**The Restoration of Activity Participation leading to Work Participation**

**A lecture presented at the 4th International Congress of Social Psychiatry held in Jerusalem, Israel, 21st to 26th May, 1972**

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I am pleased to have this opportunity of presenting to you a new concept of treatment aimed at restoring activity participation leading to work participation.

This concept of treatment is based on a suggested classification of apparently sequential and interdependent stages of volitional growth and of activity participation, also respectively referred to as Being - in - Becoming, and Doing - in - Becoming. It is suggested that there are 5 stages of volitional development, one of these being subdivided. They are in sequential order: positive tone; self differentiation; self presentation; participation (the stage of participation being subdivided into passive, imitative, active and competitive participation); and followed by contributive and competitive action. Each stage is further divided into 3 phases: the Therapist directed, patient directed and transitional phases.

It is further suggested that these "Being" and "Doing" aspects of an individual, at any moment in time, will together comprise his creative ability and that a "work" related programme cannot be introduced until the individual concerned has attained a work readiness which is indicated by a particular level of creative ability.

Viewed in this light, it may be said that Occupational Therapists aim at restoring the creative ability of their patients; stated differently, that they aim at restoring function in its total sense of "Being" and "Doing".

It was in attempting to achieve this aim that we started seeking a clearer definition of the two aspects of creative ability, that is, volition and activity participation. This involved us in gathering information related to qualities of preparedness in patients to participate, and the qualities of handling materials, tasks and activities which these patients employed.

Because this information had to culminate in a treatment procedure, we were compelled to reduce the information gathered to its essential truths and then to convert and systematise these into principles of handling patients, and criteria for evaluating their progress.

It is these simplified truths, principles and criteria related to volition and activity participation directed toward work participation which I will present. I trust that the omission of all the complex factors inherent in the uniqueness of each individual patient, and related to the causes and symptoms of the infinite variety of pathologies, which will obviously qualify and modify this simplified statement, will be accepted in this light.

As evidence of our awareness of, and attempt at handling these modifying factors, I would like to mention that we have been applying and developing this concept since 1965 at the Pretoria College of Occupational Therapy, and that we are currently involved in research treatment programmes with the following diagnostic groups: chronic regressed psychotic patients, cerebral palsied children, and emotionally disturbed children. We have, in addition, guided short programmes with small groups of autistic children and small groups of quadriplegic and paraplegic patients. For the purpose of this paper I will confine myself to the discussion of the application of this treatment concept to the chronic regressed psychotic patients.

The first steps in the development of this concept were concerned with the clinical confirmation of our growing awareness that the growth and recovery of the volitional component of "Being" followed a general pattern. (The expression of this pattern displaying the anticipated infinite individual variations.)

It appeared that the quality of volition emerging from an individual, and therefore infused by him into his every action, remained essentially the same for a period of development, and then almost imperceptibly started taking on a new shading which heralded the next phase of volitional growth. The length of each period was determined by a complexity of factors.

The progression of volition from one stage to the next does not occur in a sharply demarcated step-wise manner but rather by means of a subtle oscillating infiltration, presenting a mixed spectrum of volitional shades at any moment in time; the progression and recession being caused by internal and external factors.

The therapeutic implications of these observations propelled us into an exciting adventure. It became more and more apparent that in the event of the decrease, distortion or destruction of volition, it was possible to present components of the patient's environment to him in such a way as to nurture his emerging self directedness, to stabilise it, and then, being led by the light and shade of colour play of the increasing robustness of his volition, to stimulate the next stage of volitional development.

It is obvious that the implementation of such a programme makes high demands on the acuity of the Therapist's sensitivity to the changing nuances of the needs of each patient. At the same time, however, the elucidation of the sequential stages of volitional development offers the Therapist a clearly defined direction of treatment.

It was at this stage of our research that the "Doing" component of the Being - in - Becoming claimed our attention. Our observation led us to define sequential stages of activity participation, or Doing - in - Becoming. It soon crystallised out that not only do the stages of "Doing" appear to be parallel to those of "Being", but that they appear to relate in a constant pattern.

It is logical that an individual is only capable of "Doing" that which he has actualised in "Being", but gradually a new challenge emerged in the realisation that the processes of volitional growth and those of the growth of activity participation are interdependent. As the content and criteria of the respective stages of volition and activity participation became clearer, so our assessment of patient's needs, and the selection, grading and method of presenting activities, became more effective. We were now not only concerned with the extrinsic values of helping the patient to develop better ways of performing more activities, but with the intrinsic values of progressively and concurrently stabilising the patient's preparedness to participate, not only in the immediate activity but in life in general. In fact, we were attempting to restore the patient's creative ability by integrating volitional development with the growth of activity participation. Moreover, we were specifically directing activity participation towards work participation or its nearest equivalent.

At this stage I would like to present a definition of creative ability -

Creative ability in an individual is manifested in his creation of a tangible or intangible product. The quality of his action (Doing) reflects the quality of the volitional component of his "Being". The level of his "doing" is characterised by the level of his ability to form relational contacts with materials, people and situations, by the measure of his anxiety control, by his manifestation of originative ability and by the quality of his preparedness to actualise himself through exercising effort in action which makes maximal demands on his potential.

In the practical treatment situation, the concept of restoration of creative ability now became synonymous with the concept of restoration of activity participation, since we were equally concerned with the indivisible factors of quality of volition and quality of participation. We were now forced to direct our efforts towards an analysis of the activities which would elicit the desired volitional quality and the appropriate act of participation from the patient. This has obviously involved an analysis of the factors concomitant to creative ability, such as methods of structuring activity situations, of handling patients, and of presenting materials, tasks and activities at every stage of creative ability.

It is necessary to clarify a few basic facts pertaining to the restoration of creative ability without elaborating on the background philosophy. The latter is obviously not possible in a paper of this length. Suffice it to say that as creative ability involves the individual as a totality of psyche and soma, vitalised by spirit, factors such as his cultural background, his past, present and future, in fact, his personal historicity and his intellectual and personality structure will all play a vital role in the restoration of his creative ability.

The stage of creative ability attained by a patient may be ascertained from the predominant creative attitudes and characteristics expressed by him in action, which covers the broadest spectrum of his living at any one period of time. However, as there is a fluid fluctuation between stages of creative ability, the patient will, during the same period, demonstrate characteristics of previous stages as well as those of the emerging stage.

As creative ability grows in the depth dimension, in addition to its vertical progression, there will be concurrent and continued depth expansion of all stages of volition and activity participation achieved. Furthermore, an individual functioning at the higher levels of creative ability will demonstrate characteristics of different levels of activity handling, dependent on his interests and aptitudes. In fact, it has been found that participation in a new activity is most effectively achieved by individuals functioning at the higher levels of creative ability, when the activity is presented according to the stages of activity participation.

It has been interesting to observe that although diagnoses and related symptomotology play a relatively minor role in the treatment of patients at the lower stages of creative ability, they assume increasing significance as the patient progresses. Knowledge of pathology and interaction with psychiatrists is the most vital factor in the success of treatment.

The basic rationale pertaining to treatment aimed at restoring the patient's increasing desire and ability to participate in activity is to ensure that he will experience gratification in participation. Therefore situations have to be very carefully structured. The nature of the activities, the demands inherent in their handling and the method of presenting activities have to be meticulously graded. It has been found that the patient passes through three main phases in each stage of participation; the therapist directed phase, the patient directed phase and the transitional phase.

In the grading of activities, they have been reduced to basic materials, followed by simple derived materials and then simple tasks which are upgraded to form, in sequential order, general activities, work related skills and, finally, work.

Demands are introduced in accordance with the level of the patient's response, and are classified into physical handling, intellectual, emotional and social demands. Of these, the demands related to physical handling have been the simplest to grade. In the light of Guilford's crystallisation of 23 components of intellect, it is obvious that we use only a very gross grading of intellectual demands.

Our grading of social demands is more sophisticated. It starts from egocentric action and total acceptance of the patient, with total compensation for him on a Therapist to patient basis, and gradually introduces, in the following order, contact with and manipulation of materials and objects, various qualities of contact with people and, ultimately, the various gradings of interpersonal ability involving selected and unselected individuals and groups. Each one of these gradings could be elaborated to form a paper of this length.

The treatment venue, as well as the total situation, is structured to invite and facilitate the participation of the patient at every stage of creative ability. The Therapist's skill at relating to the patient and at selecting and presenting the materials and activities will guide the patient through the stages and help him to progress from the Therapist directed to the patient directed and transitional phases of each stage. For purposes of clarification, I propose naming again the stages of volitional development and those of activity participation separately, and then, because the terms assume certain meaning by constant association, with ideas developed in a particular situation, and so may have a completely different connotation to people outside that situation, I will give short explanations and concentrate on the clinical treatment implications.

The suggested stages of volition are positive tone; self differentiation; self presentation; participation (the four subdivisions of participation are passive, imitative, active and competitive); the next stages are contribution or competitive contribution. The suggested stages of activity participation are: pre-destructive; destructive; incidental - creative; and explorative action; then the four subdivisions of participative action which are, respectively, passive, imitative, originative and product centred participation, followed by contributive and competitive contributive action.

The first stage of volitional growth is therefore that of positive tone. The parallel stage of activity participation ranges between pre-destructive and destructive action. This marks the very first and therefore obviously extremely tentative, fragile and vulnerable volitional effort made by the patient towards the reality of a self directed and purposeful life. At this early stage, the emerging volition of the patient is perceived by the Therapist as a new Tone or Tension in the "Being" of the patient. It is a pre-functional tone which permits the emergence of volition but does not dictate the nature or content of its expression. The expression may thus be tentatively and inconsistently positive or equally hesitantly negative and destructive.

The clinical picture of the chronic regressed psychotic patient at the stage of positive tone is well known. It is one of an individual whose identity is submerged by biological and pathological forces, whose appearance is grossly neglected ... a patient who is often wet and dirty, presenting with bizarre behaviour, distorted thought processes, including distorted concepts and loss of reality orientation; a totally dependent, emotionally blunted individual who has lost his identity and possesses neither the volition nor the ability to participate.

Before describing the characteristics of the parallel stages of activity participation, which are pre-destructive and destructive action, it must again be stressed that the patient's action at each stage is first invited, elicited and assisted (Therapist directed) until it becomes patient directed, at which phase it is confirmed and stabilised, whilst the patient is encouraged and stimulated to proceed to the transitional phase before the whole process is repeated at the next stage of activity participation.

Against the background of total unconditional acceptance of the patient, he is handled in a matter of fact, thoroughly relaxed and constant manner. Concepts are reality bound and no expectations are set or implied. Verbal and physical contact is kept at a minimum, and used at the discretion of the Therapist. The general direction of treatment is aimed at inculcating sensory experiences. A wide variety of stimuli relevant to his daily life and stage of volition are therefore presented, at the level of the patient's ability to assimilate them. The patient moves from the pre-destructive action of pre-functional experimentation to destructive action.

The venue for his "Creative Ability" programme will be relatively stimulus free and will permit destructive handling. Only basic and simple derived materials, such as ground, paper, cloth and wood will be presented. These may be graded in terms of texture and resistance to handling. Reality concepts are strictly adhered to and all negative associations which the patient may have retained are avoided. The patient will be assisted to make direct body contact with the materials in a destructive action, including tearing, throwing, breaking, biting and crushing. No tools are used and only gross and basic motor coordination gained in the pre-destructive stage, are used at the patient's optimal tempo and rhythm of movement. Absolutely no intellectual or constructional demands are made. It is envisaged that the patient will gradually differentiate between the concepts "whole" and "broken". Socially, the patient may not even be aware of others, and has not even achieved manipulative contact with "things". Initially there is no emotional content in the patient's action but as the patient directed and transitional phases of destructive action emerges, the patient shows signs of the satisfaction which he derives from destructive action.

The second stage of volitional growth is that of self differentiation and the parallel stage of activity participation is that of incidental creative action. This stage marks the commencement of a quantitative rather than a qualitative self discovery in a patient. At this stage, the quality of his self discovery is obviously very far removed from the ultimate "self awareness", progressively attained by a mature individual who, through the acuity and clarity of his insight, becomes aware of the nuances of his uniqueness. The patent is now ready to discover basic boundaries between the "me" and "not me" on a predominantly concrete level. He appears to be most receptive to body image concepts and he may be led to a wider self identification by including gross motor function, basic emotional responses and primitive egocentric decision making, such as that regarding his comfort or discomfort, satisfaction or dissatisfaction.

The patient at this stage is clinically similar to the one at Positive Tone, generally uncared for in appearance, assumes a slouched posture and moves in an uncoordinated fashion. He displays inappropriate behaviour, such as spontaneous violent outbursts or sudden withdrawal, he often hallucinates and is socially unaware, for example, he may indulge in bizarre eating habits, stuffing objects like stones and cigarette ends into his mouth. One or other of the variety of speech disturbances is often present.

This is the stage of incidental creative actions. The Therapist observes signs which indicate that the patient is ready to move out of the destructive stage, although she often includes short spells of destructive action for the purpose of stabilising his progress. The background handling is still total unconditional acceptance and permissivity. She transmits a genuine respect for the patient's uniqueness. His name, as well as the concepts of "You" and "yours", are constantly referred to, and the programme includes intensified concept retraining and basic self-care procedures. The venue contains only selected stimuli, and social stimuli are still presented on a one way basis - the patient still being purely the recipient. There will be social exposure to others at the same stage of creative ability, but treatment will still be predominantly on an individual basis.

In order to elicit incidental creative action, the Therapist meticulously plans and structures a purely one-step immediate gratification task which will result in a coincidental surprise product, sufficiently dramatic to satisfy the patient. Emotional content is stimulated in all spheres. The task must be one which makes absolutely minimal demands on the patient's physical handling skill, his intellect or social ability. There is no pre-planning or decision making required from the patient. An infinite variety of one-step tasks have been developed to introduce a wide variety of materials, such as waxed paper batiks, marbling, various forms of paint handling and metal/magnet design making.

As soon as the patient stats to "explore" those materials which he is handling, the transitional phase leading to explorative action has been reached.

The next stage of volitional growth is that of self presentation; the parallel stage of activity participation is that of explorative action. The individual at this stage gives evidence of a desire to present the "self" which he has "identified". He makes a move towards "introducing" himself to the world of people and things to which he is "returning".

Clinically the patient is now interestingly different. He usually has acquired a "Body image" and can execute basic self-care activities. Although his discretion in terms of, for example use of make-up and manner of dress, may initially leave much to be desired. He shows a greater variety of emotional and physical responses and his total dependence has change to a need for "guidance". Certain basic expectations and norms related to personal care and social behaviour now become possible and, therefore, correction and judgement are subtly introduced. However, as these patients frequently suffer from a depleted self esteem, justified approval plays a dominant role in his handling.

As an element of "exploration" is now infused into all spheres of the patient's life, he will also give evidence of explorative creative action. The element of enquiry becomes a feature of the patient's material handling.

The Therapist now has to assume the responsibility for evoking and guiding explorative action, for involving his intellectual ability and for introducing materials representing mainly the clerical, operative and domestic areas of work. Observations of patient preferences and intellectual attributes are extremely important at this stage of a work related programme. In treatment periods which are graded in time and stimulus intensity, the patient is invited to gain information about the content of his world by exploring the properties of the materials he handles. Properties which pertain to solid, gaseous and liquid matter, and which include simplified practical concepts such as, for example, compressibility, ductility, expansion, conduction, hardness and viscosity.

The presentation of these properties occur by means of stimulating reality orientated handling of a large variety of objects and materials compatible with the patient's total level of function and applicable to his own life.

The patient is "coincidentally" involved in components of tasks representing the sociological work areas mentioned, but is not expected to understand the sequence of steps involved in the activity nor to plan, modify or anticipate these steps.

Demands related to physical coordination are now increased. Intellectual capacity becomes apparent and intellectual deficits a limiting factor. The patient is exploring his emotional capacities and ho the social level, he will now choose the company of certain individuals and experiment with social responses. There are indications that for the first time, he is ready for a patient-Therapist relationship, from which an echo-relationship develops towards the people and things around him.

The fourth stage of volitional growth covers all the subdivisions of participation, which are passive, imitative, active and competitive. The parallel stages of activity participation cover the stages of passive, imitative, originative and product centred participative action. As this paper cannot pretend to provide the detail necessary to convert it into a clinical instruction sheet, I propose to treat the volitional and activity participation stages of the four subdivisions - passive, imitative, active-originative and competitive-product centred participation - on a comparative basis.

The stage of participation marks the transition from "mere action" on the part of the patient to his "ability to participate". The differentiation is inherent in the concepts "handling" materials and tasks (or component parts of an activity) on the one hand, and "participating" or being involved in a complete activity on the other. It is during these four stages of participation that the Occupational Therapy approach changes radically from being patient-centred to being product-centred. A work preparation programme is intensively pursued, involving the concurrent treatment of the patient with evaluation of his recovering work capacity. The clinical picture presented by the patient is that of an individual who is generally more "intact" and whose appearance, motor function, mode of behaviour, emotional content, speech and social interaction is more appropriate (reality orientated) than at the previous stages. Problems are more directly related to the pathology, and patient needs can no longer be generalised because they relate more specifically to the individual differences demonstrated by personalities. The presentation of pathological symptomotology consequently also reflects these individual differences. Interpersonal ability is still not mature or reliably constant.

In a work related atmosphere, norms and standards are introduced on a compensatory level, but are upgraded in terms of rigidity until they are ruthlessly aligned to the norms of the work situations appropriate to the patient's potential.

At the stage of passive participation "situational content" is emphasised. The patient is given information (physical, emotional and intellectual content) relevant to each situation with which he passively identifies. He is, in addition, involved more directly by the Therapist in activities. She now verbalises the sequence of activity components and credits the patient retrospectively with norms inadvertently achieved by him.

As the patient gathers volitional robustness, he will find satisfaction and security in imitating activities. The stage of imitative participation makes the greatest demands on the Therapist's evaluation of the patient's ability, and her ability to select and grade suitable activities. These activities are now directly related to the applicable sociological areas of work. Grading is done in the realms of physical response and mental response. According to L Watson, factors included in physical response are resistance, reach, repetition and intricacy, or coordination. Under mental response she classifies complexity (incorporating memory, organisation and delay of gratification), abstraction (involving planning, concentration, initiative, predictability and the ability to apply principles). The whole gamut of influencing factors both related and unrelated to the activity become crystallised in the quality of the product. The efficacy of the patient's usage of time and the variations of his emotional responses ranging, for example, between indifference, enjoyment and aggression, are observed and taken into account in the ongoing treatment/work evaluation programme.

The principles of assured success applies most stringently to the patient's participation at the stage of imitation. Work habits are systematically and gradually inculcated and cover the patient's personal presentation, social presentation and work competence in each work-related situation selected for the treatment programme.

As soon as the patient can maintain a standard which approximates his apparent potential within a work area, and as soon as he starts infusing an unmistakable quality of "wanting to improve or modify" set tasks, then he has moved on to originative participation. This quality of participation implies self imposed norms, and heralds the product-centred stage of creative ability during which industrial norms are imposed, and competitive forces operating within the patient in respect of these norms, in respect of the efforts of others, and in respect of his own efforts, become apparent in his actions. The quality of the patient's social interaction is graded to reach a stage where he readily adjusts socially and interpersonally in situations demanding subordinative and cooperative responses from him.

At the stages of contribution and competitive contribution, we leave the treatment precincts. The concept of commitment to task gradually replaces that of "participation in activity" and all the qualities defined as characteristics of creative ability emerge, become stabilised, and ultimately refined as the highest level of total function evolves within the individual.

In conclusion, let me state that our research has convinced us that it cannot be taken for granted that the ability to work will be coincidentally and simultaneously restored in an activity programme aimed primarily at the treatment of a pathological condition or its related symptoms. Nor can we accept that work ability can be arbitrarily superimposed at the end of a treatment programme which has not been structured specifically as a work related programme.

I am convinced that work participation in a patient will be most effectively restored by a programme which is aimed at the sequential development of creative ability, in fact, an activity participation programme aimed specifically at work participation.

Acknowledgements:

The term "Being - in - Becoming" was inspired by Florenc Kluckhohns article "Dominant and Variant Value Orientation" (Rehab. Literature. February 1972, Volume 33 no.2) although a different meaning has been assigned to the term.

I would like to acknowledge with sincere gratitude, the encouragement, cooperation and, above all, inspiration which I receive from my colleagues and students of the Pretoria College of Occupational Therapy, especially Mrs Dain van der Reyden and Lyn Watson. I would like to express my appreciation to my colleagues working in affiliated hospitals who have all contributed to the formulation of these concepts by assisting in their clinical implementation and evaluation.