Review Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2023; 15(4):622-630
doi: 10.18863/pgy.1224990

A Self-Care Deficiency Syndrome: Self-Neglect

Bir Öz Bakım Eksikliği Sendromu: Öz-İhmal

Cansu Güler[1], Esra Engin[2]

[1]Muğla Sıtkı Koçman University, Muğla
[2]Ege University, İzmir

ABSTRACT

Self-neglect is the individual's failure to show the necessary attention and care in his own care. Self-neglect manifests itself as non-adherence to treatment, failure to maintain personal and environmental hygiene, and maladaptive health behaviours. At the global level, although self-neglect is frequently seen especially in the elderly population, it is seen in all age groups and especially in disease groups where disability is in question and their caregivers. Self-neglect, which is divided into two categories as intentional and unintentional, is an important cause of morbidity and mortality. Failure to maintain accepted self-care standards caused by self-neglect threatens not only personal but also public health and well-being and increases the burden of health services and health care costs. Self-neglect is difficult to detect because individuals are isolated and do not have the risk of directly harming themselves. Due to reasons such as non-compliance with current treatment, ineffective health management, these individuals' access to the health system is disrupted and the diagnosis and intervention of self-neglect is delayed because they only apply to health services in emergencies. Health professionals working in the field of public health and mental health, especially community mental health professionals, have important responsibilities for the diagnosis and intervention of self-neglect.
Keywords: Self-care, self-neglect, mental health, intervention

ÖZ

Öz-ihmal, bireyin kendi bakımında gerekli dikkat ve özeni göstermemesidir. Öz-ihmal tedaviye uyumsuzluk, kişisel ve çevresel hijyeni sürdürememe, uyumsuz sağlık davranışları şeklinde kendini göstermektedir. Küresel düzeyde, öz-ihmal özellikle yaşlı nüfusta sıklıkla görülmekle birlikte her yaş grubunda ve özellikle yeti yitiminin söz konusu olduğu hastalık grupları ile bakım verenlerinde karşılaşılmaktadır. İstemli ve istemsiz olarak iki kategoriye ayrılan öz-ihmal önemli bir morbidite ve mortalite nedenidir. Öz-ihmalin neden olduğu, kabul gören öz-bakım standartlarının sürdürülememesi yalnızca kişisel değil toplum sağlığı ve refahını tehdit etmekte ve sağlık hizmetlerinin yükünü ve sağlık bakım maliyetlerini de arttırmaktadır. Bireylerin izole ve doğrudan kendilerine zarar verme riski taşımamaları nedeniyle öz-ihmalin tespiti güçtür. Mevcut tedaviye uyumsuzluk, sağlığı etkisiz yönetme gibi nedenlerle bu bireylerin sağlık sistemine girişleri aksamakta ve yalnızca acil durumlarda sağlık hizmetlerine başvurmaları nedeniyle öz-ihmalin tanılanması ve müdahalesi gecikmektedir. Öz-ihmalin tanılanması ve müdahalesi için özellikle toplum ruh sağlığı profesyonelleri başta olmak üzere halk sağlığı ve ruh sağlığı alanında çalışan sağlık profesyonellerine önemli sorumluluklar düşmektedir.
Anahtar sözcükler: Öz bakım, öz-ihmal, ruh sağlığı, müdahale

Introduction

One of the barriers to health promotion and promotion is self-neglect associated with self-care (Reed and Leonard 1989). Self-neglect is defined as the individual's not showing the necessary attention and care to his own care (Gibbons et al. 2006). Hansen et al. (2016) defined self-neglect as the failure of an individual to meet their basic physical, emotional and social needs or their refusal to meet these needs. The United States' National Committee for the Prevention of Elder Abuse and the National Adult Protective Services Association define self-neglect as "an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including obtaining essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health and general safety, and managing one's own financial affairs" (Naik et al. 2008). Self-neglect, which was first noticed by home health care nurses, started to be investigated after it was determined that the underlying reason for patients' neglect of self-care programs was not due to previously defined reasons such as suicidal thoughts, anger, maladaptive behaviour and disorientation. Although it was previously confused with an organic disorder such as dementia, Diogenes syndrome, scattered home syndrome, hoarding syndrome and social isolation, the concept of self-neglect has been proposed as a new concept to describe the phenomenon (Reed and Leonard 1989, Gibbons et al. 2006).

Address for Correspondence: Cansu Güler, Muğla Sıtkı Koçman University Faculty of Health Sciences Department of Psychiatric Nursing, Muğla, Türkiye **E-mail:** janskynju@gmail.com
Received: 27.12.2022 | **Accepted:** 02.02.2023

The addressing of self-neglect differs according to countries (Gibbons et al. 2006). While it is evaluated as a medical psychiatric syndrome due to underlying mental illness in Australia, England and Ireland, it is examined under the topics of elder neglect and abuse in the United States of America (USA) (Reed and Leonard 1989, Gibbons et al. 2006, Day 2010, Day and McCarthy 2016). In the USA, self-neglect is considered within the scope of neglect and abuse, while individuals who neglect themselves are defined as victims and it is emphasized that only vulnerable and destitute adults can be in this situation. Contrary to what is defined in the USA, in Europe and Australia self-neglect is considered separately from neglect and abuse since it does not occur within the framework of trust relationships. However, it is mentioned that in these continents, self-neglect may be a result of neglect and abuse, and the opposite may also be the case (Day 2010).

Self-neglect, together with accompanying problems, is considered as a crisis that causes concern in health and social areas. The current literature shows that self-neglect is accompanied by serious conditions such as death (Dong et al. 2009; Johnson, 2015b), impaired health (Johnson 2015b), frequent hospitalizations (Dong 2016), the need for a nursing home or sheltered housing (Gibbons 2006, Dong and Simon 2013), elder abuse, or caregiver neglect (Dong et al. 2013). The individual's inability to maintain socially and culturally accepted self-care standards and non-compliance with treatment threatens not only the health and well-being of the individual, but also the health of the community (Gibbons et al. 2006, Dong et al. 2009, Dong et al. 2010a). Addressing self-neglect with all its aspects will increase the knowledge of health professionals about the complex factors associated with the individual's participation in health and social services, while making important contributions to the protection and promotion of public health (Reed and Leonard 1989, Gibbons 2006, Dong et al. 2009). Although many descriptive and methodological studies on self-neglect can be found in the international literature (Dong et al. 2010b, Braye et al. 2011, Dong et al. 2012a, Dong and Simon 2013; Dong 2016), a limited number of published studies on the subject have been reached in the national literature (Ozmete et al. 2018). The aim of this traditional review is to define the concept of self-neglect, to explain the diagnostic criteria, categories, epidemiology, risk factors, theoretical perspective and results of self-neglect, and to reveal the roles of health professionals in self-neglect intervention, together with the measurement tools and ethical dimension.

Diagnostic Criteria

The complex and multidimensional self-neglect phenomenon can reach life-threatening dimensions (Day and Leahy-Warren 2008a, Gibbons 2009, Day and McCarthy 2016). While self-neglect emerges as a problem that ranges from mild early symptoms that are difficult to define such as non-compliance with the recommendations of healthcare professionals to serious dimensions related to health management in the form of ineffective treatment regimen and non-compliance with treatment (Lauder et al. 2001, Gibbons et al. 2006), it can reach pathological dimensions with hoarding, inadequate personal and environmental hygiene, and maladaptive health behaviours (Gibbons et al. 2006, Johnson 2015). While early symptoms of self-neglect can only be identified by the caregiver who takes close care of the individual, the main danger is that they cannot be detected until the individual applies to the health services due to a serious self-neglect or until the healthcare professionals observe overt self-neglect behaviour (Gibbons et al. 2006, Hansen et al. 2016). The fact that many self-neglecting individuals have almost no contact outside the home (Rosen et al. 2017) and do not have the risk of harming themselves directly delays the discovery of self-neglect (Gibbons et al. 2006). The status of the place of residence gives more precise clues about self-neglect (Rosen et al. 2017). In a study with paramedic and emergency medical technicians who had the opportunity to evaluate the state of the house during emergency response and transportation in the US state of New York, Rosen et al. (2017) concluded that employees can easily detect self-neglect.

Examining self-neglect in one dimension can give misleading results. For this reason, a detailed examination of the individual's personal appearance, the status of the residence and health behaviours will give more reliable results. The personal appearance of these individuals includes dirty clothes, bad body odour, and unkempt hair and nails (Gibbons et al. 2006, Johnson 2015a). An unhealthy home environment, the presence of rodents in the house, many pets, and structural deterioration in the house describe the appearance of the dwelling (Day and McCarthy 2016). Health behaviours are generally in the form of non-compliance with treatment or risky health behaviours, inconsistency or failure to comply with the recommendations of health professionals, refusing to take drugs, hoarding drugs, neglecting the maintenance of medical devices, engaging in dangerous behaviours such as smoking while using oxygen, and ignoring the symptoms of illness (Gibbons et al. 2006, Dyer et al. 2008, Day and McCarthy 2016).

Due to the similarity of its symptoms, the case of self-neglect can be confused with the case of self-care deficiency

syndrome and suicide. First of all, despite the harmful and life-threatening potential of self-neglect, it has no clearly stated purpose or direct cause. It is not intended to end the person's life immediately, and the effects of the behaviour are cumulative and occur over time. In this respect, the phenomenon of self-neglect differs from suicide. On the other hand, self-neglect represents a different phenomenon from self-care deficiency syndrome, since it covers various dimensions of the individual's self-care needs and is repetitive. In addition, in order to evaluate whether there is a deviation in health behaviours leading to self-neglect, the individual must have knowledge of the prescribed personal care program and have the necessary basic resources (cognitive competence, psychomotor skills, financial resources, etc.) to carry out the program. It is necessary to talk about self-neglect if the individual does not have health behaviours despite having knowledge, skills and financial resources (Reed and Leonard 1989).

Objective criteria were needed to define cases of self-neglect in the context of health measures to be taken, and firstly, Gibbons (2006) developed valid diagnostic criteria for health professionals to identify self-neglect in the early period. The diagnostic criteria for identifying self-neglect are as follows:

Self-neglect may be mentioned when there is inadequate personal and/or environmental hygiene and/or at least two of the following:

1. Ignoring health problems or missing appointments
2. Uncontrollable health problems that may require emergency intervention
3. Inadequate preventive practices (diet, exercise, smoking cessation)
4. Medication or treatment mismanagement despite a clear understanding of the rationale for abstinence recommendations
5. Failure to follow preventive or diagnostic tests related to health status

Self-Neglect in Two Categories

Self-neglect is explained in two categories according to whether it is intentional. The degree of intentionality is evaluated according to the existence of a universally accepted cognitive or functional disorder, adequate financing, or availability of resources such as social support (Gibbons et al. 2006). Intentional self-neglect, primary self-neglect or active neglect type includes conscious or unconscious choices and manifests itself with a cumulative set of lifestyle-related lack of self-care behaviours (Gibbons 2006, Day and McCarthy 2016). Intentional self-neglect is mostly associated with situations such as personal choice, lifestyle, desire to keep control, personality type and fear of institutionalization, and there should be no underlying psychiatric disorder (Gibbons et al. 2006). In this type of self-neglect, the self-care needs necessary for the health and well-being of the individual are interrupted for reasons such as not wanting to be a burden to others and remaining independent (Gibbons 2006). It is stated that the underlying reason for an individual's neglect of health needs may be related to family, culture and habits (Gibbons et al. 2006).

Unintentional/secondary/passive self-neglect can be a manifestation of an underlying condition such as dementia (Gibbons et al. 2006). Unintentional self-neglect arises unintentionally in relation to life stressors such as impaired functionality, substance abuse or loss of a significant other, associated with underlying cognitive and/or psychiatric disorders (Gibbons 2006, Iris et al. 2010). In this type of self-neglect, there is a lack of physical, mental, social or financial resources for the individual to participate in his own self-care. In an exploratory mixed method research in which the characteristic features of self-neglect were determined, Gibbons (2009) concluded that the coping capacity of individuals with unintentional self-neglect is problematic and this situation makes it difficult to perform self-care. Since unintentional self-neglect is thought to be caused by a disease or disorder, it is stated that self-neglect can be alleviated by solving the underlying problem. Therefore, in the intervention of self-neglect, it is necessary to evaluate in detail whether the self-neglect at the individual level is intentional or unintentional (Gibbons et al. 2006).

Epidemiology

Self-neglect is a lifelong phenomenon that can occur in both young and old populations. It is usually seen with hidden neglect and abuse of the elderly (Gibbons et al. 2006, Day and McCarthy 2016). Due to the fact that the studies mostly focus on the elderly population, limited data were obtained regarding the incidence of the phenomenon in the general population (Gibbons et al. 2006, Iris et al. 2010, Day and McCarthy 2016). However, it is very common in the general population (Gibbons et al. 2006, Hansen et al. 2016). Elderly protection centres

operating at the national level in the USA accept cases of self-neglect very commonly (Dyer et al. 2007). In a population-level cohort study conducted in the USA, it was concluded that the prevalence of self-neglect was 9.0% in the elderly population, and it was more common in males over the age of 85 (10.1%) than in females (7.5%) (Dong et al. 2012b). However, the racial variable may affect the frequency of self-neglect. Dong et al. (2012a) found a higher rate of self-neglect in the black adult population (13.2% in men; 10.9% in women) than in whites (2.4% in men; 2.6% in women). This rate is 4.1% in Korea (Lee and Kim 2014), and it ranges from 1.66% to 2.11% in Scotland (Lauder and Roxburgh 2012). Dyer (2005) stated that self-neglect accounts for 56% of all reported cases of neglect. In the USA, where 85,000 cases of self-neglect were reported in 2004 over the age of 60 years, self-neglect was stated as a serious public health problem that is most frequently encountered in preventive health services and needs to be addressed most urgently (Naik et al. 2008). Self-neglect is associated with the medical, cognitive, functional, social and mental states of individuals and is an important risk factor for morbidity and mortality. Therefore, detection of self-neglect is vital (Naik et al. 2008, Dong 2016, Hansen et al. 2016). When the national literature was reviewed, there were no studies evaluating the prevalence of self-neglect in the limited number of studies (Özmete et al. 2018, Ilhan et al. 2020).

Risk Factors

Gibbons et al. (2006) state that self-neglect may arise in relation to many factors. In the literature, it has been concluded that self-neglect is associated with various physical, mental and social factors such as depression (Dong et al. 2010a), learning disability, and fear of institutionalization, frontal lobe dysfunction (Gibbons et al. 2006), deterioration of executive functions (Dong et al. 2010), lifestyle (Gibbons et al. 2006), obsessive compulsive disorder, paranoid personality disorder (Pavlou and Lachs 2008), functional impairment, substance abuse (Lee and Kim 2014), difficulty in coping with life stresses (Gibbons 2009), maintaining control (Gibbons et al. 2006), and cognitive disorders such as dementia (Dong et al. 2010a). In addition, risk factors such as social isolation, poor social relations (Burnett et al. 2008, Day and McCarthy 2016), loneliness (Yu et al. 2019), low social support (Hansen et al. 2016), old age, chronic diseases, (Gibbons et al. 2006), limited access to health services, neglect of medical treatment, drug non-compliance (Day and McCarthy 2016), acute hospitalization, frequent emergency room visits (Dong et al. 2012a), malnutrition, dehydration (Gibbons et al. 2006), low socioeconomic status (Day and McCarthy 2016, Hansen et al. 2016), a poor patient-healthcare professional relationship, low education level, advanced disease symptoms, and caring for an individual diagnosed with chronic disease (Ortiz et al. 2009) make individuals more vulnerable to self-neglect. In a mixed method study examining the characteristics of self-neglect, Gibbons (2009) states that physical, social and cognitive changes that require coping skills trigger self-neglect. In the same study, Gibbons (2009) states that self-neglect is not related to aging but may be related to the complexity of health and social conditions during this period and the individual's lack of ability and willingness to deal with them. Caregivers are also at serious risk of self-neglect. It has been reported that the caregivers of individuals with chronic diseases such as mental illness and progressive cognitive disorders such as dementia may find less time for their own care, causing them to neglect their personal needs, and thus the risk of self-neglect may be high in these individuals. As a result, self-neglect behaviours are more common in these individuals (Barry and Jenkins 2007, Ortiz et al. 2009). On the other hand, socio-cultural factors such as behavioural intention towards self-neglect, cultural values and life history can also affect self-neglect tendency (Gibbons 2009, Day and McCarthy 2016).

Theoretical Perspective

Self-neglect is when an individual intentionally or unintentionally harms himself by not fulfilling his self-care needs (Gibbons et al. 2006). The phenomenon of self-neglect is associated with theories of suicide and indirect self-harming behaviour, since it is basically the individual's self-harm. Three important authorities working on the phenomenon of suicide, Menninger, Shneidman, and Farberow, have made significant contributions to the literature on self-neglect (Menninger, 1938, Reed and Leonard 1989). Menninger, who indirectly explains the forms of self-destruction, defines three types of self-destructive behaviour in his theory: chronic, focal and organic suicide. Organic suicidal behaviour, which includes self-punishing psychological factors that affect the occurrence of physical illness or increase its severity, is Menninger's self-harming behaviour associated with self-neglect (Menninger 1938, Reed and Leonard 1989). Shneidman's theory, on the other hand, associates substantial death with the concept of self-neglect, and classifies death according to whether it is intentional or not (Reed and Leonard 1989). Substantial death means to allow death to occur secretly or unconsciously or to invite death (Leenaars 2010). Substantial death behaviours such as lifestyle that exacerbates health problems, non-compliance with health recommendations, loss of desire for life, and behaviours with fatal risk are associated with self-neglect (Reed and Leonard 1989, Leenaars 2010). Various forms of self-destructive

behaviours with long-term, cumulative damaging and life-shortening effects that Farberow describes overlap with the phenomenon of self-neglect. The absence of a conscious intention to die in self-neglect, indifference to situations that may have harmful long-term effects, non-compliance with treatment for an unspecified reason, or ignoring health recommendations coincide with self-destructive behaviours (Reed and Leonard 1989).

Freud states that psychic energy or life energy or libidinal energy is instinctively the driving force necessary to meet basic physiological needs. Psychic energy needs to be directed towards external sources/objects to meet needs or obtain pleasure (cathexis). The self-neglect individual's unawareness or refusal to meet their needs can be associated with the disappearance or vanishing of the psychic energy that Freud used as a basis for mental functioning (Miller, 2008).

Consequences of Self-Neglect

Frequent hospitalizations and advanced health problems resulting from self-neglect put a heavy burden on the health system (Franzini and Dyer 2008, O'Connor 2017). In cases of self-neglect, non-compliance with medication or non-compliance with the treatment plan can render attempts to prevent or treat the disease ineffective and unrealistic. This poses the risk of hospital treatment of potentially preventable conditions or preoccupation with acute health care services. On the other hand, those with self-neglect have to seek more pharmacological treatments for the prevention and/or treatment of diseases (O'Connor 2017). In studies by Dong and Simon (2013) and Dong Simon and Evans (2012b), it was reported that adult self-neglect cases reported to social service institutions use emergency health services more, and the rate of applying to emergency health services increases as the severity of self-neglect increases. Dong et al. (2012a) concluded that patients with self-neglect had a more frequent history of hospitalization compared to those who were not self-neglect, and in another study, Dong and Simon (2013) concluded that as the severity of self-neglect increased, the frequency of hospitalization also increased. Franzini and Dyer (2008) concluded in a retrospective case-control study that the rate of benefiting from health care services is low in adults with advanced self-neglect. Based on the evaluations of community-based mental health and crisis intervention teams, Cotton et al. (2007) concluded that self-neglect cases require hospitalization three times more than other cases. The most serious consequence of self-neglect is the risk of premature death (Johnson 2015b). While the risk of death is affected by the dimension of self-neglect, it is associated with access to health care services and socioeconomic and socio-cultural factors (O'Connor 2017).

Measurement Tools

Measurement tools are needed to assess the necessity of self-neglect intervention or the effectiveness of interventions. Various scales used to assess the level of self-neglect have been developed in the international literature. The Self-Neglect in Health Behavior Scale (SNHB) developed by Reed and Leonard (1989), the Self-Neglect Severity Scale-SSS developed by Dyer et al. (2008), and the Self-Neglect Scale-SN-37 developed by Day and McCarthy (2016) are some of these scales. In the national literature, the Self-Neglect Scale in the Elderly developed by Iris et al. (2010) and adapted into Turkish by Ozmete et al. (2018) and the IM Self-Neglect Questionnaire developed by Ilhan et al. (2020) are valid and reliable measurement tools that can be used in Turkey. The scales in the national literature are scales aimed at assessing self-neglect in geriatric individuals.

Intervention in Self-Neglect

Self-neglect is not just a medical condition, it is a complex phenomenon that is difficult to detect and includes social, legal and ethical dimensions (O'Connor 2017). The burden of self-neglect on the individual and the health system is high due to the lack of education, knowledge and experience of health professionals, comprehensive evaluation within the health system, inadequacies in identifying problems, delays in detection and inadequacies in intervention, as well as difficulties in adopting a collaborative approach between hospital and community services (Reyes-Ortiz et al. 2014). Individuals with self-neglect apply to health institutions after their health condition reaches a level that requires urgent intervention, and they often apply to emergency health services (Dyer 2005, Choi et al. 2009, Hansen et al. 2016). Individuals discharged after the emergency response experience recurrent and increasingly chronic health problems due to non-compliance with the recommendations. Early and accurate diagnosis of self-neglect is vital for effective intervention. Considering the relationship between self-neglect and data such as the use of emergency services and the frequency of hospitalization, raising the awareness of health professionals for individuals at high risk for self-neglect and early diagnosis of the case emphasizes the need for self-neglect screening in acute health care institutions

(Cotton et al. 2007, O'Connor 2017). On the other hand, it is necessary to evaluate the behaviours not only in the health system but also in the living area as a whole. Research shows that health professionals who have the opportunity to evaluate the state of the home can accurately diagnose self-neglect. In a study by Rosen et al. (2017) with paramedic and emergency medical technicians who are the primary responders in emergency calls, and in a study by Johnson (2015b) with home care nurses, it was concluded that employees can easily detect self-neglect. Although the diagnosis, which is the first step in the intervention of self-neglect, is very important, standard evidence-based interventions are needed. A limited number of studies show that health professionals have a high level of knowledge and awareness of self-neglect, but their knowledge of self-neglect intervention is insufficient (Johnson 2015a). In this regard, Johnson (2015b) concluded that nurses did not receive any training in self-neglect intervention, and the lack of widely used care protocols or evidence-based guidelines left nurses unprepared for self-neglect intervention and forced them to use previously learned approaches.

Although evidence-based studies have not been found in the literature on self-neglect intervention, it is recommended that holistic interventions should be performed for the underlying or related factors (Dong 2017). In cases of self-neglect, diagnosed and untreated medical conditions may cause deterioration in decision-making abilities, which causes individuals not to seek or refuse necessary care and support, and the risk of self-neglect increases with decreases in the ability to carry out certain activities. While the decision-making capacity can become complicated depending on the experiences, habits, values, attitudes, thoughts and cultural beliefs of the individuals, it can also be impaired due to cognitive disorders, mental illnesses, mental retardation, concomitant medical conditions, medication side effects, physical injury and disability. Therefore, when evaluating self-neglect, it should be taken into account that personal preferences are an important factor along with the underlying factors. In responding to these cases, culture-specific standards of care should be taken into account in order to protect individuals and at the same time not violate their rights and respect their views (Dong 2017). Although there is not enough evidence based on specific strategies that can be reached on this subject, it is stated that solid cooperation and communication and a multidisciplinary team approach are effective in the management of self-neglect phenomena (Dong 2017, Mason and Evans 2020). Each discipline in the multidisciplinary team has important roles in responding to self-neglect by focusing on developing knowledge and understanding in society, networking and ensuring the safety of self-neglecting individuals, and most importantly, improving their daily functioning. In order to address self-neglect in a holistic and in-depth manner, this team should include mental health professionals, community health professionals, social workers and financial services institutions (Melekis 2017, O'connor 2017).

Ethical Dimension in Intervention of Self-Neglect

Although self-neglect is not considered morally good or bad (Gibbons et al. 2006), ethical dilemmas are experienced as a result of the conflict of values, beliefs and principles of individuals, society and health professionals regarding safety and risk in self-neglect intervention (Day et al. 2016). Ethical dilemma begins with the process of deciding when a health professional will consider a behaviour as a problem and intervene (Gibbons et al. 2006). The issue of whether the situation is caused by personal preference or associated with the underlying problem is the point on which the ethical dilemma is based (Johnson 2015a). Johnson (2015b), in a study with home care nurses, concluded that nurses experience an ethical dilemma between respecting patients' right to choose their lifestyle and protecting patients from the destructive effects of self-neglect. Ethical issues in dealing with these individuals include the potential conflict between personal autonomy and authority. As such, the involvement of health professionals may not always be considered therapeutic or warrant recovery (Reed and Leonard 1989). In addition, individuals may not comply with the medical regimen in line with their personal decisions, such as avoiding side effects or improving their quality of life (Reed and Leonard 1989, Kelleci et al. 2011). In some cases, as a result of the deterioration of the decision-making and judgment capacity of individuals, the capacity to protect and cope in risky situations may decrease. If the individual refuses the interventions due to his reduced capacity, it may be necessary to apply legal sanctions such as involuntary hospitalization (Gibbons et al. 2006). This situation also raises the issue of the violation of autonomy in benefiting from health services (Reed and Leonard 1989). Health professionals may override personal preferences if, due to personal preferences, the individual engages in behaviours that pose a risk to the public and/or his/her health and safety, and if the harm that may occur is more important than the individual's autonomy. For example, in cases of pathological self-neglect, such as hoarding animals and/or belongings, the individual may interfere with the life of the individual by invalidating personal preferences, since they risk both their own and public health (Day and Leahy-Warren 2008b). This process is often managed in line with laws and regulations (Day 2010, Braye et al. 2011, Braye et al. 2014). For this reason, it is important to evaluate the underlying causes of self-neglect and the individual's decision-making and judgment skills in order to prevent

the violation of patient rights and autonomy and/or the legal, physical and financial burdens of health professionals (Naik et al. 2008, Braye et al. 2014).

Conclusion

In this review study, the phenomenon of self-neglect is explained in detail and discussed in terms of self-neglect intervention measurement tools and ethical dimensions. Although the phenomenon of self-neglect can be seen in all age groups, it has often been studied in older age groups. Various physical, mental and social factors can affect the emergence of self-neglect, as well as playing an important role in lifestyle and personal choices. Self-neglect negatively affects the health of not only the individual but also the society in which they live due to progressive health problems. Self-neglect, which is difficult to diagnose before a serious health problem occurs, is an important cause of morbidity and mortality, increasing the burden and cost of health services. It is central to the identification, evaluation, orientation and continuous support of self-neglecting individuals in the field of public health and mental health and indispensable community mental health. International research on self-neglect, descriptive, methodological and qualitative studies such as diagnosing self-neglect, examining the knowledge levels and awareness of healthcare professionals, and developing reliable measurement tools are predominant. With regard to effective interventions, empirical knowledge is still weak. In this country, two scale studies for the diagnosis of self-neglect were accessed, and similarly, in the global literature, no interventional studies were found. Although research results that determine self-neglect at the population-level were accessed in the international literature, research results that determine the current situation do not yet exist in the national literature. In this regard, there is a need for longitudinal studies examining the effects of risk and protective factors on self-neglect at the global level, as well as at the national level. Conducting scientific research in this country will contribute to increasing the theoretical and practical knowledge and awareness of health professionals on the subject, to protecting mental health at the community level and therefore to reducing care costs.

References

Barry MM, Jenkins R. (2007) Mental health promotion within mental health services. In Implementing Mental Health Promotion (Eds. MM Barry, AM Clarke, I Peterson, R Jenkins): 505-562. Oxford, Churchill Livingstone.

Braye S, Orr D, Preston-Shoot M (2011) Conceptualising and responding to self-neglect: the challenges for adult safeguarding. J Adult Protect, 13:182-193.

Braye S, Orr D, Preston-Shoot M (2014) Self-Neglect Policy And Practice : Building An Evidence Base For Adult Social Care. London, Social Care Institute for Excellence.

Burnett J, Regev T, Pickens S, Prati LL, Koko, A, Moore J et al. (2008) Social networks: A profile of the elderly who self-neglect. J. Elder Abuse Negl, 18:35-49.

Choi NG, Kim J, Asseff J (2009) Self-neglect and neglect of vulnerable older adults: reexamination of etiology. J Gerontol Soc Work, 52:171-187.

Cotton MA, Johnson S, Bindman J, Sandor A, White IR, Thornicroft G et al. (2007) An investigation of factors associated with psychiatric hospital admission despite the presence of crisis resolution teams. BMC Psychiatry, 7:52.

Day MR (2010) Self-neglect: A challenge and a dilemma. Arch Psychiatr Nurs, 24:73-75.

Day MR, Leahy-Warren P (2008a) Self-neglect 1: Recognising features and risk factors. Nursing Times, 104:26-27.

Day MR, Leahy-Warren P (2008b) Self-neglect 2: Nursing assessment and management. Nursing Times, 104:28-29.

Day MR, Leahy-Warren P Mccarthy G (2016) Self-neglect: ethical considerations. Annu Rev Nurs Res, 34:89-107.

Day MR, Mccarthy G (2016) Self-neglect : Development and evaluation of a self-neglect (SN-37) measurement ınstrument. Arch Psychiatr Nurs, 30:480-485.

Dong X, Simon M, Fulmer T, Beck T, Hebert L, Dyer C et. al. (2009) Elder self-neglect and abuse and mortality risk in a community-dwelling population. JAMA, 302:517-526.

Dong X, Simon M, Beck T, Evans D (2010a) A cross-sectional population-based study of elder self-neglect and psychological, health, and social factors in a biracial community. Aging Ment Health, 14:74-84.

Dong X, Simon MA, Wilson RS, Mendes DE, Leon CF, Rajan KB, Evans DA (2010b) Decline in cognitive function and risk of elder self-neglect: Finding From The Chicago Health Aging Project. J Am Geriatr Soc, 58:2292-2299.

Dong X, Simon MA, Evans DA (2012a) Prospective study of the elder self-neglect and ED use in a community population. Am J Emerg Med, 30:553-561.

Dong X, Simon MA, Evans DA (2012b) Prevalence of self-neglect across gender, race, and socioeconomic status: Findings from the chicago health and aging project. Gerontology, 58:258-268.

Dong X, Simon MA (2013) Association between elder self-neglect and hospice utilization in a community population. Arch Gerontol Geriatr, 56, 192-198.

Dong X, Simon M, Evans D (2013) Elder self-neglect ıs associated with ıncreased risk for elder abuse in a population: Findings from the chicago health and aging project. J Aging Health, 25:80-96.

Dong X (2016) Sociodemographic and socioeconomic characteristics of elder self-neglect in an us chinese aging population. Arch Gerontol Geriatr, 64:82-89.

Dong X (2017) Elder self-neglect: Research and practice. Clin Interv Aging, 12:949-954.

Dyer CB (2005) Neglect assessment in elderly persons. J Gerontol A Biol Sci Med Sci., 60:1000-1001.

Dyer CB, Goodwin JS, Pickens-Pace S, Burnett J, Kelly A (2007) Self-neglect among the elderly: a model based on more than 500 patients seen by a geriatric medicine team. Am J Public Health, 97:1671-1676.

Dyer CB, Kelly PA, Pavlik VN, Lee J, Doody RS, Regev T et al. (2008) The making of a self-neglect severity scale. J Elder Abuse Negl, 18:13-23.

Franzini L, Dyer C (2008) Healthcare costs and utilization of vulnerable elderly people reported to adult protective services for self-neglect. J Am Geriatr Soc, 56:667-676.

Gibbons S (2006) Primary care assessment of older adults with self-care challenges. J Nurse Pract, 2:323-328.

Gibbons S, Lauder W, Ludwick R (2006) Self-neglect: A proposed new NANDA diagnosis. Int J Nurs Terminol Classif, 17:10-18.

Gibbons SW (2009) Theory synthesis for self-neglect: A health and social phenomenon. Nurs Res, 58:194-200.

Hansen MC, Flores DV, Coverdale J, Franzcp AE, Burnett J (2016) Correlates of depression in self-neglecting older adults: A cross-sectional study examining the role of alcohol abuse and pain in increasing vulnerability. J Elder Abuse Negl, 28:41-56.

Iris M, Ridings JW, Conrad KJ (2010) The development of a conceptual model for understanding elder self-neglect. Gerontologist, 50:303-315.

İlhan B, Bahat G, Saka F, Kılıç C, Oren MM, Karan MA (2020) A new screening tool for self-neglect in community-dwelling older adults: IMself-neglect questionnaire. Aging Male. 23:388-395.

Johnson YO (2015a) Elder self-neglect : Education is needed. Home Healthc Now, 33:421-424.

Johnson YO (2015b) Home care nurses' experiences with and perceptions of self-neglect. Home Healthc Now, 33:31-37.

Kelleci M, Doğan S, Ata EE, Avci D, Sabancioğullari S, Başeğmez F et al. (2011) Ideas regarding psychotropic drug use among inpatients in a psychiatry clinic and after their discharge from the hospital with follow-up by telephone. Journal of Psychiatric Nursing, 2:128-135.

Lauder W, Scott P A, Whyte A (2001) Nurses' judgements of self-neglect: A factorial survey, Int J Nurs Stud, 38:601-608.

Lauder W, Roxburgh M (2012) Self-neglect consultation rates and comorbidities in primary care. Int J Nurs Pract, 18:454-461.

Lee M, Kim K (2014) Prevalence and risk factors for self-neglect among older adults living alone in south korea. Int J Aging Hum Dev, 78:115-131.

Leenaars AA (2010) Edwin S. Shneidman on suicide. Suicidology Online, 1:5-18.

Mason K, Evans T (2020) Social work, inter-disciplinary cooperation and self-neglect: exploring logics of appropriateness. Br J Soc Work, 50:664-681.

Melekis K. (2017) Self-Neglect: A Statewide Assessment In Vermont. In Self-Neglect in Older Adults: A Global, Evidence-Based Resource for Nurses and Other Healthcare Providers. (Eds. MR Day, G McCarthy JJ Fitzpatrick): 231-239. New York: Springer Publishing Company.

Menninger KA (1985) Man against himself. Psychohist Rev, 13:9-14.

Miller PH (2008) Gelişim Psikolojisi Kuramları. (Çeviri Ed. B. Onur) Ankara, İmge Kitapevi Yayınları.

Naik DA, Lai MJ, Kunik EM, Dyer BC. (2008) Assessing capacity in suspected cases of self-neglect. Geriatrics, 63:24-31.

Ortiz N, Lamdan R, Johnson S, Korbage A (2009) Caregiver status:A potential risk factor for extreme self-neglect. Psychosomatics, 50:166-168.

O'Connor K. (2017) Self-neglect: An Isssue in Acute Care (In Self-Neglect in Older Adults: A Global, Evidence-Based Resource for Nurses and Other Health Care Providers (Eds. MR Day, G McCarthy, JJ Fitzpatrick): 114-130. New York: Springer Publishing.

Özmete E, Duru S, Yıldırım H (2018) Elder self-neglect scale: The adaptation study into Turkish. Anadolu Psikiyatri Derg, 19:87-95.

Pavlou MP, Lachs MS (2008) Self-Neglect in older adults: A primer for clinicians. J Gen Intern Med, 23:1841-1846.

Reed GP, Leonard VE (1989) An analysis of the concept of self-neglect. ANS Adv Nurs Sci, 12:39-53.

Reyes-Ortiz CA, Burnett J, Flores DV, Halphen JM, Dyer CB (2014) Medical implications of elder abuse: Self-neglect. Clin Geriatr Med, 30:807-823.

Rosen T, Lien C, Stern ME, Bloemen EM, Mysliwiec R, Mccarthy TJ et al. (2017) Emergency medical services perspectives on identifying and reporting victims of elder abuse, neglect, and self-neglect. J Emerg Med, 53:573-582.

Yu M, Gu L, Jiao W, Xia H, Wang W (2019) Predictors of self-neglect among community-dwelling older adults living alone in China. Geriatr Nurs, 40:457-462.

Authors Contributions: The author(s) have declared that they have made a significant scientific contribution to the study and have assisted in the preparation or revision of the manuscript
Peer-review: Externally peer-reviewed.
Conflict of Interest: No conflict of interest was declared.
Financial Disclosure: No financial support was declared for this study.