

## The Art of Letting Go: Reflections on De-prescribing in Dementia Care

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### Key highlights

- De-prescribing can restore clarity and dignity in older adults.
- Behavioral symptoms in dementia often needs understanding, not medication.
- Sometimes the best dementia care is choosing not to add a pill.

### The Weight of the Prescription Pad

The longer I practise old age psychiatry, the more I realise that one of the most powerful therapeutic acts is not writing a prescription—but knowing when to stop one. We work in a time when treatment often means addition: more investigations, more medications, more layers of complexity. Yet, for the frail older person, each pill carries not just pharmacology but psychology, expectation, and risk.

In psychogeriatric practice, especially in dementia care, the line between help and harm is often wafer-thin. I often meet patients with long lists of medications—each started with good intentions but rarely revisited. The morning ritual of swallowing a handful of tablets becomes symbolic: a mix of dependence, compliance, and silent fatigue.

I recall Mr. A, a 76-year-old retired bank manager with Alzheimer’s disease, brought by his wife with complaints of increasing drowsiness, falls, and apathy. His prescription list had eleven medicines—three for blood pressure, two for diabetes, and the rest for sleep, mood, and “behavioral control.” When we reviewed his regimen, I realised he had been on an antipsychotic for two years for “restlessness” that had long settled. Gradually tapering and stopping it transformed his alertness and mobility within weeks. His wife said with quiet relief, “It feels like I’ve got him back.” Sometimes, medicine gives less by giving more.

### The Behavioral Labyrinth

BPSD—Behavioral and Psychological Symptoms of Dementia—remain one of the most distressing challenges in dementia care. Agitation, aggression, wandering, and hallucinations often push caregivers and clinicians to their limits. It is tempting, almost reflexive, to reach for a prescription pad. But as we know, these symptoms are rarely “purely psychiatric.” They are communications—of pain, boredom, fear, loneliness, unmet need.

Mrs. S, 81, with vascular dementia, was labeled “violent” in her nursing home after striking a caregiver. She was prescribed a cocktail of antipsychotics and benzodiazepines, leaving her

sedated and incontinent. On review, we discovered the trigger—her dentures were ill-fitting, and she was unable to express her discomfort. Replacing them and reducing her medication did more for her wellbeing than any tablet could.

Such stories repeat in different guises. An older man who shouts at night may be frightened by shadows or memories; a woman pacing constantly might be seeking her deceased husband; a resident refusing food might be reacting to a new caregiver or unrecognizable surroundings. These are behavioral “symptoms,” yes, but they are also narratives, and if we listen closely, they tell us what the person needs more than what disease they have.

### **The Gentle Act of Subtraction**

De-prescribing is not neglect—it is clinical compassion in action. It requires patience, dialogue, and courage. It begins with asking, *Does this medication still serve the person it was meant to help?* and *Are the benefits still outweighing the risks?*

I often describe the process to caregivers as “peeling an onion.” We remove one layer at a time—reassessing behavior, function, and mood as we go. The principle is to add non-drug strategies first, then reassess the need for medicines later.

Consider Mr. T, a 79-year-old with Lewy body dementia and fluctuating aggression. His son brought him saying, “Every doctor adds a pill, but he keeps getting worse.” We began with simple changes: regular sleep routine, scheduled activities, caregiver psychoeducation, and music therapy sessions. Over two months, we gradually stopped two sedatives and one mood stabilizer. The result was striking—less confusion, better mobility, and fewer hallucinations. His son remarked, “It’s not that you changed his medicine; you changed his rhythm.” That, in essence, is what de-prescribing does—it restores rhythm to a life disrupted by layers of interventions.

### **Beyond Pills: The Psychology of Healing**

Dementia care is relational, not transactional. Every prescription has an emotional footprint—for patients, families, and physicians. Often, our urge to prescribe comes from our discomfort with helplessness. We feel we must “do something.” Yet, sometimes the most therapeutic act is presence, reassurance, and supporting the caregiver to rediscover meaning in the chaos.

Socio-environmental interventions remain the first line for BPSD, though they are the least glamorous and most demanding. Structured routines, caregiver training, environmental modifications, music, touch, and reminiscence can transform behavior without pharmacological cost. These require time, empathy, and team coordination—resources that are harder to prescribe but infinitely more powerful.

In our overmedicalized systems, we risk forgetting that medications should complement, not replace, the human environment of care. Regular medication reviews, open caregiver

communication, and interdisciplinary teamwork are vital. De-prescribing is not the end of care; it is the recalibration of care toward what truly matters.

As geriatric psychiatrists, we are not just custodians of the mind, but curators of meaning. Every pill withdrawn thoughtfully is an act of respect—for autonomy, function, and dignity. Sometimes the best outcomes emerge not from what we add, but from what we allow to settle, simplify, and breathe.

**And perhaps that is the quiet paradox of modern dementia care: that the most powerful prescription we can offer is, at times, no prescription at all.**

### **Further reading**

1. Hung A, Kim YH, Pavon JM. Deprescribing in older adults with polypharmacy. *bmj*. 2024 May 7;385.
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3. Sawan MJ, Moga DC, Ma MJ, Ng JC, Johnell K, Gnjudic D. The value of deprescribing in older adults with dementia: a narrative review. *Expert review of clinical pharmacology*. 2021 Nov 2;14(11):1367-82.

### **Bio sketch**



Dr. Debanjan Banerjee is a consultant geriatric psychiatrist at Apollo Multispecialty Hospitals, Kolkata, with clinical and academic interests in dementia care, psychogeriatrics, and public mental health. A Fellow of the Indian Psychiatric Society and trained in sexual medicine, he has contributed to research on late-life mental illness, caregiver support, and ageing policy. He is a global advisor to the ASEM Global Ageing Center, Korea and has served on various advocacy committees, including the International Psychogeriatric Association. Dr. Banerjee is also an active mental health educator, speaker, and writer, working to bridge clinical practice, research, and community awareness.