**Lecture to Creative Ability Conference**

**Pretoria, August 1994**

Both Vona du Toit and her Theory of Creative Participation have, no doubt, had a tremendous impact not only on the profession but also on the lives of many OTs. I feel extremely honoured to have been invited to speak to you this evening, firstly to introduce you to Vona du Toit and secondly to review the history and development of the Theory of Creative Participation.

The citation for the award of Hon. Fellows of the WFOT typifies the qualities for which Vona was admired and loved, not only in our own country but also abroad.

Vona qualified in 1946 as one of the first 4 South African trained OTs. After qualifying she established departments and worked in various general hospitals as well as the Pretoria school for cerebral palsied children. During short breaks in her professional career she raised 3 very special daughters of whom Marie, the eldest, also qualified as an OT. After completion of the teacher's training diploma at the University of Pretoria in 1962 she became Principal of the Pretoria College as well as Head of the Clinical Services at the HF Verwoerd Hospital.

The development of the Theory of Creative Participation led to the initiation and establishment of Vocational Rehabilitation as a fundamental and essential part of the professional contribution. This was followed by the establishment of the medical fitness for work unit at the HF Verwoerd Hospital where these principles and policies were put into action.

Another very exciting and far-reaching development in the treatment of the physically ill or disabled was the development of the Pretoria Multi-motivational Therapy Apparatus, generally known as MTA. This development was co-engineered by Vona and Mrs Ilse Eggers. Ilse has since then also spearheaded extensive technical development and research in the use of the MTA in OT.

**The review of the WFOT**

Minimal standards of training in 1971 included an entire redefinition of therapeutic media in OT.

"Media graded to restore the development of Creative Participation" was included and in this way gained international acceptance for Vona's thinking. The acceptance of sport as a treatment medium of the Occupational Therapist was also largely due to her influence.

Vona's greatest contribution has no doubt been the impetus her thinking, lecturing and actions gave to the overall development of the profession. It was largely her influence that directed the profession away from using activities for remedial and diversional purposes to the establishment of balanced programmes for the improvement of all aspects of functional performance.

Vona was always in demand as a speaker and could put across her convictions very eloquently. Vona was a highly respected member of this profession, as is shown by her many achievements which included being elected as President and Hon. Life President of the SAAOT and also the Vice President of the WFOT. This was considered a particularly significant achievement.

Her election as Chairman of the Education Committee of WFOT and the Honorary Fellowship awarded to her are again evidence of the special qualities she possessed, both as a professional and a person. It was then also quite appropriate that she would become the first Chairman of the Professional Board for OT established by the SAMDC in 1973.

The Vona du Toit Memorial Lecture, which was inaugurated after her untimely death, continues to remind us of this very special colleague of ours.

It is necessary to view Vona's achievements against a backdrop of the profession as it was 20 and 30 years ago, so as to fully appreciate the extent of her contribution. The achievements are no doubt impressive, but what, you may ask, what was she like as a person and therapist?

Although undoubtedly career orientated, Vona was primarily a wife and mother with an absolute belief in family values, caring and commitment. No student of Vona's was ever in doubt about where her priorities lay. She was usually full of fun and very "game" for student serenades, meals around her pool and sharing of fun experiences.

What was perhaps her most outstanding characteristic was her unwavering conviction in the contribution and value of OT as a profession (and no one would dare argue with her). This conviction went hand-in-hand with a tremendous sense of responsibility to her chosen profession, a sense of responsibility which she no doubt instilled in all her students. (I blame Vona du Toit for the fact that most of the class of 65, of which I am a member, are still practicing.)

Vona's powers of persuasion were legendary. I attribute the lack of research about Creative Participation largely to the fact that very, very few at the time would even have considered the need for research - Vona's word was law, and not doubted.

It was her own initiative and problem solving powers, coupled with a belief in the need to nurture initiative and creative ability in the patient that provided the basis for her approach to patients and the profession. How she managed her torturous work load still amazes me, especially as she still managed to think so creatively and get so much satisfaction from her work, even at the time of her illness.

Vona was undoubtedly a particularly inspiring teacher. Her lectures were never missed and managed to change the thinking and attitudes of all those who came into contact with her. Anyone who doubted the value or contribution of OT were speedily converted. She did however not only motivate others but also expected, and at times demanded, dedication and loyalty.

Vona was respected as a visionary, provocative thinker. She continually challenged current ideas and practices and through sheer force of conviction and enthusiasm, managed to involve all around her. Her thinking was then also clearly influenced by her existentialistic philosophy of life and a phenomenological approach to man.

The characteristics which I have mentioned create the impression of an all-powerful thinker and motivator of people. A very endearing and important other characteristic was her compassion and love for people. This was very clearly evident in the sincere interest in and concern shown towards her students (particularly those with special needs).

Vona's loyalty and protectiveness of the Pretoria College was legendary. No training was considered to be of the same standard to her and her students were most certainly the best in the country. Such was her conviction that very few dared to disagree.

Vona was a role model for many of us. She had a profound effect on our thinking, attitudes and commitment to our profession (aneure - disciples), she was much loved and greatly respected and, I must admit, also feared. Vona was a truly formidable lady who I was privileged to work very closely with for many years. It is for this reason that this is such a personal honour for me to present this talk this evening.

I will now go on to the second part of this presentation:

Time unfortunately does not allow for an in-depth review of Creative Participation. I will, however, review fundamental concepts or premises of the theory, after which I will deal with the contribution the theory has made to OT practice, the development of the theory and, finally, I would like to share some concerns with you. May I also take this opportunity to thank those of my colleagues who have contributed many valuable ideas and experiences which I have been able to incorporate in this lecture.

**What then is the origin of the Theory of Creative Participation?**

The theory developed from Vona's phenomenological approach to man and her research done on initiative - with which she equated creativity. The teachings of Buber and Kary Rogers and also Piaget's Theory of Psychological and Cognitive Development clearly influence her thinking.

Although the Theory of Creative Participation is basically a developmental one, the unique feature is perhaps the aligning of such stages with both recovery and regression.

Her ideas were first formally presented in 1968 in Hong Kong where she describes 6 stages of psychical recovery and where she referred to mainly the volitional aspects of the patient's functioning. This was followed by further refinement, development and clinical application which culminated in publications on the "Restoration of Activity Participation" and "The correlation between Volition and its expression in Action" in 1974 at the WFOT Congress in Canada.

Let us now consider those concepts which are fundamental to the theory:

It is important, to clarify terminology used as creative or creative ability as understood by many to be synonymous with talents such as artistic or musical ability or it is believed that it only refers to highly creative persons. It is therefore important to put you in perspective by discussion Vona's definition of Creative Ability which is characterised in the individual by his ability to form a relational contact with people, events and materials and by his preparedness to function freely and with originality at his level of maximum competence.

This definition presupposes a creative instinct/attitude exhibited by an inner drive which initiates or directs behaviour. It also implies the control of the negative effects of anxiety, and the expression of this motivation in action. This ACTION may be physical or mental effort, and may result in a tangible or intangible end product.

With the exertion of maximum effort to do a task or solve a problem, dynamic growth takes place - towards the actualisation of the self and the reaching of the person's creative potential. This creative potential is, however, considered to be influenced by several factors, as indicated.

Three other terms requiring brief clarification are:

* Creative response which merely indicates a preparedness to action;
* Creative participation which refers to the process of being actively involved in everyday living; and the
* Creative act which refers to end point of result of the creative response and creative participation.

As the concepts of volition and action and their inter-relatedness are fundamental to the understanding of the theory, they merit closer review:

The Volitional Component defined as being that which initiates or directs behaviour towards a goal.

The Action Component, on the other hand, represents the exertion or transformation of mental and physical effort into a tangible or intangible end product.

What is important to keep in mind is that the volition component governs the action component and that action is considered to be an expression of volition.

It is very significant to note that action, in turn, will influence volition. The nature of this influence will be determined by the success or otherwise of the ACTION.

It is then also this nurturing of a positive inter-relationship between action and volition that forms the basis of any intervention aimed at bringing about development or progression between levels.

This inter-relatedness of volition and action is believed to manifest itself in 9 segmental and interdependent stages of volition with corresponding stages/levels of action. These stages/levels represent development, progression, recovery and/or regression.

Such development or regression takes place on a continuum from totally unconstructive action leading onto action which transcends norms. It also represents a development from lack of awareness of self and environment, to egocentricism through to competing with others and yourself, and contributing to the community in which the person lives and works.

It logically then follows that mobility from one level to another could occur. The person may thus progress or regress between levels OR may exhibit characteristics of different levels at one time.

A further fundamental concept, and perhaps one not shared by other developmental theories, is that of disruption of the development of the individual's creative ability. Such disruption may be as a result of:

* physical or mental illness;
* general environmental stress;
* lack of opportunity and stimulation; or even
* specific stressful incidents

Each level further represents the accomplishment of a variety of skills and also indicated limitations with regard to that particular level of performance.

A premise crucial to the application of the theory in therapy is that success in action is considered to be essential for progression or development.

Before briefly reviewing the most commonly encountered stages, it is important to also mention that each stage represents 3 phases through which the person will progress.

The therapist directed phase is when the therapist acts as an initiator and support; followed by the patient directed, which is largely self-explanatory, and goes on to the transition phase, where the patient demonstrates signs of progressing to the following level.

I will not briefly review the 6 stages most commonly encountered during clinical practice. As mentioned before, each stage of volition has a corresponding stage of action, as indicated on the transparency.

Firstly, then, the stage of Positive Tone:

Keeping in mind the theory as discussed, I will now review the way in which the Theory of Creative Participation has contributed to professional practice in Occupational Therapy.

It has most certainly made us aware of the importance of nurturing creative ability in the individual and its significance for future recovery. The theory has likewise increased our awareness of motivation and its influence on a person's development; and also the significance of volition in therapy.

The Theory of Creative Participation has provided guidelines for planning and implementation of treatment and emphasises the use of activity and its selection analysis and application. The theory additionally not only provides extensive guidelines for graded patient handling and structuring of the treatment situation but also gives a clear indication for programme content.

The theory has also enabled us to meaningfully access and treat patients functioning at the pre- and unconstructive levels of action; patients who were previously not considered for treatment.

The emphasis which the theory placed on levels of functional performance helped OTs to direct all treatment to the improvement of such functional performance over and above remedial or diversional therapy. It is also through this particular emphasis that vocational rehabilitation, as it is currently called, developed a contribution to professional practice, (which was not at the time envisaged by Vona) was that the theory would make it possible to classify patients/clients according to the different levels of performance and in this way make it possible for us to deal with large numbers. It also enables us to plan and implement programmes for the entire population of, for example, a long term psychiatric institution.

The theory has been further adapted and is extensively used in the training of support staff and CRWs to assist them in the management of large groups of clients. The theory has been extensively and very effectively applied to upgrade the assessment and treatment of mentally retarded, mentally ill and psycho-geriatric patients/clients, particularly those in institutional care. The treatment of children has also benefitted as it has provided easily applied, developmentally based guidelines for treatment and play development.

Although not as commonly applied in the treatment of persons with physical disorders or disability, the focus on volition rather than action, which has been limited through disability, will often provide a different dimension to ?

The theory also appears to be equally applicable to different sexes, cultural groups and socio-economic levels.

Although very little has been documented, certain developments within and around the theory have taken place. This would seem to be more with regard to the application rather than the theoretical basis of the theory.

Although developed at the Pretoria College, it is now taught at several other training centres. The time allocated to the teaching thereof varies from a mere introduction to extensive requirements with regard to application in all clinical practical work.

As already mentioned, Creative Participation is now applied to the ? of large numbers, contrary to Vona's conviction that the classification of patients was unacceptable.

It would also seem that the initial emphasis on the motivation component of function has changed to greater emphasis on the action or activity participation component.

The terminology as initially formulated has been a source of some confusion as it was not readily understandable to colleagues. The term psychical recovery has, for example, been replaced almost exclusively by creative participation. TERMS describing the action rather than the volition, such as unconstructive, constructive, norm awareness and norm transcendence, have more recently been introduced. Similarly, the reclassification of levels into three groups indicating the end point/overall goal of the levels concerned indicated a new approach.

Initial publications limited the application of the theory to the treatment of psychiatric disorders and CP - chronic conditions, mental handicap and various physical disorders including head injuries which were initially excluded are now commonly treated through the application of the theory.

Whereas ? initially consisted of specific, carefully planned and graded sessions, it has been found that , in addition, full day programmes in which the basic principles have been applied to all activities of daily living are more beneficial to the patient, particularly at the lower levels of action.

At the time of the development of the theory, the possibility of the use of support staff in OT was most definitely not even contemplated. The changing role of the OT to that of manager and consultant and the training of support staff has, however, necessitated the use of a classification and management system for which the theory of Creative Participation is ideally suited.

In the same way, the changeover from Hospital and School based treatment to at least a community orientated approach has extended its application into various community and clinic settings.

Whereas the model was used to the exclusion of all else in certain training centres, apparently without critical evaluation, it is now correlated with other models, such as that of Human Occupation, and also applied in conjunction with such models.

Many therapists currently applying the Theory of Creative Participation do so almost without thinking, contrary to the initial stages when it represented a novel way of thinking and required conscious effort.

It is through the continued support and enthusiasm of Vona du Toit's followers that the theory is applied throughout the country, in all areas of practice and by a large proportion of qualified OTs and students.

As mentioned, the Theory of Creative Participation has contributed much to professional thinking and practice. Several concerns do, however, need to be addressed as a matter of urgency. I sincerely hope that this congress will clarify these issues and I congratulate the University of Pretoria, Medusa and the Vona & Marie Foundation on the initiative taken to organise this congress.

A major concern is that of a paucity of documentation and reference material. Apart from four publications/presentations by Vona herself, there have been less than 12 publications and presentations directly related to the theory during the past 26 years. Documented research remains virtually non-existent.

Sharing of ideas has been erratic to my knowledge; only one other congress has been heard for the purpose of sharing ideas on a national level and except for the Transvaal, no regional initiatives have been taken. It is for this reason that this congress is of such significance.

Assessment procedures are still un-standardised and are notoriously difficult - ask any student.

The developments and ideas of different training centres, departments and regions are not coordinated or shared.

The manifestation of the levels in children as opposed to adults, and in the physically disabled as opposed to psychiatric patients needs further documentation.

The difficulties experienced in applying the theory to acutely ill, rapidly changing psychiatric patients requires much research.

The correlation with other models currently being done at various training centres, likewise, needs to be documented and shared.

Some fundamentally concepts require greater clarification and debate, particularly the definition and inter-relationship of volition and action, also the manifestation of destructive action in adults, to name but a few.

I am sure that we are all aware that much work still needs to be done. Extensive, really outstanding clinical application of the theory has been done for ± 26 years - we need to learn about it!!

What then is the challenge to each one of us?