Hi All,

Another take on this issue of how MOHO treats development and temporality concerns its incorporation of narrative theory. The OPHI II is a good example of a means by which, together, a client and therapist may make meaning out of a developing occupational life story over time (within a MOHO framework). Moreover, the OPHI II it provides useful data to inform how that client's story might be re-told, re-interpreted, or re-initiated as part of a client's future occupational life and therapeutic process.

- Renee

This is a great remark Renée. The narrative process and its understanding through the application of the OPHI-II, as means of evaluation and intervention.

Carmen Gloria de las Heras
Chile

John:

Your ideas are very interesting and I would encourage you to pursue your thinking about the integration of narrative with these concepts, further.

What comes to mind for me is the Remotivation Process that Carmen-Gloria de las Heras established with Gary. For example within volition, there are three stages (exploration, competence and achievement) and one's therapeutic actions are graded to match those stages - these and other graded intervention concepts are very well articulated in the manual.

Please stay in touch and keep us posted on your thinking.
Renee
Dear Renee,

Many thanks.
I will definitely try to develop this into something more solid. It has been in my mind for some time.
I will post this on the group once I have done so.
I will have a look at the manual on volition and re-read that section.

Best wishes
John

Hi John, Renée and all:

This conversation brought me to a topic that is very crucial. The integration of knowledge in Occupational Therapy and how Gary has approached it in his books Conceptual Foundations of OT, and Conceptual Foundations of OT Practice (2009).

Participating in meaningful occupations of life with all aspects it considers, "automatically" serves as a vehicle to health. Occupation enhances Health. Meaning that our physical, mental, emotional conditions improve, are preserved and evolve with participation (at any level and dimension of doing), facilitating personal development. This does not mean that we will treat directly internal systems as OTs. It means that we should exercise our reflexion about the interaction of both.

Related knowledge from other disciplines gives us complementary and additional information to be able to understand the person as a whole and relate different aspects that interact in occupational participation, also in some cases (related knowledge with common vision and values with OT about the person) complement with some strategies. This related knowledge is important but does not replace the knowledge on human occupation, neither its approach we use as OTs, in this case using MOHO.

So, in practicing, ideally our therapeutic reasoning should integrate our values and our occupational focus of our Paradigm as the "guidance to keep doing occupational therapy", with theory and application of Conceptual Practice Models that promote occupational participation and Related Knowledge to improve our full understanding of the person.

How the three aspects are integrated and accompany our practice is the key element.

I would love to know more about how you integrate knowledge in your practice John. I am very interested on seeing your work!
Hello all,

I’m new to this list serve. And functionally new to MOHO, though MOHO was part of my OT education 12ish years ago.

I feel quite over my head in reading these posts in my efforts to learn about MOHO but also feel I’m in the right place.

One of my goals as I learn is to present (over a few sessions) MOHO to my OT colleagues in order to explore how we can incorporate MOHO concepts more consciously into our practice. I currently work in acute-care OT in a setting w/ several other OT practice endeavors (psych, rehab, outpatient hands, TBI, home safety evaluation, drivers rehab, & more).

My question: can you recommend how I can grade my own learning? What readings can I start with that will give me a foundation that are not too daunting time-wise or intellectually? I’d like to apply what I learn clinically, so readings on how MOHO is put in to practice in everyday clinic settings would also be great.

A appreciate in advance your help pointing me in the right direction(s).

Hellen Carreras, OTR

Colorado

October 20, 2010

Hi Helen,
I've found that the best starting point for brushing up on MOHO is the MOHO book (the most recent edition which was published in 2008). It has thorough descriptions of the components of the model and explores some of the concepts that can be challenging to grasp at first like 'occupational forms'. The book also has lots of case vignettes exploring the use of MOHO in different settings, contexts and cultures.
I would also suggest looking at the assessment tools based on MOHO once you feel comfortable with the model... I've really found them useful as they not only help you think differently about occupation but also actively inform the reasoning process and guide your decision making in collaboration with your clients. I work in an acute mental health setting and most often use the MOHOST and the OCAIRS (as well as the Interest Checklist and the Role Checklist).

Cheers,
Moses Costigan-King

October 21, 2010

Hi John:
It is so good to read your email. Exactly, the Art of Occupational Therapy. Remembering Gary, in his first book "Health Through Occupation". what a book!

I agree with you about what you say of the process of theory development. Observing, practicing and living situations with people is what drives thinking about formulation of concepts, questioning concepts, or further developing concepts and propositions for making them alive in intervention. Scholarship of practice integrates so well the roles of theorists, practitioners, researchers and clients... This is clear with what has happened with MOHO.

I think though that we, different professionals, can work towards the same goal for people, and that could work approaching the same phenomena but each having their own lenses to look at it. Not everything can be translated into OT language, but yet OTs could learn from the other theories aspects that complement our knowledge and the others could learn from ours as well, and we can work together in the same group for example with our own "giving" to the same goal. We can see in MOHO book (2008), how the language of CIF, AOTA and MOHO were shown in a parallel to see their expressions for different aspects considered. But as we said the "how" you look at them and go deep on the understanding differs.

You say it in your examples. Many times aspects that we think should be approach in a holistic way, are approached as cause effect. Even in OT happens, when groups or individual interventions are rigid and follow external expected goals, contents, timing in group modules, not giving space for flexibility, neither that the group takes its own life within certain themes. So it becomes a traditional psychoeducation or education group totally apart from real life..

One of the important principles that MOHO has explained about volition and occupational life is that interventions should be oriented to facilitate the construction or reconstruction of occupational narratives, then "we facilitate living and telling the story" not only telling the story. The doing thinking and feeling that meaningful occupational participation entails is the base in which we then can process and talk, evaluate and plan ahead. When we run occupational therapy "talking groups" with MOHO we do it to
facilitate understanding, processing and improvement of satisfactory occupational participation that goes on in people’s lives based on their occupational needs. We interwave narrative, problem solving, learning and planning at the same time. People have an active participation on choosing their priority themes of concern about their occupational life, giving feedback, teaching through their experiences and giving each other support and ideas, and then continue living their lives and reflecting on their own participation, anticipating and making new choices. I call this type of groups "Educational Self Help Groups".

About people with substance abuse..I agree with you how important is to deeply address volitional process. Occupational privation in any social class has been one of the most important reasons people had become addicts in any way in our country. This reality was studied with the OPHI-II in an study founded by a Public Service for Youth in Chile, and results showed that low personal causation and difficulties on identifying interests were prevalent factors through life that the young explained through their narratives as a motive to get into drugs "no meaning" "is there something better that this out there?" "I am not good enough" and many other expressions. The remotivation Process has been very helpful for therapists working with them.

What I can get is that your therapeutic reasoning flows at this time of your professional life, then easily comes the art..and science together..

That is what I can put in english words right now..

A big hug for you and all
Carmen Gloria de las Heras
Chile

October 21, 2010

Thank you Carmen and John for opening our minds with the thoughtful discussion.

As a Scientist (postgraduate and consultant) before my Occupational Therapy Degree, and having been a qual OT for 9 years, I completely agree, that somehow with the rigidity in some professional circles about RCT studies, we have lost TRUE scientific method, which requires astute observation skills and hypotheses that must be tested through scientific processes grounded in quality observations. As a human science, occupational therapy does recognise clearly in the texts covering evidence based practice in our field, that top grade research (ie Level 1 in hierarchy) must be inclusive of qualitative and quantitative research and statistical methods, to be of the highest quality relevant to the field of practice. I believe in Australia we need to be a stronger and louder voice for our profession to drum this point home to ourselves, peers/colleagues and health service managers. Just my opinion at this point in my ongoing development as an OT. I would further like to support John’s observation that for me, I feel my understanding of the healing benefits of occupation have deepened and I feel much more competent in explaining this to my clients, fellow OT friends and colleagues and having better success.
for clients who are ready and willing to engage with this. I even now have the courage to use OT terminology more in client chart progress notes, in case reviews and hospital acute ward rounds in the field of mental health. I’m not sure how I’m seen by my colleagues as a result, maybe as a bit of a pain, but interestingly as I progress in my growth as an OT clinician, their opinions are of less concern to me than the occupational therapy profession in the field of mental health. If this makes sense. Thanks for allowing me to express these thought via this listserv of fellow passionate OTs!

Kind regards, rosie

Rosie Bruce

**October 22, 2010**

Hi Helen,
I'm exactly like you "new to MOHO SO", now Im reading this book and i found it helpful and simple:"MOHO theory and application 4th edition , Gary Kielhofner". regards,
Leena