International Journal of Research in Medical Sciences
Golla J et al. Int J Res Med Sci. 2026 Sep;14(9):4075-4077
www.msjonline.org
pISSN 2320-6071 | eISSN 2320-6012
DOI: https://dx.doi.org/10.18203/2320-6012.ijrms20262816

Case Report

Diogenes syndrome presenting with severe self-neglect and hoarding behaviour in an elderly woman: a case report

Jaahnavi Golla*, Sreelatha Pasupuleti

Department of Psychiatry, PES Institute of Medical Sciences and Research, Kuppam, Andhra Pradesh, India

Received: 08 April 2026
Revised: 11 August 2026
Accepted: 12 August 2026

***Correspondence:**
Dr. Jaahnavi Golla,
E-mail: jaahnavi.gj1998@gmail.com

ABSTRACT

Diogenes syndrome (DS) is an uncommon behavioural condition characterized by severe self-neglect, domestic squalor, hoarding behaviour, social withdrawal, and poor insight. It is frequently associated with psychiatric or neurocognitive disorders but may also occur without a clearly identifiable underlying condition, making diagnosis challenging. We report a 76-year-old woman with a two-year history of collecting discarded materials, progressive deterioration in personal hygiene, and marked neglect of her living environment, along with recent forgetfulness. Despite severe behavioural disturbance, she remained oriented with preserved bedside memory. Clinical evaluation excluded psychotic, mood, obsessive-compulsive, and major neurocognitive disorders. She was managed with psychoeducation, behavioural strategies, caregiver involvement, and low-dose antipsychotic medication, resulting in gradual improvement over five months. This case highlights that severe self-neglect may occur despite preserved cognition, suggesting underlying executive dysfunction rather than global cognitive decline.

Keywords: Diogenes syndrome, Self-neglect, Hoarding, Elderly, Executive dysfunction, Case report

INTRODUCTION

Diogenes syndrome (DS), also referred to as senile squalor syndrome, is characterized by extreme self-neglect, domestic squalor, compulsive hoarding, social withdrawal, and lack of concern regarding living conditions.[1] It predominantly affects older adults and is frequently associated with psychiatric conditions such as schizophrenia, mood disorders, obsessive-compulsive disorder, and dementia.[2]

Despite its recognizable clinical pattern, DS is not classified as a distinct diagnostic entity in DSM-5 and is instead conceptualized as a heterogeneous clinical syndrome.[3]

The pathogenesis is multifactorial, involving psychosocial stressors, personality traits, and possible neurobiological mechanisms, particularly involving dysfunction in frontal systems responsible for executive control and insight.[4]

Individuals with DS often present late due to poor insight and resistance to intervention, and the condition is associated with significant morbidity and mortality due to complications of self-neglect.[5,6]

This report describes a case of DS in an elderly woman without clear underlying psychiatric or neurocognitive disorder, highlighting diagnostic challenges and the need for a nuanced clinical understanding.

CASE REPORT

A 76-year-old woman was brought by her son with complaints of abnormal hoarding behaviour for two years, progressive decline in personal hygiene for one year, and increasing forgetfulness over the past year.

She had been functioning independently in activities of daily living prior to the onset of symptoms.

The illness began insidiously two years prior, when she started collecting discarded items such as plastic bottles, caps, and miscellaneous waste materials from her surroundings. Over time, the behaviour progressed to include accumulation of organic waste, including animal dung and leftover food items. These materials were stored within her living space, including cupboards and corners of the house, without any attempt at sorting, cleaning, or utilisation. Perishable items were retained for prolonged periods, resulting in decomposition, foul odour, and markedly unhygienic living conditions.

Despite repeated attempts by family members to clean the environment, she resisted disposal of the accumulated materials. When questioned, she justified her behaviour by stating that the items "might be useful later" or could be sold, although she had never attempted to do so. Importantly, there was no evidence of emotional attachment to specific objects, and she did not express distress when items were discarded, but rather objected in a rigid, matter-of-fact manner.

There was no history suggestive of hallucinations, delusions, formal thought disorder, or mood symptoms such as persistent sadness, anhedonia, or biological disturbances. There were no repetitive intrusive thoughts or compulsive rituals suggestive of obsessive-compulsive disorder. No disinhibition, apathy, or personality change predating the illness was reported. There was no history of substance use or significant medical comorbidity.

Figure 1: The patient's living environment showing severe accumulation of discarded materials and marked domestic clutter.

On general examination, she appeared poorly groomed with evident neglect of personal hygiene. On mental status examination, she was cooperative but lacked awareness regarding the abnormality of her behaviour. Speech was normal in rate and tone. Thought form was coherent, with no delusional content. There were no perceptual disturbances. She was oriented to time, place, and person. Immediate, recent, and remote memory were preserved on bedside testing. However, higher mental functions revealed impaired judgment, particularly in social and practical domains. Insight was absent (Grade 0/5).

Given the clinical presentation, differential diagnoses including schizophrenia, obsessive-compulsive disorder, major depressive disorder with self-neglect, delirium, dementia, and personality disorder were considered. The absence of psychotic symptoms, lack of distress-driven compulsions, preserved cognition, and stable level of consciousness made these diagnoses unlikely. A diagnosis of DS was made.

The patient was managed with psychoeducation directed at both the patient and caregivers, behavioural strategies aimed at gradual environmental modification, and pharmacological treatment with quetiapine, initiated at 50 mg/day and titrated to 100 mg/day. Initial resistance to treatment was observed; however, with sustained engagement and active caregiver involvement, gradual improvement was noted over a follow-up period of five months, particularly in terms of cooperation with care and partial acceptance of environmental cleaning.

The persistence of severe self-neglect and hoarding behaviour despite preserved orientation and memory suggested an underlying impairment in executive functioning rather than global cognitive decline.

DISCUSSION

DS is a complex neurobehavioural condition characterised by severe self-neglect, domestic squalor, hoarding, social withdrawal, and lack of insight.[1] Despite its recognisable clinical presentation, it is not classified as a distinct diagnostic entity and is best conceptualised as a heterogeneous syndrome with multifactorial etiology.[3]

The present case demonstrates classical features of DS, including accumulation of discarded and decomposing materials, extreme environmental neglect, and resistance to intervention.[2] However, a particularly noteworthy aspect in this case is the presence of profound self-neglect in the context of preserved orientation and intact memory, which challenges the commonly held assumption that such behaviour is primarily driven by global cognitive impairment. In our patient, this dissociation between preserved cognition and severe self-neglect indicates that the underlying deficit is more likely related to executive dysfunction rather than global cognitive decline.

Most reported cases of DS are described in association with psychiatric disorders or dementia.[2] In contrast, the absence of psychosis, mood disorder, or significant cognitive impairment in this patient suggests a presentation more consistent with primary DS, which has been less frequently described in the literature.[7] This observation is important, as it supports the view that DS may exist independently of overt psychiatric or neurocognitive illness.

Emerging evidence suggests that self-neglect and hoarding behaviours in older adults may arise from selective impairment in executive functions, including planning,

judgment, and decision-making, rather than deficits in memory alone.[8] In the present case, the coexistence of preserved memory with impaired judgment and lack of insight strongly supports this interpretation and points toward underlying executive dysfunction.

Neurobiological models further reinforce this understanding. Dysfunction in frontal-subcortical circuits, particularly involving orbitofrontal and anterior cingulate regions, has been implicated in impaired behavioural regulation and insight.[4] The patient's behaviour-collection without utilisation, inability to evaluate consequences, and indifference to hygiene-can be meaningfully interpreted within this framework of impaired executive control.

Another clinically relevant observation in this case is the absence of emotional attachment to hoarded items. In hoarding disorder, accumulation is typically associated with distress and strong emotional attachment to possessions.[3] In contrast, the patient demonstrated a utilitarian rationale without emotional investment, further supporting the distinction between DS and primary hoarding disorder.

Compared to previously reported cases, which often come to medical attention after the development of complications such as infections, malnutrition, or severe functional decline, the current case was identified relatively early due to caregiver concern.[6] This allowed intervention before significant medical morbidity developed, underscoring the critical role of family members in recognising behavioural changes in individuals with poor insight.

Taken together, this case reinforces the evolving conceptualisation of DS as a disorder of behavioural regulation and executive dysfunction rather than solely a manifestation of dementia or psychiatric illness. The presence of severe self-neglect in the absence of global cognitive impairment highlights the need for clinicians to evaluate executive functions and insight carefully, even when routine cognitive screening appears normal.

This case supports the evolving understanding of DS as a disorder of behavioural regulation, where impairment in insight and executive functioning plays a central role.

CONCLUSION

DS is an under-recognised behavioural condition with significant clinical implications. This case highlights that severe self-neglect may occur despite preserved cognition, suggesting underlying executive dysfunction. Early recognition and multidisciplinary management are essential to improve outcomes.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Clark ANG, Mankikar GD, Gray I. Diogenes syndrome: a clinical study of gross neglect in old age. Lancet. 1975;1:366-8.
2. Amanullah S, Oomman S, Datta SS. Diogenes syndrome revisited. Ger J Psychiat. 2009;12:38-44.
3. Proctor C, Rahman S. Diogenes syndrome: identification and distinction from hoarding disorder. Case Rep Psychiatry. 2021;2021:2810137.
4. Finney CM, Mendez MF. Diogenes Syndrome in Frontotemporal Dementia. Am J Alzheimers Dis Other Demen. 2017;32(7):438-43.
5. O'Brien J. Self-neglect in old age. Aging Health. 2011;7(4):573-81.
6. Dong X, Simon MA. Self-neglect in older adults: a geriatric syndrome? J Am Geriatr Soc. 2006;54(12):1897-902.
7. Certo A, Nombora O, Pessoa T, Neto R, Mendes E. Hoarding disorder and Diogenes syndrome: two case reports and a narrative review. Cureus. 2025;17(1):e78289.
8. Roane DM, Landers A, Sherratt J, Wilson GS. Hoarding in the elderly: a critical review of the recent literature. Int Psychogeriatr. 2017;29(7):1077-84.

Cite this article as: Golla J, Pasupuleti S. Diogenes syndrome presenting with severe self-neglect and hoarding behaviour in an elderly woman: a case report. Int J Res Med Sci 2026;14:4075-7.