SELF-NEGLECT 1: RECOGNISING FEATURES AND RISK FACTORS

INTRODUCTION
Self-neglect in older adults is a serious public health issue and a social problem that can have profound consequences for the health and well-being of older people. It is characterised by an inability to meet one’s own basic needs and is an increasingly common problem, which can be intentional or unintentional (Gibbons et al, 2006). Those who self-neglect often live in extreme conditions of squalor and evidence suggests they are at increased risk of death and institutionalisation (Lachs et al, 1998). Self-neglect can occur across the lifespan but is more common in older people (Pavlov and Lachs, 2006a).

The complexity and multidimensional nature of self-neglect means it is difficult to detect and diagnose. Nurses and primary care staff are vital in its identification and management, and must be aware of its causes and risk factors (Lauder et al, 2006).

DEFINITION
Self-neglect is a common term used in medical, sociological and nursing research literature. There are no clear operational definitions of it nationally or internationally – Gunstone (2003) suggested a universal definition is not possible due to the dynamics and complexity of self-neglect.

Gibbons (2006) defined it as: “The inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecters and perhaps even to their community.” This definition shows the negative impact of self-neglect for the person, their family and community.

Self-neglect is a multidimensional complex phenomenon and researchers have used a variety of terminology to characterise it. Some historical categories include senile breakdown, Diogenes syndrome, senile squalor syndrome and gross self-neglect. Some researchers concur with Clarke et al’s (1975) concept of a distinct syndrome (Esposito et al, 2006; Pavlov and Lachs, 2006b), while others believe it to be a number of symptoms that can be linked to several mental and cognitive disorders (Halliday et al, 2000).

CHARACTERISTICS
The characteristics and behaviours used to describe self-neglect are:
- Living in very unclean, sometimes verminous, circumstances;
- Hoarding large numbers of pets;
- Neglecting household maintenance;
- Portraying eccentric behaviours/lifestyles;
- Poor self-care leading to a decline in personal hygiene (Halliday et al, 2000).

Research on nurses’ views of gross self-neglect has identified other characteristics including poor personal hygiene and nutrition, poor healing/sores, shabby clothes, long toenails, isolation and failure to take medication (Adams and Johnson, 1998). However, the basis for some of these features can include cognitive impairment, poor eyesight, functional and financial constraints, or poor access to podiatry services. In addition, poor environmental and personal hygiene may be a matter of personal choice or lifestyle and not down to age or cognitive changes (Dyer et al, 2003).

INCIDENCE
Self-neglect can have physical, social, environmental and health consequences resulting in failure to engage in, or access, services. This can have grave consequences for people, families and communities.

The estimated incidence of self-neglect in the UK is 0.5 per 1,000 in a population aged over 60 (Reyes-Ortiz, 2001). Self-neglect in older adults may not be evident on physical examination or identifiable outside of the home. It is difficult to detect and many cases go unreported or are unknown to services. Hurley et al (2000) surveyed 10 service agencies in Dublin. From their caseloads, 79 people from a variety of backgrounds were identified as having characteristics of self-neglect. According to unpublished data, self-neglect accounts for a large number of referrals to adult protective services and is
more common than caregiver neglect and physical abuse (Pavlik et al, 2001).

In the US self-neglect has been equated with elder abuse – reporting it is mandatory in many states (Lauder et al, 2006). In Ireland and the UK self-neglect is not considered a form of elder abuse (Working Group on Elder Abuse, 2002; Department of Health, 2000).

RISK FACTORS
In Australia and Europe, self-neglect is thought to be causally linked to an underlying mental illness. This may be a contributory factor so nurses must be familiar with, and recognise, the risk factors. Age-related changes that result in functional decline, cognitive impairment, frailty or psychiatric illness will increase vulnerability for abuse, neglect and self-neglect. The latter is frequently accompanied by a number of underlying conditions.

Risk factors are:
- Functional and social dependency;
- Social isolation;
- Delirium.

A literature review by Snowdon et al (2007) found living in squalor is often accompanied by a diagnosis of dementia, alcoholism, schizophrenia or personality disorders. Maier (2004) suggested self-neglect and hoarding may be a consequence of obsessive-compulsive disorder. Esposito et al (2006) posit that self-neglect and poor personal hygiene are linked to frontal lobe dysfunction. Executive function is maintained by the frontal lobe and executive dysfunction can compromise understanding of environmental hazards. This can result in self-care deficits, a spiralling of health and safety issues, and service refusal, leading to self-neglect (Dyer et al, 2007).

Research has found that 30–50% of those who self-neglect had no psychiatric disorder or condition that could reasonably explain their behaviour (Halliday et al, 2000). Sociological and psychological theories may offer a broader perspective than the medical model in understanding the complexity of factors associated with self-neglect (Lauder et al, 2005a). These emphasise the interplay between, cultural and social values, personal circumstances and history in viewing and responding to cases. Self-neglect can develop over time and be rooted in cultural values, family relationships and habits.

CLASSIFYING SELF-NEGLECT
It is important to differentiate self-neglect as intentional or non-intentional. The first occurs when a person makes a conscious or subconscious choice to self-neglect, whereas the second can occur as a result of underlying health-related conditions that contribute to risk of developing self-neglect (Gibbons et al, 2006). The box (see opposite page) outlines the differences, which can help identify self-neglect early on.

Patients, families, communities and healthcare staff can have varying beliefs, perceptions and cultural viewpoints about living standards and what is acceptable. Self-neglect is a complex problem that requires clinical, social and ethical decisions in its management. Complex dilemmas can arise when people appear to rationally or intentionally choose to self-neglect. It is important that health professionals accept people’s autonomy and their right to make lifestyle choices and refuse services. Critical to this, however, is assessing people’s decision-making capacity while taking account of risk and personal safety needs.

Establishing a therapeutic relationship with the person who is self-neglecting is crucial in gaining trust (Gunstone, 2003). Autonomy can be restricted if their lifestyle poses harm to themselves or their community (Lauder et al, 2005b). Lauder et al (2005a) suggested the best-practice approach is not to force services on the person.

Professionals’ judgements may help early recognition and prevention of self-neglect. Accurate, comprehensive assessment, a multidisciplinary approach, building relationships and being cognisant of lifestyle and independence are critical.

CONCLUSION
It is expected that self-neglect will increase as a result of ageing populations but the lack of a standardised definition poses problems in quantifying the issue. Nurses are key to early identification and management of self-neglect. In addition, accurate diagnosis and differentiation between intentional and non-intentional types is crucial.

- Part 2 of this unit, to be published next week, will discuss nursing management of self-neglect in the community.

---

**KEY REFERENCES**

- The full reference list for this unit is available in Portfolio Pages at nursingtimes.net

---

**PORTFOLIO PAGES ONLINE**

Portfolio Pages can be filed in your professional portfolio as evidence of your learning and professional development. They contain learning activities that correspond to the learning objectives in this unit, presented in a convenient format for you to print out or work through on screen.

- For the Portfolio Pages corresponding to this unit, log on to nursingtimes.net, click NT Clinical and Archive then click Guided Learning