



Moving towards evidence for dance movement therapy: Robin Hood in dialogue with the King

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ABSTRACT

The myth of Robin Hood is used to explore the possible dynamics between arts therapies researchers, and in particular dance movement therapy researchers, and the world of science. As professions positioned in relation to science, arts therapists are in danger of splitting and denigration on the one hand, or appeasement on the other. The case is made for a new way forward that includes making use of what arts therapists do well in terms of creativity and embodied knowing, whilst reaching out into multidisciplinary and international research partnerships. The imperative to evidence arts therapies practice has never been more urgent. Three forms of evidence are explored: Randomised Controlled Trials and systematic reviews of these; process research; and practice-based evidence from more than one practitioner using a core data set of outcome measurement. A case study is offered to demonstrate how routine outcome measures can be used to gather evidence that links outcome to process.

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Introduction

Research in the arts therapies has developed considerably in the latter part of the 20th and early years of the 21st century. British research in dance movement therapy (DMT¹) is still fairly sparse, with very little published compared to the USA. Part of this discrepancy may be due to the fact that the first British dance movement therapists to attempt research degrees did so at a time and in a setting that allowed for the development of qualitative research, before journal editors were ready to accept this as a valid approach. My own first attempt in the 1980s to publish qualitative research findings in an international journal was rejected, because the methodology did not meet the accepted standards at that time for “scientific” research; that is to say I was not using a quasi-experimental design. Since then, the same journal has published several articles concerned with qualitative research in the arts therapies, including some of my own.

DMT research is by no means as developed as some arts therapies; a search for recent articles available online on August 10th 2009 of *The Arts in Psychotherapy* (chosen as this is a major journal for arts therapies research) revealed four articles concerned with visual art interventions, two concerned with DMT, and one con-

cerned with music therapy. Of the art therapy articles, one was from Saudi Arabia (descriptive of a service development), one was joint American and Canadian (quantitative research concerning a drawing test), one Swedish (quantitative research concerning a painting test), and one American (descriptive of a mural art project). Of the DMT articles, one was German (using case study research) and the other was British, although this latter was a literature survey rather than empirical research. The music therapy article was Israeli, and used a mixed methods approach. From this snapshot in time, it is obvious that for *The Arts in Psychotherapy* at least more empirical art therapy research is published than for DMT, and that this includes a range of methodological approaches. A similar point was also made by Cruz and Berrol (2004) in their search of the *American Journal of Dance Therapy* between 1998 and 2000; they noted that only three inquiry-based articles were published during that period. Of the top 10 most cited articles in *The Arts in Psychotherapy*, one is dramatherapy, two DMT, three art therapy, and four music therapy. Of the two DMT most cited articles, one is a meta-analysis employing statistical methods and the other is an experimental study. Both of these are high-quality studies, but the most recent is 2000. Whilst it is fair to say that it takes time for an article to reach the top 10 of an international journal, the high download numbers for these two articles demonstrate that there is a need for more high quality evidence in DMT.

Despite the benefits of broadening the range of research available to the professional and research community through the inclusion of qualitative designs, I would argue that the growth in qualitative research has become part of a new orthodoxy, fuelled by a reactive backlash to the experimental paradigm and a fear

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¹ In the UK, DMT has now been renamed Dance Movement Psychotherapy. However, in view of the fact that most of the world still uses the old terminology this is adhered to in the article.



Fig. 1. Dance movement therapists – men (and women) in tights.

of science. This has resulted in ideological positioning that can be understood in the context of the English myth of Robin Hood. Robin, himself of noble blood and loyal to the King, became an outlaw when the Sheriff of Nottingham gained power (the King being away at the Crusades). I suggest that dance movement therapists, the Robin Hoods of the therapy world (Fig. 1), sometimes mistake the King of scientific inquiry for an evil Sheriff; arts therapists are prone (with some encouraging exceptions) to avoiding any dialogue with science as if that would be a betrayal of principles. There is a tendency also to see scientific research as rather mysterious, distant, and awe inspiring, and so many arts therapists do not routinely acquire or teach the research skills necessary to enter into a meaningful dialogue with scientists.

In fact, as has been argued elsewhere (Cruz & Berrol, 2004; Meekums, 2003) dance movement therapists do have skills that can be applied to research. Meekums (2003) has framed these as the ability to: work respectfully and skilfully with individuals (including the nonverbal aspects of communication); articulate and question patterns; work reflexively; make use of supervision (which in the UK is an ongoing requirement even after training and registration); be willing to be changed by the encounter; engage with the creative process; understand metaphor; embody narratives; allow “not-knowingness”; and engage with the body as a source of knowledge. To this, Cruz and Berrol (2004) add that dance movement therapists are adept at observation, gathering information, forming hypotheses, and testing these, as in the experimental method.

The problematic nature of experimental research in the arts therapies

One of the mistakes made in the past was to assume that the experimental method was the most appropriate method of inquiry, no matter how small the sample size and how many compromises had to be made. One such compromise evident in some of the early

DMT studies was to use either no control group or a fairly meaningless control group in that the “subjects” did not match in essential ways. I have in the past argued against the experimental method (Meekums & Payne, 1993), for reasons that include the difficulty in acquiring sample sizes large enough to make randomised controlled designs statistically analysable. Human systems are much more variable than, for example, cells (as a fresh science graduate I tested cancer drugs on cells); they vary in age, gender, social class, general state of health, life experience, coping style, and so on. This problem is usually addressed in one or both of two ways. First, the sample size (number of humans studied) is made as large and “representative” as possible, on the assumption that variability is accounted for through the phenomenon of “normal distribution.” Thus, if the percentage of the human population that is female is roughly 50%, then in a large enough sample size this will also be true. An alternative is to limit the variables by, for example, studying only women or men of a certain age. The problem with this approach is that the variables chosen are usually the easiest ones to limit and may not be the most important ones in affecting the bias of the result. Another problem is that, whilst isolated cells are generally assumed not to have consciousness (some would dispute this), humans are all too aware of what is happening to them. Researchers too are human beings, and know what result they are hoping for.

For these reasons, researchers of drug treatments have developed the concept of the “double-blind clinical trial,” aimed as far as possible at removing both the effects of researcher bias and the “placebo effect” (the effect resulting from taking a pill which you believe will do you good). In the double-blind trial, neither the person administering the drug nor the person receiving it knows whether the patient is receiving the new drug or something else (usually not a placebo, but “treatment as usual,” for ethical reasons). This, like all research designs, is necessarily an imperfect system as those collecting measurements might be able to guess who is in the experimental group over time, and in drugs trials blinding may be reversed due to adverse events.

When researching any form of psychological therapy, double blinds are not the design of choice, because the therapeutic relationship affects outcome and it is impossible to pretend to engage with a client. The alternative and generally accepted approach for psychological interventions, therefore, is the unblinded Randomised Controlled Trial (RCT). In this case, the double blind is discarded, large samples are used, and subjects are allocated randomly either to control (most commonly treatment as usual, waiting list, or more rarely the rather more useful option of a comparable and evidence based therapy) or experimental (treatment under investigation) groups. Dose responses (for example, trying different numbers or lengths of sessions) are not usually studied, due to the complexity of the design and analysis (the more variables that are studied, the larger the sample size needed to demonstrate statistical significance). Each separate study usually concerns itself with a time-limited intervention for a given diagnosis (for example, depression).

The RCT has thus become the “gold standard” for outcome research in the psychological therapies, and systematic reviews of large numbers of RCTs greatly influence decisions about which treatments are recommended. The ethics of waiting list controls are problematic, as they could be artificially created to acquire data, and “treatment as usual” can cover a variety of alternatives, by no means implying a homogenous group even in a single study. Evidence bases are built on these designs, and assumptions made about other therapies being less effective, often without actually testing this. A case in point is that in the UK, cognitive behavioural therapy (CBT) is now seen as the treatment of choice for a wide range of mental health conditions including depression (National Institute for Clinical Excellence, 2004) and anxiety (McIntosh et al., 2004). Given that resources are scarce, this inevitably means

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