



Model of Human Occupation

Archived List Serv Discussion

How to Explain/Differentiate Process Skills From Cognition

July 9, 2009

Hi all,

I'm currently working in a memory service for older people. Sometimes think I'm speaking a different language (and I know we've all felt that as OTs). This is regards that slippery topic of process skills and cognitive skills- and for that matter psychological/cognitive strategies versus occupational strategies.

It's sometimes such a tough concept to explain, even though to me its obvious. So why's it so difficult to explain or for others to understand? More to the point why's it such an uphill struggle in explaining its importance and relevance?

Do any of you have any suggestions on how I can pitch an explanation, as I am presenting to my team soon. Admittedly it's only a part of my presentation- but an important one. I'm sensing (and it could just be my paranoia) that psychologists get a little wary and concerned when they think we're stepping on their toes (perhaps) and talking about something they know far more about (The same happens when discussing motor skills with Physiotherapists and communication/interaction skills with Speech and Language Therapists!

So: S.O.S!!!! How do you explain occupational assessment? Occupational treatments? How do you differentiate that from cognitive/psychological assessments and treatments? Some are arguing it's the same thing!!!! Let me know what you think- PLEASE.

Iain

July 10, 2009

Hello everyone,

I have run into this many times myself and tried to explain it in many different ways, some have worked and some have failed. What, for me, has worked the best is this: I hand out a word search. I explain that if this word search represents a group process some laymen may considered it chaos (just looking at the block of mixed up letters) Some may consider it fun/ leisure/ games (recreational therapist) Some may be concerned with the meaning behind the words we are looking for (a psychologist). Some may be concerned with the motor skills to complete the activity (physical therapist). Some may be concerned with the ability to pronounce the words (Speech and language pathologists).

And I (as an OT) am concerned with the ability to take in the information (look at the sheet) problem solve, and (find the words).

This opens up a good conversation about how a group may look the same to an outsider, may even be using the same modality, but the focus/ outcome/ evaluation is different based on the professional running the group. We are not stepping on each others toes at all!

I actually made a word search on a website, and the words you are searching for are the specific goals that I can set on my unit (Ex: safety, sensorimotor, problem solving, self care, coping skills, etc.). Using these words allowed me to stimulate a dialog about the use of activity/ occupation as a modality. Again, if the word search represents a group: Yes, it is a game/ puzzle, (modality) But there is more to it then that too! As an OT am looking at this as a way to pull out specific information (finding and circling the words) about specific topic/ goals (the words we are looking for).

Hmmm... I hope this makes sense. It is easier to explain verbally with the word search as a prop. Also, my brain has checked out after a loooong week, so if this is not making sense please let me know and I will try to explain further. I am looking forward to hearing how others deal with trainings like this. I do find this educational/ advocating for OT as one of the most challenging parts of my job. However it is SO important!

Have a lovely weekend every one,

-Kristen Schuler

July 10, 2009

Dear Iain:

MOHO book is pretty clear about it.

I will try to give you clear explanation:

Cognitive capacities, physical function (muscles, joints), and other functions of internal systems belong to what is called by MOHO Objective Performance Capacity.

Capacities are basic abilities that one has and develop with maturation of the body systems over time. Examples: range of motion, muscle strength, breathing capacity, intelligence, memory, and many others that have been addressed directly by other professionals in a mechanistic way (unfortunately also by OTs)

SKILLS in the other hand are ACTIONS that are displayed to meet with the completion of different occupational forms/tasks we need for and are significant for our occupational participation. The SKILLS, or discrete actions that have a purpose, integrate different capacities when meeting occupational demands. Skills come from the interaction of our

capacities and the environment. So, an OT will work directly with the person on using skills for meeting their goals for significant daily functioning, and other professionals will work with capacities as a sole element (this has happened with the remedial, mechanistic approaches).

For example on the cognitive area: OTs work with skills such as sequencing, which integrates several cognitive capacities into a functional action. Integrates memory, attention, planning, others. Some other skills like noticing includes sensory integration capacities and others, and in the same way the rest of skills.

The same would apply to communication and interaction skills or motor skills. What you work with using an occupational orientation are the actions that are relevant to complete any occupational form/task. Reaching objects, for example, would integrate automatically different ranges of motion, degree of muscle tone and strength. But reaching is an action with a purpose in order to complete an step of a significant occupational form task, (not a sum of ranges of motion of the arm). (AMPS or ACIS have full explanations and procedures for it).

Occupational actions or skills have gone through serious studies, from which specific taxonomies based on occupation were established.

Participation in occupations automatically facilitate the use of skills to complete occupational forms/tasks, and the use of skills automatically facilitates the use of capacities and also in the other way around. This is well explained as levels of doing in MOHO book.

So, in practice, using MOHO helps to work with people directly in their occupational lives. WE evaluate and make interventions with clients on occupational participation, on occupational performance (completing occupational forms/tasks) and on skills. WE consider the importance of OBJECTIVE PERFORMANCE capacity but we do not evaluate them or intervene directly on them with MOHO. We do assess and help people with their subjective experiences of their bodies (LIVED BODY).

When you study MOHO, many things get clear in terms of our main roles as OTs and the roles of other disciplines. The best professional to work in some specific movement and strength problems is the physical therapist. The best professionals to work with sole problems of cognitions or deep emotions are the psychologists, the best to treat an illness is the physician, the best to work with the person on their occupational lives are occupational therapists who use a well developed occupational model as...MOHO. Other disciplines get worried about OTs "to rob" their role because it is true... for many years OTs have been trying to do it...because they have not had clear their role.

Try to make a good definition of OT for yourself. Try to read Conceptual Foundations. Then, go to MOHO and do the rest.

If you need a more clear or specific ideas or short concrete explanations taht have been succesful in different settings with different professionals, please let me know so I can do better for you.

Best to you
Much love
Carmen Gloria

July 11, 2009

Hi Iain,

I do hope that you get loads of really helpful responses to your email as there as many ways to pitch the answer as there are audiences to pitch it at.

Perhaps the biggest thing that MOHO has taught me is the diffrence between underlying capacity and functional performance. So, for instance, someone might have a poor memory (underlying capacity) but if they are:
aware of their abilities (personal causation);
determined to manage their situations (goals);
if they are become used to checking their diary (routine);
modify what is expected of them (roles);
are happy to ask for information (communication and interaction);
and have someone to support them and give them reminders (social group);
etc. etc etc.
.... then they will function far better than someone without these benefits

Ulitmately the way that we assess process skills as occupational therapists focuses on how people use their skills. It's not a person's knowledge, but how this is manifested in their use of knowledge. Memory, insight, concentration, awareness of time, etc all have a part to play but MOHO shows how performance capcity, and the other personal characteristics (volition and habituation) interact dynamically with the environment to affect a person's enactment of skills, performance of activities and participation in occupations. The occupational therpist's interventions focus on all 3 of these levels of doing - unlike many disciplines who concentrate on remedying underlying capacity or skill acquisition.

I'm sure that someone else can explain this better than I can, and I will be interested to read the replies.

Sue Parkinson

July 13, 2009

Hi Iain

Great post.

You may have already seen this, but Chapter 8 (p103) of the latest MOHO textbook gives some pointers and defines skills as 'observable, goal directed actions that a person uses while performing'. So skills are the functional outworking of the underlying mind-brain-body components - I presume our psychologist, PT & SLT colleagues are focusing on the latter?

So this may help you (and them) to make the differentiation.

regards

David

July 13, 2009

Hi

The struggle to introduce the ideas from MOHO, so present in the 2002 framework into the clinical setting has been a real struggle for OT in my experience. People are set in stereotyping us- or we stereotype ourselves as the upper extremity people and too many practitioners practice PT lite. The idea of process skills is one of several key ideas that really needs to get through to people before OT is practiced optimally.

I have always explained process skills as the ways one organizes themselves within an activity. This does not mean the "ability" to organize themselves- which would indicate that there is some body level function that is intact or needs remediation, but is specific to the activity- thus the environment and task can be considered as parts of the picture and we are not only focussing on "what is wrong" with the client or patient. I usually further detail organizing information, materials, time and space (leaving out full explanation of adjust/accomodate/benefit unless it appears that the other person is getting it- the concepts are more difficult). Usually I try and introduce the words (I originally learned them and was led towards MOHO from AMPS) so that their use becomes more of the norm eventually, say by 2100- but if the audience is not going to get that- I call them organizational skills, and specify that they are specific to the activity- utilizing/introducing WHO ICF language as much as possible to talk about participation and activity vs. body level/impairment. Since it sounds like we are in the same boat, thought I would share my experience with this. I hope that is helpful.

Leon

July 14, 2009

Dear all,

A big thank you to all of those who have responded to my e-mail asking how you might explain the difference, assess and treat difference between process skills and cognition (or for that matter all performance skills Vs impairments/body functions and structures).

All the responses were very useful and I will take all of your responses on board.

It's interesting and extremely encouraging to know that there is a large community of us "out there" who follow this way of practice- to me the best way (and the most researched!).

Thank you once again, and I'm sure we'll all cross paths again on this vital network.....

Iain