
Taking the Solitude Out of Self-Neglect in the Elderly

Self-neglect by older adults will be seen more and more often as Canada's population ages and the number of people living alone with dementia increases.

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Self-neglect has several, often conflicting, definitions. The early British literature is rich in descriptions of gross self-neglect, characterizing the patients as being unkempt and scruffy, with little or no contact with friends, family, neighbors or formal services.¹⁻³ It also is rich in disagreements about these patients, as some authors would exclude those who lived with others or had abnormal cognition or a diagnosable psychiatric condition. More recent literature provides the succinct and serviceable definition, "an elderly person alone who is not able to provide himself or herself the services necessary to maintain physical and mental health."⁴ The author does not restrict this definition to those who live alone, as couples, siblings and roommates can present together with self-neglect.

Epidemiology

The prevalence and incidence of self-neglect are not well understood. Numerous studies have been done, but all suffer from important

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Table 1

Differential Diagnosis

Recent onset (days to weeks)

- Atypical illness presentations (see Tables 2 and 3)

Long-standing (weeks to years)

- Dementia
- Depression
- Diogenes syndrome
- Substance abuse
- Other psychiatric disease

biases—not the least of which is under-reporting by subjects and non-response to surveys by this particular group of patients. Still, self-neglect is known to be the most common reason for referral to adult protection services, comprising 73% of referrals in one American study.⁴ The prevalence of the various forms of elderly abuse, including self-neglect, is reported to be between 2% and 10% in North America.⁶ Self-neglect is an important problem. In one cohort study, the mortality of those with self-neglect was approximately twice as high as those without.⁷

Differential Diagnosis

Self-neglect is rarely a patient's presenting complaint. Rather, oth-

ers will be concerned and ask for a physician's assessment. There is no role for any screening procedures.⁸

The differential diagnosis centers on the acuity of the presentation (Table 1). A recent onset of self-neglect, measured in days or weeks, counts as one of the geriatric giants, with the differential diagnosis presented in Table 2. Long-standing self-neglect, measured in weeks to years, has a different set of causes.

1. Recent onset of self-neglect.

The differential diagnosis of the atypical illness presentations is a useful way to approach most common geriatric syndromes, such as delirium, new-onset of falls or taking to bed. The new onset of a behavior disorder, such as self-neglect, fits with these other syndromes. All of these geriatric syndromes have a common differential diagnosis, as seen in Table 2. An atypical illness presentation is one not expected from the underlying pathology, often with the typical symptoms missing. For example, an atypical presentation of pneumonia might involve confusion and falls, without cough or shortness of breath.

Drugs are, by far, the most common cause of the atypical illness presentations, and come in three

forms: by prescription, over-the-counter, and as a source of recreation (*i.e.*, alcohol). Drug classes that are common culprits in these syndromes are sedative-hypnotics, antipsychotics and anticholinergics. Several geriatric medicine proverbs need to be considered, including “any drug can cause any side effect” and “any new symptom should be considered due to a drug until proven otherwise.”

Another common cause of an atypical illness presentation is infection, most commonly pneumonia or urinary tract infection. A positive urine culture must be interpreted with care, as it is much more likely to be coincidental than causative. The search for the underlying disease, therefore, should not automatically stop with the positive culture. Cardiac disease, particularly congestive heart failure, often presents atypically in older adults. Common metabolic causes involve sodium, glucose and calcium disorders. In geriatric medicine, it is not unusual to find several underlying diagnoses. The search for the cause(s), therefore, should not end with the first positive test.

An approach to the atypical presentations using the differential described above, supplemented by the few tests listed in Table 3, will diagnose the vast majority of these cases. As previously mentioned, this concept of the atypical presentations will work for any of the geriatric syndromes, not just new-onset self-neglect.

2. Long-standing self-neglect. Chronic self-neglect has a fairly limited differential diagnosis, as outlined in Table 1. Between 50% and 60% of these cases will have dementia and/or depression.⁹ An

Table 2

Differential Diagnosis of Atypical Illness Presentations

- Drugs (over the counter, prescription, or recreational)
- Infection
- Congestive heart failure
- Metabolic
- Some combination of the above
- Something else

accurate and timely diagnosis requires interviewing people who know the patient well.

Dementia is very common, with a prevalence of 8% in patients over the age of 65 years and 35% in those over the age of 85 years.¹⁰ It often goes unrecognized by both physicians and family. Clues to dementia in primary care include missed appointments, vague discussions of past and present symptoms, and repetitive comments and questions. Dementia can be diagnosed when there is evidence of memory impairment and some other cognitive impairment, which has had an impact on functional abilities. Discussion with family and friends is very helpful to uncover functional changes, particularly in early dementia. It can be useful to ask if there is anything the patient has given up doing over the past year.

Dementia should not be diagnosed if the symptoms are only present during an episode of delirium or if a psychiatric disease, such as major depression or acute psychosis, can better explain the findings. Criteria for the diagnosis of dementia are shown in Table 4. A detailed approach to the diagnosis of dementia and its causes, such as Alzheimer’s disease (AD) or vascular cognitive impairment, can be

Table 3

Investigation of Atypical Illness Presentations

- Complete blood count and differential
- Electrolytes
- Glucose
- Renal function
- Calcium
- Chest x-ray
- Urinalysis and culture
- Electrocardiogram

found in the Canadian Consensus Conference on Dementia.¹¹

Depression also is prevalent in older adults, and is a common cause of self-neglect. The presentation is different from that seen in younger adults. Symptoms, such as low mood, guilt and worthlessness, often are not expressed, while somatic symptoms, such as fatigue, pain and anorexia, are prominent. Classic symptoms, such as early-morning awakening, often are present. One helpful clue to the presence of depression is that the physician develops a sense of sadness while speaking with the patient. Some of the common symptoms of depression seen in older adults are presented in Table 5. Other psychiatric diseases occasionally can present with self-neglect.

Diogenes syndrome is used by some authors to refer to all cases of self-neglect, though this author reserves it for cases where no other diagnosis is apparent. Most of these patients will be diagnosed with dementia within a year or two of presentation. This syndrome refers to patients with extreme self-neglect, domestic squalor, social withdrawal and often a suspicious and hostile attitude toward the outside world.¹

Table 4

Diagnostic Criteria for Dementia

- Memory impairment
- Some other impairment of cognition
- Functional impairment
- Not solely delirium
- Not better explained by another psychiatric disease

The cause is unknown, though consensus in the literature is that it represents the interaction between a vulnerable personality (often there is a long-standing history of reclusiveness) and significant medical or social stressors.¹⁻³

Substance abuse, particularly of alcohol, can result in self-neglect. Older alcoholics present in two ways: the long-term abuser and the late-onset alcoholic. Late-onset alcoholism is more amenable to therapy. The identification of alcohol abuse often is difficult. Two of the best methods of detection are a home visit (where the empty bottles may be found) or an interview with the family. The latter interview makes sense because most patients with extreme self-neglect are unable to go out and buy their own alcohol, and so, are supplied by someone else.

Management

The new-onset of self-neglect due to an atypical illness presentation is relatively easy to manage. The underlying cause should be treated, and an environment that can rehabilitate whatever capabilities were lost during the acute illness should be provided. It also is important to ensure adequate support and services for the patient and family after discharge.

Table 5

Clues to the Presence of Depression in Older Adults

- Fatigue
- Anorexia/weight loss
- Somatic complaints
- Early-morning awakening
- Loss of libido
- Day-time sleepiness
- Irritability/anxiety
- Hopelessness
- Withdrawal from usual activities
- Sense of sadness developing in the interviewer

Patients with atypical illness presentations are more likely to die during the hospital stay, have longer lengths of stay, and be discharged to a nursing home.¹²

The long-standing causes are more difficult to treat. Dementia and substance abuse can be treated, though rarely cured. A common mistake in treating depression in older adults is to use too low a dose of antidepressant. It is important to start treatment with a low dose, but then this dose should be increased slowly to the dosages used in younger patients. A safe environment should be provided, while respecting the patient's wishes as much as possible. In the case of a competent patient, this becomes difficult—should they be allowed to languish alone, or does society have a right to impose certain standards of behavior? This author favors respecting the patient's wishes as much as possible. Certainly, the expectations on the physician are high, as any treatable conditions must be identified and adequately treated.

Legal Issues

The legal context differs between

provinces. Physicians should be familiar with reporting requirements, provincial legislation, and local services. For physicians who do not know this information, possible resources include local geriatric services, the Alzheimer Society or a seniors' rights organization.

Case Study in Self-Neglect

Mrs. K is 87, and lives alone. Her family physician, who has never seen her, refers her to the local geriatric service to evaluate whether she is able to continue living on her own. Apparently, a niece, who recently moved to town, had visited her aunt and was horrified by what she found.

Mrs. K's home is run-down, though in a nicer part of town. Her niece meets you at the door. The home is furnished in 1960s style and there are black-and-white photographs of Mrs. K and her long-deceased husband everywhere. Her dog has soiled the carpet and furniture.

Mrs. K is sitting in the kitchen, dressed untidily. She is friendly, but quiet. She seems unaware of the disorder around her.

She denies any symptoms, states she is on no medication and has had no operations or hospitalizations. However, the referral letter reported that she is on a thyroid supplement and had a mastectomy 15 years earlier. She names her family physician, but this person retired and moved 10 years ago.

Physical examination is unremarkable, other than a bite on her foot with a surrounding cellulitis. She seemed surprised by its presence, and could not describe how she received the bite.

On mental status examination, Mrs. K scores 8/30 on the Folstein Mini-Mental State Exam (MMSE),⁵ being unaware of the date, her address and having no recall of three objects at five minutes. She does not believe her home is untidy, states she cares for it alone and is out every day driving, visiting friends and shopping. She speaks of her husband as if he were still living. When you mention that her physician retired 10 years ago, she disagrees, and says she saw him just the other day.

Her niece tells you privately that Mrs K. does not recognize her, but will allow her free run of the house. When she first visited, the refrigerator was full of spoiled food and the house was much dirtier than it is currently. Mrs. K wears the same clothes daily, needs much persuasion to wash, will not use the telephone, takes no part in household chores and has forgotten that her dog needs to go out. She has no car.

The neighbors have told the niece that they have not seen Mrs. K for over a year and, other than the delivery man with the standing

grocery order and the company hired to care for her lawn, no one is seen near the home. The family physician took over the practice a year earlier, but has never had any contact with Mrs. K.

Case Discussion

Mrs. K obviously has severe dementia, most likely AD. There was nothing on her presentation or physical examination to suggest another diagnosis, such as vascular dementia or Lewy body disease. Routine investigations should be requested, as recommended by the Canadian Consensus Conference on Dementia.¹¹ In Mrs. K's case, this will amount to a few blood tests. Even if her hypothyroidism is undertreated, this is more likely a symptom of her dementia than the cause.

Management will mostly consist of helping her niece negotiate the red tape of adult protection services and guardianship (the terms may vary by district). If Mrs. K's finances are adequate, 24-hour care in the home is the least invasive option; otherwise relocation to

a supervised setting under a court order is the only feasible option.

Conclusion

Self-neglect is a sign that most physicians will eventually encounter. The differential diagnosis centers on the duration of the symptoms, and a careful assessment of cognition and mood. Dementia and depression are the most common causes of longstanding neglect. Management involves not only treatment of the underlying disease or diseases, but also an understanding of local legislation and available service agencies. Unfortunately, primary-care physicians do not feel comfortable assessing and managing these types of problems. In an Ontario survey, only 45% of physicians were comfortable assessing elderly abuse, and only 22% felt they had a good understanding of the services available for these patients.¹³ Self-neglect by older adults will be seen more and more often, as Canada's population ages and the number of people living alone with dementia increases.¹⁴

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