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Dance/Movement Therapy (D/MT) for depression: A scoping review☆

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ABSTRACT

Depression affects 121 million people worldwide (WHO, 2010). The socio-economic repercussions of depression are putting an enormous strain on UK and US governmental health budgets. Regarding treatment interventions, D/MT and other arts therapies are widely practiced around the world as a treatment of choice for depression. Research evidence suggests that exercise has positive effects on mood. Similarly, it has been argued that dance has a positive social-cultural influence on a person's wellbeing. However there are no systematic reviews that support the effectiveness of D/MT for people with a diagnosis of depression.

It is therefore important to map the field of existing research studies of D/MT for depression. In this paper a scoping review is presented that engaged with an extensive search to best answer the question: *is there good quality research evidence available regarding the effectiveness of D/MT and related fields for the treatment of depression?* A search strategy was developed to locate publications from electronic databases, websites, arts therapies organizations and associations using specified criteria for including and excluding studies. All studies meeting the inclusion criteria were then evaluated for their quality, using broad criteria of quality such as type of methodology followed, number of participants, relevance of interventions and specific comparisons made and outcome measures.

A total of nine studies were found. Six studies followed a randomized controlled trial design, and three adopted a non randomized design. At least one study met most criteria of quality. We concluded that there was a need to undertake a full systematic review of the literature and to follow a Cochrane Review protocol and procedures.

Introduction

Dance/Movement Therapy (D/MT) and Evidence-Based Practice (EBP)

It is often difficult for arts therapists, including dance/movement therapists, who are not in direct contact with academic institutions, to keep up to date with research evidence. As a result, practitioners often become disconnected from recent developments, while relying upon theoretical frameworks and their own and others' experience to inform their work. In recent years, however, dance/movement therapists, along with the other arts therapists, have been encouraged to shift towards a more cyclical process of practice which on the one hand still remains well-informed by theory and experience but on the other also draws upon research findings (Karkou, 2009). This way research becomes an integral part of practice informing clinical decisions throughout the therapeutic process. Thorough evaluation of the therapeutic work and generation of research evidence based on practice are also part of this cycle, aiming to develop improved services. Ultimately this approach to practice highlights the value of research and makes it more tangible to the working clinician. The framework for clinical practice that incorporates scientific research evidence is known as Evidence-Based Practice (EBP) (Leach, 2006; Mason, Leavitt, & Chaffee, 2002; Melnyk & Fineout-Overholt, 2005).

☆ In the UK and since 2008, the discipline is known as 'dance movement psychotherapy' and practitioners call themselves dance movement psychotherapists. For the purposes of this article the USA term 'dance/movement therapy' and its acronym 'D/MT' will be used throughout, while practitioners will be referred to as 'dance/movement therapists'.

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EBP requires a shift away from the traditional paradigm of clinical practice grounded solely in intuition, clinical experience, and psychological rationale (Leach, 2006; Mason et al., 2002; Melnyk & Fineout-Overholt, 2005). Clinical expertise is seen as important in combination with best scientific evidence, patient values and preferences, and clinical circumstances. In Dance/Movement Therapy (D/MT) in particular, Meekums (2010) argues that practitioners have at times tended to be misinformed and consequently demonize the EBP paradigm. She suggests that there is a need for dance/movement therapists to embrace research evidence including quantitative experimental studies while not losing sight of the particular strengths offered through embodied knowledge. Our intention through this scoping review is to offer this integration with respect to one particular area of evidence, namely D/MT for depression.

In order to support the shift towards EBP, it is important that good quality research evidence becomes available to practitioners. Systematic reviews and/or meta-analyses that report on and evaluate research studies are often regarded as important sources of research evidence in a particular area of clinical practice. However, there are not enough systematic reviews and/or meta-analyses available to guide practitioners. Working with depression in D/MT is one such area; while this is a common diagnosis for a number of clients seen by dance/movement therapists, there is still a marked absence of either systematic reviews or meta-analyses on the topic. This article, therefore, attempts to address the gap in the literature by reporting on a scoping review of published and unpublished research studies pertaining to the effectiveness of D/MT in the treatment of depression. The scoping review was an initial, step in order to determine whether we could undertake a systematic Cochrane Review on the topic.

Systematic reviews aim to collate all empirical evidence relating to a specific research question, using explicit, systematic, and pre-determined methods in order to minimize bias and generate reliable findings (Higgins & Green, 2011). This kind of research activity is often given priority as evidence (Eccels, Freemantle, & Mason, 2001). As a result, systematic reviews, with or without meta-analyses, are highly respected by establishments such as governmental bodies and national health systems. Some of the most respected systematic reviews are undertaken by the Cochrane Collaboration. A Cochrane Review is a systematic review that not only offers a summary of reliable evidence of the benefits and risk of health care, but does this through a very clearly defined process and clearly defined criteria. For a review to be called a Cochrane Review it needs to be part of the 'parent database' (Cochrane Collaboration, 2012, p. 1) and to be linked with the Cochrane Collaboration from the beginning to the end of this process.

In all cases and as a first step towards a systematic review, it is common for researchers to undertake a scoping review. The purpose of a scoping review is to establish the breadth of the field, key concepts and types of evidence, and what outcome measures might be relevant; in effect, to 'map' it (Arksey & O'Malley, 2005). For the scoping review reported in this article, our intention has been to map the field of D/MT for depression.

Why depression?

The World Health Organization (WHO, 2010) reports that depression affects about 121 million people worldwide and is predicted to become in 2020 the second most disabling illness in the world after ischemic heart disease. In the UK, national figures indicate a similarly large impact of depression on the general population. According to the 2000 Psychiatric Morbidity Report among adults living in private households, 8–12% of the population is diagnosed with depression at some point in their lives (Office of National Statistics, 2000). The National Institute of Mental Health (NIMH, 2010) in the US state that 9.5% of the population, which is approximately one in ten American adults, suffers from depression. Scott and Dickey (2003), in their research on the global burden of depression, suggest of those who suffer major depressive disorders 20% will have symptoms that persist beyond two years of the initial diagnosis and treatment. Whichever estimates are accepted, depression clearly represents a significant burden to families and to society; it has a negative impact on quality of life, and can lead to suicide. For example, more than 90% of Americans who take their own lives have an undiagnosed mental health disorder or a continual depressive disorder (NIMH, 2005; Scott & Dickey, 2003), Often depression goes undiagnosed; hence the real scale of the problem is probably much larger than that identified by national statistics.

Departments of Health in the UK and US acknowledge that only a few sufferers receive treatment. For example, the USA Department of Health and Human Services (2011) reports that only one in five adult sufferers receive adequate treatment in accordance to guidelines set by the American Psychiatric Association (APA) (2012); even fewer receive treatment amongst ethnic minority groups (Arean, 2011)). In the UK, The Depression Report by The Centre for Economic Performance's Mental Health Policy Group (2006) claims that two in six people who do not receive treatment could be "cured at a cost of 750 pounds" (p. 4). The focus of the report is one of economic cost and reduction of Incapacity benefits. It suggests that depression is the biggest social problem and number one cause of unemployment affecting 40% of people claiming Incapacity benefits in the UK (The Center for Economic Performance's Mental Health Policy Group, 2006). Major depression is a feature of 22% of Americans who classify themselves as unable to work and 10% of those who are already unemployed (Centers for Disease Control and Prevention, CDC, 2010). The cost of depression, the loss of productivity and medical expenses is $83 billion in the USA (Leahy, 2010) in comparison to the £12 billion a year for the UK Government (The Center for Economic Performance's Mental Health Policy Group, 2006), an enormous cost to the government but perhaps an even greater cost to the individual who on average decrease their lifetime earning potential by 35% due to undiagnosed and untreated depression (Leahy, 2010). Between 1991 and 2002 in the UK alone, prescriptions per head for anti-depressants increased by £310 million (Medical News Today, 2005). In the USA the overall costs for outpatient treatment of depression increased from $10 billion in 1997 to $125 billion in 2007 (Zorumski & Rubin, 2011), a point which illustrates the sheer expense of the pharmaceutical management of medication. Zorumski and Rubin (2011) state that there is potential to curb the costs if physicians were to prescribe less inexpensive and more generic anti-depressants and consider other evidenced-based psychotherapies rather than be concerned with prescription privileges. The London Center of Economic Performance's Mental Health Policy Group (2006) proposes a new nationwide therapy service to be put in place to counter-balance the billions of pounds lost through inactivity. The loss, when compared to the £0.6 billion it would cost to provide an effective therapy service in the UK, surely justifies the importance of therapeutic interventions for depression. The argument that remains is that a therapy service is only justified if it is effective enough in making people feel better, and enabling them back to work.

In terms of UK health policy, the last decade has seen an expansion of psychological treatments for common mental health problems. The general consensus according to both English and Scottish governments is that attitudes towards mental health, especially depression, should be less about reaction and more about prevention (The Department of Health, 2008; The Scottish Government, 2008). Governmental targets emphasize an approach towards mental health based on a social model which recognizes that healthy mental capacity is shaped by social,