**Assessment of the Levels of Creative Ability**

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It is a great honour to have been invited to contribute to this workshop. However it has caused me much anxiety and I have had difficulty in putting together information that will stimulate the experts and at the same time tempt the uninitiated. I have decided to do a formal presentation because I have a lot to say; the time is very limited. I will try to address three main issues:

1. **What** you need to do to asses creative ability.
2. **How** it should be done.
3. The **factors that limit** or influence the assessment.

I hope there will be something in this paper for all of you – even if it is only to disagree.

**INTRODUCTION**

The assessment of creative ability is just one of the many evaluations which we have at our disposal.

In my opinion the creative ability evaluation has the edge over many of the others since it reveals data that reflects the very essence of the profession viz that of a **client’s occupational performance** (function/ADL). It evaluates a **client's current ability** to initiate and execute activities in each of the **4 performance areas** (which I use synonymously with spheres of function of functional areas) which are, as you know:

* **Personal Management**
* **Social Ability**
* **Work Ability**
* **Leisure / Recreation.**

Since creative ability is essentially **a development theory focusing on occupation performance**, the evaluation **pinpoints where a client is at, within this developmental sequence, at the time of assessment**.

Creative ability can be conceptualised as a **continuum** between two poles:

* At one pole, **participation** at a level only sufficient to **support life** (what Vona called positive tone);
* At the other pole, participation at the highest level of **contribution** to fellow man and his **community.**

**PARTICIPATION AT A LEVEL SUFFICIENT ONLY TO**

**SUPPORT LIFE**

**I**

**I**

**I**

**I**

**PARTICIPATION AT THE HIGHEST LEVEL OF CONTRIBUTION**

**TO MAN AND HIS COMMUNITY**

Most of us ordinary mortals fit in somewhere in the middle, with unusual people congregated at the two poles.

**ASSESSMENT PROCEDURE**

Assessment of creative ability is quite a complex and difficult task for the inexperienced but it becomes less time and energy consuming as you internalise the theory and practice the skills.

**There are 3 basic steps in evaluation of a client:**

* Firstly, evaluation of the client's skill and behaviour with respect to the four occupational performance areas.
* Secondly, establishing the client's level of action.
* Finally, establishing his level of motivation.

I will take each one of these in turn and discuss them.

[a] **EVALUATION OF CLIENT’S SKILL AND BEHAVIOUR IN ALL 4 OCCUPATIONAL**

**PERFORMANCE AREAS**

This is something which is very familiar to us, because after all this is what we do. Within the context of creative ability our evaluation of the 4 occupational performance areas needs to be somewhat broader than when using a strictly medical model.

In the area of Personal Management, we need to study the individual’s ability to care for himself and his personal business according to norms of group and culture in which he lives. This includes hygiene, dressing, grooming, caring for his belongings and managing himself independently within his community.

Within the area social, we need to look at client’s skill:

* To communicate and interact socially with others, both familiar and unfamiliar;
* To form acquaintances, friendships and develop lasting and stable and intimate relationships;
* Also to read and comply with the overt and covert norms governing relationships and social behaviour in all situations and life roles.

 Work Ability focuses on productiveness and the evaluation needs to note the client’s ability:

* To initiate tasks and projects at the appropriate time and to see them through to conclusion, developing new ideas and methods when appropriate;
* To manage their work load and resources in the work situation be it open, sheltered or protected and without causing undue personal stress;
* We also need to note their ability to work effectively and efficiently according to the demands set within the particular work situation.

In terms of leisure on must evaluate client’s ability to realistically use their free time in a balanced and constructive manner in order to recoup the strength and energy required for living, keeping in mind interests, norms and community resources.

When considering a client’s ability and skill in each performance area, the following help focus on evaluation to provide key pointers for creative ability:

* Attitude and ability to make relational contact with objects, tasks, individuals, groups and events in the environment;
* Ability to plan, initiate and sustain effort until the task is complete, or continue at the same level of performance of the task / activity is repetitive;
* Quality of performance and their evaluation of what has been done to determine the standard the client sets for himself;
* Ability to do activities with or without supervision, the amount of environmental structure and pressure needed for adequate participation and the ability to meet norms that are et or him by others / society;
* Control of anxiety when faced with routine tasks and when confronted with new challenges;
* Ability to act with originality and to find innovative solutions to old and new problems / challenges.

It is important to remember that creative ability defines **overall performance** rather than isolated performance, thus it defines the average performance. The implication of this assessment is that we need to evaluate a client in a variety, rather than just one situation. In fact, this evaluation should become an integral part of each interaction with the client in order to achieve a good understanding of overall performance rather than the setting up of specific “test” assessment sessions which may stimulate unusual performance.

[b] **ESTABLISHING THE CLIENTS LEVEL OF ACTION**

The level of action is defined as the exertion of mental and physical effort, which results in the creation of a tangible or intangible end product.

I personally find this to be quite confusing in the sense that it implies the “creation of something”. Now while this causes few problems in the work area, there are many activities in personal management and sometimes in the social area where nothing is produced and you really have to bend your mind to even make it intangible e.g. washing your face, chatting to a friend, playing bingo. I find that the Kielhofner’s definition of “output” in the Model of Human Occupation to be very similar but more explicit to that of action, without the limitation of end products. Output he says is occupational behaviour.

Vona du Toit defined eight consecutive levels of action of “occupational behaviour” which are organised in a specific sequence where each level represents a definite step in the development process. For the uninitiated, these levels are:

* Predestructive
* Destructive
* Incidental
* Explorative
* Experimental (Passive)
* Imitative
* Original (originative)
* Product Centred
* Situation Centred (contributive situation centred)
* Society Centred (competitive contributive society centred).

While we know a lot about the first five levels, we have much less detailed knowledge about the remaining levels. If we look at the main characteristics of these levels we find that they can be divided into 3 distinct groups based on what the purpose of occupational behaviour is:

**Group 1** All activity aims towards Preparation for Constructive Action

**Group 2** All occupational behaviour is aimed at development of Behaviour and Skill for Norm Compliancy

**Group 3** All activity relates to Behaviour and Skill Development for Self Actualization

The levels of action that link to these three groups are:

**Group 1** Predestructive

 Destructive

 Incidental

**Group 2** Explorative

 Experimental / Passive

 Imitative

**Group 3** Original (originative)

 Product Centred

 Situation Centred (contributive situation centred action)

 Society Centred (competitive-contributive society centred action)

Now inherent in the theory is the notion that an individual progresses through levels in an organised and sequential manner, not skipping any. Individuals can regress and then progress again through the levels, but again this will follow the same sequence. So should creative ability be interrupted or regressions occur, a positive progressive sequence can be re-established by introducing the opportunities and resources for action at the level where the client is currently at.

As each level of action is quite extensive in terms of the skills that are developed it is important to determine where the client is within each level. Therefore, each level is divided into 3 distinct phases:

* Therapist directed = which is the 1st phase in the level and indicates that the client has just moved into that level. In this phase, the client demonstrates some limited skills of the level which can only be used if the environment is conducive. He also usually needs help to maintain this occupational behaviour;
* Patient directed = is the middle phase of the level where the client is learning and demonstrating the skills characteristic of that level – he manages to maintain the skills without environmental support and therapist facilitation;
* Transitional = this is the final phase of the level where the client is consolidating the skills characteristic of that level and shows some indication of skills appropriate in the next level but these require facilitation and environmental support.

In order to determine the level of action, we analyse the skills the patient has readily available to him to use for occupational performance. Using the theory we then pinpoint the client’s action on the action grid. Now while this is technically easy, the actual success is dependent on the therapist’s specific knowledge of the level. General overall knowledge is not good enough – you need detailed and very specific knowledge to phase the client.

I personally find it easier to start with work ability, as evaluation of a client’s task concept and prevocational skills helps to hand his ability within the action grid, e.g. if the client’s task concept is not consolidated the ceiling for function is the explorative level, while if task concept is consolidated and available for the client to use, he has achieved the experimental / passive level. Prevocational skills and especially norm awareness and norm compliancy are also very helpful with this regard.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **PERSONAL****MANAGEMENT** | **SOCIAL****ABILITY** | **WORK****ABILITY** | **FREE****TIME** |  |
| **Destructive** |  |  |  |  | Th.dirPt.dirTransitional |
| **Incidental** |  |  |  |  | Th.dirPt.dirTransitional |
| **Explorative** |  |  |  |  | Th.dirPt.dirtransitional |

When evaluating the level of action, remember that it is usual for there to be clustering of occupational performance in the four occupational performance areas. In other words, action is usually confined to the same level although the phases may be different or it be spread through two levels. It is rare for there to be a great discrepancy between the 4 occupational performance areas in terms of the action levels.

Before leaving the level of action, I need to say a few words about “exertion of maximal effort” which you need to keep your eye open for during the evaluation.

Maximum creative effort is effort that is exerted on the boundaries of the client’s creative ability in order to effect growth. Maximal (optimal) effort is usually recognised by a client demonstrating a creative response which Vona du Toit defined as prepared / openness to a creative challenge. This is an indication that the client is ready to move and grow. It can be recognised by a preparedness to tackle activities or tasks that they have failed at or been reluctant to try in the past, in spite of experiencing considerable anxiety. Maximal effort takes on many forms depending on the level. As this can be a fairly fleeting moment in a client’s occupational performance it is important to be able to recognise it and create immediately, the most optimal opportunity for growth to take place.

[c] **ESTABLISHING THE CLIENT’S LEVEL OF MOTIVATION**

Vona du Toit’s theory stated that there was direct relationship between motivation and action. Thus as you can determine the patient’s level of action by evaluating that which he does, which is observable and measurable, from this you can presume the level of motivation, which we can’t measure or even guess at.

Vona du Toit defined 6 levels of motivation:

* Tone
* Self differentiation
* Self presentation
* Participation - Passive
	+ - * Imitative
			* Active
			* Competitive
* Contributive
* Competitive contribution

 According to the theory, the levels of the action relate to the levels of motivation in the following way:

|  |  |
| --- | --- |
| **LEVELS OF MOTIVATION** | **LEVELS OF ACTION** |
| Tone | Predestructive |
| Self Differentiation | DestructiveIncidental |
| Self Presentation | Explorative |
| Participation - passive* imitative
* active
* competitive
 | Experimental (Passive)ImitativeOriginal (Originative))Product Centred |
| Contribution | Situation Centred (contribution situation centred) |
| Competitive Contribution | Society Centred (competitive contributive society centred) |

So if you assessed a client’s action to be product centred, you would presume that his motivation was competitive participation.

How do you take variations in phases of the level of action into account when defining the overall level of motivation?

When all phases of action are the same, it is quite straightforward and the overall phase of motivation is the same as the action level.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **PERSONAL****MANAGEMENT** | **SOCIAL****ABILITY** | **WORK ABILITY** | **FREE****TIME** |  |
| **Explorative** |  |  |  |  | Th.dir |
|  | X | X | X | X | Pt.dir |
|  |  |  |  |  | transitional |

In this case, the client’s overall level of motivation would be self presentation = patient directed, as explorative corresponds with self presentation and all phases are the same i.e. patient directed.

Where the phases vary, in my experience both the social and work performance areas have a moderating effect, with social being more powerful than work. So if you have a client on a level of action with two phases on therapist directed and two on patient directed, like this:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **PERSONAL****MANAGEMENT** | **SOCIAL****ABILITY** | **WORK****ABILITY** | **FREE****TIME** |  |
| **Explorative** | X | X | X | X | Th.dirPt.dirTransitional |
| **Experimental** |  |  |  |  | Th.dirPt.dirTransitional |

The level would be considered to be self presentation and the phase patient directed because of the moderating influence of social ability.

If phases of all four performance areas differed like this:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **PERSONAL****MANAGEMENT** | **SOCIAL****ABILITY** | **WORK****ABILITY** | **FREE****TIME** |  |
| **Explorative** |  |  | X | X | Th.dirPt.dirTransitional |
| **Experimental** | X | X |  |  | Th.dirPt.dirTransitional |

Again because of the moderating effect of social ability the client would be passive participation – therapist directed. However, in setting up treatment this difference between the 4 occupational performance areas would have to be accounted for in the selection of the baseline principles. This is very important in acute psychiatry units as it helps to get to the most effective Rx in the least possible time.

If the phases are very discrepant like this, I would be inclined to believe that there was a problem in the assessment either in the procedure that has been used or the interpretation of the data. However, if I had checked each level carefully and they seemed right, perhaps this is a “hazard” like Hester suggested yesterday.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **PERSONAL****MANAGEMENT** | **SOCIAL****ABILITY** | **WORK****ABILITY** | **FREE****TIME** |  |
| **Explorative** |  |  | X |  | Th.dirPt.dirTransitional |
| **Experimental** |  | X |  | X | Th.dirPt.dirTransitional |
| **Imitative** | X |  |  |  | Th.dirPt.dirTransitional |

I have talked about what you do, now let’s look at: how do you do this assessment?

The first task is:

* Screening is used to approximate the level of action which the client is on. This involves either:
	+ - The observation of the client
		- or the completion of a checklist completed by yourself, caregivers / nursing staff which help to get a broad overview of what tasks the client can do independently and what he needs help with.

It is important to note that it is not an assessment but an approximation which helps to guide and focus the detailed evaluation of 4 performance areas which is the next task.

* Detailed evaluation of 4 performance areas. The technique used for this assessment are:

**Interviewing**

While this is an important assessment tool, it has limitations. On the whole, interviewing the patient on the first two levels of action is difficult and usually quite unreliable, if information can be attained at all.

On the explorative level, however, interviewing becomes easier although clients are not always able to give a good account of their occupational performance due to their inadequate judgement and insight. They also have problems in distinguishing premorbid function as compared to current function. Therefore, the information attained from the interview is not entirely reliable in terms of its factual base.

From the imitative level upwards the data gathered from the interview becomes more reliable as clients are better able to evaluate their skills and ability to perform with respect to the demands of the community.

**Observation**

Is a very useful technique when clients are unreliable. Clients should be observed in all occupational performance areas over time and using a wide variety of situations. The observation should be as unobtrusive as possible. Yesterday concern was expressed at what exactly this means on the ground. It means that you need to observe him as often as possible both in Occupational Therapy and in the ward – not 3 or 30 times, but whenever you can.

**Activity Participation**

This, in my opinion, is the most important technique as it will give you direct information about the client’s skills, provided you select an appropriate activity. I have found activities that stretch a patient, to be more enlightening than an activity that he does automatically. The activity must be selected to analyse his skills appropriate to the approximated level. In addition, they must be appropriate to the client in terms of his lifestyle, interests and roles.

There have been therapists that have been inclined to use the same activity to assess a client’s creative ability, e.g. leatherwork key-ring. While this might enable you to compare performance of clients in terms of quality, speed, grasp of concepts, etc., it raises many questions pertaining to the individuality of clients and how their interests, roles, frames of reference, needs, etc., affect performance and therefore the evaluation of creative ability.

Having looked at **what** you need to do and **how** you should go about doing it, I want to focus on some factors that you need to keep in mind which all pertain to the individuality of the client.

**Age**

Age tends to imply a “maturation” process and coupled with this are varying life tasks and milestones which demand changes in occupational behaviour as we age. Therefore, when using the Creative Ability theory, we need to ensure that we take the individual’s age, stage of development and the milestones he needs into account when doing this assessment.

If you had two clients, one of 30 and one of 14 and their levels of action were identical, let’s say experimental-therapist directed, this would imply that they both have available the same skills and behaviours to interact with objects, materials and people and that their level of competence and quality of performance would be the same. However, these skills and behaviour, would, because of the difference in the developmental milestones, be directed at different types of activities, e.g. in the work sphere, activities with the 30 year old would focus on bookkeeping and typing skills appropriate to a Girl Friday, while the 14 year old would be involved in schooling activities.

Age may also be an indicator of whether the client was progressing through the creative level the first time round or whether they had regressed and were trying to re-establish lost ground.

When assessing the former, they tend to progress through the levels very much in keeping with the developmental sequence.

When dealing with the latter, clients often retain splinter skills from levels of action that have been lost, which act as red herrings and confuse the assessment if you don’t look out for them. I clearly remember a client from my student days whose occupational performance had been severely compromised by schizophrenia. She had difficulty in washing and dressing herself and had very poor social skills and her IPRs were almost non-existent. However, she was able to do the most complex crochet work competently. Further analysis revealed that the crocheting somehow had been retained as an automatic skill and when faced with unfamiliar tasks the skills she had available to her were extremely limited.

**Environment**

The environment has a powerful influence on the occupational performance. While Vona du Toit alluded to this, the Creative Ability theory does not specifically account for this. Kielhofner’s Model of Human Occupation is the only theory that seriously considers the environment as the external system of human occupation and theorised that it consists of four interdependent layers which moderate occupational performance.

**They are the:**

* Object
* Tasks
* Social and groups organisations
* Culture.

I have found each of these to have an important influence on occupational performance and therefore creative ability, not insofar as the sequence and contents of the levels are concerned but with respect to actual activities that are appropriate and needed by that individual.

When assessing creative ability all four of these need to be considered to determine the activity, skills and behaviour that are appropriate to a client but also the context and rules that govern these.

A very important question that is frequently asked about creative ability is: can it be used to assess clients of divers cultural groups? In my clinical experience, it is very valuable. Theoretically, this seems to make sense since creative ability defines a development sequence that is broad and it does not specify exactly what the activities are, the exact norms or how they are applied.

However the use of creative ability in cross cultural work is not easy, not because of the theory, but due to our lack of cultural sensitivity. Alfred summarised the problem well for me the other day in his comment to me ***“my students find it easy to assess creative ability in a black patient, but not in a white client”***. This is my experience with students exactly, except that my students find problems with the African clients but not with the European. I am sure that this is because of our own environmental influence and frame of reference.

Another area where environmental influences are pertinent is the psychiatric field and the question of assessment of acute and chronic patients. There has always been a tendency for clients in a chronic hospital to be evaluated higher, when compared to other clients. My personal belief is that this stems from the environment. The mental hospital creates a slightly abnormal environment for occupational behaviour for a whole variety of reasons. The clients have very few responsibilities and activities that have to be done. The rules that govern these are ‘therapeutic’, flexible and accommodating – usually quite the reverse of the community and far from the harsh realities of the real world. Yes, the client does perform better and at a slightly higher level but in the protected environment of the hospital. But this environment is not real and must be taken into account when looking at discharge and community placements or the patient will become part of the revolving door syndrome.

Lastly, I would like to say a few words about the assessment of pathology.

First, I want to talk about:

1. **ANXIETY**

Anxiety whether it stems from physical or emotional sources, markedly influences creative ability. In some cases it is a motivator and is the stimulus of a creative response and the exertion of maximal creative effort. However, it is more commonly a disorganizer of occupational performance causing regression in the level of action or a back flow to an earlier phase. Therefore during the assessment anxiety must be noted and contained if an accurate picture is to be gained.

1. **MENTAL HANDICAP**

Early work by Vona du Toit seemed to imply that this theory did not apply to the mentally handicapped. My experience is that it is very helpful when dealing with these clients. However, it is important to remember that limited intellectual resources can severely limit the creative capacity of that client. This implies that his total creative potential will be very limited, allowing very marginal growth.

1. **SEVERE MOTOR DYSFUNCTION**

While I profess to have limited knowledge of the physical field of Occupational Therapy, I am aware that there are problems in assessing creative ability in clients who are meteorically very disabled, e.g. quadriplegic. This is because there is a huge discrepancy between their ability to physically execute tasks resulting in action being low while their motivation level might be high. This has caused havoc with this theory, and we all have gone to great lengths to explain it. But it is most probable that the explanation is more complex than the narrow framework of the developmental theory and may possibly be found in the conceptual structures of Kielhofner’s model, where volitional and motivational subsystems are relatively intact but the performance subsystems are grossly disturbed. It would appear that for creative ability to apply well, all 3 subsystems must be negatively influenced by physical illness even although the extent of this may differ. This perhaps partially explains why creative ability works well for head injuries and not so well for quads.

However, in spite of these difficulties assessing the creative ability of the physical patient, it is particularly helpful when dealing with behaviourally difficult clients who are not progressing and may be destructive. It is also helpful to guide us to select activities for most other physical clients. This problem was brought home to me very clearly by a rather astute client who was asked during a clinical exam to do finger painting to promote mobility and retrain sensation in his finger. At the end of the session he muttered in a sarcastic voice ***‘I know my finger is dead, but she believes I’m brain dead.”***