

Anxiety in Dementia: Symptoms, Causes & Treatment

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Introduction to Anxiety in the Context of Dementia

Anxiety represents one of the most pervasive and distressing Behavioral and Psychological Symptoms of Dementia (BPSD), affecting a significant proportion of individuals living with cognitive impairment. While often overshadowed by more overt symptoms such as agitation or aggression, anxiety contributes substantially to suffering, functional decline, and caregiver burden. It is crucial to understand that anxiety in dementia is not merely an exacerbation of pre-existing Generalized Anxiety Disorder (GAD); rather, it is frequently a direct consequence of neurodegenerative changes, coupled with the psychological distress arising from the increasing awareness of cognitive deficits and the resulting loss of autonomy. This complex interaction necessitates a nuanced approach to definition and clinical assessment, recognizing that the ability to articulate subjective feelings of worry or dread diminishes as the disease progresses, leading to expression through behavioral proxies.

The experience of anxiety in a person with dementia is fundamentally linked to the erosion of executive functions and memory processing. The inability to recall recent events, maintain a coherent narrative, or rationally assess a perceived threat creates a constant state of uncertainty and disorientation. For instance, a person who cannot recall the location of their loved ones or cannot understand the immediate environment may experience profound terror, which manifests as persistent restlessness or repetitive questioning. Untreated, chronic anxiety accelerates cognitive decline, compromises the immune system, and significantly increases resistance to essential care activities, such as bathing, dressing, and feeding, thereby increasing the risk of negative health outcomes and exacerbating the overall trajectory of the illness.

Diagnosing anxiety in this population is complicated by the very nature of the disease, particularly in moderate to severe stages where language centers are compromised. Standardized self-report measures become unreliable, forcing clinicians and caregivers to rely on observational data. This shift requires specialized training to differentiate anxiety from other similar BPSDs, such as depression, apathy, or purely motor restlessness (akathisia). The initial presentation of anxiety may involve subtle cues--clutching, avoidance, rapid changes in demeanor, or heightened startle responses--which, if misinterpreted or dismissed, can escalate into more severe behavioral disturbances, highlighting the critical need for early and accurate identification.

Prevalence and Clinical Significance

Studies on the prevalence of anxiety in dementia vary significantly depending on the diagnostic criteria used, the stage of dementia assessed, and the specific population studied, but estimates generally range from 20% to over 50% across different dementia subtypes. Anxiety tends to be particularly prominent in the early stages of Alzheimer's disease (AD) and in certain types of vascular dementia, where insight into cognitive losses may be relatively preserved, leading to

"catastrophic reactions" when confronted with failure. The prevalence often decreases in the very late stages of the disease, though the underlying distress may simply become internalized or masked by severe apathy or profound cognitive flattening. Regardless of the exact percentage, anxiety represents one of the most frequently reported non-cognitive symptoms, making its management central to quality of life.

The clinical significance of anxiety extends far beyond momentary distress; it acts as a powerful negative predictor for several critical outcomes. Research consistently demonstrates that the presence of persistent anxiety is associated with faster rates of functional decline, earlier progression to severe cognitive impairment, and a significantly increased likelihood of institutionalization. Moreover, anxiety rarely occurs in isolation; it frequently co-occurs with depression, sleep disturbances, and agitation, creating a cascade effect that complicates overall management. When anxiety drives avoidance behaviors, the individual may refuse necessary medical appointments, medication intake, or physical therapy, thereby undermining overall health maintenance and increasing morbidity.

Understanding the cyclical relationship between anxiety and cognitive function is essential for effective intervention. As cognitive reserve diminishes, the individual relies less on rational coping mechanisms and more on emotional responses, making them highly susceptible to environmental triggers. This heightened emotional reactivity, often termed "limbic irritability," means that minor stressors--a sudden noise, a change in caregiver, or a confusing instruction--can immediately trigger intense anxiety. This constant state of hyperarousal is physiologically taxing, contributing to chronic stress, elevated cortisol levels, and potentially accelerating neurodegenerative processes, establishing a vicious cycle where anxiety fuels decline and decline fuels further anxiety.

Clinical Manifestations and Behavioral Presentation

Because verbal reporting of internal states becomes unreliable in dementia, clinicians must learn to recognize the often-subtle behavioral proxies for anxiety. These manifestations are diverse and can mimic other BPSDs, requiring careful observation over time. Common physical signs include increased motor restlessness, such as pacing, fidgeting, or persistent shuffling; autonomic symptoms like sweating, trembling, or rapid breathing; and gastrointestinal distress. Behavioral manifestations often involve repetitive actions, such as asking the same question repeatedly ("When are we going home?"), seeking constant reassurance, or exhibiting "shadowing," where the individual follows the primary caregiver everywhere due to profound fear of abandonment or being lost.

It is helpful to categorize the presentation into generalized anxiety versus situation-specific anxiety. **Generalized anxiety** in dementia often presents as chronic vigilance, a pervasive sense of uneasiness, and hypervigilance to the environment. The person may appear tense, unable to relax,

and easily startled. **Situation-specific anxiety**, conversely, is triggered by particular circumstances, often those involving sensory overload, loss of privacy, or perceived threat to safety. A classic example is "sundowning," where increased confusion and anxiety occur in the late afternoon and evening, possibly due to shifting light levels, fatigue, or disruption of the circadian rhythm, leading to increased fear and agitation during that period.

One particularly challenging manifestation is the catastrophic reaction. This occurs when an individual with dementia, faced with a task or situation that exceeds their compromised cognitive capacity, responds with an overwhelming, disproportionate emotional outburst of panic, fear, or rage. This is not defiance, but a genuine expression of terror and frustration stemming from the sudden realization of their deficits. Furthermore, anxiety can present as avoidance behaviors, particularly resistance to personal care. The person may fear the water (hydrophobia), the cold, or the perceived invasion of privacy during bathing or dressing. Understanding that this resistance is driven by fear, not malice, is fundamental to applying person-centered care strategies.

Etiological and Contributing Factors

The etiology of anxiety in dementia is multifactorial, encompassing biological, psychological, and environmental components. On a biological level, neurodegenerative changes directly impact the brain regions responsible for emotional regulation, particularly the amygdala, which plays a central role in processing fear and anxiety. Atrophy or dysfunction in the prefrontal cortex compromises the ability to modulate or inhibit these emotional responses. Furthermore, imbalances in neurotransmitter systems, especially those involving gamma-aminobutyric acid (GABA), serotonin, and norepinephrine, contribute to heightened arousal and decreased emotional stability, mirroring mechanisms seen in primary anxiety disorders.

Psychological factors are profoundly significant, particularly in the earlier stages of dementia where metacognition remains partially intact. The awareness of progressive cognitive failure--the realization that one is forgetting names, losing objects, or struggling with simple tasks--is a potent source of existential anxiety, fear of the future, and intense feelings of helplessness. This self-awareness contributes to defensive behaviors, denial, or withdrawal. Furthermore, misinterpretation of sensory input due to visual or auditory processing deficits can lead to paranoid ideation or pseudo-hallucinations, where benign shadows or noises are perceived as threats, triggering acute episodes of panic and fear.

Environmental factors often serve as the immediate triggers for underlying vulnerability. A chaotic, noisy, or rapidly changing environment can overwhelm the diminished processing capacity of a person with dementia. Factors that contribute to heightened anxiety include:

Lack of Routine: Unpredictable schedules increase confusion and perceived loss of control.

Sensory Overload: Loud televisions, crowded rooms, or bright, flickering lights.

Unfamiliar Settings: Hospital rooms, new care facilities, or even rearranged furniture in the home.
Caregiver Communication: Rushed, demanding, or critical tone of voice, or the use of complex, multi-step instructions that the person cannot process.

Addressing these external variables is often the most immediate and effective way to mitigate anxiety symptoms.

Challenges in Assessment and Differential Diagnosis

The reliable assessment of anxiety in dementia is one of the most significant clinical challenges, primarily due to the limitations of self-report measures. Standard tools designed for non-demented populations, such as the Hamilton Anxiety Rating Scale (HARS) or the GAD-7, rely on the patient's ability to introspect and articulate their internal state, a capacity often lost early in the dementia trajectory. Consequently, specialized instruments have been developed that focus on observable behaviors, such as the **Rating Anxiety in Dementia Scale (RAID)** or the Neuropsychiatric Inventory (NPI), which includes an anxiety domain scored based on caregiver observation.

A crucial aspect of assessment involves differentiating anxiety from other overlapping conditions. Anxiety must be carefully distinguished from:

Agitation: While agitation is often driven by underlying anxiety, it is characterized by excessive motor activity and verbal aggression, whereas anxiety can be internal (worry) or expressed through passive behaviors (withdrawal).

Depression: Both conditions involve distress and withdrawal, but anxiety typically involves hyperarousal, tension, and fear, while depression involves pervasive sadness, anhedonia, and vegetative symptoms.

Psychosis: Paranoia and delusional thinking can cause fear, but if the fear is tied to a fixed, false belief (e.g., "They are stealing my money"), the primary diagnosis is psychosis, even though the emotional response is anxiety.

Pain or Physical Illness: Undiagnosed pain, urinary tract infections, dehydration, or medication side effects can manifest as acute confusion, restlessness, and distress, which are easily mislabeled as anxiety.

Therefore, a comprehensive assessment must always include a thorough medical workup to rule out treatable physical causes. This medical check should be followed by a detailed behavioral analysis, focusing on the ABCs (Antecedent, Behavior, Consequence) of the anxious episode. Identifying the specific environmental triggers (antecedents) allows clinicians to develop targeted, non-pharmacological interventions rather than relying solely on medication, ensuring that the treatment addresses the root cause of the distress.

Non-Pharmacological Management Strategies

Non-pharmacological strategies are considered the first line of defense for managing anxiety in dementia, emphasizing the principles of **Person-Centered Care (PCC)**. The primary goal is to create an environment that minimizes confusion and maximizes comfort and predictability. This involves simplifying the environment, reducing clutter, minimizing noise levels, and establishing highly consistent daily routines to reduce uncertainty, which is a major driver of anxiety. Consistent assignment of caregivers is also vital, as familiarity fosters trust and reduces the fear associated with interacting with strangers.

Behavioral interventions aim to soothe distress and redirect anxious energy into meaningful activities. Techniques proven effective include:

Validation Therapy: Acknowledging and affirming the person's expressed emotion or reality, rather than correcting their misperception (e.g., if they are anxious about "going home," validating the feeling of wanting safety, rather than insisting they are already home).

Reminiscence Therapy: Using life story materials, photos, or familiar music to anchor the individual in positive memories, reducing current anxiety.

Sensory Modulation: Providing calming sensory input, such as weighted blankets, gentle massage, aromatherapy (e.g., lavender), or listening to preferred music, which can regulate the overactive nervous system.

These interventions succeed because they focus on the individual's remaining strengths and preferences, restoring a sense of control and dignity.

When anxiety manifests as repetitive questioning or pacing, redirection and distraction are powerful tools. Instead of directly addressing the anxiety, the caregiver shifts the focus to a simple, engaging task. For example, if a person is anxious about being "left alone," offering a task like folding laundry or sorting cards provides a purposeful activity that occupies the mind and hands, successfully redirecting the anxious energy. The effectiveness of these non-drug approaches is maximized when the care team is highly trained in identifying the specific trigger and responding consistently and calmly, thereby preventing the escalation of mild anxiety into acute distress.

Pharmacological Interventions

Pharmacological management is generally reserved for severe anxiety that is persistent, refractory to non-drug interventions, or poses a significant risk to the patient or others. Due to the altered metabolism and heightened sensitivity of the aging brain, medication must be initiated at the lowest possible dose and titrated slowly, with careful monitoring for adverse effects. The most commonly utilized first-line agents are the **Selective Serotonin Reuptake Inhibitors (SSRIs)**, such as citalopram or sertraline, which are effective in treating co-morbid depression and chronic

generalized anxiety. However, clinicians must recognize that the therapeutic effect of SSRIs may take several weeks to materialize, requiring patience and continued non-pharmacological support during the interim.

The use of benzodiazepines (e.g., lorazepam, alprazolam) requires extreme caution in the dementia population. While highly effective for acute panic and severe, time-limited anxiety, their long-term use is associated with significant risks, including increased sedation, impaired balance leading to a higher risk of falls and fractures, and potential for paradoxical agitation (where the drug causes restlessness instead of calm). Crucially, prolonged use of benzodiazepines has been linked to accelerated cognitive decline and dependence, making them generally inappropriate for chronic anxiety management in dementia unless all other options have failed or in situations requiring immediate crisis intervention.

In cases where anxiety is intertwined with severe agitation or psychotic symptoms, atypical antipsychotics may be utilized off-label, though this practice is heavily regulated and discouraged due to significant safety concerns. Regulatory bodies have issued black box warnings regarding the increased risk of mortality, primarily related to cardiovascular events and stroke, when these agents are used for BPSDs in the elderly. Therefore, any decision to initiate antipsychotic medication must involve a rigorous risk-benefit analysis, ensuring that the severity of the anxiety-driven behavior substantially outweighs the inherent pharmacological risks.

Impact on Caregivers and Quality of Life

The persistent anxiety experienced by individuals with dementia places an immense and often unsustainable strain on informal caregivers. Behaviors such as constant questioning, shadowing, refusal of care, and nighttime restlessness directly contribute to caregiver burden, leading to high rates of burnout, depression, and physical health decline among family members. The emotional labor involved in constantly managing another person's intense fear and distress erodes the caregiver's own psychological resources, often leading to resentment or withdrawal, which further destabilizes the care environment and exacerbates the patient's anxiety.

For the person living with dementia, chronic anxiety severely diminishes their overall quality of life (QoL). Anxiety restricts engagement in leisure activities, limits social participation, and prevents the enjoyment of simple pleasures. Even if the individual loses the cognitive capacity to articulate their fear, the physiological and emotional experience of distress remains real and profoundly negative. This suffering is reflected in reduced appetite, poor sleep quality, and a general loss of functional independence, meaning that effective anxiety management is synonymous with QoL improvement.

Supporting the care partner is therefore an indirect but critical component of managing the patient's anxiety. Caregiver interventions--including education on the disease process, training in non-pharmacological techniques, and access to respite care and support groups--are essential. When

caregivers feel competent and supported, they are better able to maintain a calm, consistent, and patient demeanor, which directly reduces the environmental triggers that fuel the patient's anxiety, establishing a positive feedback loop that benefits both parties and promotes sustained care in the home setting.

Conclusion and Future Research Directions

Anxiety in dementia is a complex, pervasive, and highly impactful symptom rooted in the confluence of neurobiological changes, psychological awareness of loss, and environmental stressors. Its accurate identification requires specialized observational tools, moving beyond reliance on verbal self-report. Effective management necessitates a highly integrated approach, prioritizing environmental modification and person-centered non-pharmacological interventions, with pharmacological agents reserved for severe, refractory cases and utilized with extreme caution due to associated risks in this vulnerable population.

Future research must focus on several key areas to improve outcomes. There is a pressing need for the development of objective, non-verbal biomarkers for anxiety in dementia, potentially utilizing physiological measures (e.g., heart rate variability, skin conductance) to quantify distress independent of verbal communication. Furthermore, research should target the efficacy of specific, tailored non-pharmacological therapies, such as customized digital cognitive behavioral therapy adaptations or virtual reality interventions designed to provide calming, familiar environments. Ultimately, improving the recognition and management of anxiety is central to alleviating the profound suffering associated with dementia and enhancing the quality of life for both the individual and their care partners.