Dear Editors,

It is always useful to remind practitioners that nonpharmacologic interventions are most effective for the treatment of neuropsychiatric symptoms of dementia, and the review in the recent issue of Caring (2020;21;2:19) provides excellent guidance. However, the summary of treatment options is provided only evidence from randomized controlled trials (RCTs) on treatment of verbal agitation, sometimes called disruptive vocalization, and it states there are “no effective interventions.” There are no RCT results for treatment of this condition because, fortunately, it is relatively rare. However, loud vocalization can cause significant disruption, affecting residents, staff, family members, and visitors. We would like to alert readers to two case studies describing an effective treatment for disruptive vocalization and suggest one simple, effective intervention.

The first case was that of Evelyn, a woman who had lived in a facility for nine years (J Gerontol Nursing 2012;38:52–56). She was originally admitted after breaking her hip, and she was a pleasant person with only mild memory loss. However, as her cognitive impairment worsened, she became a very difficult person to care for. She began to resist all attempts to provide personal care, especially bathing. Evelyn spent most of her time in her wheelchair, speaking to her clenched fist. Her speech would become distraught as she described horrific situations that she remembered from her work as a police dispatcher. Several medications were attempted to wipe away terrible images from her mind. However, none of them were effective.

The second case involved Agnes, who had moved into the facility several years before her husband, who subsequently died (Ann Palliat Med 2017;6:405–407). The couple had no children, and Agnes never received any attention. She would cry, “Help me, help me” incessantly, and sometimes, “My head hurts.” No consolation or offers of help were effective in stopping these vocalizations. Several medications were tried, but none were effective. Her vocalizations decreased somewhat when somebody was sitting beside her. Because the other residents found Agnes’s cries upsetting, she was rarely brought to an activity. Not long after, the time Agnes was placed in front of a nurse’s station where she could be observed. She also did not like to be touched, and several aides were needed for her bath.

Both facilities where Evelyn and Agnes lived established a new program for residents with advanced dementia called Namaste Care (Simard, The End-of-Life Namaste Program for People with Dementia, 2nd ed., Health Professions Press, 2013). This group activity program was designed for residents who were no longer benefiting from the usual activities because of progression of their dementia. In a Namaste Care room, a calm environment is maintained with relaxing music and pleasant scents permeating the air. An unburdened, loving touch approach to all interactions is provided by dedicated staff. Although Evelyn and Agnes were not considered ideal program participants because their vocalizations could disrupt the calm environment, the staff members had seen the beneficial effect of Namaste Care for other residents and were desperate to help Evelyn and Agnes as well.

When Evelyn was brought to the Namaste Care room, she was offered some baby roses. To everyone’s surprise, Evelyn stopped talking, took the roses, and smelled them. After Evelyn offered the roses to the Namaste Carer, she yanked them back and hit herself in the face — then, surprisingly, she laughed, which she had not done in months. After Evelyn had continued her daily sessions in the Namaste Care room, she retreated less and less into her life as a police dispatcher and was mostly quiet except for conversations with staff members. At one point Evelyn asked for some books to look through: she wanted them to be wrapped in brown paper because she enjoyed the process of unwrapping them. Another day, she asked the staff member to buy her a newspaper, which she read and smelled them. After Evelyn offered the newspaper to the Namaste Carer, she sat in front of her and rested. She was a pleasant person with only mild memory loss. However, as her cognitive impairment worsened, she became a very difficult person to care for. She began to resist all attempts to provide personal care, especially bathing. Evelyn spent most of her time in her wheelchair, speaking to her clenched fist. Her speech would become distraught as she described horrific situations that she remembered from her work as a police dispatcher.

Namaste Care continued to accept touch after she left the program. Their time in the Namaste Care room provided a “trickle-down effect” to other personal care, which was a welcome change for the staff.

Conflict of Interest: Ms. Simard published a book describing Namaste Care.

Dr. Wright is the chair of the Society’s Ethics Committee. He is medical director of three communities in Richmond, VA.

Letter to the Editors: Nonpharmacologic Interventions for Verbal Agitation and Disruptive Vocalization

By Joyce Simard, MSW, and Ladislav Volcmer, MD, PhD

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