CLINICAL VIGNETTE

Believe it or Not? Elder Abuse Allegations from a Patient with Dementia

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An 82-year-old woman with reported history of dementia was brought to the hospital on a 5150 hold for grave disability after she fled from her son while at a bank and asked for help at a nearby grocery store. Per patient, she had moved to California from Michigan a year ago to help take care of her son and his "medical condition." However, her son has been coercing her into giving him money from her pension. She reported that her son and his girlfriend have also used physical aggression against her to obtain the pension checks. She was reportedly paying $400/month towards room and board but was forced to sleep in the living room instead of a bedroom. Her son and his girlfriend allegedly belittled the patient by reminding her that she had dementia and believed that she could not comprehend the situation.

The patient denied taking any home medications, but had been prescribed amlodipine 5 mg daily, cyanocobalamin tablets, and donepezil 5 mg daily. She denied any history of substance abuse. She completed high school and previously worked as a receptionist before retiring. Her ex-husband was a record company executive and they had two sons.

On chart review, the patient had been previously admitted a month prior after being found wandering in the street by the police with similar claims of elder abuse by her son. The admitting medical team had spoken to her son who had answered their questions with reassurance that she had done this before and that her dementia was progressing. An adult protective services report was filed, and she was released back into his care. During this admission, Psychiatry ultimately lifted the 5150 hold after determining that she had paranoia secondary to her dementia.

On admission, she was afebrile, heart rate 58, blood pressure 146/63, and oxygen saturation was 100% on room air. She was well-groomed and in no acute distress. She had a thin body habitus with mild temporal wasting. Her hearing was intact without any hearing aids. She did not have any ecchymoses or scars on her body. Heart, lung, and abdominal exams were unremarkable. Cranial nerves II-XII were grossly intact with a normal cerebellar exam; no cogwheeling, rigidity, or tremors were noted. She was able to recite days of the week backwards albeit slowly. Her Montreal Cognitive Assessment score was 11/29; she was unable to read the numbers to complete the trails task but demonstrated other deficits in visuospatial and executive function, in addition to deficits in language (naming, verbal fluency), delayed recall, and orientation.

Labs were notable for a vitamin B12 level of 170 with MMA of 257 (upper range of normal); her TSH and free T4 were within normal limits and RPR was nonreactive. Urine drug screen was negative. Head CT showed mild generalized brain atrophy and mild chronic microvascular ischemic disease.

The patient did not permit the medical team to speak to her son over concern that he would locate her again and repeatedly requested to return to her family in Michigan. With her permission, the team spoke with her stepsister and niece in Michigan who revealed that the son's "medical condition" was drug and alcohol abuse. The patient had previously lived with her stepsister for about 5 years until her son flew to Michigan to bring the patient back to California with him. According to her stepsister, the patient's memory had already been declining at that point; she was requiring assistance with her transportation and medications, and the police had to bring her home on three different occasions because she had gotten lost when wandering. Following discussion between the medical team, the patient, and her family, she was discharged to a skilled nursing facility with plans for her family to fly from Michigan to California in a few weeks to bring her back. She was also provided a personal phone so that she could contact her stepsister and niece directly.

Discussion

Elder abuse is an umbrella term for different categories of abuse including psychological, physical, sexual, emotional, financial, confinement, and neglect. According to the National Council on Aging, about 1 in 10 Americans age 60 years or older have suffered from one of these forms of abuse,[1] but they may also experience multiple types of abuse simultaneously.[2] Psychological abuse is the most common form of abuse[3] and financial exploitation is the most commonly reported type of abuse.[4] However even physical abuse remains underrecognized among health providers. A 2017 multicenter study in the Chicago area found that half of older adults who presented to the hospital with evidence of physical abuse had documented histories of revictimization, but only 57% had their abuse reported to Adult Protective Services or the police.[5]

Individuals with dementia are particularly vulnerable to elder abuse due to a combination of victim and perpetrator factors.[2,6] They are highly dependent on their caregivers, and as a result they may fear retaliation or losing support if they report abuse. Caregivers may experience significant burden, stress, and conflict as the dementia progresses and behavioral issues develop such as agitation or aggression develop. Studies suggest caregivers will admit to abusive behaviors when asked in a supportive manner. A 2008 study of 129 dyads of patients with dementia and their caregivers in Southern California[7] utilized a 90-minute assessment including interviews, a series of validated instruments, and a home tour and found that 47% of care recipients had been mistreated, with 89% experiencing psychological abuse, 20% physical abuse, and 30% neglect. A recent study of 33 patients and their non-professional caregivers in Spain used the 8-question Caregiver Abuse Screen (CASE) and found that over half of the non-professional caregivers (e.g. spouses or children) endorsed some form of abuse.[6]

In our patient, we had high suspicion for psychological, financial and physical abuse. Unfortunately, her diagnosis of dementia may produce anchoring bias at the previous admission, resulting in the patient being discharged back home with her alleged perpetrator. Our case reinforces the importance of obtaining collateral information from multiple sources, with effort to contact persons other than the alleged perpetrator. While our patient was able to speak for herself and able to repeat a consistent story over time, patients with more advanced dementia may not recall details of the abuse. Therefore, any discrepancies in the history or exam should lead health professionals to screen for elder abuse.[8] A recent review identified 15 elder abuse assessment tools for the home environment, with the recommendation for further testing in different cultures and conditions such as dementia.[9] The Abuse Interventional Model provides a framework for identifying risk factors for elder mistreatment and developing a plan to prevent or mitigate elder mistreatment.[10] Through this case, we hope that health care providers maintain a low threshold to screen for elder abuse and advocate for patients at risk of abuse.

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