

## SPECIAL ARTICLE

# Psychotic symptoms in dementia: Calling for family-sensitive and multidisciplinary approaches at all levels of care



Marta Fournier<sup>a,b,\*</sup>, Manuel Gonçalves-Pereira<sup>a</sup>

<sup>a</sup> NOVA Medical School | Faculdade de Ciências Médicas, Universidade Nova de Lisboa, CHRC, Associated Laboratory REAL (LA-REAL), Lisbon, Portugal

<sup>b</sup> USF Ajuda, Unidade Local de Saúde de Lisboa Ocidental, E.P.E., Lisbon, Portugal

Received 18 September 2025; accepted 2 November 2025

Available online 21 January 2026

## KEYWORDS

Capgras syndrome;  
Delusion;  
Delusional disorder;  
Caregiver;  
Dementia;  
Primary care

**Abstract** Psychotic symptoms and other neuropsychiatric manifestations in dementia are distressing conditions that deeply affect patients, carers, and staff. Low awareness and doubts about the competence of primary care services to intervene contribute to underdiagnosis and suboptimal management.

We critically discuss what may and may not be done in primary care, building on the case of a 79-year-old man with dementia who developed Capgras delusion (a typical misidentification syndrome), believing his wife was replaced by impostors. We highlight diagnostic and therapeutic challenges, discussing practical advice potentially applicable in many other neuropsychiatric conditions.

Referrals to specialists are needed but continuity of care and a family-sensitive practice remain crucial (this patient's symptoms and his wife's distress seemed to enhance each other in circular manners). Primary care is pivotal in relation-centred dementia management, to help address the biopsychosocial needs of patient and carers.

A multidisciplinary, task-sharing approach may improve dementia care, particularly in resource-limited settings.

© 2026 The Authors. Published by Elsevier España, S.L.U. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

\* Corresponding author.

E-mail address: [marta.fournier@nms.unl.pt](mailto:marta.fournier@nms.unl.pt) (M. Fournier).

**PALABRAS CLAVE**

Síndrome de Capgras;  
Delirio;  
Trastorno delirante;  
Cuidador;  
Demencia;  
Atención primaria

**Síntomas psicóticos en la demencia: necesidad de enfoques multidisciplinares sensibles a las necesidades de las familias en todos los niveles de atención**

**Resumen** Los síntomas psicóticos y otras manifestaciones neuropsiquiátricas en la demencia son alteraciones complejas que afectan profundamente a los pacientes, sus cuidadores y los profesionales. La baja concienciación y las dudas sobre la capacidad de los servicios de atención primaria para intervenir contribuyen a un infradiagnóstico y a una gestión subóptima de la enfermedad.

Discutimos críticamente lo que se puede y no se puede hacer en la atención primaria, basándonos en el caso de un varón de 79 años con demencia, que desarrolló un delirio de Capgras (un típico síndrome de falsa identificación), creyendo que su esposa había sido reemplazada por impostores. Destacamos los desafíos diagnósticos y terapéuticos, discutiendo consejos prácticos que podrían ser aplicables en muchas otras alteraciones neuropsiquiátricas.

Es necesario derivar la mayoría de estos pacientes a especialistas, pero la continuidad de la atención y una práctica sensible a las necesidades familiares siguen siendo cruciales (los síntomas del paciente y la angustia de su esposa parecían reforzarse mutuamente de manera circular). La atención primaria es fundamental para una gestión de la demencia centrada en las relaciones, ayudando a abordar las necesidades biopsicosociales de los pacientes y sus cuidadores.

Un enfoque multidisciplinario y el reparto de tareas pueden mejorar la atención de la demencia, especialmente en entornos con recursos limitados.

© 2026 Los Autores. Publicado por Elsevier España, S.L.U. Este es un artículo Open Access bajo la CC BY-NC-ND licencia (<http://creativecommons.org/licencias/by-nc-nd/4.0/>).

## Introduction

Psychotic symptoms, namely delusions and hallucinations, are frequent manifestations of dementia, falling under the umbrella-expressions “neuropsychiatric symptoms” or BPSD (the “behavioural and psychological symptoms of dementia”). Among them, misidentification syndromes are (neuro)psychiatric conditions that include the Capgras delusion<sup>1</sup> such specific psychotic experiences, despite rare, are most challenging to patients, families and staff across all levels of care (not only psychiatry or neurology services).

The Capgras delusion was described in 1923 as the firmly held belief, not affected by rational argument, that a familiar person, typically a close relative, has been replaced by an identical impostor.<sup>2</sup> A systematic review identified schizophrenia (32%), organic delusional disorder (19%), and dementia (15%), as the most frequent underlying conditions.<sup>3</sup> Concerning Capgras delusion in general, further details on epidemiology, clinical characteristics, differential diagnosis, aetiology/explanatory hypotheses, treatment and prognosis may be found elsewhere.<sup>4,5</sup>

In dementia, the (sometimes transient) conviction about impostorship is often accompanied by anxiety, fear, and aggressive outbursts. While Capgras delusion is more typical of later stages, it may also occur early during the disease process. In any case, the picture affects family carers, threatening communication and relationship quality, and increasing subjective burden. The estimated prevalence in dementia ranges 4–15%, mainly in Alzheimer’s disease or Lewy Bodies’ subtypes.<sup>5</sup> Notwithstanding, vascular and parkinsonian subtypes are also frequent.<sup>6</sup>

A recent systematic review of case studies of Capgras syndrome in dementia found that the condition is not managed

in standardised ways.<sup>6</sup> While pharmacological interventions (primarily antipsychotics) may help, a significant number of patients either experienced no change or a worsening of symptoms, and there was a noticeable lack of psychosocial strategies among the reported interventions. The authors also underlined the potentialities of person-centred approaches to address the needs for care.<sup>6</sup>

In this paper, we aim to discuss what can be done about psychotic symptoms in general, and misidentification syndromes in particular, in primary care or generalist contexts, either in collaboration with specialised services or when this is difficult. In fact, referral, information exchange and case discussions are often hindered, due to barriers originated in the health system, or to patient or carer’s factors. We build on transcripts of an outpatient consultation, exploring both patient and carer’s experiences, the impact on their relationship, and the challenges in clinically managing such cases. While providing the context for this consultation, we do not intend to report the case in full, only to ground our discussion on a real, typical scenario.

## Case: what happened during a consultation

A 79-year-old Caucasian male was taken to a primary care medical appointment by his wife. She was deeply concerned by his frequent claims, for about three months, that she was not his wife, as “other women” replaced “the real one” (sic). The patient reported having to deal with multiple impostors, his wife occasionally disappearing for no reason, which would lead to angry outbursts or withdrawal.

About two years before, at presentation of symptoms of major cognitive dysfunction, laboratory studies, including serum levels of vitamin B12 and folate, were unremarkable

but a brain CT scan demonstrated chronic microangiopathic leukoencephalopathy. His past medical history included benign prostatic hyperplasia, asthma, and gastric cancer in remission. A neurologist had diagnosed vascular dementia, about one year before the consultation (nine months before the first delusional episode), although it was not possible to obtain a brain MRI. After being prescribed quetiapine 25 mg bid, the patient was seen by other neurologists and psychiatrists, in public and private practice. After attempts to titrate anti-dementia (e.g., memantine) and antipsychotic medications (e.g., haloperidol), there was no significant clinical change except for superimposed, iatrogenic parkinsonism.

At time of this consultation, the general practitioner (GP) was the only clinician *de facto* in charge. Throughout the encounter, the patient's narrative offers a window into the lived experience of psychotic symptoms in dementia, namely Capgras delusion. He describes a chaotic reality: "there are times where there are one, two, three or four people and all of them say... I'm your wife, I married you... and there's no point in contradicting". This core belief is accompanied by a sense of loss, as he reports that his real wife "just vanishes". The resulting distress is evident when he recounts searching for her: "I just stay there, all alone...and a little while later, she's also there, sitting on the sofa." This unpredictable cycle leads to intense emotional reactions. His wife notes that he becomes "very angry, very anxious..." and can be physically aggressive, as evidenced by an incident where he "once threw away his wedding ring, punching himself on the chest..."

Occasionally, the patient attempts to cope through suppression and avoidance. Sometimes, he struggles with doubt or even accept that some of these experiences are abnormal, overtly calling for help. He may consciously try to escape the belief: "Sometimes I even look for things to do... for all this to disappear from my head". There are moments of striking self-awareness and desperate appeals: "I know there is something wrong with my head... I do need help". This is accompanied by fear, anxiety and loneliness, and he poignantly explains: "I feel unprotected and alone in the world".

The wife had scheduled several individual appointments with the GP, attempting to solve her husband's symptoms and desperately calling for help herself. As the sole carer, she was experiencing significant burden and psychological distress despite often refraining from openly expressing them. These feelings eventually came out during the consultation. While dedicated to her role ("I always tend to do everything with him by my side, to always be there for him") she tries to self-manage. Her frustration is directed more at her husband's altered behaviour than cognitive decline, as his frequent rejections leave her disqualified and helpless. This emotional toll is clear: "This messes with me a lot because, I mean... I have to understand that it's his mind, but it just makes me feel confused...". She admits feeling exhausted and irritable, regretting her overreactions. Her narrative highlights the ambivalence of caring for a loved lifelong partner who, due to dementia and the superimposed psychotic symptoms, had become "difficult to recognise" (sic) and unpredictably threatened all peace of mind. Major depression was eventually diagnosed, with

but partial response to a serotonergic antidepressant and the GP's continued support.

At that moment, no other health or social care responses were available to either patient or carer.

## Discussion

This case of misidentification syndrome in dementia, suggesting intermittent Capgras delusion, illustrates challenges to all involved. One empathises with the patient, insecure in face of overwhelming threats. One also empathises with the carer, mourning a past confident whose clinical symptoms became the main source of distress. Their relationship of decades is apparently jeopardised. And what about the GP, indeed any health practitioner, unsure of what to do?

At time of primary care consultations like the one described, many such cases are also being followed by specialists in dementia (neurologists, psychiatrists, geriatricians). These situations are complex, even for experienced specialists, and collaborative efforts are crucial to the best interest of patients and families. Even when specialists are deeply involved, issues frequently arise, of a varying nature across countries. We can illustrate this with barriers to access (primary care may have universal access within the National Health System, but not all persons actually have GPs and timely access to specialists is not the rule) or problems with effective liaison between neurologists/psychiatrists and GPs (information may not circulate bidirectionally).<sup>7,8</sup>

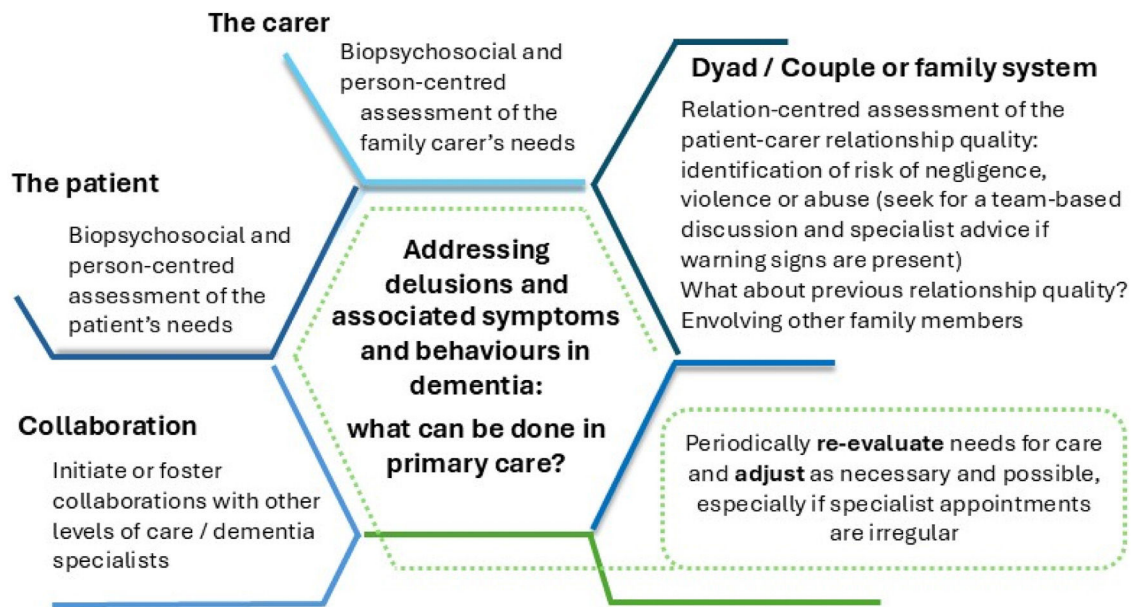
Although much may exceed what is required from a competent GP, we would like to focus on the undesirable but frequent scenario where specialists are less available in practice. What may help the primary care team if (at least transiently) all by themselves, to help that family? A sensible approach is outlined in Fig. 1. But for the sake of clarity let's start with what is not the realm of the GP.

## Examples of how can dementia specialists help

The patient may have already been observed by a specialist (e.g., neurologist) and sent back to their GP with information on a dementia subtype diagnosis and a therapeutic plan. Notwithstanding, indications to refer them again include the exclusion of treatable conditions like space-occupying lesions, particularly with high clinical suspicion after a basic neurological examination (e.g., *de novo* focal signs). Specialists will be more able to differentiate typical Capgras delusions from reduplicative paramnesias (misidentifications involving places and events, not people) or prosopagnosia (the inability to recognise faces, non-delusional in nature), possibly having to exclude e.g., non-convulsive seizures, right lobe lesions with neglect, migraine, stroke, pituitary tumours.<sup>2-5,9,10</sup>

The cost-effectiveness of further investigations (neuroimaging, other tests) warrants discussion<sup>11,12</sup> and must be thoughtfully considered. In fact, in the routine clinical practice/non-specialized centres of many countries, exhaustive investigations are not possible or practical.

Other dementia specialists (e.g., psychiatrists) are also needed to better address risk of aggression or self-harm,



**Figure 1** Addressing delusions and associated symptoms/behaviours in dementia in primary care: a practical framework for general practitioners. *Note:* based on the authors' experience, in accordance with published case discussions in dementia care, e.g.,<sup>9,16</sup> and general recommendations from e.g., the NICE Guidelines for people living with dementia and their carers,<sup>11</sup> the Spanish Psychogeriatrics Society (SEPG).<sup>18</sup>

either in patients or carers. Sometimes, a psychiatric involuntary admission may have to be considered.

Anyway, during a substantial part of the process, primary care services will always remain at the frontline: continued clinical monitoring and support are paramount, fostered by interdisciplinary collaboration,<sup>7</sup> and even more so when access to the higher levels of care is difficult.

### What features are important in the person-centred and relation-centred clinical formulation?

This patient had fluctuating insight and perhaps this added to his suffering. Conceivably a part of his aggressive, challenging reactions was understandable given that he felt completely alone, lost, misunderstood, neglected, or abused. Hypothesising some BPSD as understandable signs of distress, and not necessarily of brain disfunction, may help find a rationale for approaches that are more person-centred.<sup>9,11</sup> It is often said that the D (in BPSD) could stand not only for "dementia" but for "distress", as experienced by the patient.<sup>9,13</sup>

The carer's subjective burden and distress contributed to clinical depression, a condition to be treated. All this, together with her ambivalence towards the situation (i.e., the unbearable duty to support her husband) and possible guilt feelings,<sup>14</sup> may be associated with "expressed emotion", meaning emotional overinvolvement, criticism and hostility towards the patient.<sup>15</sup> Carer's burden, depression and "expressed emotion" arguably display bidirectional associations with the patient's BPSD.<sup>9,16</sup>

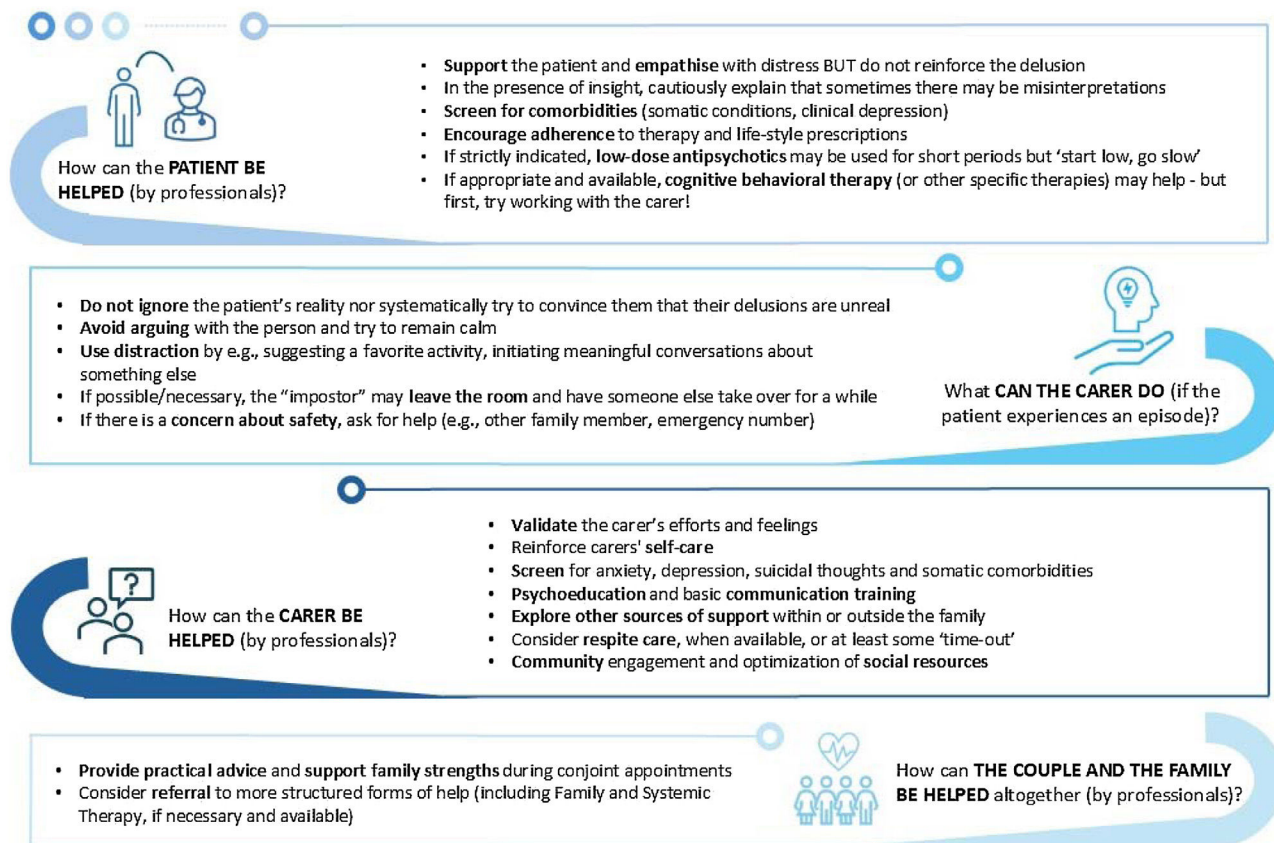
In the literature, there are references to long-standing ambivalence towards the 'object' of misidentification as a predisposing factor.<sup>4</sup> This can be suggested by accounts of

both negative emotions (hostility, fear, contempt) and affection or dependence. If our patient deeply resented certain characteristics of his wife, a psychodynamic interpretation would understand the delusion as a more socially acceptable expression of his anger, directed towards a "stranger" and not the loved spouse. But this was not so in our case; even if it were, the sensible clinician would keep this hypothesis to himself and focus on what usually helps in practice. In fact, both BPSD and carer stress contribute to poor relationship quality in patient-carer dyads<sup>17</sup> and are amenable to change.

### And what can be done in primary care?

Complex biopsychosocial conditions call for multiple approaches, frequently unfeasible in primary care. Nevertheless, there are simple examples of what remains possible e.g., controlling blood pressure, diabetes or sensory problems, preventing sedentarism and frailty. The urge to address BPSD may overshadow general physical care, but both are often interlinked, and the latter will always be necessary.

Regarding neuropsychiatric symptoms, perhaps much falls under the scope of action of sensible GPs, after all. Practical suggestions to address delusions and associated symptoms in people with dementia, and misidentification syndromes in particular, can be drawn from clinical experience, the literature and international recommendations.<sup>1,9,11,18-25</sup> These include what may be done (in primary care as elsewhere) to help patients, family carers and couples or families as systems (Fig. 2). Sometimes, family carers find by themselves effective ways of helping the patient, sometimes they need extra-help to walk that long, winding road.



**Figure 2** Practical suggestions to address delusions and associated symptoms and behaviours in people with dementia, taking Capgras delusion as an example. *Note:* based on the authors’ experience, in accordance with published case discussions in dementia care, e.g.,<sup>9,16</sup> and general recommendations from e.g., the NICE Guidelines for people living with dementia and their carers,<sup>11</sup> the Spanish Psychogeriatrics Society (SEPG).<sup>18</sup>

Starting with the patient, a priority is to listen, better for a while than never, empathising with anxiety, sadness, loneliness and despair, but carefully avoiding reinforcing the delusion (it is true that the patient experiences those beliefs, but the beliefs are not themselves true). If the patient has some insight, it may help to cautiously explain that their condition may sometimes lead to misinterpretations.

Turning to more ‘medical’ issues, the GP will timely screen for comorbidities (somatic conditions, clinical depression) and encourage adherence to therapy, focusing on comorbidities and risk factors (e.g., cardiovascular). He will keep in mind that psychopharmacological interventions are only indicated when non-pharmacological approaches have failed, or facing a significant risk of self-harm or aggression. When antipsychotics are necessary, they should be used at low doses and for short periods. Clinicians must monitor side effects, as even atypical antipsychotics (except clozapine – which should be left to a specialist – or low-dose quetiapine) can cause akathisia or pseudo-parkinsonism, often mistaken for increased agitation or apathy, respectively. Periodic re-evaluation is most relevant when specialist appointments are irregular.

Finally, cognitive behavioural therapy, other forms of psychotherapy or occupational therapy, where available, should be considered, but this requires articulation with

other professionals and/or mental health teams. The first-line approach is providing carers with advice in non-pharmacological strategies (e.g., communication training), starting by modelling it during consultations.<sup>9,26</sup>

In fact, the carer needs continued (emotional and practical) support. One must validate their efforts and feelings and reinforce self-care. Clinically significant anxiety, depression and suicide risk should be screened for, mainly when subjective burden rises, and managed adequately. Asking about constant worrying, depressive mood, anhedonia or ‘giving up’ feelings may not be postponed. Notably, if somatic vulnerabilities exist, blood pressure or glycemia may also rise as a correlate.

Family psychoeducation should be offered in structured ways to improve knowledge and skills, and lower ‘‘expressed emotion’’. When this is not possible, and although behaviour change is difficult in the face of stressful situations, carers’ may consider simple strategies, on a ‘‘trial and error’’ basis: acknowledging the distress (not ignoring the patient’s reality) does not mean acknowledging truth in the delusion; do not try to convince the person systematically that delusions are unreal (delusions are firmly held beliefs) and avoid arguing with them, aiming to remain calm; advise ‘‘distraction’’ by suggesting a favourite activity (listening to music, walking, drawing, looking at a photo album) or engaging in meaningful conversations about something else;

if possible/necessary, the “impostor” may leave and have someone else take over until the worse is over (episodes or anger are frequently time-limited); if there is a concern about their own safety, the carer should exit the room as calmly as possible and ask for help (family member or emergency number).

Carers may explore other sources of support within or outside the family. They may sometimes accept a limited ‘time-out’ prescription to decrease the risk of exhaustion, providing the patient with a plausible explanation and company (friends, other family members).

For the couple and family as a whole, providing practical advice, fostering cohesion, positive communication and problem-solving during conjoint appointments can be highly beneficial. This can help mitigate the erosion of relationships and provide a basis for managing future episodes of psychotic outburst. Where appropriate and available, referring the family to more structured interventions, as family and systemic therapy, should also be considered.

A detailed discussion of structured family work in dementia and practical advice in routine family-sensitive clinical practice may be found elsewhere.<sup>9</sup>

## Conclusion

Effective primary care management should go beyond symptom control to foster social health<sup>27</sup> within a family-sensitive perspective. ‘The person comes first’, in Kitwood’s terms, but our case supports that being ‘person-centred’ also means ‘relation-centred’.<sup>28,29</sup> Carers’ unmet needs (e.g., knowledge about dementia, psychological distress) and family dynamics, must be considered.<sup>9</sup> Otherwise, psychotic symptoms will flourish in a stress-laden atmosphere, despite all medication. Although specialised psychosocial interventions are most often needed, they should be reinforced at every level of health and social care.

Arguably, low awareness of delusional conditions in dementia risks underdiagnosis and undermanagement in primary care, as many practical interventions (erroneously) seem outside the GP’s reach. Regardless of clinical dilemmas and the benefits of referrals to specialists, continued support is most important.

Undoubtedly, GPs frequently find themselves alone with patients and families, either lacking the opportunity to refer many cases timely or to get adequate feedback from specialists.<sup>7</sup> Community dementia care implies effective task-sharing and interdisciplinary collaborations,<sup>7</sup> currently far from feasible in many countries and settings. But this does not exempt us from omitting what can be done in routine clinical encounters, being dementia specialists or not. Primary care teams are in a privileged position to address part of these issues.

## Ethical considerations

We confirm that the study was conducted in accordance with all ethical standards and that informed consent was obtained.

## Key messages

- Capgras delusion in dementia is underrecognized, leading to diagnostic and management challenges.
- Primary care plays a crucial role in supporting both patients and carers, even more so in the presence of limited access to dementia specialists.
- A relation-centred approach is essential, addressing carers’ distress while possibly preventing worsening of behavioural symptoms.
- Task-sharing and interdisciplinary collaboration may improve dementia care delivery.

## Funding

This research did not receive any specific funding.

## Conflict of interest

The authors have no conflicts of interest to report.

## Acknowledgements

We reported a patient scenario mostly based on the transcripts of an audio recorded outpatient consultation in primary care. This record had been originally obtained for the study “Dementia in primary care: The patient, the carer and the doctor in the medical encounter”, funded by the Bayer Research Grant/NOVAHealth Ageing 2018, Universidade NOVA de Lisboa. Written informed consent was provided by all those involved in the consultation.

We are thankful to Filipa Barreiros, who was responsible for the transcripts.

## References

1. Cummings J, Pinto LC, Cruz M, Fischer CE, Gerritsen DL, Grossberg GT, et al. Criteria for psychosis in major and mild neurocognitive disorders: International Psychogeriatric Association (IPA) consensus clinical and research definition. *Am J Geriatric Psychiatry*. 2020;28:1256–69.
2. Geddes JR, Andreasen NC, Goodwin GM. *New Oxford textbook of psychiatry*. Oxford University Press; 2020.
3. Pandis C, Agrawal N, Poole N. Capgras’ delusion: a systematic review of 255 published cases. *Psychopathology*. 2019;52:161–73.
4. Edelstyn NM, Oyeboode F. A review of the phenomenology and cognitive neuropsychological origins of the Capgras syndrome. *Int J Geriatr Psychiatry*. 1999;14:48–59.
5. Currell EA, Werbeloff N, Hayes JF, Bell V. Cognitive neuropsychiatric analysis of an additional large Capgras delusion case series. *Cogn Neuropsychiatry*. 2019;24:123–34.
6. Margariti C, Mircea MT. Capgras syndrome in dementia: a systematic review of case studies. *Curr Alzheimer Res*. 2024;21:312–23.
7. Balsinha C, Gonçalves-Pereira M, Iliffe S, Freitas JA, Grave J. Health-care delivery for older people with dementia in primary care. In: Ibvijaro GO, Mendonça-Lima C, editors. *Primary care*

- mental health in older people. Cham: Springer International Publishing; 2019.
8. Kerpershoek L, Wolfs C, Verhey F, Jelley H, Woods B, Bieber A, et al. Optimizing access to and use of formal dementia care: qualitative findings from the European Actifcare study. *Health Soc Care Community*. 2019;27:e814–23.
  9. Verdelho A, Gonçalves-Pereira M, editors. *Neuropsychiatric symptoms of cognitive impairment and dementia. Neuropsychiatric Symptoms of Neurological Disease*. Springer; 2017.
  10. Ellis HD, Lewis MB. Capgras delusion: a window on face recognition. *Trends Cogn Sci*. 2001;5:149–56.
  11. National Institute for Health and Care Excellence (NICE). In: *Dementia: assessment, management and support for people living with dementia and their carers*. NICE guideline [Internet]; 2019. Available from: [www.nice.org.uk/guidance/ng97](http://www.nice.org.uk/guidance/ng97)
  12. Gauthier S, Rosa-Neto P, Morais JA, Webster C. *World Alzheimer Report 2021: Journey through the diagnosis of dementia*. London, England: Alzheimer's Disease International; 2021. <https://www.alzint.org/resource/world-alzheimer-report-2021/>
  13. Warren A. BPSD reconsidered: diagnostic considerations to preserve personhood in persons with dementia. *Front Dement*. 2023;2:1272400.
  14. Losada-Baltar A, Mausbach BT, Romero-Moreno R, Jiménez-Gonzalo L, Huertas-Domingo C, Fernandes-Pires JA, et al. Longitudinal effects of ambivalent and guilt feelings on dementia family caregivers' depressive symptoms. *J Am Geriatr Soc*. 2024;72:1431–41.
  15. Safavi R, Berry K, Wearden A. Expressed Emotion in relatives of persons with dementia: a systematic review and meta-analysis. *Aging Ment Health*. 2017;21:113–24.
  16. Zhang F, Cheng ST, Gonçalves-Pereira M. Factors contributing to protection and vulnerability in dementia caregivers. In: *Genetics, neurology, behavior, and diet in dementia*. Elsevier; 2020. p. 709–22.
  17. Marques MJ, Woods B, Hopper L, Jelley H, Irving K, Kerpershoek L, et al. Relationship quality and sense of coherence in dementia: results of a European cohort study. *Int J Geriatr Psychiatry*. 2019;34:745–55.
  18. Sociedad Española de Psicogeriatría (SEPG). In: *Consenso Español sobre Demencias*; 2020. <https://www.sepg.es/consensosobredemencias>
  19. Development Group of the Clinical Practice Guideline on the comprehensive care of people with Alzheimer's disease and other dementias. Development Group of the Clinical Practice Guideline on the comprehensive care of people with Alzheimer's disease and other dementias. Quality Plan for the National Health System of the Ministry of Health, Social Policies and Equality. Agència d'Informació, Avaluació i Qualitat en Salut of Catalonia; 2010. *Clinical Practice Guidelines in the Spanish National Health Service: AIAQS No. 2009/07*.
  20. Mercier C, Rollason V, Eshmauey M, Mendes A, Frisoni GB. The treatment of behavioural and psychological symptoms in dementia: pragmatic recommendations. *Psychogeriatrics*. 2024;24:968–82.
  21. DGS - Direção Geral de Saúde (Portugal). Norma DGS 053/2011 de 21 de abril de 2023 (atualização 21/04/2023) – Abordagem Diagnóstica e Terapêutica do Doente com Défice Cognitivo ou Demência. [Internet]. Available from: <https://normas.dgs.min-saude.pt/2011/12/27/abordagem-terapeutica-das-alteracoes-cognitivas/>.
  22. Manthorpe J, Moniz-Cook E. *Timely psychosocial interventions in dementia care: evidence-based practice*. Jessica Kingsley Publishers; 2020.
  23. McDermott O, Charlesworth G, Hogervorst E, Stoner C, Moniz-Cook E, Spector A, et al. Psychosocial interventions for people with dementia: a synthesis of systematic reviews. *Aging Ment Health*. 2019;23:393–403, 288 p.
  24. Harris H, Barak Y. 'She is not my wife': a rare and complicated case of Capgras syndrome. *Psychogeriatrics*. 2022;22:879–81.
  25. Namasivayam AA, Fischer CE, Abler V, Creese B, Gastiazoro MP, Hermida AP, et al. Recommendations for management and future investigation of psychosis in neurodegenerative disease: findings from the International Psychogeriatric Association (IPA) working group. *Int Psychogeriatr*. 2025:100133.
  26. Livingston G, Sommerlad A, Orgeta V, Costafreda SG, Huntley J, Ames D, et al. Dementia prevention, intervention, and care. *Lancet*. 2017;390:2673–734.
  27. Dröes RM, Chattat R, Diaz A, Gove D, Graff M, Murphy K, et al. Social health and dementia: a European consensus on the operationalization of the concept and directions for research and practice. *Aging Ment Health*. 2017;21:4–17.
  28. Kitwood TM. *Dementia reconsidered, revisited: the person still comes first*. Open University Press; 1997.
  29. Adams T, Gardiner P. Communication and interaction within dementia care triads. *Dementia*. 2005;4:185–205.