Family Connect

Disruptive Vocalizations (DV)

The Facts

- Disruptive vocalizations (DV) is a common problem among cognitively impaired older adults.
- DV is common in long-term care settings, affecting 10-30% of nursing home residents.
- Assessing DV as a Need-Driven Dementia-Compromised Behavior (NDB) is 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, or setting in which they occur.
- Both distressed sounding and distressing to hear.
- The result of some form of brain injury (e.g., severe dementia).
- Indicative of unmet physical, psychological, or social needs, or a reaction to physical or environmental stress.

Disruptive vocalizations are also known as:

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

Frequent DVs cause challenges in caregiving, and deserve assessment and intervention.

Who Exhibits DV?

The frequency, duration, and intensity of 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 minority of persons with DV engage in DV without obvious provocation for many hours a day (Severe Disruptive Vocalization).

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. DV deserves our attention!

The University of Iowa | Iowa Geriatric Education Center

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Types of DV

DV includes a variety of verbal expressions, ranging from the fluent use of words to repetition of nonsensical sounds. DV can be considered either *aggressive* or *agitated*.

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, such as personal care (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 (e.g., hours vs. minutes).
- Underlying causes are 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

Severe DV

Severe DV occurs in the minority.

- Persists for hours each day in spite of best interventions.
- Often persons do not respond to behavioral/medication interventions, or do not respond consistently.
- The same interventions that help for some will make others worse.
- Highly individualized intervention approaches are required.
- Believed to be part of terminal phase of disease, suggesting use of hospice approach.
- Most severe DV problems require patience, but will probably resolve themselves.

Medication Management

- Use medications only as an adjunct to behavioral interventions.
- Select medications with the lowest adverse side effect profile.
- Use standing doses, since effects are cumulative.
- Start at the lowest dose possible and adjust upwards.
- Change one medicine at a time to evaluate effectiveness.

Speak with your provider or pharmacist about symptoms and medication options.

Triggers to DV

Common triggers to DV include:

- Overstimulation
- Understimulation (too little or infrequent stimulation), sensory deprivation
- Unable to move, 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

General DV 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 ones’ 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 (e.g., heartbeat, nature sounds)
- Play music, preferably using a personal device with headphones (e.g., relaxing, favorite tunes)
- Engage in spiritual activities if indicated from past history
- Use white noise (e.g., fan, hairdryer, other loud, continuous noise that drowns out other sounds)
- Use sound amplifier to provide direct feedback to person regarding volume of their voice

Specific DV Interventions & Management Strategies

Overstimulation

- Decrease noise and commotion, remove to quiet area
- Use calm, quiet approach, and speak slowly and clearly
- Avoid large group activities or congregate dining
- Create home-like settings and routines, and adapt personal care routines to reduce fear and agitation

Understimulation

- Involve in social, leisure activities, or have the person sit near activities (e.g. where others walk by)
- Increase environmental sounds (e.g., hair dryers, loud music via earphones or in room)
- Increase light, especially natural light
- Use vibrating or rocking chair
- Use aromatherapy or pet therapy, and offer dolls, stuffed animals, or soft blankets

Specific DV Interventions & Management Strategies, *Continued*

Depression
- Reduce or eliminate sources of stress and factors causing fear
- Offer talking options to discuss fear, anxiety, or grief (e.g., family support, chaplain, therapist)
- 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-on-one activities to distract or redirect attention
- Reminisce regarding strengths and positive experiences
- Encourage involvement and socialization
- Use antidepressant medications

Psychosis
- Increase lighting, put on glasses, use hearing aide
- Reduce or eliminate illusions by simplifying the environment
- Provide specific reassurance (e.g., “You are safe with me”)
- Redirect or distract to an alternative activity, reminisce or review life history
- Increase appropriate auditory or visual stimuli (e.g., music, old movie, video of family)
- Speak slowly and clearly
- Avoid confrontation or “you are wrong” messages
- Use antipsychotic medications

Pain & Discomfort
- Treat underlying diseases
- Schedule toileting and use bowel protocols
- Offer snacks and fluids
- Employ exercise or range of motion activities
- Reposition, stand, or change chairs
- Assess and reassess pain: document nonverbal pain behaviors to justify medication adjustments

Fatigue
- Regulate or control length of activities, and monitor number and type of appointments or visits
- Adjust level of stimulation: alternate high stimulus activities with low stimulus activities
- Schedule quiet times (e.g., rest in recliner, naps of short duration)

Immobility
- Help the person to walk or move in wheelchair regularly, escort outdoors
- Offer choices for positioning, position in place person enjoys, and reposition and turn often
- Use alternative seating (e.g., recliners)
- Reduce or eliminate restraints