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Agitation in Alzheimer’s Dementia: From Expert Consensus to Clinical Practice

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You’re listening to ReachMD. This medical industry feature, titled “Agitation in Alzheimer’s Dementia: From Expert Consensus to Clinical Practice,” is sponsored by Otsuka and Lundbeck. Here’s your Host, Dr. Turck.

Drs. Grossberg and Sanford are paid consultants of Otsuka Pharmaceutical Development & Commercialization, Inc.

Dr. Turck:
This is ReachMD, and I’m Dr. Charles Turck. Today, we’ll be discussing the expert panel recommendations on identifying and managing agitation in Alzheimer’s dementia that were published in *Postgraduate Medicine* in June 2025. We’ll also be exploring how clinicians can implement these recommendations in practice.

The expert panel and subsequent publication were sponsored by Otuska and Lundbeck -- not an independent entity.

Joining us today are two members of that expert panel: Drs. George Grossberg and Angela Sanford. Dr. Grossberg is the Inaugural Henry and Amelia Nasrallah Endowed Professor as well as the Director of the Division of Geriatric Psychiatry in the Department of Psychiatry and Behavioral Neuroscience at the Saint Louis University School of Medicine. Dr. Grossberg, welcome to the program.

Dr. Grossberg:
Thank you for having me.

Dr. Turck:
Also joining us from the Saint Louis University School of Medicine is Dr. Sanford, who’s a Professor in the Division of Geriatric Medicine in the Department of Internal Medicine. Dr. Sanford, thanks for joining us today.

Dr. Sanford:
It’s great to be here.

Dr. Turck:
Well, let’s dive right in. Agitation is a challenging symptom to manage in Alzheimer’s dementia. Dr. Grossberg, how would you define agitation in Alzheimer’s dementia, and why is it so important for clinicians to recognize it early on?

Dr. Grossberg:
You’re right—agitation in Alzheimer’s dementia is common. In fact, nearly half of patients living with dementia due to Alzheimer’s disease will experience agitation during the course of the illness.[1] Clinically, it can look like restlessness, wandering, asking repetitive questions, or resistance to care. And this also places a burden on caregivers, increases healthcare use, and often accelerates the need for institutional care.[1]

So that’s why the expert panel emphasized early recognition that allows for early intervention that may improve quality of life for both patients, as well as caregivers and families.[1]

How about you, Dr. Sanford? I’m interested in the primary care perspective.

Dr. Sanford:
Identifying and treating agitation was really a cornerstone of the panel’s work, and we agreed that agitation is underreported among

these patients in routine practice.[1]

And in primary care, families don't typically walk in saying, "My spouse is agitated." Instead, they say things like, "She's been cranky," or "He has a short fuse lately." So the panel wanted to provide clinicians with the right language and practical strategies to uncover those clues to identify agitation in a proactive way that fits into clinic visits.[1]

Dr. Turck:
So, Dr. Sanford, would you tell us about some of those practical strategies we can use to identify agitation early during routine visits?

Dr. Sanford:
Absolutely. One of the key recommendations from our expert panel was to include agitation screening by proactively asking about behavior and personality changes at every visit. Patients rarely identify agitation themselves, so we rely heavily on caregivers. Their observations are often the earliest and most reliable indicators of agitation.[1] So for example a spouse might say, "He's just more on edge lately," or, "She won't sit still." And it's crucial for us, as clinicians, to pick up on that kind of language.

Unfortunately, caregivers may not recognize the agitation or they may just assume it's part of the cognitive impairment, so caregiver education is also important.[1] And it's not enough to just ask, "Has anything changed?" Instead, we need to ask for specific questions.

Let me turn to you, Dr. Grossberg. How do you approach this during a busy clinic visit, where time is always tight?

Dr. Grossberg:
Simple, direct questions can make all the difference. So I'll ask caregivers things like, "Have you noticed your loved one being more irritable, cranky, or restless lately?" Those words resonate because they're often the words that families use to describe what they're seeing. That question normalizes asking about behavior the same way we ask about vitals or falls during each visit. And as caregivers start to expect the question, they'll bring up behavioral changes with you much earlier.[1]

I also recommend caregiver-friendly tools, like the Agitation in Alzheimer's Screener for Caregivers, or the AASC®, which are easy to use and can be helpful in identifying agitation symptoms.[1]

Dr. Turck:
Now, Dr. Sanford, when you suspect agitation in a patient with cognitive decline, how do you go about determining whether it's truly related to Alzheimer's dementia or another cause?

Dr. Sanford:
That's an important point, because agitation isn't always related to Alzheimer's disease progression. In primary care, I've seen patients whose behavior suddenly changed because of a urinary tract infection, a new medication, untreated pain, or even from environmental triggers.[1] So the first step is to pause and ask, "Could something reversible be driving this?" Otherwise, we risk treating the wrong thing.

Dr. Grossberg, how do you view the differential diagnosis for agitation?

Dr. Grossberg:
I completely agree. The goal is to encourage a systematic approach before attributing agitation to Alzheimer's dementia, and to ensure that other potential contributors are considered. Because, as you mentioned, there's a range of factors that can mimic or exacerbate agitation.[1]

So our aim was to offer practical, evidence-based recommendations that clinicians can realistically apply in the busy clinical setting, which is why we emphasized a stepwise, structured process to rule out other causes first.[1]

For example, the Gerontological Society of America decision tree is a useful guide here. It helps us check for medical conditions, medication side effects, psychiatric comorbidities, and environmental triggers before labeling agitation as part of dementia. Frameworks like this can help clinicians quickly make an assessment and avoid missing a treatable condition.[1]

Once other causes are ruled out and agitation is identified as Alzheimer's-related, structured guidelines can really help. Tools like the IPA checklist, and the Alzheimer's Association's DETeCD-ADRD frameworks offer clear, practical steps for assessing behavior and applying evidence-based, nonpharmacologic approaches so clinicians can respond consistently and effectively.[1]

Now, when it comes to managing agitation in Alzheimer's dementia, frameworks are key because they turn a subjective process into a systematic one. That's why we emphasize models like DICE—Describe, Investigate, Create, Evaluate—and the Investigate–Plan–Act approach. They help clinicians stay focused, even in a short visit. With DICE, for example, I'll ask the caregiver to describe the behavior, look for triggers like sleep or medications, and create a simple plan to test before the next visit.[1]

Dr. Sanford, you use these frameworks with patients and families, too—how do they help you in your practice?

Dr. Sanford:
They're invaluable because they reflect the biopsychosocial-environmental model—we look beyond biology to include environment, routines, and relationships. So, if a caregiver says, "My wife refuses to bathe," DICE prompts questions like: is the water too cold? Is she embarrassed? - which lead to tailored solutions. And because we reassess what works overtime, care remains flexible as the disease progresses.[1]

Dr. Turck:
For those just tuning in, you're listening to ReachMD.

I'm Dr. Turck, and today I'm speaking with Dr. George Grossberg and Dr. Angela Sanford, authors of an expert panel report sponsored by Otsuka and Lundbeck, that provides guidance on recognizing and managing agitation associated with Alzheimer's dementia.

Let's talk more about management for agitation in Alzheimer's dementia. Dr. Grossberg, what are some strategies that should form the foundation of every care plan?

Dr. Grossberg:
Well, nonpharmacological interventions should always be the starting point. They're individualized and evidence-based, and they carry less risk than medications.[1] This might include music therapy, aromatherapy, Montessori-based activities, exercise, or simply keeping a predictable daily routine. For some patients, something as straightforward as a structured morning walk can dramatically reduce agitation later in the day.[1]

So, if we understand what's triggering the behavior, we can modify the environment or routine in a way that reduces distress without adding medication.

Now, Dr. Sanford, how do you approach these interventions with families in primary care to make sure they're realistic for their day-to-day lives?

Dr. Sanford:
It's really about finding a balanced approach that meets the patient's needs and feels sustainable for the caregiver. I ask what the patient enjoys, what calms them, and what tends to trigger frustration, and then what the caregiver feels they can realistically manage. The best care plans are the ones that fit naturally into daily life.

Dr. Turck:
And when agitation escalates and nonpharmacologic approaches aren't enough, Dr. Sanford, how should clinicians think about pharmacologic treatment?

Dr. Sanford:
Nonpharmacologic strategies can be very effective, but delayed identification and management of agitation in Alzheimer's can lead to poorer outcomes for both patients and caregivers, so it's important to intervene early before it escalates.[1]

Now, when nonpharmacologic approaches don't work, I try to add pharmacologic treatment. The key here is to approach it carefully, weighing the risks and benefits for that individual patient. I still frame it as building on a nonpharmacologic foundation, not replacing it.[1]

Dr. Turck:
So Dr. Grossberg, what guidance did the expert panel provide on this?

Dr. Grossberg:
Well, we emphasized that medications are reserved for severe cases where agitation is persistent or posing a risk to safety.[1] Historically, clinicians have sometimes tried drug classes such as antidepressants, anticonvulsants, or antipsychotics, but these are mostly off-label, come with safety concerns and limited to no efficacy. So, the consensus was to use those options with great caution, if at all, and to always lead with a clear risk–benefit discussion.[1]

But brexpiprazole is currently the only FDA-approved treatment in the United States for agitation associated with dementia due to Alzheimer's disease.[1] In clinical trials, patients treated with brexpiprazole showed statistically significant reductions in frequency of agitation symptoms with improved Cohen-Mansfield Agitation Inventory, or CMAI, total scores from baseline at Week 12 compared to placebo.[1]

Brexpiprazole showed a favorable safety profile. It was generally well tolerated, with the most common side effects being things like headache, mild sleep change, or dizziness—similar to placebo in most cases. It showed minimal risk of cognitive impairment, sedation, or movement problems.[1]

So, overall, when built on a foundation of nonpharmacologic care, brexpiprazole offers clinicians an evidence-based option for managing agitation in Alzheimer's dementia.[1]

Dr. Turck:
And as we approach the end of our program, I'd like to hear more about that partnership with caregivers. Dr. Grossberg, what are the best practices for engaging them in the process?

Dr. Grossberg:
Caregivers are essential partners in care—they're the first to notice changes and manage day-to-day strategies.[1] That's why we recommend clinicians involve them in the care plan and check in on their well-being. In my practice, I routinely ask about how they're coping, their sleep, their stress levels, because caregiver burnout directly affects patient outcomes. Supporting caregivers is just as important as supporting the patient.

What about you, Dr. Sanford? How do you bring caregivers into the process?

Dr. Sanford:
I start by validating them. Caregivers often feel guilty or frustrated when agitation occurs, and I remind them it's part of the disease, not their fault, and not their loved one's fault. I also give them a concrete role—tracking when behaviors happen, what triggers them, and what helps—so that they can report back after trying nonpharmacological strategies. When caregivers feel supported and engaged, the entire care plan works better.

I also like to share practical resources with families and caregivers such as the AASC® that we mentioned before and the Behaviours in Dementia Toolkit, which offers evidence-based tips for managing challenging behaviors. I also point them to the Caregiver Action Network for online resources, support, and for education.[1]

Dr. Turck:
Thank you both. This has been a really insightful discussion on how to move expert panel recommendations into real-world practice.

I want to thank my guests, Dr. George Grossberg and Dr. Angela Sanford, for their insights on implementing these expert panel recommendations on diagnosing and managing agitation in Alzheimer's dementia into routine clinical practice.

Dr. Grossberg, Dr. Sanford, it was great speaking with you both today.

Dr. Grossberg:
Thank you for having us.

Dr. Sanford:
Thank you for this important discussion.

ReachMD Announcer:
This medical industry feature was sponsored by Otsuka and Lundbeck. If you missed any part of this discussion, visit Industry Features on ReachMD.com, where you can Be Part of the Knowledge.

References:

1. Grossberg GT, Sanford A, Montano CB, et al. A US-based practitioner's guide to diagnosis, evaluation, and evidence-based treatment of agitation in Alzheimer's dementia - recommendations of an expert, multispecialty advisory panel. *Postgrad Med*. 2025;137(6):469–485.

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