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Stretching the limits of cognitively disabled performers through dance/movement therapy

By: Dr. Prof. Rob Baum, Primary Health Care Directorate, University of Cape Town.

Stretch was a long-running theatre collective of cognitively and physically disabled adults in an Australian community centre. Historically directed by a dance/movement therapist, Stretch has emphasized therapeutic processes and social interaction over performance quality.

The new director's mandate to integrate the group presented many challenges, including issues of disclosure, privacy, competition, and access. But integrate Stretch and its new inclusivity radically and positively affected political and social awareness, while boosting group morale and aesthetic quality, as an international performance showed.

Keywords: Dance/movement therapy, intellectual disabilities, integration, dance/theatre, community.

Introduction

The subjects of this article are integration of non-disabled with disabled individuals in a performance group and utilization of dance/movement therapy (DMT) to help generate contemporary theatre. The model for integration is a performance collective formerly known as Stretch, comprised of cognitively[1] and physically (mild to severely) disabled adults. Initially organised in the 1990s with weekly meetings and bi-yearly performances, this group is one of several innovative programs facilitated by an Australian community arts centre. The article examines techniques drawn from DMT and other therapeutic art forms, and the possibilities for creative arts therapies that lie in their interconnectedness. It reflects upon principles and politics of care in disabled populations in Australia, with the hope of sparking interest, discussion and comparative examples from dance movement therapists, theatre directors and disability arts workers. It also details major changes in the Stretch collective’s structure, how they affected us, and the accomplishments of members individually and collectively. Although the account derives from my own work in Australia[2], the issues addressed affect many world communities, perhaps in particular nations with socialised medicine and palliative care.

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[1] Although physical disabilities are sometimes differentiated, for instance, as ‘acquired,’ ‘congenital,’ ‘mild to severe’ or ‘progressive,’ people with cognitive disabilities are generally lumped and dumped into a single programme and setting without apparent regard for difference. It is not differentiation in nomenclature, but recognition of vast difference in need, that would be useful in developing appropriately stimulating programs. Thus I have been handed (and led) a single ‘cognitively disabled group’ comprised of people with Asperger’s, severe autism (non-verbal, low-functioning), behavioural disorders such as random physical and emotional violence, bi-polar, schizophrenia, Down Syndrome, and Turner’s Syndrome. I have also worked in aged care, in a programme that included people living with dementia/Alzheimer’s as well as people who were fully switched-on and competent, Down Syndrome, and young but with Alzheimer’s .

[2] I worked with the group from 2005-2009 inclusively (five years).

Setting

The setting is one of the more prominent and progressive community arts centres in Australia, the group one of several innovative programs facilitated by the centre. Originally advertised almost 20 years ago for people with intellectual disabilities, the program still boasts many of its founding members; thus Stretch Theatre is less a class than a club (without its own clubhouse), usually meeting in the Basement Theatre of the Footscray Community Arts Centre's Victorian manse. It has developed into a performance collective of people with cognitive, behavioural and physical (mild to severe) disabilities, generally ranging in age from 22 to 55. The group is an after-hours activity, meaning that some members attend after working day-jobs—always something to celebrate in a world where people with disabilities are often overlooked—as people as well as employees. Timeliness, safety after-dark, and watchfulness are therefore other critical issues we address in our sessions.

The Work

In addition to the movement spectrum typical of dance/movement therapy, with Stretch I worked on memory skills in verbal utterance and physical gesture, consonant replication of movement (relative mirroring), improved physical strength and flexibility, and—perhaps most importantly—the ability to effectively translate and transport the products of improvisation into quotidian life. Most of these tasks are accomplished through games inserted into the warm-up or subsequent activities; most can also be worked on at home, should the member have the discipline to continue to work outside the group, or a carer to support the exercises off-site. When an activity or action meant to be successively repeated is introduced as a game it is often more palatable—and fun. This is the reason for theatre games, which have as their continuing outcome the learning of skills or patterns.

Group History

Before I can address the structure and politics of the collective, I must move backward: there are two immediate issues in dissonance with the purpose and function of this group. First, although the collective is considered a community-based theatre group, ostensibly dedicated to learning theatre techniques and making theatre, in fact the group's leaders have always been dance movement therapists with backgrounds in theatre. Although this may not have been the conscious intention of the program facilitators at this community centre, it is no coincidence that the majority of the Stretch members are and have been non-verbal, or at least non-verbally proficient and comprehensible, and that dance is the theatre art (Cohen, 1975) *par excellence* of corporeality, intrinsically therapeutic and historically non-verbal.

Why is this significant? First, with its roots in the study and performance of dance, dance/movement therapy (DMT) is a psychotherapeutic modality dedicated to utilising non-verbal media. The possibilities of abetting an individual's expression and repertoire through DMT are therefore demonstrable (Wiener, 1999) as well as enjoyable. Consequently, the centre's engagement of theatre professionals skilled in non-verbal work has resulted in the employment of a DMT to run the sessions. But as a result, the primary and overriding concerns of the instructors involve the psycho-social needs of the participants rather than (only) their dramatic capabilities, and include a desire for increased movement repertoire, range of motion and stability; enhanced self-esteem, and constructive body image—in short, the customary purview of a dance movement therapist rather than a traditional theatre director (Chodorow, 1991; Costonis, 1978; Espenak, 1981; Bloom & Stevens, 1998). The transformative qualities experienced in the theatre are also a core element of DMT (Lewis, 1993) and a combination of DMT and theatre techniques can produce a critical performance ethic alongside desirable behavioural changes. Thus the presence of DMT in the performance collective shapes theatre training as well as production of the work and, more importantly in my opinion, the individual as a member of society. This is not the customary domain of a theatre director.

Second, although it may not always have been the case, the group is today composed of members whose enormous challenges are visibly physical as well as intellectual. Under my direction members' *physical* abilities received as much attention as their *cognitive* abilities. This is partly due to my own background, including a life of performance; 20 years of teaching expressive movement at tertiary level[3]; a number of years of volunteerism with Wheelchair Athletes, Special Olympics, and psychiatric ward recreation programs; and ongoing training in diverse performance modalities, most lately theatre improvisation (apart from my ongoing study and practice of dance/movement therapy). It is also partly a result of Australian laws that protect individual privacy, and the concomitant refusal or failure of individuals and organizations to disclose disability issues of all kinds (Oliver, 1984); that is, the Australian *milieu* greatly determined procedure and process in my clinical practice. Liability, already a thorny legal issue, becomes in this way an omnipresent ethical, medical and security problem that threatens to close down programs and possibilities in Australia. Disability, however, becomes an open secret, the details of an individual fiercely protected by a benevolent government that does not admit the difficulties of providing disability care without informed methodology (Oliver, 1984; Davis, 1995; Morris, 1991).

The categories of disabilities, impairments and handicaps (HID) are relative concepts, socially defined: although the deaf are impaired or handicapped in most hearing communities, the hearing person who knows no sign language is handicapped among Deaf. HID may be acquired at any time in life, through injury, illness or by simply aging. HID may also be resisted, ignored, abused, exacerbated, denied or overcome. (Many learning difficulties/disabilities constitute a reformable impairment, for instance those responding to Slingerland.) Apart from reform-able HID or treatable illnesses, the notion of 'overcoming' HID is anathema in disability discourse. A Human Resources Equal Opportunity Commission study reported the most crucial HID issues as social access and peoples' attitudes (Harris, 2004). Self-awareness of impairment is often the insurmountable condition and may lead to depression or death. The landmark legislation of Americans with Disabilities Act of 1990 :

> acknowledges that disability depends upon perception and collective judgment rather that on objective bodily states: after identifying disability as 'an impairment that substantially limits one or more of the major life activities,' the law concedes that being legally disabled is also a matter of 'being regarded as having such an impairment.' Essential but implicit to the definition is that both 'impairment' and 'limits' depend on comparing individual bodies with unstated but determining norms, a hypothetical set of guidelines for corporeal form and function arising from cultural expectations about how human beings should look and act (Thomson 1997: 6-7, citing *ADA 6*).

Refusing the medical model in which disabilities require treatment, disability discourse helps to generate an overdue concept of disabled people as well, whole and functioning (Fletcher, 1974). But when applied to real situations, the result may be a mental (and potentially legal) nightmare. Students in university programs are placed at risk each semester by policies of mainstreaming in which many disabilities are (expected to be) ignored; these include diagnosed and undiagnosed physical, intellectual and psychiatric disabilities. A legally blind student walked into scaffolding and lighting equipment, and fell after climbing a short platform; a schizophrenic student frightened rehearsal partners with her violent behaviour; a student with an (unknown to most) acquired brain injury committed suicide as she became well, leaving classmates awash with guilt and sorrow. In each of these cases, departments are obligated to accept and include students, maintain confidentiality about issues, and provide adequate duty of care. Yet, few professors have received (or sought) any training in disability issues—let alone psychiatric care—or have an understanding of appropriate methods to contain mental disturbances while

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[3] As part of my 'day job' (academic) I teach expressive movement to students who are primarily interested in learning to act—or rather, to become professional actors and actresses, which is (unfortunately) often not the same thing. Most of them actually want to practice or, in some cases, learn techniques for being other people. What they are instead confronted with is a class dedicated to being themselves. This can be daunting. We work a great deal with body image, developing power, strength and agency in addition to grace and personal connectedness. Creativity is a given—invariably present, but requiring various means to be unlocked.

protecting the entire student population[4]. Don't mistake my intention: as one who has trained in and continues to study disability issues, I believe fervently in inclusion. But I also feel that the system (in all its complexity) has an obligation to competently and sympathetically support students with special needs, and that this must be mandated in any inclusion policy. Otherwise, 'mainstreaming' becomes synonymous with 'survival of the fittest.'[5]

When applied to the elements of community theatre, failure to disclose or equip those in charge could be disastrous. In the Stretch community program, there are generally 15 members present at any time, engaged in significant physical, emotional and psychological work. Without receiving even the most rudimentary information about the members (who are my clients), I am more likely to place them and others at risk. To my surprise, I discovered that even a community organiser overseeing the program had not been given vital information about clients' medical realities (e.g., who is on medication, why, how much and how often; who is prone to *petite mal* or *grande mal* seizure disorders, high/low sugar levels, or bi-polar mood swings; what side effects medication or other treatments have produced, including involuntary twitches, grimaces and violent interactions; potential problem behaviours and their appropriate handling and de-fusing). Quite recently members of the collective were asked to provide details of medication and medicalisation in writing, and this picture was made available to me. That this didn't occur earlier—despite the fact that some individuals come unaccompanied by a carer, and that this program takes place in the evening after the rest of the centre has closed—is a curious gap between law and jurisdiction. The written notifications were a result of my responsible relationship with the centre (responding to my requests), but also challenges the group had already faced (responding to my difficulties). I was fortunate to work under people capable of making major changes (as I demonstrate later in this text).

Here are a few examples of this gap from community programs with which I have worked.

One male member had 'episodes' lasting from two seconds to two minutes. He suddenly and spontaneously stopped speaking or moving, and seemed unresponsive to all external stimuli. (I say 'seemed' because there remains no professional verification of any medical issue; the member's disabilities are the only known 'issues' attached to his medical profile.) In each case, he eventually and rather casually recognised me and rejoined the group activity without any apparent notice or memory of the incident[6]. Over one four-week period I noted a weekly increase in the number of episodes and reported them to the program facilitator as well as his carer. Neither one could tell me (because they didn't know) whether he had epilepsy or some other disorder, or whether the issue had ever been diagnosed or examined by a medical doctor**.**

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[4] Dancer Marian Chace developed dance as a therapeutic modality in the 1940s; in 1974 the new American Dance Therapy Association defined the discipline as 'psychotherapeutic use of movement as a process which furthers the physical and psychic integration of an individual' (Stanton 1). Modelled on humanistic psychology, DMT enables expression through movement and manifests respect for and belief in clients as catalysts in their own healing. Other creative arts therapies (music, art, drama) encourage access to emotional expression through artistic process, but may require professional 'unpacking' or mediation; psychodrama, for instance, relies upon verbalisation. In DMT the incorporation of psychological experiences promotes healing (Fletcher 1974); thus DMT may be sufficient without adjunct therapies, particularly for the non-verbal—as Chace's early work with locked ward schizophrenics shows (Fletcher 6). Nonetheless, many DMTs augment their clinical practice with other creative arts therapies.

[5] For instance, the social model of disability deems normatively constructed environments as disabling for people with disabilities (I am including here people with impairments and handicaps). Seeing the discursive parallel between female and disabled bodies, disability feminism considers the effects of disability on people's lives.

[6] For invaluable help in negotiating this bewildering complex of responses, or non-responses, see Kalish, B. (1971) 'Body Movement Therapy for Autistic Children,' Proceedings of the American Dance Therapy Association; and Leventhal, M. B., ed. (1980) Movement and growth: dance therapy for the special child, Symposium on Dance Therapy for the Special Child—New York City 1979 (New York: Graduate Dance Therapy Program and the Department of Dance and Dance Education in the School of Education, Health, Nursing, and Arts Professions of New York University).

Another member, a young woman with Down Syndrome, had ‘episodes’ of a different nature. She might suddenly sit down during or after a physical activity, completely incapable of articulating her distress except through the physical symptoms of over-exertion. After several repetitions of this behaviour I intervened and she was taken for testing. It was discovered that the young woman was diabetic. It was unclear, however, whether the episodes were a result of disease or her poor physical condition (weak heart and obesity, issues commonly found with Down).[7]

In a (day-time) program, an autistic client showed sudden outbursts of violence. On one occasion, he became violent with a female client, damaged another person’s possessions, and ran away from the centre as we neared the end of our (five-hour) day. Shortly thereafter, upon arriving early and finding him outside, his parents were furious because we had ‘allowed’ him outside without supervision. (He had actually managed to imprison us in the building, which was then undergoing renovation; this was evidence of his cognitive capacity to strategise, as well as to manipulate; see Adler 1968.) The parents not only took no responsibility for their son but also promptly rewarded him by taking him out to tea! Now that we were aware of the extent of his behaviour (and the parents’ complicity) we might have worked more productively with him. But unfortunately his parents used this as an excuse to remove him from the program and keep him at home, against the advice of social workers.

There are many such examples, some more grave: the worst occurred in the general, mainstreamed population at a tertiary institutions, where a failure to report chronic fatigue, panic disorders, schizophrenia, or even anemia has resulted in fainting, disruption to classes, and the need for emergency services. In one case I encountered in New Zealand, a man with a known psychiatric issue was withdrawn from institutional care in an effort at mainstreaming, and subsequently set his family’s house on fire. Ostensibly, mainstreaming follows disability politics of inclusion, but in reality it can be guided by economic pressures on facilities.

New challenges

Because of my extensive background in theatre and movement, ongoing community engagement, and life experience with disabled communities, I was invited to work with the Stretch collective when their dance/movement therapist moved on after 10 years of dedicated and successful work. As the new director of the company, I was asked to fulfill several entirely new requirements: to include practitioners of other art forms in the group’s training schedule, artists who would lead the group for two or more weeks in succession during a term of about 10 weeks; to focus on techniques that could lead to presentation of entertaining work, thus sustaining current funding and perhaps attracting more; and to integrate the regular membership with non-disabled people (Davis, 1995, Tregaskis, 2004), drawn from the community. Before discussing the members’ development in the new program, I will examine these tasks and the problems they introduced.

Initially I felt challenged and discouraged—challenged by the need to teach and develop techniques in a group with severe cognitive disabilities, and discouraged by the apparent desire of the community program’s facilitator to discard a dance/movement therapy approach and replace it with community theatre practice (Goodill, 2005). I was also aware that while the members might articulate a desire for (unspecified) theatre skills, they might actually derive more physical and psychological benefit from dance/movement therapy; they had, after all, worked with the same DMT for 10 years, many of them from the program’s commencement. For me to ‘acquire’ a working group with such a long history together was a difficulty in itself: group dynamics and behaviours, including some violence, were well established and entrenched. As I later discovered, the gender imbalance — of the then 12 members, eight were male —would generate other issues (Meekosha, 1998: 163).

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[7] These appear syndromic but are not ineradicably linked to Down, as I have seen in individuals whose families actively resisted the physical and cognitive limitations of the Syndrome (see Hilyer 1993).

The task of bringing in other artists to work with the members presented an additional strain. How was I to keep the program's structure intact when unknown others would be placed in interim leadership roles? Should I be present during the weeks that others ran the program, and how would that affect the members and other leaders? Would those practitioners know how to work with a group of cognitively disabled adults, or simply apply their customary methods of teaching to this group? Could they work therapeutically with the group—and should they? And, during the periods that the members were practicing other art forms, how would I achieve my greatest responsibilities: maintain a useful and healthy presence, ensure the members' emotional and psychological safety, keep the group together, and sustain our therapeutic results?

Although these requirements produced weeks of agonised thinking and planning, they were actually not the most difficult of those set before me. I was initially most concerned by the facilitator's decision to integrate this small disabled community, and what that might mean and do to the collective already in place (Oliver, 1984). In my journal, kept for my ongoing professional DMT supervision, I wrote the following passage under the heading 'Politics:'

…I feel tension between wanting to use dance therapy and being pushed to run a performance ensemble; I am also concerned about the facilitator's intention to integrate the group (with NUNS).[8] I am worried because although this suits the political imperative to create inclusive environments, it is at the loss of a rare exclusive group for cognitively disabled adults. That is, the push towards inclusion is happening at the needy end of the spectrum, not among able populations. The delicious and sensitive skills of the members may well cave in when they are in the general population. As with my NUN groups I do not perform for them but only witness: I do not want my movement to become a model for what is 'right, normal or desirable' (Notes, 13 August 2005).

But the issue was not in my control: at this point the group, which had met for its 10+ years under the name 'Stretch,' was renamed 'Integrate' (subsequently modified to 'Integrate Stretch'). By order of the program's facilitator, we were now integrated. The group was expected to take in non-disabled people from the community, and I was obligated to integrate them into our training, practice, rehearsals and productions. My primary fear was that disabled members would be disadvantaged in this mix (Fries, 1997).[9] I had seen how such a policy of inclusion had played out in a physical theatre group of non-disabled women: despite the professed feminist politics of inclusion and equity, the smaller, slimmer, younger and stronger women were given better roles, more activities and greater prominence than the large, overweight, older or 'differently-abled' women (Hilyer, 1993; Morris, 1991). How much more likely would it be to see privilege in an integrated company? And how would I be able to strategise training directed at bodies in struggle and people with cognitive and processing problems, while managing to engage the attention of new, non-disabled members?

I speculated that I would be forced to jettison the dance/movement therapy component of the work, focus solely on theatre technique, and drag along the original members—or marginalize them as non-disabled members caught on to the theatre exercises and speedily surpassed them. (In fact, I privately believed that part of the *point* of this move towards integration was to remove a therapeutic *motif* from Stretch). But something quite different was to occur.

Since assuming leadership of Stretch, I had permitted the non-disabled people (carers, parents and adult siblings) who accompanied the group's members to come in and view the night's result, generally a series of improvised performances. This was a novelty, as the drivers had been accustomed previously to sitting in an anteroom for the entire two-hour

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[8] The term 'normal urban neurotics,' or 'NUNS,' is commonly used by dance/movement therapists to describe so-called 'normals' (neuro-typicals), or a seemingly unaffected, non-medicalised population.

[9] I had enjoyed a previous placement with Gawith Villa, a residential institution that had recently closed down its own specific art programs for disabled people in order to integrate their residents into mainstream programs. While I understood and agreed with the policy, the effect was that many disabled residents were left without appropriate, accepting community arts groups which with to participate.

period of the class. In September 2005, I received the mandate to integrate the group. At first I watched in trepidation for an influx of non-disabled community people. There were none—yet. The following month I became pro-active, inviting caregivers and interested visitors to participate in the entire night's program from warm-up to closure. From that time, non-disabled people shared in the session's dance, theatre, singing and drawing and (if chosen by the original members of the group) became partners in short forays into storytelling through theatre and movement improvisation. The original members maintained the majority control and voice. As it turned out, the non-disabled joiners were all quite happy to fit themselves into this fun, cohesive — and inclusive — club.

My invitation to the caregivers accompanying the disabled members both fulfilled and subverted the program facilitator's objectives for the group: I made no initial overtures towards 'unrelated' non-disabled people, whose objectives might overtake my own in providing a safe, unchallenged place and time for members to enjoy creative self-expression; therefore all non-disabled participants had either training or experience in living with or caring for people with intellectual disabilities (Bogdan & Taylor, 1989). As an unplanned side effect, this informed and improved my abilities in the population. Although ostensibly working towards artistic technique with a mixed abilities group, I structured DMT exercises and interventions (Levete, 1982; Payne, 1992) in which caregivers could also participate and explore themselves in the present—sometimes forgetting their professional roles and responsibilities to members, which had a positive effect on all of us. Most significantly, their increased access to the exercises and concepts in which the group engages empowered the caregivers to work at increasing range of motion, sociability and self-esteem in the members outside our group sessions, in their care homes—as well as in themselves.

Two professional caregivers (who between them were responsible for four of the regular members) regularly reported on their facilitation of our interventions at home, and the results of their continuous work were readily discernible in the abilities and positive outlook of the members they brought to sessions. Similarly, two members who live with their families (one of whom was accompanied to sessions by a parent) made no progress between sessions. It became clear that their parents (including one who joined us) were not comfortable with changing the situation as they had come to know it.

Barbara Hilyer (1993) notes that mothers of children with disabilities are often blamed for the existence or degree of the children's disabilities, lack of independence, failure to thrive, or inability to progress or respond adequately to treatment. But the same mothers may embody their sense of guilt and grief by inadvertently contributing to the disability—doing for the child what the child can do for itself; such behaviour may result in adults with relatively few usable life-skills, such as the ability to take in laundry, make dinner, or even assist in a rudimentary way. In the Stretch group, for example, only one individual lives independently (in an apartment of the house occupied by his mother). From this apartment he visits his mother for meals about half the week, but also enjoys making some of his own meals in his part of the house, lightly combining pre-mixed foods but also cutting vegetables and cooking them. Of the other men in the group two live conventionally at home with their parents, and the rest live in group-houses.

Initially the non-disabled attendees were restive; they complained about the physical or psychological demands of the exercises, and were inclined to take copious breaks or hang back. The new nightly command 'Ok, now everyone roll your eyes at me!' came in response to a carer's displayed lack of self-confidence. In particular, the carers in attendance showed their own stage fright, personal inhibition, and coordination issues. As the months passed, the carers became more skilled (but the disabled members had more training and were predisposed to the work), more interested and more flexible (but did not approach the ease or grace of the members in improvisation); they (like the original members) looked forward to coming to Stretch. Some carers came to sessions even when their clients were too ill to come! In my last two years with the group we absorbed several non-disabled people who came on their own, unattached to a program of care, and who stayed because they liked the atmosphere, the people, the training, and the freedom of not being perfect. Eventually I felt comfortable in inviting others to join us, such as tertiary students, arts practitioners and people simply seeking a dance class. The members hadn't changed their values: it is I who had learned, become comfortable with their generous and inclusive nature, and recognised their capacity for holding their own in an integrated setting.

Thomson hopes to 'move disability from the realm of medicine into that of political minorities, to recast it from a form of pathology to a form of ethnicity' (Thomson, 1997: 6). This would suit the attitude expressed by Integrate Stretch where we were able to include and show sympathy towards even the very challenged, *non-disabled* participants, and together create a sense of a whole, a funny and fun-loving collective. Because the greatest irony was that the non-disabled people who joined the collective did not arrive with or show the talent of the disabled members. I know, of course, that the term 'talent' is not thoroughly germane (or used) in a disability context. But in the realm of conventional theatre practice, in which I was trained, learned to perform, and continue to teach, the term has meaning.

I think it is important, here, to distinguish the original members from a generic disability context (which does not actually exist, but is assumed to exist). The people admitted into Stretch were, historically, people with intellectual disabilities, but the people drawn to the group were also already interested in and predisposed towards performance and its particular contexts. They leapt up to improvise; they joined in singing with the music during tea-time; they insisted that I watch them negotiate an exercise; they showed off for each other. Performance is a context in which they excel and exult, and the infusion of non-disabled others (which in other populations would have been seen as an intrusion) is one they are exceedingly patient in accommodating. In particular, the disabled members do not seem to mind, or notice, that (for example) we often need to repeat the choreography[10] because the *carers* have mixed it up.

Performance aesthetic

In speaking (essentially, complaining!) about the political exigencies I was forced to master, I have not yet spoken of the performance *ethos* exhibited by Integrate Stretch. Prior to my association with the group, performances were not so much built as derived, usually from the spontaneous, improvisational material of the members.

> The move towards de-institutionalisation has thrust [disability] populations into mainstream programs and facilities, a trend towards 'integration' of [disability] with non-[disability]. This trend eventually found its way into performing arts, where it manifests in new structures of performance, innovations in embodiment representation, and a potentially wider audience base.[11] The confluence of wheelchair-bound, deaf, blind, cognitively impaired and able-bodied performers by its sheer representational nature results in new performance styles; secondarily, the appearance of chairs, walkers, canes and other orthotics, creates new possibilities for choreographic shaping and theatre blocking, character development, stage signage, performative symbolism, and dramatic meaning (Britain's White Paper, 1989).

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[10] By 'choreography' I mean, in a general sense, both choreography devised for the group (by the members and/or by me), and the choreography of folk and period dance. In my third year with Stretch, I increasingly incorporated steps and sequences from square dances, circle dances, or contra-danse in general. I began spontaneously one night, using a circle dance, as a means of explaining a type of coordination, and expanding bi-lateral motion. I thereafter made these dances a constant feature of our work, following Marion Chace's incorporation of circle dances with psychiatric populations, for purposes of concentration, coordination and (yes) beauty. See Sandel, S., Chaiklin, S. and Lohn A. (1993) Foundations of dance/movement therapy: The life and work of Marian Chace (Columbia, Maryland: The Marian Chace Memorial Fund); Schoop, T. (1974) Won't you join the dance?: A dancer's essay into the treatment of psychosis (New York: Mayfield Publishing Co.); Stanton-Jones, K. (1992) Dance/movement therapy in psychiatry (London: Tavistock/Routledge). Chaiklin notes that the circle dance although used prolifically by Chace did not originate with Chace (workshop with Chaiklin 2007), a reminder that there are other aspects to explore in dance, choreography, and simple shaping..

[11] For a critique of the actual audience composition, see Gabb, K. (2003), 'Theatre and Disability,' Arts Access Blue Page (Melbourne: Arts Access).

In our first performance under my direction, I followed this model so as to see and assess the performance outcomes *as performance*—that is, rather than as disability theatre. What I saw was often funny—because several members of the group are themselves funny, and because the unplanned nature of the 'sketches' includes members running on during or otherwise interrupting other members' improvisations. This is sometimes considered a form of humour, even 'gallows humour,' which is reliant upon rather than refusing of difference.

Curiously, although these may be acceptably humorous features of theatre improvisation (depending upon the culture of a given group) they were not felt to be appropriate by all the Stretch members—demonstrating the individualism and difference within a group of long-time friends. One man, in particular, who rather than improvising on class night worked diligently at home to craft a narrative in mime, expressed feelings of insult when another member burst onto the stage during his 'story,' in order to upstage him by running, screaming, beating her chest, then turning to the audience to elicit applause. He had apparently endured this sort of behaviour from her (and perhaps from others in the group) for years (hence my earlier reference to the group's entrenched unproductive behaviour). As he worked at developing his theatre/movement skills, he desired to show them without the show-stopping entrances of another member. He considered himself a professional artist, and even took to coming to class in a kind of uniform to signify that he was a mime.

Although I had radically managed to shift the structure and dynamics of the group, I was unable to completely eradicate this behaviour. We returned to this subject a number of times, sometimes using psychodramatic techniques (both these members were largely non-verbal) to help them express their needs to perform and be seen. From one showing I discovered that the mime was seen as the younger brother in this group, and therefore had not received the same respect from the older members. He would eventually decide — by himself — that what was required was to leave this 'family' and establish a new one, a departure that was deeply painful for all of us.

But I also saw the possibility of changing the codes. In order to train the members in theatre etiquette, as well as theatre technique, I broke the mould of one-two person improvisational vignettes, and introduced a through-composed work in which all members participated at the same time. As my personal performance interests in theatre tend towards contemporary theatre[12] influenced by practitioners such as Twyla Tharp, Robert Wilson, Romeo Castelucci and Pina Bausch, I experimented with tempo, gestural language, spatial dissonance, and abstract dance/ movement.

The members' intellectual disabilities did not warrant an unprofessional attitude towards what became known in our group as 'the work.' Members were encouraged to arrive on time, work quietly on the evening's techniques, cut loose during a 'release' period of free dance, and remember the work in successive weeks—the responses I require at university or in professional work. The results were extraordinary (or so I thought at the time): they behaved very much like my tertiary students. Thus I finally learned that difference is a construction.

The members were also capable of greater creative capacities than I had previously seen displayed. On the night of one performance in 2009, in fact, I did the unthinkable: uncomfortable with the feel of part of our existing 25-minute work, I took out a movement segment from the middle, and introduced a new movement segment to replace it. When I made the change, the movement replacement was still in the form of an idea rather than specific gestures. What's more, we did not have time before the performance to practice it, and so I was forced to explain where it fit, and in a minute or two convey the idea of what would later consume about five minutes of movement in the middle of the piece.

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[12] For a comparison of new disability practices in contemporary theatre, see Kuppers, P. (2003), Disability and Contemporary Performance: Bodies on Edge (New York:Routledge).

I had been instructed, repeatedly, that people with intellectual disabilities cannot handle change. And I was aware that professional actors would have found this rapid, almost haphazard, change in the middle of a piece—without even a rehearsal—daunting. Imagine my surprise when everyone remembered the new bit when we came to the spot, took it on, and ecstatically performed it! In retrospect, I realized that we could have continued that new section much longer, as it was so well received by members and audience alike. We were a wild success.

But at the time I was still amazed at the unexpected cognitive abilities of the group, the flexibility of the members in the face of new work, the admission of stage fright yet the exhibition of professional deportment, and the way in which the whole piece hung together despite some very last-minute tinkering on the part of the director. This experience would radically transform my paradigm for working with people with intellectual disabilities. Hence the 'limits' of cognitively disabled performers (as suggested by this article's title) are actually limits *on* these performers—placed externally, that is, by the society in which they live. Their greatest gift to me is that I no longer perceive those limitations.

What would come next? My hope was that Integrate Stretch would eventually replace me—that the group would develop a successor from among those members with intellectual disabilities. This personal desire for the group is in line with a radical disability politics, which sees the rise, development and emergence of people with disabilities as their own leaders and spokespeople. To date this has not happened, but it may yet. The experience of that professional 'awakening' in the public eye could have very interesting consequences.

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Corresponding author: Dr. Prof. Rob Baum, Email: rob.baum@uct.ac.za