



February 2013

Letter from the Editor: The Importance of Frames of Reference

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Recommended Citation

Dirette, D. P. (2013) "Letter from the Editor: The Importance of Frames of Reference," *The Open Journal of Occupational Therapy*: Vol. 1: Iss. 2, Article 1. Available at: <https://doi.org/10.15453/2168-6408.1039>

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Letter from the Editor: The Importance of Frames of Reference

Keywords

guidelines for practice, model of practice, framework, theory, evidence

Credentials Display

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DOI: 10.15453/2168-6408.1039

The categories for publication in *The Open Journal of Occupational Therapy* (OJOT) include Applied Research, Topics in Education, Guidelines for Practice and Technological Guidelines, Opinions in the Profession, and Letters to the Editor. The category I would like to discuss in this letter is guidelines for practice. The founders of OJOT made a decision to publish guidelines for practice, or what we in occupational therapy (OT) have historically called frames of reference.

Frames of reference are theoretically-based guidelines for practice that assist therapists with clinical reasoning related to the evaluation and treatment of specific problems (Mosey, 1996). In recent years the term “guidelines for practice” has become more commonly used than the term “frames of reference” while others have used the terms “model of practice” (Nelson, 1997) and “conceptual practice models” (Kielhofner, 2004). Regardless of the term that is used, the purpose of these guidelines remains the same. They provide a framework with which a therapist is able to make clinical decisions based on a scientific, theoretical foundation. The parts of a guideline for practice include a theoretical base, problems addressed, and evaluation and treatment guidelines. Guidelines for practice are not diagnosis specific, but rather they address problems that people with a variety of diagnoses may experience.

Within the OT profession there have been some discussions that seem to imply that guidelines for practice are not necessary to the profession. Some authors take the position that therapists can focus exclusively on using occupation as the basis of interventions (Christiansen, 1990; Nelson, 1996;

Yerxa, 1988) and others support a phenomenological orientation in which reflection is the basis of interventions (Schön, 1983; Turpin, 2007). While the use of both occupations and reflection are important aspects of our profession, neither of them can adequately provide a basis for treatment of all of the problems with which our clients present. For example, many therapists work with populations who have severe cognitive limitations, such as those clients who are emerging from a coma. These clients often present with changes in muscle tone, low arousal levels, and pain. Providing the opportunity for the person to participate in purposeful and meaningful occupations is not an option at this point and attempts to use reflection would be futile. Treatments may incorporate some meaningful occupations, such as listening to familiar music, but those occupations are not the primary focus of the treatment at this stage.

Over the last decade, the primary focus of the health professions has become providing treatment based on research that demonstrates the effectiveness of the interventions. This, of course, is evidence-based practice. The definition of evidence-based practice is taken from evidence-based medicine, which states that it is the “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). These authors further explain that this practice means “integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett et al., 1996, p. 71).

In his plenary speech, titled “Evidence-Based Practice and Knowledge Translation in the Era of Healthcare Reform: Opportunities for Occupational Therapy,” presented at The American Occupational Therapy Association’s 91st Annual Conference and Expo in 2011, Dr. Ken Ottenbacher discussed the need to connect evidence-based practice to theory. He asserted that OT is a science-based profession. We should not choose treatments from clinical convenience or from traditional orientations, but rather choose treatments based on scientific theories.

As pointed out by Ottenbacher (2011), within the steps for conducting evidence-based practice, which include questioning, searching, evaluating, and implementing (Rosenberg and Donald, 1995), the concept of using theory is not apparent. The concept of theory as an underlying framework for practice is also not apparent in the definition of evidence-based practice. Although Sackett et al. (1996) allude to theory by saying that clinically relevant research may be from the “basic sciences of medicine,” they clearly emphasize the use of “clinical research” (p. 72). The definition of evidence-based practice includes the integration of clinical reasoning into the process. The question is, however, what is the basis of our clinical reasoning? I propose that there must be another step in that process. In addition to questioning, searching, evaluating, and implementing, we must also be developing guidelines for practice based on theoretical knowledge.

Guidelines for practice provide our profession with the means for making the

scientists and the practice developed and tested by applied scientists. The step that must be apparent is that the applied scientists are using a theoretical base for the treatments that are being researched. If, as applied scientists conducting research to provide evidence for practice, we do not test theoretically-based guidelines for practice, then we run the risk of becoming technicians who focus our research on a series of various techniques to decide when, how much, how often, and with whom the techniques work the best. We lose our scientific base in that process.

The OT profession has a strong history of using theory as the basis of our treatments. Our most well-known example is the work done by Dr. Jean Ayers. Jean Ayers (1979) developed the Sensory Integration frame of reference based on theories of neuroscience that she studied as a post-doctorate student at the Brain Research Institute at the University of California, Los Angeles (Miller & Walker, 1993). Dr. Ayers described her work as putting the facts together from theories so that we could use them to solve our clients’ problems. In our pursuit of evidence-based practice, we, as a profession, seem to have lost sight of this need to develop sound guidelines for practice to solve our clinical problems.

Not all of our inquiries have to rise to the level of Dr. Ayers’ lifetime accomplishments to make a contribution to the profession. Each of us faces clinical problems for which there are no guidelines for practice. One example from my clinical practice comes to mind. As a therapist working in a rehabilitation hospital, I was met with the clinical problem in which clients with flaccid

hemiplegia and edema developed contractures in the joints of their affected hands. The acute care hospitals were using the techniques outlined at that time as best practice including elevation, compression, and retrograde massage. Yet, when I removed the compression gloves to conduct an initial assessment, I was frequently frustrated to find significant loss of passive motion in the joints due to contractures.

There was evidence to support the treatments that were being used to effectively reduce the edema in the hands of people with hemiplegia. By the time they were admitted to the rehabilitation hospital, most of the clients had no residual edema, but they had developed contractures. The therapists were doing harm by following the evidence to support the treatment of edema. As a therapist, looking to the evidence was not helpful in solving this clinical problem.

To help solve this clinical problem, I found theoretical information about the edematous fluid that explained the process of how the protein-rich edematous fluid thickens when sitting in a joint and how that thickened fluid turns into a solid to form a contracture. Further exploration of dynamic theories revealed the necessity of frequent movement of the joints to prevent contractures. Using this theoretical foundation, I was able to add to our guidelines for practice for treating edema in the hands of people with flaccid hemiplegia and then test the effectiveness of that treatment (Dirette & Hinojosa, 1994). The theoretical information leads us to include the use of continuous passive motion devices for the hands of people with flaccid hemiplegia.

Another, more recent example is that of self-awareness. In clinical practice, the most common treatment for self-awareness is the use of “predict, perform, and feedback” (Prigatano, 2005). When I conducted a qualitative study to explore this treatment experience from the client’s perspective, however, I realized that this process could actually do more harm than good by fostering a cycle of frustration and leading to emotional distress and increased denial of deficits (Dirette, 2002; Lucas and Fleming 2005). Theoretical information about self-awareness helped me develop a better guideline for practice that focuses on the clients’ learning perspectives and on participation in meaningful activities to enhance self-awareness (Dirette, 2010).

This, I propose, is the method for connecting theory to evidence-based practice and making our research science-based. The clinical reasoning process should lead us to explore theoretical information, which in turn should lead us to develop better guidelines for practice. We then can test the effectiveness of these guidelines for practice to develop our evidence for practice.

To promote this process, OJOT has included the category Guidelines for Practice and will publish well-formulated and innovative guidelines that are based on recent, relevant theoretical information and sound reasoning. Losing sight of our guidelines for practice puts the OT profession at risk for becoming a profession of technicians. We encourage authors to explore the latest theoretical information and to use that information to develop innovative guidelines for practice that solve clinical problems. Those guidelines for practice can be submitted to OJOT.org and will be peer reviewed

under the criteria provided in the author guidelines for those submissions. We hope OJOT will provide authors with the opportunity to publish new treatment ideas that are grounded in the latest theoretical information and that can contribute to the OT profession.

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