**Creative Ability and the Physically Disabled Client**

**Elisabeth Holsten**

**Published in the "Vona and Marie du Toit Creative Ability Workshop" - conducted on the 3, 4 & 5 August, 1994 in cooperation with the Departments of Occupational Therapy, MEDUNSA and the University of Pretoria**

The physical patient has always been the stepchild in creative ability. The question arises –

**WHY?**

*Is the problem too complex – or too obvious?*

*Do we perhaps with the physical patient enter a more technical relationship?*

*Is it just a problem of documentation and publishing?*

*Is the situation too painful or vulnerable?*

It is even more strange to think that the first documentation after Vona’s death appeared in the physical field. I want to refer you to Imme Shipham’s description of the levels of creative ability in the quadriplegic patient – an outstanding piece of work.

1. **WHICH PART OF CREATIVE ABILITY IS AFFECTED IN THE PHYSICAL PATIENT**
	1. **The Primary Effect of Physical Pathology**

Creative Ability consists of 2 components – motivation and action. It is the Action part which is primarily affected by physical pathology.

Externalization in action is reflected in:

* Exertion in drive
* Mental and cognitive action
* Expression through the body
* Communication and relation to people
* Process skills such as planning and decision making
* Sensorimotor mechanisms

It is obvious that mainly the latter part of action – the sensorimotor mechanism together with the acceptance of the new or changed body is affected.

* 1. **The Secondary Effect of Physical pathology**

Although initially only the sensorimotor mechanism is affected – all the other components may be affected at a later stage. Patient loses drive, becomes unmotivated, doesn’t want to communicate with people, is unable to plan and make decisions, etc. Even the mental and cognitive action which is not affected may become a disadvantage in that the patient is fully aware of what is happening to him. In summary, patient may become incapable of mastering himself and his environment.

This spreading of the problem may be the result of the integration of soma, psyche and spirit – man is totality. Early intervention is necessary to prevent this extension of the problem.

Whether there, at any stage of illness, can be a discrepancy between volition and action, remains a question.

Acceptance of new self can remain a battle for the rest of a client’s life – the process of acceptance may never be completed.

1. **HOW DO THE LEVELS PRESENT IN A PHYSICAL PATIENT?**

**(In Summary. Only the first 4 stages will be discussed.)**

* 1. **Tone**

The patient is just alive and is not prepared to differentiate his new self. This may be present as two different reactions:

* The patient may be so shocked that he is not prepared to face the new self

or

* There may be an unrealistic view of the future.
	1. **Self-Differentiation**

There is an erratic motivation to

* Define the new body, and
* Finding out about residual abilities or what is still possible.

The patient is at risk in that he cannot take the full reality. Motivation is usually dependent on the realization: ***“this I can do.”***

If we as therapists are not aware that patient cannot take full reality – we may be the cause of him regressing to tone.

* 1. **Self Presentation**

Motivationally, patient is now directed towards exploring his abilities, learning the basic skills necessary for his life, and presenting himself with his new abilities to the outside world.

This again is a very painful stage in that the patient, in presenting himself, becomes aware of norms of his immediate environment. If support is not provided, again he may easily regress to the previous stage.

* 1. **Passive Participation**

Patient has learned basic skills and is now motivated to use the learned skills in the real world, the outside world, with norms of society. The patient cannot cope on his own and needs direction from therapist.

The above will guide us in the assessment of the physical patient.

1. **THE HANDLING OF THE PHYSICAL PATIENT AT THE VARIOUS LEVELS OF CREATIVE ABILITY**

It is of utmost importance to nurture intrinsic motivation of the patient – as motivation is the underlying dynamic of occupational behaviour.

I would like to present Susan Doble’s ideas on what to do with our client.

**We should**

* Influence the task environment
* Ensure that tasks are meaningful
* Facilitate personal control and competence.

according to the requirements of the specific level of creative ability.