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**Weber, Hermanus Karel**

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# An Exploration of the Effectiveness of Role-Play in Assisting Individuals with Intellectual Challenges to Understand Social Cues at the Selwyn Segal Home, Johannesburg, South Africa

Hermanus Karel Weber

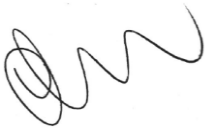
A Research Report in the Field of Drama Therapy
in Partial Fulfilment for the Degree of Master of Arts in Drama Therapy

University of the Witwatersrand
February 2020

## Declaration

I, the undersigned, hereby declare that the work contained in this research report is my own original work and that it has not previously, whether in its entirety or in part, been submitted to the University of the Witwatersrand or any other for the purposes of a degree.

**Name:** Hermanus Karel Weber

**Signature:** 

**Date:** 16 February 2020

## Dedication

I dedicate this research to my aunt who fought Multiple Sclerosis until the end; who introduced me to the life of a person with disabilities in South Africa, who phoned me every year to remind me to register for the masters programme, and who is the reason for my interest in working with people with disabilities.

A special dedication to my partner, Steffen, who made my dream come true of becoming a drama therapist. Without his continuous support, encouragement and care, this journey would not have been easy.

Lastly, a special dedication to my mom who taught me love, respect, and empathy.

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To my clinical supervisor, Yaela Orelowitz, thank you for reviewing my session plans and your insightful input.

To Lara Milner, Dinah Maduna, Eric May, Ntombi Mbatha and most of all, the research participants at Selwyn Segal, without whom this research would not have been possible, I deeply appreciate your contribution to this study.

Thank you to my friend, Nina, who was always willing to listen to my session plans, offering suggestions to spice up the games, and supporting me through this process.

To my family and friends who stood by me, even though months passed without seeing them, and who kept reminding me of my dream, I thank you dearly.

## Abstract

This study, conducted at the Selwyn Segal Home, Johannesburg, South Africa, explored the effectiveness of role-play in assisting individuals with intellectual disabilities to understand social cues as there is insufficient research on role-play and intellectual disabilities in a South African context. The limited social interactions of people with intellectual disabilities often leads to their being unable to understand social cues, which decreases their opportunities to broaden their social environments. Practice-based research, in the form of drama therapy sessions focussing on role-play, was applied at the Selwyn Segal Home for people with intellectual disabilities. Improvisational and therapeutic games formed a cornerstone of this study, aiding the creation of group cohesion, and fostering a culture of mutual understanding, helpfulness and sensitivity toward others during the drama therapy sessions. Through the role-play, the pro-social behaviour and empathy of the participants were highlighted. Furthermore, role-play provided the participants with a means to communicate with their whole body, as opposed to pure verbal communication. It has been found that the fictional world of role-play allowed the participants to identify positive and negative social cues, and to suggest solutions as to how to rectify unwanted or negative social cues. The opportunity to witness the role-plays of other participants promoted their understanding of social cues, and their ability to see themselves from a different perspective. However, this study has its limitations due to the socio-cultural background and the safety of the residential centre. This study cannot necessarily be duplicated as it would need modification to be applied in other South African contexts.



**Keywords:** role-play, intellectual disabilities, South Africa, drama therapy, social cues.

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*Intellectual disability (intellectual developmental disorder) is characterized by deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. The deficits result in impairments of adaptive functioning, such that the individual fails to meet standards of personal independence and social responsibility in one or more aspects of daily life, including communication, social participation, academic or occupational functioning, and personal independence at home or in community settings.* (American Psychiatric Association, 2013:31)

# Chapter 1

*Special is the word they use when they talk about me*
*They assume that my diagnosis fully defines me*
*Sometimes I wish I could only be heard and not seen*
*That's what I often think about when I daydream*
(Brewer, 2019: sp)

This chapter outlines the background to this research and provides a justification for the study. People with disabilities are often overlooked, and in some cases, are excluded from society, and discriminated against for being different. This exclusion and discrimination is referred to as ableism. In South Africa, mental health and disability have taken a backseat in societal integration, leading to the exclusion of people with disabilities and a lack of education around disability. The term "disability" covers a broad range of more specific disabilities, with intellectual disability being one of them. People with intellectual disabilities experience limited abilities in their practical and social aptitudes, restricting the scope of their social interactions. Overcoming some of these limitations was explored in this study through drama therapy and role play, allowing the research participants to explore social cues in the safety of the fictional world.

## Introduction

Disability refers to adverse limitations experienced by individuals in their attempt to operate in society (Rapley, 2004). In my experience, these limitations often lead to the disregarding of people with disabilities. This study refers to people with intellectual disabilities as opposed to intellectually disabled people, as a disability is what someone has, and not who someone is. The Arc, an American disability rights organisation, maintains that referring to people with disabilities minimises their disability, putting their humanity first and their disability second. Furthermore, it defines people with intellectual disabilities by their individual strengths, and abilities, and not by their disability (Smith, 2016). By focusing on strengths and abilities, people with disabilities can regard themselves as a person first, and their disability as being a secondary part of themselves. Drama therapy applies a strength-based approach; rather than treating symptoms and addressing pathology, drama therapy focuses on the adaptive and functional capacities of the clients to promote transformation, growth and healing (Nash & Haen, 2005; Gallo-Lopez, 2005).

Ableism is seen as the source of discriminating against people with disabilities, focussing on the disability and not the person. "Ableism is not just a matter of ignorance or negative attitudes towards disabled people; it is a trajectory of perfection, a deep way of thinking about bodies, wholeness, permeability and how certain clusters of people are *en-abled* via valued entitlements" (Campbell, 2018:11. Emphasis in the original). Society's pursuit for perfection has caused the marginalisation of people with disabilities, prompting this study to explore how some of the limitations faced by people with intellectual disabilities could be addressed, without focusing on what society deems as the norm. Positivist research focuses the theorising of the disabled body on trying to measure an objective phenomenon from the standpoint of deviation from what is considered normal (Birik, 2015). This method perpetuates ableism as a person is being judged according to standards that are regarded as the norm, or normalcy. The notion of ableism measures disability by society's responses to people with impairments, and not by personal characteristics (Miller, Parker & Gillinson, 2004). Shildrick (2012) maintains that people with disabilities are discriminated against, oppressed, and alienated because their embodied selves display the opposite of what society deems to be properly human.

This study focussed on the application of role-play in drama therapy with people with intellectual disabilities, as little research has been conducted in this particular field with this client group in South Africa. McDonald, Schwartz, Gibbons and Olick (2015) argued that individuals with intellectual disabilities should be included in research studies in order to inform and address any disparities in this population. Most of the research on drama therapy and disabilities is focussed on learning or developmental disabilities. The term "learning disability" is used to describe a diverse group of conditions, which could manifest similar symptoms; academic underachievement or failure not due to any other sensory or cognitive impairment (Flack, 2005). Shannon & Tapan (2011:297) define developmental disability as "a physical or mental impairment that begins before age 22 that alters or substantially inhibits a person's capacity to do at least three of the following; (1) take care of themselves, (2) speak and understand clearly, (3) learn, (4) walk or move around, (5) make decisions, (6) live independently, and (7) earn and manage an income." Physical disability is a condition in which an individual experiences significant change or loss in their body function or structure, resulting in limitations in their physical activity, impacting on their daily lives (Taleporos & McCabe, 2005).

Intellectual disability is not a particular disease or pathology as there are many causes. Causes can be divided into biomedical, social, behavioural, and educational risk factors (Harris, 2010;

Rapley, 2004). People with intellectual disabilities encounter many obstacles in their lifetime due to limitations in their adaptive abilities. Adaptive behaviour is the learned social and practical skills needed to function in society. Restricted adaptive abilities limit a person's ability to respond appropriately in certain social or environmental settings (Rapley, 2004). I have encountered people who view intellectual disabilities as a disease. Most of the literature about the social competence of people with intellectual disabilities is focussed around the location of competence and based on linguistic capacity (Rapley, 2004), leaving a gap in knowledge about non-linguistic capacity, like body language. "… the world is a part of bodily memories, feelings, perceptions and impressions – a connected world. This philosophical position of a connected world can be seen to reflect some of the core processes… at the heart of dramatherapy. These include the dramatic body and embodiment where the self is seen as being intrinsically connected to the world it perceives through participation in arts processes" Jones, 2007:76). Within dramatherapy the client can explore the relationship with their body in terms of the unwanted memories and experiences with which their physical self connects (Jones, 2007). The relationship a person has with their body and its rhythm specifies the extent to which they feel in control. Acting assists people to take their place in life by using their body and its rhythms (Van der Kolk, 2014)

I became aware of the difficulties that physically disabled people in South Africa face on a daily basis, after my aunt was diagnosed with Multiple Sclerosis. Towards the end of her life, my aunt was wheelchair-bound. By having to push her in her wheelchair, I realised how little space our South African society has for people with physical disabilities. There were seldom ramps for wheelchairs or handicapped bathrooms, and accessible parking spaces were often used by able-bodied drivers.

This research was positioned in using the drama therapy technique of role-play with people with intellectual disabilities. It investigated how role-playing supports the drama therapy process for people with intellectual disabilities to explore their understanding of social cues. My interest in intellectual disability was developed after a friend's daughter was born with an intellectual disability. Observing her play and interactions with other toddlers and adults, I started thinking how drama therapy could be utilised in her development, as drama therapy offers a safe space for experience and exploration.

The role-playing used in the research study was based on stories as they help clients to make sense of their lives through identification with the themes and structures of stories (Landy,

1991). Whether clients tell their own story or take on roles from a story shared by the drama therapist, the clients are provided with the opportunity to engage in and work through issues by being distanced from their reality through symbols, fiction or metaphor (Jennings 1999). Landy (2009) stated that story is the content of the individual's dramatic expression and that the individual is in role when telling the story. Furthermore, he stated that there can be no role without a story.

## Rationale

> Undermined as mothers, fathers, workers, lovers and in a host of other capacities, disability is a life lived before a looking glass that is cracked and distorted by the vandalism of normality. (Hughes, 2012:68)

### *South Africa and Disability*

The Life Esidimeni tragedy brought the state of mental health care in South Africa into public focus when one hundred and forty-four individuals passed away during the relocation of patients (Trotter, 2017). The patients were moved from Life Esidimeni to various unlicensed care homes, in a bid to save money (Hodal & Hammond, 2018; Lund, 2016). Before the Life Esidimeni tragedy, the general population in South Africa were not aware of the difficulties faced by people with disabilities, and their family members. Individuals with psychosocial disabilities are marginalised in South Africa due to social, economic and political factors (Mahomed, 2016). Shakespeare (2012) asserts that people in rural areas are disadvantaged even more because services are concentrated in the cities. Although the South African Human Rights Commission (2017) stresses the importance of equality for people with disabilities by advocating for the same rights that apply to those without disabilities, such as inclusion in communities, these individuals are still excluded from society in South Africa due to a lack of education about mental health issues. Goodley and Runswick-Cole (2014) posited that our thinking about people is altered in the presence of disability. In South Africa, there is an exclusion of people with disabilities from mainstream society due to a neglect of their wider social needs (Maart, Eide, Jelsma, Loeb and Ka Toni, 2007). The exclusion of people with disabilities in South African society is not based on one specific disability.

> … some of the problems… pit latrines are difficult to use for people with physical or visual impairments… lacking space for people who use wheelchairs; steps or other obstacles may render buildings inaccessible… paths or roads may be uneven, potholed and impassable in wet weather… lack of safe crossings make it dangerous to cross roads; there may be concerns about security. Transport options may be limited to inaccessible buses or vans… drivers being prejudiced against carrying disabled people because of extra time and hassle (Shakespeare, 2012:274).

Danie Marais (2018), Universal Design and Accessibility Manager at the National Council of and for Persons with Disabilities (NCPD) posited that persons with disabilities remain deeply frustrated by the public transport system in South Africa as a result of excluding the needs of people with disabilities in the design process. Furthermore, he stated that people who struggle to access public transport are seen as weak by society, rather than society realising that the problem does not lie with the person with the disability, but with the infrastructure. "…disabled South Africans continue to be systematically disadvantaged in all spheres of society. Moreover, these disadvantages are layered 'intersectionally', with the worst conditions experienced by traditionally disadvantaged groups…" (Black & Matos-Ala; 2016:336). In a study conducted by Maart *et al.* (2007) it was found that living in an urban, built up environment presented more barriers with regard to mobility and accessibility. The prejudice against people with disabilities does not stop at transport and facilities, it also extends to academic institutions and the social environment.

Anthony Gama (2019) attested that the University of the Witwatersrand (Wits) was the only university in South Africa to accept him with his hearing impairment. Furthermore, he stated that he thought of starting his own media company as there are not many deaf people in the media, and Deaf TV was recently closed. This inequality is exacerbated by the lack of interpreters on news channels and subtitles on television programmes. Gama (2019) argued that there is limited access for the hearing impaired in South Africa, and that only 20% of the country's infrastructure is accessible to them. I have experienced the Rea Vaya bus station – a public transport bus system in Johannesburg, South Africa – not to have any services for the visually or hearing impaired, adding to the stigmatised marginalisation and exclusion of people with disabilities.

In a study conducted by Duncan Yates (2019) from the Disability Rights Unit at Wits, it was found that physical and attitudinal barriers on the Wits campus were the most prevalent among students with impairments. The physical barriers that they identified were inaccessible classrooms and buildings, unfavourable exam conditions for hearing and visually impaired students, paper-only textbooks, PowerPoint Presentations in small font, as well as uncaptioned videos. The identified attitudinal barriers were stigma, being judged negatively when students disclose their impairments, leading to the stigma impacting on the social support available to the students. Yates (2019) also maintained that people with disabilities are further marginalised with only one-fifth of persons with severe disabilities between the ages 20-24, gaining access to universities in South Africa,

One of the people with severe disabilities who gained access to a South African university is Heidi Lourens who holds a PhD in Psychology. She made a powerful statement at the Disabling Normativities Conference at the University of the Witwatersand (02/10/2019) saying, "The disabled body cannot take part in the banquet of possibilities; the flesh and the world prevent them." Furthermore, she asserted that between the social and medical models of disability, there is the real life of the person with disability, the life that is being discriminated against by society and infrastructure, and sometimes by their own friends and family.

Lourens (2019) insisted that if a person complains about their disability, the people close to them are scared that they will fall into a pit of self-pity. Feelings of inferiority and being silenced are increased by the difficulty of asking for help, without coming across as weak or giving up your independence, and this can lead to internalised oppression. "One of the most disabling of the 'in here' barriers is 'internalised oppression' and 'its unconscious and insidious effects on the psycho-emotional well-being of disabled people. . .' (Reeve as cited in Hodge & Runswick-Cole, 2013:316). In addition to having to deal with the oppression from society and restricted services, the internalised oppression that people with disabilities experience exacerbates their feelings of marginalisation and social exclusion.

McKinney and Swartz (2020) maintain that while accommodations for students with disabilities – in higher education – include the provision of additional time for tasks and separate examination venues, many institutions are unwilling to provide the reasonable accommodations that students require. Furthermore, they posit that understanding and providing reasonable accommodations for students with psycho-social and learning disabilities in higher education institutions is lacking. McKenzie and Macleod (2012:27) argue that in South Africa "the progress made in terms of disability rights has not been fully extended to intellectual disability, partially owing to the perceived incompetence of intellectually disabled people in terms of speaking for themselves and in terms of fulfilling the qualities of the rational, universal person who forms the basis of human rights."

*Intellectual Disability and Drama Therapy*

People with intellectual disabilities experience difficulty in showing empathy and placing themselves in the shoes of another (Harris, 2010). This affects their ability to understand social cues. Role-play was applied in this research study, as the action of taking on different roles in role-play allows the individuals to see social cues from different perspectives and aids in the understanding of why it is important to follow social cues. Seeing themselves from the

perspective of another allows the individuals to experience how their behaviour and actions might impact on someone else. Moreover, role-play creates the opportunity for individuals to explore moral reasoning in a safe space (Landy, 2005; Jones, 1996). Empathy and pro-social behaviour play a bigger role in the moral agency of people with intellectual disabilities than moral reasoning (Harris, 2010). Role-playing scenes about moral reasoning could assist people with intellectual disabilities to understand social cues, through performing and witnessing behaviours that are right and wrong.

Understanding social cues does not mean that people with intellectual disabilities do not need any other help, although it does aid them in social interactions. People with intellectual disabilities need supports to promote their well-being (Rapley, 2004). These supports are resources to enhance their development, education and interests; the supports do not categorise people with intellectual disabilities but rather focus on the needs of each person, and they can enhance the personal functioning of the individual (Rapley, 2004) through social activities and peer interaction, as well as role-play (Landy, 2009; Emunah, 2009).

Role-play is a natural process; Landy (2009) asserted that the ability to imagine oneself as someone else is not learned behaviour. Every person takes on a different role depending on the life situation they are in, for instance, a mother also takes on the role of a wife and the role of a daughter (Landy, 2009). This made role-play an effective technique to use in working with people with intellectual disabilities. According to role theory (Landy, 2009) a person who cannot take on different roles is seen as psychologically limited because they cannot live with the contradictions of thought and action, and they only adopt one role or a cluster of specific roles. The process of taking on different roles, allows participants to work with their psychological abilities. Just as actors take on different roles, and use roles to present certain qualities, so do people take on roles in real life situations. Actors take on roles to project specific qualities of a character. This same role of an actor is also used to test different ways of being in various social interactions (Landy, 1991). The role-play allows participants to test their own ways of being, and explore ways of how they could be different, through performing as well as witnessing others perform. A person's role repertoire (Landy, 2009) speaks to the person's ability to adapt to social environments (Landy, 1991) and to have healthy social relationships. The role-plays used in this study assisted the participants to experience different scenarios with a range of social interactions.

Limited social relationships can have a negative effect on people with intellectual disabilities

as it may lead to social and emotional withdrawal, low levels of motivation, and low levels of energy (Mazzi, Baccari, Mungai, Ciambellini, Brescanin & Starace, 2018). People with intellectual disabilities live within a definitive social space with a boundary between themselves and others. The social network of most people with intellectual disabilities consists of their families, carers and other people with intellectual disabilities (Bigby & Craig, 2017). Understanding social cues could aid in broadening the social network of people with intellectual disabilities, in that they would not be regarded as being different or abnormal.

> In modernity the threshold of repugnance narrows attitudes to bodily and intellectual difference – particularly bodies and minds that do not conform to the hygienic norms of somatic control and appearance – harden into aversive emotions like fear and disgust and into the conviction that impairment is a tragedy (Hughes, 2012:68).

In a study conducted by Bigby and Wiesel (2019), it was found that some community members did not want to engage with people with intellectual disabilities as they were discouraged by any unexpected behaviours that might occur, like sudden aggression, vocal or physical (Van den Bogaard, Nijmanc, Palmstierna & Embregts, 2018). Gardner (2007) argues that aggression and disruptive acts are the most occurring behavioural challenges of persons with intellectual disabilities, and they are influenced by biomedical, psychological and environmental conditions. I believe that the fear and disgust displayed by community members might be linked to limited education on disability, or a lack of approaches in assisting people with intellectual disabilities to learn and practice social interactions. Even though they are largely marginalised, people with intellectual disabilities have greater access to community life in our modern societies due to disability rights movements and evolving public attitudes (McDonald et al. 2015), although these movements and attitudes still need to be developed more to ensure the complete inclusion of people with intellectual disabilities.

My drama therapy Honours degree research focussed on the use of story and role as drama therapy techniques in a South African context. This research led me to respect the strength of storytelling and role-playing in drama therapy and to realise how they make drama therapy accessible to varied audiences. These two techniques allow clients in the South African context to express themselves in their home language, and it allows for therapy to be culturally adapted. During my weeks of observation at Hope School – for physically disabled leaners from the age of 3 years to Grade 12, following the same curriculum as mainstream schools – I became increasingly aware of how drama therapy could aid the learners. In a conversation I had with the head of foundation phase at Hope School, she confirmed my belief that drama therapy could

be beneficial to the students with disabilities. She stated that what she has found with her students is that traditional psychology tends to focus on the negatives of the student's disabilities, and that drama therapy could assist the students in building confidence and self-esteem. By using stories in drama therapy, Ann Cattanach (2005) assisted a seven-year-old boy in building his self-confidence. She states that telling stories and playing out stories allows a child who lacks power to control their world. Similarly, Lee Chasen (2005) used spectacle and ensemble in group drama therapy to enhance the self-confidence in children.

This research project was conducted at Selwyn Segal Home in Sandringham, Johannesburg. This centre provides a home for people with intellectual disabilities. Most of the social skills training for people with intellectual disabilities is largely based on deficits identified by care workers (Hartley & MacLean, 2009), as they engage with the groups on a regular, and often long-term bases. This focus of this research study – social cues – was identified by the care manager of the centre where the study was conducted. She suggested social cues as the focus, having interacted with the residents over the years and experienced a lack of understanding of social cues. The intellectual disabilities of the residents vary, from low functioning to high functioning, the centre does not only cater for a specific intellectual disability. The centre was integrated into the Chevrah Kadisha group in 2005. The Chevrah Kadisha is the oldest Jewish organisation in Johannesburg, and the largest Jewish welfare organisation on the African continent catering for people of the Jewish faith (Chevrah Kadisha, 2020).

People with intellectual disabilities have limited interpersonal skills and do not always understand personal boundaries or acceptable social cues. Moreover, people with intellectual disabilities do not necessarily make choices controlled by external forces, as they do not always understand the concept of socially accepted behaviour (Rapley, 2004). The value that this research might add to the field of drama therapy is whether using role-play can benefit the understanding of social cues in people with intellectual disabilities, including empathy and theory of mind. Empathy comprises knowledge of the outside world and the ability to understand and respond with care, as well as sharing an affective state, like happiness (Fagiano, 2019). Theory of mind is "the ability to attribute emotions, intentions and knowledge to oneself and others" (Sterck & Begeer. 2010:3). Understanding social cues might reduce the exclusion and marginalisation of people with intellectual disabilities, as they would be able to interact socially without sudden outbursts or inappropriate responses. Another value that it might hold is how this drama therapy technique needs to be adjusted to work with this specific client group.

**Aims and Objectives**

Aims:

- To determine whether role-playing can be used with people with intellectual challenges.
- To determine the effectiveness of role-playing as a tool to enhance the ability of people with intellectual challenges to understand social cues.

Objectives:

- Conducting 8 drama therapy group sessions with people with intellectual disabilities at Selwyn Segal Home in Sandringham, Johannesburg.
- Using role-play in drama therapy sessions to enhance the ability of people with intellectual disabilities to understand social cues.

**Research Question**

To what extent does role-playing assist people with intellectual disabilities to understand social cues?

**Conclusion**

Marginalisation and exclusion of people with disabilities is present within all types of disability. In South Africa, this is largely due to little or no education about disability, and limited availability of research. South Africa's infrastructure and services are exacerbating the difficulties faced by people with disabilities. Moreover, care homes for people with disabilities are not always accessible to all South Africans. People with intellectual disabilities are marginalised and excluded out of fear of unpredictable behaviour, or disgust for being "abnormal". Through participating in role-play and exploring different scenarios and behaviours, it is possible for people with intellectual disabilities to learn about and practice social interactions, while being distanced from reality. Through practicing, the behaviours and social cues expressed in the role-play could then be assimilated into real life.

# Chapter 2

## Introduction

The conceptual framework that informed this research is discussed in detail below; the social model of disability, the behavioural perspective of psychology, and the drama therapy technique of role-play. A critical discussion of the literature that informed this study follows on from the conceptual framework.

## Conceptual Framework

The medical model of disability maintains that a person with a disability's quality of life could be enhanced through medication, and that the medicine is expected to alleviate the disability (Cooper, 2013). This model also regards the disability first, and not the person, and believes that the disability needs to be fixed for the person to be able to fit in with the normative values of society. On the other hand, the social model of disability claims that societal structures exclude people with disabilities from society and that it is society's duty to ensure the inclusion of people with disabilities. This social model regards the person first, and the disability as a secondary part of the person. Apart from facing physical barriers to operating in society, people with intellectual disabilities also face social barriers, in that they rarely possess the skills to interact socially. Barnes (2012) maintains that the perspective of the social model does not negate the value of medical, re/habilitative or educational interventions but rather draws the attention to the limitations of these interventions regarding the advancement of the empowerment of people with disabilities.

This study is grounded in the social model of disability, and sees the participants as human beings first, and their intellectual disability as a part of them, rather than seeing them as their disability. Drama therapy is humanistic in nature and builds on the healthfulness of the person (Emunah, 2009). Drama therapy provides a link between the creative arts and psychology as it has the ability to place the psychotherapeutic process firmly within the parameters of daily life (Fontana & Valente, 1993). The behavioural perspective of psychology links with the social model in this study, as it argues that behaviour can be learned through modelling and conditioning (Corey, 2013), with cognitive insight and behavioural change forming essential parts of the drama therapeutic process (Emunah, 2009). The behavioural perspective was applied in this study through the use of role-play based on stories. Role-play allowed for the

exploration of different behaviours, and the practicing of these behaviours in order to transfer them into real life

The social model of disability expresses that disability is socially and environmentally defined because the term "disability" refers to how society views the impairment. Harris (2010) proposed that intellectual disability is a state of human functioning in society, therefore he advocated for the social model of disability. This model argues that social structures are prejudiced against people with limited resources, and that societal structures need to be adapted to remove this prejudice (Wolff, 2010; Rapley, 2004), and that these people are disabled by society and not their impairments as they are treated as misfits (Williams, 2011).

This study upheld the beliefs and principles of the social model of disability; the participants were not seen as having a medical condition, but they were regarded as people who could be assisted in gaining more societal inclusion. The social model of disability fosters acceptance and inclusion (Wolff, 2010) and it moves away from the person's disability towards barriers created by society. The impact of the social model of disability is individual and collective transformation (Morgan, 2012); the individual rejects previously held conceptions that disability is a personal tragedy, and the collective adopts a different approach to meet the needs of people with disabilities. The role-play created a safe space where participants could together enact a world without preconceptions, and focus on their strengths.

Wolff (2010) referred to the status enhancement of people with intellectual disabilities. This is the process of changing social or cultural structures in order for the people to do more with the resources that they possess. Although he also stipulated that status enhancement is more applicable to people with physical disabilities, this study provided an opportunity for the participants to enhance their own statuses by exploring and understanding social cues, as people with intellectual disabilities face social barriers that keep them from ordinary social achievements (Williams, 2011). However, the social model has also been criticised. Rapley (2004) reasoned that intellectual disability remains outside the scope of the social model and that it is still understood as a natural, biological impairment that cannot be socialised. French (in Rapley, 2004) argued that the most extreme impairments are difficult to solve through the social model. Furthermore, Shakespeare and Watson (2002) contended that the social model has outlived its practicality and it should be put aside as it has to many gaps and inadequacies. They also stated that the social model has only been useful in Britain and that in other countries

civil rights and social causes have materialised successfully. Nevertheless, the social model provided a foundation, and a benchmark for society to change their attitudes and behaviours towards people with disabilities. If it were not for the social model, we would still be regarding disabilities only as a medical condition and we would not have had the opportunity to change societal views in order to include people with disabilities and to see them as human beings.

With the foundation laid by the social model of disability, the behavioural perspective of psychology was incorporated in this study, as it asserts that behaviour is learned through different processes, like conditioning and modelling (Corey, 2013). During drama therapy, the client makes a connection between their inner world and life experiences. Through the drama therapy sessions, the client can find new alternatives to their life experiences (Jones, 2007), which resonates with the behavioural perspective (Corey, 2013). Furthermore, drama therapy can be associated with the behavioural perspective as it incorporates various dramatic-expressive forms that hold therapeutic potential; including, but not limited to, playing characters in a fictional reality in order to explore life experiences, using stories and myths to elicit themes for exploration towards personal growth, and the creation of rituals (Jones, 2007).

Focussing on social cues and the ability of adults with intellectual disabilities to read them, it was important that this study could identify unwanted behaviour (Austin, 2012) and address it through learning new behaviour during role-play that then, through practice, can become habitual and automatic (Burton, 2001; Corey, 2013; Botha & Moletsane, 2012). The behavioural perspective is action oriented as it focusses on what can be changed (Burton, 2001); this was applied to look for positive change. Critics of the behavioural perspective argue that causes of behaviour should be based on mental states and structures and not on observable behaviour (Moore, 2010). In addition to this, critics also proclaim that the behavioural perspective treats symptoms and not causes, asserting that the client's history and environmental circumstances are less important. Another criticism is that therapists have a power relationship with their clients and thus exert control and influence over the clients (Corey, 2013). In order to curb this, the therapist needs to take cognisance of their influence and focus on client-oriented goals.

Role-playing has also been introduced in traditional psychotherapy. Corey (2013) claimed that role-playing and behavioural rehearsal are useful therapeutic techniques. This behavioural rehearsal is then transferred into the client's real life. Goffman (in Rubenstein, 2006) believes

that there are two types of communication between people: expression given and expression given off. The expressions that are given off become the roles that are performed in social contexts; these expressions involve speaking, choosing to stay silent or responses to conversations. As stated by the care manager at the centre, the behaviours given off by people with intellectual disabilities are not always regarded as socially acceptable; for example, calling someone names or having anger outbursts. The concept of role is used in drama therapy through role-playing different characters or personalities. Role-playing allows the participants to explore various roles that they are having difficulty with in real life (Emunah, 2009), enabling them to increase their role repertoire (Landy, 2009). Mary Booker (2011) commented that people with intellectual disabilities have a limited role repertoire. Role-playing various characters was introduced in this study, offering the opportunity for participants to access dormant roles (Landy, 2009) or to ameliorate known life-roles.

Landy (1990) postulated that role is a process of action pertaining to a person's status and it allows the person to become their true selves by internalising social substance. The type of role that a client takes on in a drama therapy session allows the therapist to acknowledge the part of the client that needs to be seen, heard and acknowledged (Landy, 1991). Even though this study focussed on social cues, the participants were free to take on any role in which they felt comfortable. Being a research study with a specific aim, the participants could not explore Landy's above-mentioned roles in-depth. Landy's role theory states that people are role players and role takers by nature, they can imagine themselves as someone else (Landy, 2009; Booker, 2011). Furthermore, it stipulates that a person's personality is constituted of various interactive roles. These roles are understood as specific behavioural patterns that indicate ways of thinking, feeling and acting; role is not fixed and can change or adapt to different life situations.

The drama therapy techniques, role and story, are interrelated. There can be no role without a story (Landy, 2009) as stories cannot be told without the storyteller taking on a role. Storytelling helps clients to make sense of their lives by identifying with the themes and structures of stories (Landy, 1991), and this can help the client cope with negative emotions in various ways (Frude & Killick 2011). One of these ways could be through the therapist adding a positive outlook to a sad part of the story, for instance; "The princess was taken by the giant, do you think the prince would go and save her?" This study made use of known fairy tales, as well as stories created during the sessions. Story is the content of the individual's dramatic expression, it can be fictional, but it becomes a reflection of issues in the individual's life

(Landy, 2009). The metaphors that are used in stories allow clients to be distanced from their reality (Jennings, 1994), and explore their true selves without fear. This distance can be referred to as the "imaginal realm" (Landy, 2009:73) or the make believe of the fictional world.

The social model of disability directed the focus away from the medical model's view of disease, towards society and personhood, allowing people with disabilities to be seen as human beings. Grounding this research in the social model of disability, facilitated the incorporation of the behavioural perspective of psychology through the application of role-play. Should the medical model of disability have been the only known model, people with intellectual disabilities would never have had the opportunity to participate in humanistic research.

## Literature Review

Various topics around disability and drama therapy have been analysed as groundwork for this research. A short explanation of disability and intellectual disability has been included as a precursor to this research. Studies have indicated that there is a strong relationship between disability and drama. The fictional representation of drama has been utilised to educate people about disability, as well as allowing people with disabilities to showcase their talents and to portray life from the perspective of a person with a disability. Studies have also called attention to the oppression and stigmatisation faced by people with intellectual disabilities, both externally and internally, often due to their limited social knowledge. Nevertheless, research has indicated the benefits of drama therapy in working with people with disabilities.

### *Disability*

Grönvik (2009) identified three ways in which disability is defined; firstly, through functional limitations which stems from a medical understanding of disability in which the disability is recognised by blindness, deafness other physical changes in the body. Secondly, through legal or administrative definitions of disability which originates from the distribution of welfare benefits to disabled people. The third definition of disability is a subjective definition, where the person views themselves as disabled. There is no 'average' disability among people. Some people have impairments that are temporary, some impairments can be invisible. Some people have multiple impairments, and some people's impairments are more severe than others. People with disabilities have a diverse range of opinions and identities and cannot just be classified under the term 'disabled.' Some people with disabilities identify themselves as disabled, and some do not (Miller, Parker & Gillinson, 2004).

Barnes and Mercer (2010) assert that Western medicine equates disability with a professionally diagnosed condition that causes functional limitations. These diagnoses and functional limitations lead to the social exclusion of people with disabilities. Furthermore, they state that impairment is the biological element in disabled people's oppression, as they are unable to perform to a non-disabled ideal. Even though Barnes and Mercer mention the medical view of disability and the biological element, their explanation of the impact of the disability on people's lives aligns with the social model of disability. However, their statement refers to disability as a whole.

According to the American Psychiatric Association (2013; 2017), individuals with intellectual disabilities experience difficulties in mental abilities, intellectual and adaptive functioning. Intellectual functioning includes learning, problem-solving and judgment. Three areas of difficulties in adaptive functioning have been identified: Conceptual - language, reading, writing, math, reasoning, knowledge, memory; Social – empathy, social judgment, communication skills, the ability to follow rules and the ability to make and keep friendships; Practical - independence in areas such as personal care, job responsibilities, managing money, recreation and organizing school and work tasks. The list of intellectual and adaptive functioning limitations has been mentioned to give the reader a deeper understanding of the complexities faced by people with intellectual disabilities.

*Drama and Disability*

> It has been commented that society expects its [disabled] members to act [disabled]. The implication of this is that the bearings of a crippled person, when in the company of a non-[disabled] person, should be submissive and acquiescent . . . but with performance, the very act of controlling the particular medium for a certain time in front of a largely passive, captive crowd, actually does allow for the possibility of clearing away much of the mythology that has been created about disability (Tomlinson, 1982:11 – 12).

Society's view of people with disabilities has been challenged through the development and application of developmental drama (Booker, 2011). Developmental drama is a useful method to apply when working with people with disabilities. It is process-orientated; it is about being, learning and developing together in a social and dramatic context, and not about achieving tasks. The process involves exploring issues and feelings being experienced inside each person, between people and within the group as a whole, while engaging in an activity. Developmental drama is about the change that happens within individuals and within the group over a period of time. Developmental drama has formed a cornerstone of this research study, not only

because of the target group, but rather the process-oriented feature of learning and developing together. Drama therapy and developmental drama are both activities focussing on the processes that occur in the dramatic activities, and these actions safely contain the activities within the session (Booker, 2011). This safe container, referred to by Jones (2007) as the playspace, allows the participants to experience the dramatic world without harm. Developmental drama is not the only model used in working with people with disabilities in the performing arts, theatre has also been utilised.

Tomlinson (in Conroy, 2009) asserts that theatre offers a different view of people living with disabilities. The stage offers the performer with disabilities a sense of power and status because of his presence on stage; as performer, actor and an object of the audience's attention. Drama is the art of human interaction and communication; within the drama we confront conflicts and discover resolutions. The heart of drama is in our everyday life and the different roles that we play (Bing & Gaffney, 2003). Role-play, in drama, allows for participants to interact with each other and see each other in different ways, than the normal daily roles they portray. The actor's presence allows him to get to the point of the action deeply and foster all the transformative resources of the action. This fosters a new understanding in audience members, and a new way of viewing people with disabilities.

For the performer with disabilities, the performance allows a shift from life to stage, allowing the actor to reveal and acknowledge their feelings and the feelings of others, so that in the action performed, they can realise a psychophysical attunement of considerable empathy (Fiaschini, 2012). The intensity of this empathy promotes therapeutic effects in terms of well-being, awareness and individual and collective change, with real consequences in daily life, just as role-play can be linked to real life. This same surplus energy is evident in group role-play, allowing the participants' natural creativity to interact with each other, increasing sensitivity to others and empathy, thus introducing the topic of social cues.

Daily life enables the actor's body to be 'naturally' focussed and present. For physically disabled people, the stage becomes the goal of a desired process of individuality, a public space where it is probable to exist, where it is possible to express oneself. The stage, the make-believe world, enables the actor to be elsewhere, a place chosen to give society proof of their identities. The presence of actors with disabilities has an important therapeutic effect on the audience: the veracity of their actions and their bodies allows the audience to perceive the world of the disabled, and represent feelings as they are, even the most painful ones, without any cognitive

or artistic orientation. (Fiaschini, 2012). Although Fiaschini reports on physical disability, his findings have been included as people with intellectual disabilities and their audiences encounter similar experiences. Hoffman (2016) speaks of two ways of witnessing mental illness in theatre; the observational method that allows the audience to observe – as an outsider – everything that takes place around the character with a mental illness. The second being the experiential method which places the audience in the mind of the character with the mental illness, to experience the world from the character's point of view.

As reported, drama and disability have been in partnership for many years. Throughout the years, drama and disability have become international in reach and orientation. Disability theatre aims to address and redress the idea of disability in the arts and society. Undermining stereotypes and stigma on the one hand, and pressing the boundaries of aesthetic resolution on the other, disability theatre is thus both activist and artistic in orientation (Johnston, 2010; Johnston, 2016). Disability theatre is not the only opportunity for people with disabilities to be in community with other people. Disability culture offers people the opportunity of identifying as a disabled person, and allows people with disabilities to validate collectively the shared experiences of their lives, and to find ways of representing these lives truthfully.

> …disability culture is, in its most raw state, unique, in that it is inherently immutable. There is a purity about it, in that it is the only way of life which is not in any way manufactured. It is not fundamentally connected, for example, with fashion, the climate, geography, economics, whim, intellect, class, taste, design or etiquette. It is a culture primarily born from the experience of the unusual body and, unlike other cultures, it will never become ancient history unless there comes a time when impairment is eradicated (Vasey, 2004:106).

Conroy (2009) declared that a person living with a disability performs the role of a producer of disabled culture. This study did not include, or contribute to disability theatre, or disability culture as it was conducted at a residential centre, but it held similar values of undermining stereotypes and building community through role-play.

*Disability and Drama Therapy*

> Drama therapy is a form of applied drama… Drama therapists harness the doubleness of drama for the treatment of individuals in psychological, physical, and existential pain. Drama therapy is not only rooted in the natural developmental processes of play, role playing, and storytelling, but also in the more sophisticated art form of theatre... In drama therapy, clients… enact roles and stories, creating aesthetically pleasing images through movement, voice, and a wide range of emotional expression. The main difference between theatre and drama therapy is that in the former, the person is in service of the persona, the fictional role; whereas, in the latter, the persona is invoked and worked through as a means to reveal the person (Landy, 2005: xiii).

Drama therapy, being rooted in play, role-playing and stories, is a unique and accessible therapeutic approach to apply to intellectual disabilities. Drama therapy is flexible, and it encompasses various therapeutic methods that can be relevant to people with intellectual disabilities. Self-expression can be developed through the creative media used during the therapy process, and independence and confidence can be achieved through training in social skills and life skills during role play (Brudenell, 1987). The culture of drama therapy sessions aims to foster mutual understanding, helpfulness and sensitivity toward others (Crimmens, 2006), and these themes should be explored in the stories engaged with in the sessions. Traditional stories and fairy tales provide an existing structure (Crimmens, 2006) for the research participants. These stories allow the participants to engage with real life issues while being distanced from them (Landy, 2009; Crimmens, 2006). Furthermore, drama therapy offers the opportunity to pass on the power, by allowing participants to advocate for themselves (Bailey, sp).

*Story*

Crewe and Maruna (2006) suggested that people tell stories about themselves to protect themselves from anxieties about their lives and their ability to control their environment. Stories help people to structure their world and to create meaning from it (Dennis, 2007). Poletta, Chen, Gardner and Motes (2011) asserted that stories told by groups or communities create the feeling of belonging and a shared identity. The sharing of stories builds community, and it allows the group members an outlet for thoughts or emotions experienced due to feeling like outcasts in society. Stories provide a fictional world that we can visit together; a place where we can go to explore the difficulties that reality brings and to return stronger and more confident (Golding, 2014).

Storytelling can be seen as a bridge between inner psychological worlds and outer real worlds (Golding 2014). Chavis (2011) and Golding (2014) reason that stories enrich people's lives and they encourage mental health as they evoke responses from individuals who have personal meaning to them. Story and role-play form a unit, stories can be told and then enacted in role-play, or an improvisational role-play can tell a new story.

*Role*

> Moreno identifies three main types of roles – somatic, social and psychodramatic – which cover all possible aspects of an individual's identity. Somatic roles include activities such as sleeping and eating, social roles include family, economic and occupational spheres, whilst psychodramatic roles are those of fantasy and internal life (in Jones, 1996:203).

Role is understood as a social term, as a person cannot be in a role without reference to other people (Meldrum, 2005). People have expectations of how a person should behave when in a certain role (Meldrum, 2005; Booker, 2011). Robert Landy (2009) asserted that human beings are role takers and role-players by nature. People can naturally imagine themselves as someone else or act like someone else. By taking on different roles in a drama therapy session, the clients can explore their own life-roles (Jones, 1996; Emunah, 2009) as well as other roles that they might find challenging. Moreover, role-play grants the opportunity for individuals to learn valuable skills like communication or confidence. Robert Landy's (2009) Role Method of drama therapy includes eight steps wherein the client's counter-role could surface. The client is able to reflect on the counter-role that emerged through the role-play. The counter-role can be presented as a life-role that the client struggles with. Taking on different roles allows participants to explore different social cues in different contexts, depending on the scenario being acted out.

Role-play offers participants the opportunity to explore and experiment with different ways of interacting and relating to others (Jones, 1996). In the fictional world of story, role offers the participants a safe container for any feelings that would be too frightening to share directly (Nash & Haen, 2005). Role-play allows the drama therapist to expand the participants' perspectives and choices, granting them the opportunity to view issues or events differently (Emunah, 2005). Taking on the role of someone else also enables the participant to see themselves from a different perspective (Emunah, 2005), offering them an insight into their behaviour.

*Intellectual Disability and Oppression*

Barnes and Mercer (2010) stated that marginalisation refers to the removal of a social group from everyday life. This is another form of oppression for people with disabilities as they are removed from conventional life through their education and accommodation in special institutions. Disabled people experience oppression in education, employment, financial circumstances, the built environment, housing, transport, and leisure. Another form of oppression that people with intellectual disabilities face, is social exclusion (Bigby & Wiesel, 2019). In a recent study conducted by Bigby & Wiesel (2019), little evidence was found of friendly encounters turning into friendships between people with intellectual disabilities and the broader public. In the same study, people with intellectual disabilities were treated with

impatience, condescending remarks, or actions that discriminated against them and made them believe that they were not welcome in the community. Role-play could assist individuals with intellectual disabilities to understand social cues and to practice social interactions, effecting an increase in social interactions outside of the therapy space, possibly reducing oppression from society.

Unfortunately, the oppression does not stop at social exclusion; the impact that the disability has on the lives of people with intellectual disabilities also extends to their physical health. Emerson (2010) found that the exposure to overt acts of disablism is linked to poor health outcomes. The results of his study support the view that health and social policies that are custom-made to the specific social and cultural contexts of minority groups would be more beneficial. The effects that social exclusion has on an individual are vast; and could cause anxiety, depression, and suicide attempts. Furthermore, it has also been proved that it could lead to an unhealthy immune system, reduced blood pressure regulation and sleeping patterns (Kiat, Straley & Cheadle, 2017), exacerbating aforementioned health outcomes. For the participants in the study, the above-mentioned was not applicable. The centre provides the necessary health care. Having said that, it is important to keep the additional health risks faced by people with intellectual disability in cognisance, especially for a therapist working with the target group.

*Disability and Stigma*

Darling (2013) postulated that people with disabilities viewed themselves negatively. Furthermore, she stated that people without disabilities reduce people with disabilities to being less human. Goffman (1963) referred to stigma as an attribute that is deeply discrediting. He identified three types of stigma: the one is physical disabilities; the second is mental disorders; the third is classification due to minority groups. According to stigma theory (Goffman, 1963) when a person meets someone with a disability, that person classifies the person with disabilities based on the disabled attributes. This generalisation of people with disabilities exacerbates their feelings of marginalisation and exclusion. The social model of disability echoes Goffman's stigma theory, stating that society classifies people as disabled based on what they perceive as the norm.

Many of the people being stigmatised start accepting that their "stigmatisers" are right, leading to an internalised sense of shame and inferiority. This internalisation could cause people with

intellectual disabilities to become passive and helpless, as they believe that they are worthless and do not deserve any better treatment (Goffman, 1963; Mackelprang & Salsgiver, 1999).

> Internalized Oppression is an insidious effect of any oppression… people with disabilities are targeted with a lifetime of discriminatory attitudes and practices, ranging from negative messaging to blatant exclusion to threats or actual violence, perhaps resulting in death… Internalization is a collective experience of a population of people that has been targeted… come to internalize certain values, meaning 'feeling' and 'believing' that they may not, should not, or cannot participate or succeed in activities available to non-disabled people (Saxton, 2018:26).

Corrigan & Rao (2012) presented a similar argument, they opined that self-stigmatisation occurs when the person with the disability internalises societal attitudes and opinions toward intellectual disability, which leads to self-discrimination, a low self-esteem and low self-efficacy, as asserted by Watson & Larson (2006).

Role-play is a powerful technique to dispute stigmatisation; it allows individuals with intellectual disabilities to challenge stigmatisation and fight self-stigmatisation in the playspace, a safe space created within the therapy room (Jones, 2007). The fictional world (Jones, 2007; Landy, 2009) of role-play encourages the individual to become empowered and energised through adopting positive self-perceptions, rejecting stigma and discrimination (Watson & Larson, 2006). Role-play in the group setting allows the individual with intellectual disabilities to feel acknowledged and supported, fostering a positive identity (Watson & Larson, 2006), and self-empathy (Jones, 2007).

However, stigma is already being addressed through some programmes. The Very Special Arts Hellas in Greece (Couroucli-Robertson, 2011) created a project that aims to make young people aware of the talents and abilities of people with disabilities. Couroucli-Robertson affirms that people often shy away from people whom they perceive as unknown, strange or unusual. This project breaks down barriers which, in turn, reveals misconceptions. The social model of disability, the behavioural perspective of psychology, Couroucli-Robertson's programme, and role-play are ways in which the stigmatisation of people with disabilities are being challenged.

*Intellectual Disability and Communication*

Some individuals with intellectual disabilities find it difficult to communicate (Boardman, Bernal & Hollins, 2014). In a study conducted by Schalick, Westbrook and Young (2012), it was found that communication with intellectually disabled individuals could be improved by using simpler sentences and words, using more non-verbal signs and open questions, as well

as allowing the individuals to introduce topics of discussion. However, either/or questions might be more useful than open questions. The findings of this study proved beneficial for my research study; by simplifying my language and keeping sentences and instructions short, the participants were able to follow what I communicated. Another way to improve communication with individuals with intellectual disability is to check continuously that they understand before moving on (Schalick, Westbrook and Young, 2012).

The research participants of this study consisted of one group, Casson (2004) recommends group therapy because it allows group members to relate to others and express themselves. He proposed that an individual asserts identity by speaking up for themselves, therefore check-ins at the start of the session – seeing how everyone is feeling that day – is a useful activity as it offers everyone in the group a chance to talk, limiting isolation. Check-ins are also useful as an initial ice-breaker and allow everyone to become present in the room.

*Social Cues*

The care manager at the centre where the research study was conducted, suggested that it would be beneficial for the participants if the study focussed on social cues. Social cues play an important role in communication. These are symbols expressed through facial expressions, body language, tone of voice and personal space or boundaries (White, 2019; Wright, 2019). People with intellectual disabilities show a lack of understanding of social interactions and difficulty interpreting and using social cues (Bergman, 1987). Social cues allow people to read social interactions and pick up aspects in the interaction that are not being said through words. The ability to read and understand social cues could benefit the research participants' social interactions outside of the centre.

Mu and Royeen (2004) maintain that the use of natural cues in the natural environment is important for social interaction. They argue that a smiling cashier at a McDonalds restaurant should be enough of a prompt to know that they are ready to take your order, instead of being told to place your order. They conclude by stating that responding to natural cues is not always possible for people with disabilities but that it is imperative for these people to participate in a meaningful way as opposed to not participating at all. Casson (2001) found that creative action techniques are beneficial for learning social skills, as "the creative activity facilitates the integration of unconscious material, strengthens the ego, and promotes personal development" (Casson, 2001:24). Role-plays could be adapted to any social scenario that a person with

intellectual disabilities might experience. The creativity of the role play allows these people to practice these social scenarios in a make-believe world.

**Conclusion**

Drama and theatre have entertained society for centuries, and have been utilised in working with the disabled for many years. The meeting point of drama, theatre, and disability is where disability stigma has been confronted in a more public forum. In 1963, Irving Goffman published his stigma theory, proposing that society identifies people based on any attributes that they deem disabled, and outside of the norm. The social model of disability reiterated Goffman's theory by stating that society should be changed – that it is not the work of the medical profession to 'fix' someone– in order for people with disabilities to be included. Furthermore, the social model of disability argues for society to be more inclusive of people with disabilities and that people with disabilities need to be regarded as humans, and seen for who they are, rather than seen as their disability. The behavioural perspective of psychology was applied alongside the social model in this study, as it argues that behaviour can be learned through modelling and conditioning. The role-play formed the basis upon which the behavioural perspective of psychology was implemented, as it allowed for the exploration of different behaviours, and the practicing of these behaviours in order to transfer them into real life. Drama therapy allows for drama and the disabilities to meet, and be explored, in a safe playspace. Role-playing in this safe playspace offers participants the opportunity to challenge the stigma and oppression that they face in a fictional world, creating different ways of being and rehearsing these behaviours for real life.

# Chapter 3

> *Intervention efforts in the field of ID are considered tertiary prevention. These efforts seek to reduce problems associated with the disability and maximize normalized participation in daily life activities as opposed to efforts that attempt to change the fundamental nature of the disorder* (Hartley, Voss-Horell & MacLean Jr. 2007:426).

## Introduction

This chapter outlines the methodological approach and research design that was applied in this research study. The assumptions of the study are discussed, as well the ethical considerations pertaining to a study with people with intellectual disabilities.

## Methodology

Somers (2002) adduced that drama making as a research process is more interested in discovery rather than proof, and in contextual findings rather than generalisations. This research aimed to discover how role and role-play can assist intellectually disabled individuals to understand social cues. The role play allowed for the participants to discover different social cues by enacting social behaviour in various contexts. Somers (2002) continued his argument for drama making as research by stating that practice is the key to all aspects of drama and theatre. Practice-based research is conducted through live performance practice, it is used to determine how and what it may be contributing to new knowledge or insights (Piccini, 2004). In light of this study, performing the role-plays was used as a means of gathering data. The creative artefact – musical performances, poetry, scripts and dramatic performances – forms the key component to the contribution to knowledge. The creative artefact that was explored in this research was the contribution of story and role to understanding social cues. In practice-based research, the creative act is applied as an investigation that is designed to answer a research question that is related to the practice of an art, and cannot be answered by other research methods (Skains, 2018).

Graeme Sullivan (in Skains, 2018) identified a practice-based research framework with four key areas where this research can be conducted; the first is theoretical, where research issues and problems are explored. The second category is conceptual, where artists create pieces in an attempt to understand the creative pieces themselves and not necessarily respond to a gap in academic knowledge. For example, an author may be interested in the effects of different narrative perspectives on a short story. The dialectical practice-related research forms the third

framework outlined by Sullivan (in Skains, 2018), and it explores the human process of experiential meaning-making: how we connect to other minds through artistic media. Sullivan's final framework is contextual, in which the research study is implemented as a method to bring about social change, like morality plays. This research falls in the third category in that it explored how people with disabilities connect with each other through story and role.

Practitioners of practice-based research frequently apply reflective analysis to their creative projects (Skains, 2018). My reflections, dependent upon my memory, was conducted after the creative act, which was every session. I recorded the research processes in the form of process notes which were analysed later. These subjective methods of documentation, in the form of personal records, offer an awareness and refinement into the creative practice (Skains, 2018). Process notes were used as a means of data capturing because I believe that video or voice recording of the sessions would take away from the authenticity of the participants' interactions, knowing that they are being recorded. Furthermore, reflexivity was key in becoming conscious of how my identity, experiences, position, and interests influence my creative practice. Once the research study was completed, I used the process notes to reflect on the sessions as a whole.

Due to this research study focussing on the effectiveness of role-play, a summative study was conducted, as summative research determines the effectiveness of an intervention with people. The results of the intervention will clarify whether the intervention strategy was effective or whether only parts of the intervention were effective (Patton, 2002). I conducted drama therapy sessions with residents at Selwyn Segal Home for the intellectually disabled, with a focus on role-playing. I administered pre- and post-assessments to determine the effectiveness of the drama therapy intervention. Jones (1996) mentioned that the aim of assessment in drama therapy is to find information about the client and any difficulties they may be facing, this is referred to as the initial assessment. The summative evaluation is a retrospective look at the work to indicate whether the aims have been met (Jones, 1996). The assessments are discussed in more detail below.

The assumption of this research was that if the intervention works with intellectually disabled individuals in an English-speaking, Jewish residential centre in South Africa, it should work with other intellectually disabled individuals in other contexts within South Africa. However, cultural diversity must be considered. Ciornai and Canda (in Jones, 1996) have stressed the

importance of taking into account how the change sought for in arts therapies is influenced by cultural and socio-economic factors, and the therapist needs to adapt the therapeutic process according to the client's cultural and social background. The client's internal as well as external circumstances should be considered. As a therapist working in South Africa, it is of utmost importance that the therapist is sensitive to cultural differences. The assumption that this research study could be applied to other contexts within South Africa should be scrutinised, and the process adapted to the specific client group. Yalom (2005) maintains that a therapist should create a new therapy for each client. In this notion of Yalom's, the outcome of research studies should also be adapted to suit the population or client group in which it would be applied.

**Research Design**

Pre- and post-assessment methods were applied in this research, in order to test the effectiveness of role-play in assisting adults with intellectual disabilities to understand social cues. Pre-assessment gauged the research participants' view on social cues and whether they can identify acceptable versus unacceptable social cues in a fairy-tale that was shared with them. The use of the fairy-tale will be discussed in more depth in the following chapters. The social relationships section of Jones' (1996) Adaptation of Scale of Dramatic Involvement Assessment was used, as this method assesses the focus of the participants and their understanding of social relationships.

Summative assessment was based on projective tests – Landy's Tell-A-Story assessment method – using role-play, which has also proved to be successful in the behavioural approach of psychology. This assessment approach focussed on the behaviour displayed by the research participants. Role-play has been used as a training tool in behavioural literature and suggested as a viable strategy for practicing coping skills (Rubenstein, 2006), and thus used as the main drama therapy technique in this research study. Robert Landy and Jason Butler (2012) developed the Tell-A-Story assessment method; it evokes a creative act from the participant, and the participant reflects on their actions after the creative act. This assessment method was adjusted to focus on the group of participants instead of individual participants. The group was divided into three smaller groups and given the task to create a role-play with social cues being evident. During reflection, questions were asked pertaining to social cues within the story.

Certain aspects of Landy's Role Method (2009) were used in this research process. Impersonation forms the basis of any creative drama activity (Landy, 1991), the premise that

“I am me and I am not me”. Two styles determine how roles are performed in relationship to reality; presentational styles are more intellectual and based on universal truths, while representational styles are more emotional. This study focussed more on presentational styles of roles, looking at the social cues present in the interactions.

A closed group was used in this research study, as people with disabilities need time to adjust to changes of any kind, and keeping the group membership consistent helped to alleviate any anxieties (Brudenell, 1987). The group sessions were scheduled to be 45 minutes long as concentration levels differed. The sessions incorporated the following since it provided the base and the boundaries for people with disabilities to enjoy the sessions, and for drama therapy to be successful (Brudenell, 1987):

- Enjoyment and personal growth;
- Time and pace – allowing a space for expression;
- Importance of movement – gaining awareness of space around the body;
- Contact with others – bridging gaps in making eye contact and awareness of others.

Eight sessions were conducted over a period of eight weeks – on Tuesdays from 15:15 – 16:00 – in the TV lounge of the centre, since the room was not utilised during these times.

The research participants were residents from Selwyn Segal Home in Sandringham, Johannesburg. The participants were selected by the care manager and included eight of the residents who are higher functioning. Eight participants is the maximum number for drama therapy sessions to be significant. The participants ranged in ages from 20 – 60 years. Process notes were written after each session for data recording.

**Ethical Considerations**

Ethics should be considered in all research studies; however, the scope of the ethics differs for each target group. Individuals with intellectual disabilities need to understand the nature of the research, as well as any risks or benefits in participating. If research subjects have an intellectual disability, it needs to be determined which subjects are able to make the decision to participate in the research, and that full informed consent has been obtained (Carlson, 2013). The researcher had to explain the scope, duration, and rationale for the research in a way that could be understood by the participants.

In addition to understanding the nature of the research, the well-being of research participants, as well as avoidance of harm, is important when working with people with disabilities (Bryen, 2016; Harris, 2010). Beneficent action was taken to ensure low risk and high benefits for the participants; the participants were in a room with no physical obstacles, and two care workers were present at all times. Consent was given voluntarily by each participant at the start of each session; I asked them if they would like to participate in the session and ensured that they answered me with a either by nodding their head or saying, "Yes." The privacy, anonymity and equality of research participants were taken into consideration, although the nature of the research participants could impact on the privacy and anonymity; the participants were proud to announce to the other residents that only they were selected for the drama therapy group. The privacy of the research participants had to be carefully monitored by ensuring that no other residents entered the lounge during the drama therapy sessions, however, this was not the case as some residents did not understand why they could not observe the group. Confidentiality could have been breached when the research participants returned to their accommodation and discussed the sessions with their friends.

Due to the nature of the participants' disabilities, the consent forms (Jones, 1996) were signed by their parents or guardians. I signed a confidentiality agreement with Selwyn Segal Home to conduct my research, and the participants gave their voluntary verbal consent at the start of each session.

**Conclusion**

The chosen methodology and research design ensured that the aims and objectives of this research study could be explored in-depth. The use of role-play allowed the participants to engage in a research study without feeling that their actions were being analysed for data. The pre- and post-assessment methods could be conducted in a way that felt natural for the participants; as part of the fictional world and role-play. Ethical implications have been maintained as strictly as possible by both researcher and research participants, allowing for a research study without harm or negative implications.

# Chapter 4

## Introduction

The eight research sessions were recorded in the form of process notes, and the data from these notes were analysed to measure the effectiveness of role-play in assisting individuals with intellectual disabilities to understand social cues. Each session will be explained and discussed in this chapter.

The psychopathology of all the participants included intellectual disability, with some of the participants presenting comorbidity (American Psychiatric Association, 2013); Down's syndrome, hyperthyroidism, depression, bipolar identity disorder, and schizo-affective disorder.

The participants who were selected by the care manager changed during the first two sessions; some of the selected participants opted out of the sessions before it started, and two participants opted out after the first session. The two care workers who were participating in the sessions invited six new participants during the second session, and they participated in all the subsequent sessions. These new participants were also higher functioning residents, like the original group selected by the care manager.

## Sessions

> Drama therapists are flexible. We have the capacity to foster transformation; to encourage authentic expression, criticize the systems of oppression, have the dis-empowered speak through the tools of drama therapy. Drama Therapists utilize both the personal and political; from within the group to working with an individual (Forrester, 2001:8).

I developed eight session plans before the onset of this research study, however, the session plans had to be adapted each week to accommodate where the participants were at, keeping it in line with the aims and objectives of the study. The structures of each session, however, remained consistent. The over-arching aim of the sessions was to use role-play to assist the participants in understanding social cues, as was indicated by the care manager due to her experience of the residents not understanding social cues. However, the participants who were selected by the centre were all higher functioning, which could have impacted their pre-existent knowledge of social cues. Two of the care-workers, a male and a female, participated in all eight sessions and also helped with the understanding of my instructions by the participants, as they already had an established relationship with the participants in a caring role (Booker,

2011), and they assisted the participants to make sense of the experience through the language they used with the participants in their caring role (Booker, 2011).

Each session started with a check-in – verbally or non-verbally – to gauge how the participants were feeling on the day (Casson, 2004). This was followed by a warm-up in the form of stretching and/or games, allowing for body awareness or embodiment (Jones, 1996), spontaneity, and group cohesion to develop (Johnstone, 1989; Spolin, 2010). Some of the games were also tailored to introduce the idea of personal boundaries, and mobilising the energy in the room (Emunah, 1994). The main event of the session was different in each session. This was followed by a reflection, allowing the participants' opinions to be acknowledged (Jones, 1996; Casson, 2004) – verbally or non-verbally - and a grounding.

The grounding became a ritual for the closing of each session; all the participants and I stood in a circle, digging together with our make-believe shovels, each getting a turn to make a sound, expressing how they were feeling, which was mirrored by the rest of the group. Hearing their sound mirrored by the group gives the participants a sense of being acknowledged (Jones, 1996; Casson, 2004). Furthermore, just like a mother's mirroring of her infant child exhibits acceptance, so does hearing their voices mirrored by the group fill the participants with a feeling of acceptance (Booker, 2011). The grounding not only allowed for the participants to return to reality (Jones, 1996), but the ritualization of the closure helped to give the participants structure and a sense of security (Snow, 2009). These therapeutic techniques were present in each session, instilling the values of a safe and contained space.

*Session 1*

Before the session started, I informed the participants that they were not forced to participate and they could tell me if they do not like an activity or do not want to participate. The one male participant immediately said that he did not want to do it because he does not like it. I asked him if he would be willing to give the session a chance first, before he decides that it is not for him, and he agreed.

From the commencement of the study, I had to adapt the sessions plans. The session started with four participants, and the initial warm-up game needed more people to be successful. During a discussion with one of my clinical supervisors, it was suggested that for the first session, I only play one game for the duration of the session in order for the participants to start feeling comfortable with me, as well as with one other in the same space. Because the first warm-up game could not be played, I decided to play the second game for the whole session.

The game I chose to play is called "K. I. N. G. Spells King"; it is an adaptation of Viola Spolin's (2010) "Cheese It" game. This game was selected as it brings the group together and allows them to understand the rules of games, and it also releases psychological responses (Spolin, 2010).

The game was further adapted as we played: I offered that the participants should make a sound or a movement when the King turns around. After my initial offers, I invited the group members to offer suggestions, these included walking sideways, walking funny, jumping like a kangaroo, twirling around, dancing when you have to freeze, making a sound when you have to freeze. Without having introduced role-play yet, the participants engaged in role-play through taking on these different walks and movements, thus not behaving like themselves (Landy, 2009). This role-taking came naturally and spontaneously, without the participants having to think about it or practice it (Landy, 2009). The male participant who wanted to leave at the start of the session had a big smile on his face and he also suggested movements for the game, engaging spontaneously (Johnstone, 1989; Spolin, 2010). This game was beneficial for building trust and unity among the participants, and also among the participants and me.

*Session 2*

At the start of the session, the male participant who said he did not want to take part in the first session, came to excuse himself and said he does not feel like being part of the group. When one of the female participants heard this, her reaction was, "He is going to miss out on all the fun." Two participants offered their explanation of what drama therapy is to the new group members who joined from the second session; that it includes fun, song and rhythm. For the check-in, the group members made a sound of how they were feeling, and the rest of the group mirrored it. I asked if they had any ideas on why it is important to know each other's feelings, and the group members all agreed with one participant who suggested that if you mirror them, you know how they feel and then you know how to handle them. I then asked them if they had any suggestions as to why we are mirroring each other, but no one offered a suggestion. I asked them if they thought that by mirroring someone, the person being mirrored feels acknowledged, and they all agreed with murmurs or nodding their heads in agreement. These questions were the first steps toward introducing social cues.

After the warm-up, I explained to the participants that we were going to enter storyland but in order for us to do so, we needed a gate to enter into storyland. I invited the participants to use cloths and furniture in the room to build this gateway. Constructing the gateway to storyland

built belief in the fictional world by allowing clients to participate actively in creating the fictional world (Wagner, 1980). Once inside storyland, I asked the participants what they saw and the following offers were provided: trees, birds, waterfalls, and animals. I asked every participant if they had an offer, as some participants were shy to speak up.

I told the story of Goldilocks, and adapted it so that the story took place in our storyland. Alida Gersie (in Meldrum, 1994) asserts that fairy-tales hold a form of conveying information, and that memories are evoked through the use of fairy-tales. Furthermore, the use of fairy-tales in drama therapy is also useful to create dramatic distance (Jennings, 1994); allowing the participants the opportunity not to face difficulties or issues directly, but through the fictional world.

At the end of the story, I asked the participants whether they thought Goldilocks behaved wrongly in any way, and if she did, how it could be changed. Solutions offered by the group were that she should not sit on the baby bear's chair as she knew she would break it; she should have apologised to the family for sleeping in the bed, and made the bed after using it; she should have made baby bear a fresh bowl of porridge. Lastly, papa bear told her that she cannot just enter people's homes and eat their food and use their furniture, she has to ask permission before she does it. I asked the participants if any one of them would like to retell the story of Goldilocks and change it to incorporate the positive solutions offered by the group, but no one offered. I then retold the story of Goldilocks and included the solutions offered by the group. The story ended where Goldilocks apologised for her behaviour, the bear family accepted her apology and from then on, she ate porridge with them every morning. Before we exited storyland, I invited any participant to offer a song that we all could sing as we left storyland. We hummed the song together as we dismantled the gate, allowing participants to leave the fictional world and re-enter reality (Jones, 1996).

"Fairytales are doubtless metaphors for many truths, but they can only be understood in context. Their deep significance in many cultures is clearly not confined to children" (Bannister, 2003:41). Fairytales contain strong moral lessons where kindness is rewarded (Hoffman, 2018). Furthermore, fairytales focus on one situation rather than the more complex situations covered by myths. The story of Goldilocks allowed for the participants to explore reality through the metaphor (Jones, 2007) of Goldilocks 'overstepping the boundaries of social cues' by entering the house of the three bears without their knowledge, eating their food and sleeping in baby bear's bed without consent.

We all got back in a circle and I invited the participants to embody (show with their bodies) the following feelings: when people take what is not yours, when someone breaks something of yours, when someone apologises and asks for your forgiveness. "Embodiment in dramatherapy involves the way the self is realised by and through the body" (Jones, 2007:113). Showing their feelings with their body allowed the participants to express their feelings and have them acknowledged by the group. Levine (2010) asserts that our thoughts are guided by our sensations and emotions. Embodying the above-mentioned feelings also allowed the participants to focus on their bodies and where in the body the various emotions sit, and what to do to rectify unwanted emotions (Levine, 2010). Upon asking the participants if they thought that feeling these emotions in their bodies might help them to not let the negative feelings stay with them for a long period, they answered that they did not know. Through further probing and asking them if the feeling of anger is shown (embodied) as clenched fists and stomping feet – as displayed by some of the participants – how can this be changed to not feel angry anymore. The one care-worker suggested that maybe you can unclench your fists and stop stomping. I asked the participants if they would like to try that; I offered the same question, to show (embody) the feeling if someone breaks something of yours, and once they embodied the feeling, I requested for them to release the tension in their bodies, and asked them if they felt any difference. Some participants agreed that the feeling of anger left their bodies when they released the tension. I suggested to the participants that when they experience these feelings again, they should remember where in the body they felt it, and release the negative feeling by relaxing that part of the body.

*Session 3*

At the start of the session, one of the participants apologised to me for "not being herself" in the previous session and that she was feeling much better. The warm-up activity I introduced is called "Emotional Greeting"; where the participants greet each other with different emotions as called out by the therapist – happy, sad, angry, frustrated – by only using the word *hello*. This warm-up game gave the participants the experience of expressing and dramatizing feelings (Emunah, 1994). Going around the circle, I invited each participant to share any character from a book, movie or real life that they would like to be. Allowing the participants to choose their own characters provided them with the opportunity to take responsibility in the session (Casson, 2004), and it enhanced the belief in the fictional world and the character (Johnstone, 1989) as the participants had knowledge of the respective characters. The participants were invited to choose costumes and/or props for their characters, allowing them

to create a fictional role (O'Neill, 1995). I explained to the participants that they were all going on a journey together, and invited them to suggest where they were going, and what they needed to do there, building the belief in the fictional world they were going to enter (Wagner, 1980). One of the participants offered that they were going to the moon to look for a treasure.

I narrated the story of this group of people getting into a space rocket, landing on the moon and looking for treasure. However, one rule of the role-play was that they could only find the treasure if they worked together, allowing me to observe their social interactions. This method provided containment as the role and the narrative were the same for the whole group, creating a sense of self and others, developing turn-taking and joint attention (Booker, 2011).

The group found four treasures on the moon and they decided they must share it among the group. Upon asking the group how they are going to divide four treasures amongst the eight of them, they proposed that they could sell it to me and then divide the money. As the "banker", I placed the money in the centre of the circle and invited everyone to take their share. At first everyone took different amounts, I asked them if that was fair and they all agreed that it was not. I asked if they could find a solution to that, and they all agreed that the money must be put back in the centre and then everyone should take the same amount. I invited the participants to place their money in the centre of the circle and I started leading them in a rhythmic clapping, to lead them back into reality (Jones, 2007; Landy, 2009). As the group clapped together, I moved the money out of the circle and then invited each participant to say their name, thereafter the group mirrored their name. Clapping to a rhythm not only reinforced the group cohesion (Emunah, 1994) but also allowed the participants to become aware of being out of the fictional world.

The participants' awareness of the inequality in sharing the money the first time around, highlighted their understanding of sharing the reward with everyone who worked together. I admired the one participant's comment; "We are not selfish," after the equal distribution of the money. This comment demonstrated how the participants could link the role-play to real life (Corey, 2013; Jones, 2007; Landy, 2009).

*Session 4*

The main event of this session included the use of hats, so the hats were introduced during check-in and utilised during the remainder of the session. The participants could choose any hat as their check-in, and speak back to the hat as to how it represented how they were feeling, allowing them to project their feelings onto the hat (Jones, 1996). The warm-up continued with

the use of the hats, in a game called “Musical Hats”; where hats get passed around the circle, and when the music stops, the participants had to wear the hat that was in their hands and stand according to a character/role that would wear that specific hat. This game allowed them to embody different roles (Jones, 1996) and to evoke improvisation and spontaneity (Johnstone, 1989; Spolin, 2010).

As a bridge-in to the main event, the participants walked around the space wearing the hat they ended up with during the last round of musical hats. I invited them to start walking like a person wearing a hat like that would walk, then giving the character a name, deciding where that character lived and what work they did; granting them the opportunity to become a different role (Landy, 2009; Meldrum, 2005). For the main event, the participants paired up as their characters and selected an A and a B in the pair. First, A would take off their hat and, as themselves, interview B in character, asking three questions about the character that had been developed earlier in the session; what is their name, where does the character live, and what work does the character do? Once A thanked B, A would put on their hat again, and get into character. B would then take off their hat and, as themselves, interview B in character, asking the same questions. This activity allowed the participants to engage in social interaction while being in a different role (Andersen-Warren & Grainger, 2000), and it offered them the opportunity of stepping into- and out of role (Landy, 2009).

The reflection was planned to discuss social cues during the interviews and how certain behaviours of the interviewee or the interviewer made them feel, but the participants were laughing so much from excitement that we ended the session with the digging ritual. Upon rumination, I realised that I could have introduced a relaxation or focussing exercise in order to discuss the social cues.

*Session 5*

At the end of every month, the centre hosts an amalgamated birthday party for everyone who celebrated a birthday during that month. This session coincided with the monthly birthday celebration. The participants came to the TV lounge directly after the birthday party, and they were very excited, continuing to talk and dancing around the room. I tried to play a focus game with them, but they continued talking and dancing. The stimulation at the birthday party excited them too much, as they “have difficulties regulating emotions and behaviour in an age appropriate fashion” (American Psychiatric Association, 2013).

At the beginning of the session, I introduced "Transformations" where a piece of cloth is sent around the circle and every participant is invited to transform the cloth into anything else. This activity helps to focus the participants' attention, and stimulates imagination (Jennings, 1999). I initiated this game trusting that it would give the participants the opportunity to focus their attention in the therapy space and let go of the excitement from the birthday celebrations. However, the participants were still distracted and I introduced the game of "Wah-Skida", (Emunah, 1994;Johnstone, 1989; Spolin, 2010) to establish focus, where a clap is sent around the circle, or it can be returned by saying "skida," but this proved to be in vain.

Having told me in previous sessions that "K. I. N. G. spells King" is their favourite game, I suggested to the participants that we play it. This game brought the group together as they already knew the game and did not have to focus on learning new rules or to apply any thought processes. After playing, we ended with the closing ritual of digging, which also proved to be challenging as they could not concentrate on whose turn it was, or what the sound was that had to be mirrored.

*Session 6*

For the warm-up, the participants moved together in the space, while warming up parts of – and becoming aware of their bodies (Boal, 2002). Landy's Invoking and Naming a Role method was used as a bridge-in to the main event. In this method, the therapist invites the participants to focus on one part of their body as they walk around the room, and to allow movement to extend from that part of their body. The therapist then invites the participants to create a character from that body part and movement; focusing on how it moves, talks, what the character's mannerisms are, and what the character's name is. This method allowed the participants to create their own role from a part of their bodies (Landy, 2009). The participants were invited to greet each other in their roles; this gave them the opportunity to take responsibility of their chosen roles (Booker, 2011) and the playing out of those characters (Frydman, 2016; Meldrum, 2005).

In role, the participants were invited to pair up and communicate with each other by only using the body part that their role was developed from, enhancing their newly developed roles (Frydman, 2016; Meldrum, 2005). I invited the participants to sit down as the audience, and using Theatre Sports (Boal, 2002) invited pairs to 'perform' for the audience, using their body part roles as they did in the previous activity. I gave them different scenarios; selling a hat, trying to take something from the other person, trying to put a hat on the other person's head,

and trying to give something to someone. Watching each other perform was thoroughly enjoyed by the group; they laughed throughout the performances and commented; “That’s so funny,” or “Look at that,” and gave each performance a resounding applause.

*Session 7*

The initial plan was for the group to create a performance highlighting social cues and rehearse it in this session, to be performed in the last session. However, I changed this into an improvisational skit in three groups. This decision was based largely on my observations of how this group enjoyed watching each other perform and also their lethargy; this session took place on Thursday the 12th of December, and it was the day before they finished working for the year. As the participants entered the room, the majority of them told me how tired they were, one commented that he did not know if he was ready for the session. Yalom (2005) maintains that a therapist needs to meet the client where they are at.

After asking the group if they would like to perform for each other, and receiving a resounding, “Yes!” I divided them into three groups and gave each group a scenario to rehearse and then perform. The first group’s scenario was someone giving flowers to their significant other and the third person wants to take the flowers. The one participant in this group did not understand the instructions, so the care-worker – who was a part of this group – narrated the story while performing with the other two participants. In the performance, the male participant wanted to give the female participant a bouquet of flowers, but the care-worker kept jumping in-between the couple trying to take the bouquet. Upon reflection, the participants suggested that the person should have just given one flower to the third person, as there was a whole bouquet.

The second group’s scenario was two parents in the shop with their child, and the child wanted to have a doll. The one parent agreed but the other parent refused. Upon reflection, half of the participants said that the family should have discussed it at home, and the other half suggested that they should have just given the child the doll because she really wanted it.

The scenario of the third group was that two people had to persuade the third to believe in fairies. During reflection, the group agreed that you cannot force someone to do something that they do not want to do, and you need to respect their views.

Performing their improvised skits allowed the participants to engage in projected and embodied playing, while exploring social cues. Through witnessing each other, support and different perspectives were enhanced (Jones, 1996; Bailey, 2009; Landy, 2012).

*Session 8*

> The ending of a whole series of sessions needs particular consideration. A sense of completion is required, of journey's end, and the celebration that brings with it (Booker, 2011:69).

Being the last session, and considering that all the participants were getting into the festive spirit, I decided that our last session would just be a celebration of our time together. To keep the consistency and structure of the previous sessions, we started with a warm-up game where each participant offered a movement that was mirrored by the rest of the group. I took cupcakes for all to share, and as we sat around the table enjoying the cupcakes, I invited the participants to share what they appreciate or like about each member of the group. The participants could not understand this question, so they all answered what would have been my second question; what they liked about the drama therapy sessions (Booker, 2011); these included dressing up, games, performance and just wanting to carry on every Tuesday.

## Discussion

> At its very core, the flow of therapy should be spontaneous, forever following unanticipated riverbeds; it is grotesquely distorted by being packaged into a formula… One of the true abominations… is the ever greater reliance on protocol therapy in which therapists are required to adhere to a prescribed sequence, a schedule of topics and exercises to be followed each week (Yalom, 2005:34).

Playing the same game for the first session proved to be beneficial for both the participants and for me. The structure and rules of the game set the tone for the research sessions; that there would be structure and rules. In her book on Developmental Drama, Mary Booker (2011) talks about the value of repetition in establishing anticipation, and enabling group participation. Landy maintains that play is one of the main elements that informs the practice of drama therapy (Jones, 2007). Furthermore, playing in drama therapy has therapeutic meaning; this being allowing the participants and myself to build trust (Yalom, 2005) and group cohesion. Developmental drama formed a cornerstone of this study because it is process-orientated; it is about being, learning and developing together in a social and dramatic context, and not about achieving tasks (Booker, 2011).

The game of "K. I. N. G. Spells King" was the perfect choice as it upheld the principles of developmental drama; establishing group cohesion through being together in play and not about competition or achieving tasks. One group member volunteers to be King for the first round. The king stands against the wall on one side of the room, facing their back to the rest of the group members who are standing in a line next to each other, on the other side of the room, facing the king. With their eyes closed, facing the fall, the king says "K-I-N-G spells king" and once they've completed this line, they turn around. While the king says the aforementioned line, the group members have to walk /run towards the wall. Once the king turns around, the group members have to freeze. Any group member who is caught moving by the king, has to go back to the starting point. The king then repeats the line, and turning around, until the first group member touches the wall, who is then the new king. Warren (2003) highlights the value games like this; they help to create a favourable atmosphere for cohesion, improve concentration and attention, and they develop body awareness and balance. Body awareness play a pivotal role in drama therapy (Jones, 2007).

> Beginnings and endings are important. They should be the same for each session. Through ritualising beginnings and endings, a very holding container is created for the rest of the session. The containing sense of the 'known' allows the clients to tolerate the 'unknown' things that can and will occur within the rest of the session (Booker, 2011:50).

The consistency in the structure of the sessions was beneficial for this target group. The ritualised check-in, warm-up and grounding activities gave the participants structure and a sense of security (Snow, 2009). Van der Kolk (2014) highlights the healing power of community through music and rhythm. He continues by arguing that our sense of agency and control is defined by our relationship with our bodies and its rhythms. Colwyn Trevarthen (in Van der Kolk, 2014) posited that our rhythmic body movements, guided by our brain, allows us to act in sympathy with other people's brains. The closing digging ritual granted the participants the opportunity to gain a sense of control of their bodies through rhythmically digging, breathing and repeating each others' sounds before returning to their daily routine outside of the therapy group.

The offering of suggestions on how to walk, or how to behave in the freeze introduced role-play in the sense that the participants had to walk or behave like someone or something that isn't them. This reiterated Landy's (2009) statement that role-play is a natural process and the ability to imagine oneself as someone else is not learned behaviour and every person takes on a different role depending on the life situation they are in.

Even though only four participants and the two care workers were present in this session, the group cohesion that was developed carried over to the new participants. This might be attributed to the fact that the participants share the same accommodation and have an already established bond. The culture of the sessions was to foster mutual understanding, helpfulness and sensitivity toward others (Crimmens, 2006). This was proved through the participants assisting the person who was king by reminding them what to do, showing that they care more about playing the game and having everyone participate, rather than not helping the person who was king so that they could win the game.

The offer made by the one participant that it is important to know other people's feelings as it helps you to know how to approach them, was an indication to me of their understanding of empathy. Harris (2010) maintains that empathy and pro-social behaviour play a big role in the moral agency of people with intellectual disabilities. My questions introduced social cues in a way of getting the participants' view on human interaction.

Constructing and entering the gateway to storyland (Wagner, 1980) allowed the participants to be transported into the fictional world where they could immerse themselves in the story and the characters. Storytelling helps clients to make sense of their lives by identifying with the themes and structures of stories (Landy; 1991), and this can help the client cope with negative emotions in various ways (Frude & Killick 2011). Story is the content of the individual's dramatic expression, it could be fictional, but it becomes a reflection of real life (Landy, 2009), and it can be seen as a bridge between inner psychological worlds and outer real worlds (Golding 2014).

For the pre-assessment, the social relationships section of Jones' (1996) Adaptation of Scale of Dramatic Involvement Assessment was used – telling the story of Goldilocks and asking questions afterwards – assessing the participants' understanding of social relationships, and how they understood social cues in the story. This section of Jones' method tests the understanding and engagement in social relationships on a Likert scale, which was adapted for this research study:

1. *Awareness and response to the behaviour of the characters in the story*:

| Fully Aware | Partially Aware | Not Aware at all |
|---|---|---|
| ☐ | ☐ | ☐ |

2. *Ability to provide socially acceptable solutions*:

| Fully Able | Partially Able | Not Able at all |
|---|---|---|
| ☐ | ☐ | ☐ |

At the start of telling the story of Goldilocks, some of the group members said that they knew the story. I asked them if they would like to hear it again and they all agreed. After telling the story, I asked the group if they thought Goldilocks did anything that she should not have done; this was a more indirect way for me to introduce social cues. At first, they could not think of anything so I revisited every scenario in the story and asked, in each scenario, that if Goldilocks did that to them would they be happy. Once I phrased it in a more personal manner, the group members identified Goldilocks' actions that were not acceptable.

The majority of the group displayed awareness of how Goldilocks did not behave in the correct manner by eating the food, breaking the chair, and sleeping in the bed. The majority of the group were also able to provide solutions to the story so that Goldilocks would not be in trouble,

but they also showed a moral awareness as the solutions ensured that Goldilocks would not act in a wrongful manner. The assessment was conducted within the storyland that the participants created, allowing the participants to be distanced from their reality (Jennings, 1990), and explore social interactions through the metaphor of the story of Goldilocks. The participants' suggestions that Goldilocks' behaviour was wrong in taking food and using the bear family's house, indicated to me that the participants had an understanding of what social cues are. In drama therapy, the life-drama connection (Jones, 1996) is when participants draw from real life to understand behaviour or actions that transpired in the fictional world, or vice versa.

Embodying the various emotions after they dismantled storyland allowed the participants to connect the fictional world with reality (Landy, 2009; Jones, 2007), and it offered them the opportunity to feel where in their bodies various emotions sit (Levine, 2010). "We gaze, touch and speak, and through… our sensations, know ourselves and each other… Without access to the feeling sense, through bodily sensations, our lives would be one dimensional… our physical life and feeling life… depend upon embodiment" (Levine, 2010:273). When the participants are able to pay attention to their bodily sensations, they are able to enhance their creativity and purpose in life, as they would be able to reduce their negative feelings (Levine, 2010). Van der Kolk (2014) argues that through embodiment we will learn to feel what we feel, and know what we know. If I were to repeat this study, I would include more improvisational games (Johnstone, 1989; Spolin, 2010) before we enter storyland, to allow the participants to be fully immersed in the fictional world (Jennings, 1994).

The apology offered to me by the one participant saying that she was not herself in the previous session, conveyed her understanding of social interactions – her need for me to know that she was not how she always is – as well as her enthusiasm to participate in the sessions. The session where the participants went on a journey to the moon to look for treasures was the first session dedicated to role-play. By asking the participants to choose which character they would like to be, where they will go to on a journey, and the reason for the journey, gave the participants freedom and empowerment (Casson, 2004). The story narrated by me that they were going to the moon to find treasures provided a fictional world that the participants could visit together; where they could explore the difficulties of working together to find the treasures and to return stronger and more confident (Golding, 2014) when they had to decide how to divide the treasures among them. This story and role-play evoked responses from the participants that had personal meaning to them; that it is not right for some to get more money than the others because they all worked together (Chavis, 2011; Golding, 2014).

Moreover, in the fictional world of the story of the moon journey, the roles that the participants chose offered them a safe container for exploration and deciding which of the other participants they wanted to team up with to search for treasures (Nash & Haen, 2005), expanding their perspectives and choices. Coming back to earth and having to decide how they would share the treasures, granted them the opportunity to view issues or events differently (Emunah, 2005) and think of new solutions. Brudenell (1987) argues that people with intellectual disabilities show a lack of understanding of social interactions and difficulty interpreting and using social cues. However, the participants' reasoning that the treasure should be shared equally indicates to me that in the role-play and the fictional world of story, their understanding of social interactions came to the fore. Harris (2010) suggests that empathy and pro-social behaviour play a big role in the moral agency of people with intellectual disabilities, and this was evident when the participants shared with the group what they were going to do with their money; the majority of the group said they would buy themselves some nice things: big houses, expensive cars, go on holiday, buy their family gifts, and give the rest to charity or to people who struggle.

Jones (1996) and Emunah (2009) assert that by taking on different roles in a drama therapy session, the individual can explore their own life-roles as well as other roles that they might find challenging. Furthermore, they proposed that role-play grants the opportunity for individuals to learn valuable skills like communication or confidence. These statements were proved during the role-play interviews. I could clearly observe how, through the role-play, the confidence levels of two participants increased. These two participants were usually shy and did not provide suggestions or feedback during the previous sessions, although during this role-play they transformed into two confident individuals who were very proud to introduce themselves – in character – to the rest of the group, and one of them offered their interviewing pair to go first. It was apparent that the personal functioning of these individuals (Rapley, 2004) through peer interaction, as well as role-play (Landy, 2009; Emunah, 2009), was enhanced.

The roles shared by the participants during their interviews each had their own story; what their name was, where they came from, and what work they did. In drama therapy, storytelling helps clients to broaden their experience of the world, and it provides an understanding in human psychology (Frude & Killick 2011) through the fictional world (Jennings, 1994). Story is the content of the individual's dramatic expression, it could be fictional, but it becomes a reflection of issues in the individual's life (Landy, 2009). Being interviewers in-role allowed the participants to interact in the safe containment of "being someone else" and thus different social cues and different ways of interacting could be practiced. If I were to conduct this study again,

I would repeat this session the following week, allowing participants to take on another character, and to decide on their own interviewing questions. This would enhance their responsibility taking (Casson, 2004) as well as their spontaneity and improvisational skills (Johnstone, 1989). Moreover, asking their own interview questions provides them with the opportunity to practice social interaction and behaviour (Corey, 2013; Landy, 2009).

Play is one of the main elements informing the practice of drama therapy (Jones, 2007). Because people with intellectual disabilities experience limitations in their adaptive abilities, their capacity to respond appropriately in certain social or environmental settings is limited (Rapley, 2004). Eleanor Irwin (2005) claims that non-players are unable to hold sustained interaction with others. Even though the participants were overly excited from the birthday party, through playing games they were still able to engage in social interaction, by explaining the game to participants who have forgotten the rules, by offering suggestions of how they should move or what they should do during the freezes, and making sure that everyone was ready to start the next round with the new king. Winnicott states that an individual is only able to be creative and use their whole personality during play, and that it is only in this creativity that an individual discovers themselves (Irwin, 2005). This session dedicated to playing games was beneficial in the sense that the participants were all involved, and that the games we played were exploring social interactions. In future, I will not doubt myself for dedicating a session in the middle of the research study to play games, as these are also therapeutic (Jones, 2007).

Most of the literature about the social competence of people with intellectual disabilities is focussed on linguistic capacity (Rapley, 2004), leaving a gap in knowledge about non-linguistic capacity, like body language. The sixth session was positioned in embodiment and role-play, exploring how these two techniques could aid in understanding social cues. “Embodiment in dramatherapy involves the way the self is realised by and through the body. The body is often described as the primary means by which communication occurs between self and other” (Jones, 2007:113). The roles that were evoked from a body part (Landy, 2009) brought a new dimension to the behaviour and performance of the participants.

The movements that the participants ascribed to their respective body-part-roles highlighted how their confidence levels had increased. The one participant who usually had rigid and restricted movements called her role “Skeleton” and her whole body became fluid, almost like jelly, as she communicated through her body. Similarly, a male participant who always kept his distance from other participants during role-play seemed to have forgotten about his

personal boundaries, and with his body he moved freely towards and around the participants. These body-part-roles allowed the participants to explore beyond their comfort zones, as perceived by me. The dramatizing of the body involves how an individual relates to their body, and develops through their body, when involved in dramatic activities within drama therapy. Embodiment in drama therapy encompasses the way the self is realised through the body. Some describe the body as the primary means by which communication occurs. The body and the mind are engrossed in exploration during dramatic activities (Jones, 2007).

Mary Booker (2011) commented that people with intellectual disabilities have a limited role repertoire. However, during this embodiment role-play, the participants performed roles that have not even been experienced by the care-workers or by the other participants who share the same accommodation. One soft-spoken participant, who displayed restricted movement and a non-threatening demeanour, took on the role of a masculine rugby supporter; he embraced the role by making sounds in a deep, angry voice, standing with his legs wide apart and his hands clenched in fists. Another participant who usually needed me, or one of the care-workers, to stay with her to explain what to do, started dancing enthusiastically when it was her turn to perform.

The embodiment role-playing allowed the participants to access dormant roles (Landy, 2009) or to enhance known life-roles. Drama therapy offers the opportunity to pass on the power, by allowing participants to advocate for themselves (Bailey, sp), and this activity offered participants the opportunity to be in control of their bodies, their actions and decision-making. Each participant decided what part of their body their character would develop from, as well as the character's movement and name. Furthermore, the participants decided how they would go about performing their given scenario without input from myself or the other participants. Should this research study be repeated, more sessions should be designated for embodiment-role-play, allowing the participants to interact freely with their bodies and not verbally (Schalick, Westbrook and Young, 2012; Boardman, Bernal & Hollins, 2014).

When the participants performed their improvised role-plays to the group, they stepped into the shoes of actors. Just as actors take on different roles, and use roles to present certain qualities, so do people take on roles in real life situations (Landy, 1991). In role, the participants – in the role-play of two people trying to force another to believe in fairies – experienced what it was like to be the aggressor, being confronted with what it was like if someone tries to force something on you; and to be the victim. The participants witnessing the performances were

able to see negative social interactions and social cues objectively, as an outsider. Phil Jones (2007) proclaims that people's life experiences are validated when they are performed for someone else, as their encounters are empathised with and responded to. This performance also benefits the establishment of a relationship between the experiences in the therapy space, and the individual's life experiences. Furthermore, he states that drama therapy creates the possibility of finding new meanings through the playful and experimental space of drama therapy.

The summative assessment was based on projective tests – Landy's Tell-A-Story assessment method – using role-play, which has also proved to be successful in the behavioural approach of psychology. This assessment approach focussed on the behaviour displayed by the research participants. Role-play has been used as a training tool in behavioural literature and suggested as a viable strategy for practicing coping skills (Rubenstein, 2006), and thus was used as the main drama therapy technique in this research study. The Tell-A-Story assessment method; evokes a creative act from the participant, which is reflected upon afterwards. The group was divided into three smaller groups and I gave each group a scenario that they had to plan, rehearse, and perform for the bigger group. The aim of these performances was to assess whether the weeks of role-play and story assisted the participants to understand social cues.

Harris (2010) contended that people with intellectual disabilities experience difficulty in showing empathy and placing themselves in the shoes of another, which affects their ability to understand social cues. Upon reflection of the three improvised role-plays, the participants were able to identify which social cues were wrong in the respective performances, and were able to suggest different ways of interaction. Moreover, the participants also showed empathy for the characters who were not treated fairly during the role-plays, suggesting how they could have been treated better. The role-play provided the opportunity for the participants to read social cues, and explore moral reasoning in a safe space (Landy, 2001; Jones, 1996).

"It is the affective sharing of one's inner world *and then the acceptance by others* that seem of paramount importance. To be accepted by others challenges the client's belief that he or she is basically repugnant, unacceptable, or unlovable. The need for belonging is innate in us all. Both affiliation within the group and attachment in the individual setting address this need. Therapy groups generate a positive, self-reinforcing loop: trust-self-disclosure-empathy-acceptance-trust" (Yalom, 2005:83). Further to being accepted by the group, in empathic and mutually understanding groups, participants come to the realisation that each one of them contribute to

the group cohesion (Yalom, 2005) allowing for them to build reciprocal relationships. These cohesive and mutually understanding groups share a sense of support, reassurance and insight (Yalom, 2005).

Even though responding to natural cues is not always possible for people with disabilities (Mu and Royeen, 2004), within the performing and witnessing of the role-plays, the majority of the participants were able to understand the social cues, and offer suggestions for unwanted social cues. They proposed that you cannot force someone to do, or believe in something that you do, and that you have to respect their opinion or point of view. Furthermore, they suggested that the person who had a whole bunch of flowers should have given one or two of the flowers to the other person who really wanted a flower, as there were enough flowers. They also put forward that the parents should not have had the discussion about the doll in the shop in front of their child, but rather in private.

Fiaschini (2012) argues that in disability theatre, the disabled actor's understanding of feelings can reach unforeseen profundity. Furthermore, their ability to express themselves leads them to perform actions that are symbolic and communicative; exhibit professional skills, as well as gestures that combines precision and feeling in a skilled manner. By developing the excess energy that makes them alive, that keeps them present and creative, the 'disabled' actor turns out to be actually 'able,' either from a formal point of view or on the level of content, with many positive results. The role-plays explored in this study allowed the participants to become actors, and to experience social interactions, as well as themselves from different perspectives, in a safe and contained space. They were given the opportunity to become someone else and to act like another person, allowing them to experience a different part of themselves. Moreover, the scenarios given to the groups were different from their everyday lives, granting them a chance to participate in a context that might be unknown to them. Through these role-plays, the participants exhibited empathy; responding with care (Fagiano, 2019), as well as theory of mind; attributing emotions and intentions to oneself and others (Sterck & Begeer. 2010).

Having been grounded in the behavioural perspective of psychology, this study was action oriented, focusing on whether behaviour could be changed (Burton, 2001). Difficult or unwanted behaviour – the inability to understand social cues, as specified by the centre – was addressed through learning new behaviour during role-play, practicing this behaviour and linking the role-play to real life in order for the behaviour to become habitual and automatic (Burton, 2001; Corey, 2013; Botha & Moletsane, 2012).

Although some participants sometimes had difficulty in following instructions, or understanding what I was saying (Boardman, Bernal & Hollins, 2014), the presence of the care-workers in the sessions was of great value. The care-workers could explain to the participants in a language that has developed between them (Booker, 2011). However, as much as I could, I made use of simpler sentences and less instructions (Schalick, Westbrook & Young, 2012).

While people with intellectual disabilities may experience internalised stigmatisation (Goffman, 1963; Mackelprang & Salsgiver, 1999), it was not presented by the participants in any of the sessions. Apart from not being the focus of the study, possibilities of this could be because the activities or sessions did not provide a platform for the participants to talk about it, or because of the safe and contained space. Role-play is a powerful technique to dispute stigmatisation; it allows individuals with intellectual disabilities to challenge stigmatisation and fight self-stigmatisation in the playspace, a safe space created within the therapy room (Jones, 2007). The fictional world (Jones, 2007; Landy, 2009) of role-play encourages the individual to become empowered and energised through adopting positive self-perceptions, rejecting stigma and discrimination (Watson & Larson, 2006). Role-play in the group setting allows the individual with intellectual disabilities to feel acknowledged and supported, fostering a positive identity (Watson & Larson, 2006), and self-empathy (Jones, 2007).

**Limitations**

> …therapy isn't quick or simple, and neither is research (Berman, Chapman, Nash, Kivlighan & Paquin, 2017:245).

Researcher-therapist bias is one of the limitations of this research. It can be difficult to separate the researcher and therapist roles (Finlay, 2011), with special care taken to identify boundaries and roles. A researcher also wearing a therapist's hat might identify another issue in the session which they would like to spend more time on, to 'therapise,' but cognisance needs to be taken not to veer away from the research aims and objectives (Finlay, 2011).

An aspect that prevents this research from being applied to the broader South African context is the fact that this research was conducted in a Jewish care home, where the participants were all higher functioning, predominantly Jewish, and all of them white, with an English, Western frame of reference. The participants and the care-workers all knew each other and interacted on a daily basis, which could have affected the authenticity of the role-plays or social interactions. The participants live in a protected environment where they receive food, medical

attention, and a warm bed to sleep in, something that is not prevalent in the larger South African population.

Another limitation is that it was a small sample of only eight participants. Furthermore, the time of the year influenced their thoughts and feelings as they were all looking forward to the December holiday. Although it was very beneficial that the two care-workers participated in the sessions, their ability to communicate with the participants and explain instructions could have affected the interaction between myself and the participants. Although I did not interview the care-workers after the research study, my observation of them was that they were also surprised by some of the participants' behaviour displayed in role.

**Recommendations**

Bing and Gaffney (2003) postulate that the heart of drama is in our everyday lives and the different roles that we play. I recommend that role-play be utilised in other communities with people with intellectual disabilities, to further research the possibility of role-play to assist these individuals to understand social cues. Furthermore, mixed groups from different socio-cultural, socio-economical, and socio-political backgrounds should be used in further research because of South Africa's differences in society.

I would also recommend that further research with mixed groups include at least 12 sessions, allowing for participants to establish group cohesion and for the researcher to identify and adapt their language accordingly, as well allowing for sessions to be repeated in order to practice real-life situations (Corey, 2013; Landy, 2009). Besides this, I would also recommend that the summative assessment be kept in small groups, as opposed to the whole group performing at once, as witnessing social interaction and social cues is beneficial to the participants' experience and understanding of social cues (Jones, 2007).

**Researcher's Reflections**

> To work in disability arts, or in arts for disabled people, is to experiment with one's own positioning and to struggle with the meanings that arise at the point where practitioner (disabled or nondisabled) meets work. Quite apart from the analysis of power between disabled and non-disabled people, the self-abnegation of the facilitator collides with the self-aggrandisement of the guru, and in the midst of the personal reflection is the need to move beyond questions of self, towards creating work that has 'immediate relevance'." (Conroy, 2009:5)

The above quote encapsulates my time at the Selwyn Segal Home. Wearing the hats of both the therapist and the researcher was rather challenging at times. When I had to adapt session plans to meet the participants where they were at in the moment, I kept doubting myself; wondering whether I should stick to the proposed session plan, wondering whether I was veering away from doing research and reverting to running a drama group, wondering if it is for me that I am changing the session plan, or for the participants. Every day, I left the centre wondering "am I actually doing research?"

During my time at the home, I experienced Bigby and Craig's (2017) assertion that the social network of most people with intellectual disabilities consists of their families, carers and other people with intellectual disabilities. A group of the Selwyn Segal residents went on a camp to Cape Town with some of the care-workers. Even being outside of the centre, in a different city, these residents' social interactions were still limited.

It was interesting how some of the residents would enter the TV lounge during the sessions to see what was happening, and then the participants would tell them to leave because they were not supposed to be there. This showed me that they were proud to have been chosen to be part of the drama therapy sessions, and they regarded those 45 minutes as their time, and the TV lounge as their space; which reminded me of the safe and contained therapy space that Jones (2007) speaks about. My interactions with some of the other residents outside of the therapy space was fulfilling and endearing, giving me a glimpse into their lives; two men told me about their work, and how they were looking forward to the December holiday. Another one told me about his girlfriend and insisted on giving me his signature. One particular man greeted me at the door every week and engaged in conversation until it was time for him to leave the room for the session to start. I did not once have to ask him to leave because the session was about to start, he knew exactly who all the participants were, and when he saw that they were all present, he said goodbye and left the room. Although he was not a participant, my interactions with him highlighted his understanding of social cues and social interactions in that he left the room as soon as he knew all the participants were present, and I did not have to explain to him why he needed to leave. Some of the residents greeted me, often asking what I was doing there, and when I told them I am there for a drama therapy group, they always asked if they could also participate.

The South African Human Rights Commission (2017) stresses the importance of equality for people with disabilities by advocating for the same rights that apply to those without

disabilities, such as inclusion in communities, and the Selwyn Segal Home offers exactly this. The residents are treated with the utmost respect, the care-workers have a passion for what they do, and the facilities are in pristine condition. The centre has an annual concert, and the higher functioning residents are working in the community in various jobs.

> Drama is an example of human interaction. It is concerned with human beings communicating with one another; verbally, physically and emotionally. Most importantly, this dramatic interaction is part of our everyday lives (Warren, 2003:111).

This research gave me a renewed belief in the power of drama; observing the participants every week and how they became more outgoing with every week that has passed. After the third session, one participant insisted on showing us a dance before every session started. A participant who was very wary of participating at the beginning started arriving early for the sessions, having a smile on their face the whole way through. During our last session, this participant also asked me when in the new year we would continue with these sessions because they are very enjoyable. The participants who had difficulty communicating verbally flourished in the activities where embodiment or sound was present, making drama therapy such a valuable method in working with people with intellectual disabilities as it is tailored to suit the participants. After the first embodiment session, the participants who have difficulty with verbal communication automatically utilised their bodies in communication.

One of the participants has a speech impairment; at the start of this study I had difficulty understanding what the participant was saying, however, by the end of the study, I could understand what the participant was saying. Yet, this might be due to my spending time with the participant and learning their style of communication. The participants value a sense of community and sharing; they always made sure every group member got a chance to participate, even selecting the "King" when there was a participant who did not manage to become "King," for being too slow. Throughout the sessions, I experienced how the participants' confidence grew; either by arriving early, by offering to participate first, by being fully immersed in the role-play, or by offering suggestions to problematic situations.

Although the participants were informed from the start that I would only be conducting eight sessions with them as it is part of a research project, they developed a bond with me, and continued asking if I would come back in the new year and conduct sessions with them every week because they really enjoyed the group. On my last day, I left the centre with the recurring, burning question of "am I actually doing research," along with a very heavy, but immensely fulfilled heart. This burning question might have also been fuelled by some of the participants'

existing understanding of social cues. The participants at Selwyn Segal not only assisted me in being able to conduct this research study, but their sheer honesty, openness and willingness to participate also reminded me to never lose sight of my own journey, and my own life purpose.

> …the fact that being human always points, and is directed, to something, or someone, other than oneself - be it a meaning to fulfil or another human being to encounter. The more one forgets himself - by giving himself to a cause to serve or another person to love - the more human he is and the more he actualizes himself (Frankl, 1984:133).

## Conclusion

> Creative action techniques are beneficial for learning social skills, as the creative activity facilitates the integration of unconscious material, strengthens the ego, and promotes personal development (Casson, 2001:24).

People are role players and role takers by nature and can imagine themselves as someone else (Landy, 2009; Booker, 2011), and a person's personality constitutes of various interactive roles. These roles are understood as specific behavioural patterns that indicate ways of thinking, feeling and acting; role is not fixed and can change or adapt to different life situations. This statement was applied in this study with people with intellectual disabilities. The participants entered the fictional world of role-play with ease and excitement.

Introducing drama therapy to the participants through games allowed them to play uninhibitedly and to build trust among themselves, and between themselves and me (Jones, 2007; Booker, 2011). The playful nature of the participants influenced their readiness for role-play. The role-play not only allowed the participants to take on different characters, but it also granted them the opportunity to witness the other participants in their role-play performances. This did not only contribute to the research study but also to the relationships of the participants in seeing their friends from different perspectives.

The scenarios of the role-plays focussed on unwanted social behaviour – the inability to understand social cues, as specified by the centre – and these behaviours were easily identified by the participants who witnessed the role-play. Furthermore, the participants displayed empathy toward the characters who were being bullied or victimised, showing and ability to put themselves in the shoes of another. Their pro-social behaviour was evident through the solutions or suggestions they offered to change the troublesome behaviour. Their understanding of social cues in the role-plays was discernible through their commentary and suggestions during reflection. However, the fact that the participants selected by the group were

higher functioning, could have impacted their pre-existing knowledge and understanding of social cues.

Through this study, the participants' restricted adaptive behaviour could be explored, and their adaptive abilities were strengthened through the role-play in the fictional world. Role-play has proven to be effective in assisting individuals with intellectual disabilities to understand social cues, however, in a limited context. The safety of the centre, the participants' pre-established relationships and their socio-cultural background do not necessarily allow this research to be applied to other contexts within South Africa.

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## Appendix A

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

dfldramaforlife

WITS SCHOOL OF THE ARTS
DRAMA FOR LIFE
Arts for Social Transformation and Healing

**Participant Information Sheet**

Good day

My name is Karel Weber; I am a Masters student in Drama Therapy at the University of the Witwatersrand in Johannesburg. As part of my studies I have to undertake a research project, and I am investigating the effectiveness of role-play in assisting individuals with intellectual disabilities to understand social cues.

As part of this project I will conduct eight drama therapy sessions with a group of residents at Selwyn Segal home. Your child/child in your care has been selected by the care manager to participate in these sessions.

I will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. The participants may withdraw at any time or choose not to participate. The sessions will be completely confidential and anonymous, and I will not disclose the information to anyone else. I will be using pseudonyms to represent the research participants in my final research report. If the research participants experience any distress or discomfort, we will stop the sessions or resume another time.

If you have any questions afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report and will be available to my supervisors and lecturers.

If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone + 27(0)11 717 1408, email hrec-medical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Yours sincerely,

Karel Weber

**Cell:** 076 374 5698
**Email:** karel.wbr@gmail.com

***Director*** Warren Nebe **T** + 27 11 717 4729 | ***Administration*** Khangwe Simeli **T** +27 11 717 4726 **E** Khangwe.simeli@wits.ac.za
***Operations Management*** Munyaradzi Chatikobo **T** +27 11 717 4615 | ***Student Recruitment, Scholarships and Welfare*** Natasha Mazonde **T** +27 11 717 4755 | ***Media and Communication*** Zanele Madiba T +27 11 717 4672
Private Bag 3, WITS, 2050, South Africa | **www.wits.ac.za** | **www.dramaforlife.co.za** | **facebook:** drama for life | **twitter:** drama_for_life

## Appendix B

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

dfldramaforlife

WITS SCHOOL OF THE ARTS
DRAMA FOR LIFE
Arts for Social Transformation and Healing

**Consent Form**

**Drama Therapy**

Drama therapy uses a variety of techniques in the therapy process; storytelling, role-play, miming, puppetry, drawing, arts and crafts, theatre games, improvisation, imaginative play and music. Clients in drama therapy are invited to practice desired behaviours and interpersonal relationships, broaden their life-roles, and exercise the change they wish to see in themselves.

**Client-Therapist Relationship**

This will be a professional and therapeutic relationship. In order to preserve this relationship it is important for the therapist and client not to have any other type of relationship. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services cannot be allowed between client and therapist.

**Confidentiality**

Discussions in group sessions are confidential. No information will be released without the parent/guardian's written consent, unless mandated by law. In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to the client or another person, including law enforcement and medical personnel. By signing this Consent Form, the parent/guardian is giving consent to the therapist to share confidential information with all persons mandated by law, and the care manager of the home if deemed necessary. Clients will not divulge any information from other participants in the group. These sessions will not be recorded.

It is the guardian's right to terminate therapy at any point.

I,_____ parent/guardian of

_____ hereby give consent to participate in the eight drama therapy sessions as per the Participant Information Sheet.

_____ _____

SIGNATURE DATE

***Director*** Warren Nebe **T** + 27 11 717 4729 | ***Administration*** Khangwe Simeli **T** +27 11 717 4726 **E** Khangwe.simeli@wits.ac.za
***Operations Management*** Munyaradzi Chatikobo **T** +27 11 717 4615 | ***Student Recruitment, Scholarships and Welfare*** Natasha Mazonde **T** +27 11 717 4755 | ***Media and Communication*** Zanele Madiba T +27 11 717 4672
Private Bag 3, WITS, 2050, South Africa | **www.wits.ac.za** | **www.dramaforlife.co.za** | **facebook:** drama for life | **twitter:** drama_for_life

**Appendix C**

11 June 2019

To Whom It May Concern,

Selwyn Segal (Society for the Jewish Handicapped) is a residential facility for people with intellectual disabilities ranging from moderate to profound.

I hereby give permission for Karel Weber to conduct his research at Selwyn Segal.

Please do not hesitate to contact me should you require anything further.

Kind Regards,

Lara Milner | Care Manager | Selwyn Segal
113 George Avenue, Sandringham
t: +27114837538 | +27114837530
laram@jhbchev.co.za | www.jhbchev.co.za | www.facebook.com/chevrahkadishajhb
http://www.linkedin.com/company/chevrah-kadisha | https://twitter.com/chevrahkadisha

## Appendix D

Student Placement
Student Contract with Workplace

Memorandum of agreement entered into by and between Selwyn Segal Centre ("organisation") and Karel Weber ("student").

1. **Terms of Placement**

The student is placed at Selwyn Segal Centre for a period of 8 weeks, and will commence his practical work on 5 November 2019.

The student will run a minimum of eight group sessions with eight residents of the Selwyn Segal, chosen by the senior management team, who they believe will benefit most from the drama therapy as explained by the student.

2. **Working Hours**

The student shall be placed at Selwyn Segal Centre as agreed. The agreed time and days of work is as follows:

- 05 November
- 12 November
- 19 November
- 26 November
- 28 November
- 03 December
- 12 December
- 17 December

The time will be from 3.15pm until 4pm, held in the Selwyn Segal TV lounge.

3. **Confidentiality**

The student shall not communicate events within Selwyn Segal Centre to any person outside the functional scope of his study requirements, and will not divulge any information to any unauthorised person.
All documents, including files, file contents and other reports, shall be kept safe and in a confidential manner.

| | |
|---|---|
| _____ | _____ |
| **Karel Weber** | **Lara Milner** |
| **Student** | **Care Manager** |
| | **Selwyn Segal Centre** |
| **Date:** _____ | **Date:** _____ |

1

## Appendix E

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**Session Number:** 1

**Date:** 5 November 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Relationship & Trust

**Aim:** Building relationship & trust among the group members and drama therapist

**Objective:** Introducing clients to drama therapy

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Welcome** | Therapist welcomes the clients to the session. Therapist explains that he will be conducting eight sessions with the clients.<br><br>Therapist explains drama therapy to the clients. | Setting the duration of the group therapy.<br><br>Allowing clients to understand what drama therapy is. | 5 min | |
| **Check-in** | Therapist invites clients to make a sound of how they are feeling. | This will enable the therapist to gauge how | 5 min | |

| | | | | |
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| | Second round – groups mirrors the sound. | the clients are feeling in that moment.<br><br>By mirroring the sound, the client is affirmed to be seen. | | |
| **Warm-up** | **Name Game:**<br><br>Clients stand in a circle - one person walks to another saying that person's name. That person then walks to another saying their name, etc.<br><br>**King/Cheese it:**<br><br>King stands against the wall with his/her back to the group. The group stand in a line at the other end of the room. The king counts from 1 – 10 while the others move towards the king. The moment the king says cheese, the group has to freeze – king sends back those who he/she saw moving. | Allowing the therapist to learn the clients' names. Allowing clients to acknowledge each other in the space.<br><br>(Adapted from Spolin, 2010)<br><br>This game brings the group together and allows them to understand the rules of games, and releases psychological responses (Spolin, 1986). | 4min<br><br>10min | |

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| | First person to reach the king is the new king.<br><br>**Mirror:**<br><br>In pairs, clients choose to be A or B. B follows A's movements and then A follows B's movements. | To assist clients to see with their full body and to reflect the other (Spolin, 2010). | 2min | |
| **Bridge-in** | Show clients a picture and discuss what they see. | This picture will be used for the main event. | | Picture |
| **Main Event** | **Yes and storytelling:**<br><br>In a circle, every person gets a chance to add to the story, starting with 'yes and.' | Allowing clients to contribute to the story (Johnstone, 1989). Allowing therapist to gauge the group's ability of storytelling. | 10min | Picture |
| **Bridge-out** | Therapist packs away the picture. | | | |
| **Reflection** | Short discussion of how they feel about the storytelling experience. | Allowing clients' contributions to be acknowledged. | 5 min | |
| **Grounding** | **Digging Game:** | This creates group cohesion and will be | 4min | |

| | | | | |
|---|---|---|---|---|
| | In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | used as a beginning ritual for every session. | | |

**References:**

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**Session Number:** 2

**Date:** 12 November 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Social Cues

**Aim:** Pre-assessment: Exploring different social cues

**Objective:** Identify the clients' understanding of what social cues are and how to apply them

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in** | Therapist invites clients to make a movement of how they are feeling.<br><br>Second round – group mirrors the movement. | This will enable the therapist to gauge how the clients are feeling in that moment.<br><br>By mirroring the movement, the client is affirmed to be seen. | 3 min | |
| **Warm-up** | **Dodging:**<br><br>Clients walk around the space without touching each other. Therapist invites clients to take up as much space as | Introducing the idea of personal boundaries and mobilising the energy in the room (Emunah, 1994). | 4min | |

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| **Focus** | possible with their bodies. Therapist invites clients to increase the speed they are walking at, while taking up as much space as possible, without touching anyone.<br><br>**Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | This creates group cohesion and ritual. | 4min | |
| **Bridge-in** | **Gateway to the land of story:**<br><br>Tell clients that we will be going to the land of story – but they need to first build the gateway to this land, so that we can enter through it. | Building belief of the fictional world by allowing clients to actively participate in creating the fictional world (Wagner, 1980). | 10min | Chairs<br><br>Cloths |
| **Main Event** | **Story Assessment:** Therapist tells a story to the clients, which is | Allowing therapist to gauge the clients' understanding of social cues. | 10min | |

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| | focussed around social cues.<br><br>Therapist asks clients if they can identify any social cues and these cues were applied correctly in the story. | The social relationships section of Jones' (2007) Adaptation of Scale of Dramatic Involvement will be used to gauge clients' understanding. | | |
| **Bridge-out** | Therapist invites clients to travel back to Selwyn Segal.<br><br>Once all the clients have exited through the gateway, allow clients to dismantle the gateway. | Allowing clients to leave the fictional world and return to reality (Jones, 2007). | 4min | |
| **Reflection** | In a seated circle, therapist asks clients if the social cues and its application that were identified in the story also happens in real life. | Life-drama connection (Jones, 1996).<br><br>Allowing clients to make connections between the fictional and real. | 6min | |
| **Grounding** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a | Ending ritual. | 4min | |

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| | turn to make a sound, the others mirror. | | | |

**References:**

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**Session Number:** 3

**Date:** 19 November 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Encountering Role

**Aim:** Acknowledging different roles & introducing dramatic narrative

**Objective:** Allowing clients to identify roles

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in** | Therapist invites clients to say which character in a book or movie is their favourite and why. | Introducing the idea of roles. | 5 min | |
| **Warm-up** | **Emotional Greeting:**<br><br>In pairs, therapist invites clients to greet each other in different emotions – called by the therapist (happy, sad, angry, etc.)<br><br>**Line Repetition:**<br><br>In pairs, clients choose A and B. A says 'yes' | Giving clients the experience of expressing and dramatizing feelings (Emunah, 1994). | 2min | |

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| **Focus** | and B responds with no. Repeat a number of times and change places.<br><br>Can also add 'help me' respond with 'I can't'<br><br>**Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Allowing clients freedom from anxiety about acting (Emunah, 1994)<br><br>This creates group cohesion and ritual | 2min<br><br>4min | |
| **Bridge-in** | The therapist tells the clients they are a group of heroes who are going on a journey to accomplish a task.<br><br>Every person gives their hero role a name and chooses one costume or prop item. | Building the belief of the fictional world we are going to enter (Wagner, 1980) and allowing the clients to create a fictional role (O'Neill, 1995). | 5min | Props<br><br>Costumes |
| **Main Event** | Therapist narrates the story of the heroes' journey, pausing in-between giving the actors an opportunity to | This method provides containment as the role and the narrative is the same for the whole group. Creating a sense of self and others, | 10min | |

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| | act on what was narrated.<br><br>Therapist brings the story to a close. | developing turn-taking and joint attention (Booker, 2011). | | |
| **Bridge-out** | Therapist invites clients to take off the costume/put back the props.<br><br>In a standing circle – clients say 'I am no longer *hero's name,* I am *real name*. | Returning to reality and allowing clients to de-role (Landy, 2009). | 3min | |
| **Reflection** | In a seated circle, therapist invites clients to discuss any social cues that they were aware of in the role play. | Life drama connection (Jones, 1996). Allowing clients to create a link between the fictional world and reality. | 10 min | |
| **Grounding** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | This creates group cohesion and will be used as a closing ritual for every session. | 4min | |

**References:**

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O'Neill, C. 1995. *Drama Worlds*: *a framework for process drama*. Canada. Pearson Education.

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**Session Number:** 4

**Date:** 26 November 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Becoming another

**Aim:** Exploring a role

**Objective:** Becoming a fictional role

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in** | Therapist invites clients to choose a hat from the circle that represents how they are feeling, and they explain why they chose it. | Allowing participants to project their feelings onto the hat (Jones, 1996). | 5 min | |
| **Warm-up** | **Musical Hats:**<br><br>Every client puts on a hat and creates a posture of how someone wearing a hat like would look.<br><br>Therapist plays music and clients send hats | Allowing clients to embody different roles (Jones, 1996). | 3min | |

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| **Focus** | around the circle. When the music stops, the clients have to put on the hat they ended with and create a posture. Repeat.<br><br>**Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | This creates group cohesion and ritual | 4min | |
| **Bridge-in** | Clients walk around the space wearing the hat they ended with during warm-up. They start walking like a person wearing a hat like that would walk.<br><br>They give this character a name, decide where they live, and what they do. | Allowing clients to become a different role (Landy, 2009; Meldrum, 2005) | 3min | |
| **Main Event** | **Interviews**:<br><br>Take off hats. | Allowing clients to engage in social interaction while being a different role | 15min | |

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| | In pairs, choose A and B.<br><br>A (out of role) tells B about his character. Person A then puts on the hat and become the character. Person B (as themselves) interview A. | (Andersen-Warren & Grainger, 2000). | | |
| **Bridge-out** | Therapist invites clients to put their hats back in the middle of the circle. As they put the hat on the floor, they say their real name out loud. | Returning to reality and allowing clients to de-role (Landy, 2009). | 2min | |
| **Reflection** | Invite clients to draw one moment in the play-acting that they felt a social cue was not used correctly or was completely absent. | Life drama connection (Jones, 1996). Allowing clients to create a link between the fictional world and reality. | 10 min | |
| **Grounding** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Closing Ritual. | 3min | |

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Frydman, J.S., 2016. 'Role theory and executive functioning: Constructing cooperative paradigms of drama therapy and cognitive neuropsychology', *The Arts in Psychotherapy,* 47, 41-47

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**Session Number:** 5

**Date:** 28 November 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Developing Role Individuals

**Aim:** Taking responsibility for a role

**Objective:** Exploring how to interact as a specific role

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in** | Therapist invites clients to say what they always dreamed of being (fireman, judge, doctor etc).<br><br>After everyone in the circle shared, each person makes a statue of how they think that profession would look like. | Further exploring roles (Landy 2009; Meldrum, 2005) and embodying these roles (Jones, 1996) | 5 min | |
| **Focus** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a | This creates group cohesion and ritual | 4min | |

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| | turn to make a sound, the others mirror | | | |
| **Warm-up** | **Walk the room**<br><br>Clients walk around the room as themselves, at a comfortable pace. Therapist invites clients to greet each other with their eyes, then hands, feet, legs.<br><br>Therapist invites clients to start walking like the person in their dream profession would walk. Therapist then invites clients to greet each other as these roles, only using sounds. | Allowing clients move together in the space, being cognisant of personal boundaries, while taking on a role and exploring non-verbal interaction (Boal, 2002) | 2min<br><br>4min | |
| **Bridge-in** | The therapist tells a story about the roles/characters that the clients have chosen. | Introducing the fictional world to the clients through story (Jennings, 1999) | 3min | |
| **Main Event** | Clients play out the story told by the therapist. The therapist | Allowing the clients to take responsibility of their chosen roles (Booker, 2011) and | 20min | |

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| | prompts when clients veer off topic.<br><br>Therapist brings story to a close. | playing out those roles (Frydman, 2016; Meldrum, 2005). | | |
| **Bridge-out** | Therapist invites clients to walk around the room as their role. Therapist invites clients to say their own/real names out loud repeatedly. Every time they say their name, they shake off their role. | Returning to reality and allowing clients to de-role (Landy, 2009). | 3min | |
| **Reflection** | Invite clients to draw one moment in the play-acting that they felt a social cue was not used correctly or was completely absent. | Life drama connection (Jones, 1996). Allowing clients to create a link between the fictional world and reality. | 10 min | |
| **Grounding** | **Digging Game**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Closing Ritual | 4min | |

**References:**


Boal, A. 2002. *Games for actors and non-actors*. New York. Routledge.

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**Session Number:** 6

**Date:** 3 December 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Role method

**Aim:** Invoking a role

**Objective:** Creating a role from a body part

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in**<br><br>**Focus** | Therapist invites clients to show a gesture of how they are feeling.<br><br>**Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Allowing clients to show their feelings through embodiment and non-verbal communication (Jones, 1996; White, 2019)<br><br>This creates group cohesion and ritual | 4 min<br><br>3min | |
| **Warm-up** | **Walk the room** | Allowing clients to move together in the space, while warming | 4min | |

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| | Clients walk around the room, without touching each other. Therapist invites clients to focus on different parts of their body. Feeling the movement and sensations.<br><br>Therapist invites clients to greet each other with their heads, then knees, fingers, hips. | up parts of their bodies and becoming aware of their bodies (Boal, 2002). | | |
| **Bridge-in** | **Invoking & naming role:**<br><br>While clients walk around the room, therapist invites them to focus on one part of their body and allow movement to extend from that part.<br><br>Therapist invites clients to create a character from that body part and movement – how it | Allowing clients to create their own role from a part of their bodies (Landy, 2009) | 4min | |

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| | moves, talks, mannerisms etc.<br><br>Invite clients to name the character.<br><br>Invite clients to enter playspace in role. | | | |
| **Main Event** | Clients introduce themselves to the others while in role. The therapist will create a scenario for the clients to play out, depending on their choice of roles. Adding social cue issues. | Allowing the clients to take responsibility of their chosen roles (Booker, 2011) and playing out those roles (Frydman, 2016; Meldrum, 2005). | 15min | |
| **Bridge-out** | Therapist invites clients to freeze, focusing on the body part that the character was developed from. Clients move that part and name what it is and what its use is. | Returning to reality and allowing clients to de-role (Landy, 2009). | 2min | |
| **Reflection** | Invite clients to discuss if it was easier or more difficult to read and/or apply social cues when | Life drama connection (Jones, 1996). Allowing clients to create a link | 10 min | |

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| | they were not themselves. | between the fictional world and reality. | | |
| **Grounding** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Closing Ritual | 3min | |

**References:**


Boal, A. 2002. *Games for actors and non-actors*. New York. Routledge.

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**Session Number:** 7

**Date:** 12 December 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Telling-A-Story

**Aim:** Invoking a role

**Objective:** Creating a role from a body part

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in** | Therapist invites clients to use a body part to represent how they are feeling. | Allowing clients to show their feelings through embodiment and becoming aware of their bodies (Jones, 1996) | 3min | |
| | **Transformations:** Each person transforms a piece of fabric into something else. | Stimulating the clients' imagination (Jennings, 1999). | 3min | |
| **Focus** | **Digging Game:** In a circle, clients 'dig' in rhythm – each getting a | This creates group cohesion and ritual | 3min | |

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| | turn to make a sound, the others mirror. | | | |
| **Warm-up** | **Rhythm and Movement**<br><br>Standing in a circle, one client goes into the middle and starts a movement accompanied by a sound and any rhythm they like. The others try to imitate. Once the person in the middle is ready, they stand in front of someone else who then has to enter the circle and make their own movement, sound & rhythm while others copy. | Allowing clients to undo their own mechanisations and restructuring their own way of being (Boal, 2002). This also creates group cohesion. | 4min | |
| **Bridge-in** | Therapist reminds clients about the previous sessions of role-playing and social cues.<br><br>Tell clients that they will come up with their own | Allowing clients to create their own story and roles (Landy, 2009; Jones, 1996 ) | 2min | |

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| | story and roles showcasing social cues. | | | |
| **Main Event** | Clients create and rehearse their play. | Allowing the clients to take responsibility of their chosen roles (Booker, 2011) and playing out those roles (Frydman, 2016; Meldrum, 2005). | 24min | |
| **Bridge-out** | Therapist invites clients to pack away all the props and costumes.<br><br>Remind clients that they will be performing in the next session. | Returning to reality and allowing clients to de-role (Landy, 2009). | 2min | |
| **Reflection** | Therapist asks if there are any issues in the group that needs to be addressed. | Ensuring group cohesion for the performance. | 2min | |
| **Grounding** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Closing Ritual | 2min | |

**References:**

Boal, A. 2002. *Games for actors and non-actors*. New York. Routledge.

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**Session Number:** 8

**Date:** 17 December 2019

**Venue:** Selwyn Segal Lounge

**Duration:** 45 Minutes

**Theme:** Telling-A-Story

**Aim:** Assessing the effectiveness of the drama therapy sessions

**Objective:** Determining whether role-playing assisted people with intellectual disabilities to understand social cues.

| | **Description** | **Motivation** | **Time** | **Resources** |
|---|---|---|---|---|
| **Check-in**<br><br>**Focus** | Therapist invites clients to make a movement and sound of how they are feeling.<br><br>**Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | Allowing clients to show their feelings through embodiment sound (Jones, 1996)<br><br>This creates group cohesion and ritual | 3min<br><br>3min | |
| **Warm-up** | **Rhythm and Movement** | Allowing clients to undo their own mechanisations and | 4min | |

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|---|---|---|---|---|
| | Standing in a circle, one client goes into the middle and starts a movement accompanied by a sound and any rhythm they like. The others try to imitate. Once the person in the middle is ready, they stand in front of someone else who then has to enter the circle and make their own movement, sound & rhythm while others copy. | restructuring their own way of being (Boal, 2002). This also creates group cohesion.<br><br>Keeping this the same as last week to ensure continuity of the process. | | |
| **Bridge-in** | Therapist invites clients to walk around the room, focusing on every body part, the sensations and sounds it makes.<br><br>Therapist invites clients to put on their costumes and start walking like their roles, introducing each other as their roles. | Allowing clients to step into role (Landy, 2009; Jones, 1996) | 10min | |

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| **Main Event** | Performance of their play. | Allowing clients to engage in projected and embodied playing, while exploring social cues. The clients are witnessing each other enhancing support and different perspectives (Jones, 1996; Bailey, 2009; Landy, 2012). | 0min | |
| **Bridge-out** | Therapist invites clients to pack away all the props and costumes.<br><br>Therapist invites clients to touch three things in the room and say what it is (table, chair, etc).<br><br>In a standing circle, each client says their real name. | Returning to reality and allowing clients to de-role (Landy, 2009). | 3min | |
| **Reflection** | Therapist invites clients to discuss the performance and if any new understandings or experience of social cues arose. | Allowing clients to analyse and make sense of the performance (Snow, D'Amico and Tanguay, 2009) | 10min | |

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| **Grounding** | **Digging Game:**<br><br>In a circle, clients 'dig' in rhythm – each getting a turn to make a sound, the others mirror. | This creates group cohesion and will be used as a beginning ritual for every session. | 2min | |

**References:**


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