

# ASSESSMENT AND MANAGEMENT OF PSYCHOSIS IN PERSONS WITH DEMENTIA

## Overview:

Psychosis is a common clinical feature of dementia. Hallucinations and delusions are the two most common types of psychotic symptoms in all types of dementia. Hallucinations occur in up to 25% of patients while delusions are present in up to one-third of Alzheimer's patients. Auditory and visual hallucinations are most common; especially in persons with hearing or eyesight abnormalities. Delusions often include fragments of truth from the patient's circumstances. Common delusions include theft by caregiver, abandonment, infidelity of spouse, abuse and neglect. Delusions rarely reflect suspicions that occurred before dementia and these troublesome symptoms are the product of brain damage.

## Neurobiology:

Hallucinations and delusions can be produced by a wide range of medical problems, medications, and sensory problems. The healthcare team should exclude delirium, sensory impairment, and new medical problems as the precipitant for the psychotic symptoms.

Hallucinations and delusions are uncommon in patients with early-stage Alzheimer's disease but these manifestations are quite common in early-stage Lewy body dementia. Many demented patients in the mid- or later stages will describe psychotic symptoms. Late-stage demented patients may be unable to explain fear or anxiety produced by hallucinations or false beliefs. Patients with advance-stage dementia who demonstrate agitation, withdrawal, or irritability may be experiencing psychotic symptoms. Patients who refuse to eat or leave their room may suffer from paranoid delusions, e.g., fear of poisoning, harm by staff, etc. Behavioral manifestations of paranoia or delusions include resistiveness, demanding to eat from sealed containers, etc.

The abrupt onset of hallucinations and delusions, or the presence of these symptoms in early-stage dementia raises concern that some other disease is present, e.g., delirium, brain tumors, etc. Hallucinations and delusions generally appear slowly over a period of months with gradually increasing behavioral response by the patient.

Table \_\_

### Common Delusions

1. Theft
2. Abuse
3. Infidelity
4. Life Circumstances

The treatment of psychotic symptoms in dementia depends on the severity of distress produced by the symptom. Demented patients with pleasant hallucinations or delusions need reassurance but no medication. Treatment is required when the psychosis produces

distress, functional decline, and risk to patient or caregiver. *Example:* weight loss due to paranoia about food.

The treatment of psychotic symptoms requires the prescription of antipsychotic medications. Older antipsychotic drugs should be avoided because of high risks for drug related complications. The new antipsychotic medications are highly effective in reducing psychotic symptoms in dementia. Doses should be titrated from the lowest possible starting dose to avoid excessive sedation or other side effects. The treatment team understands common or dangerous side effects related to antipsychotic medication use.

The assessment of psychosis in Alzheimer's disease depends on the clinical symptomology. Psychotic symptoms associated with dementia generally evolve over a period of months with insidious onset and slow progressive nature. Abrupt onset of psychotic symptoms suggests some other disease process such as delirium or depression. The evaluation of psychosis includes a search for medical causes such as new medications, unrecognized infections, etc., as well as possible psychiatric causes that include depression.

Treatment for psychotic symptoms requires identification of target symptoms and selection of appropriate antipsychotic medications. Old antipsychotic medications should be avoided in the demented patient because these drugs produce significant side effects and risk for other complications such as falls or diminished oral intake. All of the new antipsychotic medications have demonstrated efficacy in suppressing psychotic symptoms for dementia; however, clozapine is a difficult medication to use and this medication should be reserved for specific therapeutic indications, e.g., psychosis associated with Parkinson's disease. Typical beginning doses for antipsychotic medications are one-quarter to one-half of initial doses (See Table \_\_\_\_). Most medications require about one week to reach steady state and dose adjustments should be preformed on a weekly basis based on clinical outcomes. A patient who fails to respond to an atypical antipsychotic after 4 to 6 weeks of an adequate dosing should be cross-titrated to a different antipsychotic medication with a similar titration schedule. Patients should be tried on each of the antipsychotic medications before a trial of an old typical medication is used.

The failure to respond to antipsychotic medication raises several issues including non-compliance with the medication, medication administration errors, or misdiagnosis. A Patient who fails to respond to the first medication can be switched to a drug with a dissolvable preparation such as Risperdal or Zyprexa to assure adequate compliance. Delusional, suspicious demented patients may cheek or spit medication with great skill.

Polypharmacy is generally contraindicated in psychotic patients. No studies document superior efficacy of two antipsychotics versus one medication. In fact, little research substantiates the value of treatment with more than one antipsychotic drug at a time.

Patients who develop significant extrapyramidal symptoms such as Parkinson's disease or akathisia should be switched to Seroquel, which has a very low EPS profile. Anticholinergic agents should be avoided as treatment for EPS-related to medication administration because these drugs produce significant confusion. Adjunctive therapy with benzodiazepines carries significant risks for sedation, disinhibition, or falls.

Psychotic symptoms associated with dementia tend to persist for prolonged periods of time; however, behavioral consequences of psychotic symptoms may improve with time. The decision to attempt dose reduction for psychosis associated with dementia depends on the severity of the psychotic symptoms, dangerous behaviors produced by the symptoms, and level of distress experienced by the patient. Persistence of psychotic symptoms despite therapy, suggests that dose reduction may cause exacerbations. Individuals with complete response to medication and total elimination of symptoms may tolerate less medication. Each patient requires individual assessment. In general, dose reductions should be considered 6 to 12 months following initiation of therapy for patient who are totally symptom-free. Patients who have persistent, but non-problematic psychotic symptoms can be considered for dose reduction at one year. Patients who have episodic breakthrough behaviors produced by psychotic symptoms should remain on the medications until a breakthrough behavior have not been present for at least a year. Dose reductions should occur at about 10% per month.

Both old and new antipsychotic medications produce side effects and the clinician should be familiar with standard symptoms including parkinsonism, tardive dyskinesia, and akathisia. Patients who develop new disabling medical problems may tolerate dose reduction because the patients are less able to physically respond to internal stimuli.

Behavioral management is the treatment of choice for mild symptoms and behavioral interventions are important for patients who require medication. Delusional patients often had beliefs systems that are clearly false; however, the staff or family should not argue with the patient or attempt to reason with the individual. Distraction, redirection, and structured activities are extremely helpful in reducing patient distress and confrontation. Bored, hungry, thirsty, or wet patients are more likely to become irritable with psychotic symptoms.

Family education is an important part of psychosis management in dementia. Family should understand that false beliefs are not a manifestation of premorbid suspicions or beliefs. For example, an accusation about family caregivers stealing or spousal infidelity does not reflect longstanding suspicion about the family's honesty or faithfulness.

Specific kinds of delusions are fairly common in Alzheimer's disease. The delusion of life circumstance is a false belief about the present living arrangement, family structure, or financial status. Patients who make statements such as "I need to go home to my babies" or the farmer who states "I need to go back to the farm to bring in the animals" are examples of delusions of life circumstance if the patient is unable to be diverted or dissuaded from the belief. These symptoms should not be managed with psychotropic medications unless behavioral interventions fail and the consequence of this belief

produces danger to staff or residents. Delusions of theft often occur when items are misplaced and confused patients blame the loss of such items on the caregivers. Infidelity is a common delusion that produces great distress in the caregiver subjected to the accusation.

Conclusion:

Psychosis is a common symptom in mid- to late-stage Alzheimer's and other dementias. The fundamentals of care include a thorough evaluation, identification of target symptoms, use of behavioral interventions and the judicious use of antipsychotic medications when indicated by the circumstances. Most patients with psychotic symptoms can be adequately managed through a combination of medical, behavioral, and psychiatric interventions until the immediacy of the symptoms passes.

