Although the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition has changed the name dementia and has included it under the diagnostic entity of neurocognitive disorders (NCD), it still has retained the term dementia for the purpose of continuity, and states that it can be used in settings where physicians and patients are accustomed to it.¹ The term NCD includes delirium, amnesia, and dementia. Although we discuss to some extent all major types of NCD in this issue of *Psychiatric Annals*, the primary focus is about the most common type—Alzheimer’s disease (AD). AD is mostly a diagnosis of exclusion, when all other subtypes of NCD have been ruled out.

Neuropsychiatric symptoms are nearly universal in patients with major NCD and cause significant distress in patients and caregivers. Most of the time when nonpharmacologic approaches fail, pharmacologic agents are required. There are currently no US Food and Drug Administration-approved agents for neuropsychiatric symptoms. The current mainstays of AD treatment—acetylcholinesterase inhibitors—have not shown significant benefits in delaying progression of mild cognitive impairment to dementia.²,³ Whenever antipsychotics are used, the lowest effective dose should be used, attempts should be made to taper the dose (eg, after 6 months), and discontinuation should be attempted if symptoms have abated.

A range of neuropsychiatric symptoms are commonly brought to clinical attention in patients with major neurocognitive disorder. These include symptoms such as delusions, hallucinations, agitation, aggression, depression, anxiety, apathy, disinhibition, wandering, and aberrant motor behavior. Patients commonly present to clinicians with these symptoms, and studies have reported a prevalence range from 60% to 90%, with the prevalence of symptoms increasing with the severity of dementia.⁴,⁵ Certain delusional themes have been commonly reported in patients with major NCD. These include delusions of other people living in their homes (phantom boarder syndrome), personal items being stolen, caregivers or family members being replaced by imposters (misidentification syndromes, such as Capgras delusion), delusions of being poisoned or not treated well, and spouse committing infidelity.⁶

The cognitive component of decision-making (being able to attend, absorb, retain, and reason with information provided) is often the area of capacity that is called into question in a geriatric population. Because decision-making is an interactive process, impair-
ments in those steps can lead to impairments in appreciative and evaluative understanding. Clarifying whether an elderly person’s cognitive functioning is being impaired by an affective or medical condition that may improve with treatment (ie, depression or delirium) versus a chronic and worsening condition (ie, dementia) will impact assessment of capacity for treatment. However, without baseline assessment of a patient’s functioning before hospitalization, it can be challenging to differentiate between these conditions.⁷

Neuropsychological assessment uses quantitative and qualitative evaluation methods to assess cognitive, behavioral, and emotional functioning in patients. Neuropsychological assessment has utility for assisting caregivers in psychiatry and other disciplines in differential diagnosis, defining functional capacity, assessing pre-treatment/posttreatment change, and providing recommendations for patient management. The assessment of decision-making capacity is supposed to be task-specific. Living alone requires multiple tasks throughout the day with unpredictable occurrences that cannot all be assessed by the clinician. Naik et al.⁸ argue that conceptualizing autonomy only in terms of decision-making is inadequate in such cases and that executive autonomy, which they define as the “ability to implement and adapt plans, especially when faced with both predictable and unexpected challenges,” must also be assessed and considered. Although concern for physical safety is often a focus of providers, fostering independence is also important and

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is strongly related to psychosocial well-being. 

Even though this issue highlights some of these topics, our main focus has been to address the challenges faced in using antipsychotics in this population, to diagnose properly the type of NCD by using psychological testing for diagnosis and management, and to help keep these patients independent and give them as much autonomy as possible.

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