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Case Report

Decoding self-neglect in an elderly woman with chronic foot ulcer using COM-B model

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ABSTRACT

Self-neglect among the elderly is an increasingly recognised yet under-addressed issue in global health. Defined as the inability to meet one's basic needs for health and well-being, self-neglect is often driven by psychological, social, and cultural factors. This study presents the case of Mrs. P, a 60-year-old woman from rural South India, with a nine-year history of a progressively worsening large ulcer over the lateral malleolus of her right leg. Despite multiple opportunities for medical intervention, she repeatedly refused surgery, influenced by deep-rooted magico-religious beliefs, caregiving responsibilities for her daughters with schizophrenia, and fear of disrupting familial duties. This case highlights the complex interaction of these factors in an elderly woman with a chronic, non-healing ulcer. The COM-B (Capability, opportunity, motivation-behaviour) model was used to analyse the barriers behind her prolonged self-neglect and refusal of surgical care. This case shows how reduced psychological capability (lack of knowledge), limited physical and social opportunities (absence of alternative caregiving support), and poor motivation (belief in supernatural causes rather than medical solutions) collectively sustained her self-neglect. Chronic self-neglect in elderly patients is often maintained by complex biopsychosocial factors. The COM-B model provides a useful framework for systematically identifying and addressing these barriers. Interventions should go beyond medical advice, incorporating family involvement, cultural understanding, and psychological support to empower elderly individuals towards health-promoting behaviours.

Keywords: Health promotion, COM-B model, Self neglect, Case report, India

INTRODUCTION

World health organization (WHO) estimates that the elderly aged 60 years and above have gained prominence in the contemporary world. The world will cross 2 billion older adults by 2020.[1,2] However, that brings an array of age-associated problems, one of which is self-neglect, which is frequently ignored or included in the latter. Self-neglect, defined as "the inability to provide self-care in a socially and culturally acceptable way at the personal level that has dire consequences towards their health and well-being as well as to the community at large," has become a severe and unnoticed problem.[3] Self-neglect indicates a higher ratio of incidence among the elderly.[4,5]

Self-neglecting older adults tend to withdraw from social support, medical care, or even financial assistance, even when needed.[6] The wide-ranging field of neglect affects the overall health of many, most of whom are affected by underlying medical or psychiatric issues. Addressing self-neglect associated with an individual is of far greater importance than external issues surrounding a person, as it has greater consequences.[7]

There are several theoretical models formulated to explain health-related behaviors.[8] These include the health beliefs model, which postulates that the patient's behaviour relies on the benefits and barriers as perceived by the individual. Subjects who anticipate negative health outcomes perceive higher risks as they are more likely to participate in health promotion activities.[9] Other intrapersonal theory which is widely used to understand behaviour is The theory of planned behaviour (TPB) which builds on the health beliefs model by incorporating subjective norms that is the impact of one's family, friends, and healthcare providers on the individual's behaviour.[10-12] However, most of the theories at the individual level do not incorporate the complex social and physical environment in which the behaviour occurs.[13] Moreover, these theories completely ignore the role of habits, self-control and emotional processing as factors affecting behaviour change.[14] Self-neglect among the elderly is a complex interplay and thus requires a behavioural model which can incorporate both internal factors and external factors. Those who are self-neglecting may be bound by internal factors such as self-insufficiency that do not permit seeking help even when it is necessary. Even if the internal factors are overcome by the individual, he/she may face external barriers in social support, finances, or physical difficulties, which can disregard self-care.

In this article, in order to understand self-neglect among elderly patients, the COM-B model is utilised. The COM-B model has three components for behaviour change (B): capability (C), opportunity (O), and motivation (M). Capability here refers to the person's psychological capability(knowledge) and physical ability (skills/ stamina) to engage in behaviour. Whereas opportunity refers to the external factors which make the execution of a particular behaviour possible. It included two components: physical opportunity, which are opportunities provided by the environment, and social opportunity, which are opportunities due to social and cultural norms. Motivation refers to the internal processes which influence our decision-making and behaviours. It is of two types: reflective motivation, such as plans, beliefs or goals and automatic motivation, which involves emotions and habits that may not enter conscious awareness. The COM-B components interact through positive and negative feedback loops, creating dynamic systems of behaviour.[15,16] This framework allows for identifying barriers to behaviour change, and once the barrier is identified behaviour change wheel (BCW) is utilised to plan intervention.[17] Thus, it can help design specific interventions aimed at increasing capability, opportunities and motivation among the self-neglecting elderly.

CASE REPORT

Mrs "P" is a 60-year-old female resident from a village in South India. She recollects nothing special about her childhood other than that she was healthy, lively, and academically good. She got married at a young age. Her husband is a degree holder in service with a private company. She reported troubles posed by the husband and in-laws, troubled through abusive language, and social isolation. She had two sons and twin daughters. The sons are married, working, and live in different towns in India. However, both of her daughters are schizophrenic and are not able to maintain themselves. At some stage later on, gradually she began attributing the problems of the family to black magic and some demons, especially after the health of the daughters became unfavourable. She refused proper medication, believing that any such interference would worsen the conditions because, according to her, it was being influenced by supernatural beings.

In November 2015, she developed a small ulcer on the right foot, which kept progressing, for which she reluctantly visited a surgeon and was recommended a minor operation involving skin grafting and rest for 1-2 weeks. The surgery offered to her was refused because of her fear that she might not be able to leave her daughters unattended. She fears surgery and believes that alternative remedies will heal her ulcer. For over nine years, the ulcer has greatly expanded and impacted her ability to move around, but still, she rejects medical help. An examination in October 2024 reveals a large ulcer, circular in shape, located above the lateral malleolus of the right leg; measuring 10×10 cm, the edges are thickened and fibrosed with sloughing on the floor. The skin around the ulcer shows hyperpigmentation and thickening. Unilateral non-pitting pedal oedema up to the right knee joint is present, suggestive of possible venous insufficiency. All peripheral pulses are palpable (Figure 1 (A and B). There is no history of diabetes mellitus or hypertension, or any other chronic conditions. She does not smoke or drink alcohol, and there is no history of drug abuse.

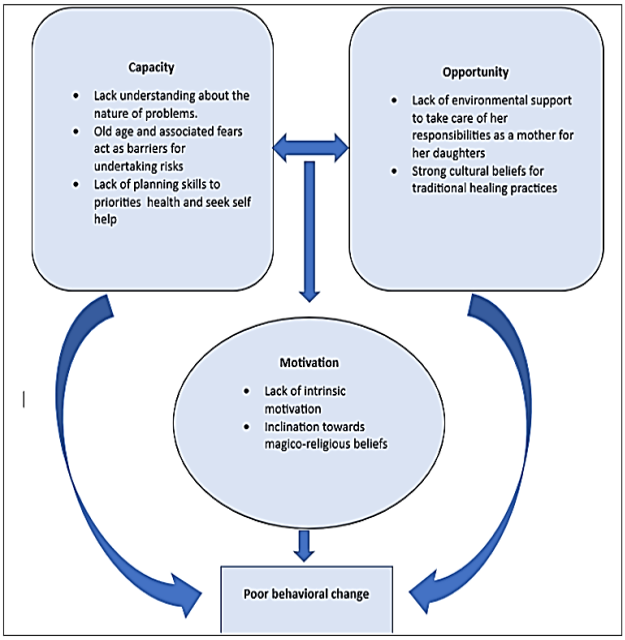

Figure 1: Behavioural change using COM-B model.

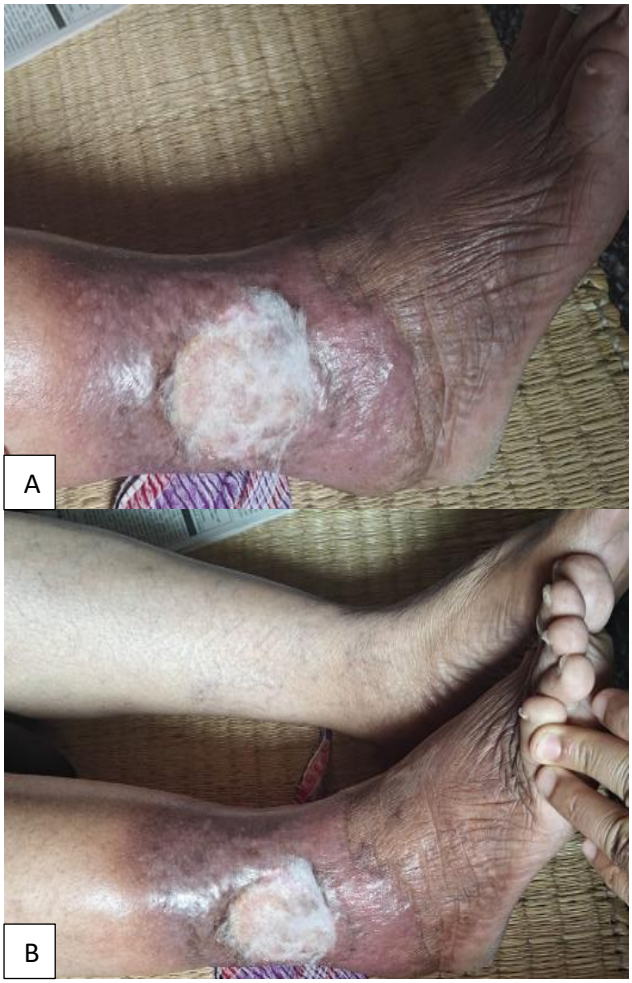

Figure 2 (A and B): Foot ulcer and skin changes in the elderly woman.

DISCUSSION

The failure by Mrs P to pursue surgical intervention for her ulcer can be explained in the context of the COM-B Model, whose components are capability, opportunity, and motivation for the behaviour (Figure 1). Her psychological capability to opt for the surgery is fairly low since she considers it unnecessary; moreover, she does not understand the risk associated with the persistent ulcer. The patient also lacks the understanding of the nature of the problem and the skills to plan and prioritise her health, indicating lower psychological capability. To increase psychological capability of patient, interventions should compassionately correct her misconceptions by providing clear, relatable evidence about the benefits of surgery and the risks of delaying treatment.[18] Connecting her with individuals who have undergone similar procedures could help alleviate her fears.

The capability of the patient to go for surgery is negatively reinforced by the external opportunities presented to her. The strong religious beliefs in alternative medicine and home remedies limit her social opportunities. Additionally, she sees surgery as a potential disruption to her caregiving duties. The lack of environmental support to take care of her responsibilities as a mother for her daughters seems to reduce her physical opportunities. However, she has reported ample support from family members and encouragement from family, highlighting positive social opportunities. Encouraging open, supportive discussions within her family can further reinforce the safety and necessity of surgery while respecting her cultural values. Her biggest concern is the well-being of her twin daughters, who rely on her for care. The fear of leaving them unattended during her recovery adds to her hesitation. To ease this worry, a solid caregiving plan should be in place to assure her that her children's needs will be met in her absence. Gradually introducing her to the healthcare system, starting with non-invasive consultations or minor procedures, can also help build her trust and confidence in medical care.

Further, if we look at the third component of the model, it can be seen that there is a lack of intrinsic motivation due to the inclination of the patient towards magico-religious beliefs. The low capability and limited opportunities have also negatively impacted the motivation of the patient for surgical intervention. While her family supports surgical intervention, her scepticism toward conventional medicine and preference for alternative explanations, such as attributing her condition to supernatural causes, create a significant barrier. To address this lack of reflective motivation, healthcare providers could involve trusted community figures, such as spiritual advisors or cultural advocates, who can help bridge the gap between her beliefs and modern medical practices.[19,20]

A thoughtful and empathetic approach that blends education, cultural sensitivity, and practical support is crucial in helping Mrs. P overcome these barriers. By addressing her fears, involving her support system, and providing her with the resources she needs, healthcare providers can guide her toward making proactive health decisions. COM-B framework ensures these efforts are structured, compassionate, and aligned with her values, allowing her to prioritise her well-being without feeling like she is neglecting her responsibilities.

CONCLUSION

This case study highlights a pattern of self-neglect shaped by deeply ingrained beliefs, caregiving duties, and emotional barriers. Through the lens of the COM-B model, it becomes clear that changing a patient's mindset requires addressing misconceptions about surgery, challenging societal norms that reinforce neglect, and empowering her to take charge of her health. By fostering a sense of self-worth and demonstrating the long-term benefits of prioritising her well-being, healthcare providers can help Mrs. P move past self-neglect and make informed, proactive choices for her health.

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