Occupational Therapy

Fifth Edition

in Psychiatry and Mental Health

Edited by
Rosemary Crouch
Vivyan Alers

WILEY Blackwell

Occupational Therapy in Psychiatry and Mental Health

Occupational Therapy in Psychiatry and Mental Health

FIFTH EDITION

Edited by

Rosemary Crouch

Ph.D. Occupational Therapy
Medical University of Southern Africa (MEDUNSA)

and

Vivyan Alers

M.Sc. Occupational Therapy
University of the Witwatersrand
B.A. Social Work
University of Stellenbosch

WILEY Blackwell

Registered Office
John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
9600 Garsington Road, Oxford, OX4 2DQ, UK
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK
111 River Street, Hoboken, NJ 07030–5774, USA

For details of our global editorial offices, for customer services and for information about how to apply for permission to reuse the copyright material in this book please see our website at www.wiley.com/wiley-blackwell

Library of Congress Cataloging-in-Publication Data

Occupational therapy in psychiatry and mental health / edited by Rosemary Crouch and Vivyan Alers. – Fifth edition.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-1-118-62422-7 (pbk.)
I. Crouch, Rosemary B., editor. II. Alers, Vivyan M., editor.
[DNLM: 1. Mental Disorders–rehabilitation. 2. Occupational Therapy–methods. WM 450.5.O2]
RC487
616.89′165–dc 3

2014005426

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image © Delia Mason, delia.e.mason@gmail.com

Set in 9.5/11.5pt Palatino by SPi Publisher Services, Pondicherry, India

1 2014

Contents

Contributors

Vivyan Alers M.Sc. Occupational Therapy (University of the Witwatersrand) B.A. Social Work (University of Stellenbosch) Nat. Dip. Occupational Therapy (Vona du Toit College, Pretoria) Cert. Sensory Integration Assessment and Intervention (South African Institute of Sensory Integration SAISI) Cert. Therapeutic Spiral Model (Therapeutic Spiral International, USA)

Vivyan has worked as a lecturer at the University of the Witwatersrand for 10 years and as a private practitioner in psychiatry and paediatrics for 20 years and was founder of a non-profit organisation Acting Thru Ukubuyiselwa.

Co-editor of the third and fourth editions of "Occupational Therapy in Psychiatry and Mental Health."

Susan Beukes M. Occupational Therapy (University of Stellenbosch) B.Sc. Honours in Medical Science (University of Stellenbosch) B. Occupational Therapy (University of Stellenbosch)

Head of the Division of Occupational Therapy at University of Stellenbosch 1988 to 2013. Chairperson of the Education Committee of the Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy of the Health Professionals Council of South Africa (2005 – 2008).

She has extensive experience in the psycho-social field, occupational therapy programmes and interventions in psychiatric hospitals, work rehabilitation programmes, workshops for the disabled and the establishment of service learning projects in communities.

Sylvia Birkhead M. Occupational Therapy (University of Pretoria) B.Sc. Occupational Therapy (University of the Witwatersrand).

Lecturer in the Occupational Therapy Department at the University of the Witwatersrand and University of Mauritius. Examiner for the H.P.C.S.A. for the Board examinations for Occupational Therapy Assistants to upgrade to Occupational Therapy Technicians.

Winner of the O.T.A.S.A. / Lifehealth Albie Sachs' Award for exceptional service to the disabled in South Africa (2004).

Tania Buys M. Occupational Therapy (Cum laude) (University of Pretoria), B. Occupational Therapy (Hons.) (University of Pretoria) B. Occupational Therapy (University of the Free State).

Lecturer in vocational rehabilitation in the Occupational Therapy Department, University of Pretoria. Part time private practice conducting Functional Capacity Evaluations in the physical, neurological and psychiatric areas. Currently registered for a PhD in occupational therapy at the University of the Witwatersrand.

Daleen Casteleijn Ph.D. (University of Pretoria), M. Occupational Therapy (University of Pretoria), Post Graduate Diploma in Higher Education and

Training Practice (University of Pretoria), Post Graduate Diploma in Vocational rehabilitation (University of Pretoria), B. Occupational Therapy (Hons.) (Medical University of Southern Africa, MEDUNSA), B. Occupational Therapy (University of Pretoria).

Senior Lecturer, Occupational Therapy Department, Faculty of Health Sciences, University of the Witwatersrand

Daleen's field of occupational therapy is mental healthcare with a research focus on routine outcome measurement in mental healthcare settings and psychometric properties of instruments that measure change after intervention.

Chantal Christopher Post grad. Diploma in Clinical Management of HIV/AIDS (University of KwaZulu-Natal (http://www.ukzn.ac.za/)) B. Occupational Therapy (University of Durban-Westville)

Senior Tutor and lecturer in Occupational Therapy at the University of KwaZulu-Natal (http://www.ukzn.ac.za/) where she facilitates learning using interactive and Freirean principles.

Ray-Anne Cook M. Occupational Therapy (University of Stellenbosch), B. Occupational Therapy (University of Stellenbosch) Cert. Sensory Integration Assessment and Intervention (South African Institute of Sensory Integration SAISI)

Ray-Anne is in private practice specialising in paediatrics, sensory integration, autism and ADHD of all ages. Chairperson of the South African Board for Sensory Integration (SAISI). Training therapists, teachers and parents in the area of specialisation for SAISI. Author of workbook on the occupational therapist's role in treating ADHD.

Rosemary Crouch Ph.D. Occupational Therapy (Medical University of Southern Africa, MEDUNSA) M.Sc. Occupational Therapy (with distinction) (University of the Witwatersrand), B.Sc. Occupational Therapy (University of the Witwatersrand), Diploma in Occupational Therapy (University of the Witwatersrand.)

Adjunct Professor, School of Therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg.

Senior lecturer in the Department of Occupational Therapy at the University of the Witwatersrand from 1972 to 1989, part-time senior lecturer at MEDUNSA and University of Pretoria, practitioner in the private psychiatric field for 20 years. Mellon research mentor and research mentor at the University of the Witwatersrand from 2007 to the present.

Editor of the first two editions of "Occupational Therapy in Psychiatry and Mental Health." Co-editor with Vivyan Alers of the 3rd and 4th editions.

Patricia de Witt M.Sc. Occupational Therapy (University of the Witwatersrand) National Diploma Occupational Therapy (Pretoria College of Occupational Therapy)

Adjunct Professor, Head of Training of the Occupational Therapy Department, School of Therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand.

Educational interest is in the application of Models of Practice and occupational therapy for mentally ill clients in both hospital and primary health care.

Madeleine Duncan D. Phil. Psychology (University of Stellenbosch), M.Sc. Occupational Therapy (University of Cape Town), B.OT (University of the Free State), B.A. (Hons.) Psychology (University of Durban-Westville), National Diploma Occupational Therapy (Pretoria College of Occupational Therapy)

Associate Professor, Department of Health and Rehabilitation Sciences, Faculty of Health Sciences, University of Cape Town

Madeleine's professional interests are in occupational therapy philosophy, mental health and higher education.

Louise Fouché M. Occupational Therapy (University of Pretoria), B. Occupational Therapy (University of Pretoria), Diploma in Groups and Interpersonal Communication (cum laude) (University of Pretoria), Diploma in Higher Education (University of Pretoria).

Lecturer in psychiatry and group-work and part-time lecturer in the Diploma in Vocational Rehabilitation course in the Department of Occupational Therapy at the University of Pretoria.

She has worked for many years in places of safety such as Weskoppies Hospital's Adolescent Unit and in acute psychiatry at Worcester Hospital.

She is presently working at Pines Private Psychiatric clinic in Cape Town.

Stephanie Homer B.Sc. Occupational Therapy (University of the Witwatersrand). Lecturer and Rural Practice Supervisor, Department of Occupational Therapy, Faculty of Health Sciences, University of the Witwatersrand.

Lecturer and trainer at the Tintswalo Hospital Training Centre for Community Rehabilitation Workers (Department of Occupational Therapy, Faculty of Health Sciences, University of the Witwatersrand.) At present working with midlevel worker projects and education programmes that strengthen community based rehabilitation skills both in students and rural therapists.

Robin Joubert D. Ed. (University of KwaZulu-Natal (http://www.ukzn.ac.za/)), M.O.T. (University of Durban-Westville), B.A. (University of South Africa UNISA), National Diploma Occupational Therapy (Pretoria College of Occupational Therapy)

Lecturer at the University of the Free State. Associate Professor and Academic Leader in the Department of Occupational Therapy University of KwaZulu-Natal (http://www.ukzn.ac.za/).

She is currently involved in coordinating, supervising and examining post graduate research at the University of KwaZulu-Natal (http://www.ukzn.ac.za/).

Michelle Moore B. Occupational Therapy (University of the Free State)

Assistant Director: Occupational Therapy, Free State Psychiatric Complex

Michelle has worked in the field of psychiatry since 1996 with experience in acute, long term and forensic psychiatry. The institution has a large care centre for mentally challenged patients where she has an interest in skills development and protective workshops.

Diedre Niehaus M. Early Childhood Development (University of Pretoria), B. Occupational Therapy (University of Pretoria)

Diedre specialises in early childhood development and trans-disciplinary therapeutic work with children and families.

Ann Nott B. Occupational Therapy (Hons.) (Medical University of Southern Africa MEDUNSA) B.Sc. Occupational Therapy (University of the Witwatersrand)

Ann has experience in the psychiatric field in acute rehabilitation, vocational rehabilitation, neurology, oncology, gerontology and occupational group therapy. She is an independent consultant to insurance companies for Functional Capacity Evaluations for psychiatric clients and a Job Coach and Case Manager.

Claire Prowse B.Sc. Occupational Therapy (University of Cape Town).

She is a clinical supervisor at the University of Cape Town and is an external supervisor.

Claire works in a psychiatric clinic where she develops, manages and facilitates life skills programmes and individual assessments for adolescents and adults. She is interested in developing programmes in schools to up-skill the youth to better manage life stressors.

Marita Rademeyer M.A. Clinical Psychology (Rand Afrikaans University RAU)

Clinical Psychologist in private practice and Chairman of Jelly Beanz Inc. (Non-profit organization)

Marita works with children and families who have experienced trauma and abuse. She is the co-author of "Voices of Hope - Therapeutic stories for Africa's children". She develops and facilitates training for mental health professionals on child mental health issues.

Lee Randall M.A. (Boston School of Occupational Therapy, Tufts, U.S.A.), B.Sc. Occupational Therapy (University of the Witwatersrand), Post Graduate Dip. Voc. Rehab. (University of Pretoria), Certified Health Economics (Victoria, New Zealand), Certified Med. & Law (University of Southern Africa UNISA) Certified Medical Evaluation of Professional Drivers (F.P.D.), Certified Workwell Practitioner (U.S.A.)

She has professional interests in vocational rehabilitation, psychiatric disability, FCE's / medico-legal work and disability equity in the workplace. Lee achieved a Fullbright Fellowship and worked in the USA and New Zealand. She is presently completing a Ph.D. study through the Steve Biko Centre for Bioethics at University of the Witwatersrand.

Catherine Shorten B.A. Socio-cultural Anthropology (University of South Africa UNISA),

Occupational Therapy Assistant (OTT) Diploma (Sandringham Gardens), Occupational Therapy Technician (OTT) (HPCSA Board). Fashion Design and Management Diploma (with distinction) (FDM College, Johannesburg) Fashion design and pattern cutting Diploma (with distinction) (City and Guilds Institute of London)

Awarded 'Top academic student' in the Occupational Therapy Assistant training course. Awarded 'OTA of the Year' in 2004.

Specialising in adult psychiatry. At present organising and presenting training workshops for Occupational Therapy Technicians.

Lyndsey Swart M. Occupational Therapy (University of the Free State), B.Sc. Occupational Therapy (University of the Witwatersrand), Post Graduate Diploma in Vocational Rehabilitation (University of Pretoria), Certificate in Advanced Labour Law (University of Southern Africa UNISA), Certified Joule FCE Evaluator and Trainer (Valpar International Corporation, USA,) Private practitioner offering vocational rehabilitation consultancy and functional capacity evaluations.

She has extensive experience in the field of vocational rehabilitation and functional capacity evaluations.

Dain van der Reyden L.L.M. Medical Law (University of KwaZulu-Natal (http://www.ukzn.ac.za/)), B.A. (University of South Africa UNISA) Nat. Dip. Occupational Therapy (Pretoria College of Occupational Therapy).Teachers Diploma in Occupational Therapy (University of Pretoria),

Honorary Senior Lecturer University of KwaZulu-Natal (http://www.ukzn.ac.za/)

She has practised as a clinician in mental health care and as a senior lecturer at the University of Durban Westville, now the University of KwaZulu-Natal (http://www.ukzn.ac.za/), for 40 years. Her interests are professional ethics and health care legislation; psychiatry; education and training and the Vona du Toit Model of Creative Ability.

Annamarie van Jaarsveld M. Occupational Therapy (University of the Free State), Nat. Dip. Occupational Therapy (Vona du Toit College, Pretoria), Cert. Sensory Integration Assessment and Intervention (South African Institute of Sensory Integration SAISI).

Head of Department, Department of Occupational Therapy, Faculty of Health Sciences, University of the Free State. She is currently registered for a PhD at the University of the Free State. She has been involved with the South African Institute for Sensory Integration (SAISI) for the past 30 years.

Lana van Niekerk Ph.D. (University of Cape Town), M. Occupational Therapy (University of the Free State), B. Occupational Therapy (University of the Free State).

Associate Professor and Head of the Occupational Therapy Division, University of Cape Town for 17 years. At present Head of the Division Occupational Therapy at University of Stellenbosch.

She is currently involved in two projects: A cost-utility of supported employment as a strategy to integrate persons with disability in work and an exploration of critical success factors for sustainable work creation projects, with a focus on livelihood creation in Lesotho. She is also completing a qualitative research synthesis on critical factors for sustainability of subsistence entrepreneurship.

Kerry Wallace M.Sc. Occupational Therapy (University of the Witwatersrand), B.Sc. Occupational Therapy (University of Cape Town) Cert. Sensory Integration Assessment and Intervention (South African Institute of Sensory Integration SAISI) Certified DIR®:FCD™ (Profectum Foundation, USA) Certified Neuro-developmental Assessment and Treatment (NDTA, Florida USA)

Research Associate University of KwaZulu-Natal (http://www.ukzn.ac.za/). Established and works at a non-profit organisation (SPOTlight Trust SA) which provides therapeutic services to underprivileged children and training to their educators and caregivers.

Lisa Wegner Ph.D. (University of Cape Town), M.Sc. Occupational Therapy (University of Cape Town), B.Sc. Occupational Therapy (University of the Witwatersrand).

Associate Professor and Chairperson of the Department of Occupational Therapy at the University of the Western Cape.

She has more than 20 years of experience as an educator. Her research focuses on adolescent risk and protection and interventions that promote youth development and reduce risky behaviour

through leisure. She is the co-developer of HealthWise South Africa: Life Skills for Young Adults, a school-based intervention that promotes youth development and reduces risky behaviour through leisure.

Kobie Zietsman B. Occupational Therapy (University of Stellenbosch) (Cum Laude).

Kobie is the Senior Occupational Therapist at Randfontein Care Centre since 1983, being responsible for the development of rehabilitation programmes for 500 long term mental health care users.

She developed an outcomes measure, the Functional Level Outcomes Measure (FLOM) to enable the Multi-Disciplinary Team to group each Mental Health Care User according to a functional level. Appropriate rehabilitation programmes are developed according to these levels.

Preface

The opportunity to update the fourth edition of this book arose with the prospect of updating current chapters and creating new ones. New research and current trends in occupational therapy in the field of psychiatry and mental health is reflected by experienced clinicians and academics in this fifth edition. The DSM-5 has challenged authors to change and together with other coding systems such as the ICD-10, we hope and anticipate that this has resulted in a comprehensive and updated volume.

This edition has been compiled and edited in a manner in which the chapters inter-relate. It is important for the reader to recognise that the content matter of one chapter makes reference to another. For example, the chapter on acute psychiatry makes reference to the chapters on creative ability and trauma. The chapters in the child psychiatry section, which discuss early intervention with young children at risk for mental health disorders, relates to the discussion of children with psychosocial disorders and the trauma chapter. It is important to note that an attempt has been made to cover mental illness and psychosocial disorders across the complete life span.

Since the publication of the fourth edition of this book, there has been excellent research undertaken around the Vona du Toit Model of Creative Ability (VdTMoCA) in South Africa and the United Kingdom. This is a proudly South African Model which was brilliantly conceived by Vona du Toit and first published in 1962. Vona's untimely death precluded her from taking part in any research to validate and standardise the model. In 2012, Daleen Casteleijn received her Ph.D. for her research on an outcome measure based on the Vona du Toit Model, the APOM (Activity Participation Outcome Measure 2010), which has been widely acclaimed and used for student training. Kobie Zietsman and Daleen Casteleijn have together contributed the chapter on long-term psychiatric care. Both the APOM and Kobie Zietsman's work, the FLOM (Functional levels Outcome Measure 2010), which are also based on the Vona du Toit Model, are discussed. The importance of this model, which has recently been addressed by Wendy Sherwood in the United Kingdom, has led to its growth and the development of a website for easy accessibility. Patricia de Witt has updated her chapter on the theories of Vona du Toit in this edition and many authors refer to this chapter.

The move from the medical model to the more community systems model is evident in all the chapters, especially those related to child psychiatry. The child within the context of the family is pivotal and new theoretical models are emerging. The Floortime DIR (Developmental Individual Relationships), Ayres Sensory Integration and the Dynamic–Maturational Model of Attachment and Adaptation are all included in this edition.

Two new chapters on ethics and culture are, we believe, pertinent to modern-day approaches in occupational therapy in this field. The different contexts and systems need to be fully understood by the occupational therapist working in the mental health field in any setting, in any country. Other new chapters are those on acute psychiatry, early intervention for young children at risk, specific occupational therapy with adolescents, eating disorders and ADHD.

The Internet companion for interactive participation on the Internet is also a new innovation for the fifth edition. The case studies and questions have been specifically designed for this.

We would like to thank all the dedicated authors for their work and commitment to this publication and the push towards research in occupational therapy in the psychiatric and mental health fields. We hope that this edition will encourage innovative scholarly research in occupational therapy to blossom in order to validate the latest clinical expertise in occupational therapy.

The editors would like to thank Dr. Daleen Casteleijn for her very valuable and expert assistance in editing this book and also Matty van Niekerk for expert advice regarding the legal matters associated with the publication. Thank you too to Elizabeth Lane for her expertise in the English editing.

It should be acknowledged that the Crouch Trust (047-796-NPO), a registered non-profit organisation for occupational therapy research in the psychiatric/mental health field, has been the financial backbone of this edition. The Crouch Trust holds the accrued funds from the royalties from all the past editions of this book.

Rosemary Crouch and Vivyan Alers

Foreword

The fifth edition of *Occupational Therapy in Psychiatry and Mental Health* follows the fourth edition by eight years, time enough to see many changes in the ever expanding psychosocial field of occupational therapy which has kept up with the changes in psychiatric diagnoses, management and multidisciplinary treatment of people with mental illness in South Africa and internationally.

Since the publication of the first edition 22 years ago, the book has continued to grow in popularity; thanks to the efforts of the editors Rosemary Crouch and Vivyan Alers who continue to explore new horizons bringing together, both from a research and best practice perspective, from highly accredited local and international experts.

The editors have sought to make the book user friendly by linking different chapters and clustering the topics together. The quality of the book is further enhanced by the addition of the internet companion for interactive participation on the Internet.

The content of the book is comprehensive covering a wide range of topics within the field of psychosocial occupational therapy stretching across the lifespan and ranging from therapeutic techniques to ethical aspects of practice.

This book is essential reading for all occupational therapists and other members of the multidisciplinary team practising in South Africa and internationally, at both an undergraduate and postgraduate level. This comprehensive, relevant and current overview of the psychiatric occupational therapy field is a valuable addition to current academic literature.

Professor Lorna Jacklin, F.C.P., S.A., M.Med. (Paed), University of Pretoria, M.Sc. (Child Health), University of Witwatersrand, Mbb.Ch. (University of Witwatersrand).
Department of Paediatrics
University of the Witwatersrand

Part 1

Theoretical Concepts in Occupational Therapy

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

Patricia de Witt

Occupational Therapy Department, School of Therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

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

Occupational Therapy in Psychiatry and Mental Health, Fifth Edition. Edited by Rosemary Crouch and Vivyan Alers.

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 'creativeness' 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 Occupation 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
Participation	
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 handing	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 (abstract element 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	Imitative 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) 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)	
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 frequency 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