Dealing with behaviors brought on by **hallucinations & delusions**

John Dean, Josefa Domingos & Nancy Hillmer

Parkinson's Specialists

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Our goal for today

Ensuring that **care partners** & people with PD know how to:

self assess **better report** **manage**

Illusions, hallucinations & delusions in Parkinson's

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I was diagnosed with mild PD this past May, and I am 73 years old. Any idea if the hallucinations and delusions are behaviors that I should look forward to?

- Participant question

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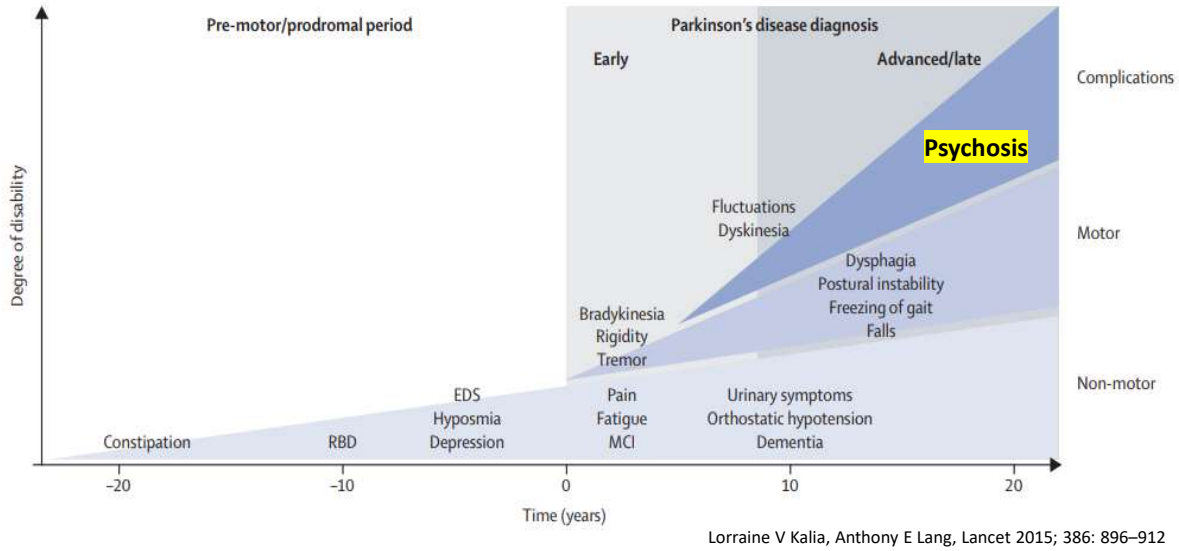
Psychosis in PD: illusions, hallucinations & delusions



Lorraine V Kalia, Anthony E Lang, Lancet 2015; 386: 896–912

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VS

PART OF THE DISEASE MEDICATION RELATED

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Insight/Cognition

MINOR ILLUSIONS

Misperceptions of real stimuli that are often visual in nature.

From Ominic H. ffytche et al., Nat Rev Neurol 2017 l. 2017 February ; 13(2): 81–95.

MDS- UPDRS

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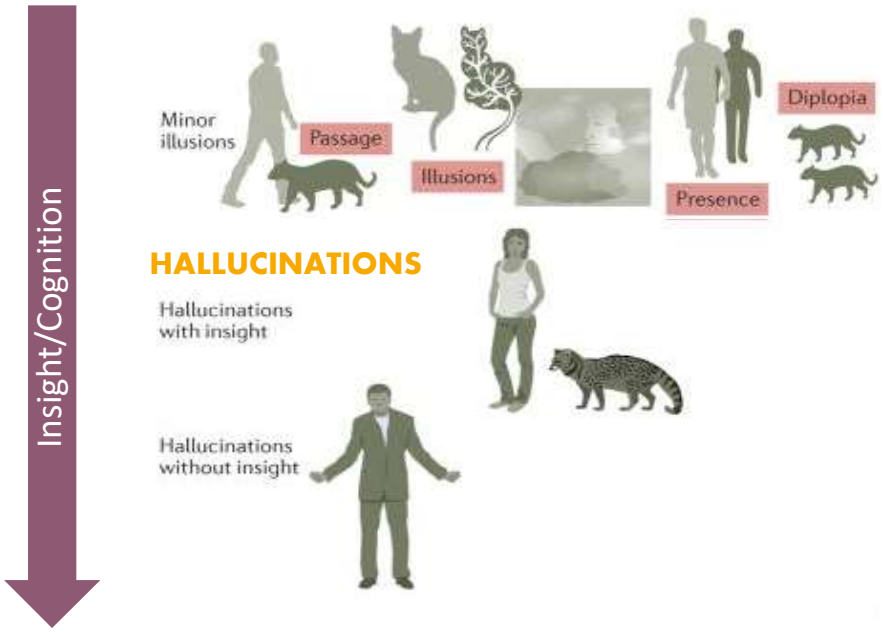

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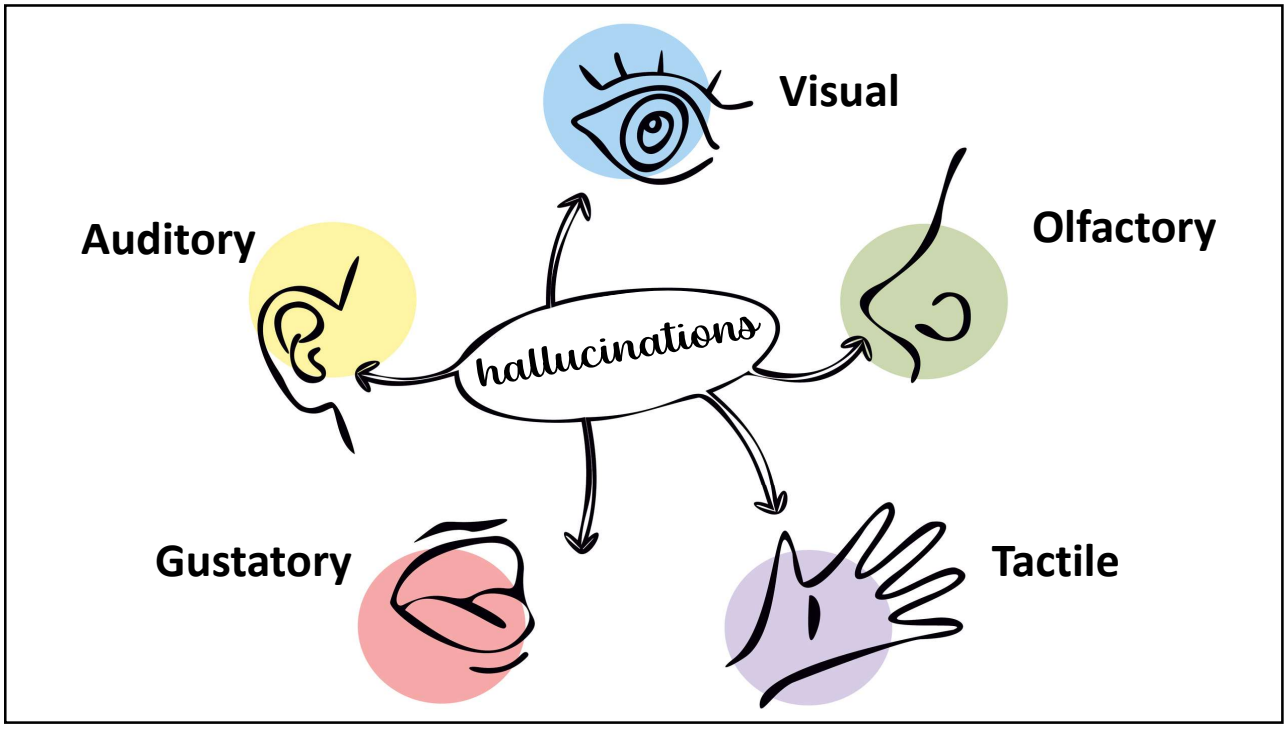

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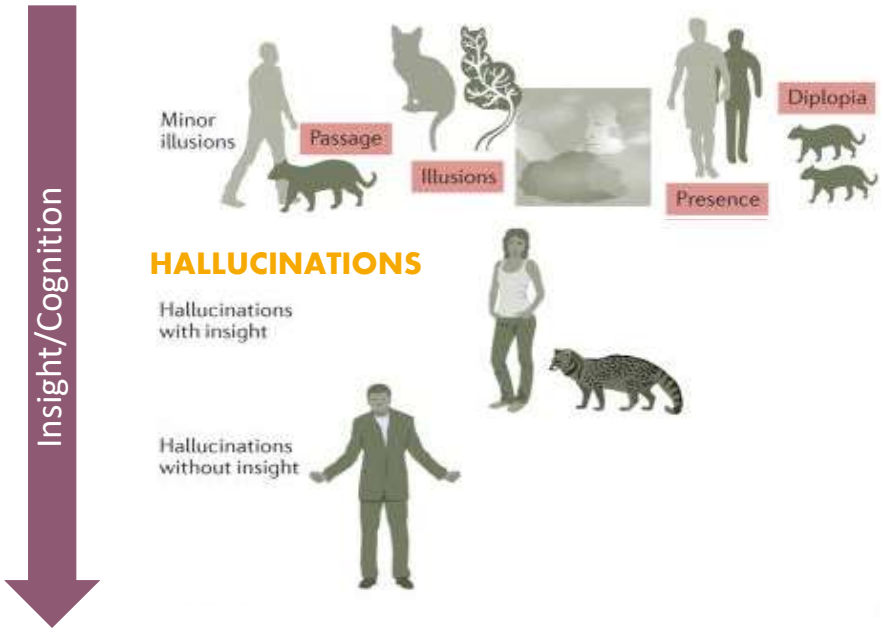

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Visual hallucinations

- Minor hallucinations: less likely to be disruptive and, therefore, are **less likely to be spontaneously reported**
- "Well-formed hallucinations": seeing people, animals or other entities that other people cannot
  - May include reoccurring subjects or contents
- Inanimate objects are less common

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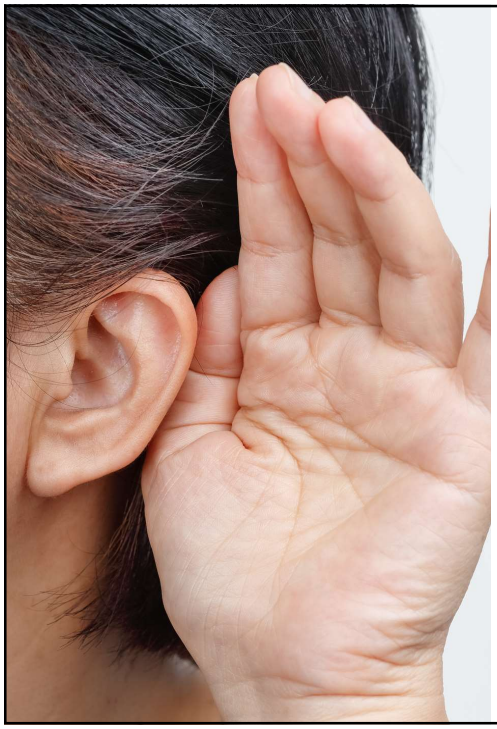

Auditory Hallucination in PD

- Less common
- Hear noises or sounds when there is nothing about to explain them
- Hear telephone, doorbell, radio, music that people near can't hear
- Sound of somebody walking in the hallway
- Indistinct whispers or voices (threatening) commenting on what they're thinking or doing
- Less likely to be present in isolation to other hallucinations

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Tactile

- Feel that someone is touching you, but when you look nobody is there
- Experience unusual burning sensations or other strange feelings in or on your body that can't be explained

Olfactory

Notice smells or odors that people next to you seem unaware of and which don't seem to come from your surroundings

Gustatory

- Uncommon
- Generally seen with visual hallucinations

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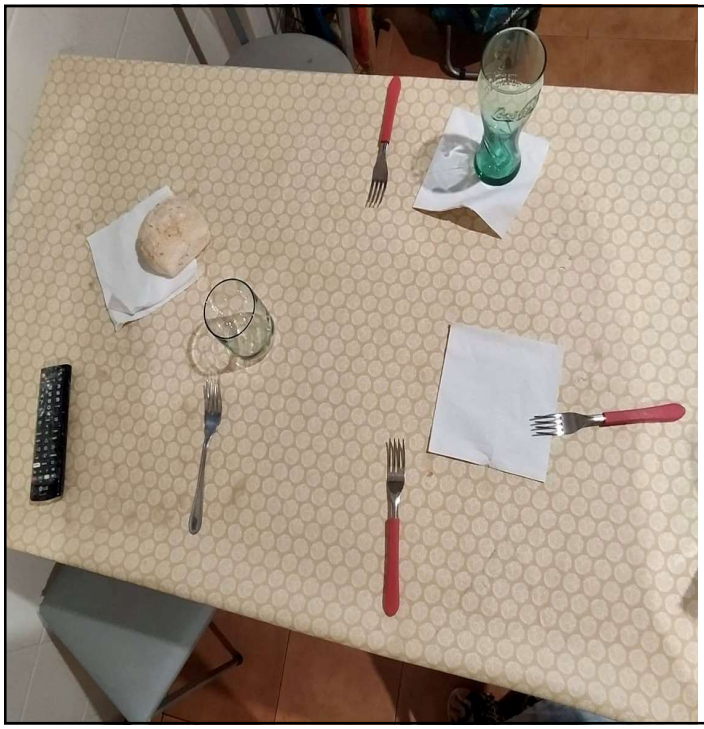

- Progression is variable. But as disease progresses, they may become more vivid, more complex and more persistent, typically with a decrease in insight.
- The individual might know it is not real and even express it after the fact or when queried during a doctor's appointment but when they are living it, it's real and may act on it in real-time, by setting the table with one more place ("superficial insight").

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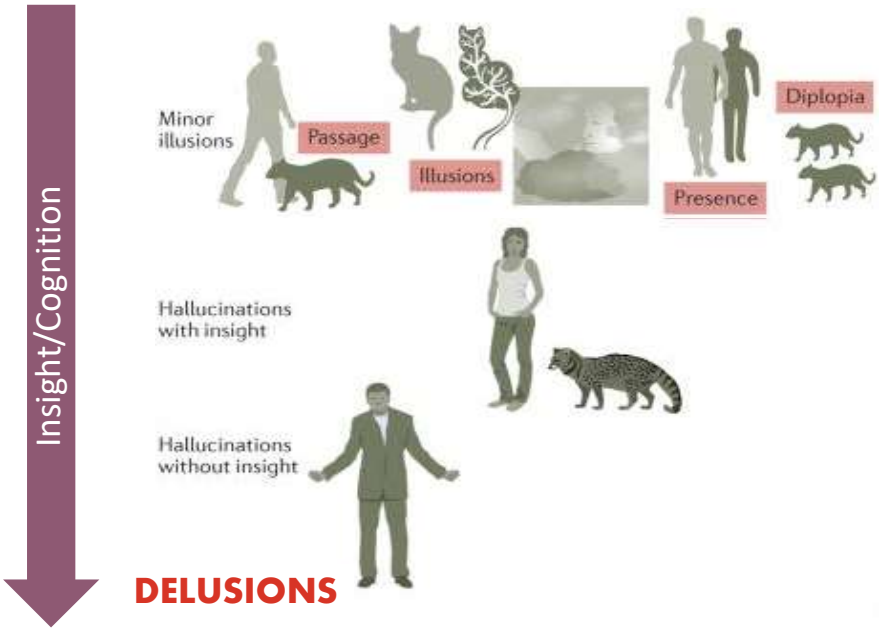

MDS- UPDRS

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How do you feel these symptoms **impact your daily life activities**?

RESULTS FROM QUESTIONNAIRES

Minimal, rare occurrence.
Troublesome and frightening.
Dwells on retelling - seems to live with them all day.
Disruptive - unpredictable and suspicious **Dangerous** (caused him to run out of house at least three times and/or being unwilling to go into a room in the basement). **Fearful** of people both inside the house (911 call that there were 15-20 guys outside our house. Standing on the bed with a weapon threatened by the backrests at the end of the bed); **Confrontational** (handyman painting our rooms saying he stole our money); **Accusatory** (my marital infidelities with many.

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How do you feel these symptoms **impact your daily life activities**?

RESULTS FROM QUESTIONNAIRES

Worrying, Disruptive, troublesome, affects social activities.
Feels like the floor is rumbling, makes him more unsteady.
Troublesome. I always feel under investigation.
Frightening, disruptive of sleep.
Somewhat or not usually troublesome, but do require management
The person is in a memory care facility; so far, the symptoms have not been too disruptive.

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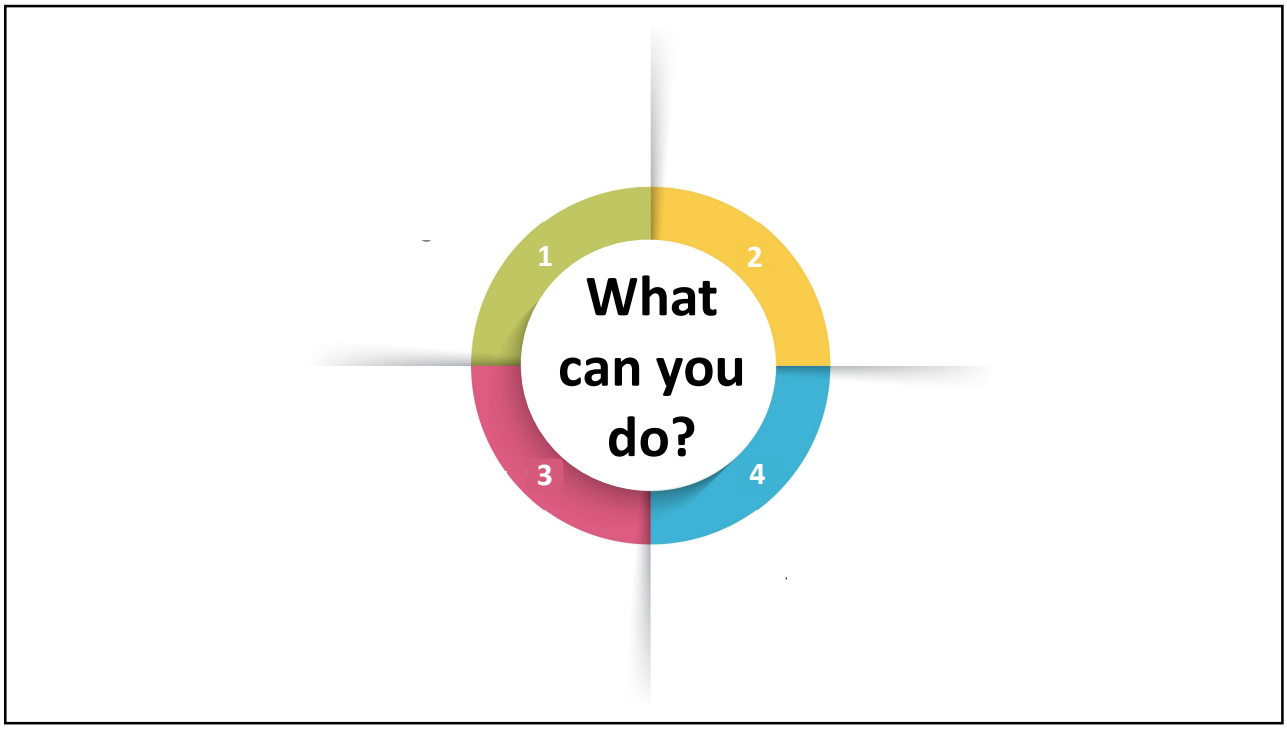
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What can you do?
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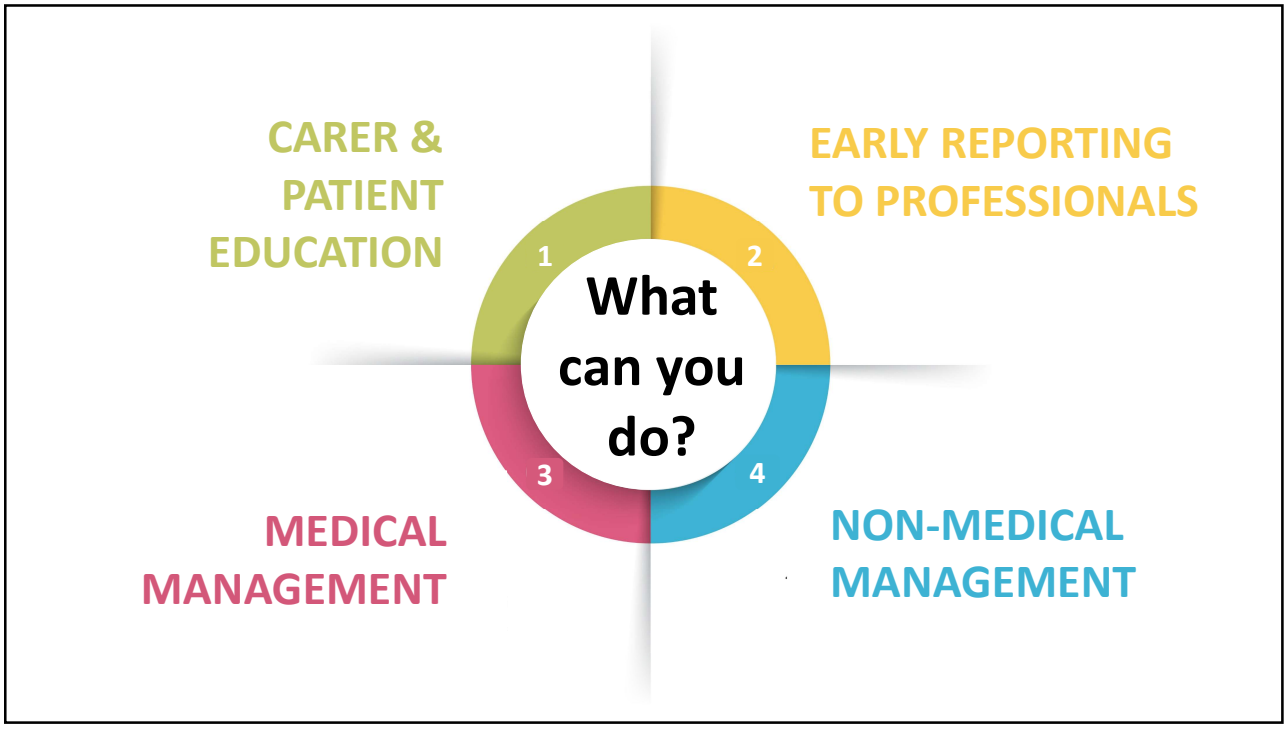
CARER & PATIENT EDUCATION
EARLY REPORTING TO PROFESSIONALS
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What can you do?
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4
MEDICAL MANAGEMENT
NON-MEDICAL MANAGEMENT

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CARER & PATIENT EDUCATION

Getting to know…

- What are some common signs or experiences of early and later hallucinations & delusions in PD?
- How often do they occur? When? Where?
- How to manage them? What strategies may be helpful to deal/manage with these symptoms when they occurring?

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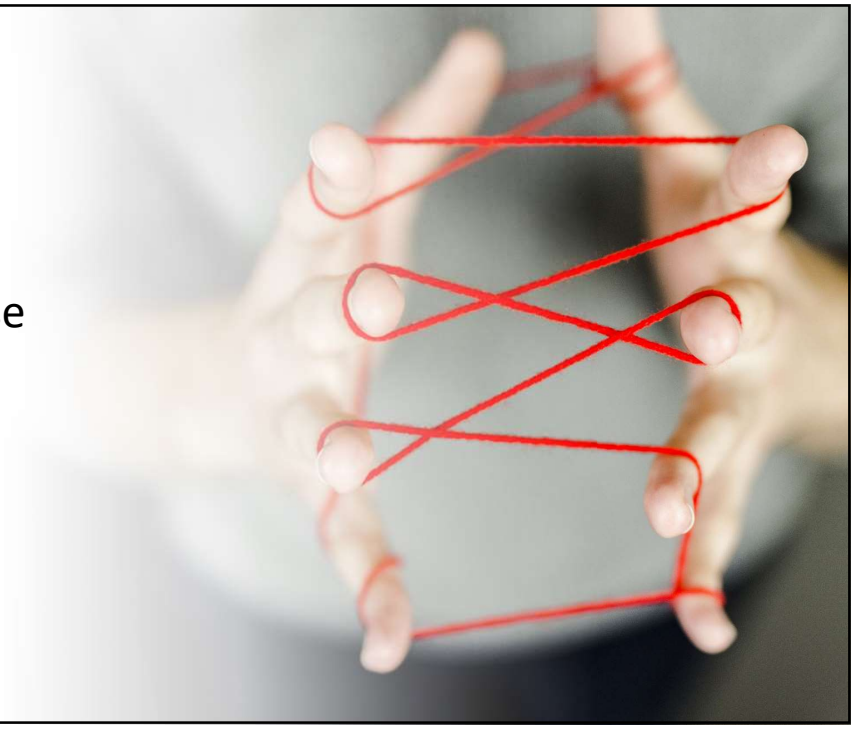
Getting to know…

Risk factors

Older age
Duration of disease
Visual problems
Sleep problems
Cognitive decline

Emergency crises can elicit too



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Reporting: What to do?

Acute: Report to the neurologist (asap).

Chronic: Assess hallucinations/ delusions onset or progression between formal assessments.

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Why is early reporting important?

- **Enable early diagnosis & allow for monitoring progression of psychotic symptoms throughout the disease**.
- **Identifying effectively triggering pharmacological or medical causes** - Reversible causes like problems with attention/cognition, sleep, visual, medical emergency that can be targeted to reduce psychosis symptoms.

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Things to consider when assessing

Frequency: Can occur many times per day

Duration: Seconds to minutes

Time of day: Usually occurs in the evening or at night first

Active reporting in-between consultations

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There are also self assessment tools

- **Self-report questionnaire**—the Psychosis and Hallucinations Questionnaire (PsycH-Q).
  - Specifically written in "nonscientific" language, allowing for easier self-identification of these symptoms.
- **Question from MDS UPDRS**, with a range of 0–4
  - Has your loved one ever shared that they have seen, heard, smelled or felt things that were not really there?

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How does your neurologist address or treat hallucinations and delusions?

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1. Look for **reversible causes**

- Sleep disturbances
- Visual problems
- Underlying medical emergency (e.g., concurrent infections)
- Sudden acute cognitive decline
- Medications - overdose, search for polypharmacy, anticholinergics

Oetz CG, et al, Nature Review 2009; Rabey JM, PRD 2010

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note

Psychotic symptoms must be recurrent or continuous for ≥1 month in order to rule out delirium and brief psychotic disorders.

Ravina B, Mov Disord. 2007;22: 1061–1068

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2. Decide whether the psychosis is **troublesome** (harmful, frightening)

1. Monitor closely
2. Medication adjustment.
3. Add new specific medication.

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Medications

There are **medication options available** specifically designed for hallucinations and 'psychosis' associated with Parkinson's Dementia and Lewy Body Dementia.

Talk to your doctor about options that may be suitable for you.

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But be aware to **avoid medications that block dopamine or acetylcholine**

- Neuroleptics - antipsychotic medications.
- Cold medication – dextromethorphan interacts.
- Anti-emetics – prescribed to help with nausea and vomiting
- Older Parkinson's medications such as Artane

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How to manage and deal with hallucinations and delusions?

non-medical strategies & tips

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Behavior management strategies

Environmental modification

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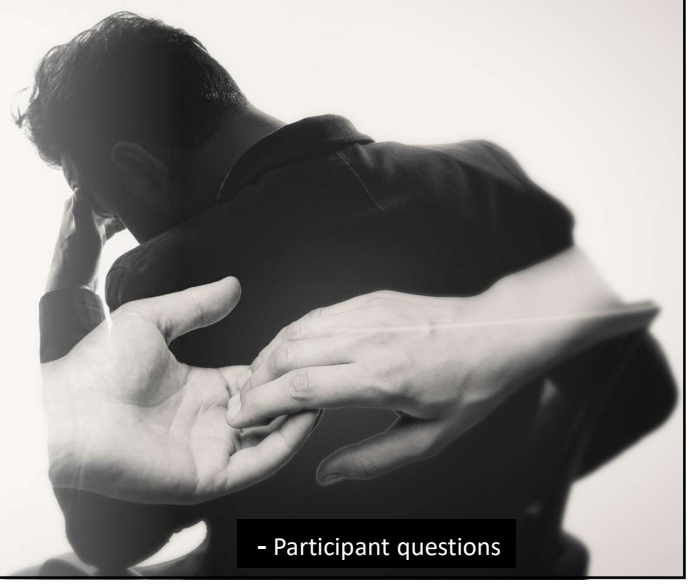
"How might a partner respond when spouse dwells on his dreams…as if they were his life?

Does going along with a hallucination encourage development of a related delusion?"



- Participant questions

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To take part or not to take part?

Recognize that it is real for the person:
Tell them what they are experiencing is not real **to you**.

With insight

Take part in the person's reality **enough for redirection.**

Without insight

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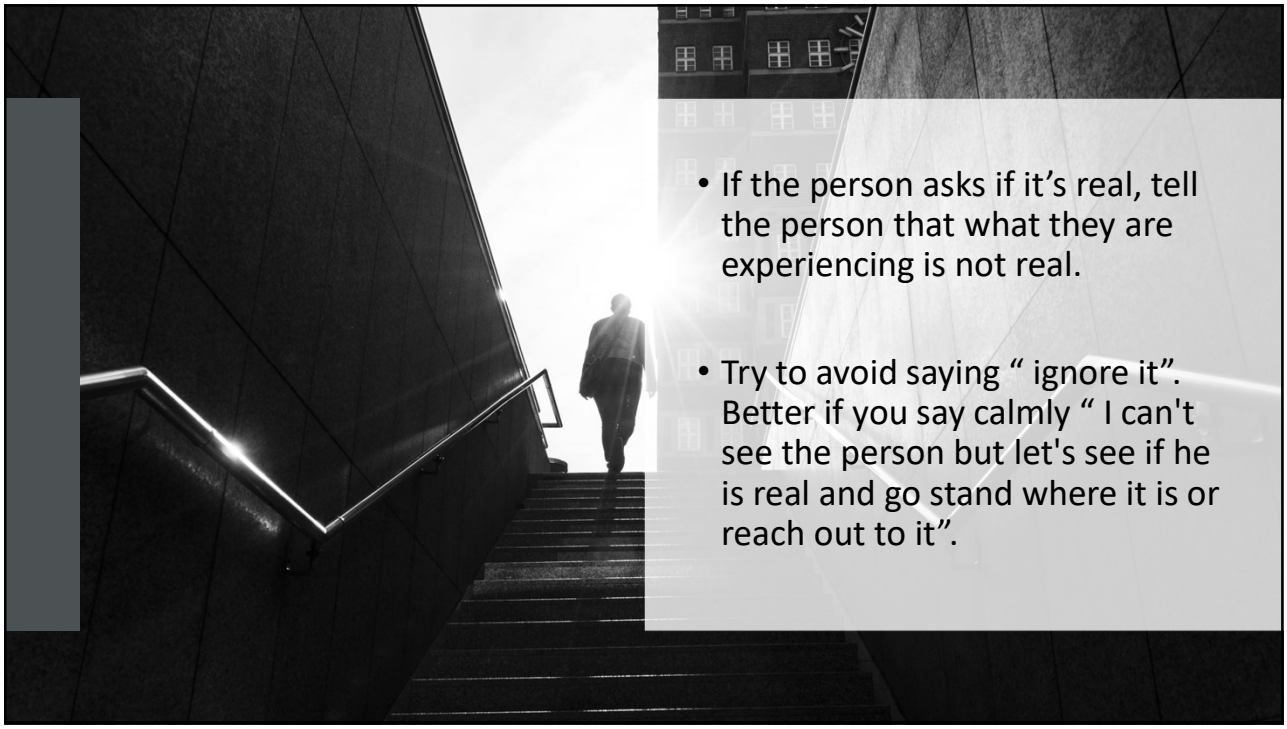

- If the person asks if it's real, tell the person that what they are experiencing is not real.
- Try to avoid saying " ignore it". Better if you say calmly " I can't see the person but let's see if he is real and go stand where it is or reach out to it".

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Identify what helps control or reduce the severity

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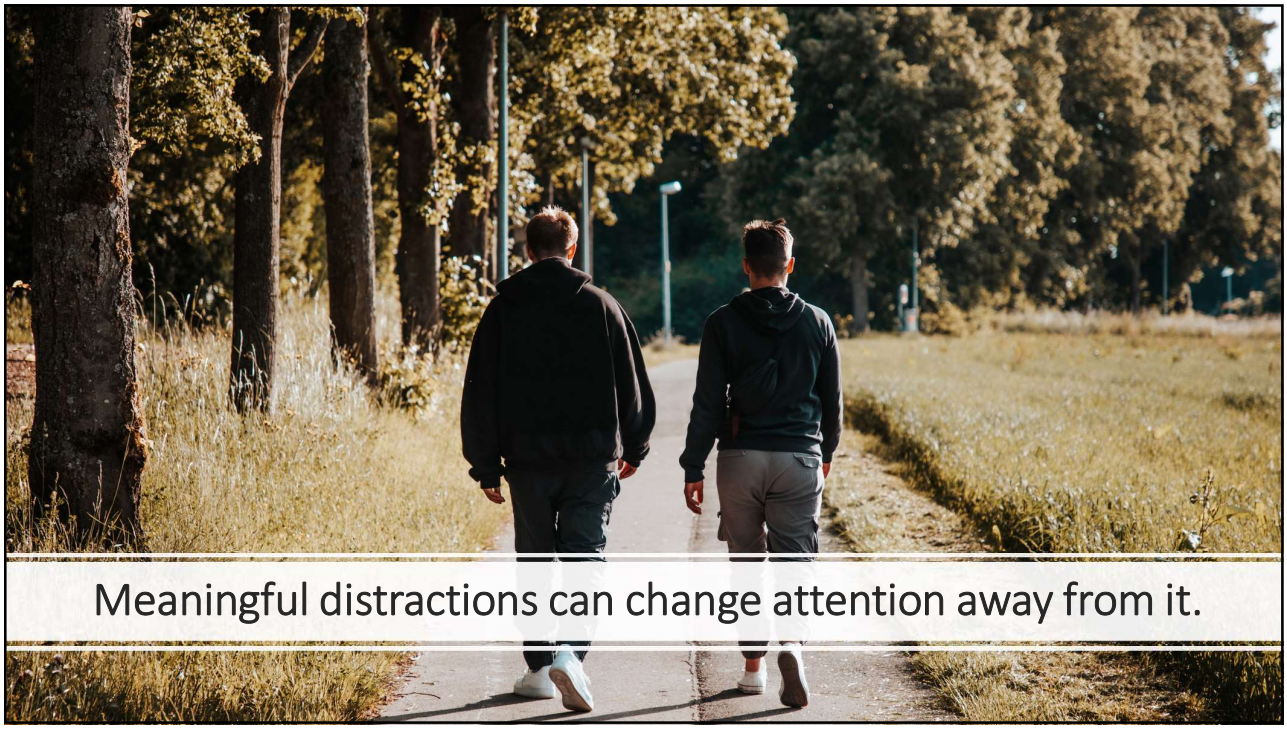

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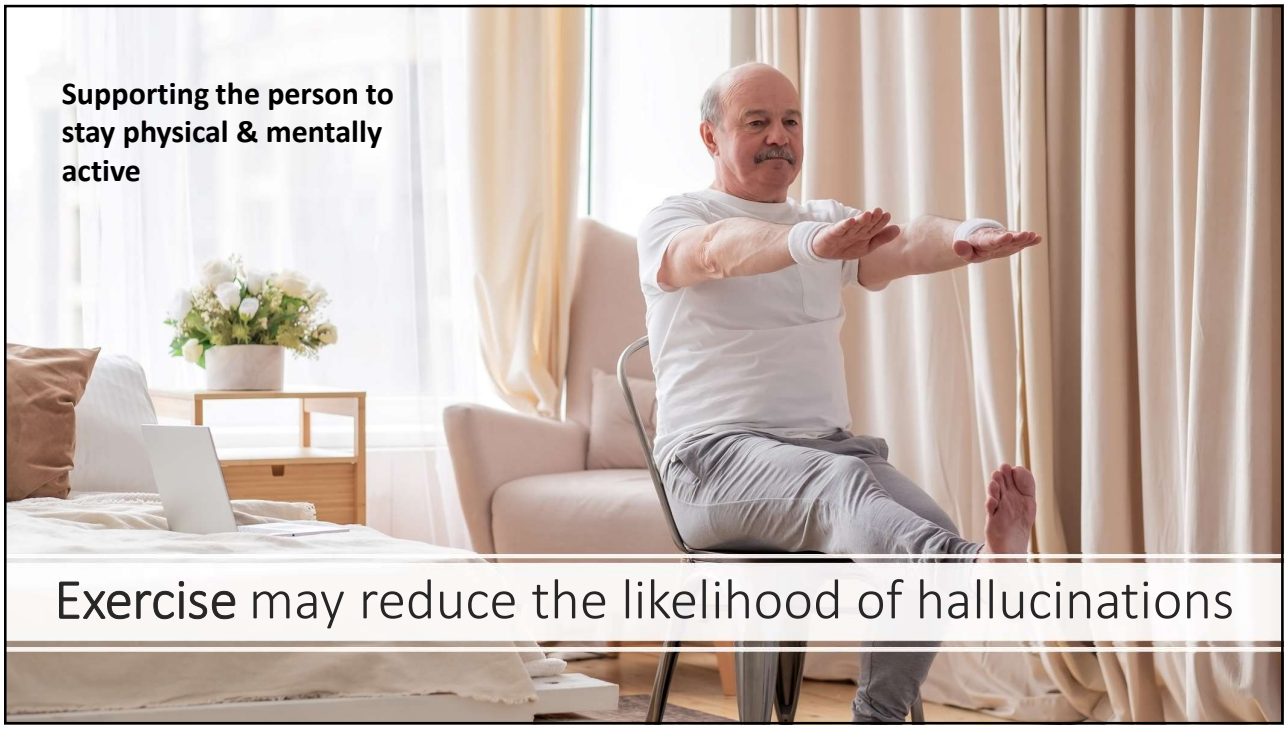
Supporting the person to stay physical & mentally active
Exercise may reduce the likelihood of hallucinations

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Hsu MH, et al. BMC Geriatr. 2015 Jul 18;15:84.
Music therapy may reduce anxiety & easily distract.

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Identify the triggers to minimize frequency and severity.

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Environmental modification
Removing obscure things that not easily recognized.

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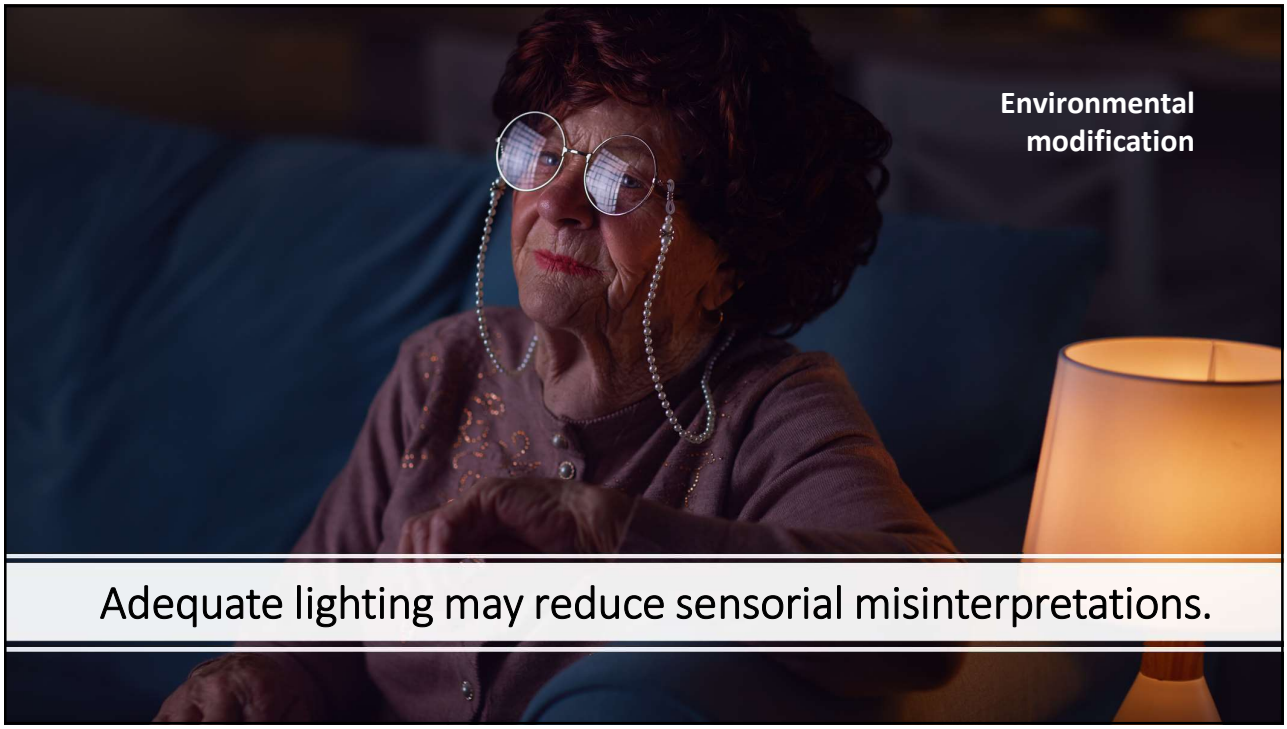
Environmental modification
Adequate lighting may reduce sensorial misinterpretations.

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Keep surroundings familiar & maximize time there.

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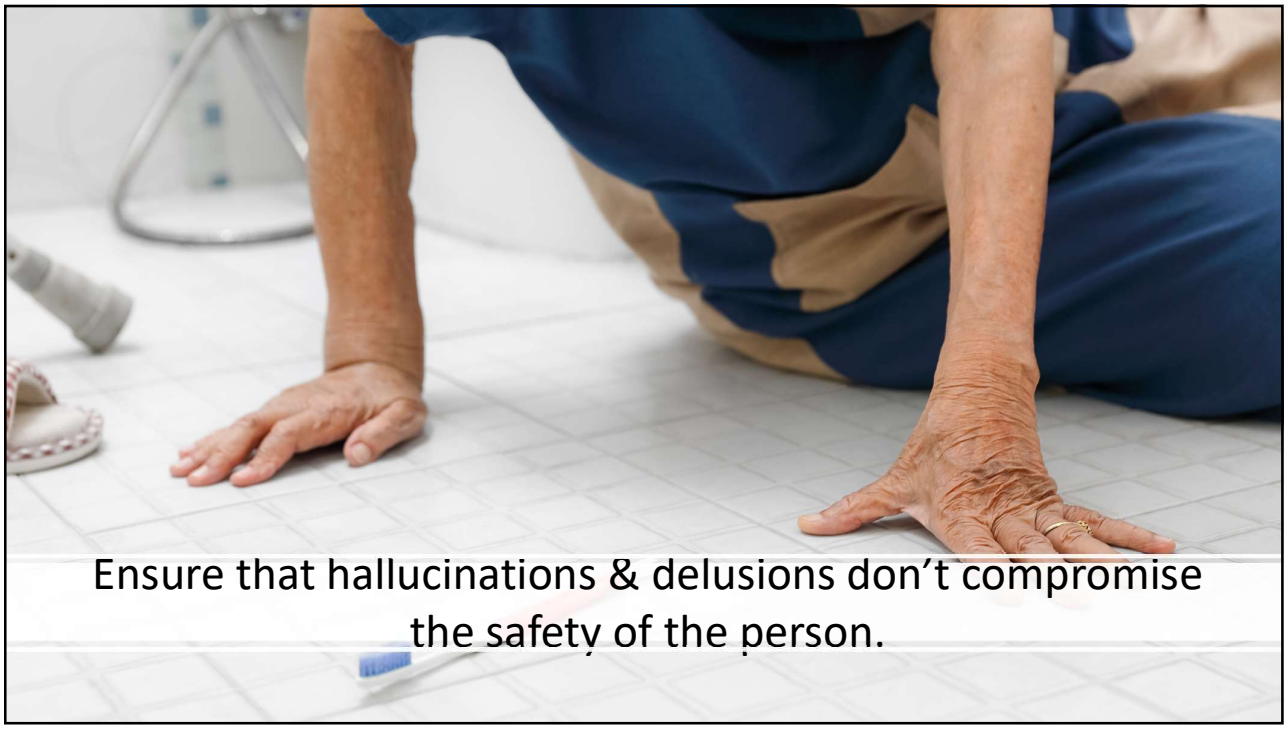

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General management tips

• **Getting help**: knowing who to call for help? Getting Psychological treatment if applicable. Formal caregiver.

• **Adapting to the change:** adapt to meet your loved one’s new needs around time management and planning. Being resilient in the fluctuations of the person (someone you can count on in one hour vs not able to count on the person in the next hour).

• **Care for the care partner is critical.**

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CARER & PATIENT EDUCATION

What can it look like?
What are the risk factors?
Treatment options?

EARLY REPORTING TO PROFESSIONALS

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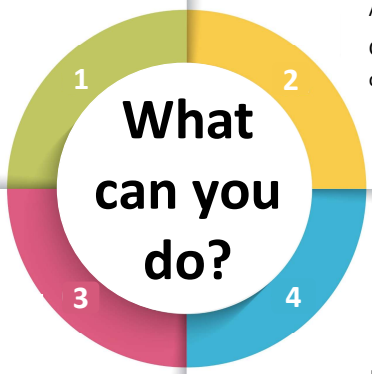

MEDICAL MANAGEMENT

1-Decide whether the psychosis is **troublesome** (harmful, frightening):

a. Monitor closely

b. Medication adjustment.

c. Add new specific medication.

NON-MEDICAL MANAGEMENT

Behavior management strategies

Changes in the environment

Others

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Tuesday September 13th 2022 | 2:30 pm - 4:00 pm

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John Dean, Josefa Domingos & Nancy Hillmer

Parkinson's Specialists

INOVA | Parkinson's and Movement Disorders Center

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Thank you for participating
- John Dean, Josefa Domingos & Nancy Hillmer

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