Letter to the Editor

While reading the first issue of Research in Gerontological Nursing, I was particularly interested in the review by Curyto, Van Haitsma, and Vriesman entitled “Direct Observation of Behavior: A Review of Current Measures for Use with Older Adults with Dementia” (Vol. 1, No. 1, pp. 52-76). I did not read very far before I was troubled. In the first section of the article, Theory Underlying Direct Observation of Behavior, the authors state, “Although direct observation has a long history of use in the field of behavior analysis, its use with the dementia population is relatively new and often not guided by theory” (pp. 52-53). The authors discuss several instruments to measure pain in older adults with dementia (Feldt, 2000; Horgas, Nichols, Schapson, & Vietes, 2007; Krulewitsch et al., 2006; Lane et al., 2003; Leong, Chong, & Gibson, 2006; Richards, Nepomuceno, Riles, & Suer, 1982; Villanueva, Smith, Erickson, Lee, & Singer, 2003; Warden, Hurley, & Volicer, 2003). Theory-guided direct observation of behavior in older adults with dementia is well established in the literature, especially in the pain literature. One of these theories is the biopsychosocial model of pain management (Davis & Srivastava, 2003; Ferrell & Ferrell, 1996; Ferrell, Ferrell, & Osterweil, 1990; Gatchel, 2004; Killinger, Morley, Kettner, & Kaurie, 2001).

Eighteen years ago, Ferrell et al. (1990) stated that pain research using “The Integrated Approach to the Management of Pain” should be explored (p. 31). The theoretical components of this paradigm include biological, mental health, and socioenvironmental variables. Thus, cognitive, behavioral, and affective components all contribute to sensory and emotional experiences and synergize to create a pain experience (Ferrell & Ferrell, 1996).

Davis and Srivastava (2003) outlined four geriatric outcome measures in the biopsychosocial model. Outcomes 1 and 2 are evidenced through direct observation of behavior (p. 28):

- Changes in patient activity.
- Changes in pain and related behavior.
- Changes in constant pain.
- Changes in attitude to pain-centered goals.

Anxiety, depression, panic disorder, substance abuse, and other social causative factors are contributory to the pain experience (Gatchel, 2004). Thus, the biopsychosocial model offers a conceptual framework for research and treatment of pain in older adults with dementia through the direct observation of behaviors.

REFERENCES

Response:

The letter writers highlight well-established theory guiding direct observation of behavior in older adults with dementia, especially in the pain literature. There are indeed some direct observation measures that are created based on established theory, but several measures (some of which were not included in the review, as they did not meet the inclusion criteria) also exist that include only behaviors specific to a particular setting or stage of dementia and are not reflective of theory regarding the behaviors selected for observation.

The letter includes an excellent example of the benefits of using a theoretical model when creating or selecting an observational measure. The given example highlights how the biopsychosocial model of pain management is able to guide direct observation measures of pain. This model includes theoretical components such as biological, mental health, and socioenvironmental variables and explains how cognitive, behavioral, and affective components all contribute to sensory and emotional experiences of pain. This theory outlines what behaviors would be important to observe and measure, as well as provide guidance on comprehensive treatment strategies that would create the kind of change detected through direct observation.

Fortunately, we are starting to see more examples like the one described above in how theory can guide the direct observation of negative or maladaptive and positive or adaptive behavior in older adults with dementia. When considering negative behaviors, some observational measures include all behaviors documented during observations, behaviors that lead to a specific negative outcome, or other means of determining what behaviors will and will not be included, rather than basing selection of behaviors on theory. The needs-driven, dementia-compromised behavior model describes stable individual background factors (neurological, cognitive, physical abilities, habits, personality) and proximal factors (physiological and psychological needs, physical and social environment) that contribute to negative behavior by producing unmet needs in the individual with dementia (Algase et al., 1996). Work by Beck et al. (1998) and Cohen-Mansfield and Deutsch (1996) has expanded on this model by looking at four subtypes of behaviors, person characteristics, and environmental conditions that are linked with these specific subtypes of behavior. This is promising and may help promote the development of more sorely needed theory-driven observational measures that define what negative and positive behaviors are important to observe and can detect change in response to theory-driven treatment strategies.

REFERENCES


Kim J. Curyto, PhD
Batavia, New York

Kimberly Van Haitsma, PhD
North Wales, Pennsylvania

Deedre K. Vriesman, BA
Grand Rapids, Michigan