

Theory and application of the Vona du Toit Model of Creative Ability - A scoping review

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Introduction

The Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al, 2019) is an occupational therapy practice model developed in South Africa.

The VdTMoCA explains the relationship between a person's volition, motivation and action, which are essential for one's ability to respond creatively to life's demands. The term creative refers to bringing about something new (tangible and/or intangible), as a result of exerting effort to meet and master challenges. From a developmental perspective, one's creative ability is observable in nine sequential levels of creative ability (Figure 1), each having a term describing the volition and one for the associated action. Movement through each level occurs in three phases: therapist-directed, patient-directed and transitional.

The VdTMoCA guides the whole OT process from information gathering and assessment to the provision of a detailed guide to treatment/intervention and outcome measure tools (Van der Reyden et al, 2019). The VdTMoCA has a 50-year history in South Africa, and in the last 20 years it has become increasingly used in the UK, Japan, Singapore and Australia (Sherwood & Wilson, 2019). The Model's Creative Participation Assessment form (CPA) features in the American text on assessments in mental health (Ryan et al, 2022). Within texts, it is purported that the VdTMoCA can be used with any individual, of any age whether in wellness or experiencing trauma, disability or ill-health (De Witt 2005; Van der Reyden et al, 2019; Sherwood, 2021). However, the peer reviewed and research literature on the VdTMoCA has not been explored. In order to inform occupational therapists of the evidence-base of the VdTMoCA and its scope for practice, a scoping review was undertaken.

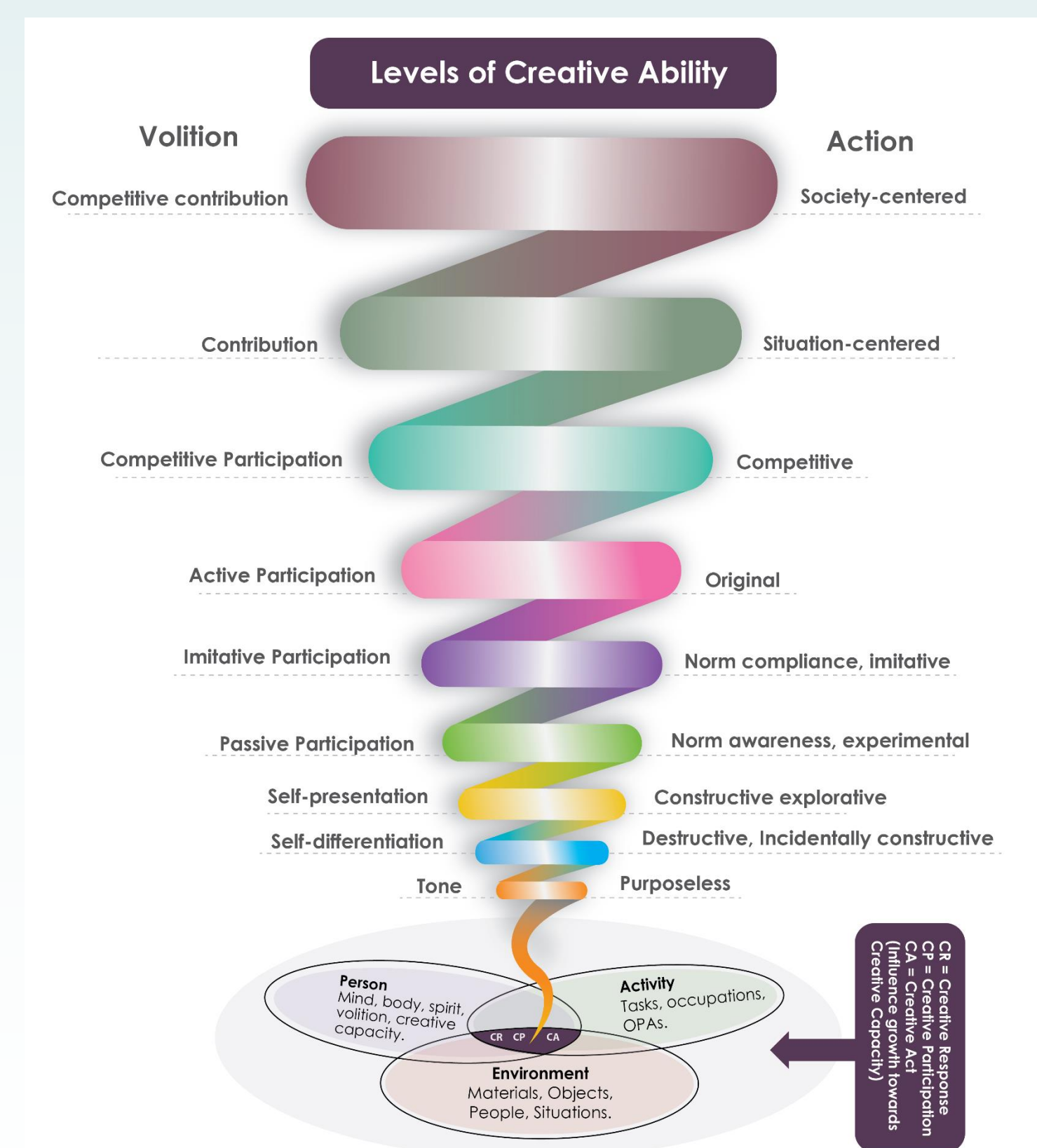


Fig 1 The VdTMoCA (Van der Reyden et al, 2019, p61)

Aims of the scoping review

- To map theoretical investigations and clinical application of the Model
- To identify strengths and weaknesses of the Model

Methodology

This scoping review followed the steps of Arksey and O'Malley (2005). Stage 1: Identifying the research question. Our research question was: How is the VdTMoCA used by Occupational Therapists and what are the reported strengths and weaknesses?

Stage 2: Identifying relevant studies. We searched for relevant studies in peer-reviewed articles and Theses and Dissertations (T&D). The inclusion criteria for peer-reviewed articles was that the VdTMoCA was applied to screening, assessment, intervention or outcomes in any population. Opinion pieces had to focus on or discuss the VdTMoCA in more than 50% of the article. For T&D studies, the purpose of the research should clearly focus on aspects of the VdTMoCA.

Stage 3: Study selection. The Prisma diagram (Fig. 2) shows how many studies were included.

Stage 4: Charting the data. The Covidence software program was used to chart the data according to set criteria linked to the aims of the study.

Stage 5: Collating, summarising and reporting the data. Tables and graphs collated and summarised the data as presented in the Results.

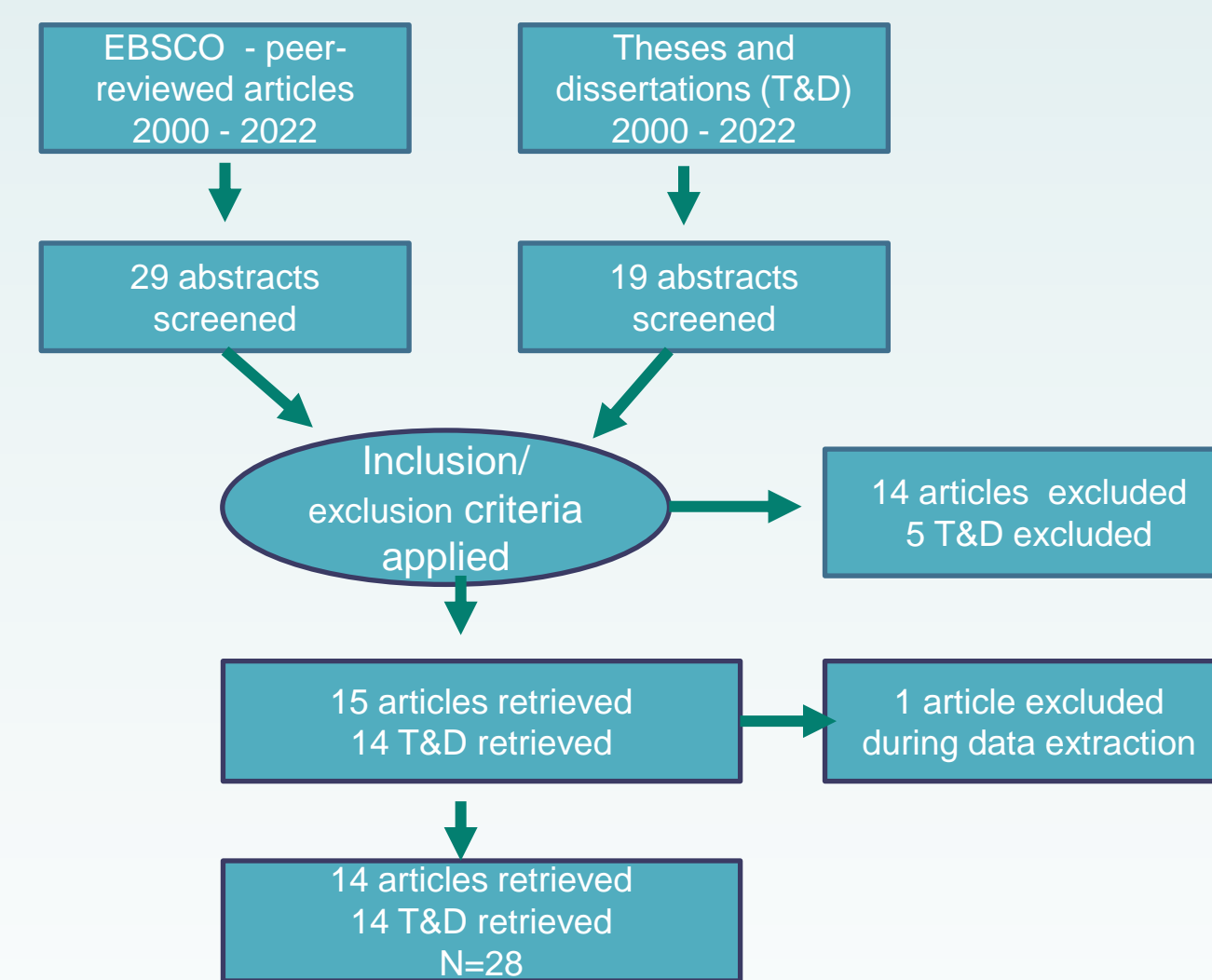


Fig 2 The PRISMA diagram

Results

The 28 studies were mainly done in South Africa (n=20) with six from the UK and one study done in the UK and South Africa. Two commentary articles were not country specific. There was a mix of study designs.

Strengths of the VdTMoCA

The strengths of the VdTMoCA overshadowed the weaknesses. More strengths than weaknesses were reported in the last three years. The strengths were categorised into 8 themes (Fig. 3).

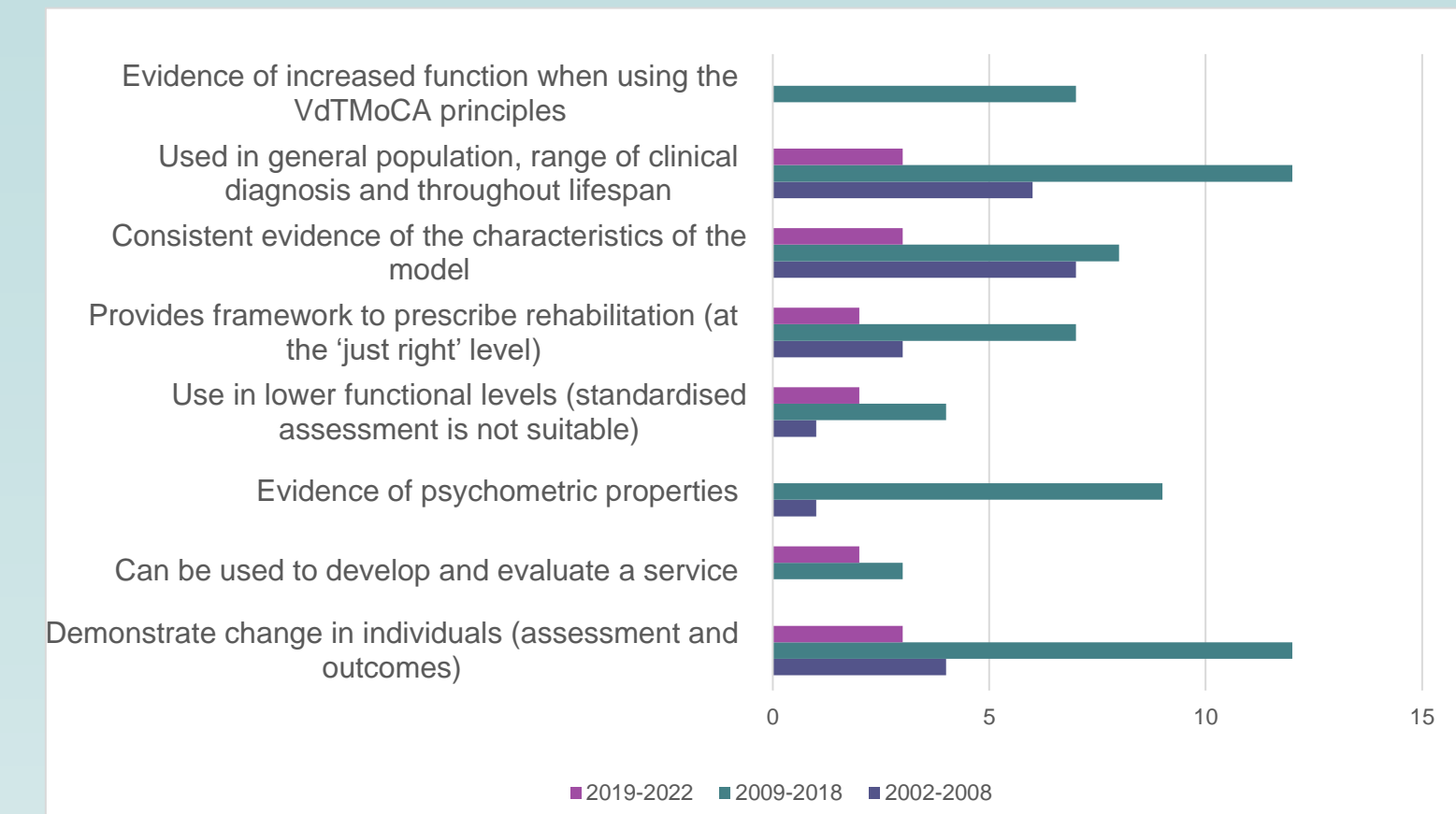


Fig 3 Strengths of the VdTMoCA

For clarity, evidence of characteristics of the model refers to descriptions of levels of creative ability, core constructs and the assessment and intervention processes, and purported benefits, e.g. enables therapy with people on all levels of ability. Evidence of psychometric properties refers to validity, reliability and sensitivity.

Weaknesses of the VdTMoCA

The researchers noted that some weaknesses* were reported prior to two major initiatives in relation to the VdTMoCA: the ICAN international conferences which started in 2009 and the publication of the full text on the VdTMoCA in 2019. These events in relation to reports of weaknesses are reflected in the time periods in Fig. 4.

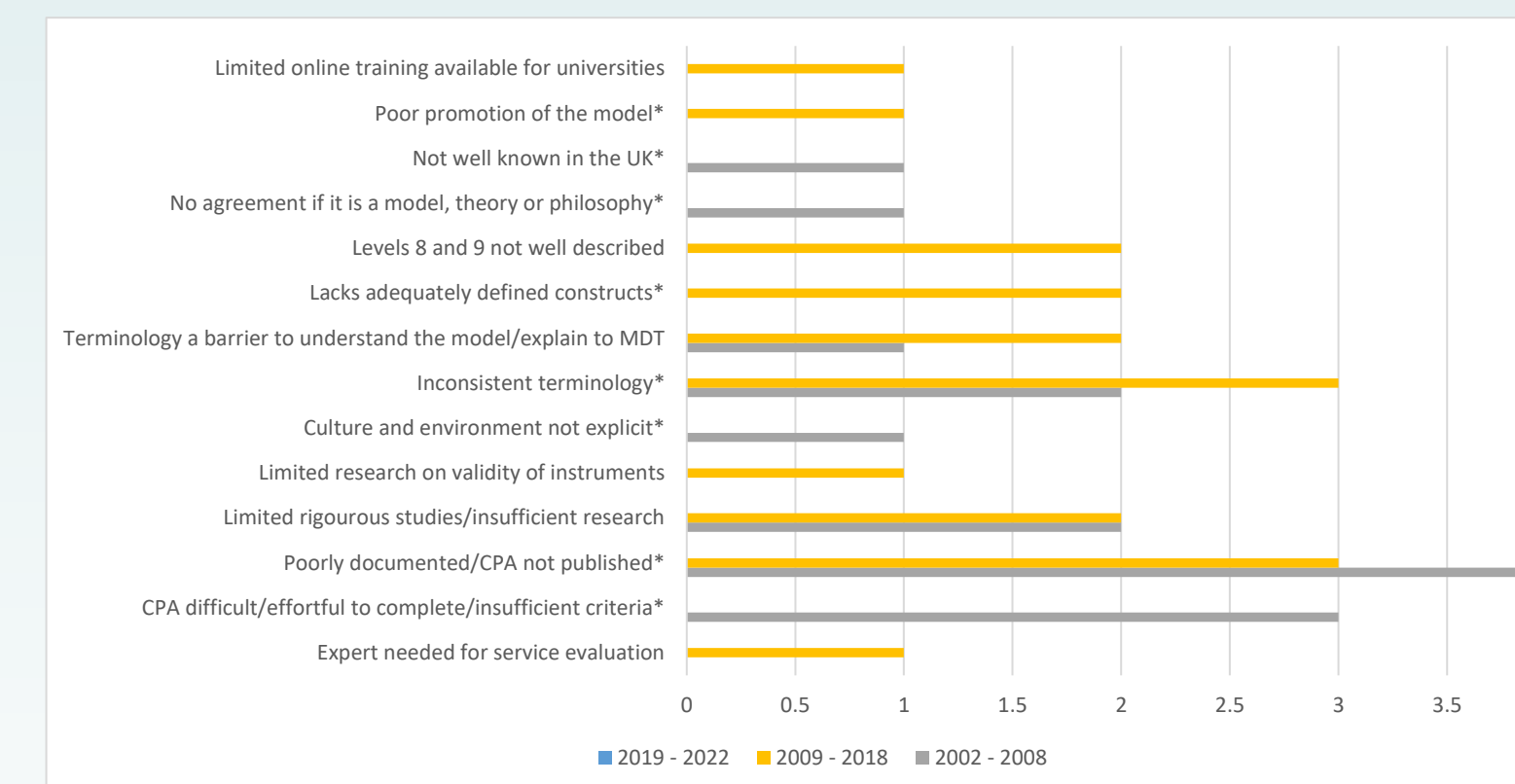


Fig 4 Weaknesses of the VdTMoCA (* weaknesses addressed since 2019)

Study range

A range of research topics were reported (Fig. 5) using a broad range of designs. Measuring change using the APOM was the most studied topic and 50% of the studies were undertaken in the past three years.

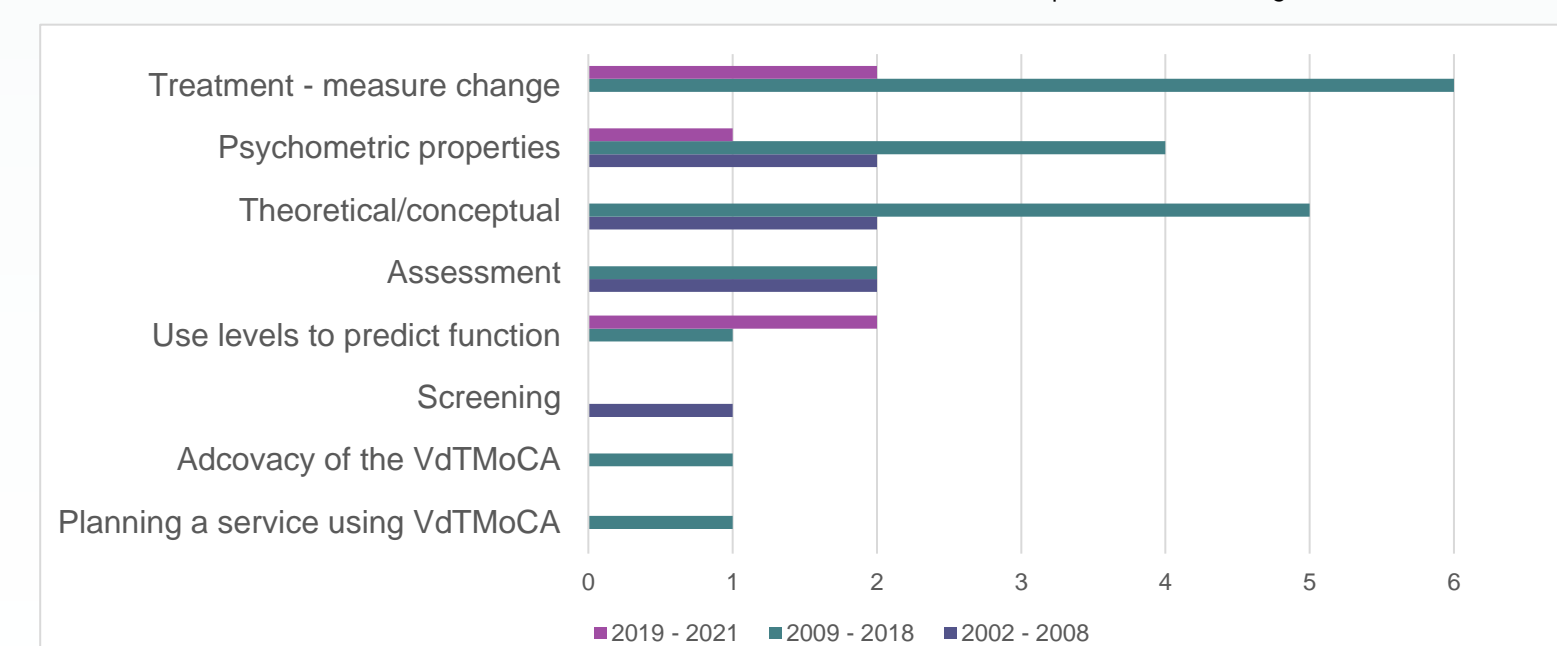


Fig 5 The research topics

Discussion

Effectiveness of the VdTMoCA has been demonstrated through pre-post studies which supported the excellent clinical application of the Model. Unfortunately, no randomised control trials (RCT) to date have been implemented. RCTs are the gold standard of evidence.

One of the strengths is the Model caters for lower functioning clients (Tone, Self-differentiation, Self-presentation) who cannot be adequately assessed with commonly used standardised assessments. Such utility of the Model was often raised anecdotally, regarding both assessment and intervention, e.g. the VdTMoCA guides intervention/rehabilitation at the 'just right' level to promote engagement. The Model's treatment principles are clearly valued, e.g. informing correct therapy presentation and handling. However, evidence for this strength of the Model needs empirical support.

There were no weaknesses mentioned in the period 2019 – 2022. This could be that many weaknesses marked with *, such as inconsistent terminology and lack of publication of the Creative Participation Assessment (CPA) have been addressed with the publication of a VdTMoCA full text in 2019. Nevertheless, research is needed on terminology and constructs of the model. Two terms needing consideration to reflect the client-centred values of the Model are the terms of the phases: therapist-directed and patient-directed. The highest levels of creative ability (levels 8 & 9) are not usually seen in clinical practice but are more likely evident in a minority of people in wellness (Van der Reyden et al, 2019). The need to research and better define these levels has also been expressed (Joubert 2021; Fouche 2021).

Conclusion

The VdTMoCA has developed as a practice model in terms of theory development and application to practice. Its validity has been improved through research into core constructs, psychometric properties of assessment and outcome measurement tools and confirmation of the existence of the levels of creative ability. This suggests the VdTMoCA is on a healthy path with signs of progressing from Lewin's (1947) speculative stage of theory development based on observation and experience to the descriptive stage, researching "what is really happening" (Reed 1984, p. 5), and testing theory. The historical paucity of VdTMoCA research has been addressed to an extent, but there is still scope for research in every aspect of the VdTMoCA. It is noted that there is unpublished research with valuable findings, but non-publication limits the evidence base of the Model, hence Occupational Therapists are encouraged to research and publish.

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