Where is the theory in ‘theory meets practice’?

Associate Professor Moira O’Connor

Theory meets practice

- Looking to the future - many futures and many ways
- Research in palliative care is often related to changes in practice – guided by clinical colleagues and multidisciplinary
- Research is often in response to gaps in service delivery
- Working towards best practice
- A strength - but is it also our Achilles' heal?

Translation

- A common theme: ‘Theory meets practice’. ‘The nexus between theory and practice’. ‘Linking research, theory and practice’, ‘from theory to practice’.
- Translation emphasised
- Where is the theory?
- Theory building remains a challenge

Benefits of theory driven research

- What underpins behaviours
- ‘Why’ not just ‘what’
- Understanding and explanation
- Mechanisms of change - enables testing of a particular mechanism bring about change
- Interventions based on a clear theoretical framework and a prior needs analysis; this is not the case for the majority of research or interventions at present
- Focussed interventions not just: “Let’s try this” and “Let’s just add this”
- Leads to hypothesis testing
- Enables lasting change
- Theory informing practice

How?

- Qualitative research may be helpful in ‘unlocking’ what mechanisms underpin behaviour
- In a recent qualitative study of men and women cancer carers, the majority of women gave accounts which could be characterised as ‘fraying connections’, regardless of cancer stage, in contrast to the men carers who gave accounts of strategies of ‘re-patterned care’, and reported higher levels of psychological well-being and coping[1]

How?

- In health psychology – focus on changing behaviour
- Changing behaviour is difficult
- Experiments used to examine what is happening – which particular theory is driving the change – e.g. theory planned behaviour or self efficacy or a combination
- But….
- We can't do that
- Or can we?

Measures

- Measures need to be tailored specifically to the mode of intervention, rather than global measures e.g. general distress
- Without this research evidence, there is not a strong case to be made for the development of specialised interventions which differ from the information and support that characterises ‘usual care’
- May partly explain why many interventions do not appear to be effective

Examples

- 2013 systematic review and meta-analysis recommended that education for cancer pain management should use self efficacy[2]
- 2014 theory-led review of studies recommended using Normalisation Process Theory to analyse the implementation of clinical practice guidelines[3]
- 2013 review of mechanisms underpinning interventions for well-being and health of individuals with cancer. Cognitions (i.e., expectancies, illness representations), self-efficacy, and psychosocial resources (e.g., self-esteem)[4]

Examples

- Interventions targeting couples appear to be more effective than interventions focussing solely on the carer
- Cancer as a relational experience using a model of two-way coping - drawing on systemic-transactional theory[5]
- Coping as an interaction between the stress signals and communication style of one partner and the coping responses of the other
- Interventions to be tailored to the specific needs of men and women carers, across stage of the caring experience

Quesions

- Is this important?
- Is this as important as implementing changes in practice?
- Benefits and challenges?
- Where to next?

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