Dance Therapy for People with Schizophrenia

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Key words: movement therapy/randomized controlled trials/mental health

Background

Dance therapy or dance movement therapy is defined as “the psychotherapeutic use of movement as a process which furthers the emotional, social, cognitive, and physical integration of the individual.” It may be of value for people with developmental, medical, social, physical, or psychological impairments. Dance therapy can be practiced in mental health rehabilitation units, nursing homes, and day care centers and incorporated into disease prevention and health promotion programs.

Objective

To evaluate the effects of dance therapy for people with schizophrenia or schizophrenia-like illnesses compared with standard care and other interventions.

Search Methods

We searched the Cochrane Schizophrenia Group Trials Register (July 2007), inspected references of all identified studies (included and excluded), and contacted first authors for additional data.

Selection Criteria

We included all randomized controlled trials comparing dance therapy and related approaches with standard care or other psychosocial interventions for people with schizophrenia.

Data Collection and Analysis

We reliably selected, quality assessed, and extracted data. We excluded data where more than 30% of participants were lost to follow-up. For continuous outcomes, we calculated a weighted mean difference (WMD); for binary outcomes, we calculated a fixed-effect risk ratio (RR) and their 95% confidence intervals (CIs).

Results

We included one single blind study (total n = 45) of reasonable quality (tables 1 and 2). It compared dance therapy plus routine care with routine care alone. Most people tolerated the treatment package, but about 40% were lost in each group by 4 months (RR = 0.68, 95% CI = 0.31 to 1.51). Positive and Negative Syndrome Scale (PANSS) average endpoint total scores were similar in each group (WMD = −0.50, 95% CI = −11.8 to 10.8) as were the positive subscores (WMD = 2.50, 95% CI = −0.67 to 5.67). At the end of treatment, significantly more people in the dance therapy group had a greater than 20% reduction in PANSS negative symptom score (RR = 0.62, 95% CI = 0.39 to 0.97) (figure 1), and overall average negative endpoint scores were lower (WMD = −4.40, 95% CI = −8.15 to 0.65). There was no difference in satisfaction score (average Client’s Assessment of Treatment Scale score, WMD = 0.40, 95% CI = −0.78 to 1.58), and quality-of-life data were also equivocal (average Manchester Short Assessment of Quality of Life score, WMD = 0.00, 95% CI = −0.48 to 0.48).

Authors’ Conclusions

There is no evidence to support—or refute—the use of dance therapy in this group of people. This therapy remains unproven, and those with schizophrenia, their carers, trialists, and funders of research may wish to encourage future work to increase high-quality evidence in this area. Full details are reported elsewhere.2

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Table 1. The Rohricht 2006 Study

Methods
Allocation: randomized (opening sealed envelope by a blinded person).
Blinding: single (assessor). Duration: 10-wk treatment + 4-mo follow-up.
Setting: community, London, UK.

Participants
Length of illness: 12.1 ± 10.5 y (BPT group), 10.8 ± 7.3 y (SC group).
Exclusion criteria: evidence of organic brain disease, severe/chronic physical illness, substance misuse.

Interventions
1. BPT + routine care: including 5 stages: (a) opening circle, describe feelings and energy level; (b) warm-up section standing in a circle and warm-up using different body parts and movements; (c) structured task section, mirroring each other’s movement, creating body image sculpture in partners; (d) creative movement section, group mirroring, creating group sculptures, reflecting on how this feels; (e) closing circle, reflecting on group experience, refocusing on self with body-oriented exercises such as self-touch, verbal integration. Frequency: 60–90 min/session, 20 sessions over 10 wk. *N* = 24.
2. SC + routine care: therapist facilitated a safe and supportive atmosphere and gave the participants opportunity to talk about specific difficulties. The group then engaged in discussing their experience and trying to identify the contributing factors to the problems. Main strategy used is problem-solving strategy. Frequency: 60–90 min/session, 20 sessions over 10 wk. *N* = 21.

Outcomes
Leaving the study early. Mental state and behavior: PANSS, PANSS symptom reduction rate. Satisfaction with treatment: CAT, MANSA. Adverse events: EPS.

Note: *DSM-IV*, *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition); BPT, body-oriented psychological therapy; SC, supportive counseling; PANSS, Positive and Negative Syndrome Scale; CAT—Client’s Assessment of Treatment Scale; MANSA—Manchester Short Assessment of Quality of Life; EPS—Extrapyramidal Symptom Rating Scale.

Table 2. Risk of Bias

<table>
<thead>
<tr>
<th>Item</th>
<th>Judgment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate sequence generation?</td>
<td>Unclear</td>
<td>Randomized in blocks, no details reported.</td>
</tr>
<tr>
<td>Allocation concealment?</td>
<td>Yes</td>
<td>Sealed envelope.</td>
</tr>
<tr>
<td>Blinding?</td>
<td>Unclear</td>
<td>Single but not tested.</td>
</tr>
<tr>
<td>Incomplete outcome data?</td>
<td>No</td>
<td>40% participants lost at follow-up, not addressed.</td>
</tr>
<tr>
<td>Free of selective reporting?</td>
<td>Yes</td>
<td>No selective reporting.</td>
</tr>
<tr>
<td>Free of other bias?</td>
<td>Yes</td>
<td>Study supported by East London and The City Mental Health Trust and an unconditional grant by Pfizer and Wyeth.</td>
</tr>
</tbody>
</table>

Fig. 1. Mental State: Negative symptoms—not improved (Positive and Negative Syndrome Scale Negative Symptom Reduction Less Than 20%–40%. CI, confidence interval.

References