# The utility of self-care theory as a theoretical basis for self-neglect

William Lauder PhD MED RMN RCNT RNT DipEd DipN
*Associate Head of Department, Department of Nursing and Midwifery, Highland Campus, University of Stirling, Inverness, UK*

Submitted for publication 28 June 2000
Accepted for publication 26 January 2001

Correspondence:
*William Lauder,*
*Department of Nursing and Midwifery,*
*Highland Campus,*
*University of Stirling,*
*Old Perth Road,*
*Inverness IV2 3FG,*
*UK.*
*E-mail: william.lauder@stir.ac.uk*

LAUDER W. (2001) *Journal of Advanced Nursing* **34**(4), 545–551

**The utility of self-care theory as a theoretical basis for self-neglect**

**Aim.** This paper sets out to explore the utility of self-care theory in understanding self-neglect. Further theoretical development of both self-care and self-neglect theory and attending core concepts is an important objective.

**Background.** The notions of self-neglect and self-care are frequently linked in the literature. The relationship between self-neglect and self-care is not clear and the strengths and limitations in using self-care theory to facilitate a greater understanding of self-neglect will be addressed. Specifically the issues of self-care agency, self-care requisites, objectivity, class and culture, and lifestyle choice will be critically evaluated in the context of self-neglect theory.

**Conclusion.** Self-care theory has a useful role to play in furthering our understanding of self-neglect. Self-care theory is able to explain some aspects of self-neglect but not others, although this may be a reflection of the relatively underdeveloped state of self-care theories or alternatively may reflect a more fundamental limitation in our ability to fully explain human behaviour.

**Keywords:** self-neglect, self-care, theory development, squalor, Orem, poor hygiene, diet

## Introduction

Many descriptions of self-neglect have proposed self-care as one of its core concepts (Rathbone-McCuan & Bricker-Jenkins 1992). In this paper the use of self-care theory as a vehicle to understanding self-neglect will be explored critically. A number of key concepts in the self-care literature will be explored in detail and the discussion will focus heavily on Orem's work on self-care (Orem 1991). Foster and Bennett (1991) identify some of the key concepts in Orem's theory of self-care as self-care, self-care requisites and self-care agency. The adequacy of these concepts, in conjunction with other key concepts such as objectivity, in furthering our understanding of self-neglect will be discussed.

In the 1980s Hudson (1989) alluded to the lack of extant theoretical frameworks to guide self-neglect research. In the decade or so since this observation, with a few notable exceptions, such as the Adaptive Compensation Theory (Rathbone-McCuan & Bricker-Jenkins 1992), this remains essentially true. There remain no robust tried and tested theories of self-neglect in the published literature.

Most theories of self-neglect, however, explicit or implicit, are rooted in the values and assumptions of the medical model. It can be suggested that Orem's notion of self-care, whilst purporting to deal with nursing phenomena, also shares many of the key assumptions of the medical model. The philosophical and methodological assumptions underpinning these nursing-medical constructions of self-neglect are seldom made explicit by authors.

### Self-neglect

Severe self-neglect is a constellation of behaviours which includes household squalor, poor diet, failure to look after one's health and poor personal hygiene. Mental and physical health problems as well as inability to sustain and develop

good interpersonal relationships are other well known of signs and symptoms associated with self-neglect. The issues of hygiene, squalor and housing are inextricably linked to severe self-neglect (Johnson & Adams 1996). Houses of self-neglecters are often found to be dirty, littered with household rubbish and faeces and in a general state of advanced disrepair. The household circumstances of people described as self-neglecting are well documented in the professional literature and are occasionally sensationalized in visual and print-based popular media.

*Self-neglect and self-care*

Self-care has been proposed as a central concept in understanding self-neglect (Fabian & Rathbone-McCuan 1992, Shah 1992). Orem's theory of self-care was used to explain self-neglect and to justify the appropriate nursing intervention in two cases of self-neglect documented in nursing journals (O'Rawe 1982, Moore 1989). The need to care for one's own personal hygiene, household cleanliness and nutrition are examples of factors which affect health and well-being. Inadequate standards of personal hygiene and household cleanliness and poor nutrition are frequently cited symptoms of self-neglect (MacMillan & Shaw 1966, Clark *et al*. 1975). Thus self-neglect can be defined as the failure to engage in self-care acts which adequately regulate functioning, supply adequate levels of food, take actions to prevent, alleviate, cure or control conditions which affect life, health and well-being (MacMillan & Shaw 1966, Clark *et al*. 1975, Ungvari & Hantz 1991, Gannon & O'Boyle 1992, Shah 1992). It can be suggested that persons described as self-neglecting do not provide optimum levels of self-care. In terms of Orem's (1991) theory of self-care they can be described as having a self-care deficit. Thus at face value it appears there may be a seemingly obvious logical relationship between self-care and self-neglect, although this claim requires to be rigorously tested.

*Self-care agency*

Orem (1991) describes self-care agency (SCA) as the power and capability to engage in self-care. Gast *et al*. (1989) employ a broad definition of SCA when they define it as those capabilities of individuals which enable them to engage in self-care. Orem proposed that SCA is an acquired ability which is influenced by internal and external variables. Internal variables include cognitive functioning and knowledge, with education and the ability to work as examples of environmental variables. If Orem's theory is to be used to explain self-neglect it follows that deficiencies in SCA must necessarily play a major role in the mediation or development of self-neglect in a given individual. It can be proposed that individuals who have impaired capabilities (for example, dementia, knowledge deficit) will have lower levels of SCA, and will therefore have a limited ability to engage in self-care actions. In a previous study the hypothesis that individuals with self-neglect would have low levels of SCA was supported (Lauder 1999a), a finding which lends weight to the utility of SCA in understanding the processes which are implicated in the development or the mediation of self-neglect. This is an important theoretical insight and is an alternative explanation to the medical model which simply assumes that a disease is directly causally related to self-neglect.

Nevertheless this finding obscures the fact that although a statistically significant difference was observed between a group of non-self-neglecters and a group of self-neglecters some self-neglecters had higher SCA scores than many non-neglecters. A number of interesting methodological questions emerge from this finding which are frequently overlooked in the research literature. In essence, problems in attempting to describe individuals' behaviours from procedures designed to describe groups are brought into focus. Probabilistic generalization, in which findings are based on grouped statistics, informs us about populations but not about individuals within that population. Rubin and Babbie (1989) refer to this as the ecological fallacy. Barley (1988) puts this point succinctly when suggesting that probabilistic generalization always involves telling a little lie in the service of the greater truth. Probabilistic generalization is not a limitation of self-care or self-neglect theories *per se*, but a limitation in the use of theoretical and empirical work which attempts to describe the individual on the basis of the general.

*Self-care requisites*

Self-care requisites are viewed by Orem (1991) as those factors which are necessary prerequisites for health and well-being. These factors range from basics such as oxygen and food, to more complex factors such as social interaction (Orem 1991). Self-care requisites can be either universal, developmental or health deviation. Universal self-care requisites include the maintenance of a sufficient intake of air and the maintenance of a sufficient intake of water. Developmental self-care requisites show some overlap with universal self-care requisites but are directly related to developmental processes such as ageing. Health deviation self-care requisites include seeking medical attention and following a prescribed treatment regime.

Lauder (1999b) has described a number of cases of self-neglect in which some self-care requisites are met whilst others are not. In one of these cases a self-neglecter met universal requisites and not health-deviation requisites. In a second case the individual did not meet universal (household

and personal hygiene) but met health deviation requites (taking prescribed medication). In a third case some health deviation requisites were met (following wound dressing regimes) whilst other health deviation requisites (seeking health care advice) were not met by the same individual. It is not clear in Orem's theory why someone would fail to meet one type of self-care requisites (Health) and not another (Universal), nor is it clear why some types of health requisites are met whilst other health requisites are not met. Self-care theory may have to adopt a position similar to Maslow's (1970) Hierarchy of Needs in which some more basic and fundamental needs are given priority over other less fundamental. Even this suggested position is based on an set of assumption about the relative importance of a range of self-care requisites.

It can be suggested therefore that Orem's notions of self-care requisites have both strengths and limitations in furthering our understanding of self-neglect. Orem's concept of self-care requisites provides a useful heuristic to describe the various types of self-care which self-neglecters demonstrate. This concept might facilitate a more differentiated picture of self-neglect to emerge as it would allow neglect of hygiene to be differentiated from neglect of health care activities. This may be useful inasmuch as it allows behaviours which are better seen as public-environmental health problems to be distinguished from health care problems. The need to reconsider the public health element of severe self-neglect has been proposed by Halliday *et al*. (2000) and thus to this extent self-care has significant practical implications in our response to the self-neglecter.

## Self-neglect and lifestyle choice

Choice in this context refers to being responsible for the type of lifestyle one leads or wishes to lead and the extent to which people with self-neglect have responsibility, either through acts of commission or acts of omission, for their own self-neglecting lifestyle is an interesting issue. The question which arises now is 'to what extent do people who are categorized as self-neglecting choose to adopt a particular lifestyle?' The competing active and passive hypotheses of self-neglect encapsulate this problem. The active hypothesis proposes that self-neglect is the consequence of a deliberate and wilful decision to lead a particular lifestyle. The passive hypothesis, by contrast, proposes that self-neglect is not a consequence of some deliberated choice but the result of circumstances (that is disease) outwith the control of the individual.

The notion of responsibility can also be found in the self-care literature (Cavanagh 1991, Orem 1991, Gast 1996). Responsibility and self-care are linked by Sullivan and Munroe (1986) when they argue that self-care is a self-initiated, deliberate and purposeful activity linked to health and well-being. Cavanagh (1991) also links self-care explicitly to responsibility and lifestyle choice when claiming that, for whatever reason, individuals at any given time may choose not to engage in self-care even when they have the functional ability to do so. Therefore Orem's theory or any other theory purporting to deal with self-care and self-neglect, must necessarily give an account of the relationship between self-neglect, self-care responsibility and lifestyle choice. Similarly the literature on self-neglect does not provide a satisfactory explanation as to whether individuals intentionally choose to neglect themselves (Johnson & Adams 1996).

Orem (1991) proposes that self-care ability may be limited as a result of factors which are outwith the control of the individual. Thus Orem's theory suggests that an individual's behaviour is rational and open to choice except in circumstances in which the individual's ability to reason is constrained. Orem develops this idea when arguing that an individual's self-evaluation of care measures, not knowing what to do or how to do it, and the presence of disease may limit what that individual can do for themselves by way of self-care actions. In effect Orem's view would favour the passive hypothesis of self-neglect. Orem does not appear to accept individuals may make a conscious and rational choice not to engage in what others may perceive as necessary self-care. The assumption made by Orem and for that matter much of the self-neglect literature is that not to engage in self-care, certainly to the extent that is evident in severe self-neglect, cannot be a rational decision and must by definition be a consequence of underlying pathology. It can be suggested that it is an implicit assumption in Orem's theories that individuals who have an illness, especially a psychiatric or psychological illness, have a reduced or nonexistent capacity for intentionally engaging in self-care acts. In contrast to Orem's view, Cavanagh's (1991) claim that individuals at any given time may actively choose not to engage in self-care even when they have the functional ability to do so, accommodates both the passive and active hypotheses of self-neglect.

The problematic nature of the notion of responsibility for choosing to lead a self-neglecting lifestyle is further illustrated in patients who have moderate-severe dementia and have been diagnosed as being self-neglecting. Dementia sufferers may have little control over their actions and thus it is difficult to see how self-neglect can be described as intentional in such instances. It is questionable whether these individuals have the intellectual capacity to make an intentional choice to self-neglect. People with dementia may not

have that sense of agency necessary to engage actively in the deliberative process which underpins self-care actions. If one cannot choose to do a thing, one cannot choose not to do this thing? This brings into doubt the validity of classifying people with dementia as self-neglecting. In a number of other documented cases it is clear that severe self-neglecters state that their so-called self-neglecting lifestyle is one of choice (Reyes-Ortiz & Mulligan 1996). It is often assumed that such individuals have an underlying mental health problem or personality disorder which limits choice. A view which is held even when these self-neglecting individuals claim that that is the way they wish to lead their lives. This is a rather tautological argument which does little to clarify the nature and extent of choice in self-neglect.

This aspect of Orem's work can be argued to be underdeveloped and little reference to the existing literature on the philosophical issues underpinning these propositions is evident in her work. The philosophical notions of choice and responsibility are specific examples of ideas which are not well developed in Orem's work. Self-care theory, like the medical model, proposes that to care for one's self is a rational act, and that humans as rational beings are inherently predisposed to engage in self-care. People who do not engage in 'appropriate' self-care are by implication not rational (they must be ill and diseased). The disease hypothesis is yet another example of a tautological argument which does not account for different ideas values on what is 'appropriate' and also fails to recognize that some people may make a rational decision, in terms of their own values and beliefs, not to engage in some aspect of self-care. That is not to suggest that all severe self-neglect behaviours are rational, even when judged in the context of the meanings and values of the self-neglecting individual.

## Self-care, self-neglect and the family

Riehl-Sisca (1989) claims that although Orem indicates that nurses can care for families, the basic unit of care for Orem remains the individual. Riehl-Sisca asserts that this may create problems for community nurses who must care for family systems, and by implication care for the self-neglecter and their family. Gast (1996) describes Orem's position as one which stems from the ideology of individualism. Gast suggests that Orem's theory is culturally bound within cultures orientated towards the individual rather than the family and to this extent it should be regarded as culturally biased.

Families have been shown to be supportive towards people who have been categorized as self-neglecting and in other instances implicated in the development of self-neglect. In one case of self-neglect it was agreed by relatives and care workers that the self-neglecter could not have lived in her own home if it were not for the support of her family (Lauder 1999b). A finding which is consistent with Orem's (1991) notion of dependent-care giving. The dependent care-giving notion proposes that others can offer care in order to compensate for an individual's self-care deficits.

In another case of self-neglect a woman did not seem to put her own care as a high priority relative to that of her family (Lauder 1999b). She neglected herself in order that she could care for members of her family. The paradox is that her capacity to care for others, in what were very trying circumstances, appeared very high. The relationship between self-care ability and the care-giving burden is described by Schott-Baer (1989). Schott-Baer argues that family traditions may have a negative impact on female family members and, by implication, females may have a particular role in relation to care-giving which may, in certain circumstances, have a detrimental influence on them. The conflict between family duties and personal need occurs when family members must, on occasion, make choices between the value they put on meeting the care demands of other family members and the value they place on their own self-care (Schott-Baer 1989, 1993). Orem (1991) also proposed that self-care may be adversely affected by caring for another. Orem (1995) outlines a number of factors which limit an individual's capacity to engage in self care and includes 'family members' or others' deliberate interferences with the performance of the courses of action necessary for individuals to know and meet their therapeutic self-care demands' (p. 239); and 'patterns of personal or family living that restrict engagement in self-care operations' (p. 239).

Orem's claim that families can be both supportive or a barrier to efficient and effective self-care provides a useful insight into self-neglect and is consistent with previous case study findings. Whilst it has been claimed that Orem's orientation towards self-care is an individualist one, her work does inform and illuminate the complex relationship between self-care, self-neglect and the family. To this extent self-care theory contributes to understanding the relationship between families by placing self-neglect in the context of family dynamics. This important and relevant insight is largely missing from the self-neglect literature and to this end self-care theory makes a useful contribution to self-neglect theory.

## Objectivity

Another limitation of self-care theory in relation to self-neglect is the lack of objective, observable and universal standards for many self-care requisites and self-care demands

(Gast 1996). Gast believes that these apparently objective phenomena are in fact normative judgements of what is thought to be an adequate level of self-care in a given set of circumstances, a problem that lies at the very root of the notion of self-neglect. What objective, observable hygiene and other self-care behaviours or absence of these behaviours can be stated to be acceptable or unacceptable but non-pathological, or indeed unacceptable and indicative of a diseased state? There are few, if any, universal cut-off points on which to base judgements about standards of hygiene and squalor. Notions of cleanliness, hygiene and self-care probably vary from culture to culture and from subculture to subculture. Such a criticism represents an important philosophical and theoretical challenge to self-care theory as a framework for understanding self-neglect. Self-neglect and self-care should not be thought of as objective *a priori* states but are in fact value judgements of behaviours that do not conform to social norms in a given culture, and in a particular historical period.

Orem (1995), in common with the proponents of the medical model which underpins much of the recent work on self-neglect (Johnson & Adams 1996), operates from a realist philosophy. Realist philosophy, although accepting that individuals have a subjective view, proposes that there is an *a priori* reality. In this *a priori* reality objective standards and criteria exist against which behaviours and beliefs can be judged. A realist position is evident in Orem's (1995) limiting factors for engaging in self-care which include: (1) refusal to make a decision when a desirable and suitable course of action has been identified and (2) predispositions which result in perceptions and appraisals of situations that are not in accord with reality. If one assumes that there is an objective and value-free reality then certain behaviours are symptoms of a diseased state. If one takes the opposing view this process represents value judgements dressed up and legitimized by nursing-medical language and diagnostic systems.

Laurin (1996) argues that the ontological basis of Orem's theory is rooted in the Aristotelian-Christian positivist tradition. Positivist ontology is the dominant tradition in Western nursing and medical thinking. Ashworth (1997) identifies the belief in an unequivocal reality which is comprised of a set of relationships between specific variables and scientific theories, all of which are amenable to empirical testing, as the essence of positivism. Laurin (1996) suggests that this tradition proposes that phenomena have an existence independent of the observer. This proposition is central to Orem's theory of self-care.

If positivism, or its newer probabilistic version, postpositivism, is to be the basis for our understanding of self-neglect it follows that when self-neglecters believe that their lifestyle is deliberately chosen and is to their liking, they can still be diagnosed as suffering from a medical syndrome. A position which is justified on the basis that the individual displays a number of behaviours which match a predefined list of behaviours characteristic of a category of disease. These categories have been prescribed by professional groups, most notably the medical profession. Thus self-neglect in this view exists *a priori* and can be known and objectively measured.

In contrast the idealist philosophy which underpins constructionist theories of self-neglect (Lauder 1999b) asserts that there are multiple truths and these are socially constructed (Penticuff 1996, Sandelowski 1996).

Ford-Gilboe *et al.* (1995) state that

> Stemming from the ontologic position of relativism, reality in the interpretative (constructionist) paradigm exists as multiple, sometimes conflicting, mental constructions of everyday life experiences that are situational and context dependent. Thus, truth is both complex and alterable based on on-going experiences and their meanings to the person (p. 17).

Guba and Lincoln (1989) argue that the philosophical underpinnings of constructionism are radically different from those of positivism. The major differences are the rejection of an objective reality and acceptance of multiple realities which are 'social constructions of the mind'. It can be seen that the constructionist tradition raises fundamental questions regarding the use of Orem's theory of self-care to understand self-neglect.

Lupton (1994) outlines a number of criticisms which have been levelled at social constructionism the most important of which, he suggests, is its relativist epistemology. The issue at dispute is, if we are to accept the relativist position that all constructions are equally valid, how are the claims of each perspective to be judged as having access to truth about self-neglect? Lupton suggests that not only does this criticism not weaken the relativist standpoint, it actually highlights a strength. He argues that only by articulating the various constructions can we fully compare, contrast and evaluate them. Dingwall (1976) suggests that even if we accept that all constructions are equally valid it does not necessarily follow that all are equally useful. This view is consistent with the pragmatic school of philosophy of science (James 1972). The pragmatic view suggests that *a priori* claims to truth are less important than the consequence of any position. Therefore if a construction of self-neglect rooted in self-care theory can be shown to produce more effective treatment, however, this may be defined and measured, it has a higher value than other competing constructions. If on the other hand the claim is that self-neglect is simply a lifestyle choice which requires no

treatment and consequently results in no adverse effects on others and increases the personal happiness of the individual, this may be the most useful construction.

The constructionist theoretical perspective and its underpinning idealist philosophy are not consistent with self-care theory. A constructionist perspective of self-care and self-neglect would place emphasis on the dynamic way in which the meaning of self-care and self-neglect for all social actors is a product of the interplay between culture, context and the individual. The dynamic rather than the static emphasis of self-care theory has practical implications as it forces one to consider how professional judgements and negotiated meanings play a key role in the labelling of self-neglect.

### Culture, class and self-neglect

Orem (1991) attempts to accommodate culture and social reality in her theory but may not deal with these notions in any substantive manner. In fact it can be argued that Orem relegates culture and social reality, along with many other concepts, to a secondary role as Basic Conditioning Factors. In effect they exert an effect through their influence on another construct, namely self-care agency.

Self-neglect may have very different meanings in different subcultures with their own norms and values. Sub-cultural differences may also include issues related to class and culture, for example would so called 'new age' travellers have the same values on standards of hygiene and cleanliness than middle-class suburbanites? In English folklore the eccentric occupies a well recognized and affectionate place. Such individuals often display some of the behaviours associated with severe self-neglect but do not find themselves drawn into the world of medical psychopathology. This raises interesting questions around the boundaries between social acceptance–social disapproval of self-care and self-neglect states and their relationship with medical disorder.

Much of the self-neglect literature describes cases of severe self-neglect who live in relatively westernized industrial countries. It would be interesting to discover whether such diagnoses are actually made in nonindustrial third world countries. Orem (1991), whilst accepting that culture and social class may influence self-care, and by implication self-neglect, does not fully accept the constructionist position that judgements of self-care and self-neglect are products of social class, culture, professional socialization and a whole range of other factors. In this context it can be suggested that a constructionist view of self-neglect is in opposition to Orem's self-care theory.

## Conclusion

Self-care theory has a useful role to play in furthering our understanding of self-neglect. It has been suggested that self-care theory, specifically Orem's theory, offers insights into behaviours which have often been relegated to symptoms of an underlying medical disorder. In addition, self-care seems a less pejorative label than self-neglect and any small event which creates a climate for a nonjudgemental approach to this phenomenon is welcome.

Self-care agency has been proposed as a useful concept in explaining how various personal and pathological factors are implicated in development of self-neglect. This finding, from a small scale study, needs to be replicated in larger studies. Nevertheless this finding highlights the ecological fallacy inherent in quantitative designs; the problem involves translating group based statistical findings to understanding the individual. The concept of self-care requisites appears to provide a useful heuristic device which enables a more differentiated picture of self-neglect to emerge. In this differentiated picture, neglect of hygiene can be distinguished from neglect of personal health-care actions. Self-care requisites may provide a useful heuristic device which has that practical implication of allowing health care problems to be responded to in an different way from problems which are essentially public health issues. Nevertheless self-care theory needs to be developed to accommodate the anomalies thrown up in the hierarchy of requisites anomaly.

Orem, whilst acknowledging the fact the culture and class can influence professional judgements, does not fully support the constructionist view that these judgements are the very products of culture and class-based structures. Self-neglect is not only influenced by both factors but may in fact not exist outwith certain cultures with their particular values on self-care, hygiene and cleanliness.

The competing philosophies of realism and idealism present problems for the self-care and self-neglect theorist and researcher. These two views are, certainly at the philosophical level, mutually contradictory although there may a tendency to overlook this problems and reconcile them at the methodological level by use of the device of triangulation. The whole question of the ability of a single theory to capture the complexities and occasional contradictions of human behaviour needs to be addressed in the context of self-neglect. Is it possible to explain a complex human phenomenon by reference to a single theory, no matter how sophisticated this theory? Self-care theory is able to explain some aspects of self-neglect but not others, although this may be a reflection of the relatively underdeveloped state of self-care theories or

alternatively may reflect a more fundamental limitation in our ability to fully explain human behaviour.

## References


Ashworth P.D. (1997) The variety of qualitative research. Part two: non-positivist approaches. *Nurse Education Today* **17**, 219–224.

Barley N. (1988) *Not a Hazardous Sport*. Henry Bolt, New York.

Cavanagh S.J. (1991) *Orem's Model in Action*. MacMillan, Basingstoke.

Clark A.N.G., Manikar G.D. & Gray I. (1975) Diogenes syndrome: a clinical study of gross neglect in old age. *Lancet* **February**, 366–368.

Dingwall R. (1976) *Aspects of Illness*. Martin Robertson, London.

Fabian D.R. & Rathbone-McCuan E. (1992) Elder self-neglect: a blurred concept. In *Self-Neglecting Elders: a Clinical Dilemma*. (Rathbone-McCuan E. & Fabian D.R. eds), Auburn House, New York, pp. 3–12.

Ford-Gilboe M., Campbell J. & Berman H. (1995) Stories and numbers: coexistence without compromise. *Advances in Nursing Science* **18**, 14–26.

Foster P.C. & Bennett A.M. (1991) Dorothea Orem. In *Theory and Nursing: a Systematic Approach*. (Chinn P.L. & Kramer M.K. eds), Mosby, St Louis, USA, pp. 99–123.

Gannon M. & O'Boyle J. (1992) Diogenes Syndrome. *Irish Medical Journal* **85**, 124.

Gast H.L. (1996) Orem's self-care model. In *Conceptual Models of Nursing: Analysis and Application* 3rd edn (Fitzpatrick J.J. & Whall A.L. eds), Appleton & Lange, Stamford, pp. 111–152.

Gast H.L., Deynes M.J., Campbell J.C., Hartweg D.L., Schott-Baer D. & Isenberg M. (1989) Self-care agency: conceptualisations and operationalizations. *Advances in Nursing Science* **12**, 26–38.

Guba E.G. & Lincoln Y.S. (1989) *Fourth Generation Evaluation*. Sage, London.

Halliday G., Banerjee S., Philpot M. & Macdonald A. (2000) Community study of people who live in squalor. *Lancet* **355**, 882–886.

Hudson M.F. (1989) Analyses of the concepts of elder mistreatment: abuse and neglect. *Journal of Elder Abuse and Neglect* **1**, 5–25.

James W. (1972) *The Meaning of Truth*. University of Michigan Press, Ann Arbor.

Johnson J. & Adams J. (1996) Self-neglect in later Life. *Health and Social Care in the Community* **4**, 226–233.

Lauder W. (1999a) A survey of self-neglect in patients living in the community. *Journal of Clinical Nursing* **8**, 95–102.

Lauder W. (1999b) Constructions of self-neglect: a multiple case study design. *Nursing Inquiry* **6**, 48–57.

Laurin J. (1996) Commentary. In *Developing a Philosophy of Nursing* (Kikuchi J.F. & Simmons H. eds), Sage, London, pp. 25–32.

Lupton D. (1994) *Medicine as Culture: Illness, Disease and the Body in Western Societies*. Sage, London.

MacMillan D. & Shaw P. (1966) Senile breakdown in standards of personal environmental cleanliness. *British Medical Journal* **2**, 1032–1037.

Maslow A.H. (1970) *Motivation and Personality* 2nd edn. Harper & Row, New York.

Moore R. (1989) Diogenes syndrome. *Nursing Times* **85**, 46–48.

O'Rawe A.M. (1982) Self-neglect – a challenge for nursing. *Nursing Times* **November 17**, 1932–1936.

Orem D.E. (1991) *Nursing: Concepts of Practice* 4th edn. Mosby, St Louis.

Orem D.E. (1995) *Nursing: Concepts of Practice* 5th edn. Mosby, St Louis.

Penticuff J.H. (1996) Tradition, rationality and truth telling in nursing inquiry. In *Truth in Nursing Inquiry* (Kikuchi J.F., Simmons H. & Romyn D. eds), Sage, London, pp. 77–87.

Rathbone-McCuan E. & Bricker-Jenkins M. (1992) A general framework for elder self-neglect. In *Self-Neglecting Elders: A Clinical Dilemma* (Rathbone-Mccuan E. & Fabian D.R. eds), Auburn House, New York, pp. 13–26.

Reyes-Ortiz C.A. & Mulligan T. (1996) A case of Diogenes syndrome. *Journal of the American Geriarics Society* **44**, 1486.

Riehl-Sisca J. (1989) Orem's general theory of nursing: an interpretation. In *Conceptual Models for Nursing Practice* 3rd edn (Riehl-Sisca J. ed.), Appleton & Lange, Norwalk, 359–368.

Rubin A. & Babbie E. (1989) *Research Methods for Social Workers*, Wadsworth, Belmont, CA.

Sandelowski M. (1996) One is the liveliest number: the case orientation of qualitative research. *Research in Nursing & Health* **19**, 525–529.

Schott-Baer D. (1989) *Family culture, family resources, dependent care, caregiver burden and self-care agency of spouses of cancer patients*. Phd Thesis, Wayne State University.

Schott-Baer D. (1993) Dependent care, caregiver burden, and self-care agency of spouse caregivers. *Cancer Nursing* **16**, 230–236.

Shah A.K. (1992) Senile squalor syndrome: a small series. *Care of The Elderly* **July**, 299–300.

Sullivan T.J. & Munroe D.J. (1986) A self-care practice theory of nursing the elderly. *Educational Gerontology* **12**, 13–26.

Ungvari G.S. & Hantz P.M. (1991) Social breakdown in the elderly, 1. *Case Studies and Management* **32**, 440–444.