



Dance is more than therapy: Qualitative analysis on therapeutic dancing classes for Parkinson's



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ABSTRACT

Objectives: To understand the benefits and limitations of therapeutic dancing classes for people with Parkinson's disease (PD) and how best to design and implement classes.

Design: A stakeholder forum explored the opinions of 18 allied health clinicians, dance instructors, people with PD and caregivers. Data were thematically analysed and interpreted within a grounded theory framework.

Results: Four main themes were identified: (1) the need to consider the stage of disease progression when designing classes; (2) recognition that dance is more than just therapy; (3) the benefits of carefully selecting music to move by; (4) ways to design classes that are both feasible and engaging. These themes give rise to the theory that dancing classes can provide more than just therapeutic benefits. Dance affords creative expression and enables people to immerse themselves in the art-form, rather than focussing on the disease. The results highlight the benefits of enabling individuals with PD to be able to express themselves in a supportive environment that does not see them solely through the lens of Parkinson's. The feasibility of dance programs can be increased by educating dancing teachers about PD and the unique needs of people living with this condition.

Conclusion: Well-structured dance classes can promote social-connectedness and joy, in addition to facilitating movement to music and physical activity. Consumers advised that careful planning of the classes and tailoring them to participant needs optimizes outcomes.

1. Introduction

Exercise and physical therapy are part of comprehensive care for people living with idiopathic Parkinson's disease (PD).^{1–5} Parkinson's is a debilitating condition with variable presentation of motor and non-motor signs.^{6–9} Gait disturbance, movement slowness and other movement disorders such as freezing of gait, rigidity and postural instability have been a key focus of conventional physical therapy.^{2,4,10,11} As the disease progresses, non-motor symptoms such as cognitive impairment, anxiety, depression, fatigue and social isolation can also occur.^{7,8,12} These symptoms can compromise health-related quality of life (HRQOL).^{7,12–15} In turn there can be a decline in physical performance,^{16–19} depression.^{13,20} and reduced social connectedness.^{21,22}

Contemporary clinical practice aims to address the motor and non-motor signs of PD, and encourages self-management within an inter-professional model.^{23–27} Clinical guidelines highlight the importance of an integrated approach.²⁸ Therapeutic dancing has been advocated as an effective component of movement rehabilitation.^{24,29–33} Dancing

incorporates creative expression and long-term participation in vigorous physical activity.^{34,35} It is also considered to be enjoyable^{31,36–38} and can be associated with improved HRQOL.^{39–41} There is increasing interest in dance as a complementary therapy, with a range of studies investigating different dance genres, music rhythms, class structures, class durations and frequencies of dance programs.^{34–36,42–45}

According to McGill et al.³³ dance studies have reported positive changes in symptoms, although they do not always adequately explore how dance influences psychological, emotion and social factors. Individuals living with PD can have multidimensional needs³⁷ and consideration of their preferences can assist with the development of a feasible dancing program.^{37,38} Although some studies have reported the experiences and beliefs of people with PD regarding dancing programs, they have been restricted to a small number of dance genres, such as Irish set dancing³⁷ and mixed dance classes.³⁸ There is a need to explore the beliefs of consumers and health professionals who have experienced PD dance programs to understand their views, needs and preferences about dance.

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The aim of this research was to explore the experience of therapeutic dancing for people living with PD and summarise important class design elements.

2. Methods

We used qualitative research methodology to inform the study design, data collection and data analysis. The study was conducted and reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ)⁴⁶ and the Standards for Reporting Qualitative Research (SRQR).⁴⁷

2.1. Eligibility, recruitment and selection of participants

Participants were invited by email from a list of stakeholders who were known to the researchers and who met the inclusion criteria. The sampling strategy ensured that participants had experience of dance therapy and could contribute in English. To be included, individuals with PD needed to have previously participated in therapeutic dancing classes, be stages I–III of the modified Hoehn and Yahr scale (HY)⁴⁸ and not have cognitive impairment assessed by the Mini Mental State Examination.⁴⁹ Dance instructors needed to be skilled in teaching different dance genres and have experience of dance for PD. Allied health clinicians such as physical therapists, music therapists and occupational therapists, were included if experienced in treating people with PD. People who were not able to give informed consent or not available to travel to the venue were excluded.

2.2. Ethics consideration

The research was approved by the La Trobe University, Australia, Human Ethics Committee (S16/119). Written informed consent was provided by all participants prior to the commencement of the forum. Participants were assured of confidentiality and anonymity and were de-identified by pseudonyms in the transcription documents. The participants were given equal opportunity to speak freely and openly during the forum.

2.3. Data collection

Data were collected in a three-hour stakeholder forum. A forum was selected to enable a large sample of a diverse group of people to contribute to the discussion on one occasion.^{50,51} In preparation for the forum, a briefing document summarising the published literature on dance for PD was sent to the participants. The meeting was held in 2016 at La Trobe University, Australia and facilitated by an independent postdoctoral physical therapist (SS), with extensive experience in qualitative research. Two allied health clinicians (PR, LF) took briefing notes regarding behaviours, body language and opinions of participants. The meeting was audio-recorded and independently transcribed verbatim.

The stakeholder forum utilised a pre-prepared ethics-approved briefing document based on the literature and focus group methods⁵⁰ and a set of open-ended questions to guide the forum discussion (Table 1).

2.4. Data analysis

The data were thematically analysed, within a grounded theory framework, to link the findings to the participants and allow for the potential generation of new theory.^{50,51} This theoretical framework was based on recognition of codes, categories, themes and sub-themes in the data and identification of the associations between them.⁵⁰ In order to conduct the research with rigor, credibility and relevance, the researchers were informed and guided by the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies.⁵²

Table 1
Questions used in the forum.

Considering dance programs for people with Parkinson's disease:
1) What should be the focus of dance for PD?
2) How should class structure be designed and implemented?
3) What dance styles should be included?
4) How repetitive should the content of the classes be?
5) What should be the duration and frequency of classes?
6) Should participants be separated into different groups? On what criteria?
7) How does music assist dancing?
8) What should dance instructors and assistants learn about Parkinson's disease?
9) Who should partner people with Parkinson's during the classes?

Two researchers (PR, SS) independently reviewed the transcripts multiple times to achieve familiarity with the data and to identify the main codes, categories and emergent themes. Each researcher independently extracted potentially relevant quotations, grouped the codes into categories and collapsed these into preliminary themes. The analytic process was iterative and the two researchers (PR, SS) repeated the code, category and theme development independently and conducted three documented skype meetings, followed by confirmation emails, until consensus was reached for the final set of themes and sub-themes. Representative quotes for each theme were selected by each researcher and these were pooled together to support the identified themes. Two other researchers (MM, JM) were available for consultation throughout the analysis process. After consensus was reached between PR and SS, the third and fourth researchers (MM, JM) independently reviewed the themes and sub-themes for context and accurate representation of the data. Data analysis was complete when all of the researchers agreed on the final themes, supporting quotes and emergent theory.

The rigor of the research was enhanced by testing credibility, transferability, dependability and confirmability.⁵³ Credibility was enhanced by two researchers independently reviewing the data coding, category development and discussing emergent themes. Transferability was enhanced by recruiting a variety of participants from diverse professional, health backgrounds and duration of PD. Dependability was enhanced by audio-recording the forum, note-taking throughout the forum, independent verbatim transcription of audio-recordings, comparison of the audio-recording against the transcripts and documentation of findings from data analysis. Confidence in confirmability was achieved when the same codes and themes emerged from participants of different backgrounds.

3. Results

Twenty people were invited to the forum and 18 agreed to participate. The stakeholder forum included six allied health clinicians (four physical therapists, one occupational therapist and one music therapist), five dance instructors, five people diagnosed with PD and two caregivers (Table 2). The mean disease duration of people with PD was 8.8 years (range 2–20). An overarching theme that emerged from this research was that therapeutic dance links exercise, management of movement disorders and the artistic experience. People's experiences in dance therapy programs were influenced by the overall artistic experience, the selection of music, the expertise of the dance instructor, disease stage and the infrastructure of the dance venue. Emergent themes from the forum are detailed below, along with discrete sub-themes and supporting participant quotations. The quotations are linked to the data by participant codes, followed by their qualifications (people with PD [PD], caregivers [C], dance instructors [DI], physical therapists [PT], occupational therapists [OT], music therapists [MT]), transcript page and line number(s) [eg. S: PD, T1, P8: 340–350].

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