

An introduction to conceptual models of practice and frames of reference

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OVERVIEW

This chapter provides an introduction to frames of reference and conceptual models of practice within occupational therapy. It commences by exploring the rationale for having theoretical constructs in practice. It continues by examining the challenges that theoretical terminology has posed occupational therapists, before defining key terms used in this text. The proliferation of frames of reference and conceptual models of practice is then discussed and a guide for future theoretical development and evaluation presented. Following this, the relationship between conceptual models of practice and frames of reference in this text is explained.

Key points

This chapter:

- introduces conceptual models of practice and frames of reference
- emphasizes the importance of language and understanding theoretical terminology
- discusses the development of theory in occupational therapy
- examines the stages of theoretical development of conceptual models of practice.

Why have frames of reference or conceptual models of practice?

Imagine the following scenario. After a few weeks of feeling unwell, you consult your doctor, who decides that you should go to see a consultant surgeon. Your consultation goes as follows:

You: Doctor, I haven't felt well for several weeks. My stomach's upset. I've lost my appetite and some weight, and I don't feel that I have the same energy and get up and go that I normally have.

Consultant surgeon: I see. Well, I tell you what ... why don't I do some tests?

You: What are you testing for?

Consultant surgeon: Not sure, really. I have a few personal favourite tests that I've used a lot. Did I tell you I've been qualified for over 20 years? So I think I'll use those and see what they show up. I reckon I know what I'm going to do anyway.

How would you feel leaving this consultation? It probably wouldn't engender much confidence that your health was being considered in a structured, evidence-based manner.

It is difficult to come up with 'answers' in health-care, and all the more so in professions such as occupational therapy that have inherently broad aims. However, it is known that professionals' individual perspectives are highly vulnerable to a range of biases and heuristics when making clinical judgements (Gilovich et al 2002), regardless of their clinical 'expertise'. It is also true that experience and 'time served' as a practitioner are fairly consistently shown to have no effect on improving clinical judgements (Grove & Meehl 1996, Grove et al 2000). Knowledge of such inherent limitations of individual perspectives supports the acceptance and development of evidence-based decision-making approaches to therapeutic interventions. Frames of reference and conceptual models of practice are an ideal way in which clinicians can use theory, in a structured manner, to conceptualize clients' difficulties, shape intervention and evaluate success. Using a well-developed

frame of reference and/or conceptual model of practice encourages therapists to consider a whole range of options that they would perhaps be less likely to do if left to their own devices.

In her review of the history of occupational therapy in the UK, Wilcock (2001) attributes the first use of the terms 'frame of reference' and 'model' to Miss McLean, an American occupational therapist working as a lecturer in England (McClellan 1974). McClellan's rationale for the development of a structured theory to underpin occupational therapy practice was financial. Hospital management, McClellan (1974) argued, was no longer willing to tolerate therapeutic interventions for reasons of enjoyment alone. The requirement to demonstrate the value of practice had dawned and the development of theories, McClellan suggested, would enable the evaluation of practice and research to be undertaken (McClellan 1974). In today's world of clinical governance and evidence-based practice, finance remains a dominant driver in the development of theory. It is certainly true, now more than ever, that the demonstration of effectiveness is of vital importance — not only for the good of the patients who receive the service, but also for the good of the profession as it faces increasingly probing questions about its worth in a financially challenging climate.

Structured theories develop out of a desire to explain the function and mechanisms of impact of occupational therapy, and help explain why a person is experiencing a particular problem, what a potential solution could be and why a particular intervention works. Structured theories provide explanations and describe the relationship between different aspects of a person (Kielhofner 2009). Theories also identify occupational therapy's unique contribution to health and assist in defining professional boundaries (Feaver & Creek 1993b).

Supporting the use of structured theory in practice does not negate the requirements for occupational therapists to use their judgement. Occupational therapists have to decide which conceptual model provides the best evidence base and supporting structure for the setting in which they work. Sometimes this will be self-evident; it is highly unlikely that a psychodynamic frame of reference would be a useful *primary* frame of reference in an orthopaedic ward; the occupational therapist is more likely to use a biomechanical frame of reference and an associated conceptual model of practice. At other times, however, the case may not be so clear and a careful

appraisal of the available evidence is required to inform theoretical decisions and the directions of practice.

Defining and understanding theoretical terminology

Having articulated the rationale for having a structured theoretical basis for practice, we must now examine the importance of developing a clear understanding of the key terms that are used to articulate them. This is not straightforward as 'different writers use them [theoretical terms] in different ways and their meaning is modified by the context in which they are used' (Feaver & Creek 1993a, p.4).

The description of occupational therapy theory rapidly evolved from the mid-1980s on. Contemporaneously, the language that described theory developed and terms such as *paradigm*, *model*, *frame of reference* and *approach* were often used interchangeably and with different meanings by various authors (e.g. Reed 1984, Mosey 1986, Creek 1992, Kielhofner 1992, Young & Quinn 1992, Hopkins & Smith 1993). Such variation adds considerably to the confusion of clinicians, students and academics who try to understand and evaluate contrasting conceptual foundations of practice. Hagedorn (2001) likened the struggle to understand the various uses of terminology in occupational therapy to the following discourse between Alice in Wonderland and Humpty Dumpty (Lewis Carroll, *Alice Through the Looking Glass*):

'There's glory for you!'

'I don't know what you mean by "glory",' Alice said.

'I meant, "there's a nice knock-down argument for you!"'

'But "glory" doesn't mean "a nice knock-down argument",' Alice objected.

'When I use a word,' Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean — neither more nor less.'

Whilst the debate about the 'correct' use of terminology appears to have abated, it is important to remain mindful that specific terms are still being used by different people in different ways. One solution to this is the development of internationally recognized standard definitions of theoretical terms and concepts. However, whilst this is a tempting

proposal, it is questionable whether it could be meaningfully achieved. Differences in definitions of terminology are not simply semantic; they frequently expose an author's conceptual bias. By way of example, two contemporary definitions of 'models', developed by theoretical leaders in the field, are provided here. Creek (2003, p. 55) defines a model as a '*simplified representation* of the structure and content of a phenomenon or system that describes or explains certain data or relationships and integrates elements of theory and practice', whilst Forsyth and Kielhofner (2005, p. 91) highlight how 'the strength and application of MOHO [a well-known conceptual model of practice] is *neither simple nor formulaic*. Instead it aims to understand important multiple dimensions of each client's unique experience and bring a sophisticated understanding to bear on the life issues facing each client in practice' (author's emphasis added).

These contrasting contemporary definitions of models of practice illustrate:

- the reason why a universally defined shared terminology is unlikely to work
- the continuing importance of truly understanding the perspective of an author(s) when reading and appraising literature relating to occupational therapy theory and practice.

Whilst theory should never be presented as unnecessarily complicated, neither should its inherent complexity be watered down towards an unachievable simplicity. Theoretical terminology is important; it defines key terms and enables the succinct communication of complex ideas. However, terminology can require effort to understand. It is easy to become disheartened when faced with a massive amount of new theoretical 'language' to grapple with. As a result, some students and clinicians may venture no further with such texts. This elective loss of knowledge is not simply a personal issue; one's professional capacity is also diminished through a lack of engagement with the profession's rich knowledge base. Students, clinicians and academics are therefore encouraged to grapple with their frustration (if they have any) and engage with theoretical terminology where it exists, in both this text and others. The investment of time and reflective thought, as well as discussions with peers and colleagues, will all assist in further understanding the concepts that are being communicated. If you sustain your engagement with such literature, you will encounter a

wealth of knowledge that you would otherwise have left undiscovered.

Theoretical definitions used in this book

In order to give meaning to the structure of this book and to assist the reader in following the arguments and propositions contained within, it is necessary to define some key theoretical terms. Where possible, these definitions have been adhered to throughout the text. In defining theoretical terms, consideration has been given to lessening confusion by providing clear and (hopefully) uncontroversial taxonomy. Some terminology has already been introduced in the preceding chapter; however, it is repeated here for clarity.

- *Paradigm*. The shared consensus regarding the most fundamental beliefs of the profession.
- *Frame of reference*. Theoretical or conceptual ideas that have been developed outside the profession but which, with judicious use, are applicable within occupational therapy practice.
- *Conceptual model of practice*. Occupation-focused theoretical constructs and propositions that have been developed specifically to explain the process and practice of occupational therapy.

Occupational therapy's theoretical proliferation

The development of formalized theory came relatively late in the genesis of occupational therapy. Whilst its development is welcomed, the manner in which it has occurred has, perhaps, not always been helpful. One example of this is the variance in theoretical depth of some of the profession's 'models' of practice.

Hagedorn (2001, p.131) outlined 11 person-environment-occupational performance models (termed conceptual models of practice in this current edition). Some of these were based on ongoing research; others represented the perspectives of an individual or a small group of occupational therapists at a particular moment in time. Whilst the publication of scholarly debate on occupational therapy's theory base is invaluable, the proliferation of personal perspectives shaped as nascent conceptual models of

practice does not meaningfully support the development of occupational therapy's knowledge base and can increase confusion amongst clinicians and students in an already complex field.

Conversely, occupational therapy should not necessarily be limited to the few conceptual models or frames of reference that have an established evidence base. The profession's theoretical development would be poorer if the above call for rationalization of personal conceptual models was understood as an attempt to stifle novel ideas and innovations. New conceptual models of practice/frames of reference, which recognize or perceive limitations in existing theories or practice and aim to address these, should be welcomed. They will enhance the knowledge base and encourage greater debate and understanding within the profession. However, these developments should contain sound theoretical arguments and vision of future development.

Kielhofner (2009) suggests that sustained development of a conceptual model of practice is required to ensure that its theoretical constructs are valid and useful. Furthermore, as well as providing a theoretical structure, a conceptual model of practice should also develop appropriate assessments and technology (e.g. intervention protocols) for use in practice (Kielhofner 2009). As such developments require to be gradually developed and tested, it is perhaps useful to consider what the developmental stages of a conceptual model of practice should be.

Proposed stages of theoretical development

The following stages are based on a review of conceptual models to date and outline a proposed developmental sequence that illustrates the required developmental stages of contemporary conceptual models of practice. Frames of reference, as applied knowledge, are likely to have undergone a similar process within their original knowledge base. The process of integrating frames of reference is therefore different and is referred to throughout this text (see Chapters 6–10).

Whilst the developmental stages of conceptual models of practice suggest a general progression, it is acknowledged that some of these stages may occur simultaneously.

Develop initial conceptual ideas

- Why is a new theoretical construct necessary?
- Form a basis for a new theoretical perspective.
- What are the factors that differentiate this construct from existing conceptual models?

Refine conceptual ideas

- Present the conceptual model to the occupational therapy community.
- Work with others (academics, clinicians and clients) to refine ideas and understandings.
- Continue to present refinements for critical appraisal and debate.

Test theory in practice

- This can be achieved through the use of a variety of research methods to examine the validity of the developing theories' claims in practice situations.

Develop tools for practice (technology for application) (Kielhofner 2009)

- Develop self-report assessments, interview schedules, observation measures etc.
- Develop protocols that support the clinician to enable them to use the information they gain using the model and associated tools to assist the client.

Increase the evidence base for the conceptual model

- Refine the theoretical arguments and understanding on the basis of research carried out in clinical settings.
- Build the evidence base for the validity, reliability and utility of the conceptual model and its associated tools for practice.

Verify the conceptual model and associated tools for practice externally

- Theoretical constructs are rigorously tested by people with no personal bias as regards their success or failure.
- The tools for practice are evaluated by people with no personal bias as to their success or failure.
- Publications from independent research support the conceptual model's theoretical basis and utility in practice settings.

The relationship between conceptual models of practice and frame of reference

Developed and evidence-based conceptual models of practice provide a rigorous organizational structure that avoids personal biases and heuristics. In doing so, such models also ensure that interventions remain occupation-focused. Frames of reference are useful supports to conceptual models of practice and bring with them additional knowledge, tools and priorities. Frequently, occupational therapists will use one or more frames of reference in conjunction with their selected conceptual model of practice. The frames of reference should be selected before the assessment and goal-setting commence, as they may shape and influence the information that is gathered and the interventions that are employed to meet a client's goals (Fig. 5.1).

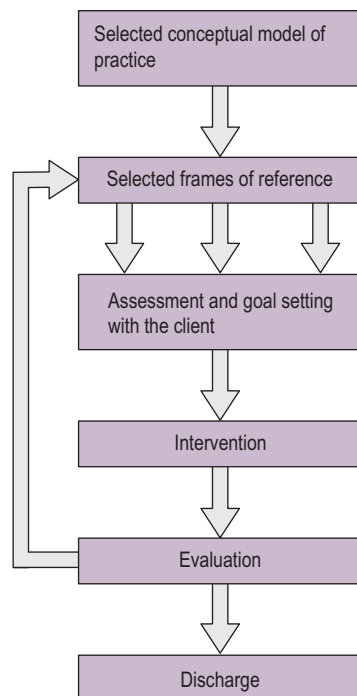


Fig. 5.1 • The relationship between conceptual models of practice and frames of reference.

Selection of frames of reference and conceptual models of practice in this book

Amongst other theoretical developments, this book provides a detailed introduction to five frames of reference and five conceptual models of practice. The selection of each theoretical approach was not an arbitrary one, but was based on their prominence within the literature, developing evidence base or commonality of use in practice. Not all the models and frames of reference presented in this text have equal evidence to support their practice. Indeed, at least one of them (the *Kawa* (River) Model) challenges the nature of evidence-based practice (Iwama 2006). Inclusion in this book should not therefore be seen as a form of endorsement. The reader is presented with a range of conceptual models and frames of reference to inform their thinking, and asked to critique each to decide what influence these will go on to have on their practice.

Summary

This chapter has introduced the importance, use and relationships of frames of reference and conceptual models of practice in occupational therapy. Their importance in assisting structured clinical decision-making has been highlighted. The chapter explains the relationship between conceptual models and frames of reference, underlines the importance of their continued development, and introduces the rationale for the selection of the frames of reference and conceptual models of practice introduced in this text.

Reflective learning

- In your own words, describe what a conceptual model of practice and a frame of reference are.
- Imagine you are explaining the importance of conceptual models of frames of reference to someone in your family. What would you say?
- What basis would you use when considering which conceptual model and/or frame of reference to use in practice?

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