An exploration of the different forms of theoretical knowledge valued and used by occupational therapists in mental health practice

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This thesis is submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy (Occupational Therapy) School of Health Sciences, University of Newcastle, NSW, 2308, Australia

April 2013
Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University’s Digital Repository, subject to the provisions of the Copyright Act 1968.

Signed: ________________________ Samantha E. Ashby
Date: ____________
Presentations and Publications Arising From the Thesis

Refereed Journal Publications:

Ashby, SE, Ryan, S, Gray, M & James, CL 2012, 'Factors that influence the professional resilience of occupational therapists in mental health practice', *Australian Occupational Therapy Journal*.

Conference Paper Presentations:

Ashby, SE 2010a, 'Professional journeys in mental health: Developing professional resilience', in *15th World Federation of Occupational Therapy Congress*, Santiago, Chile.

Ashby, SE 2010b, 'The theoretical knowledge valued and used by experienced occupational therapists working in mental health practice', *15th World Federation of Occupational Therapy Congress*.

Ashby, SE 2011a, 'Exploring how occupational therapists use theoretical knowledge in mental health practice', *COT Annual Conference*.

Ashby, SE 2011b, 'Exploring the theoretical knowledge used in mental health practice', *COT Annual Conference*.

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### GLOSSARY

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<td>Borrowed or shared theoretical knowledge</td>
<td>Occupational therapists in mental health practice adopt or borrow knowledge from other professions, primarily psychology (Duncan 2006). The forms of borrowed theoretical knowledge are often described as frames of reference.</td>
</tr>
<tr>
<td>Codified or propositional knowledge</td>
<td>Codified or propositional knowledge includes discipline-based theories and concepts, which are integrated with practical processes and procedural knowledge, and further influenced by subjective impressions, interpretations, and experiences to create practice knowledge (Eraut 2007).</td>
</tr>
<tr>
<td>Community of practice</td>
<td>Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Wenger, McDermott &amp; Snyder 2002). In occupational therapy they can include the professional networks, organisations, and professional reference groups.</td>
</tr>
<tr>
<td>Conceptual knowledge</td>
<td>Conceptual knowledge is espoused theory, which guides practice but is not directly responsible for occupational therapists’ treatment interventions. (Osmond 2005).</td>
</tr>
<tr>
<td>Explicit knowledge</td>
<td>The knowledge practitioners can articulate and link to practical actions.</td>
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Frames of reference

For consistency throughout the thesis I use the term ‘frame of reference’ (Krefting 1985; Townsend & Polatajko 2007) to refer to those theories containing propositions or rationales, which underpin treatment approaches. According to Duncan (2006) they are ‘theoretical or conceptual ideas developed outside the profession but with judicious use, are applicable within occupational therapy practice’ (p. 45). This term is used to refer to models of practice based on propositional knowledge: They have explicit assumptions, propositions, and provide treatment approaches. They provide a bridge between theory and practice and offer hypotheses and propositions for treatment interventions (practical actions and behaviour) (Blesedell Crepeau, Cohn & Schell 2009; Krefting 1985; Mosey 1981; Townsend & Polatajko 2007).

The American Psychological Association (2012) describes psychological frames of reference as ‘theories of psychotherapy’. These psychological frames of reference include Acceptance and Commitment Therapy (ACT) (Hayes & Lillis 2012); Dialectical Behavioural Therapy (DBT) (Linehan et al. 1999); Narrative Therapy (Madigan 2010); Brief Solution-Focused Therapy (BSFT) (de Shazer 1988); Cognitive Behavioural Therapy (CBT) (Beck 1976) and Contemporary Attachment Theory (Schore & Schore 2008). In the occupational therapy literature additional frames
<table>
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<th><strong>Instrumental use of knowledge</strong></th>
<th>Instrumental use – denotes directly observable changes in behaviour or practical actions (Dunn 1983 cited in Osmond 2005). In this thesis, it refers to knowledge used directly with service users to work on a specific impediment to their engagement in their chosen occupations, i.e., those things people do to maintain their self-care, engage in leisure or productivity, which can include paid or unpaid forms of work.</th>
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<tr>
<td><strong>Mental health practice</strong></td>
<td>A term used in the Australian public health system. It encompasses other terms referred to in the occupational therapy literature – ‘psychiatric’ and ‘psychosocial practice’.</td>
</tr>
<tr>
<td><strong>Meta-models</strong></td>
<td>Traditionally, the classification of theories depends on what they seek to explain. For example, grand theories, or meta models (Mills 1959), are overarching theories which attempt to explain more or less everything in society by drawing on abstract conceptualisations, such as scientific theories and research.</td>
</tr>
<tr>
<td><strong>Midrange theories</strong></td>
<td>Occupation-focused models are midrange theories as they seek to describe one phenomenon and do not provide direct interventions for practice.</td>
</tr>
<tr>
<td><strong>Occupational therapy</strong></td>
<td>Occupational therapy is defined by its international governing body, the World Federation of Occupational Therapists (2012) [WFOT], as:</td>
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</table>

of reference described are the behavioural, humanistic, and psychodynamic (Duncan 2006).
A client-centred health profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement (p.4).

<p>| Occupations | In occupational therapy, a core aim of intervention is the enablement of meaningful occupations to promote health and a sense of wellbeing. In the language of this unique professional domain, occupation is defined as meaningful by the client and can include ‘chunks of activity that can be named in the lexicon of the culture’ in which the person lives (Zemke &amp; Clark 1996, p.vii) . |
| Occupation-based practice | This is the explicit use of occupation to achieve a client’s goal – a goal orientated to his or her occupational issues. It focuses on service-users’ occupational issues and enhances and supports an occupational perspective. Occupation-based practice involves the use of occupation as both a ‘means’ and ‘end’ of therapy (McLaughlin Gray 1998). |
| <strong>Occupation-focused models</strong> | Midrange theories describe occupational behaviour and participation devised by occupational therapists for use in the profession. In occupational therapy, Duncan (2006) defines midrange theories as ‘occupation-focused theoretical constructs and propositions that have been developed specifically to explain the process and practice of occupational therapy’ (p. 45). Occupation-focused models are thought to be conceptual, and central to the study of occupation. They offer a theoretical basis for practice by providing explanations about the process and practice of the profession (Ashby &amp; Chandler 2010; Duncan 2006). |
| <strong>Paradigms</strong> | ‘Professional paradigm’ is a term which, when used in occupational therapy, is defined as a shared consensus about the most fundamental beliefs of the profession (Kielhofner 2009). ‘Personal paradigms’ (Törnebohm 1991) reflect a social-constructionist approach. They are unique to particular situations, and they are the result of collective context-based processes rather than universal movements. Törnebohm distinguished between a therapist’s personal paradigm, which comprises four mutually reinforcing components, namely, (i) worldview, (ii) interests, (iii) field of action, (iv) competence, and the broader professional paradigm. |
| <strong>Personal knowledge</strong> | Personal life experiences form part of the ‘personal knowledge domain’ (Bazeley 2007). |
| <strong>Phronesis</strong> | ‘Phronesis’ or ‘practical wisdom’ is the prudence and capability of a person to consider a mode of action and to deliver change in order to enhance their quality of life or personal wellbeing (Hughes 2001a). |
| <strong>Practice wisdom (personal knowledge)</strong> | A term used to describe craft knowledge, and the judgements required to make professional decisions. It refers to the Aristotelian notion of ‘poiesis’. It is the use of knowledge with judgment or with wisdom (Trevithick 2012). |
| <strong>Practice theory nexus</strong> | The intersection that occurs during clinical interactions with service users. |
| <strong>Praxis</strong> | The action resulting from professional judgements. According to Aristotle, disciplines can be divided into three categories: theoretical (theoria), technical (technē), or practical (praxis). These divisions are derived from his observations of how people in each discipline makes the decisions, which influence their practical actions, referring to this professional reasoning and decision making process as praxis (Hughes 2001a). |
| <strong>Process or procedural knowledge</strong> | This refers to the practical application of knowledge to occupational therapy process during assessment, treatment planning, and evaluation phases, i.e., ‘how to do things’. |
| <strong>Professional codified knowledge</strong> | An overarching term which includes discipline-based theories and concepts, which blend with practical, process and procedural knowledge, based on impressions, interpretations and |</p>
<table>
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<tr>
<th>Propositional knowledge</th>
<th>This refers to the factual knowledge generated formally through research and scholarship: ‘It includes scientific knowledge (from the sciences), aesthetics (from the arts) and logic (from philosophy)’ (Higgs, Jones &amp; Titchen 2008, p. 154). It requires translation into procedural knowledge or the ‘knowing how’ used in practices.</th>
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<tr>
<td>Recovery</td>
<td>A terms defined by Anthony (1993, p. 11) as ‘A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability’.</td>
</tr>
<tr>
<td>Service user</td>
<td>The term ‘service user’ is used in this dissertation as it reflects its use in Australian policy documents, and recovery approach literature. Other literature refers to service users as clients, patients or consumers.</td>
</tr>
<tr>
<td>Tacit knowledge</td>
<td>Tacit knowledge describes the intrinsic practice knowledge which forms a practitioner’s thinking and doing which can be espoused through the use of reflective practice (Polyani 1966; Schön 1983).</td>
</tr>
<tr>
<td>Technical rational</td>
<td>The term technical rational skill is used to describe the skills and practices of professionals,</td>
</tr>
<tr>
<td>skills</td>
<td>or artisans. It indicates a focus on the technical aspects of practice and the instrumental knowledge that informs ‘how to’ (Schön 1983).</td>
</tr>
<tr>
<td>Theoria</td>
<td>Theoria refers to the knowing, or informing which underpins an action.</td>
</tr>
<tr>
<td>Theoretical knowledge</td>
<td>In occupational therapy, theoretical knowledge is usually described using the terms ‘paradigm’, ‘conceptual models of practice’ and ‘frames of reference’ (Duncan 2006).</td>
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</table>

### Definition of Knowledge Domains

| Professional knowledge domain | In this thesis, this term refers to occupational therapists’ philosophical core beliefs and assumptions. These assumptions include occupational wellbeing – described as ‘an experience in which people derive feelings of satisfaction and meaning from the ways in which they have orchestrated their occupational lives’ (Townsend and Polatajko 2007, p.372). This also refers to the efficacy of occupation as a therapeutic medium. |
| Theoretical knowledge domain | In occupational therapy, theoretical knowledge is usually classified as conceptual or directional – guiding practice through treatment approaches and specific therapies. However, as noted in the thesis, little is known about how different forms of theoretical knowledge are integrated into occupational therapists’ practice in mental health. Some authors in the health profession describe theoretical knowledge as ‘propositional’ because |
theories are based on propositions or assumptions (Higgs, Jones & Titchen 2008).

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<tr>
<th>Service-user domain</th>
<th>This domain refers to the expertise of service users regarding their lived experience of mental illness and illness experience. Service users can also refer to those people who care for, or live with a person with mental health issues, who are also involved in developing plans with the person and the occupational therapists.</th>
</tr>
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<tr>
<td>Personal knowledge domain</td>
<td>This refers to pre-profession and the personal experiences of work and life which impact on professional practice.</td>
</tr>
<tr>
<td>Factual knowledge domain</td>
<td>Factual knowledge refers to codified, or research-based knowledge. It contributes to the ‘knowing what’ aspects of practice. For occupational therapists in mental health practice, this includes knowledge from the clinical sciences, psychiatry, along with policy knowledge about State Mental Health Acts and other relevant legislation.</td>
</tr>
</tbody>
</table>

**Abbreviations**

ACT—Acceptance and Commitment Therapy

BSFT—Brief Solution-Focused Therapy

CBT—Cognitive Behavioural Therapy

CMOPE—Canadian Model of Occupational Performance and Engagement

CPD—Continuing Professional Development

DBT—Dialectical Behavioural Therapy
MOHO—Model of Human Occupation

OPM -Aus—Occupational Performance Model-Australia
ABSTRACT

This thesis adds new insights and understandings about the integration of theoretical knowledge in the personal paradigms of occupational therapists in mental health practice, a previously unexplored area of research. The qualitative research used narrative inquiry to explore the professional histories of nine occupational therapists who worked in mental health practice in a regional area of Australia. Thematic analysis of professional histories highlighted the crucial episodes, practice contexts and social values, which informed the value and use of different forms of theoretical knowledge across time. This study contributed new information about the nexus between occupation-focused models and practice by identifying a spectrum of theoretical knowledge use. Bronfenbrenner’s (1979) social ecological model provided a lens to view the data and to consider the ways in which macro, meso and microlevels’ environments shape practitioners valuing and use of different forms of theoretical knowledge. If used in tandem, the tacit use of occupation-focused models conceptualised and drove the direction of therapy towards occupational goals, whereas the explicit and instrumental use of psychological frames of reference resulted in visible explicitly psychologically oriented practical actions. Findings suggested professional self-care strategies, including professional socialization and the adoption of negotiation skills, were key responses to environmental tensions, which arose from the practice knowledge discourse, and dominant discourse dimensions. Pressures to adopt biomedical and psychological discourses often diminished the use of the occupational perspective discourse in phronesis and praxis and subsequently on reduction of occupation-based practice.
The study identified that drawing upon professional knowledge domains and occupation-focused models appeared to protect professional identities. Professional resilience and identity were crucial in assisting practitioners to resist the pressure to adopt, rather than adapt, psychological modalities. This thesis highlights the need for further research into strategies at the macro, meso and microlevels which maintain the use of occupation-focused theoretical knowledge and the development of professional resilience in mental health practice.