The University of Iowa | Iowa Geriatric Education Center

INFO-CONNECT

Disruptive Vocalizations

The Facts . . .

⇒ *Disruptive vocalization (DV) is a common problem among cognitively impaired older adults.*

⇒ *DV is common in long-term care settings, affecting as many as 10 to 30% of nursing home residents.*

⇒ *Adverse effects of DV can be huge - frustration for staff, irritability among other residents, retaliation toward the vocalizer, and stress for everyone involved.*

⇒ *Assessment of DV as a Need-Driven Dementia-Compromised Behavior (NDB) is the key to effective intervention.*

What is DV?

The term Disruptive Vocalization (DV) is used to describe verbal utterances that are:

- Excessively loud and/or repetitive in nature.
- Socially inappropriate due to the intensity, frequency, duration and/or setting in which they occur.
- Both distressed sounding and distressing to hear.
- The result of some form of brain injury, often severe dementia.
- Often indicative of unmet physical, psychological or social needs *or* a reaction to physical or environmental stress.

Also known as:

- Problematic vocalization
- Verbally agitated behavior
- Vocally disruptive behavior
- Aggressive vocalization
- Noisy behavior

Who exhibits this behavior?

The frequency, duration and intensity of the DV vary substantially:

- THE MAJORITY OF PERSONS WITH DV:
  - ⇒ Are vocally active for short, discrete periods of time, often in response to clearly identifiable stimuli.
  - ⇒ Exhibit behavior that is manageable.
- A SMALL MINORITY OF RESIDENTS WITH DV:
  - ⇒ Engage in DV without obvious provocation for many hours a day.
  - ⇒ Are called *Severe Disruptive Vocalizers*.

The greatest management problems are not the rare DVs of the many,

but the frequent DVs of the few.

Both types of behavior deserve assessment and intervention.

Why focus on DV?

Some believe DV is the most frequent, persistent and annoying of all dementia-related behaviors.

The adverse impact of DV can be huge, leading to:

- Frustration and distraction for staff;
- Anxiety and agitation for other residents;
- Retaliation toward or isolation of the person who vocalizes; and
- Increased stress for everyone involved.

In short, DV deserves our attention!

Types of DV:

- Includes a wide range of verbal expressions, ranging from the fluent use of words to repetition of nonsensical sounds.
- Can be roughly grouped into verbalization that is considered AGGRESSIVE or AGITATED as outlined below.

Verbally Aggressive Behaviors

The following are characteristics of verbally aggressive behaviors:

- Tend to be situation-specific.
- Duration is often time-limited.
- Behavior is a reaction to perceived threat like personal cares (e.g., being bathed).

Examples of these behaviors include:

⇒ Making threats of bodily harm
⇒ Cursing or swearing
⇒ Use of profanity or obscenities
⇒ Accusatory language
⇒ Threats
⇒ Sexual comments
⇒ Harassment
⇒ Racial insults
⇒ Name calling

Verbally Agitated Behaviors

The following are characteristics of verbally agitated behaviors:

- Tend to be generalized.
- Duration is longer-lasting (i.e., hours vs. minutes).
- Underlying causes are often difficult to detect.

Examples of these behaviors include:

⇒ Moaning
⇒ Yelling
⇒ Screaming
⇒ Nonsensical sounds or noises
⇒ Calling out
⇒ Repetitive questions
⇒ Grunting
⇒ Grumbling or negative comments
⇒ Constant talking

It is important to note that this division is arbitrary. Problems associated with DV are highly individualized.

Triggers to DV

Common antecedents or "triggers" to DV include:

- Overstimulation
- Understimulation, sensory deprivation
- Immobility, restricted movement
- Pain, discomfort
- Fatigue
- Psychotic symptoms
- Depression
- Psychological distress
- Caregiver behaviors
  - ⇒ Ignoring the person or behavior
  - ⇒ Telling the person to be quiet
  - ⇒ Asking the person why he/she is yelling

Medication Management

- Use medications only as an adjunct to behavioral interventions.
- Select medications with the lowest adverse side effect profile.
- Use standing doses, not prn, since effects are cumulative.
- Start at the lowest dose possible and titrate upwards.
- Change one medicine at a time to evaluate effectiveness.

Severe DV

Remember – severe DV occurs in the minority!

- Persist for hours each day in spite of "best interventions."
- Often do not respond to behavioral/medication interventions, or do not respond consistently.
- Same interventions that help for some will make others worse.
- Highly individualized approaches required.
- Prognosis per one large study: Good News and Bad News after 6 months:
  - ⇒ 66% vocalized fewer hours.
  - ⇒ 45% considered improved by nursing staff.
  - ⇒ 25% died.
- Believed to be part of terminal phase of disease, suggesting use of hospice approach.
- **The bottom line?** *Most severe DV problems require patience, but will probably resolve themselves.*

Managing Severe DV

- Provide staff education — frame as dementia-related behavior.
- Create one or more sound-proof bedrooms or quiet rooms.
- Provide ear plugs for staff who must provide care.
- Place near hearing impaired residents.

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DV Interventions & Management Strategies

UNDERSTIMULATION

- Involve in social, leisure activities.
- Place near activities, traffic (e.g., nurses station).
- Increase environmental sounds (e.g., hair dryers, loud audiotapes via earphones or in room).
- Increase light, especially natural light.
- Place in vibrating or rocking chair.
- Use aromatherapy.
- Use pet therapy.
- Offer dolls, stuffed animals, or soft blankets.
- Maximize sensory function.

OVERSTIMULATION

- Decrease noise and commotion.
- Remove to quiet area.
- Use calm, quiet approach.
- Speak slowly and clearly.
- Avoid large group activities or congregate dining.
- Create home-like settings and routines.
- Adapt personal care routines to reduce fear and agitation.
  - ⇒ Provide privacy.
  - ⇒ Use one versus many caregivers.
  - ⇒ Tell person what you are doing and why.
  - ⇒ Slow down.
  - ⇒ Offer explanations.
  - ⇒ Use gentle touch and stay in visual field.

DEPRESSION

- Reduce or eliminate sources of stress and factors causing fear (e.g., room, roommate change).
- Offer talking options to discuss fear, anxiety, or grief.
  - ⇒ Day-to-day staff
  - ⇒ Family support, phone calls
  - ⇒ Chaplain services
  - ⇒ Therapist, counselor
- Slow down and listen to concerns.
- Remember fears are real to persons.
- Provide specific reassurance (e.g., methods to promote safety and comfort).
- Offer one-to-one activities to distract or redirect attention.
- Reminisce regarding strengths and positive experiences.
- Encourage involvement and socialization.
- Use antidepressant medications (see chart).

PSYCHOSIS

- Maximize sensory input.
  - ⇒ Increase lighting.
  - ⇒ Put on glasses.
  - ⇒ Use hearing aide.
- Reduce or eliminate illusions.
- Simplify the environment.
- Use validation principles to reassure.
- Redirect or distract to an alternative activity.
- Increase appropriate auditory or visual stimuli (e.g., music, old movie, or video of family).
- Speak slowly and clearly.
- Provide specific reassurance (e.g., “You are safe with me.”).
- Reminisce or review life history.
- Avoid confrontation or *you-are-wrong* messages.
- Use low-dose, high potency antipsychotics (see chart).

PAIN/DISCOMFORT

- Treat underlying diseases.
- Schedule toileting.
- Institute bowel protocols.
- Offer snacks and fluids.
- Employ exercise or range of motion activities.
- Reposition, stand, or change chairs.
- Schedule pain medications versus prn use.
- Titrate pain medications upward using alternative categories of pain relief (see chart).
- Assess and reassess pain level.
- Document nonverbal pain behaviors to justify medication increases or adjustments.

FATIGUE

- Regulate or control length of activities.
- Monitor number and type of appointments or visits.
- Adjust level of stimulation (see *Overstimulation).*
- Alternate high stimulus activities with low stimulus activities.
- Schedule quiet times.
  - ⇒ Rest in recliner
  - ⇒ Time out in room
  - ⇒ Naps of short duration

IMMOBILITY

- Ambulate or wheel person regularly.
- Escort outdoors.
- Offer choices for positioning.
- Reposition and turn often.
- Use alternative seating like recliners.
- Position in place person enjoys.
- Reduce or eliminate restraints.

GENERAL INTERVENTIONS

- Use massage and comforting touch.
- Provide specific reassurance (e.g., “You are safe with me.”).
- Avoid generalities (e.g., “It’s okay.” or “You’re fine.”).
- Provide a hot water bottle.
- Provide stuffed toys, soft objects, or dolls to hold.
- Make and play audiotapes of loved one’s voice.
- Use rocking chairs or beds.
- Make and play videotapes of loved ones at home, reminiscing or talking to resident.
- Play audiotapes of familiar sounds.
  - ✓ Heartbeat
  - ✓ Nature sounds, like ocean waves, wind or waterfall
- Play music.
  - ✓ Preferably personal cassette with headphones
  - ✓ Relaxing, classical tunes (e.g., Pachelbel’s Canon in D)
  - ✓ Favorite tunes from the past (e.g., hymn, western, big band)
- Engage in spiritual activities if indicated from past history.
- Use “white noise.”
  - ✓ Fan noise
  - ✓ Hairdryer blowing
  - ✓ Other loud, continuous noise that “drowns out” other sounds
- Use sound amplifier to provide direct feedback to person regarding volume of his/her voice.

DV: Medication Management

Antidepressants

Prescribed for vocalizers who exhibit symptoms of depression or mood disturbance.

- Persons with sudden unexplained vocalization or crying are good candidates.
- Low serotonin associated with impulsivity.
- Provides rationale for using medications with serotonergic properties like SSRIs.
- Many options:
  - ⇒ Citalopram
  - ⇒ Trazodone used because of sedating qualities
  - ⇒ Antidepressants used successfully to treat depression in past

Antianxiety

Prescribed for vocalizers with anxious appearance or features.

- Benzodiazepines should be used with caution due to potential negative side effects.
  - ⇒ Sedation with associated fall risk
  - ⇒ Disinhibition, making behavior worse
  - ⇒ Rebound anxiety on discontinuation after prolonged use
- Valuable in managing short-term anxiety (e.g., appointments, procedures).
- Low doses of short-taking medications preferred:
  - ⇒ Lorazepam
  - ⇒ Alprazolam
- Buspar may also be used.

Antipsychotics

Prescribed for vocalizers exhibiting psychotic symptoms, including hallucinations (unreal sensory experiences) or delusions (false, fixed beliefs).

- Medications with the fewest anticholinergic side effects are preferred.
- Literature review suggests use of:
  - ⇒ Risperidone as first line
  - ⇒ Haloperidol, olanzapine as second line
  - ⇒ Quetiapine or traditional low potency antipsychotics as third line
  - ⇒ Thiothixene also recommended by some
- Monitor extrapyramidal side effects (e.g., stiffness causing more discomfort).

Anti convulsants

Prescribed for severe DV, persons who are resistant to other therapies and who exhibit other agitated behaviors such as physical aggression.

- Used as mood stabilizers:
  - ⇒ Divalproate
  - ⇒ Carbamazepine
  - ⇒ Gabapentin
  - ⇒ Topiramate

Psychostimulants

Prescribed occasionally for persons who fail to respond to traditional antidepressants.

- ⇒ Methylphenidate
- ⇒ Dextroamphetamine

Other Options

- Acetylcholinesterase inhibitors
  - ⇒ Have been found to reduce cognitive and behavioral symptoms in dementia and theoretically should reduce DV.
  - ⇒ e.g., donepezil, galantamine, rivastigmine
- Electroconvulsive Therapy (ECT)
  - ⇒ Reported to eliminate DV in patients resistant to other medications, but use still quite controversial

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