**An Investigation into the correlation between Volition and its expression in Action**

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Research aimed at gaining greater insight into volition and its expression in action has been carried out since 1965 at the Pretoria College of Occupational Therapy in the Republic of South Africa. The following diagnostic groups are being studied: chronic regressed psychotic patients; cerebral palsied children; emotionally disturbed children, including autistic children; and quadriplegic and paraplegic patients.

It is necessary first to establish a common frame of reference by sharing basic definitions.

Volition, as defined by Coleman, is "any inner condition of the organism that initiates or directs its behaviour towards a goal".

For the purpose of this paper, "action" will be defined as the exertion of drive and mental and physical effort which results in the creation of a tangible or intangible product.

Results of research suggest that:

* The growth and recovery of volition appears to follow a constant sequential pattern.
* Likewise, the growth and recovery of action appears to follow a constant sequential pattern.
* The stages of volitional growth and recovery and those of action appear to be interdependent and to relate to one another in a constant fashion.
* Volition and action are inseparable, so that the growth and recovery of volition must be influenced by the nature and content of the action elicited from the patient.

So it was that the term "creative ability" came into use to denote the combination of an inner volition or drive towards action, and the externalisation or expression f the volition in action.

Creative ability in an individual is therefore comprised of volition and action, which results in the creation of him of a product. The product may be tangible or intangible, but it must be perceivable by others; that is, there must be evidence of effort.

The following factors were isolated as being components of creative ability and sufficiently constant to serve as criteria of its quality:

* The quality of the individual's ability to relate to materials and objects, people and situations;
* His ability to control the negative effects of anxiety;
* The degree of initiative or originality infused by him into his thought and action (the correlation of initiative with the quantity and quality of intellectual endowment must be acknowledged);
* The quality and degree of effort which he is prepared to channelize into the tasks and challenges set him in all spheres of life.

This means that assessment of an individual's creative ability will of necessity involve evaluating the above components of creative ability, together with the quality of the patient's volition and the nature and content of his action.

Based on these definitions and criteria, descriptive terms were coined for each level of volition and each parallel level of action. These are as follows:

Levels of volition (in order of emergence) are Positive Tone, Self Differentiation, Self Presentation, Passive Participation, Imitative Participation, Active Participation, Competitive Participation, Contribution and Competitive Contribution. Levels of action parallel to volition are: Pre-destructive, Destructive, Coincidentally Constructive, Explorative, Work-ready Participative, Originative Participative, Competitive Product-centred Participative, Contributive and Competitive Contributive action.

Before describing each stage of creative ability, it is necessary to discuss some supplementary definitions and concepts. First, the definitions of creative response and creative capacity:

Creative response is each positive attitudinal reaction which the individual displays towards an opportunity or challenge. It represents a preparedness in the individual to muster all his resources in appropriate and maximum effort.

Creative capacity is the creative potential available to an individual. Creative capacity will obviously be influenced by genetic and environmental factors such as personality structure, the degree of quality of intelligence, and personal historicity.

To summarise then: any individual has a certain creative capacity which is determined by genetic and environmental factors. That area of his creative capacity which he has actualised, and which is reflected by the quality of his volition and his actions, is his creative ability. In order to increase his creative ability the individual has to respond creatively, that is, be prepared to make maximum effort in implementing action.

Some important supplementary concepts are as follows:

Creative ability will reflect the individual as a totality of psyche and soma vitalised by spirit.

The progression of creative ability from one stage to the next does not occur in a sharply demarcated step-wise fashion. Not only is there a subtle merging of one stage into the next, but there are three distinctly discernable phases at each stage of creative ability: the Therapist-directed phase, Patient-directed phase and Transition phase. There is therefore a continuous fluid phasing and merging. Hence the restoration of creative ability demands a meticulously planned and graded treatment sequence, largely dependent for its success on the sensitivity and perceptivity of the Therapist.

At the Therapist-directed phase of each stage of creative ability, the Therapist stimulates, nurtures and directs the patient's actions, then, provided the patient has the creative capacity, he will progress to the Patient-directed phase. This represents the patient takeover, in which he selects and implements the action appropriate to his stage. From here he enters the Transition phase in which characteristics of the next stage are detectable.

At any one time it is likely that the patient will show evidence of previous stages of creative ability and he may also demonstrate qualities and characteristics of the next stage. It is therefore important to determine an individual's level of creative ability over the widest range of his reactions. Initially, observation of the quality of his volition and action has to be undertaken in the most representative range of activities for the greatest part of his day. Drawing conclusions from isolated situations must be avoided, particularly as the elements of constancy, predictability and reliability are, in fact, determining factors.

It must be stressed that a patient who has reached the limits of his creative capacity will not progress any further, and that the Therapist will have to modify her approach to prepare him for a satisfying life at that level.

Creative ability grows in the depth dimension, in addition to its vertical progression, hence there will be concurrent and continued depth expansion of all stages achieved. For example, the process of self differentiation will progress on a more sophisticated and abstract level throughout the subsequent stages of creative ability. Furthermore, an individual functioning at the higher levels of creative ability will use different levels of activity handling, dependent on his familiarity with the materials, his interests and aptitudes. For instance, a patient at the stage of originative product-centred action is likely to resort to the explorative handling of a material new to him.

It has been interesting to observe that although diagnosis, related symptomotology and personality idiosyncrasies play a relatively minor role in dictating the treatment of patients at the lower stages of creative ability, these factors demand increasing attention in treatment as the patient's creative ability increases.

It has been found that a patient cannot respond to a formal work preparation programme until he has attained a "work readiness" at the stage of passive participative volition and "work-ready" participative action.

At the lower stages of creative ability when the patient is unmotivated and inactive, the creative ability treatment programme will dictate a relatively large proportion of his total action and the influence on him will therefore be more directed, controlled and total. As his creative ability increases, the patient becomes more available to bombardment from a vast diversity of stimuli, and treatment principles have to be infiltrated into more and more areas of his life in order to maintain the influence of the programme.

The fundamental catalysing factor in restoring creative ability is to ensure that the patient experiences satisfaction and success in action in order to build up pleasant associations and pleasurable anticipation of future action. Treatment situations therefore must be meticulously graded in content, structure and presentation, and all the factors isolated as being components of creative ability must be taken into consideration.

As it is obviously not possible to give a detailed description of each component of creative ability at each of the stages and phases of recovery, I will confine myself to the most definitive quality of volition and action, relating specifically to material handling, product creation and relational contact with people. I regret that much is lost in eliminating the growth of emotional content involved in the handling of situations, the control of anxiety and the demonstration of particular qualities of initiative and effort. For instance, it is fascinating to observe all the nuances and complexities of emotional development starting from the very low intensity, undifferentiated emotions of pleasure, anger, distress and fear, and leading through aggression, anxiety, tenderness and joy, to the ultimate capacity to share, identify with and compensate for others in a maintained intimate relationship.

Stage One:

Volitional Positive Tone and Pre-destructive Action

The patient appears to be volitionally blank. Haphazard physical movements and environmental stimuli appear momentarily to impinge on a sensory field, causing short lived and superficial awareness, which apparently registers as a sensation of taste, sound, touch or position in space. There is no discernable evidence of material handling, product creation or relational contact with people.

The volition and action essential for progression to the next stage is the demonstration of the very beginning of a primitive "intention" and "attention". The patient must have acquired the ability to "reach out" to materials and objects, and to make fleeting contact with them. This involves the intention to contact, and the physical ability to grasp, hold and release.

The patient should be capable of a basic recognition of the presence of people, as opposed to objects.

Stage Two:

Volitional Self Differentiation, coupled with Destructive and Coincidentally Constructive Action

The volition is feeble, erratic and egocentric. It may be elicited by activities which are designed to define body boundaries, basic body function, and self-differentiating concepts.

There are two types of action at this stage. The first to emerge is Destructive Action. This action is characterised by a preparedness to make direct bodily contact (hands, feet, teeth) with basic and natural materials such as ground, leaves, sticks and paper, in destructive action. The products of action are therefore the resultant fragments.

From Destructive Action, the patient must acquire a concept of wholeness, as opposed to brokenness. He must recognise that the fragmentation of material is the result of his own destructive action, and he must have gathered the momentum to elect to execute destructive action using a diversity of materials, and to derive a basic satisfaction from this type of material handling.

The second type of action is Coincidentally Constructive and, as such, represents the transition from destructive to constructive action. The effect or product of action is purely by chance and immediate, and is totally unplanned on the part of the patient. This stage presents a challenge to the Therapist to structure meticulously planned one-step activities resulting in products which are dramatic and pleasing enough to elicit a reaction of pleasant surprise, satisfaction and identification from the patient. As the product is produced purely by chance, the elements of planning, evaluation and comparison are eliminated. Various forms of paper and fabric batiks, marbling, and sand and glue activities are suitable for coincidentally constructive material handling.

In his relational contact with people, he gradually becomes aware of the "otherness" of people outside himself and equally gradually he becomes accessible to contact from others, provided they accept him completely and totally compensate for him. At the same time, there is the emergence of a feeble effort to contact others. The emphasis is almost exclusively on egocentric, afferent (or inward) contact. The ability to form a relationship is totally lacking.

In order to move to Constructive Action, the patient must be able to comprehend that he is the cause and creator of the visible and tangible effects of his action. He must also develop the ability to focus his attention on material and perform more coordinated handling actions, such as placing, rubbing, turning, lifting, which are essential for constructive handling.

Stage Three:

Volitional Self Preservation and Explorative Action

There is a volitional readiness in the patient to present the newly and very basically differentiated self to people and situations. The quality of volition now becomes progressively influenced by the unique personality traits and the intellectual capacity of the individual. The character of volition is one of intention and enquiry.

In action, materials, objects and tools are all handled exploratively, with the emphases placed on gaining information about, and becoming familiar with, a wide variety of materials, objects, tools and situations, rather than on the product. However, a product may emerge as a result of the investigation of the properties of the material being handled, rather than as a result of actual planning of a product. The product is thus the unplanned or semi-planned result of explorative handling. Action may consist of many steps, and 4- to 5-step activities may be presented to the patient, provided step-by-step guidance is available and provided no norms are set regarding the quality of the product or the speed of performance. Approval is given for the purposefulness of the explorative action, for the integrity of his desire to gain information about materials and tools, and for skill in their use.

Relational contact with people will also be explorative. In an effort to establish social boundaries, the patient will try out various forms of behaviour, primarily to investigate which elicit acceptance and which elicit rejection from others.

The patient will indulge in fairly rapid interchanges of relational components and their opposites, such as love and hate, tolerance and intolerance, shallow extrovert behaviour and withdrawal.

Due to his lack of sensitivity to the needs of others, the patient will tend to manipulate people, but the emergence of an ability to "play with others" is significant evidence of the development of efferent (outward) relational responses as well as receptivity to a more demanding and un-compensating contact from people.

The emotional content and maturity necessary to form and maintain interpersonal relationships is still lacking, so interpersonal contacts (except, perhaps, for the stabilising contact with the Therapist) are still inconsistent, unpredictable and motivated by egocentric considerations such as the pleasant feeling of being "in favour".

Before the patient can move to the next stage, he must have gained familiarity with, and information about, a wide enough range of materials and tools to provide the security necessary for participation in work-related tasks. He must realise that knowledge about materials and tools is essential for constructive action. He must gain sufficient identification with the products of his actions to feel a pride in what he makes, and a desire to possess them.

Most important of all, he must have become task and product conscious, which evolves out of task comprehension.

Stage Four:

Volitional Passive Participation coupled with Work-ready Participative Action

Volitionally the patient is now robust enough to move into a formal work preparation programme involving the execution of selected tasks out of a variety of appropriate work areas. He is now capable of experiencing task-fulfilment, which is composed of a series of related facets. These are: the ability to comprehend or form a concept of tasks consisting of five or more steps; to identify with the task and accept it as his own responsibility; to execute the task with help and guidance; to decide when the task is completed and to derive a measure of satisfaction from it. Before the patient is expected to participate in tasks, he should be invited to identify with each component of each task.

Action progresses from material handling to product creation. As the patient is still dependent on external stimulation to tackle and complete tasks, his performance will be erratic and his self expectations may be unrealistic. He relies heavily on the Therapist for help in sequencing the steps in a task and for providing task content compatible with his performance understanding and ability.

Because action is product-centred, and especially as he makes the decision regarding task completion himself, there is an emerging need for the product created to be evaluated.

However, as negative evaluation of his efforts will be too threatening to him at this stage, evaluation is done by retrospectively highlighting his achievements, that is, after he has completed his product, rather than during the process of production. Additional explanations, which will ensure success in future products, as well as reasons for the successful aspects of the completed product, must be provided. At the same time, the patient should be encouraged to evaluate his own efforts and products against standard or industrial norms.

In his relational contact with people, the patient gradually attains a relatively stable and predictable interpersonal relational ability, as opposed to the superficial and erratic interpersonal contact demonstrated by him in the previous stages.

His relational experiences should be extended by including him in selected group situations which cover the social, personal and work spheres of life, and which include specialised group techniques, such as psycho-drama and puppetry. He should be exposed to a variety of interpersonal situations representative of his own pattern of life, which demand from him a varied spectrum of adaptive social behaviour. Supplementary programmes which provide him with the opportunity to care for animals and to assume responsibility for patients on lower levels make an important contribution to his sensitivity to the needs of others.

It is obviously necessary to provide him with the type of support which will ensure success and result in the growth of justifiable self confidence and self esteem, and so stimulate independent active participation.

In order to move to the next stage of creative ability, the patient must have attained and stabilised the ability to implement all the facets of task fulfilment independently. The sequencing of the steps comprising the progressively more complex tasks set him is the facet of particular importance. These tasks should be selected from a variety of work areas considered appropriate and realistic in terms of his future.

He must be able to tolerate the change in the Therapist's attitude and in the treatment tempo which results from the conversion from a patient-centred approach to a product-centred approach.

He must have acquired work habits relating to personal and social presentation in the work situation, and the relevant work competence.

He must be able to function independently in groups which are appropriate to his particular intellectual and social level.

Stage Five:

Volitional Imitative Participation and Imitative Participative Action

Volitionally the patient is now product- and task-orientated at the level dictated by his residual pathology, intelligence, education and skill.

The presence or absence of additional creative capacity will play a deciding role in the structure of his programme. Patients in the lower ranges of intelligence and those who have retained significantly deviant behaviour, will probably be prepared for placement in imitative repetitive types of work (imitative work must not be confused with one-step, low grade process-type work).

The quality of the patient's volition is imitative over the total range of the personal, social and work spheres of life. The volitional qualities of initiative and competition with self and others are still lacking. The patient seeks to lose his identity (avoids being singled out) by merging with a group.

Action is stimulated by inviting him to imitate, as accurately as possible, models selected from relevant work areas, and graded in every facet of task fulfilment and in every component of creative ability. The selection and grading of models which will absorb and extend the patient's maximum ability will determine the efficacy of this programme.

The norms used in evaluation are: the level of demand inherent in the product which he is capable of imitating; the exactness of every aspect of his imitation; the speed of his performance; and the measure of his integration as a worker, judged in relation to his co-workers and the authority figure. Whilst the Therapist evaluates products created by the patient on a comparative basis, she encourages him to express value judgements of his own work.

He should be able to comprehend all the requirements inherent in duplicating the product set as the model, and then, with suitable preparatory instructions, independently construct his own version of the model. He should now automatically progress through the facets which comprise task fulfilment.

Relational contact with people:

This is a period of consolidating interpersonal behaviour. Because the patient desires to conform, group pressure plays an important role in moulding his behaviour, and becomes a valuable aid in channelizing and modifying the behaviour of the individual.

The element of intensity and intimacy in relationships is still lacking, although the patient will gradually extend his capacity to compensate for others less adequate than he is.

He enjoys group situations and prefers the role of follower to that of leader, although towards the end of this stage he will start attracting attention to himself by attempting different roles. He "tries to be funny", indicating the emergence of a more mature sense of humour. Before he can move to the next stage, the patient must demonstrate the desire and potential to improve on, and modify, the process or design of the tasks set him. In other words, he must show evidence of initiative and original thought.

He must formulate and respond to realistic self expectations and must be capable of applying relevant self discipline in all spheres of his life.

Stage Six:

Volitional Active Participation and Originative Participative Action

Volition is directed at achieving at least the standards which apply to open labour work, and to the associated social norms appropriate to his level of intellect and aptitudes. In addition, in order to benefit the situation the patient makes an effort to improve on the standards set by infusing initiative and original thought into the task.

The element of originality permeates action, and the patient will experiment with new uses and combinations of materials and will, with new integrity, attempt to improve on his capacity to fulfil tasks which demand concentrated, sustained and maximum effort.

Relational contact with others:

The capacity to maintain relationships at an intimate level emerges and with it the capacity to perceive the needs of others and to compensate for their faults and inadequacies. In fact, the patient becomes capable of the give and take aspect of "sharing" in a relationship and of showing loyalty.

He can adapt behaviour and experiment with different roles in diverse situations. He learns to subordinate himself to others on the one hand, and to assume leadership responsibilities on the other. The emergence of added derived emotions, such as compassion and tenderness and their complex nuances, will bring a new subtlety and enrichment to his interpersonal relationships.

In order to move to the next stage, the patient must be capable of making and sustaining effort, not only in areas which represent his interest and reflect his aptitudes, but in new areas of endeavour which are unfamiliar to him and outside his central interest field. He must be able to complete all aspects of a task, the surrounding "drudgery" as well as the exciting aspects.

He must indicate that he has the potential to compete, and to tolerate failure and negative criticism.

Stage Seven:

Volitional Competitive Participation coupled with Competitive Product-centred Participative Action

Volition is competitive, and the individual demonstrates a determination to improve on standards attained by himself, and on those attained by his peers. This presupposes the crystallisation by him of ideals, and a capacity to strive towards their attainment. Satisfaction and fulfilment is derived from competing in all spheres of life.

Effort can be sustained at a maximum level in spite of frustrations which lead to a significant delay of gratification. He is able to convert failure into potential success by mustering renewed and intensified effort. He actually creates anxiety by creating competition, and uses it as a mobilising incentive.

Action is also competitive in nature; it is disciplined and dictated by the standards which the individual seeks to surpass. The complexity of the products will now, more than ever, be dictated by the personality structure and physical and intellectual endowment of the individual. The standards, which he sets himself, will apply to immediate products and projects undertaken, and will not reflect the level of abstraction and universal application aimed at by the individual in the contributive and competitive contributive stages. These two stages will not be considered in this paper as volitional deficit and dysfunction are not present in the highest stages of creative ability.

Relational contact with people:

Discretion is exercised in relationships, which ensure that they are maintained at a personally and socially acceptable level. Interpersonal relationships are predictable and stable, and the individual will direct his behaviour towards the benefit of others. He will derive fulfilment from creating opportunities which will allow others to experience a feeling of importance, competence, achievement, security and status.

The individual moves towards the highest levels of interpersonal skill which pertain at the stages of contribution and competitive contribution. At these stages he is capable of sustaining an attitude of loyalty in the face of apparent injustice. The ability to identify completely with the needs and moods of others becomes integrated into his interpersonal attitude and he achieves the capacity to establish relationships which permit the emergence of a diversity of "I thou" moments, and a sense of "mutuality".

In conclusion, the programme directed at the restoration of creative ability should hinge on the recognition and clinical interpretation of landmarks in the recovery of each of the components of creative ability. It should enable the Occupational Therapist to map out the direction of her treatment with accuracy, and to establish valid criteria for selecting, presenting and grading the activities and content of her programme at each stage of creative ability. In fact, I believe that the application of this concept will enable the Occupational Therapist to systematise the treatment of the patient from the earliest stage of illness and volitional deficit, to the point at which he will be ready to resume activity, or work, at the highest level of mental, physical and creative ability of which he is capable.

References:

1. Buber, Martin. "I and Thou". Clark, Edinburgh.
2. Coleman, J.C. "Psychology and Effective Behaviour". Foresman and Company.