



Effectiveness of dance/movement therapy on affect and psychotic symptoms in patients with schizophrenia



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ABSTRACT

Schizophrenia is a debilitating and pervasive mental illness involving a range of cognitive, behavioral, and emotional dysfunctions alongside impaired occupation or social functioning. Previous studies have suggested that dance/movement therapy (DMT) could be useful for the treatment and management of the symptoms of schizophrenia. This study investigated the effects of DMT on affect and psychotic symptoms in patients with schizophrenia. The DMT group ($n = 18$) received both DMT and medical treatment over 12 weeks, and the control group ($n = 20$) received only medical treatment. The DMT group showed a significant decrease of state anger and depression compared to the control group after treatment (for state anger, $F(1, (1, 36) = 2.26, p < .05$; for depression $F(1, (1, 36) = 5.92, p < .01$), and attained a significant increase of anger control compared to the control group after treatment ($F(1, (1, 36) = 5.11, p < .01$). For psychotic symptoms the DMT group showed a significant decrease of negative psychotic symptoms compared to the control group after treatment ($F(1, (1, 36) = 5.12, p < .01$). DMT is therefore presented as a treatment program that can reduce negative affect with anger control, and improve negative psychotic symptoms.

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Introduction

Schizophrenia is a debilitating and pervasive mental illness involving a range of cognitive, behavioral, and emotional dysfunctions with impaired occupation or social functioning (Villa & Pai, 2013). The core symptoms for schizophrenia diagnosis should be followed by one of delusions, hallucinations, and disorganized speech. Unlike neurotic mental disorders, schizophrenia tends to go chronically along with one's life, and its genetic factors cannot be ignored on the level of his or her family medical history (Janicak, Marder, Tandon, & Goldman, 2014). The psychopathology has substantial impact on the quality of life and social and occupational function. Thus schizophrenia creates a considerable socioeconomic burden (Zeidler, Slawik, Fleischmann, & Greiner, 2012).

Schizophrenia is a highly stigmatizing disorder and many individuals with this diagnosis feel devalued and discriminated (Dickerson, Somerville, Origoni, Ringel, & Parente, 2002). Societal,

and sometimes medical, views include the belief that schizophrenia is a chronic and debilitating condition from which individuals have little chance of recovering (Angermeyer, Matschinger, & Corrigan, 2004). This conceptualization can be threatening and distressing to those given the diagnosis, and is likely to contribute to the high level of depression experienced by many patients with schizophrenia (Bosanac & Castle, 2013).

Schizophrenic psychopathology is multidimensional and heterogeneous (Mossaheb et al., 2014). Factor analytic studies have often shown positive, negative, and disorganization factors (Cichocki, Cechnicki, & Polczyk, 2012). Positive symptoms include delusions and hallucinations, and negative ones include affective flattening, alogia, avolition, anhedonia, and asociality. While psychopharmacotics are effective in improving positive symptoms, their effectiveness on negative symptoms is limited (Van Os & Kapur, 2009).

Anger and its expression are especially important considerations for patients with schizophrenia as they often show aggressive behaviors that can result in harm to themselves and others. Schizophrenic patients' aggressive behaviors are linked to the underlying psychopathology of thought and perception disorders and to the lack of anxiety and impulse control that impairs their ability to withhold minor complaints. Thus, diagnosis,

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symptom identification, and noting their progression may help predict these aggressive behaviors. Anderson's model (Lindsay & Anderson, 2000) suggests that aggressive behaviors are triggered by aggressive cognition, affect, and arousal. According to this model, anger that influences violent behaviors can be categorized as either situational or dispositional anger; and anger expression can be categorized into "anger out," which involves displaying aggressive language or behaviors toward another person or object, and "anger in," which involves repressing or containing anger. The concept of "anger control" was added later to explain individual differences in patients' efforts and their will to control anger expression (Speilberger, Reheiser, & Sydeman, 1995).

Besides medical treatments for schizophrenia, psychosocial rehabilitation therapies, such as dance/movement therapy (DMT), were found to be effective. "Dance therapy" was introduced by Chase as a supplementary treatment method (Chace, 1953). Currently, "movement therapy" is combined with sports therapy and is utilized in the field of psychiatry. DMT utilizes physical activities and sensory stimulation to help restore patients' ego integrity through creative movements. DMT can effectively enhance interpersonal relationships and communication skills, control anger and aggressiveness, and prevent social regression (Mutri, 2002). Furthermore, adequate physical activity and regular movements can improve cardiopulmonary functions, enhance physical strength and joint flexibility, strengthen the body's homeostasis and immune functions, and lower sensitivity to anxiety and depression.

With the results of previous studies, we hypothesize that DMT can have a positive effect on affect and psychotic symptoms in patients with schizophrenia compared to the control group receiving only medical treatment. This study investigated the effects of DMT on anger, expression of anger, depression, anxiety, and positive and negative symptoms in hospitalized schizophrenic patients.

Methods

Design

The current study involved pre- and post-tests. The participants received sufficient explanations regarding the study and were educated on the overall DMT process. The DMT and control groups were comparable in socio-demographical and clinical characteristics (Table 1).

Participants

Participants were recruited through the Wonkwang University hospital. The psychiatric diagnosis was confirmed by a licensed psychiatrist based on Diagnostic and Statistical Manual of Mental Disorders-5 (American Psychiatric Association, 2013). We obtained written informed consent from all participants after explaining to them the aims and procedures of the study. Study inclusion psychiatric criterion was schizophrenia. Exclusion criteria in the current study were comorbidity with other psychopathologies – such as depression, bipolar disorder, and drug addiction – and current/past medical history for various neurological disorders, such as brain damage or dementia. Patients with IQ scores lower than 70 and those deemed incapable of filling out a survey on their own were excluded. To eliminate the influence of dosage change of antipsychotic drugs administered to patients, the experimental and control groups maintained their drug dosages during the study period.

Procedure

A 60-min DMT session was held once a week for 12 consecutive weeks. DMT was explained to participants before the beginning

Table 1
Demographic and clinical characteristics of subjects.

	DMT group (n = 18)	Control group (n = 20)
Gender		
Male	8	10
Female	10	10
Age ($M \pm SD$)	41.5 $\pm$ 10.5	41.8 $\pm$ 11.1
Education year ($M \pm SD$)	10.3 $\pm$ 2.4	11.0 $\pm$ 2.1
Marital status		
Unmarried	11	12
Married	3	3
Divorced	3	4
Other	1	1
Onset age of illness ($M \pm SD$)	21.3 $\pm$ 3.4	20.5 $\pm$ 4.7
Duration of current illness ($M \pm SD$)	8.9 $\pm$ 4.2	8.4 $\pm$ 5.8
Subtype of schizophrenia		
Paranoid type	12	13
Undifferentiated	5	5
Others	1	2
N of types of medication taken		
$M (SD)$	4.5 (1.3)	4.5 (1.3)
Range	2–10	2–10
N (%) of subjects on medication with clozapine		
- Has taken clozapine	5 (27.7)	6 (30)
- Has not taken clozapine	13 (72.3)	14 (70)
N (%) of subjects on medication during trial		
Typical antipsychotic	5 (27.7)	7 (35)
Clozapine	2 (11.1)	2 (10)
Quetiapine	1 (5.5)	2 (10)
Olanzapine	2 (11.1)	3 (15)
Risperidone	8 (44.6)	6 (30)

DMT = dance/movement therapy.

of the study. The DMT intervention comprised 12 weekly 60-min sessions. In the initial stage (Sessions 1–4), self-awareness was developed; in the intermediate stage (Sessions 5–8) interpersonal relationships were facilitated; and in the final stage (Sessions 9–11), relationships between the individual and group were formed, with Session 12 serving to conclude the intervention and conduct post-tests. The treatment process is explained in Table 2. A total of 18 patients with schizophrenia received both the DMT and medical treatment, and 20 patients with schizophrenia received only medical treatment as a control group. A researcher who had completed DMT professional courses at Wonkwang University in 2010 and has previously conducted DMT sessions conducted the intervention. Before the study, participants were provided detailed explanations regarding study purposes and procedures, based on which they signed research participation agreements indicating consent. Participants were randomly assigned to the DMT or control group by flipping a coin. Because this study focuses on improving affect and psychotic symptoms in patients with schizophrenia, the scales related with depression, anxiety, anger, and psychotic symptoms were used in this study.

Measurements

In order to measure the effect of the DMT program, the clinical rating scales used included STAXI, BDI, STAI, and PANSS. Participants were also asked to complete the program evaluation form at the end of the last session.

State-trait anger expression inventory (STAXI)

The STAXI provides a self-reported measure of the experience and expression of anger in 44 items (Speilberger, 1988). Individuals answered on a 4-point Likert scale ("Not at all" to "Almost always") to assess either the intensity of their angry feelings or the frequency in which anger is experienced, expressed, or controlled.

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