

1 Creative Ability: A Model for Individual and Group Occupational Therapy for Clients with Psychosocial Dysfunction

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Key Learning Points

- An understanding of the theory that supports the Vona du Toit Model of Creative Ability
- The focus on motivation on each level of action
- Occupational behaviour and skills characteristic of each level of action
- Treatment outcomes and principles/guidelines to support and facilitate growth within the levels of action during occupational therapy

The purpose of this chapter is to provide updated information about the Vona du Toit Model of Creative Ability (VdTMoCA) and its application to clients with psychosocial dysfunction. It is intended for students and novice occupational therapists working in a variety of mental health care settings. This chapter can be used in conjunction with other chapters in the book and is based on the 4th edition of Crouch and Alers (2005).

Throughout this chapter, the term 'individual' will be used when referring to people in general, and 'patient' is used when referring to a mental health care user in a hospital setting in an occupational therapy process. Throughout the chapter, the masculine pronoun is used, but the term also includes the feminine.

Introduction

The Vona du Toit Model of Creative Ability (VdTMoCA) was described in a series of academic texts between 1962 and 1974 (du Toit 1980). This model fits well into a practice model, the criteria for which are described by Reed and Sanderson (1999, p. 71) and Creek (2010, p. 43). It provides a framework to assess and treat a patient's performance in the occupational performance areas (OPAs) of personal, interpersonal, recreational and work spheres. du Toit described this as a living profile (du Toit 2009).

This model is useful for occupational therapists working with large groups of patients in mental health settings, as well as in many other areas of

the profession, where the patient group is diverse in terms of age, gender, cultural group, language, needs, chronicity and diagnosis. The VdTMoCA is helpful in coping with such diversity as it enables the occupational therapist to group patients efficiently in terms of their occupational performance (OP) abilities and needs.

As an occupational therapist, du Toit ascribed to the beliefs central to the profession's philosophy that occupational therapy actively engages a patient in purposeful, meaningful and goal-directed therapeutic occupation in order to improve or maintain health and quality of life (du Toit 2009). The VdTMoCA and its associated theory do not dictate specific activities or occupations for patients, but only describes the characteristics that therapeutic activities and occupations should meet, to be appropriate to the patient's level of action. This model presupposes that occupational therapists will use their clinical reasoning, knowledge and skill of activities and occupations and analysis to select activities to be used as a therapeutic means or ends (Reed & Sanderson 1999). These must be appropriate to patients' individual profile and be considered meaningful, purposeful and goal directed in the context of the patient's life, needs, values and environment.

Fundamental concepts in the theory of creative ability

The concepts of 'creativity' and 'being creative' are central to the understanding of creative ability theory. While these terms are not unique to occupational therapy, occupational therapists use them in a unique manner to describe a patient's ability to change or extend his OP, thus being able to do some aspect of his daily occupations that he was not able to do before or since the onset of his occupational dysfunction.

Creative ability is described by du Toit as:

his ability to form a relational contact with people, events and materials, and by his preparedness to function freely and with originality at his maximum level of competence (du Toit 1991, p. 23).

According to du Toit, the development of creative ability occurs within the boundaries of an individual's

'creative capacity'. She defined creative capacity as the creative potential an individual has, which could possibly develop under optimal circumstances (du Toit 1980). Creative capacity varies from one individual to another and is influenced by factors such as intelligence, personality structure and the human body's capacity to support participation in purposeful activities. du Toit used a slightly different taxonomy for the OPAs to that used in the Occupational Therapy Practice Framework: Domains and Process (American Occupational Therapy Association (AOTA) 2008) and used the terms:

- personal management to include 'activities of daily living' as well as 'instrumental activities of daily living';
- social ability to include 'social participation' and 'communication and social performance skill';
- work ability to include education and work;
- rest and sleep was not included but 'constructive use of free time' was used instead of 'leisure' (du Toit 1980).

As with all other concepts that denote human potential, individuals seldom reach full potential, and there is always some capacity in reserve for growth. An individual's ability to translate creative capacity into participation in purposeful activity is consistent with his level of creative ability and is limited or facilitated by contextual factors such as opportunities or lack thereof and contextual support for purposeful engagement.

To grow in a creative ability sense, the individual has to exert maximum effort. Maximum effort refers to the exertion of 'creative effort' at the boundary of an individual's creative ability to achieve growth. Exertion of maximal creative effort therefore extends that individual's creative ability. However, three other aspects also need to be present for this to occur:

- (1) Creative response (du Toit 1980) reflects the positive attitude or response, which an individual displays towards any opportunity offered to him associated with occupational engagement. It reflects the individual's preparedness to use all his resources to participate for anticipated pleasure, gain or acknowledgement, in spite of some anxiety about his

capabilities and the success of the outcome. It precedes creative participation.

- (2) Creative participation (du Toit 1980) is the process of being actively involved in activities and occupations concerned with everyday living relevant to the individual's level of development. This concept refers to taking an active, rather than a passive, role in the activities of life and engaging in such a way that it challenges his abilities and resources.
- (3) Creative act (du Toit 1980) is the result of an individual's creative response and creative participation, in terms of producing a change in activity participation, which may be tangible or intangible.

Therefore, to behave creatively and extend the level of creative ability, an individual has to:

- Have a positive attitude towards an occupational opportunity offered to him by a therapeutic activity despite some anxiety (creative response)
- Be actively engaged in 'doing' the activity which offers the appropriate right challenge (creative participation)
- Work towards producing an *occupational* product or outcome that denotes some activity participation change, be it tangible or intangible (creative act)

While growth in the process of participation in daily activities is always the desired outcome, it does not always occur independently, and occupational therapy is required to facilitate this. To achieve the desired growth, occupational therapists need to manipulate the therapy situation to the best advantage of the patient. This is done by selecting the most appropriate therapeutic activity (in consultation with the patient) and applying therapeutic principles, methods and techniques. It must be recognised that it takes hard work and repetition of the action, by both the patient and the occupational therapist, to achieve creative ability gains.

Furthermore, du Toit described 'volition' as being a central concept within creative ability theory. She described volition as having two components: motivation and action. These two components are intrinsically linked. The motivational component represents the energy source for occupational behaviour, and the

action component brings about the conversion of energy into occupational behaviour; thus, motivation governs action since it is only possible to express the motivation that exists within the individual into action (du Toit 1980).

The working definition of motivation used by du Toit was that described by Coleman. He described motivation as the inner condition of an organism that initiates or directs behaviour towards a goal (Coleman 1969). du Toit described this as meaning 'being in becoming' (du Toit 2009, p. 53). However, the definition of intrinsic motivation is more precise. Intrinsic motivation is the biological or innate urge to explore and master the environment through occupation (Wilcock 1993; Kielhofner 2002). Thus, intrinsic motivation is the fundamental source of energy for activity participation and occupational-related behaviour.

du Toit believed that the motivation that directed creative ability had different areas of focus at different stages of occupational development, which laid the foundation for the development of subsequent stages. This led to her description of six different and sequential levels of motivation, each with their own qualities that direct activity participation, thus developing specific occupational milestones.

These levels indicate what 'motivates' an individual to engage or participate in everyday activities. They also indicate changes in the nature and strength of intrinsic motivation as it develops through the levels of creative ability.

Action is defined as 'the exertion of drive, or mental and physical effort which results in the creation of a tangible or intangible product' (du Toit 2009, p. 43). Like motivation, action can also be organised into levels. These levels describe the sequential differences in the nature and quality of the individual's engagement in activities that is described in terms of ability to form relational contact with others, events, materials and objects in the environment, as well as the characteristics of engagement (see Table 1.1).

During the course of both the levels of motivation and action, the individual accomplishes a wide range of skills and occupational behaviours. It is important therefore to be able to distinguish where the patient is at within a particular level, namely, the beginning, the middle or moving towards the next level. The following phases are used to

Table 1.1 The relationship between levels of motivation and action.

Levels of motivation	Levels of action
Tone	Purposeless, unplanned action
Self-differentiation	Unconstructive action Incidentally constructive action
Self-presentation	Constructive, constructive explorative action
<i>Participation</i>	
Passive	Norm awareness experimental action
Imitative	Imitative norm-compliant action
Active	Transcends norms, individualistic and inventive action
Competitive	Competitive-centred action
Contribution	Situation-centred action
Competitive contribution	Society-centred action

describe this and can be applied at each level of both motivation and action:

- Therapist-directed phase indicates that the individual is demonstrating skills and occupational behaviour characteristics of both the previous and current levels. However, without support, structure and encouragement, he is not able to maintain the functioning characteristic of this current level, and occupational behaviour will easily regress to that of an earlier level. Thus, the patient needs the support of the therapist to produce the occupational behaviour consistent with the beginning of the current level.
- Patient-directed phase indicates that the individual's occupational behaviour is generally characteristic of the requirements of that level. He can maintain this occupational behaviour relatively independently provided the context is supportive.
- Transitional phase indicates that the individual is demonstrating occupational behaviour consistent with the current level but is able to demonstrate some occupational behaviour and characteristics of the next level under optimal conditions.

Development of creative ability

The development of creative ability describes how activity participation develops along a continuum from existence and egocentrism to contribution to the community and society at the highest level.

While the end of continuum represents the optimal level of activity participation, few individuals reach this ultimate goal due to the limitations in fulfilling their creative potential or capacity as a result of human system incapacities and contextual constraints. Development starts at birth and continues throughout life. Although development is usually progressive, it need not always be so. Development is not always consistent, with growth taking place in spurts. These are followed by periods of consolidation while the individual remains in a relative 'comfort zone'.

A dynamic relationship exists between the external environment and the development of creative ability in any individual. While the external environment provides the challenges and opportunities for growth, new opportunities and circumstances may create stress that lead to regression. Development of creative ability is therefore dependent on 'the fit' between the readiness of the individual to grow creatively (i.e. creative response, creative participation and creative act) and the appropriate right challenge that occupations and their environmental context provide (de Witt 2002).

The normal developmental process may be limited or disrupted, either temporarily or permanently, by illness, disability, trauma, environmental limitations or barriers, which may lead to a delay in development or regression in varying levels of severity.

Illness, disability or trauma disrupts creative ability due to difficulties within the human system, which fail to support previous levels of occupational behaviour. On the other hand, barriers or constraints in the external environment may result in occupational deprivation. This is a situational barrier, such as the lack of funds or insufficient objects, opportunity, time, or occupational injustice where there may be institutional or political barriers. There could be policies which limit an individual's opportunity for occupational engagement (Wilcock 1998).

Like all other developmental models, creative ability is subject to the following theoretical assumptions (du Toit 2009):

- Human development occurs in an orderly fashion throughout life.
- Steps within the developmental process are sequential and cannot be omitted.
- An individual has an innate drive to encounter his world and master its challenges.
- As an individual exerts maximal effort, changes in the internal and external environment will demand adjustment and reorganisation.
- Confronting change creates tension, disequilibrium and stress, which represent a necessary developmental opportunity.
- An individual's response to the demands for change can result in adaptation, mastery and growth, while an inability to adapt results in maintaining the current level of creative ability or regression and dysfunction.
- An individual's ability to master developmental tasks is influenced by his internal human capacities, both physical and psychological skills, life experiences and the availability of resources and opportunity within the occupational context and finally successful adaptation. This usually leads to achievement of a developmental step, self-satisfaction and societal approval and promotes future success in meeting challenges (Bruce & Borg 2002).

Creative ability also has two main characteristics:

- Sequential development: the growth and recovery of creative ability, which follow a constant and sequential pattern. This means that growth and recovery of both the motivation and action components follow a stable and sequential pattern in which no level or phase may be omitted.
- Action is therefore a direct manifestation of the motivational component of an individual's creative ability, and this is evident in the nature and quality of an individual's activity participation and behaviour.

The levels of motivation and action relate to one another in a stable and sequential manner, as indicated in Table 1.1.

Creative ability is dynamic and varies with the individual's circumstances, confidence, anxiety level and the demands that occupations and their contexts make on a person's human system. Thus, there is a forward and backward flow between the levels of his creative ability, which is related to security in the former and stress in the latter. This tends to be a gentle forward and backward flow between two levels, rather than a violent movement across the continuum of all levels.

Assessing the level of creative ability and recording the levels of creative ability

The determining of a patient's level of creative ability does not require a special assessment. The patient's level of creative ability can be determined from any comprehensive occupational therapy assessment but involves three sequential steps which relate to the clinical reasoning or interpretation of the assessment information.

Step 1: *Evaluation of occupational skills and behaviour*. This should be included in the client's initial and comprehensive assessment prior to commencement of treatment. It should also be part of the ongoing monitoring of his condition, so that the developmental momentum of creative ability can be maintained in all facets of intervention.

The assessment of the patient's current level of creative ability should be based on observation and clinical evaluation of his occupational skills and behaviour in as wide a variety of situations as possible. This assessment should not be based on what the patient's reports he can do, but on a practical evaluation of his current behaviour and skill in all areas of OP. While the patient's occupational history is pertinent in trying to establish treatment outcomes and goals, it is what the patient is currently able to do that is relevant in this assessment. This can only be achieved by involving the patient in an activity to determine his current OP. The nature of his engagement and the quality of performance will determine his level of action. In consultation with the patient, and considering his interests and aptitudes, the occupational therapist will select an activity which has purpose, relevance and meaning to the patient but also has the opportunity to elicit satisfactory assessment information. The activity should preferably be unfamiliar yet

within his frame of reference so that the occupational therapist is not accessing a habituated skill or routine. The activity should create a challenge for the patient so that he has to think and process the activity, but it should be able to be completed within approximately 45 minutes. It should have a concrete end product and encourage active participation to facilitate the task concept assessment.

Understanding the level of creative ability is facilitated by taking careful note of the following:

- The patient's attitude and ability to make relational contact with materials, objects, people and events in the environment
- His ability to plan, initiate and sustain effort until the activity is complete or to continue at the same level of performance over time if the activity or task is repetitive
- His quality of performance and the ability to evaluate what has been done and the standard set for himself
- The ability to do activities with or without supervision, the amount of environmental structure required for adequate participation and the ability to read cues and meet norms that are both overt and covert
- The ability to control anxiety when faced with obstacles and new challenges
- The ability to act with originality, to solve problems and to act on decisions made
- Finally, the response to engagement and emotional response to performance and the end product (See Table 1.2.)

Step 2: *Establishing the level of action.* As each level of action defines the occupational skills and behaviour characteristics of that level, it is possible to categorise the patient's behaviour and skill in the OPAs according to the levels of action. Using the information gathered about the patient's occupational skills and behaviour, analyse his level of action in each OPA. Make a cross in the grid in the appropriate column, positioning it to indicate the phase of the action. If there are marked variations, review the assessment data to ensure that it represents the patient's overall pattern of OP, rather than his habituated skills.

This is most commonly done on a grid system, such as the one in Table 1.3.

Where the level of action is clustered in all OPAs, determining the overall level of action is straightforward, as the example in Table 1.3. Table 1.3 shows that the client's occupational skills and behaviours are on a level of constructive exploration in all OPAs but in the patient-directed phase in three areas (social, work and free time). In one OPA (personal management), the phase has been rated as being transitional. This indicates that although occupational behaviour and skills are all characteristic of the constructive explorative level, there are some skills and behaviours that are associated with the norm awareness experimental level of action under optimal circumstances. Thus, using the principle of majority rules, the patient's overall level of action is constructive explorative patient-directed phase.

Table 1.4 indicates that although all OPAs are within the norm awareness experimental level, personal management and social ability fall within the patient-directed phase, while work and leisure fall within the therapist-directed phase. When there are two OPAs in one phase and two in another, the following principles can be applied: social ability has the most impact on OP, followed by work ability. Since the social OPA has a governing influence, the overall level of action would be constructive explorative patient directed.

Where there is variation in the patient's level of action in the four OPAs, determining the level of action is more complicated. Table 1.5 indicates a variation in the level of occupational skills and behaviours in four OPAs: the social ability is constructive exploration on the patient-directed phase; in both the work and constructive use of free time areas, skills are characteristic of the norm awareness experimental action level, but in the work area, there are a few indications of skill and behaviours of the imitative norm-compliant level (transitional phase); in the personal management area, although skill and behaviour are predominantly imitative norm-compliant in nature, some norm awareness experimental behaviour is still evident (therapist directed).

Thus, the client's overall level of action is norm awareness experimental – fluctuating between therapist-directed and transitional phases. Clustering usually occurs within the level or across two levels, so the example in Table 1.5 would be unusual. As stated earlier, when marked variations occur, the occupational therapist should review the

Table 1.2 Summary of the Vona du Toit's levels of creative ability.

	Tone	Self-differentiation	Self-presentation	Passive participation	Imitative participation	Active participation	Competitive participation
Action	Undirected, unplanned	Incidentally constructive or unconstructive (1–2 step tasks)	Constructive exploration (3–4 step tasks)	Product centred (5–7 step tasks)	Product centred (7–10 step tasks)	With originality – transcends norm expectations	Product centred
Volition	Egocentric to maintain existence	Egocentric to differentiate self from others	To present self. Unsure	Robust. Directed to attainment of skill	Directed to product, a good product; acceptable behaviour	Directed to improvement of product, procedures, etc.	Directed to participation with others to compare and evaluate self in relation to others
Handle tools and materials	Not evident	Only simple everyday tools (e.g. spoon)	Basic tools for activity participation – poor handling	Appropriate skill	Good	With initiative	Very good
Relate to people	No awareness	Fleeting awareness	Identification selection, makes contact, tries to communicate, superficial	Communicates	Communicates/interacts	Have close interpersonal relationships and intimacy; can assist others and adapt, make allowances, have consideration of others	Can adapt, make allowance, have consideration of others, have close interpersonal relationships and intimacy; can assist others
Handle situations	No awareness of different situations	No awareness or ability	Stereotypical handling, makes effort but unsure or timid	Follower, variety of situations, participates in a passive way	Manages a variety of situations, appropriate behaviour	Can evaluate, adapt, adjust according to need; can deal with problems	Can evaluate, adapt, adjust according to need; can deal with problems
Task concept	No task concept, basic concepts	No task concept, basic and elementary concepts	Partial task concept, compound concepts	Total task concept, extended compound element (abstract concepts)	Comprehensive task concept, integrated abstract concepts	Abstract reasoning	Abstract reasoning
Product	None	None	Simple – familiar activities, poor-quality product	Product of fair quality (aware of expectations)	Product of good quality (according to expectations)	Quality – can adapt, modify, exceed; have expectations; evaluate; upgrade	Quality – can adapt, modify, exceed; have expectations; evaluate; upgrade

(continued)

Table 1.2 (cont'd)

	Tone	Self-differentiation	Self-presentation	Passive participation	Initiative participation	Active participation	Competitive participation
Assistance or supervision needed	Total assistance and supervision (24 hours)	Physical assistance and constant supervision	Constant supervision needed for task completion	Regular supervision	Guidance, supervision, regular for new activities and occasional for known activities	Guidance, formal training (own responsibility), help to supervise others	Guidance, formal training (own responsibility), help to supervise others
Behaviour	Bizarre, disorientation	Bizarre, little reaction, disorientation	At times strange behaviour, hesitant, unsure, willing to try out	Follower but will participate passively – occasionally strange	Socially acceptable behaviour, generally controlled	Acceptable, shows originality	Socially acceptable or correct, variety of situations, adaptable, plan action behaviour
Norm awareness	None noted	None noted	Start to be aware of norms	Norm awareness (aware of expectations)	Norm compliance (do as expected, required standard)	Norm transcendence (do better or more than norm) and adapt effectively. This is graded from activities and situations to a variety of situations	Norm transcendence (do better or more than norm) and adapt effectively. This is graded from activities and situations to a variety of situations
Anxiety and emotional responses	Limited responses	Limited uncontrolled basic emotions. Comfort or discomfort is easily evident	Varied, usually low self-esteem and anxiety, poor control	Full range of emotions, mostly controlled; makes effort	Subtle differences, compassion and self-awareness, anxiety used	New situations – anxiety, normal emotional responses (anxiety motivator)	Consistent and original
Initiative effort	None noted	Fleeting, minimal	Effort inconsistent, not sustained and not maintained; decreased frustration tolerance	Varies	As expected, effort required and sustained	Consistent and original	Consistent and original

Source: Adapted from Table 1.7 by De Witt in Crouch and Alers. Original with permission from D. van der Reyden.

Table 1.3 An example of a clustered level of action.

	Personal management	Social ability	Work ability	Use of free time	Phase
Purposeless, unplanned Unconstructive Incidentally constructive Constructive, constructive exploration	X	X	X	X	Th directed Pt directed Transitional
Norm awareness experimental Imitative norm-compliant Individualistic and inventive Competitive centred Situation centred Society centred					

Th directed, therapist directed; Pt directed, patient directed.
X signifies the level of motivation or creative ability level.

Table 1.4 An example of a split action grid.

	Personal management	Social ability	Work ability	Use of free time	Phase
Constructive, constructive exploration Norm awareness experimental	X	X	X	X	Th directed Pt directed Transitional

X signifies the level of motivation or creative ability level.

Table 1.5 An example showing a variable level of action.

	Personal management	Social ability	Work ability	Use of free time	Phase
Constructive, constructive exploration		X			Th directed Pt directed Transitional
Norm awareness experimental			X	X	Th directed Pt directed Transitional
Imitative norm-compliant	X				Th directed

X signifies the level of motivation or creative ability level.

assessment data to ensure that the current OP has been assessed correctly, at the same time taking note of habituated skills.

Variations in the level of action between the different OPAs must always be accounted for in planning the programme as the levels of action are used when planning treatment by using the action grid. The occupational therapist therefore mixes and matches the principles and guidelines of treatment so that they fit the patient's needs and reflect the variation in the action grid.

Step 3: Establishing the level of motivation. As motivation is difficult to observe and measure directly, the occupational therapist must presume the patient's level of motivation from the quality and nature of his observable occupational skills and behaviour. It has already been discussed that there is a stable relationship between the levels of motivation and the levels of action (see Table 1.1). Using the data recorded on the level of action grid completed in Step 2, a presumption can be made about the patient's level of motivation.

Additional recording tools have been developed to record outcomes in regard to the level of activity participation and functioning. These tools are the Activity Participation Outcome Measure (APOM) (Casteleijn 2010) and the Functional Levels Outcome Measure (FLOM) (Zietsman 2011) and complement the VdTMoCA. The APOM and FLOM are used to indicate the baseline functioning before intervention commences. Measurements are taken again during or after intervention to track and record change in activity participation or functioning in the client (see Chapter 10 by Zietsman and Casteleijn).

Application of creative ability to intervention in psychosocial occupational therapy

Mental illness has a negative influence on the patient's ability to live efficiently and to behave in a creative manner. Some psychiatric disorders have a more disorganising effect on OP than others. The same psychiatric disorder may influence the OP of two individuals differently, or there may be some differences in the same individual from one episode of illness to another. Psychosocial occupational therapy aims to improve or maintain the OP of

mentally ill patients. This is done by improving or maintaining skills and abilities within the OPAs to facilitate independent living as far as this is possible, improve health and well-being, facilitate quality of life and reduce the chances of regression.

Creative ability theory can be applied to all psychiatric disorders diagnosed on the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) (American Psychiatric Association (APA) 2013) and can be aligned to the International Classification of Functioning, Disability and Health (WHO 2001). It can be applied to both acute and chronic conditions and can also be used equally effectively in hospital- and community-based treatment settings.

A patient's level of creative ability forms the platform from which the occupational therapist manages specific OP as well as the patient's factors and performance skill problems.

The levels of creative ability

As described previously, creative ability represents a continuum of occupational behaviour, which is divided into levels of motivation, each with their corresponding levels of action. Due to similarities in the overall purpose of levels, they can be divided into three quite distinct groups:

Group 1: Preparation for constructive action. This is where the main purpose of these levels is for the development of functional body use as a prerequisite for engagement in activities.

Group 2: Behaviour and skill development of norm compliance. Both concentrate on developing the occupational behaviours necessary to live and be productive in the community and comply with the prescribed norms of the society and group within which he lives.

Group 3: Behaviour and skill development for self-actualisation. Concentration is on developing leadership skills and occupational behaviours that are novel in any aspect of life. It may involve developing new products, methods of doing things, use of advanced technology, problem-solving processes, or solutions to complex problems, challenges and situations.

For the aforementioned groups, motivation and action are directed towards the benefit of self in the

early levels and later towards others in a specified group of people and then towards society at large. These levels demand personal dedication, self-motivation and continuous critical reflection and self-evaluation. People functioning on this level do not need to see the results of their efforts immediately, and they often wait many months, years and even a lifetime to see the results of their work.

Description of the levels

Group 1

Tone

Motivation on this level is directed at establishing and maintaining the will to live, which du Toit (1980) called 'positive tone'. This includes the biological tone, which is the starting point for development of all human systems that are required to enable OP.

Purposeless and unplanned action

Action on this level is purposeless and unplanned and patients have no OP skills. They are defenceless, dependent and incapable of caring for themselves. They have to be protected, cared for and nurtured. They lack awareness of themselves and their bodies as being separate from the world around them. Their 'actions' are mainly automatic, appear purposeless and are not goal directed, but these actions contribute to the development of the internal human systems so as to achieve 'biological tone'.

These patients are unable to care for, provide for, or defend themselves in any way. They have very little or no control over their bodies and bodily functions. They need to be washed, dressed, toileted, fed, cared for and protected. They have little awareness of others. They attempt to communicate their basic needs of discomfort, hunger or thirst, but this is non-specific, for example, they may grunt or shout, but this seldom identifies the problem or the extent of their distress. Language is frequently absent or, if present, is often only monosyllabic and is mostly incoherent. They usually respond positively to nurturing and are usually able to recognise daily caregivers. They appear to be unable to identify different situations, other

than a momentary awareness of strangeness or familiarity, but are distressed by changes in routine and daily patterns.

These patients are totally non-productive in an occupational sense and have no concept of 'doing'. There is little evidence of intention or effort. They can focus their attention momentarily on stimuli. Their physical movements are uncoordinated, often reflexive and haphazard. They are unable to demonstrate any constructive occupational behaviour. They have no concept of free time.

Patients with psychiatric illness, who regress to this level, are usually severely disordered. They are disorientated and severely impaired in all the psychosocial client factors and performance skills, which incapacitate them.

The treatment outcomes on the purposeless and unplanned level of action are:

- To encourage positive tone and biological tone
- To stimulate the patient maximally via all his sensory modalities

To achieve these outcomes, all members of the multidisciplinary team must adopt a uniform treatment approach. Patients on this level are so occupationally incapacitated that a specific programme of activities is not practical. However, all interactions with the patient should focus on stimulating awareness of his own body, making him aware of things and others in the environment, and stimulating the sensory and motor systems to promote biological tone.

The occupational therapist or occupational therapy assistant (OTA)/occupational therapy technician (OTT) is totally responsible for the initiation and maintenance of the therapeutic relationship. The occupational therapist must give everything in the relationship and expect nothing in return, not even recognition of himself/herself as an individual. The patient and his behaviour must be accepted unconditionally and should not be reprimanded for accidents. Interaction with the patient should be warm and caring, and the patient should be treated with dignity and respect. Caregivers should also be patient and persistent, making regular contact with the patient to try to bring him into contact with the here and now, even if only momentarily. This is done by continuously talking to him, in a slightly raised voice to attract his attention, making use of physical contact (but with discretion), calling him by

his given name and by describing the environment, objects and events to the patient without expecting a verbal response. All staff should be encouraged to verbalise the processes involved in caring for the patient and should never talk about him in his presence.

These patients are usually treated in their room or a familiar room in the ward. The treatment area should be stimulating but should not be distracting or overwhelming. The external stimuli should be changed from time to time to prevent habituation, and his attention should be drawn to the changes. If practical, patients should not sit in the same place all day even if immobile; they should be seated in places with different environmental stimuli. If at all possible, patients should be actively encouraged to move around and taken out of doors regularly, although this should be supervised. If the patient is very mobile, he should be contained within the ward area as he may get lost. Draw the patient's attention to the objects and people in the environment, but the patient should not be exposed to continuous therapeutic intervention. Therapy should be divided into a few short sessions (five minutes), spread throughout the day, but also included in caregiving interventions.

The patient is unable to engage in any constructive activity but must be encouraged to engage and make contact with objects and materials from the environment and context. These should be presented singly in a consistent manner, with much repetition. Objects or materials should be placed in his hands, and its basic concepts and properties should be verbalised to him, encouraging him to focus attention on it all the time whilst in contact with it. The objects and materials should stimulate all the senses and allow for physical handling and interaction within his capabilities and should be non-toxic in case he puts them into his mouth. They should be non-breakable should the patient handle them in an uncoordinated manner. Do not expect him to be able to use the object or materials during this stage unless it is habituated. The only purpose is for him to focus his attention on it momentarily, and once his concentration is exceeded, the object or material will probably be discarded.

If the patient shows signs of becoming more receptive to stimulation, it should be gradually upgraded by the following: increasing the fre-

quency of the stimulatory sessions; the duration; the number of objects and materials to which he is exposed, both in a session and over a period of time, and encouraging him to focus his attention on the object or material more frequently and for longer.

If the patient shows signs of becoming less receptive to stimulation, the programme can be downgraded by reversing the principles listed earlier.

There are three criteria that should be used to evaluate whether a patient is ready to move to the unconstructive level, which is the next level of action. These criteria are increasing receptiveness to environmental stimuli, ability to focus and maintain attention more than fleetingly (one to two minutes) and indications that his interaction with materials and objects is becoming unconstructive.

The second level of motivation in Group 1 is self-differentiation. There are two levels of action associated with this, namely, unconstructive and incidentally constructive.

Self-differentiation

Mentally ill patients who deteriorate to the self-differentiation level show evidence of severe, incapacitating factors and performance skills. Frequently, the expression of disturbances in patient factors and performance skills is more evident because it is more active and more verbal than on the level of tone. Disorganisation of thinking, language impairments and aggressive and bizarre uncontrolled behaviour are common. Patients on this level are usually found in chronic institutions, which provide habilitation and rehabilitation programs.

The level of motivation is directed at three areas: establishing and maintaining awareness of self as a separate entity from the environment, the objects and people in it; achieving control over the body including bladder and bowel, self-soothing and feeding; and learning the basic skills involved in using the body to interact with the world and integrating these into coordinated behaviours and learning basic social behaviours such as person recognition, basic culturally appropriate greetings, making requests and complying with commands.

Unconstructive action

This is the first level of action to appear in the self-differentiation level. It represents the most

primitive interaction that the patient has with the world. Unconstructive action aims to assist the patient to define his body boundaries and to practise the basic skills necessary for material and object handling. He is not necessarily unconstructive in an aggressive sense, but handles materials and objects non-constructively in order to examine the basic properties of materials and to help develop the basic human system skills needed to enable OP on later levels.

These skills include focusing of attention, basic concept formation (such as form, shape, texture), basic elements of thinking, deciding and planning, body concept, perception, coordination, balance, movement and hand function. This in turn stimulates primary intention and construction that occurs coincidentally on the next level of action.

Unconstructive action has the following characteristics: patients are receptive to external stimulation and are prepared to make contact with the environment using their bodies; action is of short duration (two to five minutes), and the patient shows an inability to sustain effort; action is non-constructive in that no end product is produced, other than fragments or a change in the form or volume of the material, owing to his non-productive interaction with it. This interaction is unplanned and non-specific and does not take the properties of the materials or objects into account during the interaction. It is, however, the first step in the exploration of materials and objects and the ability to interact with them. In all OPAs, the patient remains incapable, dependent and defenceless.

He is still not able to do any personal care tasks for himself or even assist with them. However, because the patient is more receptive to environmental stimuli, the interaction between the environment and the body in activities related to bathing, dressing and feeding makes him aware of his body and its functions. Verbal reinforcement facilitates this. For example, when the patient is bathed, the contact with the water, the facecloth, soap, and the towel makes him aware of his body and its boundaries. He can use his hands to splash the water and hold the soap.

In the social environment, patients are more open to social contact. They are able to recognise the caregivers as familiar or unfamiliar and develop a preference for some caregivers over others. They respond positively to nurturing.

Communication remains difficult with only familiar caregivers able to understand. They have difficulty in communicating their needs effectively, even though language may be present. They sometimes use simple words and gestures to communicate and may resort to slapping and physical withdrawal if distressed. Patients have no concept of social norms. They are still unable to recognise situations as being different, and consequently, behaviour is not differentiated from one situation to another.

There may be evidence of bizarre behaviour resulting from psychotic phenomena, disturbed concepts and the need for self-stimulation such as rocking, head banging and genitalia stimulation.

They learn to respond to simple commands such as 'sit here', 'lift your arms' and 'take that out of your mouth'.

Emotions are feebly displayed, and, although there is a differentiation between the expression of positive and negative emotions, negative emotions are often more obvious than positive ones, and anger and unhappiness are often expressed through shouting and sometimes hitting out. Anxiety is apparent if the patient is distressed or frightened but if distracted, like all other emotions, dissipates quickly.

Patients tend to be more active and mobile than those on the previous level, but they seldom venture out of their immediate environment. Their action remains non-constructive, but there is evidence of conscious direct physical interaction with materials and objects in the environment. This results in a change of volume, shape or fragmentation of materials and change of position of objects. Interaction with materials and objects is sustained for short periods. Material and object handling still does not appear to reflect any active thinking, although they are attracted by colour and shape, indicating a developing awareness of basic concepts. The non-constructive interaction with materials and objects like banging, tearing, throwing and pulling is the first step in the development of the part-whole concept. As the patient's basic concepts are developed, he is able to recognise and match shapes, colours, size and textures of objects and materials, but he usually cannot name them until the next level.

Patients still have no concept of the use of free time.

Treatment outcomes for clients on the unconstructive level are to:

- Consolidate body awareness especially body boundaries
- Stimulate the physical awareness of people and objects in the environment and the sense of familiarity/non-familiarity
- Stimulate focusing of attention for at least five minutes
- Facilitate the primary patient factors and performance skills needed for basic interaction with the environment

As with patients on the previous level, for treatment to be successful, all multidisciplinary team members should be involved in the treatment programme regardless of their discipline. All should be actively involved in the planning of the treatment so that principles/guidelines are consistently applied in all caregiving activities even though they might take more time. Stimulation does need to be applied according to a specific plan so that stimulation is changed regularly to avoid habituation and overstimulation is prevented.

Incidentally constructive action

This is the second level of action to develop on the self-differentiation level.

This level is characterised by unplanned, unintentional, constructive action that results, by chance, in an immediate, recognisable end product. This one-task activity stimulates the consolidation of the part-whole concept and of 'making something' that is different from the parts used. There is a tendency for incidentally constructive action to be repeated in both the same and other situations, which stimulates generalisation. du Toit (1980) saw this as the essential precursor to constructive activity participation.

Although patients on this level still remain dependent on others for care, safety and security, they establish the basic skills necessary to care for themselves, although they are not yet able to do this without supervision.

As the patient's body concept becomes consolidated, he is able to learn the basic skills and behaviours involved in care and control of his body, hygiene, dressing, feeding and toileting.

During this stage, the patient achieves basic competence in the practical skills involved in these activities but continues to have difficulty with the following: timing and control of toileting, putting shoes on the correct feet and coping with fastening, selecting appropriate clothes and carrying out all of the aforementioned tasks independently and at an acceptable level of performance.

Patients learn to do these basic personal activities within a specific routine set by caregivers. This stimulates the start of the concept of temporal organisation of activities. Patients often get distressed when the routine is disturbed as it provides a sense of security and predictability to his life.

In the social situation, the awareness of familiar people is extended to those other than caregivers, which helps to extend their orientation to person although the naming of people remains inconsistent. They can be very demanding, wanting immediate gratification of needs.

Communication becomes more coherent and they are able to communicate their needs more efficiently, although this is egocentric and simple.

Patients continue to have little awareness of social norms although they do start to differentiate between right and wrong from the response of the caregiver. For example, they may be praised for eating their food but reprimanded for spitting on the floor. Behaviour continues to be undifferentiated from one situation to another and bizarre behaviour again may be evident in response to psychotic phenomena.

Tantrums may occur if the patient's needs are not met as soon as he would like or if he is restricted or refused something he desires.

The patient is able to focus his attention more easily and concentrate on his activity for longer, initially 5 minutes and extending to 10 minutes active concentration towards the end of the level. He can interact with materials and objects, usually more than one or two at a time, unintentionally producing an immediate, clearly recognisable end product, which is a direct result of his interaction with the world. Although he demonstrates no desire to do anything with what he has produced, he might practise this incidentally constructive response a number of times, not always immediately, but within a few hours or days.

Basic concepts are usually consolidated on the therapist-directed phase with patients able to name

objects and verbalise the basic properties that need consideration when interacting with the objects or materials. Elementary concepts also develop, and by the transitional phase, patients can use most of the common objects within his environment although he may still have difficulty in describing these verbally.

These patients are often more mobile and are reluctant to sit for long periods of time. They appear to want to be of help and can do simple tasks or chores directed by the caregiver. They are more aware of the environment. They can recognise the different people and can identify the different rooms where activities take place. They can identify their own bed area and become very possessive about their possessions. Their orientation to person and place is improved, but they are quite sensitive to changes in the environment, although they often cannot identify the nature of the change. Patients on this level continue to have no concept of free time, but often enjoying leisure activities like singing, clapping to music as well as basic ball games and activities with balloons.

The **treatment outcomes** for patients on the level of incidentally constructive action are:

- Consolidation of body concept
- Making patients aware of their body parts, shape, size and functions by using sensory stimulation during hygiene and other tasks involving movement and interaction with materials and objects
- Improvement of their awareness of the physical presence of others in the environment by exposing them to people other than caregivers, for example, other patients and staff, and focusing their attention on others during the treatment process
- Development or improvement of the physical and psychosocial client factors and performance skills necessary for constructive action by encouraging incidentally constructive interaction, with possibilities for practice and repetition
- Basic orientation to person, place and time, as well as basic skills of personal care

Occupational therapy programmes for these patients may be planned, designed and monitored by an occupational therapist in

consultation with a trained OTA/OTT. The caregivers should also be actively encouraged to use the principles of treatment effectively, even if this is more time-consuming. A specific programme of therapeutic activities prescribed by the occupational therapist should be introduced into a ward programme, and specific therapy sessions can be introduced as well so that treatment is now extended beyond caregiving activities. This treatment can be implemented by an OTA or OTT.

These patients should also be handled in a caring and dignified way. Positive and appropriate behaviour should be rewarded and unacceptable behaviour, such as defecating on the floor, screaming or biting or hitting others, be reprimanded in a kind and non-punitive manner. It is important to talk to the patient clearly, in a slightly raised voice to attract his attention, but not to shout. Continuously orientate the patient in terms of person and place, making him aware of others. He should be called by name and actions verbalised and made aware of the environment and the different activities that occur there. Stimulate orientation to time by orientating him to the day, date, year, time of day and seasons and the events that take place regularly, and as well as those that are more irregular like a birthday. The occupational therapist should verbalise the patient's activity and movement to encourage development of basic and elementary concepts and body concept and keep his attention when stimulating him. He should be encouraged to look at the occupational therapist, if it is culturally appropriate, which assists with contact with reality and the 'here and now'.

The treatment situation should be stimulating, but there should be no external stimuli that unduly overwhelms or distracts the patient. External stimuli can be increased as his active concentration improves.

Patients should be contained within the ward area as they are often disorientated especially on the level of unconstructive action but should be moved to different areas within the ward for different activities: bathroom for personal hygiene activities, dining room to eat and the lounge for stimulation activities. The various wards and rooms should be stimulating but not overwhelming or distracting. Colour and labels

should be used to facilitate orientation, and patients should be made aware of changes in the environment, for example, a new flower arrangement. Encourage them to extend their world by looking out of windows, creating an awareness of the objects and people outside. If the weather is good, patients should be taken out of doors for short walks or just to sit in the garden for a short period.

Treatment time should be broken up into a number of short sessions of between 10 and 20 minutes. There should be at least two to four sessions during the day. Treatment programmes can start to incorporate activities from different OPAs and may also be part of some of the caregiving processes such as bathing, washing, dressing and eating. Some patients on this level may require habit training associated with personal care skills and routines. This should be negotiated with the nursing staff until the skill has been achieved. The daily execution should be managed by the nursing staff with the occupational therapist responsible for checking that the skill is maintained. Treatment will only be effective if it occurs on a daily basis.

The treatment principles for both levels of action, that is, the unconstructive level and the incidentally constructive level, at the self-differentiation (level of motivation)

Although there may be slight differences in approach, most principles are similar on this level. Those that are different will be indicated.

These patients should be handled in a caring, nurturing and dignified way. Caregivers should not talk to them as though they are children or use a patronising approach. On this level, the patient should be accepted unconditionally including his behaviour.

Greet patients regularly and talk to them about what is happening in the environment so as to raise their level of awareness about what is happening around them. Verbalisation during all activities, in order to stimulate basic orientation to person and place, all basic concepts and to start the stimulation of elementary concepts. Call all objects and people by their correct name. Ensure that you have the patients' attention, and encourage them to look at you if that is appropriate. This will help to bring them into contact with reality. Physical contact to gain their attention should be used with discretion.

Encourage cooperation in all caregiving activities, and facilitate body action to assist them to participate in these activities, for example, lift arms when dressing or open mouth when feeding, and positively reinforce this.

Patients should be treated in small groups with patients on the same level of action for short stimulation groups – usually only a single session a day and no more than about 15 minutes. The group should consist of no more than six group members, and the group leader needs to be consistent in approach. Group treatment assists in developing awareness of others and the environment but expects little interaction. The occupational therapist should encourage introductions and an awareness of the characteristics and activity of each member of the group.

The treatment situation must be well organised before the patients arrive so that the session can start immediately. Materials and equipment must be at hand, and the workplace should be carefully structured, taking safety and ergonomic factors into account. Where possible, no tools should be used, and patients must be encouraged to make direct contact with the materials and objects with their hands. Remember to include time for basic hygiene such as hand washing and regular toileting.

The ward areas should be planned or structured to promote orientation. This is particularly important during the later phases of the incidentally constructive level. Calendars and clocks should be correct and clearly displayed. All doors should be clearly marked, especially the toilet.

Patients must be given clear, simple, direct, verbal step-by-step instructions. Instructions should be repeated frequently in exactly the same way every time, so that they do not have to deal with new elements that were not present earlier.

Treatment materials should be presented one at a time and the patient should be made familiar with the basic concepts of the material and objects. They should stimulate the part-whole concept wherever possible. Objects and material should not require fine coordination or skilled action or require physical resistance. Verbalise the texture, form, shape and size of the material or object while encouraging patients to make relational contact with it via their senses. The patients should look

at, hold, feel, taste, listen to and smell the item in question, verbalising the movement of involved body parts and the physical action involved, for example, rolling, patting, squeezing and so on. Encourage unconstructive action actively at this early stage as patients interact with the materials. Praise and positively reinforce them for any effort. Do not expect constructive action.

Objects and materials used should, where possible, come from the natural material group. They should demand no prior knowledge for patients to interact with them and should be edible, non-toxic and safe if mishandled. They should fall within their frame of reference and be part of their environment.

Grade physical demands of activities by increasing the range of movement required from small to larger coordination expected during interaction with objects and materials. Although coordination will still be poor grade the movement from very slow to a little faster and increasing the control of their actions.

Grade psychological demands of activities in the following way:

- Extending the period for which patients can keep their attention focused
- Stimulating memory by encouraging them to name objects, materials and people by increasing the need for awareness of objects and people in the environment
- Upgrading the amount and quality of cooperation required from the patient in caregiving activities

In the unconstructive action level, the following criteria need to be met before a patient is ready to move onto the next level if:

- he shows interest in interacting unconstructively with all materials and objects
- he shows some indication for intention
- basic concepts are evident
- he is showing some interest in elementary concepts
- he is more aware of immediate environment and is orientated to persons who interact with him

If the aforementioned criteria are met, then he is ready to move to the next level.

When facilitating incidentally constructive action, demonstrate by physically moving his body through the desired movements, until he has the idea. Repeat the action until he is able to do it alone. Remember that the quality of what he does will be poor and he will still need help, support and structure.

Incidentally constructive activities representative of all OPAs should be planned, prepared and structured for the patient. All that should be required of him is to interact with the materials and objects in the activity to produce an end product/outcome that he did not expect. Activities must give immediate gratification. An edible end product often has more impact. Activities should clearly show the impact of his effort and the difference between the parts and the whole. All that can be expected is that he should interact with materials and objects.

The activities should be concrete, simple and should facilitate the patient's knowledge and control of his body as well as pre-functional physical and psychological factors and performance skills. The activities also need to help develop basic self-care skills and encourage verbal communication.

The following aspects need to be graded:

- Therapy centred on all caregiving activities to the introduction of specific therapy sessions
- Treatment only within the ward setting to therapy in occupational therapy department and outside
- Patient cooperation in basic self-care activities to more independence in these skills but still requiring supervision
- Increasing the physical demands of activities
- Increasing rate, control and range of movement, coordination, duration and physical effort
- Increasing the psychological demands of activities on body concept by grading from body awareness to identification of body parts and their function to more functional use of the body and control of body processes within the activity
- Extending the patient's active and passive concentration span by extending the concentration demands of the activity, and as his level of distractibility improves, so more external stimuli can be introduced

- Grading from minimal awareness of self and familiar others to more consistent awareness of both self and others
- Grading the temporal and spatial relationship to the client by discussing 'before and after tea' and spatial concepts, such as 'sitting next to', 'in front of' or 'on the left or right' of a person sitting next to him. Increasing the orientation expected from orientation to person, place and then a basic sense of time

Should the patient show indications of deterioration, the aforementioned principles can be reversed to accommodate this.

The patient is ready to move onto the next level when body concept is consolidated and when toileting is independent with only rare accidents. He must have the skill to carry out hygiene tasks with some supervision of safety, although the quality of performance may be poor. The patient should be aware of self and others and the temporal and spatial relationship between them. The patient should be able to interact with materials and objects in an incidentally constructive manner and should show interest in more constructive exploration. He should also be orientated to person and place and have some orientation to time.

Group 2

Self-presentation

On this level, motivation is directed towards the development of individuality, but at the same time, a sense of belonging to a group develops. The development of the basic components of self-concept is evident as well as presentation of self to others. The most basic and fundamental skills involved in social interaction and interpersonal relationships (social awareness, social judgement, basic social skills, relating to others, and socially acceptable behaviour) are also developing. The patient's motivation is directed to the exploration of his ability to influence the environment, to be constructive and to discriminate between interests. Basic elements of productivity and OP in all OPAs are emerging (achieving task concept, an awareness of pre-vocational skills and a concept of leisure).

Throughout this stage, patients demonstrate a readiness to present the newly differentiated self to others and to explore the world and define its reality and their place within this. Exploration of the world is a co-requisite for constructiveness and productivity, which develop in this and subsequent levels.

Constructive explorative action

Constructive explorative action can be defined as the intentional investigation of materials, objects and others in the environment in search of understanding a person's occupational identity (Kielhofner 2002) and success through 'doing'.

This exploration is directed towards establishing the particular properties of materials and objects and the way in which they can be influenced through purposeful engagement and interaction. It is also the reaction of the materials, objects and others in the environment to the patient and marks the first step towards productivity. The more he interacts with others and objects in the environment, the more he learns about his effectiveness as an occupational being. It is the start of the development of personal causation (Kielhofner 2002) and successful OP.

During the course of this level, the patient learns many of the fundamental skills needed for independent living, but the need for structure, encouragement and support as well as external organisation precludes him from using these skills independently.

Patients with mental illness often regress to this level of action during periods of acute illness and also plateau on this level in the chronic phase. During this stage, the limitations placed on OP by affected factors, performance skills and environmental resources are evident in how he engages occupationally with his environment. Symptoms in all of the psychosocial factors and performance skills can impact on a patient's ability and limit OP throughout the constructive explorative level. Although psychiatric symptoms are less severe than on the earlier levels, psychopathology remains of moderate intensity. Patients on this level can be found in acute units, mental hospitals and care centres. When the psychiatric condition is controlled, they can also live in halfway houses, a protective environment,

within a protective family unit provided the context has the resources to cope with them. They can seldom work in the open labour market unless the job is simple, undemanding and highly supervised.

In the therapist-directed phase of this level, patients consolidate their basic hygiene, which had to be supervised on the previous level. The quality and efficacy of OP become more socially acceptable. However, they cannot organise these skills into a routine and need reminders to carry them out, but can execute them independently. Patients can dress themselves efficiently and can select clothes, but they are not really concerned about the appropriateness for the situation or the weather. The less choice there is available, the more appropriate their clothes tend to be.

In the patient-directed phase, the patients learn to care for their clothes, personal belongings and their immediate surroundings. They develop some awareness of the need to be presentable and so learn to wash, iron, sew on a button, keep personal belongings safe and orderly, etc. In spite of this, they still wear clothes for several days, but they recognise that they should change. They like to have their own belongings and develop preferences for clothes, which reflect their own individuality. Choice may still not be socially appropriate. All these tasks need supervision by the occupational therapist or nursing staff, and assistance should be given where needed.

In the transitional phase, patients develop an interest in and explore refined forms of self-care and grooming. At the start, they become concerned about how they look and the need to be dressed appropriately for the situation, weather and activity. They also develop some basic skills for independent living, for example, making their bed, making tea and sandwiches, sweeping and washing dishes. Clients usually change their clothes regularly. If facilities are available, patients can do their own washing, although relatives frequently do this if he is hospitalised. Care of clothing and belongings is more regular, but the quality is not always socially appropriate.

Throughout this stage, patients master the basic skills associated with independent living. However, they often manage themselves poorly when not supervised. They have difficulty organising their activities into a routine, using their time

effectively and organising their routines and resources, and therefore, they cannot live independently. However, if relatives or caregivers organise a routine, patients are able to execute these personal domestic activities, although the quality is generally poor. They find it difficult to be persistent and disciplined.

Patients come into the constructive explorative level with an awareness of the physical presence of others. This is further refined in the therapist-directed phase as they recognise other patients from their ward and can sometimes name them. They can differentiate between staff and other patients. In the patient-directed phase, they become aware of the fact that others in the environment have needs and feelings. During the transitional phase, their recognition of the needs and feelings of others becomes more accurate as their social judgement improves, but they have difficulty in responding to these cues appropriately.

Throughout this level, the patient develops basic social skills. The quality and appropriateness of verbal and non-verbal skills improves towards the transitional phase. Conversation remains superficial and egocentric throughout the level. Conversation also tends to reflect the patient's psychopathology, and they have difficulty in dealing with interpersonal anxiety.

In the patient-directed and transitional phase, patients tend to form egocentric, superficial, child-like and transient relationships with people within their immediate environment and they develop dependency relationships with caregivers. These 'buddy' relationships with others tend to be short-lived and tend not to tolerate absences and differences of opinion. Social behaviour in the relationship is often inconsistent and they often disregard the feelings of others.

Relationships with family members may be strained especially if there is a history of aggression, conflict about delusions and other behaviours associated with their illness. The insight of the family into the patient's condition often influences their support and tolerance of him and his illness. Patients often have a disturbed sense of belonging to groups. Either they feel quite detached from family and secondary groups or overdependent on one or another group.

The most important development in this level is the emergence of the task concept and the nature

of engagement, which is essential for doing activities independently and for being productive (de Witt 2003).

The task concept has two interacting concepts, firstly:

- Understanding the process of the activity, which is similar to understanding the activity as a whole described by du Toit (2009).
- The understanding the influence of his effort, having a sense of engagement in the activity and that the activity is the product of his effort. This appears to be the same concept as identifying with the task also described by du Toit (2009).

These two concepts are influenced by a patient's interest in and recognition and ownership of the task at hand. This implies that the development of an understanding of the task is more likely to be facilitated when the activity is both within his range of interests and frame of reference. The activity should also meet his personal needs and environment demands; be sanctioned by the socio-cultural group; be goal directed in the sense that the occupation should have a purpose and goal, which is both valued and meaningful; and the activity should provide the right challenge to stimulate interest and fully engage energy levels and resources (Reed & Sanderson 1994).

The second concept is the nature of a patient's engagement in the activity. The following five interacting aspects describe the process of a patient's engagement essential for productive action:

- (1) Task selection relates to the patient's decision 'to engage'. Task selection appears to imply that the decision 'to do or engage' needs to be made first, and this is followed by deciding between the options that the environment offers. Task selection is the most difficult aspect in the therapist-directed phase. However, throughout the constructive explorative level, the occupational therapist should offer patients the opportunities and resources to engage in therapeutic activities that are potentially meaningful, purposeful and goal directed and within their abilities. However, a patient must make
- (2) Task execution relates to how a patient goes about the process of the task. This includes how he interacts with the activity resources and uses his internal capacities to work through the steps of the activity, as well as the level of motivation required to keep to the task at hand and sustain effort until the task is complete. This is poor at the beginning of the constructive explorative level and improves considerably towards the end.
- (3) Task completion indicates that a patient is aware that the end of the activity has been reached and no more work is needed or desired. In the therapist-directed phase, patients want an end product, but cannot conceptualise the end. They often believe that the activity is complete after only one step. In the patient-directed phase, they seem more concerned with the process than the end, while on the transitional phase, the patient knows what is needed for completion, although he does not necessarily act on this, but acknowledges that more could be done.
- (4) Task evaluation indicates a patient's capacity to evaluate the quality of what has been done, as well as the effort that is needed. This evaluation is not robust or accurate; rather, it is the capacity to look at what has been done in a reflective manner. Thus, a patient exercises his interpretative and evaluative skills in relation to his performance in order to develop his sense of personal causation.
- (5) Task satisfaction usually implies a patient has the ability to gain a positive emotional response from engagement that should reinforce his engagement. However, emotions in relation to engagement are quite conflicting, for example, frustration and disappointment when the end product is not exactly what was expected, but pleasure at the fact that something was achieved even though the quality is poor. Patients on this level seldom achieve realistic task satisfaction due to their inadequate self-concept, resultant low self-esteem and unrealistic judgement (de Witt 2003).

Throughout this level, the patient's participation is goal directed. Although an end product is usually produced, the emphasis during this level is on the process of exploring how the patient can interact with and influence the materials, objects and people encountered during the process, rather than on end product itself. However, the production of a reasonable end product is important to support personal causation and the fragile self-esteem.

This constructive exploration is also directed to the way in which the patient can influence or affect other situations and things in the world to find out about himself and his abilities and use this knowledge to enhance his occupational engagement.

Throughout this level, OP is influenced by a poorly developed self-concept and difficulty in making a concrete decision where there are more than two or three options or where the options are very similar (positive to positive) or equally poor (negative to negative). Patients also have difficulty with all abstract decisions and working at an acceptable rate. They either work too fast and impulsively or too slowly. Due to inadequate pre-vocational skills, the quality of their work is usually poor. In addition, they have difficulty in delaying gratification for long periods of time, and their ability to confront and cope with obstacles in the activity process is poor.

On this level, patients start to develop leisure interests. This is facilitated by their discrimination of activities into those they are attracted to and those they are not, based on their past experience and interests. At the same time, they develop the understanding that some activities are for the purpose of work or survival, while others are only for pleasure and recreation. In the patient-directed phase, the concept of leisure is firmly established, and in the transitional phase, they develop or regain a few isolated interests, but are not able to pursue them or leisure activities independently. They often intend to participate but they need structure and support to do so.

Throughout the constructive explorative level, characteristics of the patient's personality and his background are more evident and need to be considered more specifically in the activities selected in the treatment programme.

Patients may have some awareness of their occupational incapacity but seldom realise the reason for it or what needs to be done to improve it. This limited insight often does not allow patients to fully understand the value of occupational therapy. This influences their ability to cooperate fully, and they need continual encouragement to do so.

There are three main principles for treatment for patients on this constructive explorative level:

- Give the patient the opportunity to present himself to others in different situations to facilitate awareness of others, to practise both verbal and non-verbal social skills, to gain an impression of ability to interact with and react to others and to form fundamental relationships.
- Give the patient the opportunity to explore his ability to influence the materials and objects in his environment so as to gain an impression of his abilities, and this will help develop his concept of himself and his feelings of competence as an occupational being (personal causation).
- Consolidate the task concept and facilitate constructive explorative engagement in all activities and occupations.

The occupational therapist needs to be encouraging and supportive of the patient because of his poor self-concept, as he frequently feels insecure about his ability. As a result, engagement and effort in activity are inconsistent, resulting in too much or too little activity. Patience is needed as this insecurity is usually reflected in all behaviours. The patient's individuality should be facilitated and emphasised in all interactions. This can be done by asking the patient for his opinions and ideas and acting on these if practical; sharing the patient's contribution and pointing out his achievements to others as this helps to develop the external feedback system needed in the development of self-esteem and effective OP; executing the patient's wishes if they are realistic and fall within therapeutic goals and discussing those that do not; and giving the patient the opportunity to make decisions concerning his activities and actions and encouraging him to take responsibility for them if this is realistic.

Expectations for behaviour and OP should be made clear to the patient. Covert norms need to

be made overt but the expectation for compliance remains low. These overt norms should be used to help his judgement of performance and of situations. Patients should be made aware of inappropriate and unacceptable behaviour in a non-punitive and accepting manner with the suggestion of more appropriate actions. However, actions that may be harmful to others must be firmly handled.

Patients are frequently reticent to be involved in occupational therapy. They should be firmly encouraged but not forced. Involvement can be facilitated by using a roundabout method of inclusion and by sharing the responsibility for the activity with the patient initially. A clear simple explanation about the role of occupational therapy within his total treatment and the setting of session outcomes that measure improvement may also help.

The occupational therapist should actively encourage the patient to present himself to others in an appropriate way. He should be given many opportunities to do this, and the occupational therapist should facilitate communication between him and others.

The occupational therapist should also enable constructive exploration of his ability by giving him the opportunity to make relational contact with materials, objects and others and should focus his attention on the effect of and result of his actions. The occupational therapist should help the patient to direct his energy towards active engagement in a wide variety of activities and interactions to facilitate the development of the task concept and the nature of his engagement so as to explore his ability to be constructive. Throughout this level, pre-vocational skills should be stimulated to develop awareness, rather than to actively improve these skills.

Patients require a half-day treatment programme where sessions are spread throughout the day with adequate rest periods in between. The patient should be given a copy of his treatment programme. Initially, he will need reminders to attend, but towards the transitional phase, he should be encouraged to be more independent and be expected to report to the occupational therapist if he is unable to attend.

The programme should include both individual sessions and activity groups, both structured and spontaneous. Sessions should be approximately 45 minutes. The occupational therapist should always be at hand to give assistance, encouragement and

support and to dissipate anxiety that the situation or activity may provoke.

Treatment situations should be varied and should be appropriate to an activity in which the patient feels safe and secure. The treatment situation should be stimulating, but external stimuli should be adjusted to the patient's level of distractibility. Special care must be taken to orientate the patient to a new treatment environment and the expectations for behaviour should be made clear to him. The treatment situation should be well organised with set locations for tools and materials. It is important as this gives the patient security and helps organise his actions in relation to the environment.

Other patients should be included in the treatment environment, but they should be involved in their own activities. This is important to promote interaction, to give feedback and to help the patient to learn to share the time and attention of the occupational therapist.

The occupational therapist should prepare the selected therapeutic activity appropriate to the patient's phase and should structure the workplace to promote pre-vocational skills, safety and ergonomics. In the transitional phase, the patient should be encouraged to assist with this. The occupational therapist should initially clear up and pack away after the treatment session, but can direct the patient to do some aspects of the clearing up to promote awareness of a tidy area. Patients should be encouraged to label and store their own activities in a safe place to promote awareness of the environment.

On this level, all activities should be presented in a way that evokes a feeling of anticipation and competence. Patients tend to use verbal instructions more effectively than other types, and these should be given in a stepwise manner.

Presentation and teaching should facilitate the development of the task concept and nature of engagement, facilitating what the patient thinks should happen during each step. Written and verbal instructions should be introduced only after facilitating the patient's thinking about the activity process so as to guide the processes or steps to be followed to complete the task. Demonstration should be used with discretion so as not to form a model for interaction with materials, others and objects and thus reduce constructive exploration.

Evaluation of performance should be facilitated on a concrete level. The patient should be encouraged to recognise the point at which the activity or his participation is complete and the purpose of the activity is reached.

Throughout treatment, emphasis should be placed on the patient's effort and involvement with the materials and processes and not on the end product. In spite of this, it is important that the results of the patient's interaction be positive; therefore, the occupational therapist should direct the patient's participation to important aspects of the activity in order to ensure success.

In the therapist-directed phase, no norms should be set for quality or rate of performance. In the patient-directed and transitional phases, patients should be made aware of the norms relating to quality of performance, but compliance to these should be facilitated but not be expected.

All activities should enable the patient to constructively explore objects, materials, tools and equipment and the way he can influence them to enhance his occupational engagement. As the patient's task concept is not consolidated, it is acceptable for him to do only some aspects of an activity, with the occupational therapist doing most of the planning and preparatory steps. The patient should do the execution and completion steps. Each task can consist of between four and seven steps. Activities should include the following:

- Assist in the development of task concept and facilitate engagement, and he should be encouraged to make concrete decisions about the end product in terms of such aspects such as colour or what will be done with it.
- Should be within the interests and frame of reference of the client, be purposeful and meaningful to him and also be sustainable in the context of his life.
- Not be childish or demean the client in any way.
- Encourage tool and material handling and should be infallible or easily controlled with a good end product.
- Be unfamiliar so that client cannot compare current ability with any previous skill.
- Be selected so that nobody else is using it. This ensures that copying does not reduce exploration.

- Not include elements of competition or actively compare the client's skills or performance with that of others.
- Always be concrete and straightforward so as not to raise the patient's anxiety unduly.

Grading should take place in the following areas:

- Interpersonal contact: Social situations should be concrete and structured, but the people to whom he is exposed and with whom interaction is facilitated should vary from known selected people to known unselected people to unknown and unselected people.
- Attendance: In the therapist-directed phase, the client needs to be fetched for treatment. In the patient-directed phase, the patient should be encouraged to attend treatment with other client's, even if he needs reminding. In the transitional phase, the patient can usually attend treatment independently but needs to have the time and venue clearly stated, and frequent reminders are needed. Inconsistencies in punctuality must be tolerated.
- Engagement: This needs to be actively facilitated throughout the level. However, in the therapist-directed phase, exploration should be actively facilitated, whilst in the patient-directed phase, the patient should be given the opportunity to direct his own exploration. In the transitional phase, some opportunities for experimental action should be introduced into activities that are predominantly consistent with the constructive explorative level.
- Behavioural expectations: Initially, all behavioural disturbances should be tolerated, but the patient should be tactfully and supportively made aware that his behaviour is not socially appropriate or acceptable and should be given some alternative suggestions for more acceptable behaviour. In the two later phases, the patient should be given the opportunity to try out and explore the alternative behaviours suggested.

Should the patient show signs of deterioration, the grading principles mentioned earlier can be reversed.

The criteria which mark the movement to the passive participation level are as follows:

- The consolidation of the task concept and an interest in being involved in all aspects of the activity, particularly showing concern around the end product
- An interest in the rules or norms which govern behaviour and activity participation
- An ability to work through an activity without constant supervision and individual attention
- Consolidation of basic social skills and an increase in awareness of people and social situations and an interest in the norms governing social behaviour

Passive participation

This is the first of the four levels of participation. Motivation on this level is directed at establishing the rules and norms accepted by the social setting in which the patient lives and according to which occupational behaviour is judged. Motivation is more extensive and goal directed as the patient shows interest in the totality and purpose of activities. He is not yet able to initiate these independently but does demonstrate the ability to sustain interest and effort in activities. Effort, ability and behaviour are characteristically erratic. The patient is easily influenced by others whom he perceives as demonstrating socially acceptable behaviour.

During this level, ideals and morals are more evident. Patients' functioning on this level become aware of the interpersonal, social, political and economic factors influencing their immediate environment and also the macro environment. This awareness leads to the identification of potentially threatening environmental stressors. Their poor anxiety control and limited behavioural resources negatively influence spontaneous participation, particularly in unfamiliar situations. Throughout this level, the patient's emotional repertoire is extended. More refined emotions such as regret, pride, sympathy and loyalty become evident, and he has more control of his emotional response. If provoked, threatened or stimulated strongly, emotional control is tenuous. The patient still has a low self-esteem and is hesitant to engage in occupations.

Norm awareness experimental level of action

Occupational skills and behaviour tend to be both passive and erratic. Patients on this level tend to be

the followers, doing what others do and say, and they want to blend into the crowd. However, on a psychological level, they tend to be more stable despite their engagement seeming passive: they watch and listen to everything going on around them to establish those occupational behaviours and skills that are both acceptable and unacceptable and the effects of compliance and non-compliance. They actively experiment with their own behaviour by following what others do. This is to establish how society will react and how acceptable their behaviour will be within their specific context.

On the OP level, the patient is developing and achieving a number of skills essential for independent living.

He has a well-ordered, independent and efficient hygiene routine. The skills acquired on the previous level such as the care of clothing and belongings are further developed. However, the quality of performance is negatively influenced by undeveloped pre-vocational performance skills, erratic effort and the lack of ability to organise these skills into a practical routine. Patients need structure to be organised, or they leave the chores until they are pressurised into doing them. An example is only doing washing and ironing when they have no more clothes to wear or shopping when there is no more food. They show an interest in socially acceptable refined forms of self-care, grooming and fashion. In the therapist-directed phase, their interest needs to be focused on these issues, while in the patient-directed phase, they actively experiment with them when encouraged. In the transitional phase, patients tend to experiment more independently. Throughout the phase, patients show a hesitancy to initiate tasks.

The ability to budget time and funds is limited, and there is a tendency not to be able to organise time effectively, to be 'crisis driven' and to be impulsive. There is some disorganisation of personal business such as accounts and income tax. Throughout the level, patients express the desire for independence, but they need outside supervision and structure to achieve this.

Interpersonal activity is directed towards being accepted and belonging to a group. Communication is usually rational and logical, and they can discuss a wide range of subjects, although patients demonstrate a reluctance to give their opinion if they are unsure of the opinion of the group. Conversation

can be maintained effectively if other parties take most of the responsibility. They are able to form interpersonal relationships, but relationships tend to be egocentric. They have a tendency to form intense, sometimes inappropriate, relationships, which often are short-lived. Patients on this level find groups anxiety provoking. They like to be involved with the group but not to be singled out to give an individual opinion or make a suggestion. They tend to take on a spectator role but are actively involved in the group process although they offer little, unless specifically invited to do so. Due to their desire to be 'one of the crowd', they have difficulty in being assertive and in dealing with a difference of opinion and resolving conflicts. Assertive skills tend to start developing during this level.

Occupational behaviour becomes progressively more product centred. The consolidated task concept facilitates his desire to work through an activity from beginning to end. Although patients are eager to participate, they have difficulty in initiating activities. Once started however, they work reasonably effectively but are reluctant to participate in any activity where success is not ensured. They need less supervision but they still need to have the steps and sequence confirmed. Throughout this level, they are concerned with the pre-vocational performance skills required to make their activity acceptable. Judgement of performance remains problematic although it improves towards the transitional phase. They tend to judge their performance in terms of good or bad and either blame the materials, tools or environmental factors rather than how they contributed to the problem or have an unrealistic desire for perfection and excellence which they are not able to meet.

Patients are able to sustain effort and quality of performance over time, although this tends to be inconsistent. They are able to deal with some obstacles during the course of the activity but are unable to demonstrate initiative. Quality of performance tends to improve towards the transitional phase.

Domestic or survival skills are encouraged on this level. In the therapist-directed phase, the patient can be responsible for caring for his bed area and personal possessions. He is able to take care of his room, clean up and pack things away, but the quality varies and the organisation of these activities is poor.

He is able to make nutritious meals with encouragement and structure. However, motivation to do this on a regular basis is inconsistent.

Patients who have achieved this level can work on the open labour market, but the work environment has to be very structured and organised and supervision is required. The job should be such that variations in quality and rate of performance should not be too important to job security.

A greater range of interests in recreation develops throughout this level although discrimination of interests is largely dependent on others. Patients will actively participate if organised and encouraged. If others are not available to encourage them, they tend to use their time unproductively or passively.

High-functioning individuals can regress to norm awareness experimental action as a result of a relapse of their psychiatric condition. The illness is usually of mild to moderate severity, and the psychopathology has an individualised presentation. These patients may be hospitalised in acute- or medium-term units and are often in a pre-discharge phase. A number of controlled mentally ill individuals on this level may also be found in the community, participating in day-care or other rehabilitation facilities.

The main aims of treatment at this level are as follows:

- Make patients aware of norms and experiment with those occupational behaviours and skills which will make them acceptable to the society in which they live.
- Prepare them for the imitative norm-compliant level which follows.

Patients should be handled with patience, and the occupational therapist should be tolerant of their inconsistent effort and inability to produce behaviour and work of a consistent standard. Patients should continuously be made aware of the norms, both overt and covert, and they should be encouraged to evaluate the acceptability of their own and the group's occupational behaviour and performance. They should be encouraged to participate in their treatment, remembering that their participation will be passive and will need extra support to initiate activities. Encouragement will be needed from time to time until the task or

activity is complete. They will need to read cues for socially appropriate behaviour and understand why behaviour is inappropriate. Assist patients with assertiveness, conflict resolution, problem-solving, value clarification as well as the understanding of the consequences of inappropriate or socially unacceptable behaviour. They need to be given opportunities and facilitated in developing healthy acquaintance relationships into a more meaningful relationship.

During this level, pre-vocational performance skills should be actively trained or retrained, although compliance is likely to be erratic.

Patients should be included in a full-day programme, which should be negotiated with each one. The programme should be extended beyond the time for occupational therapy and should help them structure their free time in the late afternoon, evening and weekend. The programme should include both individual and group activities (both task and discussion).

Any occupation-appropriate treatment area can be used. However, for group work, the atmosphere needs to be accepting and permissive, while for individual activities, a work-related atmosphere should be created allowing for norm awareness experimentation. Others should be included and involved with work-orientated or work-related activities. The treatment area should be structured in keeping with the patient's concentration. Preparation of the activity and workplace should be done together with the patient. He should be given the responsibility for cleaning up, packing away and storage of the tools, materials and activities. The occupational therapist should, however, direct and check this.

The patient should be given comprehensive instructions that clearly define the sequence and the contents of steps of an activity. He should be given practice at following all types of instruction. The occupational therapist should ensure that he grasps what needs to be done and how it should be done before starting. He should be given some guidelines on how to check his progress. A patient should be allowed to decide when the activity or step is complete and should be encouraged to work without continuous supervision and to ask for assistance. The occupational therapist must help

them to evaluate their effort, quality and progress in work as well as the reasons for success or failure. In the therapist-directed phase, patients find this difficult, and it is necessary to focus the evaluation on the properties of the activity such as the size, colour or texture. They may be given an example against which to evaluate their work. In the patient-directed phase, the evaluation should be done at the end of the activity because of the patient's inability to tolerate negative feedback and their fear of failure. In the transitional phase, evaluation of quality can be introduced during the course of the steps of the activity.

The activities used in treatment should make patients aware of the norms and be mainly concrete but introducing some abstract elements. The patients should be involved in all the steps. The activities must be successful and also give patients the opportunity to improve their pre-vocational performance skills initially and later their vocational skills, but should not expect any initiative.

Activities should enable a patient to learn and practise the higher order social skills such as assertiveness and conflict resolution and also be given the opportunity to form relationships with people who were previously acquaintances.

On this level, the treatment is graded as follows:

- Increase the expectation for more consistent pre-vocational performance skills and effort.
- Initiation of familiar activities independently as the client moves towards the transitional level.
- Increase the complexity of the activities.
- Abstract elements can also be introduced into activities on the patient-directed phase.
- Some specific vocational skills can be introduced in the patient-directed phase.

The patient should meet the following criteria before moving to the next level:

- Start to initiate familiar activities consistently.
- Demonstrate the desire to comply with the norms of all situations or activities.
- Should become less dependent on environmental structure to direct actions and activities.
- Pre-vocational performance skills should be consolidated.

Imitative participation level of motivation

During this level, motivation is predominantly directed at complying with the norms set by society. The patient actively seeks to be part of the group and context to which he belongs and does not wish to be identified as being different from others, although individuality is evident within the patient. Motivation is product centred and directed towards productiveness, but there is little evidence of initiative and there is a reluctance to actively compete and compare skills with those of others. Patients on this level are very stressed by the unknown and unfamiliar and any situation where the norms are unclear. The major developmental task that takes place during this particular level is the establishment of an independent, self-supporting and self-sustaining lifestyle, which is defined by the group in which he lives.

Imitative norm-compliant level of action

At this level, individuals may have been successfully treated and are now integrated back into society. They will now be referred to as 'clients' as they will no longer be in a hospital setting but may be attending clinics as outpatients and private appointments on a regular or infrequent basis. These clients may be seen in some specialised units for substance abuse or eating disorders. They may also be seen in the community when transitioning from a hospital to community after a period of illness.

This level of action indicates that people do what is asked of them, no more and no less. Although there are individual and cultural variations in what is considered to be norm compliant, there are some general trends.

In the personal management area of OP, behaviour concerning hygiene and care of clothes and belongings is usually consistent and efficient. Refined forms of self-care and grooming are usually fair with the client developing awareness of fashion and suitability of dress for a wide variety of situations and occasions. There may, however, be a tendency to follow fashion, which may not be totally appropriate, but it does create a sense of belonging or being part of the group.

Clients on this level are mature enough to look after others: pets, children and parents. While they are able to deal with their practical needs, they may still have difficulty in dealing effectively with their emotional needs. Management of personal business usually improves, but there may be impulsive spending on things that will improve their social acceptability, for example, clothing, a car, and the latest craze object.

All social behaviour is directed towards belonging. More mature, intimate relationships tend to develop during this level, but egocentric needs are still evident. Communication is usually efficient and basic social skills are good. However, assertiveness skills are not yet consolidated. Clients tend to function well socially in familiar situations but poorly in unfamiliar situations and in situations where the norms are not very clear. They tend to be followers rather than leaders, and acceptance by others is important. They are very susceptible to group pressures and sensitive to acceptance or rejection by group members.

Independent living and productivity are the main focus of attention on this level. This includes setting up and maintaining a home within financial restraints. In the therapist-directed phase, the client experiences difficulty in coping with the stresses of being responsible for himself and in managing the chores in an orderly and effective manner, but this tends to improve towards the transitional phase.

In the work area of OP, the client's participation is goal directed and norm compliant. He is able to do what is asked of him efficiently, provided that the activities are straightforward, do not have any unexpected hitches and do not demand any initiative and complex problem-solving on his part. Pre-vocational performance skills are good, and vocational skills develop either due to formal or informal vocational training. While work tolerance and endurance is more robust, clients often feel overwhelmed by their workload, even if it is not extensive, and find it difficult to manage their time appropriately.

In the recreational sphere, they tend to be involved in activities which are in vogue with other members of the group.

As with the previous level, psychopathology, although characteristic of the condition, usually has

an individualised presentation. Psychopathology may be of mild to moderate intensity as social, occupational and recreational performance may be interfered with, but the client is not usually occupationally incapacitated.

The **outcomes of treatment** expected are as follows:

- Compliance with norms in all OPAs appropriate to the group and society in which they live.
- The ability to look after themselves independently complying with community norms and pressures.
- To be productive and be able to work effectively and efficiently and to use leisure time in a health-promoting constructive manner.

The therapeutic relationship should have more qualities of maturity than previously, being based on mutual trust and respect, with elements of both give and take. The client should be considered a partner in the treatment. The occupational therapist should handle the client firmly in terms of norm compliance while being sensitive to the anxiety this may cause. Expectations should be negotiated and clearly stated and generalised to as many treatment situations as possible. The client should be given recognition for imitative norm-compliant responses. If he is unable to comply, be supportive, and help him to explore the reasons for failure and explore alternative behaviours that may increase the possibility of success.

Plan the programme with the client and establish the goals and norms towards which he should be working. Where practical, the client should have a full-day programme and should be given the responsibility for compliance or lack thereof. The treatment programmes should be balanced and include the following:

- Work-related or work-simulated activities for approximately half the treatment time
- Sport and recreational activities for approximately one sixth of the time
- Group activities for the rest of the time

All treatment should emphasise the following:

- Personal independence
- Mature relationships where loyalty, cohesion and conformity to group norms are reinforced

but at the same time supporting individuality and assertiveness

- Consolidation of pre-vocational performance skills and development of vocational skills
- Stress management, problem-solving, conflict resolution and value clarification

The therapeutic value of all activities used in the treatment programme should be carefully explained. The client should use all types of instructions from resource material although technical skills may need to be demonstrated. Instructions should emphasise the purpose for undertaking the activity and the sustainability of the activity/occupation in the context of the client's life. Instructions should outline the technique and method to be used and give tips for success and clearly indicate the norms against which performance will be judged. A completed, high-quality end product can be used to rate or compare performance. All activities must facilitate norm compliance.

As the client moves from the therapist-directed phase, the demands of the activities should be increased as follows:

- Increasing the number of steps, the elements of fallibility, the complexity of the method and decreasing the completion time.
- Elements of abstract thinking, decision-making and problem-solving can also be introduced when the patient-directed phase has been achieved.
- Gradually upgrade the demands for norm compliance in all OPAs.
- Decrease the structure and support and increase demands for independent personal management and lifestyle within the contextual opportunities and constraints.
- Increase the demands for productive and vocational ability.
- Increase demands for constructive and healthy use of leisure time.
- Increase demands for effective use of coping skills in the face of environmental demands.

The following are the indications that the client is ready to move to the next level:

- The client should be able to structure and execute familiar activities consistently meeting the norms set efficiently.

- The client should be prepared to meet the challenge of unfamiliar situations in spite of some anxiety.
- The client should become aware of shortcomings within the current method of an activity or behaviour and have an interest in exploring possibilities for improvement or change.

Group 3

The levels that fall into this group are least well described in the VdTMoCA. This does not mean that they are immune to psychiatric disorders, but they seldom require occupational therapy assistance. In the case of psychiatric illness, there may be some regression from their OP from their premorbid state; these individuals are seldom occupationally dysfunctional. For this reason, the levels falling in the group will not be described. Information of these levels is to be found in du Toit (2009). These levels are:

- (1) The active participation level of motivation
 - (a) Transcends norms, individualistic and inventive level of action
 - (b) Competitive participation
 - (c) Competitive-centred action
- (2) Contribution and competitive contribution

Conclusion

As stated at the beginning, the purpose of this chapter is to provide introductory information about the VdTMoCA and its application to patients with psychosocial dysfunction. It is intended for students and novice occupational therapists working in a variety of mental health care settings.

Research and development into the work of VdTMoCA is ongoing in a number of countries but predominantly in South Africa. Terminology, concepts and occupational therapy strategies are being developed as this chapter is published. A strong team of experienced and dedicated occupational therapists have joined forces to develop this exciting theory further. (Refer to the website of MCAIG 2013.) However, the material in this chapter is simple to work with and can be an inspi-

ration to many occupational therapists working in many areas of occupational therapy but particularly to those working with the severely mentally ill. It is here that this work is unique to the psychiatric field and where the occupational therapist has over the years made a significant contribution.

Questions

- (1) Define the following in your own words and the relationship between these concepts: creative capacity, creative response, creative participation and creative act.
- (2) Define in your own words the concept of 'creative ability'.
- (3) Define in your own words the term 'maximal creative effort' and state its relationship to creative ability.
- (4) Define the terms therapist-directed phase, patient-directed phase and transitional phase. Discuss the value of these terms for the levels of motivation and action.
- (5) Make a table indicating the relationship between the levels of motivation and action.
- (6) Describe the steps in the assessment of creative ability.
- (7) Make a table indicating the similarities and differences of OP between each of the levels of action.
- (8) Make a table indicating the similarities and differences in the principles required for handling, structuring the treatment situation, presentation and teaching of the activity, activity requirements and grading of treatment that would be used in the first four levels of action.

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