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Learning Through Recreation - An Experiential Report with the Mentally Disabled

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Abstract

This paper is an experiential report of the clinical utility of recreational learning in a group of mentally disabled who had poor attention span, decreased initiative and poor verbal communication. The present paper gives details about the programme. At the end, certain recommendations are made to carry out such programme in a better way.

Key words -
Recreation,
Communication,
Attention,
Initiative

The unique characteristic of occupational therapy is the use of carefully planned activity as a treatment medium. Activity therapy includes the broad heading of pre-vocational training, self care or activities of daily living and social and recreational learning through participation [1]. The present paper is an experiential report of the clinical utility of recreational learning in a group of mentally disabled individuals.

The programme was conducted at the Rehabilitation Centre, a day hospital, at the National Institute of Mental Health & Neuro Sciences, Bangalore (NIMHANS). Details regarding the functioning of the centre, its clientele and staff pattern have been reported earlier [2].

Procedure

Patients were selected for the study through recreation programee on the basis of certain target problem behaviours rather than psychiatric diagnosis. Following a detailed behaviour analysis by the clinical psychologist, patients with the following behavioural deficits were identified:
(a) poor attention span
(b) decreased initiative and
(c) poor verbal communication and interaction leading to a pattern of under-socialized behaviour.

Sample

Although treatment could have been done on a one-to-one basis, a group based approach was selected for two reasons:
(1) the pressure of the time and
(2) because people live and function in a group, learning of social skills can be facilitated.

To enhance the group process it was decided to kept the group process homogeneous and certain inclusion criteria were identified:
(i) All male
(ii) 18-30 years of age
(iii) Kannada and English speaking
(iv) Middle, lower-middle socio-economic status.

Twelve patients were selected using the above criteria. However, the final sample comprised of ten patients as two stopped attending the centre even before the beginning of the recreation learning programme. Six patients had a diagnosis of schizophrenia and four had mild mental retardation. The group had a mean age of 24.75 years.

Methods

All patients were undergoing pre-vocational training in their respective sections. The recreation programme was carried out Monday through Saturday for 1 ½ hours daily in a separate room. The programme was structured and supervised by the occupational therapist. An activity schedule was drawn up which included brush and finger painting, clay modelling, craft work and collage making. One session per week (Saturday) was kept opened for patients to structure their time for themselves.

The actual training during sessions was carried out by various vocational instructors trained in specific skills such as pottery, craft, painting, etc. The occupational therapist maintained an individual case record for each patient. During the first week of the programme, information was gathered about the patient through observation of his participation in the various activities with regard to the following:
(a) his ability to concentrate on a given task
(b) his motivation to attend
(c) his degree of skill and manual dexterity and
(d) his ability to relate to peers and the supervisor.

A qualitative record of progress made on these parameters was maintained throughout the remaining period of the programme. The programme was carried out over a period of six months.

Results and Discussion

The first observation the supervisor's made was that the patients enjoyed the recreation hour. This was

indicated by their coming on their own, often ahead of time, and showing their eagerness to open the lock of the room. Initially patients were engaged in individual based activity which helped in improving their attention span, eye-hand coordination and manual dexterity.

Gradually, they were introduced to work in which they had to participate in a cooperative manner such as one holding a frame while the other hammered some nails in place. Group work was then introduced with two groups of 5 each having to work on making posters or collages. It was noticed that these activities naturally introduced the need for communication and, in their enthusiasm and excitement in doing the task, the patients overcame their anxiety and inhibitions in this regard.

Finally, and what we perceive as being the most important, we observed that patients had spontaneously reported their activities to family members. This in turn, brought family members to the centre who were curious to see what was really happening. Many of the participants expressed a wish to take home something that they had made to "show off" at home. In fact, the response was overwhelming. One parent, a working mother, who had never found the time to come for her family counselling appointments saying that she was too tied up with her dual roles actually took leave to report that her son was making up stories. She broke down in tears as she found that her son too could do something creative. The ice was broken and significant headway made in individual therapy with the mother who had, hitherto, harboured a very negative attitude towards the son. Towards the end of the programme the most noticeable change was the marked increase in self-confidence and self-esteem that the recreation learning programme brought about in the patients.

Limitation and Conclusions

The programme was introduced as an ad hoc experiment in activity therapy without expecting far reaching changes in the social skills sphere. No formal pre and post-assessments were conducted. Experimental reports can, therefore, be biased in favour of over-reporting of positive results. However, from the experience gained we have a few suggestions and guidelines to offer.

We recommend that the recreation learning group comprise optimally of 10-15 patients as too small or too large a group may be counter-productive. The need for a trained mental health professional as a supervisor cannot be over-empahsised in view of the fact that high degree of skill is required to understand the group process and dynamics. The informal and relaxed atmosphere of the sessions facilitated social interactional and encouraged these patients, who were withdrawn, to participate actively. We also observed that several other socially desirable behaviours were encouraged and inculcated in the context of the sessions such as having to wait in turn, following certain rules, having to share materials and tools etc.

The gains made in these under-socialized patients by introducing the recreation learning for just one and a half hour each day has encouraged us to pursue this activity in a more systematic manner. We plan to use formal pre and post-assessments with the next group and introduce a follow-up component to see the generalization and maintenance effects of these treatment gains.

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