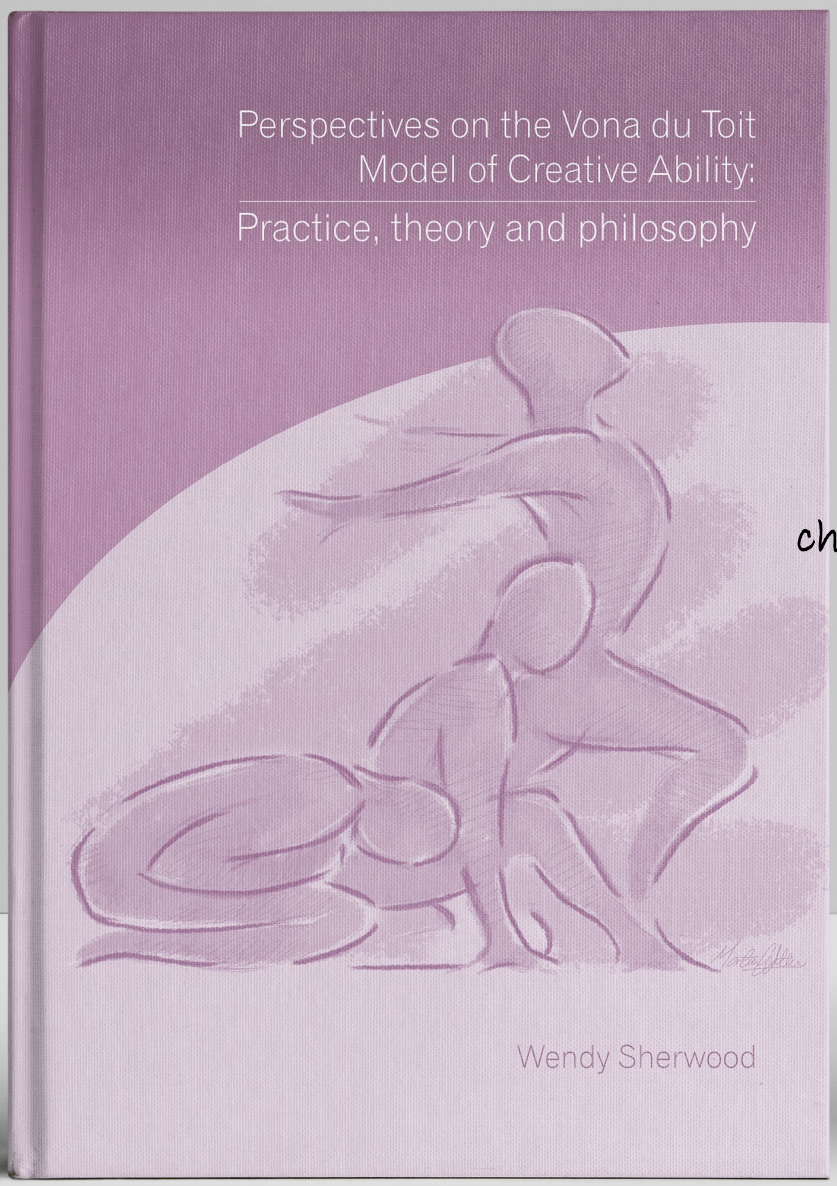
Major new occupational therapy text on the use of the Vona du Toit Model of Creative Ability in practice

13 chapters on the application of the VdTMoCA to occupational therapy in wellness, stroke rehabilitation, high secure mental health hospital, low secure forensic, dementia, children with sensory problems/sensory integration, acquired brain injury, complex needs (mental health); for developing/attending to spirituality, and VdTMoCA theory and philosophy.



See some chapter excerpts on next pages

"… provides a strong link between theory and practice, in that several of the chapters focus on specific practice areas, sharing personal experiences, programmes applied, and the activities and materials used. The way in which narratives are interwoven by several authors enables sharing and learning in a personal way".

Dain van der Reyden, Contributor to the development of the Vona du Toit Model of Creative Ability

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Perspectives on the Vona du Toit Model of Creative Ability: Practice, theory and philosophy

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CONTENTS

Excerpts from chapters

CHAPTER 01

Theory and philosophy – it's personal

Wendy Sherwood

Learning points

- Theory and philosophy of the VdTMoCA
- How VdTMoCA theory and philosophy relate to the lived experience of being and becoming an occupational therapist
- Perspectives on what it takes to know the VdTMoCA and the levels of creative ability
- Perspectives on the process and experience of self-differentiation in relation to the Self-differentiation level of creative ability, Destructive and Incidentally Constructive action

VdTMoCA theory and philosophy – it's personal

Given how extensively theory and its importance is written about in the occupational therapy literature, let's cut to the chase. It's nonsensical for occupational therapists to say "I'm not interested in theory, but in practice", or that theory is the domain of academia, not the "real world of practice", or that they need to get on and practice without "wasting time" understanding complex theory (Couldrick & Alred, 2003, p.38). It is understandable that these might be the perceptions of newly qualified therapists whose practice experience is limited to student placements only – this notion is returned to later.

Theoryless practice is in fact, a fallacy. Theory is knowledge. We have a professional knowledge base which one cannot practice without. No practice is based on no knowledge. Our place as occupational therapists is granted in practice because we are professionals – we profess to have knowledge that the average Joe on the street does not have. We must have a certain amount of knowledge in order to do the job of being an occupational therapist effectively. If we did not have knowledge (theory), we would not be equipped to understand the occupational nature of people we serve, or to address their occupational needs. In doing so, we draw on what we know to assist us in a given situation – knowledge gained from experience, theories and frames of reference. For example, one might draw upon what one knows about therapeutic use of self and counselling techniques when working with someone in grief, or the relationship between cognition and behaviour when working with someone with obsessive compulsive disorder.
Drawing on knowledge not only guides occupational therapists' practice but supports effective practice. I am a good example of the difference theory can make to being an effective practitioner. There is no doubt that although I was credited with being a proficient occupational therapist leading up to when I discovered the VdTMoCA I became a far better and effective one on learning the Model and applying it to practice. The accounts I have heard from countless colleagues, including many who are authors in this text, suggest a similar experience. Prior to knowing the VdTMoCA (hereafter referred to as the Model), although confident in working with clients who were probably on the Self-presentation (patient-directed phase) level of creative ability or above, I was aware that as a mental health occupational therapist, I was not effective, or even particularly competent in providing occupational therapy for clients who were on the first two levels of creative ability, i.e. those experiencing florid psychosis, catatonic depression, chronic or 'treatment resistant' schizophrenia or severe personality disorder with destructive behaviour. I did my best – I drew on the knowledge that I had, but it was insufficient. There was a cavernous gap in my knowledge, despite diligently studying occupational therapy, broad aspects of mental health practice, and

recommended occupational therapy models such as the Model of Human Occupation (Kielhofner, 2008) and the Canadian Model of Occupational Performance and Engagement (Polatajko et al., 2007). The VdTMoCA filled the gap, and since first trying the Model eighteen years ago, I have felt and been more knowledgeable, and subsequently better equipped to do the job of being an occupational therapist - for all clients I have worked with. So, theory is important, in fact essential.

Realising in practice the effectiveness of the VdTMoCA's focus on ability (creative ability), led to reflecting on the time when I lacked confidence and competence for providing occupational therapy to clients who were on the first two levels of creative ability. Because I had tried to engage these clients but repeatedly had been unsuccessful or engagement was 'hit and miss', I concluded, as did the rest of the multidisciplinary team that the client was "not ready for occupational therapy", or "not suitable for occupational therapy". There were definitely clients in inpatient adult mental health services who were perceived to be "not ready for OT", and not expected to be so until medication had taken effect. This is still a commonly held view in practice, as occupational therapists, support workers and students anecdotally report, and is evident in Chapter 5. However, on reflection, I realised that it was not that the client was not ready or not suitable for occupational therapy, but that *the occupational therapy I knew how to provide was not suitable for the client.* Of course! – this has to be the case unless we are withdrawing our belief in the centrality of 'doing' to human beings and therefore do not believe that all human beings are innately in need of occupation/activity participation, even if appearing unable to act on this need. Or, perhaps we have stopped viewing clients on the Tone and Self-differentiation levels of creative ability as being occupational or capable of occupational performance, which is more likely. Thinking about it, how remarkable that despite professional knowledge of the occupational nature of human beings, occupational therapists arrive at such a conclusion about 'readiness for OT'.

For me, the change in my effectiveness was the result of a shift in the relationship I had to theory. Theory and I became connected, in fact we are inseparable. As a VdTMoCA-informed occupational therapist, theory is personal. It should be the case that, as occupational therapists, theory always feels personal because theory is knowledge – there is no you as an occupational therapist without knowledge, and there is no practice that is based on no knowledge. So, the question arises as to why it took knowing the VdTMoCA for theory to be experienced as personal. I think the answer is to do with three key factors:

1. the VdTMoCA has strong philosophical foundations which are reflected in its theoretical assumptions;
2. the Model provides detailed treatment principles that act as a guide for linking philosophy and theory to practice in a practical way;
3. the personal process towards "knowing" the Model including being open to, and reflective on the lived experience of VdTMoCA philosophy and theory in the therapist-client encounter.

This combination has had a profound effect on me as a whole (private, personal and professional self). What has been forged is a lifelong connection or oneness with the VdTMoCA theory and philosophy – it's personal. This will be expanded upon and explored in this chapter, the starting point being to explore the commonly held notion of a theory-practice gap.

CHAPTER 03

Sensory Integration and Creative Ability: Towards a Symbiosis for Self-actualisation

Elize Janse van Rensburg

Learning points

- The theories of sensory integration and creative ability were developed during similar time periods in two separate parts of the world
- Sensory integration and creative ability share common assumptions
- Sensory integration and creative ability can be used symbiotically to facilitate growth, enhanced occupational behaviour and self-actualisation
- When used in combination, the theories of sensory integration and creative ability have powerful therapeutic potential

Introduction

For occupational therapists trained and practicing in the field of sensory integration, the rigorously and extensively researched sensory integration theory provides a powerful lens through which we may view our clients, as well as a potent toolbox to employ the sensory integration guided knowledge and skills to guide intervention. Similarly, the theory[1] of creative ability as presented in the Vona du Toit Model of Creative Ability (Van der Reyden et al., 2019) is another powerful contributor to the occupational therapist's toolbox – although best known for its application in the field of mental health.

In this chapter, the author reflects upon the origins and core assumptions of these two theories that may guide practice in paediatric occupational therapy. Postulates regarding change, growth and/or development are considered, and the interactive nature between the two theories are highlighted from case examples. An argument is presented that, in combination, these two theories provide a "mix" that not only answers to the call for holistic mind-brain-body consideration (Bundy & Murray, 2002) in intervention, but is also contextually relevant (Alers, 2008). Finally, a reflection on some potential conflicts or challenges that may require special consideration in practice when choosing to work with these two theories simul-

1 The term theory will be used in connection with both sensory integration and creative ability for ease of reading, although due acknowledgement is given to the development of these bodies of knowledge as, among others, theoretical frames of reference and models.

CHAPTER 04

Therapeutic steps in Low Secure Services through an Occupational Therapy pathway: A ten-week process of discovery and development

Betsey Walker

Learning points

- The role of a critical friend as an agent for change in the design and delivery of a service model
- The design, delivery and evaluation of a 10-week programme approach to delivering group-based occupational therapy
- The impact of evidencing outcomes for service users, the multidisciplinary team and occupational therapists
- Insight into what may be required to robustly embed the VdTMoCA into an inpatient forensic service, including ideas and resources for similar undertakings.

Introduction

Implementing significant changes to occupational therapy provision in a busy service can feel daunting, particularly when the stakeholders other than the occupational therapists are happy with the existing provision. This chapter outlines the process that an occupational therapy team in a low secure forensic service undertook to change its model of practice and move to group-based service delivery. This chapter is written as a descriptive and reflective account on the process, including the experience and learning from each of the following stages: reviewing the existing service provision, seeking help to apply the VdTMoCA (Van der Reyden et al., 2019a), preparing for the change, new service delivery, evaluation. The chapter concludes with a summary of how this undertaking ultimately led to a positive change for the service.
In aiming to provide the reader with some guidance on what may be required to robustly embed the VdTMoCA into an inpatient forensic service, ideas and resources for similar undertakings are included in the text and the appendices.

Low secure services

Low secure services are the least restrictive of the three types of secure care, defined by NHS England (2018) as:

view the number of groups named individuals attended and the specific aims of those groups for those individuals. A range of groups can address different components of creative ability, or target the same/similar components as needs, for example David's need to improve tool handling and increase self-esteem. The unnamed group participants only attended one group in the programme.

Box 4-1. Groups for specific level of creative ability and individuals' aims

Job Club (SP):
Ben - Improve management of own routine and ability to organise self; increase responsibility around planning.
Group participant 1 - Improve time management skills; improve ability to plan and organise self; improve problem solving skills.
Participant 2 - Maintain existing skills; improve evaluation skills; improve ability to take responsibility for a role within the group.
Participant 3 - Improve evaluation skills; develop ability to take responsibility for a role within the group; improve ability to co-operate with others.
Participant 4 - Improve planning and organisation skills; increase awareness of the needs of others.

Creative Writing (PP):
Ben - Develop effective communication in group; develop norm compliance.
Victor - Increase group involvement; encourage to develop abstract thinking and be open to other ideas.
Participant 5 - Increase ability to work and cooperate with others in a group.
Participant 6 - Increase awareness of the needs of others; improve ability to set realistic goals for self; take turns within a group setting.
Participant 7 - Develop norm compliance; increase awareness of the needs and interests of others.
Participant 8 - Develop norm compliance; to experience cognitive challenge.

Lego Therapy (SP):
Kurt - Improve tool handling; develop norm compliance.
Craig - Improve frustration tolerance; increase ability to work with others.
David - Improve tool handling skills; increase ability to adapt to others; improve self-esteem within group.
Group participant 9 - Develop norm compliance; increase awareness of others.

Cook and Share (SP):
Craig - Increase social contact; develop norm compliance; improve ability to work with others; develop routine and basic cooking skills.
Jim - Increase awareness of others; improve tool handling; assess benefits of repetition within activity.

Who Am I? (SP):
Kurt - Increase awareness of others; Develop norm compliance; encourage conversation with others.
Jim - Assess ability to retain information; increase his awareness of others.
David - Improve ability to adapt to the needs of others; improve self-esteem.
Mack - Experience enjoyment within group; improve tolerance of others.
Participant 10 - Develop norm compliance.

Gardening group (SP):
Craig - Improve ability to work with others; improve frustration tolerance.
David - Improve tool handling; increase self-esteem.
Mack - Increase frustration tolerance and ability to tolerate others in a group setting; encourage exploration of enjoyable activity.
Victor - Develop role and taking responsibility; improve planning and organisational skills.
Participant 11 - Encourage use of creative skills in alternative role; increase responsibility taking.
Participant 12 - Improve evaluation skills.

While providing treatment, the groups also afforded assessment opportunities. For example, the way that the Creative Writing group was structured and presented meant it provided specific group work conditions allowing therapists to assess Ben's Social Ability in a group setting. There were concerns about Jim's ability to retain information, therefore the Who am I? group was used to assess this ability while also attending to a treatment aim.

Below, the named service users' aims as stated in Box 4-1, are grouped for each individual to illustrate that even though they were on the same level of creative ability as others in the group programme, they had personal aims (Table 4-3).

CHAPTER 06

Stroke and creative ability

Bhavna Bahgoo and Juliana Freeme

Learning points

- Assessment of creative ability in stroke rehabilitation
- Understanding the use of the VdTMoCA as an important guideline for optimising neuroplasticity
- Application of the VdTMoCA treatment principles in stroke rehabilitation

Introduction

Stroke rehabilitation is an important field of practice in occupational therapy, as the stroke population is one of the largest groups of clients treated by occupational therapists (Nilsen et al., 2015). In the European Union, stroke is the second most common cause of death, and a leading cause of adult disability (Wafa et al., 2020). Future projections indicate a drastically increasing number of people living with stroke in the next 30 years, as populations continue to grow and people live up to an older age with an increased rate of survival after stroke (Wafa et al., 2020). The implication of the increased number of stroke survivors is that more people will be living with post-stroke impairments and disability, and will therefore require rehabilitation (Stewart et al., 2018). Up to 40% of stroke survivors suffer from residual physical disability (Larivière et al., 2018), and as many as 50% of people living with stroke will experience psychosocial or emotional dysfunction (Hildebrand, 2015), as well as a significant decrease in independence in functioning in occupational performance areas, which has an impact on stroke survivors' ability to live independently at home (Quaney et al., 2009; Kim, et al., 2014).

Stroke rehabilitation is complex due to the varied nature and severity of the physical, psychosocial and emotional symptoms, and the consequent effect on the person's ability to live and function independently. Occupational therapists are well equipped to enable persons with stroke to manage a satisfying and fulfilled life through the management of physical as well as psychosocial symptoms, and ultimately guiding individuals in improving their activity participation in all areas of occupational performance.

This chapter describes how occupational therapists can use the theory and principles of the Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al., 2019a) in stroke rehabilitation, as a powerful way to enrich the effectiveness of their intervention. Now, more than ever, occupational therapists require

Volition and action affected by stroke

Due to the interrelationship of volition, motivation and action as a central belief of the VdTMoCA (Van der Reyden & Sherwood, 2019), consideration of all these aspects of a person's level of creative ability is highly relevant in stroke rehabilitation, as both physical and psychosocial impairments are present post-stroke. The decline in the person's level of volition, as compared to their functioning pre-stroke, could be caused by multiple factors. The most apparent effect on volition and motivation is ascribed to the primary psychosocial impairments caused by the stroke, indicated by the lesion site and visible damage to the central nervous system. Impairments occur in basic and higher-level cognitive dysfunction, executive function skills, decreased frustration tolerance, impulsivity and increased anxiety and irritability, aggressiveness, apathy, and most commonly depression (Hildebrand, 2015). These can all affect volition and motivation.
An occupational therapist should not assume that a patient with mild physical impairments will be functional and independent in all areas of occupational performance and will be able to return to their pre-stroke activity participation. There may have been a significant change in the level of volition, which will affect ability to function independently in all areas of occupational performance. In these cases, the general treatment principles should be used according to the patient's level of creative ability.

The disruption in physical and psychosocial functioning post-stroke also leads to a decline in activity participation. A person's experience of action and the outcome thereof, influences volition and motivation (Van der Reyden & Sherwood, 2019). Therefore, the deterioration in activity participation secondary to the physical and psychosocial impairments, and the loss and grief after suffering the stroke, may cause a further decline in the person's level of volition (Fig. 6-1).

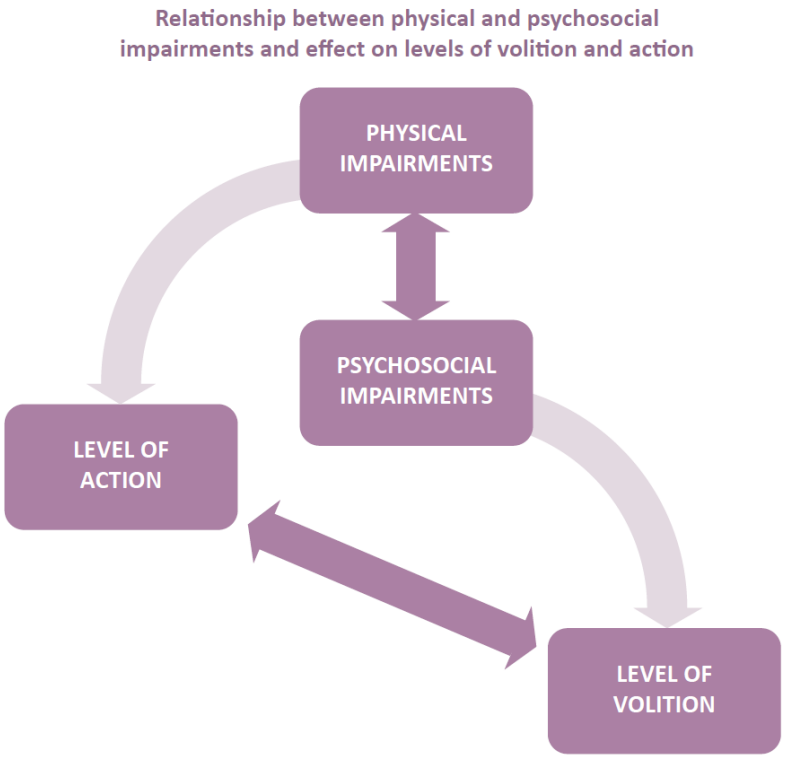


Figure 6-1. The relationship between physical and psychosocial impairments and the effect on levels of volition and action

CHAPTER 08

Application of the VdTMoCA to occupational therapy within a High Secure Mental Health Hospital

Charlotte Carpenter, Suzanne Jordan, Joanna Lawrence, Annie London, Jade Reilly, Martin Southon, Lyndsey Summers

Learning points

- Rationale for the decision to implement the VdTMoCA within a High Security Hospital
- How the model was implemented in different stages of patients' recovery
- The effectiveness of the model in capturing change in patients' skill development

Introduction

This chapter describes the journey, challenges and successes achieved via a service change for occupational therapy at Broadmoor Hospital. The occupational therapy service implemented the change to use the VdT Model of Creative Ability (VdTMoCA) (Van der Reyden et al., 2019) in response to feeling deskilled and unable to engage with patients who declined to engage in the existing therapy programme. As a result of the change of model of practice, the occupational therapists implemented a new therapy programme. Patients were invited to attend sessions in which activities had been graded to the patients' abilities. This provided treatment sessions in which previously disengaged patients, engaged. The new programme gave a platform for occupational therapists to assess patients' skill development and support patients' recovery journeys, reducing recidivism and thereby improving their overall experience and quality of life.

This chapter orientates the reader to the high security hospital context and explains the rationale leading to a decision to implement the VdTMoCA. The reader then gains insight into the strategies that the occupational therapy team employed to realise the aim of improving its service and demonstrating its value and contribution through outcome measurement. This is a detailed section, aimed at supporting readers planning on undertaking a similar process. This is followed by exemplars of how the Model informed practice, illustrated by case examples of occupational therapy assessment and treatment in distinct parts of the service for differing stages of patients' recovery: Admission, Assertive Rehabilitation and Intensive Support and Treatment (ISAT) / Intensive Care Unit (PICU).

Positive risk taking when facing violence

On ISAT, many individuals do not respond well to the usual methods of treating risk behaviours, i.e. pharmacological treatment. In this circumstance, due to expertise in carefully structuring activities/tasks and environments, occupational therapists can make a significant contribution to interventions for reducing the risk of violence, and also improve patient outcomes. Although impulsive behaviour would in the past, have been a barrier to engagement in any therapy (Pompili & Fiorillo, 2015), the risk a person poses does not mean that activities must be restricted (McNeill & Banningan, 2014). Rather, activity participation has distinct benefits. Careful use of activity and the environment is recognised to reduce violence and aggression in mental health settings and reduce restrictive practice (NICE Guidelines 2015). Hence, occupational therapists' legitimate tools of practice (e.g. use of activity, activity and environmental analysis, grading) (Mosey, 1986; Van der Reyden et al., 2019b) plus knowledge of the person-activity-environment relationship, can support positive risk-taking in terms of patients' engagement in activity. This is enhanced with knowledge of the levels of creative ability, as unpredictable, chaotic and/or impulsive behaviour is expected and understood in the first three levels of creative ability.

On the Tone level of creative ability, occupational performance is mainly reflexive, hence purposeless, unplanned action. Progression through this level is partly evidenced by turning towards stimuli, which indicates growing awareness, plus giving attention (Casteleijn & Holsten, 2019). On the Self-differentiation level, therapist-directed phase, there is fleeting attention, but little discernible intention driving behaviour other than to satisfy basic needs, e.g. for food. However, there emerges ability to respond to simple requests such as to lift one's leg, pick something up, wipe one's face. In contrast, on the Self-Presentation level, there is *intentional* investigation/exploration of materials, objects, people and situations, as well as own abilities. However, there is a great deal of impulsive action due to poor executive functioning, such as poor insight or judgement of own abilities, abstract reasoning, planning and decision-making, and poor

Table 8-9. Risk behaviours that can be expected on the first three levels of creative ability (therapist-directed phase)

Volition	Action	Risk behaviours
Tone	*Unplanned, purposeless*	
No planned action Unable to meet basic need		Smearing (over self), eating any/all objects.
Self-differentiation	*Destructive, or Incidentally constructive*	
Incoherent communication. No norm awareness. Clumsy movement. Basic emotional responses. Fleeting awareness.		Punching, kicking, head banging, grabbing, smearing, exposing self/sexually inappropriate behaviours, e.g. unacceptable touching, masturbating in public; cutting self, dissociation, self-neglect.
Self-presentation	*Explorative constructive*	
Willing to have a go/try. Enjoys process of doing. Tries to communicate and interact, but poor social skills. Poor quality handling of tools and end products. Sticks to what they like/know works.		Allegations towards staff and peers, bullying, harm, inappropriate relationships etc; sexualised behaviours, e.g. exposure, masturbation, grabbing genitals of staff or peers, verbalised sexual violence and harassment. Trading of food, medications, patients' property, sexual favours, assault on behalf of others. Impulsive behaviours, violence/using weapons, poor norm compliance, e.g. stealing. Self-harm/ inserting items planned violence that seeks a particular ending or targeting a chosen individual.

CHAPTER 10

Making sense of dementia – a multi-sensory approach based on the first four levels of the Vona du Toit Model of Creative Ability

Sylvia Birkhead

Learning points

- The needs of an increasing ageing population, specifically related to dementia
- The positive impact of the person-centred-care approach on intervention outcomes
- How to use multi-sensory stimulation graded for different levels of creative ability
- Linking stages of dementia to the levels of creative ability

Introduction

After more than two decades of working with old age home residents in South Africa, I have developed a practice-based, therapeutic approach for enriching the lives of the aged, particularly those living with dementia. A person-centred approach enables the therapist to use the most meaningful multi-sensory input in activities for each individual, and therefore bring about maximal impact on functional abilities, in line with the individual's stage of dementia.

Training in multi-sensory stimulation by Flo Longhorn, a sensory stimulation specialist from the UK, was the impetus for incorporating multi-sensory stimuli into activities being done with people living with dementia in old age homes and the community. As I trialled sensory activities for appropriateness with individuals in each of the stages of dementia, the realisation dawned that the stages of dementia correspond with the first four levels of the Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al., 2019a). This provided a theoretical framework that helped in making sense of dementia in practice for me, and led to the development of a multi-sensory stimulation programme for people on the first four levels of creative ability.

This chapter provides an overview of ageing and the stages of dementia aligned with the levels of creative ability, and goes on to explain a programme of multi-sensory activities for people with dementia at different levels of creative ability. This chapter reflects this author's personal professional development journey, hence is written in the first person. It refers to the South African context for practice, but describes practice that can be applied in any context providing care for older people.

The term client-directed is used in preference to patient-directed in relation to the middle phase of any level of creative ability, as this better reflects the person-centred approach advocated in this chapter.

that can stimulate reminiscence or create an ambience of energy or calmness. This stimulation is particularly important for individuals who cannot access the wider environment or initiate interaction with materials, objects and people. In dementia care settings, to promote and maintain maximal function through sensory cues, one could put a sign on the door to indicate where the bathroom is, or paint the toilet seat a strong colour that contrasts with the background wall/floor tiles/covering and toilet bowl. Sounds, such as cutlery and crockery being laid out on a table can be the sensory cue to direct a person to the dining room, or the smell from the kitchen can increase appetite.

Linking sensory input with levels of creative ability

In learning about the sensory aspects of functioning and approaches to the use of multi-sensory stimulation, I have drawn upon a number of authors who have developed multi-sensory practices, namely Longhorn (2007), Fowler (2007), Bowlby (1993) and Moore (2002).

Flo Longhorn demonstrated to me how to apply multi-sensory stimulation principles to individuals and to daily group-based interventions. This included providing multi-sensory stimuli to older people in the therapist-directed phase of the Tone level of creative ability (1:1 intervention), and those on the Self-differentiation level of creative ability (group programme). Following this training, the sensory components of activities were increasingly incorporated into all activities that I carried out in old age homes. Learning how sensory input can be graded according to the person's degree of function/level of creative ability, was the beginning of "making sense of dementia" practice for me. It became evident that using multi-sensory stimulation activities contributed to clients' improvement in creative ability, exhibiting mostly a shift from the Self-differentiation, Destructive/Incidentally constructive level to the Self-presentation, Constructive explorative level of creative ability. The multi-sensory input was altered slightly to allow for greater exploration or problem solving, depending on the level of creative ability. Incorporation of aspects of other multi-sensory programmes added to the input that I provided, up to the Passive Participation, Norm awareness level of creative ability.

The levels of creative ability and associated treatment principles have been used as a framework for identifying and providing guidance on activities that could be used with individuals at each stage of dementia (Table 10-1). Sensory-focused use of activities can be used on an individual basis, particularly with individuals on the level of Tone with Unplanned, purposeless action. On the levels of Self-differentiation, a group programme becomes possible and beneficial, as described later in this section. Whether intervention is on a 1:1 or group basis, clients will gain the greatest benefit from sensory input which is cognisant of each person's sensory preferences. Such information can be gained through use of a person-centred questionnaire, with input from the individual or carers and family. This information informs therapists as to which senses for stimulation are preferred, or disliked and therefore avoided. This knowledge informs the use of meaningful stimuli to each specific client. The sensory properties of all meaningful activities within a person's life should be considered, including Personal Management, Constructive Use of Free Time and work activities. I use a person-centred sensory profile questionnaire as an adaptation of Longhorn's (2007), which was conceptualised on the work of Winnie Dunn.

CHAPTER 12

Relationships between sense of self, sensory processing, and volition as manifested in the first levels of creative ability

Carla van Heerden

Learning points

- Relationships between sense of self, sensory processing, and development of volition as manifested in the first levels of creative ability
- The importance of enabling traumatised clients to re-establish a sense of who they are

Introduction

This case study talks to the experiences of working with a young woman with acquired brain injury, who was seen by a mental health occupational therapist in private practice in Australia. The Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al., 2019a) is not taught in Australian universities and is not well known at all. In this situation, the therapist dealing with the young woman (pseudonym Paula) was referred this case and found that she was not making any progress until I, as her clinical supervisor introduced it to her as a different lens through which she could view Paula's presentation.
Joint reflections between the therapist and myself, as her clinical supervisor, led to consideration of the inter-relationships between the experience of a sense of self; how sensory information is processed, and the development of volition, particularly during the first levels of creative ability. What follows, is a brief introduction to the case and context, as well as the clinical reasoning, or hypothetical anticipation of what would be required during intervention. Next, the change in focus of intervention and subsequent changes in the presentation of the client is discussed. Throughout the discussion, theoretical constructs and the implications for practice are highlighted.

Paula

Paula, a 22-year old woman, was involved in a motor vehicle accident three years before she came to the attention of a mental health occupational therapist for the first time. She presented with diagnoses of anxiety, depression and post-traumatic stress disorder associated with excessive fatigue, memory problems, poor concentration, sleep difficulties and personality changes. Functionally, Paula had been unable to work since her accident. She was unable to establish a daily routine or effectively implement anxiety management strategies, resulting in her staying indoors on her own during the day. In terms of living

CHAPTER 13

Seclusion: The end of the road for occupational therapy or a new route with the Vona du Toit Model of Creative Ability?

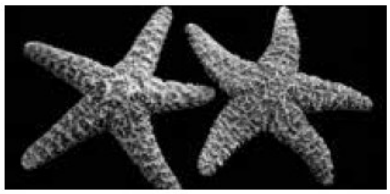
Louise Jeffries

Learning points

- How the clinical presentation of individuals in seclusion can be understood through attention to the Self-differentiation and Self-presentation levels of creative ability
- How the VdTMoCA treatment principles can be applied to occupational therapy for individuals on the Self-differentiation and Self-presentation levels of creative ability in seclusion
- How the VdTMoCA can inform care plans to exit seclusion and reduce the use of restrictive interventions
- How the VdTMoCA treatment principles can be applied as a multidisciplinary team in a forensic setting
- Questions related to the use of seclusion and forensic settings for research

Introduction

As an occupational therapist working in a medium secure forensic ward with adult males, my interest in engaging patients in seclusion began as a result of reflecting on my own practice and the national drive to reduce restrictive practices. In the past, when a patient had to be secluded it was common practice to stop occupational therapy intervention and re-commence when the patient returned to the ward. This is not the practice in all services presently, as there are occupational therapists who actively engage patients who are in seclusion. However, I have known the rationale for disengaging individuals from occupational therapy when in acute disturbance frequently throughout my career. Hence, the first half of the question posed in the title of this chapter is: Seclusion - the end of the road for occupational therapy? In this chapter, I propose that it does not need to be, based on my experience of using the Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al., 2019a) to inform not only occupational therapy, but a multidisciplinary approach to care and treatment. The sharing of how our practice on the forensic ward has since changed due to the influence of the VdTMoCA, may prompt the reader to reflect on his/her own current practice and how the VdTMoCA may influence being an occupational therapist.

Molluscs	Crustaceans	Fish
		
		
		
		

This is just one example of categorisation that we did in a series. This task was to categorise sea creatures into molluscs, crustaceans and fish. I made a large board and split it in to three sections – one for each category. Separate from the board, I had different pictures of creatures which we explored through discussion and categorised one by one, resulting in me sticking them on the board in the relevant section (category).
Myself and the observing healthcare assistant (HCA) stood at the closed door, facilitating this activity through the window in the door. As pre-planned with the observing HCA, she joined in the discussion as if we were all working together in order to reduce any demands that the patient might feel to get the answer right, focusing instead on emphasising constructive explorative action. I applied the treatment principles such as asking searching questions to facilitate exploration of the properties of the creatures we were categorising (concept formation). So, we would have rich discussions about the creatures´ appearance - the patient would clearly describe each one and we discussed the similarities and differences (as per the treatment principles).
I would usually throw in something difficult, such as asking "Is a star fish a fish?" The patient would be engrossed for up to 45 minutes – interacting, exploring, laughing and having fun (as per the treatment principles).

Perspectives on the Vona du Toi t Model of Creative Abili ty: practice, theory and philosophy.

Edi ted by Wendy Sherwood

The Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al., 2019) is an occupational therapy practice model grounded in existentialism and theories of motivation and human development. The model enables therapists to identify any individual´s level of creative ability and is therefore suitable for use in any health or social care context and with people in wellness. It provides detailed guidance on how to elicit motivation for activity participation and engagement, for maintaining this, and creating the just right challenge aimed at improving an individual´s volition, motivation and engagement in therapy, occupation and everyday life.

These qualities and benefits of the model are illustrated in this text, which is the first to provide detailed information and case examples of the application of the VdTMoCA to address the physical, mental and spiritual health and well-being of individuals in a broad range of contexts. These include stroke rehabilitation, dementia care (multi-sensory stimulation programme), low and high secure forensic services, seclusion, rehabilitation for people with complex needs (mental health), and a case example relating sense of self, sensory processing and volition for a person with a traumatic brain injury. Additionally, there is a chapter on combining sensory integration theory and the theory of creative ability to facilitate growth, and two chapters explore and make the case for understanding and facilitating growth of the spirit component of people, arguing for a change in the conceptualisation of the highest level of creative ability. Bringing the interrelatedness of mind, body, spirit together, a thought-provoking chapter explores the source of human creative ability and the effect pathology, impairments, injury and disorders have on the process of creative ability, with particular reference to schizophrenia, traumatic head injury, learning disabilities, substance abuse and pain.

Several chapters provide detailed accounts of how individual and teams of occupational therapists approached the task of embedding the VdTMoCA to transform and improve their services, providing resources as Appendices for the reader to utilise. In total, there are seven case examples to illustrate VdTMoCA informed occupational therapy, including how it can guide other disciplines for working therapeutically with individuals. Cases are also drawn upon in a discussion of some of the core philosophical and theoretical assumptions of the VdTMoCA, bringing their inseparable relationship with practice alive to deepen the reader's understanding of this valuable occupational therapy practice model.

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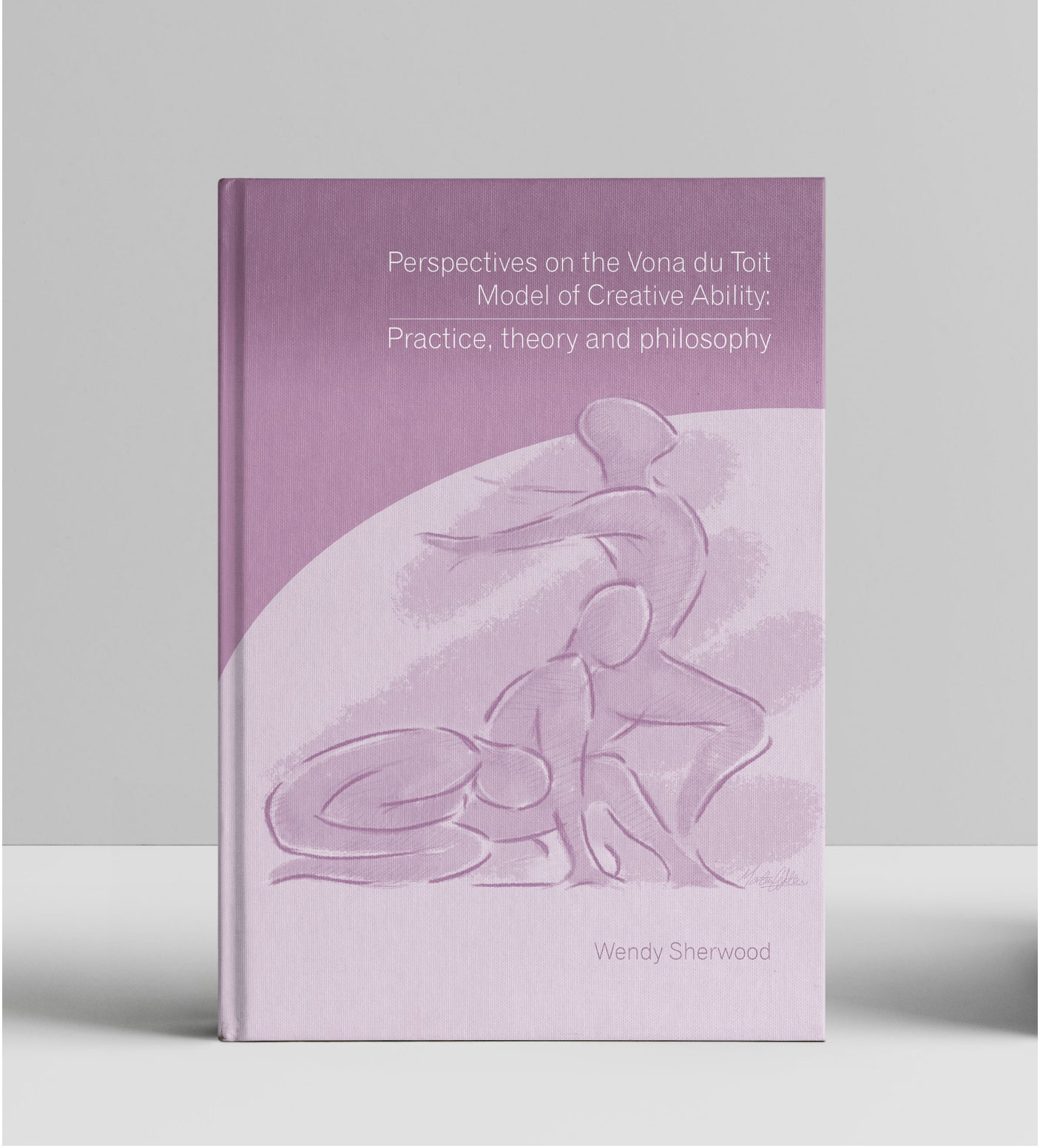

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Also : *Patient Volition and Action in Occupational Therapy* (Du Toit, 2015) (see next page), which is frequently referred to in this text— £16.00.

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Patient Volition and Action in Occupational Therapy, *Vona du Toit*.

Referred to frequently by authors of Perspectives on the Vona du Toit Model of Creative Ability (Sherwood, 2021).

This is an invaluable little book, containing original papers and presentations by Vona du Toit. Vona's original paper on ***initiative*** really sets out the philosophical underpinnings of the model, and explains fundamental beliefs about each individual's responsibility for who we become (and recover to be), and the role and responsibilities of the occupational therapist. As a philosophical paper of the 1960s, the language and style may be a little challenging at first, but this paper on initiative is worth the effort in re-reading and thinking through it.

The subsequent papers set out Vona's thinking about creative ability, progressing to the 1974 publication of the theory of creative ability.

Although there is a lot of repetition in Vona's papers because many are conference presentations, there is much to learn from the differing presentations, particularly those related to specific client groups.

The book also includes a thought-provoking chapter by Pieta Compaan who provides personal insight into recovery through the levels of creative ability, as drawn upon in the 'Perspectives….' book. There is also a WFOT presentation by Dain van der Reyden on the model - including useful diagrams.

This book may be small in size but is huge in terms of theory and guidance for the occupational therapy profession, and I am pleased to be able to bring it to the UK audience.

Dr Wendy Sherwood

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- Married, on average, by age 16 and already mothers or expecting their first child aged between 15 and 19
- Every year, 9,000+ Nepalese women and girls are victims of sexual exploitation or trafficked into India or the Middle East for domestic slavery or sex trade
- Without education, girls have little or no chance to achieve their full human potential

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