Dear all,

I am a senior lecturer in Occupational Therapy at Oxford Brookes University in Oxford. I am the module leader for a module called Consolidating Strategies for Client Centred Practice. I would like to hear from clinicians about their experiences on the following key topic which is: applying MOHO in practice particularly in physical settings. This topic can present students with particular challenges in their application to the practice setting. I want to encourage students to embrace this topic and not be put off by the difficulties which they may face. Hearing about this directly from a clinician’s personal experience would add a lot to their motivation for taking on these challenges and would empower them as professionals.

Do you think you could share your personal experience of applying MOHO into practice and the impact of that on you, your clients and the organisation that you work for? This could include, for example, your evaluation of the outcome of the intervention, your own and the client’s satisfaction with it, and organisational outcomes like communication within the team.

I am aware of the papers and books in this relation but your personal experience is more influential and would feel more real to them. Please contact me directly if you would like to help.

Many thanks
Farzaneh

October 9, 2011

Dear MOHO colleagues

In my previous email re MOHO in physical settings I had requested you to contact me directly if you have any story to share. Initially, I hadn’t thought it might be an interesting topic for others too. I have already received some emails from others who are interested to learn more about this, and so please feel free to share your experience with MOHO list server if you wish to.
Unfortunately I am not currently working as a practitioner in the UK but I have two different experiences of MOHO within non mental health settings, one from Iran where I was working in a clinic with clients of different types of physical and mental disabilities and another from Jordan where I used to teach MOHO as a model to use in all fields of practice.

I personally never had thought that MOHO is a model developed only for practice in the mental health setting. I have always seen it as a way of thinking about and conceptualizing a client’s occupational life. My first experience of applying MOHO was in a counselling center for students within the university. I had this theory that whoever is unhappy with his/her level of performance and seeks help can benefit from MOHO. Those students who used to come and see me had no diagnosis of psychological or physical illness. Then I started to apply MOHO in a multifunctional clinic in a small city that had a mixed group of patients of different ages and different diagnoses. 15 years ago in Iran I had no tools and even was not aware there would be some tools based on MOHO and I had developed my own questionnaire to seek information about these peoples’ occupational life. It was great to communicate the philosophy and language of MOHO with these clients and think together to see what we could do about their issues. I was using sensory integration, the Allen cognitive disability model, the cognitive behavioural model etc, according to the needs of my diverse client group but I was always starting with MOHO and thinking within MOHO. MOHO had become my screening tool to see where, when and how to take help from other approaches and models. Based on the MOHO assessment, I could then integrate other models, approaches or techniques to address a certain problem that had been identified by MOHO. For example, I had a client who had an amputated lower limb, had been given prosthesis but would only wear it in some social occasions. He came to me with back pain and after a series of assessments, and consulting with my physical therapy colleague, we both agreed that the problem was imbalance in body weight and consequently the uneven use of muscles. But why was he not wearing his prosthesis? MOHO helped us to look at the full profile of his occupational life, his lack of motivation for wearing it, his habits and particularly the impact of his values on the definition of his role. He was a soldier who had lost his lower limb during the war. He had developed an image of himself as a soldier who was happy to have ‘given’ his leg for his values. He was proud of his loss and thought wearing a prosthesis meant that he had not accepted what had happened to him. He thought wearing the prosthesis would mean denial of his new self-image and how he presented himself publicly. Discussing all these further, the client and I both agreed that this had put him off wearing his prosthesis even though he knew that this would help. He had also developed a series of skills to manage his daily life and different aspects of his occupational life with compensatory movements. His personal causation, in the line with his personal values, had motivated him to define a new role for himself as an ex-soldier of the war, and a new pattern of managing his daily life. His social environment was very supportive of his way of managing things and had given him lots of attention, emphasising his strength in managing his life without using his artificial limb. This, of course, had helped him to develop a high level of confidence in his ability to manage his personal life and career. However, he had ignored the consequences of not wearing his prosthesis, he was unaware of the imbalance in his back muscles as well as the weight bearing on his hand.
which had caused some damage and pain in his wrist. Together we looked at his situation. Being client centred, I only used the moho language to explain how all these elements had worked together. Using his own spirituality and the meaning that he had for his disability, I integrated the Existential therapy with MOHO. We explored his philosophy of life and the impact that the social environment had had on his decision. We finally agreed to add some physical therapy sessions followed by routine exercise at home, and worked on habituating this into his life pattern. Together we revised his definition of being a soldier loyal to his values, accepting the reality of his health condition and linking that to his other values of being a good citizen and father as these were also important to him. He acknowledged that wearing his prosthesis during some activities like driving was necessary, as from the point of view of his religion, it was important to take care of his own body and the safety of others. I knew that he had been given education on how to use his prosthesis at the time of receiving it, but I was sure that education alone hadn’t been enough as it had not acknowledged the impact of the prosthesis on his life as a whole. Later I presented a paper called ‘accepting strangers into your life’ at a conference, discussing the use of MOHO, referring to the use of prosthesis and orthosis with clients, what it means to them and how they become part of them or are rejected.

This has become a long email, but I wanted to share an example of myself applying MOHO in non-mental health settings.

Best
Farzaneh

October 10, 2011

Dear Priscilla,

Thank you for your email. I am glad that you have joined in and found the discussions useful. I personally believe applying a model has two stages, stage one is the one where you actually absorb the philosophy, think about and analyse the concepts and develop your own ideology. In this stage you try to think about your clients within the frame work of the model and then in the next step you need to apply the tools and empower your practice, and look at you whole process of therapy. For the first step reading and listening to other’s experience as you have been doing is so useful and the second step is learning to use the tools and applying them. If you have not been trained to use the tools this is not the biggest problem since by administering the tools you will acquire some skills and you can plan, achieve and then practice them. The very important bit is to understand the depth of the theory and how to interpret the results of your assessment within the concepts of the model, and this will come by practice. I have my BSc and first Master degree in OT and have an MA and PhD in psychotherapy and counselling. I have been working both as an OT and counsellor. I found MOHO a very comprehensive model as a starting point for me to organize my mind as a therapist. Then, I borrow from other psychological and OT theories and models, within the MOHO framework. I found MOHO to be a useful mediator between me and my client,
providing a sound rationale for using other theories, strategies or techniques. The systematic nature of MOHO in looking at the phenomena makes it easy to integrate other sources of knowledge with it. Also being occupation oriented I found it much easier and more touchable for clients to grasp the whole philosophy of intervention compare to applying the psychotherapy and counselling theories alone. I believe it is possible to apply MOHO in working with both client groups that you have mentioned. And there are tools like OSA particularly that are so useful to start your work with because it helps you to establish a therapeutic relationship with your client as well as acculturating them into the language of MOHO. Of course your clients may find that they do not agree with the way that MOHO conceptualizes a human occupational life or they do not find the concept of ‘human doing’ easy to accept and we know that we need to provide a rationale for what we do and have the clients agreement. But, I personally never had a problem with this and I have found MOHO to be quite straightforward for people to understand. MOHO always helped me to open a conversation about the clients’ situation and helped me to be able to justify borrowing from other theories as well. For example, I had a client who came to me with a high level of anxiety that had impacted her academic performance in the University. Interestingly she was the top student of her group and for her changing from straight ‘A’ marks to some ‘B’ meant dysfunction. She was considering her study as the most important occupation for her and had developed a high level of expectation of herself, with a perfectionism that was supported by her social environment. Being a ‘straight A’ student had become the pattern of her life. She was receiving lots of positive attention from the environment which had strengthened the value that she had for being a top student. Her performance capacity was good enough to bring success for her but her perfectionism had caused so many worries and anxieties for her in two ways. Firstly she had developed a sense of self-esteem if she was able to perform very well and if this didn’t happen then she was losing her confidence and respect for herself. Second, she feared losing the respect and support from her environment. She had received some feedback from her environment and had perceived it as negative and blaming and this had had a damaging impact on her self-esteem. She had started to perform lower than her capacity because her personal causation had become problematic and this, in combination with her perfectionism had led to her losing her motivation for working hard at her study for fear of not having the perfect result. Consequently, she was becoming more anxious and started showing some level of depression as well. To me looking at her issue with MOHO and communicating with her was a good way to put a rationale for starting my Cognitive therapy sessions with her. We agreed to have group cognitive therapy by this rationale that environment can have different impact and give her a chance to look at her issue from the perspective of others in the environment, as well. Sorry this became a long email again but I meant to say that I found MOHO in all my practice areas a very useful frame of reference with a high capacity for compatibility with other theories. I hope I am clear and you find this useful!

Best
Farzaneh
October 10, 2011

Dear Farzaneh

This is all fascinating! Thank you for giving all this information and experience.

This is the first time I have taken part in these correspondences as I have not done any training in MOHO yet. However I am about to do some part time freelance work in a secure mental health unit for older men, just set up and no OT until I start it. There will be 25 patients eventually, half with organic brain conditions and half with personality disorders and histories of long term/criminal detention under the mental health act. Return to work or home will not be realistic, but the long term goal will be discharge to an affiliated nursing home.

I have considerable experience of community mental health projects and want to set up grow-and-cook-your-own as there is a secure garden and an OT kitchen. Also I am a musician and want to use music where ever possible.

I look forward to hearing what information and guidance is out there - I have followed the emails streams over the last few years with great interest.

Best

Priscilla Reeve

I have read enough about MOHO over several years to know that it will be very useful but what to start with and how! I hope I will attract some advice.

October 11, 2011

Hi Farzaneh,

We have recently started using MOHO within an Intermediate care setting and would be willing to share our experiences so far.

I need to get signed up to listserve and then I will hopefully be able to see how best to share this information.

Thank you,

Donna Malcolm, Short term Intervention Team, Kendal

October 20, 2011

Hi there Farzaneh,
I have just set up using the MOHOST for baseline profiles, clinical reasoning, treatment planning and outcome measuring (occupation based) for the stroke unit I work on....... Just a small task!! :/

Iain Stringer OT Team Lead for Stroke Services, Kingston Hospital, SW London.