accidental dance:
dance in rehab

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In 1999 I began my work as a dance pedagogue at the Weißer Hof rehabilitation centre in Austria, just outside Vienna. The patients here were recovering from severe accidents and learning how to deal with new body situations and disabilities. Back then, the chief nurse asked me whether I would do "evening entertainment dancing" with the patients. I knew that I wanted to work with the patients, but entertainment was not what I felt they needed.
I had just spent ten years abroad, mostly in the US, dancing, choreographing, producing, teaching and collaborating, with a great emphasis on improvisation. Contact improvisation came into my life at this time (in 1997) and I found a completely new way of moving, relating and integrating myself with dance and others. So when the proposal came to me to do "something" at the rehab centre, I decided I wanted to offer contact, authentic movement and improvisation. I wrote a concept, gave it to the chief doctor, he mumbled something like "very interesting", and agreed.

I began in the evenings, after the regular therapy sessions, to work with a group of sometimes 2 to 8 people. It was difficult. Patients were tired from long days of strenuous, often painful, interventions and therapies, and I was still so full of my experiences dancing professionally that I think I overwhelmed them with my expectations. I slowly realised how different a non-dancing person's relationship to their body is compared to that of a dancer.

Photograph of Sabine Parzer

It took me many years to understand (and still does) what wonderful pathways we have as dancers to sense, know and relate to our bodies. Most people walking this earth don't have this, then they have a severe accident and multiple injuries to deal with and are expected to learn how to walk, talk and think again, yet few have consciously experienced this before.
After two years, a new chief doctor came and I asked him whether "dance therapy" could be integrated into the regular day therapy program, like the music and art therapies. At this point I shall remark that I am a dance pedagogue and do not claim to be a dance therapist. But I do say that my work is "dance in a therapeutic context". However, the institution calls everything that happens here "therapy", so I use that term.

The chief doctor agreed to my request. Then began my long and frustrating journey to educate and encourage the doctors, responsible for 200 - 250 patients in different departments, handling paralysis, brain injury, polytrauma, amputation, and less severe self-sufficient cases, to send their patients to me. It took 5 years of short introductions at team meetings, handing out of information sheets and individual communications before three women doctors in the neurological department began to understand what the work is about and began sending the right clientele on a regular basis.

Over that 5 years I had a lot of time to experiment and fail. First I failed at doing group work. It was not possible for me to teach a group of patients that often had very different levels of injuries and experiences with movement. Imagine somebody with a shoulder injury, someone with broken vertebrae and someone with a brain injury in one class.

Instead of taking groups for one hour, I began doing half-hour single sessions. This worked much better. I make a point of explaining that the sessions are about sensing their bodies and learning to find out in which ways their bodies wish to move.

I have a basic exercise, which I call the "Spinal dance", done with closed eyes, standing or sitting. It starts with the attention on the breath spreading through the body, then sensing how the weight is distributed onto the feet and the pelvis (if sitting), then moving from a very small internal impulse, beginning in the pelvis, then upper body, ribcage, shoulders, arms, neck and head. My emphasis is on the relationship between the body parts, on a "wholistic movement". Each body part can move independently but still is in relationship to the whole body.

Sensing the breath and sending it into areas that need attention is the first step to free, self-defined movement and for many people it's the first time they get to do something like that. It is often helpful in releasing physical and emotional tension that accumulates, and is a fundamental training for body awareness and movement invention. For many people it is the first time they get to experience their own movement potential.
I also use some basic Contact improvisation exercises. The finger-dance (two fingertips touching, one person leading, the other following) can be done with almost anybody. Even patients that have hemiparesis after a stroke can follow a finger-dance. I have found that this simple exercise stimulates coordination, attention and communication. The connection between the brain and the hand is reintroduced and I can offer multiple layered pathways of moving through our interaction.

For patients who can sit on the floor, I love doing "back to back"- sitting with our backs to each other, sensing the breath, letting the head fall forward gently, getting in touch with the movements of the spine through moving against the other body, or receiving the movement from the partner. If possible I let the weight gently pour back and forth and sometimes we try shifting the weight from a different position. Sometimes I play a game where you have to draw something with the back and the other person has to guess what it is. Many patients walk on crutches for months, and have alignment issues from their surgery, so back pains are common. Often patients find a great amount of relief from just this simple exercise and are happy about the possibility of touch.

Authentic Movement (AM) is the third basic method that I use. The psychologists at first were ambiguous toward my work, fearing that the trauma of the accident could come up again and throw the patients into something they couldn't handle. That never happened. On the contrary, getting in touch with inner sensations often allowed a way of healing, through integrating their experience. But I was careful. In the beginning I did AM only with people who were psychotherapists (yes they also have accidents), or who already had a lot of experience in self-discovery. Now I have become more trusting and often give people a chance to do AM, although I don't do it with psychiatric patients, people after suicide attempts or people whose accidents were too recent.

For many patients, AM is a wonderful way of getting in touch with themselves in an environment where their is almost no privacy, and where doctors and therapists take authority over their bodies. So often patients have described doing AM as finding a haven inside the institution, and a way of reconnecting to their intuition and center.

Last spring I had a wonderful woman, Melitta, in my class. She was paralyzed from the waist down after her accident 5 months ago. That is not a long time for someone in a wheelchair and usually I would not have done closed eyes work. But she was so strong and so aware of her need to connect to her inner center that we did AM many times. Each time she came out beaming, feeling like she was herself again. It made her come closer to her feelings, her despair and frustration, but also the enormous amount of power and will she has. Who else can give her that but she herself?

After eight years I am happy that I persisted on this path of doing my work in an institution within a country that is not very open to these kind of movement methods. It is a much slower process than I often wish, but body processes are much slower than we think, and changes in large medical institutions even more so. Yet the team is now learning with me, and the patients, again and again, are my inspiration to continue investigating. Every time I leave the rehabilitation centre I feel ultimately alive and connected to a larger life source.