

Dance Movement Therapy for the Treatment of Depression

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This study examined recent literature to determine the effectiveness and use of Dance Movement Therapy (DMT) as an additional treatment for depression. Seven studies spanning Europe, the USA and Asia, published during the past eleven years, were analysed. The results indicate the efficacy of DMT both as a primary and complementary group intervention with both clinically and generally depressed clients. Moreover, DMT appears most effective with men, however further research is required. New assessment measures using an iPad app are currently being developed. However, there is a need for more quality research using uniform assessment scales to ascertain which type of DMT is most effective with depressed clients; whether aspects of DMT can successfully be incorporated into a talk therapy session; and whether the therapist needs specific training in DMT to be effective.

Expressive Therapies (ET) modalities are a creative, effective means of non-verbal communication for clients who find talk therapy challenging (Malchiodi, 2015). Pearson and Wilson (2009) observed that when left untreated, unprocessed feelings can be held detrimentally in the body and generate somatic symptoms. Dance/Movement Therapy (DMT) (DMT Association, n.d.) is an ET that uses movement to release these ingrained emotions within the framework of a therapeutic relationship, providing relief and healing both physically and emotionally. DMT is used with individuals and groups, with populations dealing with mental illness and those who have difficulty learning (Zubala & Karkou, 2015). While DMT emerged in the USA in the 1960s, it is a relatively new approach to help people struggling with depression (Koch, Kunz, Lykou & Cruz, 2013). The literature on DMT and its application for treating adults with depression will be examined. (For a detailed timeline of the development of DMT please see Appendix 2).

Depression

Depression is the most prevalent mental illness in Australia, affecting over one million people annually (Clarke, 2011). Furthermore, the World Health Organisation (WHO, 2018) declared that depression is the leading disabling illness worldwide. More women than men suffer from depression, and at its worst depression may lead to suicide, the second most

common cause of death amongst people aged 15 to 29 years old (WHO, 2018). Treatment for depression mainly consists of medication and/or talking therapies, which may not be suitable for everyone, so DMT provides an alternative or addition to traditional treatments (Meekums, Karkou & Nelson, 2015).

Significant elements of DMT for depression

DMT has been incorporated into therapy for people with depression, comorbid anxiety and stress due to its active nature (Zubala & Karkou, 2015). This is significant because research has indicated that people with depression do not move their upper limbs to the same extent as healthy individuals (Koch, Morlinghaus & Fuchs, 2007). DMT philosophy is based on the concept of using bodily and motor expression in therapeutic movement to relieve the intensity of strong negative emotions held in the body (Sherwood, 2008). These suppressed emotions implicitly impact our daily interactions. Consequently, DMT's healing value occurs when movement and self-expression within a therapeutic space connect with the unconscious (Pallaro, 2007). The cathartic element of DMT may lead to corrective emotional experiences that can be shared within a safe group (Punkanen, Saarikallio & Luck, 2014).

DMT is different to dance or exercise because it integrates physical, emotional, cognitive and social aspects in treatment (Meekums, 2002). DMT group therapy also aims to promote aspects of Bowlby's theory of secure attachment, considered necessary for healthy adaptive relationships (Homann, 2010). The attachment patterns and behaviours of people with depression are generally defined as insecure or avoidant (Costello, 2013). The reciprocal movement behaviour in DMT, which is a typical aspect of secure attachment interactions, can facilitate participants' communication and may therefore enhance their sense of connection and agency (Pylvänäinen &

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Lappalainen, 2018).

In order to work as a DMT therapist in the UK or USA a Master of DMT qualification is required (Association of Dance Movement Psychotherapy, 2018; American Dance Therapy Association, 2018); however, this is not yet available in Australia (Dance Movement Therapy Association of Australasia, 2018).

History and Development of DMT

DMT originated from Austrian Reich's Body Psychotherapy in the 1940's, which recognised when people subconsciously store difficult emotions in their body, movement can free them (Karkou & Sanderson, 2006). Subsequently in the UK, Rudolf Laban, a German dance artist, noted movement revealed subconscious thoughts and emotions and created Movement Analysis categories (Newlove & Dalby, 2004; Panagiotopoulou, 2011). Concurrently in the USA, dance teachers, Marion Chace worked with groups in circles and focused on the needs of the person (Panagiotopoulou, 2011), and Mary Whitehouse focused on the process and therapeutic relationship and developed Authentic Movement (Chodorow, 1990); and Trudi Sloop used imagination for creative expressive movement (Karkou & Sanderson, 2006).

Three broad styles of DMT include the Chace approach from which mirroring was derived and is now used in most DMT approaches; Mary Whitehouse's Authentic Movement where the mover explores the unconscious and is witnessed; and the psychodynamic oriented approach where past conflicts are identified and addressed through analysis of movement and group relationships. A fourth technique, Integrative Dance Therapy, is used by therapists in Germany and integrates concepts from the first two approaches (Brauninger, 2014). In 1982, DMT received worldwide official recognition and integrated both the UK and American developments. (See Appendix 2 for DMT timeline).

Contemporary developments

Dance/movement therapy is taught in universities worldwide and is credited as effective in mind-body wellness, self-care, depression, chronic pain and chronic illnesses (Hopkins, 2016). Masters level university courses will be available in Australia in 2020 (DTTA, 2018). In order to understand the specific therapeutic mechanisms of DMT Australian research is underway to develop an iPad application to collect data about client experiences with DMT (DTTA, 2018). The iPad application may also be used to create reliable scales and technological innovation in the field, thereby contributing to the establishment of more scientific enquiry around this developing therapeutic modality.

Evidence for the effectiveness of DMT for depression

Research into the application of DMT for depression is limited globally. The majority of reliable DMT research comes from the UK, USA, Scandinavia and minimally from Korea and Germany (Kiepe et. al., 2012; Meekums, Karkou & Nelson, 2015). In Australia, despite DTTA's financial encouragement in the form of research grants, no recent Australian studies addressing depression utilising DMT were identified (DTTA, 2018). Evidence-based research from the previous eleven years consists of randomised control trials that compared the effects of DMT on depression with psychological therapies, drug treatment or other physical therapies. Depression was the primary focus of

only four European studies and a Korean study. The remaining trials included depression as one of several assessment measurements such as quality of life (Brauninger, 2014) or body image (Pylvänäinen & Lappalainen, 2018). These trials were considered to be relevant because many diagnoses, for instance anorexia, cancer and PTSD, include depression as a symptom (Chaiklin & Wengrower, 2016). (See Appendix 1 for as list of the scales used in DMT research).

There was a lack of information regarding whether all DMT participants were also receiving counselling. Trained DMT therapists conducted all the group sessions, with the exception of the Canadian study, which was conducted by nurses (Stewart, as cited in Mala, Karkou, & Meekums, 2012). However, therapists' level of skills and experience were not evaluated. This omission overlooks an assessment of their ability to develop a strong therapeutic relationship with clients to enable sufficient trust for attachment issues to be expressed (Pylvänäinen & Lappalainen, 2018).

There have been a number of pilot studies, developed with the intent to generate wider research. The Finnish pilot study did not include a control group (Punkanen, Saarikallio & Luck, 2014). The German pilot study examined the effects of physical movement on psychiatric patients with depression, comparing DMT with a group that listened to music and a group that rode a home trainer bike (Koch, Morlinghaus & Fuchs, 2007). Participants' levels of depression and vitality improved in all the studies, except the Hong Kong study, which did not lessen depression in cancer clients who had received chemotherapy prior to participation, although stress levels were reduced (Ho et al., 2016). Different styles of DMT or only some aspects of DMT were used in the studies, which meant that a clear picture of how DMT created improvements for depression did not occur, and this was compounded by typically small sample sizes (<40). Results indicated that DMT is effective for men and women experiencing depression (Koch, Morlinghaus & Fuchs, 2007), and other research has highlighted its effectiveness with adolescents (Zubala, MacIntyre, Gleeson & Karkou, 2014).

The number of sessions varied amongst the studies, ranging from less than 10 up to 36 sessions. Because most studies did not specify the precise style of intervention, accurate comparisons of their efficacy could not be made. Scales and measures (see Appendix 1) differed depending on whether the study focused on depression as the main or subsidiary client concern. For example, Pylvänäinen and Lappalainen (2018) conducted a study on depressed psychiatric outpatients with the main aim of improving body image. The majority of participants in all the studies were female apart from the study by Koch, Morlinghaus and Fuchs (2007), who concluded that men benefited more from DMT than women. Longer-term effects of this type of intervention were not included in these trials and is a recommendation in future studies (Meekums, Karkou & Nelson, 2015).

Rationale for the inclusion of DMT by counselors to treat depression

DMT has been found to be helpful for most types of depression, including clients presenting general symptoms of depression, and is most effective in people who are clinically depressed (Koch, Morlinghaus & Fuchs, 2007; Punkanen, Saarikallio & Luck, 2014; Pylvänäinen, Muotka & Lappalainen, 2015). Because individual clients experience depression differently, a single type of therapy is unlikely to be suitable for all

presentations (Meekums, 2002). DMT therefore offers therapists and clients an additional, creative, non-verbal treatment method to pharmacological, psychosocial or psychological interventions (Zubala, MacIntyre, Gleeson & Karkou, 2014). Finally, considering the financial limitations experienced by many mental health support organisations, DMT is an affordable way to treat a range of depression-related conditions. It is optimally delivered in a group format, providing meaningful and safe social interactions for people with depression.

Conclusion and recommendations for future research

Research evidence shows that DMT is useful for treating depressed people, with most dramatic results in people diagnosed with clinical depression. Group dance/movement therapy is beneficial partly due to its social aspect. There is a need for better quality research in terms of larger sample sizes, inclusion of a control group and specified style of DMT used. It would also be helpful to establish whether DMT is effective used alone, or in conjunction with talk therapy; and/or with in an expressive therapies framework, specifically, the identification of any DMT techniques that could be incorporated into the therapy room without the counsellor undergoing significant additional training. The potential healing benefits of DMT for people with depression may have been somewhat overlooked within the therapy professions due to the lack of consistent, clearly defined and agreed upon methods and measurements.

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Appendix 1

Scales and Assessments used in the Research Papers

BIA	Body Image Assessment
BDI	Beck Depression Inventory
CORE/OM	Clinical Outcomes in Routine Evaluation/ Outcome Measure
DACL	Depression Adjectives Checklist
HADS	Hospital Anxiety Depression Scale
PSS	Perceived Stress Scale
SLC-90	Symptoms Check List
TAS-20	Toronto Alexithymia
TBFI	The Brief Fatigue Inventory
TIPI	Ten Item Personality Inventory
TBPI	The Brief Pain Inventory
TPSQI	The Pittsburgh Sleep Quality Index
RQ	Relationship Questionnaire
SCL-90/R	Symptom Checklist 90 Revision
SWLS	Satisfied With Life Scale

Appendix 2

Timeline of Development of Dance Movement Therapy

1940's

Europe

- Austria, Reich's Body Psychotherapy recognised a connection between emotions and movement (Karkou & Sanderson, 2006).
- The UK, Rudolf Laban's Movement Analysis looked educationally at body movement and the emotions that are unwittingly communicated (Newlove, & Dalby, 2004; Panagiotopoulou, 2011).

The USA

- Marion Chace worked in psychiatric hospitals and focused on self-expression and the needs of the person, not the dance technique, and used circle groups and mirroring as a supportive interactive method of communication with schizophrenic patients (Panagiotopoulou, 2011).

- Mary Whitehouse worked with high anxiety clients and focused on the process and therapeutic relationship. She developed Authentic Movement in the 1950's where purposeful and spontaneous movement are used to explore the unconscious and connect with hidden emotions (Chodorow, 1990). 1950's

- Trudi Sloop worked with schizophrenic patients and used imagination to creatively encourage expressive movement (Karkou & Sanderson, 2006). 1960's

- Dancer Judith Kestenberg, observed the correlation between movement and emotions and created the Kestenberg Movement Profile. This was influenced by Laban's Movement Analysis categories (Bannerman-Haig, 2006).

- Judith Kestenberg, influenced by Laban, observed the correlation between movement and emotions and created the Kestenberg Movement Profile (Bannerman-Haig, 2006).

1982

GLOBALLY

DMT became officially recognised and integrated movement concepts developed from Rudolf Laban's work and perspectives from American dancers:

- Chace Approach which is most commonly used;
- Authentic Movement;
- the Psychodynamic Oriented Dance Therapy approach where past conflicts are identified and addressed through analysis of movement and group relationships; and
- Integrative Dance Therapy, developed in Germany integrating concepts from the American pioneers (Brauninger, 2014).

1984

FRANCE

- Schott-Billman developed Expression Primitive which focuses on cultural awareness and specific group movements with psychiatric patients

1994

AUSTRALIA

- The Dance Therapy Association of Australia formed and is now known as the Dance Movement Therapy Association of Australasia (DTTA).

NOW

GLOBALLY

- Dance therapy is now taught in universities worldwide and is credited as effective in mind-body wellness, self-care, depression, chronic pain and chronic illnesses (Hopkins, 2016).
- Unfortunately, in the USA, due to health insurance coverage issues, DMT is labelled an alternative or holistic treatment limiting it to private paying clients.

Four main types of Dance/movement therapy are practised, comprising: Authentic Movement; the Psychodynamic Oriented Dance Therapy approach where past conflicts are identified and addressed through analysis of movement and group relationships (Karkou & Sanderson, 2006); and the German Integrative Dance Therapy, which integrated concepts from the American pioneers (Brauninger, 2014). Additionally, in 1984, Schott-Billman developed Expression Primitive which focuses on cultural

awareness and specific group movements (Panagiotopoulou, 2011).

Appendix 3

Number of sessions per study

HongKong study of 6 sessions, by Ho, et al.,

Canadian study 7 sessions of by Stewart in Mala, Karkou & Meekums

German study of 8 sessions, by Koch

Swiss study of 10 sessions, by Brauninger

South Korean study of 36 sessions by Jeong in Mala, Karkou & Meekums

Finnish study of 20 sessions by Punkanen, Saaikallio & Luck

Finnish study of 12 sessions by Pylvänäinen, Muotka & Lappalainen