**Motivation and Activity in Occupational Therapy**

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I would like to express my sincere thanks to the Australian Association of Occupational Therapists for the singular honour they have bestowed on me in bringing me from South Africa to Australia. I appreciate this opportunity to meet you, to talk to you about the aspects of Occupational Therapy which we in South Africa find exciting and challenging and, most of all, to experience the stimulation and fulfilment which professional and personal interaction brings.

Your professional involvement as a group, even if one measures it only in terms of financial commitment, must be tremendous and on knows that such a materialistic assessment does not start to do justice to the quality and force of your interest which has transformed your enquiry into action. I can assure you that this has been the most thrilling experience of my professional career and I sincerely hope that at the end of my lecture and demonstration tour you will feel that it has been worthwhile.

Every profession (allied to medicine) remains on the treatment scene because of the unique and essential service which it offers; there is no place or time in this intense and competitive life, patterned as it is by economic pressures and standards, for services which duplicate those provided by other professions or for luxury services.

I have chosen "Motivation and Activity in Occupational Therapy" as the title of this paper because I am convinced that the genesis of our profession and, incidentally, the designation Occupational Therapy to our profession, was associated with the unique contribution engendered by motivation and activity. Moreover, I believe that it is in the mature interpretation and vital and discerning utilisation of these two factors (motivation and activity) that our future development lies.

I congratulate the Congress Committee on their choice of the Congress theme; it is obvious that they set out to provoke a radical professional re-evaluation and that they anticipated the stimulating and exciting response that this would bring. The question set us: "Is Occupation still the basis of Occupational Therapy?" is profound and if it succeeds only in extracting a definition of our professional interpretation of "Occupation" or whatever else you choose to extract as the "determinant" of our therapeutic armament, you will have made a tremendous contribution.

I believe, however, that once this has been done, our professional research efforts should be directed towards the practical implementation of whatever factor we acknowledge as being our raison d'être. In terms of my definition of Occupational Therapy, this factor is essentially concerned with the "creative participation" of the patient and, as such, involves motivation and activity.

It is vital for us to know how to use motivation and activity in such a way as to instil in our patients an adequate measure of physical and spiritual independence because this independence precedes his ability to participate in life as a separate entity.

We must know how to direct his willingness to participate so that it becomes creative participation and, in turn, we must know how to nurture and channelize this creative participation to become authentic work participation. The crux of the matter, as I see it, is to follow this sequence using the aim of ultimate work participation as the guide in each phase of the progression.

As a profession, we have to go to our patient with rational and defined skills. There is no security in the approach advocated in the interminable Liza and Henry song, which is to attempt to mend the hole in our bucket with straws. (I hope the patients will forgive this simile.) There is also no professional security unless theory becomes converted into specialised practical skills.

As human beings, encased as we are in a human form, our motivating force becomes synonymous with our form or body simply because it is the only instrument of expression that we have at our disposal. We use it to express everything, ranging from the most tender and sensitive communication with our eyes to the most hostile physical aggression with our total musculature.

So it seems clear to me that it we agree that "creative participation" is the operative force in Occupational Therapy, then we can only realise this if we ourselves acquire a profound understanding of each of these two factors: motivation which represents the desire to participate, and activity which represents the tangible expression of this desire. Likewise, our therapeutic media must be designed and used to bring about, as effectively as possible, the sequential process of restoring in each patient his maximum capacity to perform the most realistic activity of all, i.e. work. The patient's residual physical and mental ability will determine what point he reaches on this road. As social medicine has become more active, so it has become more perceptive and sensitive to the less obvious needs of the individual functioning in the more complex society of our time. So, also, services (mostly of an experimental nature) related to the quality of mental and physical wellbeing and standing on the periphery of medicine have flooded the social medicine panorama.

Due to our professional definition, our training and the nature of our practice, we are particularly responsive and susceptible to these emerging needs.

Let us reflect on the reason for this by taking each of the areas mentioned in turn, starting with the definition of our professional uniqueness. This I define simply; in the first place as the totality of our treatment approach evidenced in practice by our ability to treat both physical and mental pathology, in the second place by the fact that in treatment we demand the active participation of the patient, elicited by means of a motivating activity unique to each patient and of meaning to him.

In training we demand a dual endowment from the student, both the scientific ability required to master medical and natural science subjects, and the humanitarian philosophical ability demanded for the understanding of human behaviour and mental pathology. In University training these are the qualities which differentiate between the Arts and the Science directions, but we demand fairly equal attributes of both.

In our practice we are placed on the boundary between the acute treatment service of the hospital and the rehabilitation, preventative and social services of the community.

Moreover, our dual training and insight, related as it is to our therapeutic media, which historically has been vaguely defined as "human activity" - equips the Occupational Therapist to contribute in a "generally activating way over the whole area of human need". Thus there is a danger that the specific quality required of an essential service, in particular of one allied to the medical profession, may easily become submerged in non-specific activating procedures, and hence also the temptation for us to venture into pioneering fields which require for their execution initially only, the qualification of a broad insight into both mental/physical needs. In this way the humanitarian and philosophical approach very often becomes the sum total of the Occupational Therapy contribution whereas it should be used only to enhance and add an indispensable quality to our specialised paramedical treatment procedures, to serve as the matrix from which our treatment techniques emerge, and the background which determines and modifies our treatment objectives.

There are many periphery groups (amongst them the geriatric group, the mentally defective and the deaf) who, apart from actual pathology, suffer from a diminished quality of human participation in living caused by a deprivation or depletion of their mental or physical equipment. These people will respond to any approach based on the element of individual attention just because it instils a feeling of "self-worth".

They will equally respond to the element of human warmth and understanding, simply because there is a positive restorative factor inherent in human warmth and understanding. Improvement will take place regardless of whether this attention comes from a trained Occupational Therapist, a Social Worker or an untrained voluntary Welfare Worker. So, clearly the Occupational Therapist must have much more than a "general activating programme" to offer. Apart from selecting her treatment procedure, she should, in the first instance, select the patients who require her treatment. She must, in fact, have a specific restorative contribution in respect of specific pathology.

Please do not misunderstand me; I am not advocating a professional policy of static isolationism. On the contrary, I am pleading for planned movement; a progress which will be effected by the concurrent consolidation and substantiation provided by proven achievement, and enlightened, but free development. We cannot afford to be like the Lemmings who, responding to frantic instinctive forces, move forward towards their own destruction.

I think that at this stage of our development we should not dissipate our professional energy on pursuing ill-defined and relatively less significant pioneering areas. We should, I believe, rather direct our combined efforts to those fields in which Occupational Therapy can make its most significant contribution and to the specialisation both in training and practice of specific therapeutic skills.

I would, in fact, like to see us, at this stage of our development, construct a professional highway with well defined and signposted routes and definite destinations rather than to see us tread a maze of "veld paths" which barely do more than wear down the grass and which do not apparently lead anywhere.

Too diffuse an area of service would, at this sage, swamp our professional identity and could, at best, only be meagrely and superficially covered by our small numbers.

Our professional field has been limited by the development of many splinter groups; work and industrial therapists, recreational therapists, music therapists, play therapists, art therapists, and many more, and I am convinced that our profession should have selectively retained at least some of these areas either in the basic training or as post basic specialisations, by offering a more specific definition of "activity" and a clear classification of our therapeutic skills. For example, it we had claimed the restoration of the capacity to work as an integral part of Occupational Therapy and offered a scientific method to achieve this, we would not now, in many cases, be relegated to hobby activities.

So I return to the many interfaces implicit in your Congress theme, and which I am sure precipitated its formulation, to emphasise only the following: If occupation is still the basis of Occupational Therapy then it becomes our responsibility, and an occasion like this conference offers us an ideal opportunity for this to decide exactly what we mean by occupation, and exactly how we prepare ourselves to us it therapeutically. Conversely, if occupation is not the basis of Occupational Therapy, then what is? And does that something warrant our continued classification as a treatment modality. Before continuing, let me summarise what I have covered thus far: I have admitted that by virtue of our professional definition, our dual training and boundary position in practice, we are particularly well qualified to become drawn into a multitude of new services which stand on the outskirts of medicine.

Our discomfort on this score is due to the fact that these services do not quite "comply" with our definition of "occupation" or the definition of medical treatment stipulating, as it does, an allegiance to the Hippocratic Oath and compulsory medical direction.

There is, therefore, a need to review our direction because move we must. I advocated a movement towards re-affirmation of the unique elements of our origin and defined these as, firstly, our total approach, treating both the mental and physical pathology of the patient in whatever situation we found him - physical hospital, psychiatric hospital, specialised institution or the community - and secondly, our insistence on the active participation of the patient.

I suggested that our professional aim was the sensitive recognition and skilled restoration of emerging motivation and the concomitant mental quality and physical competence of the expression of this motivation, achieved through very specifically graded activities and tasks. I offered a very definite treatment sequence for the attainment of this aim utilising the inseparable elements, motivation and activity. This is the restoration of personal involvement, of spiritual and physical independence, of creative participation and, ultimately, work participation.

I expect that you have gathered by now from what I have said that if you should ask me whether occupation still is the basis of Occupational Therapy I would, after defining the term "occupation", answer with conviction that it is.

At this stage, then, it remains for me to state my case in favour of "occupation", which I define as "creative participation" culminating in work participation, and then to try to indicate the roles played by motivation and activity in the implementation of a treatment programme.

Creative participation, to my mind, is primarily the element of "doing"; but it implies that before "doing", the "doer" must discover himself as a separate, spiritually independent and unique entity, and that he must experience the desire to do. This ensures that in the doing the doer expresses, in a tangible form, something of the uniqueness of himself, i.e. he participates responsibly in fulfilling his own mental and physical potential.

Buber, I think, gets nearest to a definition in the following statement: "Man the child of man wants to make things" - he does not merely find pleasure in seeing a form arise from material that presents itself as formless, what the child desires is his own share in this becoming of things, he wants to be the subject of the event of creation.

By adding the concept of therapy to "occupation" we, of course, acknowledge a responsibility to "treat". In terms of my definition of occupation, this implies a commitment to restore the creative participation and work participation of the psychiatrically and physically ill.

I find it necessary to deal first with the rationale pertaining to activity and then that affecting motivation; in spite of the fact that in the logical sequence of treatment, activity follows on motivation. This is because when work is selected as the activity ultimately aimed at in treatment, the whole nature and quality of the Occupational Therapy Programme changes.

Our reason for adopting work as the activity, and a work related programme becomes our reason for rejecting a craft related programme, is because these two programmes are incompatible in practice. The fundamental work attitudes and work habits which we attempt to instil in the patient and the uncompromising norms and standards which we apply are inappropriate in a craft-related programme.

Work has very specific characteristics - the most basic being that it fulfils a spiritual need, that it is subject to authority, and that it is competitive in nature. From the worker it demands an emotional readiness which equips him to tolerate the more or less ruthless evaluation applied both by society and himself; a maturity which enables him to face the continuous onslaught of a challenging position which he has to maintain, and the rigid norms and standards which he has to accommodate. Ultimately, he has to resolve all the implications implicit in remuneration based on the quality of the work which he renders.

A moment of reflection on craft media will make it quite clear that the aims and principles pertaining to a work-related activity programme, graded to maintain or restore the qualities which are essential to the successful achievement of work, would be diametrically opposed to the aims and principles pertaining to a craft-related programme.

To state the case for work as "occupation" more positively, I offer the following reasons which we have found to operate in practice:

It has influenced our professional perspective to reflect the fact that hospitalisation is but an incident (however crucial) in a life which has to continue after discharge. It has altered our emphasis from one concerned with maintenance of life and the restoration of function to one concerned with the quality of life and the purpose of function. It has become the thread which gives purpose to our treatment because it navigates a direct route from the starting point to the destination of our treatment programme, by relating professional media to the emerging creative participation and ultimate work-participation of the patient.

Apart from transforming the nature of our practice, this work-related definition of Occupational Therapy has brought with it a professional self-corrective mechanism because we are compelled to evaluate each programme when we compile our final work prognosis for each patient. Furthermore, this evaluation is repeated on a post-discharge follow-up basis. In fact, it has introduced a constant re-evaluation of our treatment procedure.

At the time that we crystallised the conviction that, if we were to justify our continued classification as an essential service, we would have to direct our considerable professional resources to the restoration of the residual work capacity of our mentally and physically ill patients, it became necessary to restructure our training programme, and the treatment programme in both the physical and psychiatric training hospitals. This was a very difficult assignment because in the transition phase of training, we were teaching the students therapeutic skills and a professional emphasis, which they saw no evidence of in clinical practice.

I present to you our classification of therapeutic media which we designed to equip the students to execute a sequential work-related treatment programme from the acute stage of illness to the discharge of the patient:

Independence retraining, which concerns itself with the physical and spiritual independence of the physically and psychiatrically ill in the home, social situation and at work; this includes such skills as the construction of functional splints and aids, pre- and post-prosthetic training, and independence in activities of daily living.

The design, construction and use of motivated therapeutic apparatus. In this category, I naturally include the Pretoria Multi-motivational Therapeutic Apparatus.

Graded and modified creative media, which I interpret as the use of the creative process with the specific aim of modifying pathology in such a way as to identify and release the capacity to work.

Graded and modified work-related tasks, which includes both knowledge of the techniques, tools and apparatus used in jobs selected to represent each of the sociological work areas, and an analysis of the differentiating characteristics of these areas. This is essential if we are to analyse and grade both the quality of the motivation and the complexity of the work-related tasks used to restore the patient to his maximum work capacity.

Work assessment, which is the total assessment of the patient's work potential, culminating in the formulation of a work recommendation for final placement.

Adapted sport and recreational techniques utilising active, passive, individual or group interaction in various selected and recreational situations, the aim being to re-enforce and restore physical and intellectual function, emotional responses and social skills.

Finally, techniques developed by specialists in a particular field of research, such as the Bobath Neurophysiological Technique, the Kabat Proprioceptive Neuromuscular Facilitation Technique, Dunning's Remotivation Technique and Perceptive Testing and retraining techniques adapted in accordance with the principles of Occupational Therapy.

In the practical clinical situation we had to structure and implement entirely new work-related programmes in both the physical and psychiatric fields. In the primary physical field of practice we had to make it possible for the grossly disabled patient to experience achievement in participation, in spite of seriously depleted physical and psychological competence. By this I mean a limitation of the degree and power of movement associated with a generalised reduction of the quality of motivation and a reduction of tolerance to fatigue, frustration and pain.

As Occupational Therapists committed to treat physical and psychological pathology simultaneously, our work-related treatment programme had to be equally effective for both the kinesiological and psychological symptomotology of the grossly disabled. In practice, it soon became quite obvious that we could only do full justice to our work-related aims if we commenced the work orientation of the patient in the very earliest stages of treatment. This applied particularly, perhaps, to the grossly physically disabled patient where mental processes were not affected by pathology. The reasons for this are as follows:

Because man is a totality, the illness or injury must affect his total self, his body, mind and spirit. Psychical and physical pathology are therefore manifested simultaneously. It is in the earliest stages when the patient discovers the extent of his physical disability that he also experiences the most devastating psychological impact.

There is no justification for disregarding the intense psychical needs of the patient in the acute stage of recovery just because the medical personnel must obviously give priority to the patient's physical needs. It is quite unrealistic to heal first the body and then to attempt to repair the psychological damage.

Furthermore, it is true that emotional intensity correlates with impressionability. It is thus at the earliest stages that the patient is emotionally most precariously poised and that his values, attitudes and decisions are most vulnerable and susceptible to influence and guidance, positive or negative.

In the face of an adjustment process of this magnitude, patients almost imperceptibly begin to withdraw from active involvement and start to superimpose defensive mechanisms and impenetrable social poses which may be irreversible and, in any event, certainly retard the attainment of work participation.

Motivation, which is, in fact, at this stage, the maintenance of the desire to live and the restoration of the desire to participate actively in a work situation, must be stimulated in the earliest stages because it is in the uncertain state of imperfectly comprehended facts that the patient is overwhelmed by a conglomerate confusion of what was, and what is to be. Because at this stage the patient is forced to assume a more or less totally passive hospitalised role, his attitudes and habits have to switch from those which belonged to his life as an active contributor to those which are compatible with his life as a passive recipient. The effects of this process are similar to those which pertain to unemployment, of which Frankl says: "The most remarkable symptom of unemployment is not depression, but apathy. The unemployed becomes increasingly indifferent, and their initiative trickles away. This apathy is not without great dangers. It makes such people incapable of grasping the helping hand which may be extended to them".

Knowing that work attitudes and work habits very soon become distorted and perhaps totally destroyed by this apathy, it is obvious that a work-related treatment programme should be introduced as early as possible to prevent or reverse this negative process.

The Occupational Therapist who is involved in treating the patient from the earliest stages has the opportunity of gaining the patient's confidence and of guiding his first attempts at acknowledging his physical limitations and his first efforts at identifying with his traumatised self. She is in a position to encourage his first tentative responses towards authentic personal involvement and to elicit, inspire and encourage the growth of his practical personal involvement until it merges into participation in work. Work-participation, in itself, is not an absolute achievement but a phase of treatment which aims at increasing the intensity and quality of the patient's desire, will and, ultimately, his determination to accomplish work.

However, work is not merely any type of work, but selectively the particular work which utilises the patient's residual abilities maximally and which, accordingly, would provide him with maximal self-fulfilment and work satisfaction. In the disabled patient, work participation is a sequential process of development in which no stage can be omitted because the nature and quality of each stage inevitably affects the nature and quality of the end result.

Our aim for each patient is his reintegration into society as a participating member and at a level compatible with his residual abilities. Thus the end point of the Occupational Therapy Programme must be the evaluation of his residual work capacity and the compilation of a realistic work recommendation.

Obviously in this scheme the early introduction of a work related treatment programme considerably enhances the prospects of successful employment because evaluation is an ongoing process and the insight and information which the therapist gains in respect of the patient's psycho-dynamic processes and behavioural patterns, particularly during the early and more intense phase of recovery, enables her to interpret work assessment more qualitatively, to extract a more valid work prognosis and to formulate a more reliable work recommendation.

This scheme facilitates placement, either in a work or training situation, immediately after discharge, and is in keeping with our knowledge that the greater the time-lapse between discharge from hospital and successful re-employment, the more difficult and improbable successful re-employment becomes.

We believe that this treatment scheme will enable us to stem the present flow of unemployable disabled people from hospitals and to convert hospitals into a source of well-adjusted employable disabled, a source of new talent for the community.

Once again, to summarise then: after defining creative participation, I first extracted work as the activity which determined the quality and nature of our treatment programme; I offered our reasons for rejecting a craft-related treatment programme and our reasons for adopting a work-related treatment approach; I presented the classification of therapeutic media which we use in training to substantiate our emphasis and to equip the students to implement the approach we have chosen; thereafter, I enumerated the reasons which have emerged for introducing the work-related programme as early as possible in treatment, especially for the physically disabled. In fact, I presented the problems, the convictions and the ideals which precipitated the origin of the Pretoria Multimotivational Therapeutic Apparatus which now plays such a vital role in the execution of our work-related treatment programme.

I would now like to define and demonstrate a few models of our apparatus and project a few slides which show the College environment and the historical development of student apparatus, as well as the clinical use of a few pieces of apparatus, before proceeding to present to you our classification of motivation and a sample treatment scheme which combines motivation and activity for the quadriplegic patient.

Every piece of therapeutic apparatus is a composite unit consisting of a mechanism, which duplicates or dictates movement, at a selected joint or combination of joints of the human body, and which is adaptable in respect of the size of its components, as well as in the range and speed of movement, and in the resistance or assistance of that movement. This movement mechanism is connected to a switch which controls the supply of current to interchangeable electrically powered motivations.

This apparatus makes it possible for us to introduce an activity programme for the grossly disabled patient at a very early stage of treatment because it compensates for mechanical dysfunction whilst incorporating work-related motivations.

In addition, it ensures that our treatment is scientific, reality bound and that it moves at the urgent pace characteristic of an essential service.

For the primarily psychiatrically ill patient, we approached the problem of structuring an authentic work-related programme quite differently. We started by defining the gross stages in the recovery of mental health. These we called stages of psychical recovery. Our next task was to test the nature and quality of the patient responses, his motivation and method of expression in each of these stages of recovery.

In this way, we could identify and extract from the seemingly haphazard conglomerate of symptomotology those symptoms which appeared to be present in all patients as they struggled to recover or rediscover a motivating quality which developed into a desire and ability to work in spite of disability. These common denominators then formed the basis of our grading scheme of the "motivation" aspect of activity and it has systematised our treatment approach to both the physical and psychiatric patient.

I think we have now reached, perhaps, the most exciting phase of our development. (I seem to recall this same feeling at every other phase so far.) This is a bridging of the gap between the physical and psychiatric aspect of our training and our practice. We have very tentatively been considering our apparatus for the retraining of body image in our chronic psychiatric patients and very decidedly adopted the stages of psychical recovery to guide our selection of motivations for use with our apparatus. We find that, especially in the grossly disabled patient, the emergence of personal volition follows the same sequence.

We have, in addition, just launched a work assessment research programme at the most advanced unit for the treatment of psychoneuroses in the Republic of South Africa, after starting a similar unit at the HF Verwoerd Hospital for physical patients last year. This places us in the privileged position of pioneering in two work assessment situations, each by their different emphasis, adding significance to the other.

I now tentatively offer a sample treatment for quadriplegics which uses our Therapeutic Apparatus, which incorporates progressive stages of motivation and utilises work as the therapeutic "occupation". I quote from the paper which I am reading at the Fourth Pan Pacific Rehabilitation Congress in Hong Kong:

"Unfortunately I cannot even indicate the obvious differences between these two groups, and still less the modifications for other patient groups. In my opinion, the patient who is either physically or psychiatrically traumatised progresses through six stages of recovery. I am not referring to the reversal of pathology but to psychical recovery (provided psychical is defined according to the dictionary of psychological and psychoanalytical terms compiled by Horace and Ava English - i.e. "all the phenomena... pertaining to mind, person, self, psyche".) It is the recovery of something best described as "spiritual volition" and which I am equalling with motivations, which is related to the emergence of self-awareness and self-involvement."

It represents the growth in the patient of a motivating force responsible for commitment to contribute maximally to the quality of his own life whilst recognising that "the deepest sense of our existence is lodged with our fellowman" - van den Bergh.

These stages reflect the process of spiritual adjustment which enables the patient to accommodate those aspects of his physical disablement which are irreversible, related within the context of future time. In the psychiatric patient they represent the progressive attainment of mental health.

Each one of these phases may be prolonged or condensed; symptomatology may be overt or concealed, and may manifest itself in any one of the complex variations which form part of the vast spectrum of human behaviour.

Immediately after the injury, continued life is determined largely by the patient's physiological competence and the skill of the medical team. This neutral or biological state of "being" is a no-man's land which will persist, even after life has been assured, until the patient makes his first, perhaps virtually imperceptible but none the less active, response in favour of life. In this way, he moves into the first stage of "positive tone". It represents the crystallisation of a positive decision and the beginning of personal involvement, vulnerable and uncertain as it may be.

We are guided by two treatment premises. The first is the fact that ability, both mental and physical, proceeds from the general to the specific, and the second is that the patient must assume responsibility for himself before he can react responsibly on a wider sphere. Buber says this in the following way: "Certainly in order to go out to the other you must have been, you must be with yourself".

At this stage we introduce a programme directed inwards to the patient himself, and structured within the general area of personal independence. The progressive attainment of aspects of independence commencing with those requiring minimum physical movement has, with the advent of the electronic splints and devices, designed and constructed in our biochemistry laboratory, become much more vitally real.

Although each step in practical independence represents an end in itself, the restoration of the feeling of personal worth and dignity are bound up with a far more comprehensive definition of independence. Our programme must thus include the provision of opportunities for the patient to experience, preferably by personal manipulation, those things which are significant to him and which determine his uniqueness.

Only in this way can he experience spiritual independence and anticipate creative participation, which is synonymous with the growth of a new personal identity. We do not aim at productivity at this stage, but at instilling both an expectation of productivity and a conviction in the patient that he will be able to experience his world and express himself as a unique and separate entity.

Our apparatus has made this possible. It allows us to select any movement from a static contraction of an individual muscle, to the full range of movement at a joint or combination of joints in the required position and with the necessary support and assistance or resistance.

At this non-productive stage the specific movement activities non-dexterity devices, such as page turners, slide projectors, tape recorders and record players which bring to the patient a wealth of stimuli in the realms of learning and aesthetic experience and simultaneously provide him with physical treatment and the psychological impact of "doing".

The two restorative elements in this treatment procedure are: firstly, that the patient comes to realise that provided he makes the effort he can manipulate his environment and, secondly, that however slight his movement he can pursue his unique interests.

These experiences act as a catalyst which precipitates the second stage of recovery which we refer to as self-differentiation. In this stage the patient "looks at", experiences and discovers, i.e. becomes aware of his new traumatised self and, in fact, identifies with it.

Whatever the level of the patient's pre-trauma maturity or achievements, he has been precipitated into a completely new life, of which he has no previous experience. All skills have to be restructured within an area of new limitations, every thought that impinges on his mind has to be re-interpreted; he has to compile a new set of possibilities, his likes, dislikes, his desires, his abilities and inabilities, have a new frame of reference, and all of them have to be reclassified into a new sequence of relative importance. The patient has to clarify a multitude of facts for himself, not philosophically but by practical experience and personal confirmation.

We assist him in this process of differentiation by utilising, by means of our Apparatus, as many muscles and movements as possible to activate an extensive range of motivations. We believe that the patient should be encouraged to express all the facets which portray egocentricism as well as cooperation; destruction as well as construction.

The nature of the stage of self-differentiation is essentially egocentric, and only when the patient has gathered an adequate measure of self-acceptance can he progress to the next and more community-centred stage of self-presentation. This stage implies that the patient is ready to introduce himself as he is now, to a world that he knew and which knew him as a different entity. He must be equipped to tolerate the inevitable and continuous re-evaluation by himself and by others. "For it is in him and not between him and the world that the experience arises" - M. Buber.

Although much the same media are used in the first three stages, there is a planned progression throughout and the approach to the patient, and the aim of treatment changes accordingly.

The progression of treatment is reflected in the increased demand in respect of range and power of movement, the development from general to specific achievements in the realm of independence, and the increase of the quality and diversity of motivations as they change from being primarily self-centred to becoming primarily outgoing and community-centred in nature.

At this stage of self-presentation the patient is brought from the ward to the Occupational Therapy Department where he is stimulated to express and impose the self which he has differentiated. This is a stage of reaction rather than action.

The patient is encouraged to investigate initially, as an observer, all the facets of the total treatment programme offered. This includes selected activity groups, the graded sport programmes and the more advanced work-orientated groups. In addition to this, he is required to execute his own programme of activities within selected groups.

Having introduced himself to his environment, and having appraised the whole activity area, first as an observer and then as a non-participating member, he now propels himself into the stage of self participation.

At this stage all the important principles of work-orientation are gradually introduced. The time-allocation for this programme is progressively increased to reflect the relative importance assigned to work in the normal daily rhythm.

The patient starts with general exploratory participation in graded tasks selected from all the relevant sociological work areas, because the aim is preparation of the patient for work; i.e. the inculcation of work habits and the restoration of work capacity and not the mastery of specific work skills.

In our definition, "work tasks" represent graded assignments within a specific work area, which are complete in themselves although they may form a part of a more comprehensive activity. We use "tasks" rather than activities because in the patient with gross residual disability, his physical incompetence severely limits the range of suitable activities. The problem is pertinent because such a patient still has intact intellect, aptitudes and interests which may not be violated by presenting him with activities which would undermine his self-esteem. Moreover, we know that pride in performance forms a significant part of a sense of fulfilment and the glow of success.

"Tasks" are more effective because they permit a far more subtle grading in respect of both physical and psychological complexity whilst still retaining the basic properties characteristic of work. In summary, these properties are the need for the worker to form a concept of the whole task, his need to accept responsibility for it, to complete it, in spite of problems and, finally, to derive much satisfaction from the completion of the task that it will awaken a desire in him to undertake the next and more demanding task.

In this stage we stress two aspects of work-orientation: firstly, work habits, which incorporate attributes related to personal presentation, social presentation and work competence; secondly, work-tolerance which involves the grading of the constitutional or acquired capacity to sustain work for planned and graded periods, determined by the consideration of relevant factors associated with his disability.

The Occupational Therapist who specialises in work assessment now becomes involved in the programme and in the selection and grading of the tasks presented to the patient. We believe as Whitehouse does that "the key is the opportunity it gives to the patient to compound small triumphs of achievement and reality-testing into a background of increasing significance".

Gradually the area in which the patient functions best and from which he derives most fulfilment becomes defined as the one, out of the general arena of participation, in which he chooses to make his special contribution. This step heralds the stage of personal contribution which is the fifth stage of psychical recovery.

We use this one selected area to dictate a new series of tasks now graded to align with the stage of competitive participation which is to follow and to cumulate in the specialised procedure of work assessment.

Apart from reaffirming and upgrading work habits and work tolerance, the third aspect of work orientation, that of productive speed, is introduced where relevant. Rosenberg has defined this as "the ratio of the amount of work accomplished to the amount of time taken" and factors such as accuracy, coordination and decision making are introduced.

The more mature and uncompromising evaluation of himself and his work which comes with the introduction of these product-centred factors, testifies to the emotional readiness and physical stability required from him for the introduction of the work assessment procedure. We consider work assessment to be the end-point of the work-related Occupational Therapy Programme. We have therefore developed a work assessment procedure and established a work assessment unit for this purpose.

It is clear throughout our approach that we believe that it is basically the patient who, through his spiritual volition and personal participation, salvages himself. Obviously he relies on the skill of the medical team to restore his physical capacity, and on the early recognition and treatment of his total needs to restore his work capacity.

To be deprived of work is to be truly deprived. Frankl says: "The jobless man experiences the emptiness of his time as an emptiness of his consciousness. He feels useless because he is unoccupied. Having no work, he thinks life has no meaning".

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This paper pleads for a more specific interpretation of "occupation" in the professional designation as "creative participation culminating in work participation". It suggests that the broad and sequential process of recovery is as follows:

The restoration of personal involvement; of spiritual and physical independence; of creative participation; and ultimately, work participation.

A classification of therapeutic procedures used in the training of Occupational Therapists in the Pretoria Collect of Occupational Therapy is presented, and which equips the students to execute a work-related treatment programme from the acute stage of recovery is presented.

The Pretoria Multimotivational Therapeutic Apparatus which plays a vital role in the implementation of such a programme, particularly for the severely disabled patient, is defined and demonstrated, and finally, a model treatment programme, using this Apparatus in a work-related treatment programme for quadriplegic patients is described. Particular emphasis is placed on a suggested breakdown of the six stages through which either the physically or psychiatrically ill patient passes in his attainment of personal volition and mental health.

Vona du Toit

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