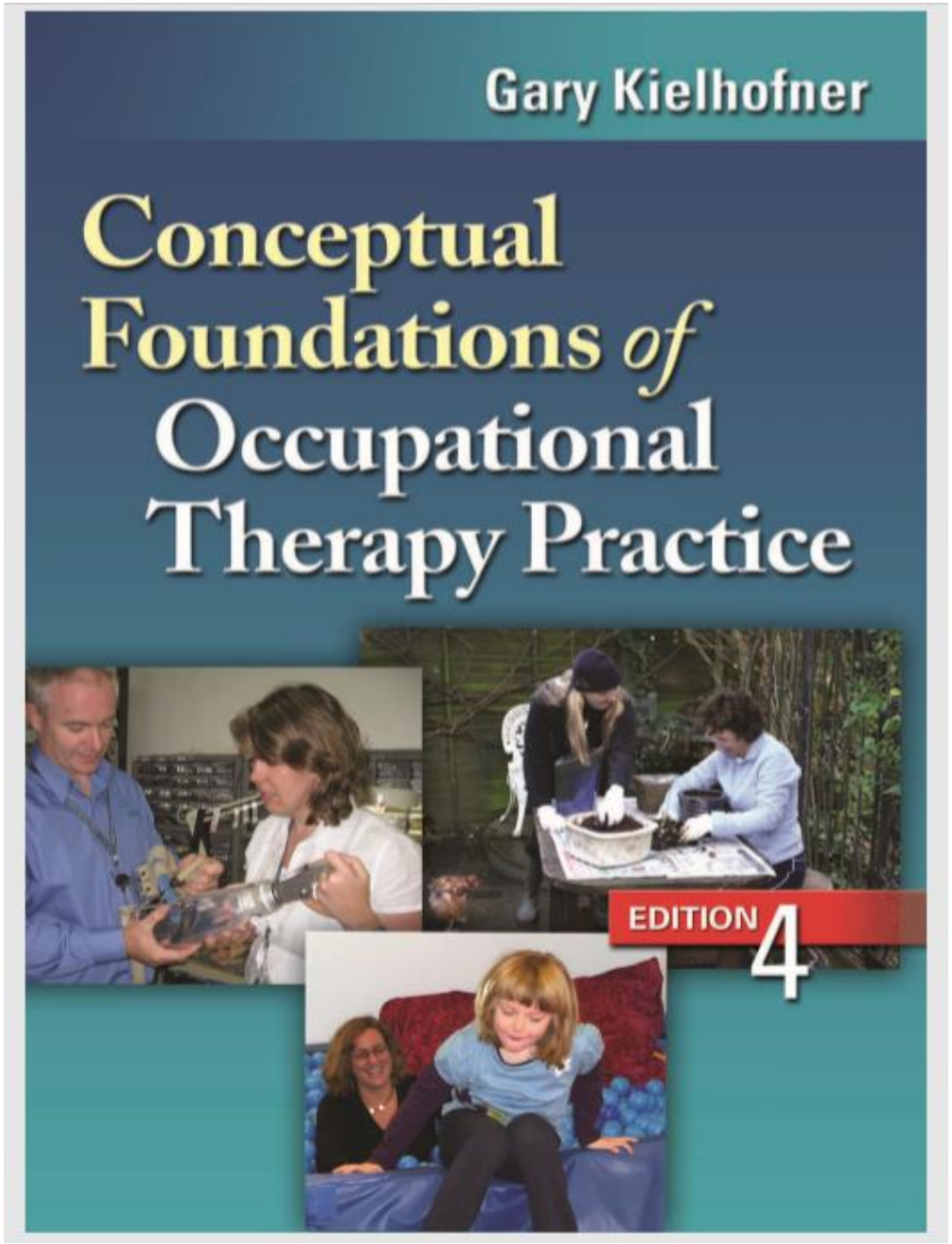

Conceptual Foundations of Occupational Therapy Practice

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CHAPTER 11

The Model of Human Occupation

A client works in a café that is operated to provide work training and experience for persons with mental health problems. With the support and guidance of an occupational therapist, the client has opportunities to develop a sense of competence and satisfaction in working. He will also develop the habits and skills necessary for success in the workplace. Importantly, the program also allows the client to take on the role of worker in a real life context where the ordinary demands and expectations, as well as the social identity of the role, are present. Like other programs based on the model of human occupation, this one emphasizes engagement in meaningful occupations to address multiple personal and environmental factors that influence occupational adaptation.

Katie Fortier is helping 9-year-old Victoria, who has diagnoses of bipolar disorder and attention-deficit hyperactivity disorder, work on a range of factors that influence her performance in school. Victoria was referred to occupational therapy due to behavioral outbursts, difficulty with socialization, and problems at school involving following rules and paying attention. Katie has carefully assessed Victoria in order to understand what her interests are and how she feels about her ability to do the kinds of things that are required in school. By guiding Victoria to participate in personally motivating activities, Katie is helping Victoria develop necessary skills (e.g., following directions, problem-solving). The intervention also reinforces positive habits that support Victoria's role as a student. Katie provides a safe and supportive environment for Victoria and serves as a positive role model for involvement in therapeutic activities. Overall, Katie's approach is holistic, in that it considers multiple factors that influence Victoria's success as a student, and client-centered, in that it reflects a thorough understanding of Katie's thoughts, feelings, and desires as well as her unique challenges.

Following a subarachnoid hemorrhage, Magnolia underwent a craniotomy and clipping of three aneurysms. She subsequently experienced residual left-sided weakness and inattention. Her treatment goals for occupational therapy included increasing her independence as well as improving the use of her affected side. Magnolia was very determined to return to her prior level of function. However, her immediate occupational goal was to be able to attend a previously planned family trip to Las Vegas, which was scheduled for one week after her discharge from rehabilitation. Given the importance of this goal to Magnolia, Erica Mauldin, her occupational therapist, organized treatment sessions to address the various tasks that Magnolia would need to perform to make the trip. Packing, transporting, and unpacking a suitcase allowed Magnolia to practice these activities prior to her trip. At the same time, these activities that reflected Magnolia's priorities allowed her to develop a sense of confidence as well as improve her endurance and use of her left side.

These three scenarios are characteristic of interventions based on the model of human occupation (MOHO). Work on MOHO began in the 1970s when the contemporary paradigm and its emphasis on occupation were emerging. In addition to its focus on occupation, MOHO also emphasized the importance of client-centered practice that reflected clients' values and desires. At that time, occupational therapy practice still focused mainly on understanding and reducing impairment. MOHO recognized that many factors beyond motor, cognitive, and sensory impairments contribute to difficulties in everyday occupation. These included problems or challenges in relation to:

- The motivation for occupation
- Maintaining positive involvement in life roles and routines
- Skilled performance of necessary life tasks
- The influence of physical and social environment (Kielhofner & Burke, 1980)

MOHO focuses on these factors. Because this model addresses broad issues faced by clients with a variety of impairments and throughout the life course, it is used in many types of intervention settings and with a wide range of populations. MOHO has also been used with clients at quite different levels of functioning. This includes both people with severe disabilities and those without disabilities who have received wellness-based services based on MOHO.

Theory

MOHO is ultimately concerned with individuals' participation and adaptation in life occupations (see Fig. 11.1). The model postulates that:

- A person's characteristics and the external environment are linked together into a dynamic whole
- Occupation reflects the influence of both the person's characteristics and the environment
- A person's inner characteristics (i.e., capacities, motives, and patterns of performance) are maintained and changed through engaging in occupations

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Concepts Related to the Person's Characteristics

MOHO conceptualizes the person's inner characteristics as three interacting elements: volition, habituation, and performance capacity (Kielhofner, 2008). Volition refers to the person's motivation for occupation. Habituation refers to how the person organizes performance into roles and routines. Performance capacity refers to the person's abilities for performance. Each of these concepts is explained further.

Volition

Volition is the process by which people are motivated toward and choose the activities they do. It begins with the universal human desire to do things and is shaped by life experiences. Volition consists of thoughts and feelings that occur in a cycle of:

- Anticipating possibilities for doing (e.g., looking forward to a weekend outing, worrying about an upcoming exam, feeling challenged and excited about a new job assignment)
- Choosing what to do (e.g., starting a new hobby, deciding to work in the yard after work, deciding to spend another hour studying for an exam in order to be better prepared)
- Experiencing what one does (e.g., enjoying a favorite pastime, feeling confident about how one completed a work task)
- Subsequent interpretation of the experience (e.g., reflecting on how well one performed during an activity or recalling how enjoyable it was to do an activity)

The thoughts and feelings that make up volition are referred to as personal causation, values, and interests; they concern, respectively:

- How capable and effective one feels
- What one holds as important or meaningful
- What one finds enjoyable and satisfying

Personal causation refers to the thoughts and feelings about personal capacities and effectiveness that people have as they do everyday activities. These include, for example, recognizing strengths and weaknesses, feeling confident or anxious when faced with a task, and reflecting on how well one did following performance.

Values are beliefs and commitments about what is good, right, and important to do. They reflect one's beliefs about what is worth doing, how to perform, and what goals or aspirations deserve commitment. People experience a sense of worth and belonging when they engage in activities that enact their values.

Interests are generated through the experience of pleasure and satisfaction in occupation. They begin with natural dispositions (e.g., the tendency to enjoy physical or intellectual activity). They further develop through the experience of pleasure and satisfaction derived from occupational engagement. Therefore, the development of interests depends on available opportunities to engage in occupations.

Volition (i.e., the cycle of thoughts and feelings that reflect one's personal causation, values, and interests) has a pervasive influence on occupational life (Kielhofner, 2008). It shapes:

- How people see the opportunities and challenges in their environment
- What people choose to do
- How they experience and make sense of what they have done

How people experience life and regard themselves and their world is largely a function of their volition. Importantly, when people experience impairments, their volition can be severely affected. People may experience themselves as losing capacities and being unable to perform as they feel is important. They may not develop or no longer enjoy activities of interest.

When volition is negatively impacted, people may make decisions that worsen or amplify the impact of their impairments. For instance, feelings of helplessness and hopelessness may lead them to avoid activities that could build their confidence and abilities. Such volitional decisions may also contribute to further loss of skills. Thus, occupational therapy based on MOHO often involves identifying and addressing clients' volitional problems. MOHO emphasizes that volition is also central to occupational therapy since the therapy process requires clients to make choices to do things. Finally, how clients experience what they do in therapy (a function of volition) to a large extent determines therapy outcomes (Kielhofner, 2008).

Habituation

Habituation is a process whereby people organize their actions into patterns and routines. Through repeated action within specific contexts, people establish habituated patterns of doing. These patterns of action are governed by habits and roles. Together, they shape how people go about the routine aspects of their lives. Because of roles and habits, most routines of daily life unfold automatically and predictably.

Habits involve learned ways of doing things that unfold automatically. They operate in cooperation with context, using and incorporating the environment as a resource for doing familiar things. They influence how people perform routine activities, use time, and behave. For instance, habits shape how one intuitively goes about self-care each morning. One's weekly routine is largely a function of habits. Even the way one completes a familiar activity is influenced by habits.

Roles give people an identity and a sense of the obligations that go with that identity. People may see themselves as students, workers, or volunteers and know how they should behave in order to fulfill those roles. Much of what people do is guided by the roles they inhabit. Roles are defined by the social system of which the role is a part (e.g., school, workplace, family, community) and by the expectations of others in that system. For instance, a child entering the role of student in grade school learns what it means to be a student from expectations given by teachers as well as attitudes and behaviors displayed by other students. The same process occurs for worker, family, volunteer, and other roles.

In a community rehabilitation center in Chile, clients engage in preparing a noon meal, maintaining the center's library, and clearing the grounds. This program provides these, and other real life occupations, as a means of enhancing clients' skills, habits, roles, and sense of meaning and efficacy in doing things.

Learning a new role involves internalizing an identity, an outlook, and an expected way of behaving.

The habits and roles that make up habituation guide how people interact with their physical, temporal, and social environments. When habituation is challenged by impairments or environmental circumstances, people can lose a great deal of what has given life familiarity, consistency, and relative ease. For example, a serious impairment such as a spinal cord injury may eliminate or interrupt all of one's occupational roles and may require one to learn a whole new set of everyday habits. Chronic conditions such as serious mental illness may interfere with developing normal roles and with establishing a functional routine guided by habits. One of the major tasks of therapy is to construct or reconstruct habits and roles so that the person can more readily participate in everyday occupations.

Performance Capacity

Performance capacity refers to underlying mental and physical abilities and how they are used and experienced in performance. The capacity for performance is affected by the status of musculoskeletal, neurological, cardiopulmonary, and other bodily systems that are called on when a person does things. Performance also calls on mental or cognitive abilities such as memory. Consequently, the biomechanical, motor control, cognitive, and sensory integration models that are discussed in this book are necessary for addressing this aspect of performance capacity. MOHO recognizes the importance of these models for addressing physical and mental capacities for performance and is typically used in conjunction with such models.

At the same time, MOHO stresses the importance of attending to the experience of performance and, in particular, the experience of having limitations in performance. It asserts that therapists should pay careful attention to how people experience impairments (e.g., paying attention to how people's bodies feel to them and how they perceive the world when they have impairments). For example, people with a variety of physical impairments frequently report feeling alienated from their bodies. According to MOHO, occupational therapy can support people to reclaim their bodies experientially and to integrate their bodies into new ways of doing things.

MOHO Concepts Concerning the Environment

MOHO stresses that occupation results from an interaction of the inner characteristics of the person (volition, habituation, and performance capacity) with the environment (Kielhofner, 2008). The **environment** includes the particular physical, social, cultural, economic, and political features within a person's context that influence the motivation, organization, and performance of occupation. Several dimensions of the environment may have an impact on occupation. These include physical spaces, objects, and people, as well as expectations and opportunities for doing things. Moreover, culture, economic conditions, and political factors also have an influence. Accordingly, the environment includes:

- The objects that people use when they do things
- The spaces within which people do things
- The occupational forms or tasks that are available, expected, and/or required of people in a given context
- The social groups (e.g., family, friends, coworkers, neighbors) that make up the context
- The surrounding culture; political and economic forces

For example, political and economic conditions determine what resources people have for doing things and culture shapes beliefs about how one should perform and what is worth doing. Further, the demands of a task can determine the extent to which a person feels confident or anxious. How well objects and spaces are suited to capacity of the individual influences how the person performs. In these and many other ways, the environment influences what people do and how they think and feel about their doing. In turn, people also may choose and modify their environments. For instance, people select environments that match and allow them to realize their values and interests.

Dimensions of Doing

As Figure 11.1 shows, MOHO identifies three levels for examining what a person does:

- Occupational participation
- Occupational performance
- Occupational skill (Kielhofner, 2008)

Occupational participation refers to engaging in work, play, or activities of daily living that are part of one's sociocultural context and that are desired and/or necessary to one's well-being. Examples of occupational participation are working in a full- or part-time job, pursuing a hobby, doing routine self-care, maintaining one's home, and attending school. Each area of occupational participation involves a cluster of related activities. For example, maintaining one's home may include such things as paying the rent, doing repairs, and cleaning. The process of doing such occupational forms or tasks is referred to as **occupational performance**. Moreover, this occupational performance requires discrete purposeful actions. For example, making a sandwich is a culturally recognizable occupational form or task in many cultures. To do so, one *gathers* together bread and other ingredients such as meat, cheese, lettuce, and condiments; one *handles* these materials; and one *sequences* the steps necessary to construct the sandwich. These discrete actions (gathering, handling, and sequencing) along with other such actions that make up occupational performance are referred to as skills.

Skills are goal-directed actions that a person uses while performing (Fisher, 1998; Fisher & Kielhofner, 1995; Forsyth, Salamy, Simon, & Kielhofner, 1998). In contrast to performance capacity, which refers to underlying ability (e.g., range of motion and strength), skill refers to the purposeful actions that make up occupational performance. There are three categories of skills: motor skills, process skills, and communication and interaction skills. Definitions and examples of each category of skill are shown in Table 11.1.

Occupational Identity, Competence, and Adaptation

Over time, people create their own **occupational identity,** the cumulative sense of who they are and wish to become as occupational beings. The degree to which people are able to sustain a pattern of doing that enacts their occupational identity is referred to as **occupational competence.** As Figure 11.1 shows, **occupational adaptation** refers to the process of creating and enacting a positive occupational identity.

People achieve coherence and meaning in their occupational identity through narratives. An **occupational narrative** is a story (both told and enacted) that integrates across time one's unfolding volition, habituation, performance capacity, and environments and that sums up and assigns meaning to these elements. Occupational narratives can either impede or focus occupational adaptation. For example, if someone's narrative portrays life as a tragedy, there is little reason to work toward goals. On the other hand, if someone's narrative portrays life as getting better, he or she will likely be motivated to work hard toward that outcome. Research has shown that occupational narratives predict future adaptation of occupational therapy clients (Kielhofner, Braveman, et al., 2004; Kielhofner, Braveman, Fogg, & Levin, 2008).

There are situations in which one is unable to enact the life story one envisions and desires. There is evidence that following onset of disability, many persons may initially experience a gap between the identity reflected in their narratives and what they are able to enact (Kielhofner, Mallinson, Forsyth, & Lai, 2001; Mallinson, Mahaffey, & Kielhofner, 1998). These same studies also suggest that one cannot have competence without an intact identity. Occupational adaptation begins with what one imagines in the occupational narrative. In the end the occupational narrative determines the meaning people assign to occupational life and guides how they seek to enact occupational life.

Table 11.1 Definitions and Examples of Skill Categories

Skill Category	Definition	Examples
Motor	Moving self or task objects (Fisher, 1999).	Stabilizing and bending one's body and manipulating, lifting, and transporting objects.
Process	Logically sequencing actions over time, selecting and using appropriate tools and materials, and adapting performance when encountering problems (Fisher, 1999).	Choosing and organizing objects in space as well as initiating and terminating steps in performance.
Communication and Interaction	Conveying intentions and needs and coordinating social action to act together with people (Forsyth et al., 1998; Forsyth, Lai, & Kielhofner, 1999).	Gesturing, physically contacting others, speaking, engaging and collaborating with others, and asserting oneself.

MOHO conceptualizes occupational therapy as a process in which clients engage in occupations that shape their abilities, routine ways of doing things, and thoughts and feelings about themselves.

Change and the Process of Therapy

MOHO asserts that all change in occupational therapy is driven by clients' **occupational engagement** (i.e., clients' doing, thinking, and feeling under certain environmental conditions in the midst of therapy or as a planned consequence of therapy). Thus, MOHO conceptualizes occupational therapy as a process in which clients engage in occupations that shape their abilities, routine ways of doing things, and thoughts and feelings about themselves. Moreover, when clients engage in occupations, volition, habituation, and performance capacity are all involved in some way. For example, in any moment of therapy, a client may be:

- Practicing skills necessary for occupational performance
- Learning new habits that shape how the occupational performance is done
- Enacting a new role
- Experiencing satisfaction and enjoyment
- Valuing the accomplishment
- Feeling competent at performance

Each of these aspects of what the client does, thinks, and feels is essential to the process of therapy. For this reason, therapists using MOHO concepts are mindful of their clients' volition, habituation, performance capacity, and environmental conditions. Therapists monitor how these elements interact as therapy unfolds. To help therapists think about the process of occupational engagement, MOHO identifies the nine dimensions of occupational engagement shown in Table 11.2. They provide a basic structure for thinking about how clients achieve change and for planning how therapy goals will be achieved.

Practice Resources

Extensive resources have been developed for this model. They include a therapeutic reasoning process, a wide range of assessments, standardized programs and intervention protocols, and a large number of case examples.

Therapeutic Reasoning

Therapeutic reasoning is a process for MOHO concepts and resources to understand and address clients' needs. Therapeutic reasoning involves six steps:

- Generating questions about the client
- Gathering information on, from, and with the client
- Using the information gathered to create an explanation of the client's situation
- Generating goals and strategies for therapy
- Implementing and monitoring therapy
- Determining outcomes of therapy

Table 11.2 Definitions and Examples of the Dimensions of Client Occupational Engagement

Dimension	Definition	Examples
Choose/decide	Anticipate and select from alternatives for action.	Decide whether to role-play a job interview or work on a resume during a vocationally oriented therapy session.
Commit	Decide to undertake a course of action to accomplish a goal, fulfill a role, or establish a new habit.	Decide to enroll in a training program to develop skills for a particular job.
Explore	Investigate new objects, spaces, social groups, and/or occupational forms/tasks; do things with altered performance capacity; try out new ways of doing things; examine possibilities for occupational participation in one's context.	Play with a new toy; try out a new motorized wheelchair.
Identify	Locate novel information, alternatives for action, and new feelings that provide solutions for and/or give meaning to occupational performance and participation.	Recognize how one's values result in decisions to engage in occupations beyond one's capacity, leading to failure.
Negotiate	Engage in a give-and-take with others that creates mutually agreed-upon perspectives and/or finds a middle group between different expectations, plans, or desires.	Mutually decide upon treatment goals with the occupational therapist.
Plan	Establish an action agenda for performance or participation.	Determine what steps are necessary to complete a task or achieve a goal.
Practice	Repeat a certain performance or consistently participate in an occupation with the intent of increasing skill, ease, and effectiveness of performance.	Work toward learning to transfer from a wheelchair to bed by repeating it with supervision from an occupational therapist.
Reexamine	Critically appraise and consider alternatives to previously held beliefs, attitudes, feelings, habits, or roles.	Rethink ways that one can still enjoy leisure activities involving sports, following an injury that limits its capacity to do the activities.
Sustain	Persist in occupational performance or participation despite uncertainty or difficulty.	Continue working toward learning a skill despite anxiety associated with performance.

MOHO emphasizes that therapeutic reasoning must be client-centered in that:

- The process reflects a deep appreciation for the client's circumstances
- The client is involved in the process to the extent possible

Therapists may move back and forth between the steps of therapeutic reasoning, which are briefly described here. The box featuring a young client named Drew and the case at the end of the chapter also illustrate this therapeutic reasoning process.

Generating Questions

Therapists must understand their clients before planning therapy. This understanding begins

Box 11.1 An Example of the Process of Therapeutic Reasoning

Drew is a first grader who has difficulty keeping his attention focused in the classroom and when doing homework. His parents have reported that he had been increasingly dreading going to school. Drew has been having particular difficulty with his homework assignments. Recently he started ignoring some of his homework assignments altogether. Drew's occupational therapist agreed to evaluate this difficulty with homework and develop a therapy plan. In doing so, she followed the therapeutic reasoning process.

Drew's mother supports him in completing his homework.

Generating Questions: The therapist began by generating questions to guide her approach to Drew. Since making decisions about doing one's homework is a function of volition, the occupational therapist began with questions about Drew's volition: Does he value school? What are his feelings about his ability to do schoolwork (especially homework)?

Gathering Information: The therapist gathered information from the teacher and from Drew's parents using brief interviews. She also briefly observed Drew in the classroom and then met with him to discuss how he approaches his homework. The therapist learned that Drew's parents highly value school performance and that Drew very much wants to please his parents. The therapist observed in the classroom that Drew was having difficulty organizing his school materials. When she asked Drew about homework, he admitted that while he sometimes found homework difficult, he also sometimes lost his homework assignments or forgot they were in his backpack. After missing several homework assignments he admitted that he "kind of gave up."

Creating a Theory-Based Explanation: Based on the information she gathered, the therapist arrived at a theory-based understanding of Drew's homework difficulties. She reasoned that while Drew has positive values about school and wants to do well, he has a poor sense of efficacy (i.e., he believes he will fail to get his homework assignments completed because of past failures). Drew's feelings of inefficacy have led him to choose to avoid homework (in Drew's words, "giving up") that, in turn, leads to further failure and a poorer sense of efficacy. She also noted that Drew's feelings are based on a genuine difficulty organizing his school materials.

Therapy Goals and Strategies: Thus she generated the following therapy goals:

- Drew's sense of efficacy for completing homework will increase
- Drew will consistently make choices to do homework

In order to achieve these goals, the therapist came up with the following plan for Drew's occupational engagement. She decided that Drew would create and learn to use a system of organizing with a homework folder. She felt it was important that Drew be a partner with her in coming up with how he could use the folder to be more organized. She also decided that she would validate Drew's feelings, collaborate with him to get the folder labeled,

Box 11.1 An Example of the Process of Therapeutic Reasoning (continued)

and develop a plan to use it. She also decided to let Drew's teacher and parents know about the folder and how Drew planned to use it, so that they could also support him.

Monitoring and Determining Outcomes: Drew's therapist planned to monitor's Drew's reaction as they worked on the folder and also to check in with his teacher and parents to see if he was able to more successfully follow through on doing his homework.

with asking questions about each client. MOHO concepts provide a framework for generating these questions. For example, therapists using MOHO ask what their clients' thoughts and feelings are in relation to personal causation, values, and interests. Moreover, they ask about their clients' roles and habits and how these things affect the clients' routines. Such questions are, of course, tailored to the clients' circumstances (e.g., age and impairment).

Gathering Information

Therapists must gather information on, from, and with the client in order to answer the questions they have generated about the client. Such information gathering may take advantage of informal, naturally occurring opportunities. For example, a therapist might learn about a client's personal causation by observing the client's behavior when facing a challenging new task or by engaging in a conversation about the client's concerns over some future task or role.

Therapists also use structured MOHO assessments. Some of these assessments focus on specific factors such as interests and roles while others capture comprehensive information on several aspects of the person and the environment. A wide range of MOHO-based assessments have been developed; they are summarized in Table 11.3. All of these assessments may be obtained free of charge or purchased on the MOHO website (http://www.moho.uic.edu/).

Creating a Theory-Based Understanding of Clients

Information that therapists gather to answer questions about their clients is used to create a theory-based understanding of those clients. To this end, therapists use MOHO theory as a framework for creating a conceptualization or explanation of each particular client's situation. As part of creating a conceptualization of clients' circumstances, therapists identify problems or challenges to address as well as strengths that can be built upon in therapy.

Generating Therapy Goals and Strategies

The theory-based understanding of clients is used to:

- Generate therapy goals (i.e., identify what will change as a result of therapy)
- Decide what kinds of occupational engagement will enable the client to change
- Determine what types of therapeutic strategies will be needed to support the client to change

Change is required when the client's characteristics and/or environment are contributing to occupational problems or challenges. For instance, if a client's personal causation is characterized by feelings of ineffectiveness, therapy would seek to enable the client to feel more effective, or if a client has too few or no roles, therapy would seek to enable the client to choose and enact new roles. In this way, identifying challenges or problems in the third step allows one to select the goals in the fourth step.

The next element in this step is to identify how the goals will be achieved. This involves indicating what occupation(s) the client will engage in to achieve the goals. It also involves consideration of how the therapist will support the client during this occupational engagement.

To support the steps of therapeutic reasoning, a therapeutic reasoning table has been developed and can be found in *Model of*

(text continues on page 161)

Table 11.3 MOHO Assessment Summary Table

MOHO Assessment	Method of Administration	Description
Assessment of Communication and Interaction Skills (ACIS)	Observation	Gathers information about the communication and interaction skills that a person displays while engaged in an occupation across the domains of physicality, information exchange, and relations. Used to generate goals for therapy related to communication/interaction skills and to assess outcomes/changes in skill.
Assessment of Motor and Process Skills (AMPS)	Observation	Gathers information about the motor and process skills that a person displays while engaged in an occupation. Used to generate goals for therapy related to motor and process skills and to assess outcomes/changes in skill.
Assessment of Occupational Functioning- Collaborative Version (AOF-CV)	Interview and/or client self-report	Yields qualitative information and a quantitative profile of the impact of a client's personal causation, values, roles, habits, and skills on occupational participation. Used to inform intervention.
Child Occupational Self Assessment (COSA)	Client self-report	Children and youths rate their occupational competence for engaging in 25 everyday activities in the home, school, and community and the importance of those activities. Used to generate goals and assess outcomes/changes in competence and values.
Interest Checklist	Client self-report	Checklist that indicates strength of interest and past, present, and future engagement in 68 activities. Used to inform intervention.
Model of Human Occupational Screening Tool (MOHOST)	Observation, interview(s), and/or chart review	Information gathered assesses impact of volition, habituation, skills, and environment on client's occupational participation. Used to generate goals and assess outcomes/changes in participation.

NIH Activity Record	Client self-report	Self-report "log" records information in half-hour intervals throughout the day on perceptions of competence, value, enjoyment, difficulty, and pain experienced when engaging in various occupations in that time period. Used to inform intervention and assess outcomes/changes in participation.
Occupational Circumstances Assessment-Interview and Rating Scale (OCAIRS)	Interview	Interview yields information to assess values, goals, personal causation, interests, habits, roles, skills, readiness for change, and environmental impact on participation. Used to generate goals and assess outcomes/changes in participation.
Occupational Performance History Interview-II (OPHI-II)	Interview	Detailed life history interview that yields (1) scales measuring competence, identity, and environmental impact, and (2) a narrative representation/analysis of the life history. Used as an in-depth, comprehensive assessment to generate goals, inform intervention, and build the therapeutic relationship.
Occupational Questionnaire (OQ)	Client self-report	Self-report "log" records information in half-hour intervals throughout the day on perceptions of competence, value, and enjoyment experienced when engaging in various occupations in that time period. Used to inform intervention and assess outcomes/changes in participation.
Occupational Self Assessment (OSA)	Client self-report	Clients rate their occupational competence for engaging in 21 everyday activities and the importance of those activities. Allows clients to set priorities for change. Used to generate goals and assess outcomes/changes in competence and values.

(table continues on page 160)

Table 11.3 **MOHO Assessment Summary Table** *continued*

MOHO Assessment	Method of Administration	Description
Pediatric Interest Profiles (PIP)	Client self-report	Assessment includes three age-appropriate scales (some with line drawings) for children and adolescents to indicate participation, interest, and perceived competence in a variety of play and leisure activities. Used to generate goals and assess outcomes/changes in participation.
Pediatric Volitional Questionnaire (PVQ)	Observation	Guides a systematic observation of a child across multiple environments to assess volition and the impact of the environment on volition. Used as an in-depth assessment of volition to generate goals and assess outcomes/changes in volition.
Role Checklist	Client self-report	Checklist provides information on past, present, and future role participation and the perceived value of those roles. Used to inform intervention and assess outcomes/changes in role performance.
Short Child Occupational Profile (SCOPE)	Observation, interview(s), and/or chart review	Information gathered assesses impact of volition, habituation, skills, and environment on child's/adolescent's occupational participation. Used to generate goals and assess outcomes/changes in participation.
School Setting Interview (SSI)	Interview	Interview works with students to gather information on student-environment fit and identify need for accommodations. Used to generate goals, inform intervention, and assess outcomes/changes in student-environment fit.
Volitional Questionnaire (VQ)	Observation	Guides a systematic observation of a client across multiple environments to assess volition and the impact of the environment on volition. Used as an in-depth assessment of volition to generate goals and assess outcomes/changes in volition.

Worker Role Interview (WRI)	Interview	Interview yields information to rate the impact that volition, habitation, and perceptions of the environment have on psychosocial readiness for the worker role/return to work. Used to generate goals and assess outcomes/changes in psychosocial readiness for work.
Work Environment Impact Scale (WEIS)	Interview	Interview works with client to assess environmental impact on participation in the worker role and to identify needed accommodations. Used to generate goals and inform intervention.

Human Occupation: Theory and Application, 4th edition (Kielhofner, 2008). This table identifies a wide range of problems and challenges that correspond to the concepts of MOHO along with types of changes that would be warranted. The table also indicates what types of occupational engagement could contribute to achieving those changes and what type of support from the therapist could facilitate change. Table 11.4 shows a small section from this therapeutic reasoning table related to personal causation.

Box 11.2 Therapeutk Strategies Identified by MOHO

- *Validating:* Attending to and acknowledging the client's experience.
- *Identifying:* Locating and sharing a range of personal, procedural, and/or environmental factors that can facilitate occupational performance.
- *Giving Feedback:* Sharing one's understanding of the client's situation or ongoing action.
- *Advising:* Recommending intervention goals/strategies.
- *Negotiating:* Engaging in a give-and-take with the client.
- *Structuring:* Establishing parameters for choice and performance by offering a client alternatives, setting limits, and establishing ground rules.
- *Coaching:* Instructing, demonstrating, guiding, verbally, and/or physically prompting.
- *Encouraging:* Providing emotional support and reassurance in relation to engagement in an occupation.
- *Physical Support:* Using one's body to provide support for a client to complete an occupational form/task.

Implementing and Monitoring Therapy

Monitoring how the therapy process unfolds may confirm the therapist's conceptualization of the client's situation or it may require the therapist to rethink the client's situation. The monitoring process may confirm the utility of the planned client occupational engagement and therapist strategies. On the other hand, it may require the therapist to change the therapy plan. When things do not turn out as expected, the therapist returns to earlier steps of generating questions, selecting methods to gather information, conceptualizing the client's situation, setting goals, and establishing plans.

Collecting Information to Assess Outcomes

Determining therapy outcomes is an important final step in the therapy process. Typically, therapy outcomes are documented by:

- Examining the extent to which goals have been achieved

Table 11.4 Excerpt From the Therapeutic Reasoning Table Showing a Problem/Challenge Related to Personal Causation and Corresponding Intervention Goals and Strategies

Problem/Challenge	Goal	Client Occupational Engagement	Therapeutic Strategies to Support the Client
• Feelings of lack of control over occupational performance leading to anxiety (fear of failure) within occupations.	• Reduce client's anxiety and fear of failure in occupational performance (e.g., "The client will complete a simple three-step meal in 20 minutes without verbalizing anxiety or concern"). • Build up confidence to face occupational performance demands (e.g., "The client will identify and participate in three new leisure activities with minimal support in one week").	• *Reexamine* anxieties and fears in the light of new performance experiences. • *Choose* to do relevant and meaningful things that are within performance capacity. • *Sustain* performance in occupational forms despite anxiety.	• *Validate* how difficult it can be to do things that provoke anxiety. • *Identify* client's strengths and weaknesses in occupational performance. • Give *feedback* to client about match/mismatch between choice of occupational forms/tasks and performance capacity. • Give *feedback* to support a positive reinterpretation of their experience of engaging in an occupation. • *Advise* client to do relevant and meaningful things that match performance capacity.

Source: Kielhofner (2008).

- Readministering structured assessments to determine whether the client's scores have improved

Both approaches are valuable means of determining whether positive outcomes have been achieved; they are sometimes used in combination.

Standardized Programs and Intervention Protocols

A large number of MOHO-based programs and standardized protocols for intervention have been developed and published. Two examples are the Remotivation Process and the Enabling Self-Determination Program.

Remotivation Process

The Remotivation Process is a standardized intervention developed for clients of any diagnosis who have significant volitional (i.e., motivational) problems (de las Heras, Llerena, & Kielhofner, 2003). This intervention was developed based on research about volition and a long process of experimentation in practice with clients who had severe motivational problems. The Remotivation Process involves three levels of intervention (see Table 11.5). The level that one begins with depends on the severity of the volitional problem. Within each level there are specific steps and strategies for working with clients to support occupational engagement that will enhance volition. A manual details how to undertake this

intervention protocol; it includes specific assessment guidelines, explanations and examples of the stages, steps, and strategies of the intervention, and case examples of clients receiving Remotivation services (de las Heras et al., 2003). This manual may be obtained online at http://www.moho.uic.edu/programs.html.

Enabling Self-Determination (ESD) Program

The ESD program was developed to enhance productivity and participation in persons facing substantial personal and environmental challenges (Kielhofner et al., 2008). This program

Table 11.5 Modules, Goals, Stages, and Strategies of the Remotivation Process

Modules	Goals	Stages and (Strategies)
Exploration	• Facilitate a client's sense of personal significance • Facilitate a client's basic sense of capacity • Facilitate a sense of security with the environment	• Validation (significant greeting; introduction of meaningful elements into the individual's personal space; participation in activities of interest to the individual; generating interaction) • Environmental exploration (introduce change to allow for exploration; keep a familiar routine for sense of security amid novelty) • Choice-making (increase novelty [new settings, people, etc.]; increase invitations for participation) • Pleasure and efficacy in action (facilitate participation in collaborative projects; incorporate feedback; facilitate a sense of life story)
Competency	• Increase emerging sense of efficacy • Begin looking at experiences as they relate to meeting goals • Develop a sense of responsibility with personal and collective projects	• Internalized sense of self-efficacy (provide physical or emotional "accompaniment" in new and challenging situations; facilitate skill learning when appropriate; introduce the counseling process and use of feedback) • Living and telling one's story (allow for "moments of reflection" or disorder in change process; continue counseling process to further insight through more in-depth analysis and questions)
Achievement	• Autonomy in a variety of settings • Striving for personal goals; making occupational choices • Seeking new challenges in relevant occupational environments • Continued learning of critical skills and new strategies/tools for seeking and confronting challenges	(Advise client; give feedback; provide information and resources; step back)

was originally developed and tested with persons who had combinations of HIV/AIDS, mental illness, and substance abuse histories. It consists of group and individual interventions designed to enhance volition and to support the development of routines, habits, and skills for new productive occupational roles. The program helps clients examine their own volition, lifestyle, and skills and begin a process of identifying personal goals for enhanced productivity.

Development of the program was guided by a prior three-year research and development project (Kielhofner, Braveman, et al., 2004) and focus groups with consumers for whom the program was designed (Paul-Ward, Braveman, Kielhofner, & Levin, 2005). A control group study provided evidence of the effectiveness of the program in helping clients achieve more productive lives (Kielhofner et al., 2008). This program is described in a detailed manual, which may be downloaded from the MOHO Clearinghouse website (http://www.moho.uic.edu/mohorelatedrsrcs.html#OtherInstrumentsBasedonMOHO).

Using MOHO requires therapists to assess carefully and come to understand a client and then to develop, implement, and monitor a plan of therapy that addresses the client's specific needs, desires, and challenges.

Case Examples

MOHO emphasizes an individualized, client-centered approach to intervention based on thorough understanding of the client's unique characteristics. For this reason, using MOHO requires therapists to assess carefully and come to understand a client and then to develop, implement, and monitor a plan of therapy that addresses the client's specific needs, desires, and challenges. Because this therapeutic reasoning process is individualized, therapists can benefit from case examples that illustrate the process. A large number of case examples have been published. Some of these can be found in the text, *Model of Human Occupation: Theory and Application*, 4th edition (Kielhofner, 2008); others are in individual articles and chapters. Citations for these resources can be found at the MOHO clearinghouse website (http://www.moho.uic.edu/referencelists.html).

Research and Evidence Base

Since MOHO was first published nearly 30 years ago, more than 400 articles and chapters based on MOHO have been published and these include well over 100 studies. This model's developers have emphasized conducting research with practice relevance (Forsyth, Melton, & Mann, 2005; Kielhofner, 2005a, 2005b) and many of the studies represent partnerships between researchers, therapists, and clients.

Resources are available to help practitioners access and use the MOHO body of evidence. First, the MOHO Clearinghouse website (http://www.moho.uic.edu/evidence_based_practice.php#Search) includes an evidence-based search engine that enables practitioners to locate citations relevant to practice topics. Citations of studies have links to *Evidence Briefs* that summarize the research and discuss its implications for practice. These can be printed directly from the website.

There are also publications that synthesize the evidence related to this model. For instance, Kramer, Bowyer, and Kielhofner (2008) have organized available evidence to answer the following practice-relevant questions:

- What does MOHO research tell us about the occupational lives and needs of people with disabilities?
- What evidence exists for the dependability and utility of MOHO-based assessments?
- What does practice based on MOHO looked like?
- What evidence is there that MOHO-based service produces positive outcomes?
- What do clients have to say about MOHO-based services?

Another example is a paper by Lee and Kielhofner (2009) that locates and synthesizes evidence related to the vocational rehabilitation practice area; evidence is organized according to common practice questions that arise when making

decisions about program design and service delivery.

Discussion

MOHO was introduced in 1980 by three practitioners seeking to articulate an approach to occupation-based intervention (Kielhofner, 1980a, 1980b; Kielhofner & Burke, 1980; Kielhofner, Burke, & Heard, 1980). Evidence indicates that MOHO is widely used in practice worldwide (Haglund, Ekbladh, Thorell, & Hallberg, 2000; Law & McColl, 1989; National Board for Certification in Occupational Therapy, 2004; Wilkeby, Pierre, & Archenholtz, 2006). A national study of occupational therapists in the United States (Lee, Taylor, Kielhofner, & Fisher, 2008) indicated that 75.7% of therapists make use of MOHO in their practice. These therapists reported that MOHO allows them to have an occupation-focused practice and a clearer professional identity. They also reported that MOHO provides a holistic view of clients, supports client-centered practice, and provides a useful structure for intervention planning.

Box 11.3

Model of Human Occupation Case Example: MARISOL

Introduction and the Process of Generating Questions

Marisol is a 45-year-old woman and the older of two sisters. She was recently diagnosed with schizophrenia. Marisol recently entered Senderos Foundation, the community center in Santiago, Chile. Andrea Girardi, her occupational therapist, knew that Marisol had a long period of poor occupational functioning prior to admission. Thus she generated the following questions about Marisol:

- What is Marisol's occupational identity and how is it reflected in her occupational narrative? To what extent has she been able to enact that identity (occupational competence)?
- What is the state of Marisol's volition? (Does she have interests? Does she feel effective? What is important to her? Does she make choices for activities based on her own volition?)
- What is her history of involvement in roles?
- What is her typical routine?
- What is her current performance capacity?
- What is her environment and how does it influence her occupational life?

Evaluation Process

In order to answer these questions, Andrea began the evaluation process, using the Occupational Performance History Interview-Second Version (OPHI-II) (Kielhofner, Mallinson, et al., 2004). This interview gathers information on clients' occupational identity, competence, and environment. It is an historical interview that ascertains the occupational narrative of the client. In the interview, Marisol described her childhood as positive and filled with family and social activities. In preadolescence, she began to experience difficulties in her student role. During this period, Marisol experienced an abusive relationship with her stepfather and became depressed. She dropped out of school and subsequently was in a relationship with an abusive partner. She has attempted and failed to re-enter the student role and has failed in attempts to enter the worker role.

Marisol discusses her life history with Andrea.

(box continues on page 166)

Box 11.3 (continued)

Most recently, two years ago, she attempted once again to return to school to study tourism but had to drop out. Following that she attempted to work as a janitor in a fast-food restaurant. With the stress of the job, her auditory hallucinations increased and she began to have conflicts with some of her coworkers. Due to both these factors Marisol quit her job.

The one activity she has been able to maintain with some consistency over a 10-year period is participation in yoga classes, which her mother teaches. The last 20 years of her life were characterized by a lack of roles and the absence of productive occupation; this was the case despite Marisol's desire for roles and her attempts to be a student or to work continuously in something. Her previous routine consisted of participating in yoga classes that her mother directed, helping in tasks of the home, and occasionally preparing lunch and listening to music.

Marisol's scores on the OPHI-II rating scales (Fig. 11.2) indicated that she had difficulty in the area of occupational identity. While she had struggled in most areas of occupational identity her primary strength was that she took responsibility for her own life and was committed to trying to achieve a more productive and satisfying occupational life. Her major problems have been in enacting that identity through sustaining roles, working toward her own goals, and performing in the way she believes she should.

The narrative slope that emerged from the OPHI-II is shown in Figure 11.3. While the lowest point in her occupational narrative was during her childhood abuse and her abusive relationship with her partner, her recent job and school failures coupled with her diagnosis represented a new low point. In spite of the difficulties that she had faced in her life, Marisol felt there was a possibility of overcoming her challenges and was able to articulate some hope for the future.

Andrea decided to further evaluate Marisol by observing her as she began to participate in occupational therapy groups. Informal observation revealed that her movements were very slow and rigid and she appeared unkempt. As a side effect of her medication, she also experienced sleepiness that interfered with her process skills and made it difficult for her to maintain an

Occupational Identity Scale	1	2	3	4
Has personal goals and projects		X		
Identifies a desired occupational lifestyle		X		
Expects success		X		
Accepts responsibility			X	
Appraises abilities and limitations		X		
Has commitments and values		X		
Recognizes identity and obligations		X		
Has interests		X		
Felt effective (past)		X		
Found meaning and satisfaction in lifestyle (past)			X	
Made occupational choices (past)		X		
Occupational Competence Scale				
Maintains satisfying lifestyle	X			
Fulfills role expectations		X		
Works toward goals	X			
Meets personal performance standards	X			
Organizes time for responsibilities		X		
Participates in interests		X		
Fulfilled roles (past)	X			
Maintained habits (past)		X		
Achieved satisfaction (past)	X			
Occupational Settings (Environment) Scale				
Home life occupational forms		X		
Major productive role occupational forms	Not applicable			
Leisure occupational forms	X			
Home life social group		X		
Major productive role social group	Not applicable			
Leisure social group		X		
Home spaces, objects, and resources			X	
Major productive role spaces, objects, and resources	Not applicable			
Leisure spaces, objects, and resources		X		

Key:

1=Extreme occupational functioning problems
2=Some occupational functioning problems
3=Appropriate satisfactory occupational functioning
4=Exceptionally competent occupational functioning

FIGURE 11.2 Marisol's Scores on the OPHI-II Scales.

Box 11.3 (continued)

appropriate pace during any task. Marisol's therapist reported the pharmaceutical side effects to her psychiatrist who decided to modify her medication.

The therapist also observed that Marisol always tended to agree with everything that was proposed, without discriminating what she was interested in or what she wanted for herself and without considering her own preferences and opinions. Andrea initially planned to use the Interest Checklist (Matsutsuyu, 1969) to help Marisol reflect on her interests. However, because Marisol had difficulty identifying which occupations were of greater interest to her, the therapist also decided to further evaluate her volition through use of the Volitional Questionnaire (a short rating scale that can be quickly competed following observation of a client in an activity) (de las Heras, Geist, Kielhofner, & Li, 2007). She completed the Volitional Questionnaire several times following observations of Marisol in various activities and groups offered in the setting. The Volitional Questionnaire confirmed that Marisol's volition was quite low and that she needed support to exhibit the most basic, exploratory level of motivation. Andrea also identified that Marisol expressed her highest motivation while playing tennis, in secretarial tasks, and when participating in English classes.

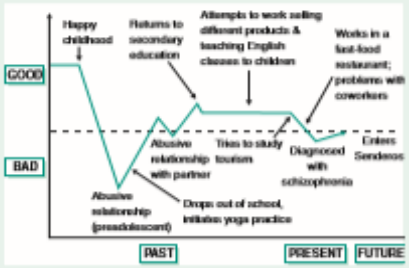

FIGURE 11.3 Marisol's Narrative Slope from the OPHI-II.

An Explanation of Marisol's Situation

Andrea created the following explanation of Marisol's situation:

> *Marisol has a history of personal trauma and a psychiatric illness that both have interfered with her ability to develop and enact a positive occupational identity. Her volition is a major area of weakness as she has difficulty identifying and choosing the things that are of interest and have significance for her. At the same time, she has a very strong value that she should be productive but does not know how to go about this. Her actual performance capacity is unknown (and cannot be fully ascertained until she is stabilized on medication).*

Goals, Strategies, and Implementation of Therapy

Andrea's goals for Marisol were:

- Increase her volition (i.e., development of her interests, identification of significant activities, and realistic belief in her abilities)
- Explore her performance in order to more clearly understand what skills she has

In order to address Marisol's low volition, Andrea decided to use the Remotivation Process (de las Heras et al., 2003) beginning with exploratory level intervention. Because the Remotivation Process requires cooperation of many people in the client's environment, Andrea presented this treatment strategy to the interdisciplinary team of Senderos. The team agreed with this recommendation and basic strategies for the validation process (step one of Remotivation) were outlined for the interdisciplinary staff.

Andrea began the Remotivation Process at the exploratory level. She worked to create a safe environment with opportunities for Marisol to engage in occupations that could promote her

(box continues on page 168)

Box 11.3 (continued)

basic sense of capacity and of pleasure in doing. As Marisol was able to do activities with some success, Andrea coached Marisol on how to be more aware of her own experience of engaging in occupation. She also helped her to interpret and reflect upon her experiences of doing things. During their discussions, Marisol indicated three possible long-term goals: to return to study tourism, to teach English classes to children, or to work with older adults. The therapist validated these goals and committed to Marisol that they would find opportunities for her to try out these areas of work.

During the second, competence, stage of the Remotivation Process, Marisol began to assume small tasks and take on roles in the community of Senderos. She agreed to work as an assistant supporting the English teacher in her classes. She also began to volunteer doing some secretarial work in Senderos. After trying out this role she became very motivated to try to learn how to use a computer. She began to spontaneously greet others in Senderos and to smile at her own achievements.

During this time, she also chose to take tennis classes that were taught by an instructor from the community. At first, she had difficulty even hitting the tennis ball. Her movements were so slow that by the time she was able to raise the racket, the ball was already past her. In spite of her feelings of incapability, she tried it again and again. Despite her difficulties Marisol really wanted to learn to play. So Andrea decided to meet with the tennis instructor in order to provide him an introduction to the Remotivation Process so that he would know what strategies to use when teaching Marisol to play tennis. Andrea also gave the tennis instructor guidance in how to grade the demands of the instruction to Marisol's level of motor skills.

As Marisol progressed (i.e., began to show increasing pleasure and a greater sense of efficacy in doing things, ability to commit herself to learning new skills, solving problems, and other behaviors indicative of the competence level of volition), Andrea decided to introduce strategies from the achievement level of the Remotivation Process. Andrea and Marisol together decided to work toward the goal of Marisol working as a tour guide. At first, Marisol indicated an interest in writing articles related to local areas of interest for a newsletter published in the center. She also began to explore the role of tour guide during outings with other members of Senderos. With support from Andrea, she researched and prepared material for giving tours on planned outings.

Marisol tries horseback riding during a group outing.

Andrea also worked with Marisol to reconstruct her occupational narrative focusing on where she wanted her life story to go in the future. Marisol's family also participated actively in Marisol's therapy process. They attended family counseling provided by the occupational therapist. In these counseling sessions the therapist explained the Remotivation Process to members of the family and demonstrated how they could best support Marisol as she passed through the three modules of the Remotivation Process.

Six months into her involvement in the center, the female participants of Senderos decided to create a special space for women (a beauty salon). Marisol proved to be very interested in it and decided to take part in the creation of the salon. Through her participation, she discovered that she had a lot of knowledge to contribute and began to see herself as more attractive and to take an interest in keeping herself well groomed. She also received validation from other members of the female group concerning her much improved appearance.

At this time Marisol started to teach in the elementary English course offered in the setting. This experience allowed her to investigate what it meant to be a teacher, how to prepare

Box 11.3 (continued)

the classes, how to adapt the methodology to her pupils, and how to prepare didactic material. To support Marisol, Andrea graded the various teaching related activities that Marisol undertook.

Marisol also decided to begin volunteer work with elderly people in order to build her sense of capacity, practice maintaining a work routine, and grow more comfortable around other people. Together, Andrea and Marisol began to look for institutions and make telephone calls. Andrea accompanied Marisol to potential volunteer settings for interviews. Marisol was accepted as a volunteer in one nursing home for the elderly and began working there. Her job was initially to accompany the elderly and to give help to the nursing personnel when feeding and bathing elderly residents. The personnel in the institution value Marisol's work and the elderly residents have grown to know Marisol and feel comforted by her presence. Marisol has worked in the nursing home for four months and mostly goes there on her own. Andrea accompanies her occasionally when she takes on new challenges such as organizing games for small groups of elderly residents.

While participating in this volunteer work, Marisol took advantage of the opportunity to participate in courses related to teaching offered in the local community. In counseling, Andrea had introduced the possibility of taking some courses related to her goals and Marisol decided that she felt prepared to take courses that would qualify her as a preschool assistant. As she took on the student role, she was able to dress and groom herself appropriately and she showed up to classes with notebooks and materials to take notes. She successfully completed the necessary courses to qualify as a teaching assistant.

Now, Marisol is looking for a place to do her practicum experience in a classroom with children. Through the Remotivation Process, Marisol has been able to develop a sense of efficacy to explore and identify her own interests and to sort out what is important to her. She has also successfully sustained a productive routine and succeeded in several roles. Most importantly, Marisol reports that now she feels much happier than at any other time in her life.

Table 11.6 Terms of the Model

Environment	The particular physical, social, cultural, economic, and political features within a person's context that have an impact on the motivation, organization, and performance of occupation.
Habits	Acquired tendencies to respond automatically and perform in certain, consistent ways in familiar environments or situations.
Habituation	An internalized readiness to exhibit consistent patterns of behavior guided by our habits and roles and fitted to the characteristics of routine temporal, physical, and social environments.
Interests	What one finds enjoyable or satisfying to do.
Occupational adaptation	Constructing a positive occupational identity and achieving occupational competence over time in the context of one's environment.
Occupational competence	Degree to which one is able to sustain a pattern of occupational participation that reflects one's occupational identity.

(table continues on page 170)

Table 11.6 Terms of the Model *continued*

Occupational engagement	Clients' doing, thinking, and feeling under certain environmental conditions in the midst of or as a planned consequence of therapy.
Occupational identity	Composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation.
Occupational narrative	A person's story (both told and enacted) that integrates across time one's unfolding volition, habituation, performance capacity, and environments and that sums up and assigns meaning to these elements.
Occupational participation	Engagement in work, play, or activities of daily living that are part of one's sociocultural context and that are desired and/or necessary to one's well-being.
Occupational performance	Doing an occupational form.
Performance capacity	Ability for doing things provided by the status of underlying objective physical and mental components and corresponding subjective experience.
Personal causation	One's sense of competence and effectiveness.
Role	The incorporation of a socially and/or personally defined status and a related cluster of attitudes and actions.
Skills	Observable, goal-directed actions that a person uses while performing.
Therapeutic reasoning	A six-step process used to understand and address clients' needs.
Values	What one finds important and meaningful to do.
Volition	Pattern of thoughts and feelings about oneself as an actor in one's world, which occurs as one anticipates, chooses, experiences, and interprets what one does.

SUMMARY

- MOHO became the first client-centered model by looking beyond impairment to other client-related factors affecting occupational performance

Theory

- MOHO is ultimately concerned with individuals' participation and adaptation in life occupations
- Volition is the process by which people are motivated toward and choose the activities they do. It begins with the universal human desire to do things and is shaped by life experiences. Volition consists of thoughts and feelings that occur in a cycle of:
  - Anticipating possibilities for doing
  - Choosing what to do

- Experiencing what one does
- Subsequent interpretation of the experience

- The thoughts and feelings that make up volition are referred to as personal causation, values, and interests
  - Personal causation refers to the thoughts and feelings about personal capacities and effectiveness that people have as they do everyday activities
  - Values are beliefs and commitments about what is good, right, and important to do
  - Interests are generated through the experience of pleasure and satisfaction in occupation
- Volition has a pervasive influence on occupational life. It shapes:
  - How people see the opportunities and challenges in their environment
  - What people choose to do
  - How they experience and make sense of what they have done
- Occupational therapy based on MOHO often involves identifying and addressing clients' volitional problems
- Habituation is a process whereby people organize their actions into patterns and routines
- Habits involve learned ways of doing things that unfold automatically
- Roles give people an identity and a sense of the obligations that go with that identity
- Learning a new role involves internalizing an identity, an outlook, and an expected way of behaving
- One of the major tasks of therapy is to construct or reconstruct habits and roles so that the person can more readily participate in everyday occupations
- Performance capacity refers to underlying mental and physical abilities and how they are used and experienced in performance
- The capacity for performance is affected by the status of musculoskeletal, neurological, cardiopulmonary, and other bodily systems that are called on when a person does things
- Performance also calls on mental or cognitive abilities such as memory
- MOHO stresses the importance of also attending to the experience of performance and, in particular, the experience of having limitations in performance
- MOHO stresses that occupation results from an interaction of the inner characteristics of the person (volition, habituation, and performance capacity) with the environment
- The environment includes the particular physical, social, cultural, economic, and political features within a person's context that influence the motivation, organization, and performance of occupation
- The environment includes:
  - The objects that people use when they do things
  - The spaces within which people do things
  - The occupational forms or tasks that are available, expected, and/or required of people in a given context
  - The social groups that make up the context
  - The surrounding culture, political, and economic forces
- MOHO identifies three levels for examining what a person does:
  - Occupational participation refers to engaging in work, play, or activities of daily living that are part of one's sociocultural context and that are desired and/or necessary to one's well-being
  - Occupational performance is the process of doing such occupational forms or tasks
  - Occupational skills are the purposeful actions that make up occupational performance. Skills are goal-directed actions that a person uses while performing
    - Categories of skills include motor, process, and communication and interaction skills
- Occupational identity is a person's cumulative sense of who they are and wish to become as occupational beings
- The degree to which people are able to sustain a pattern of doing that enacts their occupational identity is referred to as occupational competence
- Occupational adaptation refers to the process of creating and enacting a positive occupational identity
- An occupational narrative is a person's story that integrates across time one's unfolding volition, habituation, performance capacity, and environments and that sums up and assigns meaning to these elements
- Research has shown that occupational narratives predict future adaptation of occupational therapy clients
- MOHO asserts that all change in occupational therapy is driven by clients' occupational engagement (i.e., clients' doing, thinking, and feeling under certain environmental conditions in the midst of therapy or as a planned consequence of therapy)
- Each of these aspects of what the client does, thinks, and feels is essential to the process of therapy

Practice Resources

- Therapeutic reasoning is a process for MOHO concepts and resources to understand and address clients' needs. Therapeutic reasoning involves six steps:
  - Generating questions about the client
    - Therapists must understand their clients before planning therapy
    - This understanding begins with asking questions about each client derived from MOHO concepts
  - Gathering information on, from, and with the client
    - Therapists must gather information on, from, and with the client in order to answer the questions they have generated about the client
    - Such information gathering may take advantage of informal, naturally occurring opportunities
    - Therapists also use structured MOHO assessments
  - Using the information gathered to create an explanation of the client's situation
    - Information that therapists gather to answer questions about their clients is used to create a theory-based understanding of those client
    - As part of creating a conceptualization of clients' circumstances, therapists identify problems or challenges to address as well as strengths that can be built upon in therapy
  - Generating goals and strategies for therapy
    - The theory-based understanding of clients is used to generate therapy goals, decide what kinds of occupational engagement will enable the client to change, and determine what kind of therapeutic strategies will be needed to support the client to change
    - Change is required when the client's characteristics and/or environment are contributing to occupational problems or challenges
    - The next element in this step is to identify how the goals will be achieved
  - Implementing and monitoring therapy
    - Monitoring how the therapy process unfolds may confirm the therapist's conceptualization of the client's situation or it may require the therapist to rethink the client's situation
    - The monitoring process may confirm the utility of the planned client occupational engagement and therapist strategies or it may require the therapist to change the therapy plan
    - When things do not turn out as expected, the therapist returns to earlier steps of generating questions, selecting methods to gather information, conceptualizing the client's situation, setting goals, and establishing plans.
  - Determining outcomes of therapy
    - Typically, therapy outcomes are documented by examining the extent to which goals have been achieved and readministering structured assessments to determine whether the client's scores have improved
- Therapeutic reasoning must be client-centered

- The process reflects a deep appreciation for the client's circumstances
- The client is involved in the process to the extent possible

✦ Therapists may move back and forth between the steps of therapeutic reasoning

Intervention

✦ A large number of MOHO-based programs and standardized protocols for intervention have been developed and published

✦ The Remotivation Process is a standardized intervention developed for clients of any diagnosis who have significant volitional problems

✦ The Remotivation Process involves three levels of intervention (exploration, competence, and achievement); the level that one begins with depends on the severity of the volitional problem

✦ A manual details how to undertake this intervention protocol; it includes specific assessment guidelines, explanations and examples of the stages, steps and strategies of the intervention, and case examples of clients receiving Remotivation services

✦ The Enabling Self-Determination Program was developed to enhance productivity and participation in persons facing substantial personal and environmental challenges

✦ The program helps clients examine their own volition, lifestyle, and skills and begin a process of identifying personal goals for enhanced productivity

✦ Because the therapeutic reasoning process is individualized, therapists can benefit from case examples that illustrate the process

✦ A large number of MOHO case examples have been published

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