



BASKETRY

Then and Now

BASKETMAKING AND REHABILITATION

TIM PALMER

After hearing a presentation about the current use of basketmaking in occupational therapy in France, Tim Palmer was inspired to run some basketmaking sessions with patients at the Stroke Unit at Raigmore Hospital, Inverness.

The history of basketmaking in rehabilitation

In January 2017 I attended the Woven Communities basketry symposium at the University of St Andrews. Florence Cannavacciuolo, a French occupational therapist, gave a presentation on her use of crafts in the treatment of a wide variety of conditions, and the use of basketmaking in particular. She has treated people with physical disabilities, both adults and children, as well as those with behavioural and cognitive problems such as autism and impaired memory. This presentation prompted me to approach the Stroke Unit at Raigmore Hospital, Inverness, to ask if basketmaking was used in a similar fashion in the UK.

Crafts, including basketmaking, have long been recognised as being helpful in the rehabilitation of people with a variety of physical disabilities, most notably blindness. Blind Institutions of various sorts were established across the UK from the late 1800s to help provide meaningful employment for blind people and, until the late 1970s, this generally included basketmaking. The ability to undertake meaningful activity, usually taken to be remunerative work, was viewed as essential to wellbeing. Crafts were also a prominent part of life in the large long-stay psychiatric hospitals founded in the late-Victorian era, together with physical work in the farms and workshops often attached to such institutions.

The First World War saw unprecedented numbers of servicemen returning from the front with a wide variety of injuries, both physical and psychological, and this led to the foundation of many institutions for their rehabilitation.

Image above: Tension trays, square mats and basket bases made by patients at Raigmore Hospital in sessions run by Tim Palmer. Courtesy of Tim Palmer.

Some of these were part of the armed forces medical services, and some were voluntary organisations. Both used crafts as a means of helping servicemen to overcome their injuries or to find a suitable recreation or occupation that took into account their disability.

The experience of Sir Arthur Hurst at Seale-Hayne Military Hospital in Devon, and the history of the (Royal) Star and Garter Home in Richmond, both attest to the usefulness of crafts, including basketmaking, in the rehabilitation of servicemen with disability. Basketmaking was one of the crafts used by Sir Arthur Hurst in his treatment of servicemen with shellshock, and the Star and Garter Home archives make numerous references to basketmaking as one of the activities provided there until the 1980s. Photographs in the archive from the 1970s show the opening of a new Occupational Therapy department, and include some of basketmaking and chair seating using cane.

During the First World War, the Medical Superintendent of the Star and Garter Home included in several of his Annual Reports the phrase:

No case is so hopeless as to be beyond the reach of improvement or relief.

Activities of all sorts were seen to be one of the prime means of effecting improvement and/or relief.



© The Seale-Haynians

Image: The worst cases of shellshock were sent to Seale-Hayne Military Hospital in Devon where their treatment was overseen by the pioneering doctor Sir Arthur Hurst. Percy Meek, left, had been a basketmaker before the war and taught the other patients after his recovery. © The Seale-Haynians.

The Lord Roberts Workshops was another institution arising from the First World War that provided employment for disabled ex-servicemen, including basketmaking. St Dunstan's School for Blind Veterans (now Blind Veterans UK) was also formed at this time, being specifically concerned with the rehabilitation of blind servicemen.

The benefits of basketmaking for brain injury

The most noticeable effect of brain injury is usually a problem with physical activity, but the factors underlying this are more complex than is often appreciated. Performing any task requires a series of sensory inputs to the brain, modulated by thoughts and intentions, which produce a motor response. This response is then modified as a result of further sensory and cognitive feedback. Both sides of the brain are involved, and have to coordinate with each other at both a sensory and motor level. Certain areas of the brain are highly specialised and damage can lead to very specific defects. Just as moving the right side of the body is the result of left-sided brain activity, so cognitive functions are distributed unevenly between the two sides of the brain.

Basketmaking involves complex motor activity which requires cooperation and coordination between the left and right sides of the brain, fine motor skills, and a variety of sensory inputs – predominantly touch and sight, but also hearing, temperature and smell. There is also significant cognitive activity. Understanding instructions on how to make a basket can be difficult even for people with normal brain function. Basketmaking makes considerable demands on recognition of visual, numerical and motor patterns. The sensory inputs and the higher brain activity together have to control the sequence of actions, passing instructions from one side of the brain to the other in sequence.

Basketmaking can be carried out at many levels, imposing different demands on the brain. It is possible to devise exercises that are relatively simple but still produce completed pieces. This is very important, because much of the benefit of physical activity in rehabilitation is from the sense of achievement, progress and regaining of function that comes with success. These positive emotions are reinforcing, encouraging further activity and progress.

Working at Raigmore

After approaching the Stroke Unit at Raigmore Hospital, a consultant in rehabilitation undertook to identify patients with brain injury who would benefit from basketmaking, either to alleviate boredom or with the aim of helping their recovery. It was agreed that I would be independent of the occupational therapists, physiotherapists and nurses, who were all already fully occupied. I would aim to provide one two-hour session per week, generally working with two patients at a time. I would provide the materials and any equipment needed.

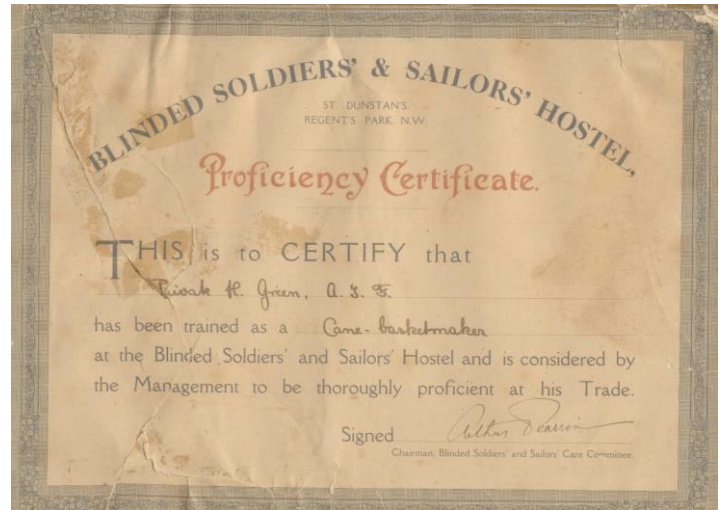


Image: All war-blinded servicemen were sent initially to St Dunstan's School for Blind Veterans. They started by making string bags and were then taught basketry by blind teachers. © Blind Veterans UK.

I set two simple tasks that involve the use of both hands – together and in sequence, alternating between right and left, and pattern recognition. The first was making a tension tray and the second a square base. Both can produce a finished piece in one session. The tension tray also opened up the possibility of making a small bowl by using the tray as a catalan base. Both tasks proved sensitive indicators of cognitive ability and of fluctuation in clinical state. Improvement can be measured in a number of ways, including the time taken to produce a finished article, the ability to use heavier willow, the error rate (particularly later in the session), the neatness of the work, and the ability to identify and rectify mistakes.



Image: One of the patients at Raigmore Hospital progressed from tension trays and square bases to using centre cane on a round base. Courtesy of Tim Palmer.

To date, I have worked with six patients. Some have had predominantly cognitive problems, while others have had problems which are more physical in nature. Two of the patients had little physical disability, and cognitive impairment was the main problem. For them, grasping the fundamental principle of a tension tray was not difficult, but consistent application of the rules was. I found working with the patients with physical problems more of a challenge because of the cognitive problems that accompany the disability. Many of the patients valued the sessions and felt their mood improved as a result.

The value and future of basketmaking

The patients who took part were all enthusiastic about it, despite the difficulties they have. They recognised the possibility of improvement through the activity, and when they had completed a piece they were proud of their achievement, recounting with pleasure the reaction of relatives and friends. The clinical psychologist attached to the ward also reported improvements in the patients doing basketmaking. The performance of the majority of patients improved over the sessions, although significant clinical deterioration took place in one. Despite this, and the increased difficulty experienced by the patient, he was keen to continue with the exercise.

Cognitive difficulties have proven to be the biggest obstacle to progress, and the approach to the tasks had to be adjusted to take these into account. A tension tray is a more complex task than making a square base from a cognitive point of view, but physically a tension tray is easier if there is a significant arm weakness.

The ward staff have been very supportive and encouraging. There is always the worry about trespassing

on professional territories, but this does not appear to have been a problem. The reaction from patients not involved was positive, even envious in some instances, and the encouragement from fellow patients is important. Egos, battered by the assault of brain injury, are supported and bolstered by this encouragement and the achievement of producing something that is evidence of continuing usefulness.

The value of basketmaking would be enhanced with more frequent sessions, but this requires a space in which to do it and people with experience and knowledge of basketmaking to help. Two charities, one local and one national, are interested in helping to provide continuation sessions, and there are some interested basketmakers in the Highlands. The next challenge is to train volunteers to supervise simple basketmaking tasks in the hospital, and to organise a community network of basketmakers and volunteers with facilities that would allow patients who have started making in hospital to continue to do so after discharge.

As ever, demonstrating added value of an intervention is key to securing funding for a service. This is another challenge, and one to be met by developing a combination of qualitative and quantitative assessments.



Image: The Amity Club was founded by Margaret Fulton and Mary Esslemont in 1950 to provide ongoing support for female psychiatric patients after they had left hospital. Basketmaking was one of the activities they undertook at their weekly meetings in Esslemont's dining room. © Catherine F. Paterson.