

A Holistic Approach to the Management of a Medically Complex Geriatric Psychiatric Client Who is Refusing Medications: A Case Report

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ABSTRACT

In the United States, despite the Black Box Warning issued by the Food and Drug Administration (FDA), antipsychotic agents are commonly used among the geriatric psychiatric patient population. Cardiometabolic, Cerebrovascular, Drugs-Induced Parkinsonism (DIP), Tardive Dyskinesia (TD), and Neuroleptic Malignant Syndrome (NMS) are just a few of the more serious adverse effects of typical and atypical antipsychotic agents. Residents in nursing homes deserve to receive optimum psychiatric care with regard to their mental health. Fortunately, almost all of the nursing homes have abandoned the use of restraints. Unfortunately, psychotropic agents (i.e., anxiolytic, antidepressant, and antipsychotic agents) are often needed in nursing homes to manage acute psychosis or disruptive behaviors, such as agitation, aggression, restlessness, screaming, fidgeting, scratching, spitting, hitting, biting, pacing, wandering, refusing care and medications, etcetera.

Nursing homes are subject to meticulous oversight by the Centers for Medicare and Medicaid Services (CMS) and are assessed using a five-star rating system. To adhere to rigorous state and federal regulations and to avoid issues during the survey window, many facilities have strict policies of discontinuing almost all psychotropic agents as soon as a resident is admitted to a nursing home, putting clients at risk of harming self or others.

In general, nonpharmacological interventions should be implemented first, followed by psychotropic agents as adjunct therapy only. However, pressure from residents' families to "do something" and clinicians' internal urges to help residents suffering with psychopharmacological agents, especially during acute agitation, necessitate creative and holistic protocol and policy revisions to manage these residents with disruptive behaviors. We owe this vulnerable population a dignified and suitable environment (Milieu) in nursing homes.

Keywords

Geriatric Psychiatry, Psychosis, Agitation, Psychopharmacological agents, Refusing medications.

Background

Elderly patients admitted to nursing homes for long-term care are known as "residents." The definition of an older adult or elderly individual varies, but the National Institute on Aging describes older adults as people aged generally 65 or older [1]. There are

about 55.8 million people in the United States over the age of 65 [2] and about 1.3 million live in nursing homes [3].

Acute agitation is one of the most common reasons for prescribing psychotropic agents for the geriatric psychiatric patient population in nursing homes. Due to the commonly complex nature of health status and significantly fewer resources available in nursing homes, managing resident health care in the nursing home setting is truly a combination of art and science.

According to the FDA, the use of antipsychotic agents is not approved for dementia-related psychosis due to the increased risk of mortality in the elderly patient [4]. Nursing homes are exhaustively regulated by the CMS and due to stringent state and federal regulations, and to avoid issues during the survey period, most facilities have strict protocols to discontinue all psychotropic agents once a resident is admitted to the nursing home.

Despite the federally mandated Pre-Admission Screening and Resident Review (PASRR) program, some residents are being admitted from acute hospitals to the nursing home setting despite mental illnesses making them ill-suited for such a transfer. PASRR was designed to avoid this by requiring screening of all referrals with mental illness, intellectual disability, developmental disability, or related conditions prior to admission to a Medicaid-certified nursing facility. The goal was to identify the best alternative placement options and specialized services for that person. Providing clinical care in the nursing home to these residents can be challenging due to comorbidities and vulnerabilities to poor outcomes [5].

In either case, increasing rates of unhoused and elderly patients with mental illness and possible substance use disorder being admitted to nursing homes means the need for strategies to accommodate them. This case report explores the underlying cause of agitation or psychosis in the geriatric population and management options to improve clinical outcomes and decrease complications and mortality.

Case Presentation

This is a 68-year-old African American female with a medical history of well-controlled hypertension, hyperlipidemia, chronic kidney disease stage 3a, cerebrovascular accident (CVA), restless leg syndrome (RLS), and SARS-CoV-2 positive. She is also a long-term resident of a nursing home.

Her psychiatric history includes moderate neurocognitive disorder due to vascular disease with behavioral disturbances, severe anxiety, and obsessive-compulsive-disorder. The resident has no history of substance use disorder.

The nursing staff reported that she had lost approximately 20 pounds in 1 month and had recently developed a stage 4 pressure injury to the coccyx area, with 100% necrosis. Her vital signs were stable. Her current routine medications include Aspirin, amlodipine, pravastatin, gabapentin, and ropinirole. Cephalexin and alprazolam were added recently by her previous provider due to acute changes in her condition.

For the past few days, the nursing staff noted increased “agitation” and a new onset of “psychosis.” The nursing home staff have been unable to redirect her. The resident was recently transferred to our medical group, as per family request, due to a change in her insurance carrier and the author was called to evaluate and treat the resident for the first time.

Mental Status Examination [MSE]

- **Appearance:** A 68-year-old African American female lying in bed, wearing a hospital gown, makes poor eye contact, looks older than stated age, obese.
- **Behavior (psychomotor):** Appears to be suspicious and in pain (striking out, uncontrollable yelling out, intermittently moaning in pain, getting agitated, fidgety, and restless). No extrapyramidal symptoms present.
- **Speech and Language:** Rate is slow, flow is delayed, with soft intensity. Poor comprehension.
- **Mood and Affect (emotions):** Mood is “tired”, and affect is constricted. Mood is congruent with affect.
- **Thought Process:** Incoherent; illogical; looseness of association (irrelevance), with some thought blocking.
- **Thought Content:** (sensorium): Noted to be internally distracted, takes a long time to respond and exhibits thought blocking. She scans the room slowly, indicating some paranoia. She is quite guarded and concise in her responses. She is also experiencing visual hallucinations (reporting demons in the room) and drew some pictures of a demon. Denies any command hallucination, no thoughts of harming self or others. Later, she made some delusional statements. While yelling out, stated “They are trying to poison me.” As such, she has been refusing care and most of her meals and all of her medications, thus putting herself in danger.
- **Cognition:**
 - Orientation: Alert and oriented x 2 (person and place) and disoriented to time and situation. She knows she is in a nursing home, but cannot recall the name of nursing home.
 - Concentration: poor, unable to list months of year backwards, spelling for backward, or serial sevens.
 - Memory: check *remote memory*: poor. Unable to list year of high school graduation or city of birth. *Recent memory*: Poor. Unable to recall what she ate this morning, or capital city of California.
 - Abstract: poor concrete thinking.
 - Constructional and Visuospatial ability: poor, unable to draw a clock showing 10 past 10.
 - Intellectual Process: below average (estimate intelligence quotient based on the interview).
- **Insight and Judgment:** Poor. Demonstrates poor understanding of illness or symptoms and impact on her activities of daily living (ADLs).

Treatment: A Holistic Care Plan

Of note, during this time, the incidence of Coronavirus disease-2019 (COVID-19) in the community was significantly higher and the families were not allowed to visit, per local health department guidelines. Her Physician Orders for Life-Sustaining Treatment (POLST) form in the chart indicated a “Full Treatment,” meaning prolonging life by all medically effective means, signed by the resident a year prior to this stroke.

Considering, the resident was not at her baseline, and she clearly was unable to make medical decisions, permission was obtained

from the administration for her family to come to the facility to discuss further options. The first option was to transfer her to the emergency department (ED) for further evaluation; however, the family was adamantly opposed due to high exposure to COVID-19 in the hospital. The local hospital had also issued a memo to keep the residents in the nursing home as long as it was appropriate to do so. We discussed several other options, such as initiating aggressive treatment, managing her symptoms, keeping her comfortable, hospice evaluation, etc. The final decision was to initiate care at the nursing home and to monitor her closely for the following 24-48 hours for possible transfer to the ED if symptoms worsened.

The following holistic care plan was developed and implemented while maintaining patient's rights and dignity:

- She had no history of psychosis; therefore, a complete work-up (complete blood count with differentials, comprehensive metabolic profile, thyroid panel, urinary analysis with culture, and sensitivity if indicated), and EKG were ordered.
- She was refusing oral hydration, meals, and medications; therefore, an intravenous (IV) line was started to give her a bolus of normal saline (NS).
- She was clearly in acute distress, unable to redirect, and refusing care. The family requested to keep her comfortable, so to improve symptoms and compliance, she was started on a low dose of olanzapine (Zyprexa) 2.5 mg intramuscular (IM) injection daily for 5 days due to unspecified psychosis, as manifested by paranoid delusional accusation and visual hallucination, refusing meals, medications, and putting herself at risk of harm.
- She was started on lorazepam (Ativan) 0.5 mg sublingual every 8 hours, as needed (Pro Re Nata- PRN) for 14 days for acute distress due to severe anxiety, agitation, and putting herself at risk of harm.
- She was refusing any medication by mouth and was in acute pain from a wound to her coccyx; therefore, her routine tramadol was discontinued and replaced with morphine sulfate 5 mg sublingual every 8 hours PRN for pain for 14 days.
- For the management of a pressure injury to her coccyx area, PO cephalexin was replaced with IV Clindamycin. After several attempts, an IV was started and the resident must have received about 75 mL of NS when she pulled her IV out. Though we anticipated that the resident might pull out the IV line, we decided not to restrain her to avoid further aggravation. The family neither wanted to restart the IV nor wanted to transfer her to the ED. The decision was made to discontinue IV and switch her antibiotics to intramuscular (IM) ceftriaxone and dilute with lidocaine to minimize discomfort.
- An on-site X-ray of the coccyx showed no evidence of acute osteomyelitis. Ideally, a magnetic resonance imaging (MRI) should be ordered; however, it was not a practical option for this nursing home resident, especially during the COVID-19 pandemic. As such, an X-ray was made to determine evidence of osteomyelitis.
- Because her repeat CBC showed only mild leukocytosis

(11500 per microliter), she remained afebrile, and had stable vital signs, she did not meet Systemic Inflammatory Response Syndrome (SIRS) criteria. Antibiotics were discontinued at this time.

- After a few days, a telehealth consultation with a wound specialist was arranged and since the pressure injury appeared healthy and noninfected, no indication was made for debridement.
- Ropinirole for RLS was discontinued due to being a dopamine agonist, most likely causing a change in her behavior (hallucination and delusions).
- All other routine oral medications were placed on hold.

Discussion

Currently, all available antipsychotic agents carry a black box warning for increased risk of mortality in elderly patients for dementia-related psychosis [4]. Sedation, weight gain, cardiometabolic, cerebrovascular, Drug-Induced Parkinsonism (DIP), Tardive Dyskinesia (TD), and Neuroleptic malignant syndrome (NMS) are just some of the serious adverse effects of typical and atypical antipsychotic agents [6]. Even though every effort is made to avoid antipsychotic agents, off-label use of antipsychotics sometimes becomes necessary.

Most of the guidelines for chronic disorders or issues, such as hypertension and diabetes, are developed in community-based populations, causing confusion in nursing homes among clinicians and state surveyors. For example, a client in the community is often prescribed a low dose of quetiapine for generalized anxiety or insomnia. However, due to strict CMS regulations (rightfully so), facility staff and the state surveyors expect these medications to be discontinued as soon as a resident is admitted to the nursing home. Even though the intention is good, it often forces providers to discontinue drugs, putting clients in danger when their symptoms return with greater severity. The rate of urgency to discontinue the medication can negatively impact the resident's ADLs, especially if they were on these medications for a longer time or when limited psychiatric history is available upon admission to make appropriate medication adjustments. This can harm the resident and lead to further state or federal survey problems [7].

A provider should always make decisions with one major principle in mind: "do no harm." This means to first refrain from doing any harm before attempting any good. Every effort should be made to find out or rule out the differential or underlying causes of behavior changes [8].

In this case, a complete work-up was ordered to rule out dehydration, renal failure, infection, or any other physical cause of psychosis. Her laboratory findings were unremarkable. However, we decided to discontinue her use of ropinirole for RLS due to its high affinity for dopamine (D2 and D3) receptors, resulting in either causing or worsening symptoms of psychosis [9].

The team decided to start her on a low dose second-generation

antipsychotic agent (such as olanzapine) instead of a first-generation antipsychotic agent (such as haloperidol). Olanzapine has both Serotonin 2A (5-HT_{2A}) and dopamine (D₂) receptor antagonist properties [6]. According to Malone and Hollier [8], olanzapine is recommended for elderly clients due to its better tolerance, greater efficacy, and safer adverse-side effect profile, as compared to other first and second-generation antipsychotic agents. The intramuscular, versus oral, route was selected because the resident had been refusing all drugs by mouth. The side effects and benefits were discussed with the family, and they agreed that the benefits of starting and continuing the psychotropic agent outweighed the risk. Without this medication regimen, there would be an increased risk of decompensation, self-harm, or harm to others. Another option is an orally disintegrating tablet (ODT) such as Zyprexa Zydis or asenapine (Saphris), which comes as a sublingual tablet; however, this approach is appropriate only for clients who can follow instructions and accept oral medication. As such, this resident was not a good candidate.

It is worth mentioning that use of long-acting injectable (LAI) antipsychotic agents should be avoided in the elderly unless a specific diagnosis (such as schizophrenia or bipolar) has been made and the client has a successful record of tolerating oral agents [10]. Another option is brexpiprazole (Rexulti), which is approved by the FDA for dementia-associated agitation with Alzheimer's disease; however, this medication is expensive and often not covered by health insurance carriers, resulting in high costs for the facility, making this option unattractive in the nursing home setting.

APA guidelines call for providers to review all other medications and drug-to-drug interactions prior to initiating medications. For example, the combination of olanzapine and tramadol can decrease the seizure threshold. So, it was a good idea to discontinue tramadol and start morphine. Another reason to switch from tramadol to morphine was to change the route from mouth to sublingual. However, the risk of sedation remained high. One mitigation to this risk is to prescribe the analgesic PRN instead of routine basis and have the nursing staff carefully assess the resident prior to administering each dose of PRN analgesic.

Outcomes and Follow up

The resident received a total of four doses of olanzapine. Her overall symptoms of psychosis improved in 1 week. She became compliant with care and all previous orally administered medications were resumed and psychotropic injections were discontinued. Anxiolytic and analgesic were continued every 8 hours for another month and were slowly tapered off over 6 weeks. She started drinking, eating some soft food, sleeping, and most importantly, smiling again!

Most acute episodes of agitation in a newly admitted resident improve without medications once the underlying cause is addressed and the resident becomes familiar with the staff. For a complex nursing home resident who is declining, every effort

should be made to assess them face-to-face, and the family should be invited to visit to obtain a clear picture of their loved ones and assist with developing an individualized care plan. For example, her POLST form indicated "FULL CODE." Considering the resident was a 68-year-old with comorbidities and severe decline, one reasonable option was to arrange a consultation with the palliative team to keep her comfortable. However, her family was interested only in more aggressive treatment at the nursing home. Transparency is vital when communicating with residents and their families regarding prognoses, to avoid any surprises. Here is one quick way to assess such a situation: Ask yourself this, "As a provider, will I be surprised if my patient dies within a week/month?" If the answer is no, then make sure their family is not surprised either!

Learning Points: Author's Recommendations for Practice

There is no consensus on the "ideal" psychotropic agent for the geriatric client. To provide safe resident care and avoid unnecessary deficiencies (such as F-758 citations) during state survey, the author highly recommends the following 13 steps:

1. Nursing home facilities should form a "psychotropic committee." Its members should include any of the following: (a) a social worker; (b) activities director; (c) dietary director; (d) registered dietician; (e) director of rehabilitation; (f) director of nursing; (g) nursing student (if applicable); (h) pharmacist, (i) a healthcare provider (either Doctor of Medicine [MD]; or Doctor of Osteopathic Medicine [DO]); or a board certified advanced practitioner, such as a nurse practitioner (NP); or psychiatric mental health nurse practitioner (PMHNP); or physician assistant (PA); etc. Either the social worker or provider should chair the committee.
2. The committee should meet weekly to review residents who have been "triggered" on the 24-hour clinical report. The committee should assess the residents and compare new changes in behavior and identify their underlying causes by reviewing labs, medication history, family history, etc.
3. The medical team should consult with the psychiatric team (either psychiatrist, psychiatric mental health nurse practitioner, or psychologist) to evaluate and treat these residents appropriately and become part of this committee to address medical and psychiatric issues collaboratively by following the practice parameters set by the American Psychiatric Association.
4. An individualized nonpharmacological intervention should always be attempted first, with exceptions made for the resident who presents with an emergency/urgent psychiatric illness.
5. Justify that any medication is being prescribed to "manage symptoms(s)," not to "control behaviors(s)." Document a clear indication for the drug prescribed. It is best practice to refer to the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association (APA) and document specifically what behavioral symptoms should be monitored

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- by the facility staff.
6. Obtain consent from the patient or responsible party before starting any psychotropic agent.
 7. Always initiate a low dose first and titrate slowly if justified due to age-related changes in pharmacokinetics and pharmacodynamics.
 8. A second-generation antipsychotic agent (such as olanzapine, risperidone, or aripiprazole) should be considered due to its lower adverse-side effect profile instead of a first-generation antipsychotic (such as haloperidol).
 9. Strive to avoid polypharmacy; utilize lowest dosages whenever possible; attempt fewer medications first; evaluate metabolic profile through the blood work; and review electrocardiograms (EKG) for QTc prolongation, torsades de pointes, or any electrophysiological cardiac abnormalities, as needed.
 10. In general, antipsychotics should not be used as a PRN basis, and if usage is unavoidable, all PRN medications must have an initial end date of up to 14-days or fewer.
 11. The provider must reevaluate the resident to justify extending the drugs beyond the initial 14-days.
 12. If appropriate, attempt a gradual dose reduction (GDR) and eventually taper off to discontinue. If symptoms worsen after the GDR, the provider may return to the previous dose and document it as a “failed GDR attempt.” Another way to achieve a GDR is to perform a thorough chart review upon admission. For instance, if the resident was taking a psychotropic agent as an outpatient and the medication was held at the acute hospital and the medication was restarted right before discharge to the nursing home because the symptoms worsened, the provider may indicate this as a failed GDR.
 13. Committee discussions should enter the resident healthcare record and be presented to the state surveyors. The committee should endeavor to
 - a. identify and monitor symptoms or behaviors with a standardized method. E.g., some facilities use a 0-1 scale by documenting any behavior present or not during the entire shift (Yes = 1, No = 0). Some facilities might capture each episode of behavior present during the shift (using a scale of 0-100). Either way, the nursing staff must be familiar with the correct coding to avoid incorrectly documenting a “Yes” for just one behavior, when multiple behaviors were present during the entire shift.
 - b. identify and implement nonpharmacological interventions prior to initiating any psychotropic agents. E.g., before starting mirtazapine for weight loss due to major depression disorder, an interdisciplinary team (IDT) should consider nonpharmacological interventions, such as involving family to bring homemade food, setup a food delivery application account (such as Doordash or Uber Eats), social media account, therapeutic leave for a few hours, video or audiotapes of family members, music therapy, pet therapy, etc.
 - c. identify and implement strategies to reduce the use of antipsychotic agents by keeping person-centered care

practices. Psychotropic agents can cause sedation and hypotension, especially when combined with analgesics, potentially causing falls. As such, nursing staff should receive in-service to emphasize assessing a resident once medication is administered for oversedation, orthostatic hypotension, or unstable gait. An IDT should assess for serious adverse effects, such as tardive dyskinesia, using a standardized assessment instrument, such as the Abnormal Involuntary Movement Scale (AIMS) prior to initiating the drug and at least quarterly thereafter, or sooner as indicated.

- d. implement policies for ongoing staff education on prevention of behavior disturbances, such as creating a calm environment, removing triggers, therapeutic communication skills, assessing for Maslow’s hierarchy of needs, use of less invasive interventions, etc. This should generally reduce the use of antipsychotic agents in the nursing home.

Patient and Family Perspective

For the patient and her family, living with these health issues felt like a “rollercoaster ride.” Watching their mother, who was once so full of life, lose her independence was deeply heartbreaking. Her son stated that overall decline; the development of a pressure injury; and her refusal to take medication, or eat, and eventually her weight loss; left the family feeling helpless. They worried about her safety and well-being, especially during the frequent changes in her mental state, which were overwhelming to cope with. Yet, they also recognized that aggressive treatments, especially during the COVID-19 pandemic, could expose her to even more risks in the hospital. They appreciated the care team’s efforts to honor her dignity, while managing her pain and agitation.

Another family member stated that the creativity of the staff in designing the “tailored care plan” and involving the family in decision-making meant “the world” to them, even when those choices were tough. It was hard to know what was best, but they knew that they just wanted their mother to be comfortable above all else.

In general, resilience is a good indicator and predictor of general wellbeing [11]. The author saw resilience in this elderly resident when her family would come to see her. She would take the medication and take some bites of home-cooked food. However, in a few weeks, the facility had to reestablish the strict COVID-19 regulations of no visitors and no food from home, etc., and the client’s room door had to be closed! As such, the client experienced a noticeable decline in health status. This author’s recommendation during such difficult times is to think outside the box, be creative, utilize resources, consult with and request other specialists to come to the facility or evaluate via telehealth to minimize pain and suffering. Set up contracted telehealth services with local providers who can administer excellent, compassionate, and holistic care to nonmobile residents, especially those with mental illness.

Summary

The experience gained during the COVID-19 pandemic can be effectively applied in the post-COVID era to drive positive outcomes. This complex medical case offers several takeaways. A low dose of a second antipsychotic agent can be safely used to obtain a favorable outcome. When a shared decision to use an antipsychotic agent is made, the drug should be used judiciously and with close monitoring, and the IDT should meet more frequently to decrease the dose and treatment duration. In general, all clients can rightfully refuse a medication without giving any valid reasons. However, if the client is unable to make medical decisions and refusing a medication puts their life in danger or causes grave disability, the reasons for refusal should be explored diligently. A person who is responsible for making decisions on their behalf (family, caretaker, etc.) should be contacted and options should be explored. In this case, medications administered by mouth were replaced with sublingual drops (morphine for pain management) or intramuscular injections (antipsychotic and antibiotics). Once the condition stabilized, the resident became compliant with the medications and all previously orally administered medications were restarted and psychotropic injections were discontinued. As a matter of fact, the resident began requesting snacks and analgesics, as needed.

Limitations

This case report represented just one example of the increasingly numerous nursing home residents with mental health illnesses who require a holistic approach to a complex clinical profile. Further studies should explore various options and establish standardized care recommendations for this geriatric psychiatric patient population.

Another significant limitation is the facility's culture and staffing challenges. While some facilities are well-staffed, others face ongoing struggles in meeting patient care demands. Compared to the hospital setting, the resident-to-nurse ratio in nursing homes is significantly higher, even though some nursing home residents can be just as complex—if not more so—than some hospital patients.

Due to these challenges and strict state and federal regulations, nursing staff frequently feel overwhelmed managing complex residents and often lack adequate ongoing training and support. As a result, they may find it safer to transfer residents to the hospital,

especially during late evenings or nights when administrative staff are unavailable.

To address this issue, the author strongly recommends that facility administrators implement ongoing training, improve staffing ratios, and strengthen support systems to create and promote a safer and more sustainable environment for nurses and residents.

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