROME

DEMOGRAPHICS

Males = Females

Can occur in younger patients.

Much more common in elderly. Average age 75.6

NOT RARE: 5/10000 adults >60.

Likely underreported by public health.

Relationship with homelessness or religious hermits.
DIOGENES SYNDROME
RISK FACTORS

Cognitive impairment.
Personality disorder.
Depression.
Living alone.
Low income.
Previous hip fracture.
Previous stroke.
DIOGENES SYNDROME
TREATMENT

ETHICAL/MEDICAL-LEGAL ISSUES:

AUTONOMY vs BENEFICENCE

DO MENTALLY COMPETENT PEOPLE HAVE THE RIGHT TO NEGLECT THEMSELVES?
DO HEALTH AUTHORITIES HAVE THE RIGHT TO INTERVENE?

GUIDING PRINCIPLE: CARE BY CONSENT
TREATMENT

DS as a geriatric syndrome e.g., impairments in many different systems ala “Geriatric Giants”: cognitive impairment, falls, incontinence, immobility, dizziness, and malnutrition.

These ‘syndromes’ benefit from comprehensive and multidimensional approaches.
TREATMENT

Global assessment:
1) Medical and psychiatric history.
2) Medication reconciliation.
3) Functional review (vision, hearing, ADLs, mobility, and continence).
4) Social history.
5) Cognitive testing.
TREATMENT

Team approach:
1) OT to perform cognitive testing.
2) Involve dietary if malnutrition.
3) SW to coordinate care.
4) Referral to Geriatric Medicine and/or Psychiatry.
TREATMENT

Avoid INVASION; Patients will reacquire trash, refuse help/follow-up, escalate hostility/suspiciousness, and deny trust and therapeutic relationships.

Some evidence Diogenes patients do worse if institutionalized against their will.
TREATMENT

Canadian model: GATEKEEPERS

Train nontraditional referral sources for seniors at-risk. Gatekeepers provide assessment, intervention, case management, and follow-up.

Daycare and community care are the main lines of management rather than hospitalization.
TREATMENT

Use of SSRIs to manage compulsive hoarding and atypical antipsychotics to manage paranoia has been reported.

Home safety: preventing additional clutter, establishing a routine cleaning plan, discarding rubbish, and organizing living space.
CONCLUSIONS

1) Depression, dementia, and alcoholism are risk factors.

2) Consider frontal lobe syndrome.

3) Not a formal DSM diagnosis.

4) Prevalent in people 60-90 years old, above average intelligence, successful work histories but lacking significant relationships.

5) Perhaps an end stage of a personality disorder.
CONCLUSIONS

6) Life long patterns of compulsiveness and paranoia combined with an inability to form relationships that progress to social breakdown.

7) Persistent refusal of help, denial of need, and withdrawal are the rule.

8) Public health, personal, and fire hazards are evident to the casual observer.

9) Prognosis is poor (mortality >45%).

10) Management is challenging. Noncompliance with treatment and follow-up are common.
WHY DO PEOPLE HOARD

Items perceived as valuable or a source of security.
Fear of forgetting or losing items.
Constant need to collect and keep things.
Fear others will obtain personal information.
Also: Sentimental value
  Decision-making
  Organizing
  Responsibility
  Control/Perfection
Q&A
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