**Physical / Neuro**

**Antoinette Smit**

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As a physical and neuro team, we felt that we cannot think of ourselves as therapists without the theory of creative ability. At the back of our minds, it helps us to determine our approach towards our patients, the selection of our activities, the media that we use and the goals that we set. I think something that is unique to the physical and neurological field is that we go far beyond the level of passive participation – and often do.

We started by just defining the difference between neuro and physical. With neuro we have the problem of cognitive impairment, but with physical we don’t. With a neurological condition, without any cognitive impairment, we say that it physical impairment. Another difference is with cognitive damage. You see there, is a specific pattern of development - the person is first orientated towards nothing, then orientated towards the therapist, then towards the immediate environment, then towards situations and people. With physical conditions only, it’s very individual, because it depends on the kind of deficits that the patient has, as a person’s pre-morbid make-up is a very individual thing.

We talked about some factors that would influence the way you assess patients. The first things to take into consideration are the internal factors. What was the patient’s pre-morbid personality? How was he before the accident, before the stroke, before the head injury? What were his expectations of life before all those things? What are they now? What was his level of volition before the accident? You have got to take those things into consideration before you assess him now. Those are the internal factors.

Then there are also the external factors that play a big part in our assessment e.g. what are the expectations and limitations that the external community places on the person with a disability? Somebody has got a speech problem – the community expects him to be cognitively impaired as well. That expectation brings forward some limitations, and that becomes his behaviour. So you might see that he is functioning on one level, but maybe he has got great potential beyond that. Another external factor could be that the ergonomics of the environment are inaccessible, a person’s behaviour might be influenced and he might seem to be functioning on a lower level than his potential. Socio-economic circumstances also have to be taken into account.

**Extremely important** in the assessment is that the level of creative participation can fluctuate in an adult after an incident like this - can fluctuate quite dramatically and within a short period of time. You can literally see a person on one level on one day and the next day he is almost like a new person. The following day it could be different - not always - but there can be fluctuations.

We then talked about factors to take into consideration in the treatment of a physical disabled person, with creative ability theory at the back of our minds. It is very important to ask yourself and to ask your patient: where do you have to go back to? In what kind of circumstances are you going to live? What roles do you have to fulfil or do you want to fulfil when you go back? We concluded that in our treatment, we must include all spheres of life. You cannot only treat personal care, but must also look at work, social and recreational needs and not just treat within the hospital situation. You must treat in such a way that a person can use those skills outside in the community. It is important to realise that you might be sending somebody back to a community which expects a very small amount of creative energy. Maybe this person has much more potential than that. The O.T. can be instrumental in achieving this. We said that we see the patient as part of the team and that we must be involved in the decisions, especially with higher levels of creative ability. But the team does not take the decisions for the patient – he can do that for himself.

Another important factor is: how can the therapist and the patient adjust the environment in order for him to achieve his potential? You cannot just accept the environment as inaccessible. Central to the whole treatment issue with creative ability is control: what can you do or what can the patient do to gain control of a situation?

We felt very strongly that a patient cannot be on two different levels at the same time, but he can move between levels and so we must be able to adapt our treatment approach, almost in an instant. People are not static. If they are under stress, their level of creative action changes and it could either increase or decrease. Much more so for disabled people because they are usually under more than a non-disabled person and so are at risk of fluctuating. Therefore it would be unfair to make one static decision to say that the person is on a specific level.

The last few thoughts are on the contribution that the theory of creative ability can make when you see a patient from within this framework. It enables you to see each individual’s potential. Then you are on that individual’s side and you are going to be the one that will refuse to give up. You will help that person to fight for a chance or an opportunity to expand his potential. We rely on the fact that it is an inborn thing that each person wants to grow. We had a very interesting discussion and we have decided that if a patient finally, in the end, wants to give up, then there is probably not much that we can do to prevent him. We had some hair-raising stories about people who actually fool us into thinking that they were functioning on a very high level and ended up committing suicide.

On the one hand we are saying that creative ability is a very worthwhile theory and we use it all the time. But you must remember are that you can be fooled by thinking that a patient is operating on one level but he may be much lower or his potential much higher. You cannot always place a person on the right level on observation only, but often need more information. We said this morning that when the neurological patient comes into the O.T. department, he functions on the highest level that he can, but when he is at home, it is a completely different story. The effect of automatic actions can also fool you.

We need to remember that assessing and putting somebody on a level of creative ability is a very subjective exercise and something which is steered by instruments. I don’t think this is very scientific as you cannot create one standard or more, but any person would be able to assess another person, which would be the same. It therefore depends a lot on your relationship with your patient.

Creative ability also has many uses outside the field of O.T. and I think it is high time we start to apply this theory to nursing and medicine in general.

**ANNEXURE D**

**SUMMARY OF GROUP DISCUSSIONS AND FEEDBACK**

**Pat de Witt**

