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Dance movement psychotherapy practice in the UK: Findings from the Arts Therapies Survey 2011

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Arts therapies practice in the UK, due to its complexity, is rarely adequately described and what constitutes main features of the professions often remains unclear. A nationwide Arts Therapies Survey was conducted in 2011 with the aim to offer a description of clinical practice with particular emphasis on work with depression. The survey received responses from 395 arts therapists, among whom 36 were dance movement therapists. While complete data from the survey is available elsewhere, this paper presents results particularly relevant to dance movement practitioners and highlights key areas of their practice, including usual work settings, client groups and preferred theoretical approaches. Both quantitative and qualitative data are used to illustrate the points discussed. Additionally, dance movement psychotherapists' responses concerning their work with depression are presented against other arts therapies professions' practice with this condition in the UK. Finally, areas for further research are recommended.

Keywords: dance movement psychotherapy; arts therapies; survey; clinical practice; depression

Introduction

Dance movement psychotherapy is a relatively young, but fast growing profession in the UK that is currently regulated by the Association for Dance Movement Psychotherapy UK (ADMP UK). Alongside art, music and dramatherapy, it is often associated with the wider field of arts therapies and is being considered a form of psychotherapy.

It has therefore been argued that the practice of dance movement psychotherapy (further referred to as 'DMP') draws upon a combination of psychotherapeutic and artistic traditions (Karkou & Sanderson, 2006). Although it is often suggested that dance movement therapists work with various client populations, in diverse settings and using a range of therapeutic tools (Payne, 2006), clear understanding to the main trends in DMP practice remains limited.

On the whole, research literature up to date has provided fairly fragmented descriptions of certain aspects of practice. By far, the most comprehensive map of the arts therapies field has been offered by Karkou and Sanderson (2006), who

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elaborate on DMP practice drawing upon a nationwide survey undertaken in 1996 (Karkou, 1998). The authors describe therapeutic principles commonly followed by practitioners and place DMP in the context of other arts therapies. Another core position in British literature offers a creative approach to DMP practice and helps situate the discipline within the broad field of psychotherapy (Meekums, 2002). Both texts define DMP in the UK context, allowing for an understanding of what the discipline involves and offering some clarification on its origins and therapeutic principles. Selected applications of DMP practice in the UK have been presented elsewhere (Payne, 1992, 2006) and case studies offer valuable insights into what actually happens in the therapy room. Despite the presence of these valuable and especially relevant in the UK context texts, the scope of DMP literature is still fairly narrow and lacks multiple perspectives. Therefore, there is a recognised need for more research in the field and more studies that identify core aspects of DMP practice as well as peculiarities and innovation.

The current report aims to add to the understanding on how, where and with whom dance movement therapists in the UK work.

Aims of the study and the current paper

This study for which the survey was conducted aimed to describe how arts therapists of all disciplines recognised in the UK work with depression. Some of the results from this project have been presented elsewhere (Zubala, MacIntyre, Gleeson, & Karkou, 2013) and will be followed by further reports, while the current paper utilises data collected in the survey to offer a description of characteristics of DMP practice in particular. More specifically, attempts to offer answers to the following questions are made:

- Who are dance movement psychotherapists in the UK?
- Where and with whom do they work?
- What theoretical backgrounds, evaluation methods and therapeutic principles determine their practice?
- What unique features distinguish DMP practice from other arts therapies disciplines?

With regard to researcher's specific interest in depression, additional question is raised:

- Do dance movement psychotherapists in the UK work with depression? What is the extent of this work?

Methodology

In order to answer the above questions, an online Arts Therapies Survey was launched in June 2011 and closed in September 2011. There were 395 responses to this survey coming from arts therapists of all four disciplines recognised in the UK, offering insights into various aspects of clinical practice, including theoretical approaches, therapeutic principles, aims, methodology and evaluation.

The questionnaire used in the survey was developed by Karkou in 1996 (Karkou & Sanderson, 2006) and consisted of multiple choice, single choice and open-ended items. They concerned the following areas of arts therapies practice: information

about work settings and client groups (eight items), theoretical influences (two items), evaluation and assessment (four items) and biographical information of therapists (six items). Another 34 questions concerned therapeutic principles that required respondents to indicate their level of agreement to provided statements on a scale of 1 to 5. These statements were grouped into six factors through prior factor analysis and were labelled: humanistic, psychoanalytic/psychodynamic, developmental, artistic/creative, active/directive and eclectic/integrative. Each of the six factors presented acceptable internal consistency (α ranging from 0.56 to 0.71) and were seen as capturing some of the complex aspects of arts therapists' practice in the UK (Karkou & Sanderson, 2006) and across Europe (Karkou, Martinsone, Nazarova, & Vaverniece, 2011).

For the purpose of the particular research on depression, the survey was adapted in 2011 to include three additional items, enabling identification of arts therapists who work specifically with the condition. An online version of the questionnaire was developed using the Bristol Online Surveys system (www.survey.bris.ac.uk). New mode of delivery and slight changes to the original survey called for an assessment of its suitability and quality, and the survey was initially evaluated in a pilot among arts therapists at Queen Margaret University. The participants of the pilot ($n = 29$) evidently accepted the online mode of delivery, agreed that the questions were easily understandable and their meanings were clear, and positively commented on the survey's structure, content and presentation. They also offered additional feedback on the valuable opportunity to take time to focus directly on a comprehensive review of their clinical practice.

Participants

The study focused on responses from arts therapists who were qualified to practise within the UK, having completed relevant training at a postgraduate level and/or having acquired licence to practise from one of the relevant regulating bodies for arts therapies. Every attempt was made to reach as many as possible of around 3000 arts therapists registered in the UK at the time (in 2010, according to Health Professions Council's [now Health & Care Professions Council, HCPC] statistics).

An invitation to take part in the survey was distributed among arts therapists in the UK with the help of Arts Therapies Professional Associations (British Association of Art Therapists, ADMP UK, British Association for Music Therapy and The British Association of Dramatherapists). The Associations agreed to include advertising material in their newsletters, e-Bulletins and members' areas on the websites. Relevant networking groups, clinical and educational settings were also informed about the study. Advertising through Professional Associations and other respected and trusted professional groups ensured that only qualified and registered practitioners had been invited to take part.

Results

The survey received 395 responses in total, coming from therapists of four arts therapies disciplines. Dance movement psychotherapists formed the smallest group ($n = 36$, 9.1% of the total sample), outnumbered by music therapists ($n = 50$),

dramatherapists ($n = 59$) and art psychotherapists ($n = 243$). The relatively small number of dance movement psychotherapists participating in this study actually represents well the proportion of these professionals in the total population of arts therapists in the UK. Data available from the HCPC (2011) and ADMP UK suggest that dance movement psychotherapists form the smallest group among arts therapies professions (around 6.5% of all arts therapists – estimate based on approximately 212 practitioners registered with the ADMP UK in 2011).

Further report is based on data collected from the 36 respondents of DMP profession, further referred to as 'DMP group' or simply 'respondents'. Whenever relevant, results are occasionally related to the total sample or other arts therapies disciplines (further referred to as 'group AT + MT + DT' where AT indicates art therapists, MT indicates music therapists and DT indicates dramatherapists).

Quantitative data analysis was conducted using SPSS19 software for descriptive and inferential statistics (IBM, 2012). Due to small number of responses given by dance movement therapists to open-ended questions, a systematic qualitative analysis was not performed. However, therapists' comments often illustrate and complement quantitative results and are therefore included in the report. When direct quotations are used, they are labelled with respondent number only (e.g. R3).

Biographical information

The total sample ($n = 395$) consisted of 84% female and 16% male respondents. In the DMP group ($n = 36$), females constituted 92% and males 8%. It is estimated (HCPC, 2011) that the percentage of female and male therapists in the total population of arts therapists corresponds to the proportions in the total sample of this study. Since dance movement therapists were not part of the HCPC in 2011 and were not accounted for in these statistics, it remains unknown whether the proportions of females and males in the DMP group is representative for the general population. However, in the generally female-dominated professions of arts therapists, a similar or possibly even stronger predominance of females among dance movement psychotherapists may be assumed.

The DMP group consisted of respondents on a wide age spectrum. Age under 41 years was declared by 53% of therapists, while the remaining 47% were over 41. Moreover, 25% of respondents were aged 30 or under, and only 17% were aged 51 or over. Interestingly, among respondents of other arts therapies disciplines (group AT + MT + DT), less than 7% were under the age of 31 and 43% were aged 51 or over. The differences between groups DMP and AT + MT + DT are statistically significant with regard to the youngest and the most mature therapists (see Table 1). Results seem to therefore suggest that there were younger practitioners among dance movement therapists than in other arts therapies disciplines. Group AT + MT + DT appeared to include significantly more mature practitioners.

Exactly 50% of respondents from the DMP group reported to have had 7 or less years of experience, while nearly 14% practised for over 15 years. Significantly longer experience was reported by many therapists of other arts therapies disciplines (see Table 1). In this group, over 35% of respondents had more than 15 years of experience and just under 20% worked for less than 3 years (as compared to nearly 42% in the DMP group).

Table 1. Biographical information of arts therapists in DMP group compared to other arts therapists: AT + MT + DT.

Biographical information of arts therapists		DMP (%)	AT + MT + DT (%)	*z*-value
Sex	F	91.7	83.3	
	M	8.3	16.7	
Age	<30	25.0*	6.7*	2.5
	31–40	27.8	22.3	
	41–50	30.6	28.4	
	51–60	13.9**	31.5**	2.8
	>60	2.8*	11.1*	2.6
Years of experience	<3	41.7*	19.8*	2.5
	4–7	8.3	16.2	
	8–11	19.4	17.0	
	12–15	16.7	11.7	
	>15	13.9**	35.4**	3.4

Note: Highlighted areas of statistically significant difference: *at 95% confidence interval; **at 99% confidence interval, based on *z*-test.

Style of working (work setting, group vs individual work, work alone vs in a team)

Therapists in the DMP group stated that they worked on their own as well as in teams with other professionals and other arts therapists nearly equally often (see Table 2). All three styles of working were reported by between 47.2% and 50.0% respondents and were similarly common among respondents of other arts therapies disciplines (proportions were not statistically different). Therapists who chose the option 'Other' commented that they worked in combination of the above and one respondent highlighted the potential loneliness of a dance movement therapist in

Table 2. Style of working of therapists in the DMP group compared to respondents in group AT + MT + DT.

Arts therapists' style of working		DMP (%)	AT + MT + DT (%)	*z*-value
Lone and/ or team work	On my own	50.0	57.7	
	Team – with other arts therapists	47.2	30.1	
	Team – with other professionals	47.2	59.6	
	Other	13.9	5.8	
Working environments	Health service	38.9**	60.4**	2.9
	Educational setting	27.8	27.0	
	Private practice	33.3	30.1	
	Voluntary agency	13.9	18.4	
	Social service	19.4	12.5	
	Other	19.4	11.4	
One-to-one and/ or group work	One-to-one	61.1**	85.5**	2.9
	Families/couples/dyads	11.1*	24.0*	2.2
	Groups	88.9**	65.5**	4.0

Note: Highlighted areas of statistically significant difference: *at 95% confidence interval, **at 99% confidence interval based on *z*-test.

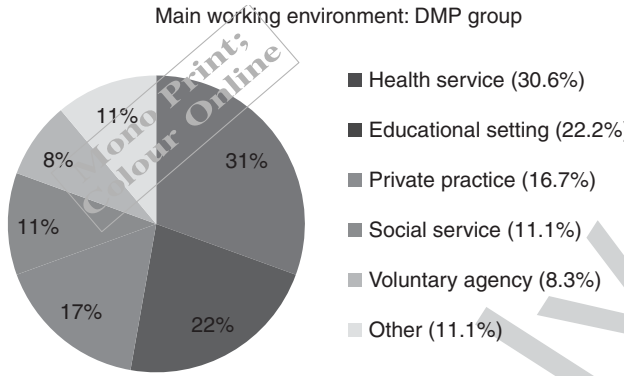

Figure 1. Main working environment, as reported by therapists in DMP group.

a clinical setting: 'Work across 2 NHS Trusts, one does not have other Arts Therapists' (R6).

Asked to select all environments, in which they see their clients, therapists in DMP group chose 'health service' most often (38.9%), followed by 'private practice' (33.3%) and 'educational setting' (27.8%). Work in voluntary agencies and social services proved less common. Although health service was indicated most often by DMP practitioners, it was even more often selected by therapists of other disciplines (group AT + MT + DT), of whom 60.4% reported that they worked in this particular environment. The difference between the two groups of therapists is statistically significant with regard to health service setting, while other working environments were indicated equally often by both groups (see Table 2). When prompted to identify only one setting as a main working environment (see Figure 1), therapists in the DMP group similarly referred to the 'health service' most often (30.6%). Among settings not listed but mentioned by the respondents were residential/care homes and charity organisations (the latter understood by the authors to belong to the 'voluntary agency' category).

Therapists in the DMP group reported that they worked with groups most often (88.9%), but practice with individual clients was also common (61.1%), while work with families and couples was reported less often (11.1%). In comparison, practitioners of other arts therapies disciplines appeared to offer one-to-one therapy most often (85.5%), followed by group work (65.5%) and, the least common, work with families/couples (24%). Differences between the two groups of therapists were statistically significant in all types of therapy offered (see Table 2). Respondents from the DMP group worked significantly more often with groups and less often with individuals and families/couples than respondents from other arts therapies disciplines.

Client groups (age group and type of difficulty)

While the data suggest that dance movement psychotherapists worked with clients from all age groups (see Figure 2), practice with adults aged 16–65 was most common (reported by nearly 70% of therapists in the DMP group), followed by work with young adults aged 17–25 (just over 47%). One-third of respondents worked

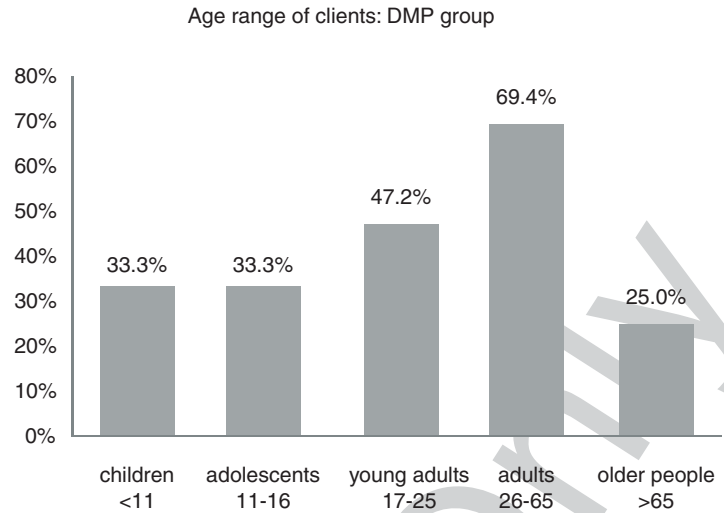

Figure 2. Age range of clients of therapists in the DMP group.

with children or adolescents, while practice with older people (aged over 65) was the least common (reported by 25% of respondents). These figures did not differ statistically for therapists of other arts therapies disciplines and practice with adult population seemed most common across the professions.

Asked to identify dominant difficulties within the main client group, 50% of dance movement therapists indicated mental health problems (see Figure 3). Learning difficulties were the next popular choice (22.5% of therapists), multiple problems were indicated by 8.3% of therapists and other difficulties received little response. Among other main client difficulties, suggested by respondents and not listed in the questionnaire, were dementia (5.6%) and difficulties on autistic spectrum disorder (2.8%). Similarly to the age of clients, their main difficulties appeared not to differentiate between the DMP and AT + MT + DT groups. For all

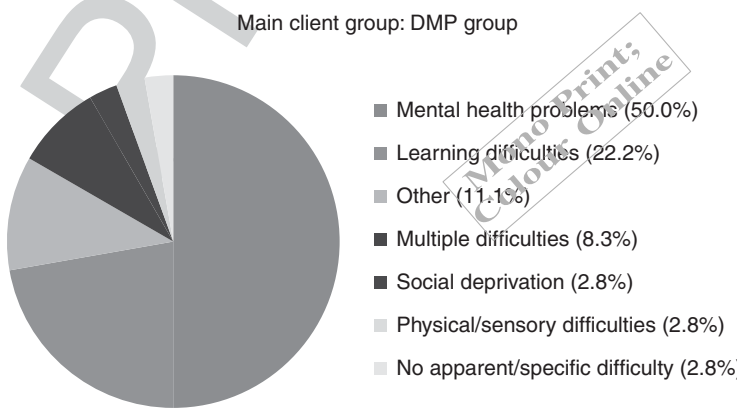

Figure 3. Main client groups, as reported by arts therapists in DMP group.

arts therapies professions, mental health problems remained the main client presentation and, with slight although not statistically significant differences, other predominant client conditions were equally common across the disciplines.

Theoretical influences

In one of the questionnaire items, therapists were asked to indicate their theoretical influences. Nearly 70% of respondents in the DMP group referred to psychodynamic theory (see Figure 4); developmental and attachment theories were also popular (indicated by just over 61%) and were followed by the work of Winnicott (50%), specific arts therapies traditions (44.4%) and integrative approaches (41.7%). Behavioural therapy and Kelly's personal construct theory were the least popular influences.

In order to examine whether the reported theoretical influences were common among arts therapies practitioners in general, of whether specific theories had an impact

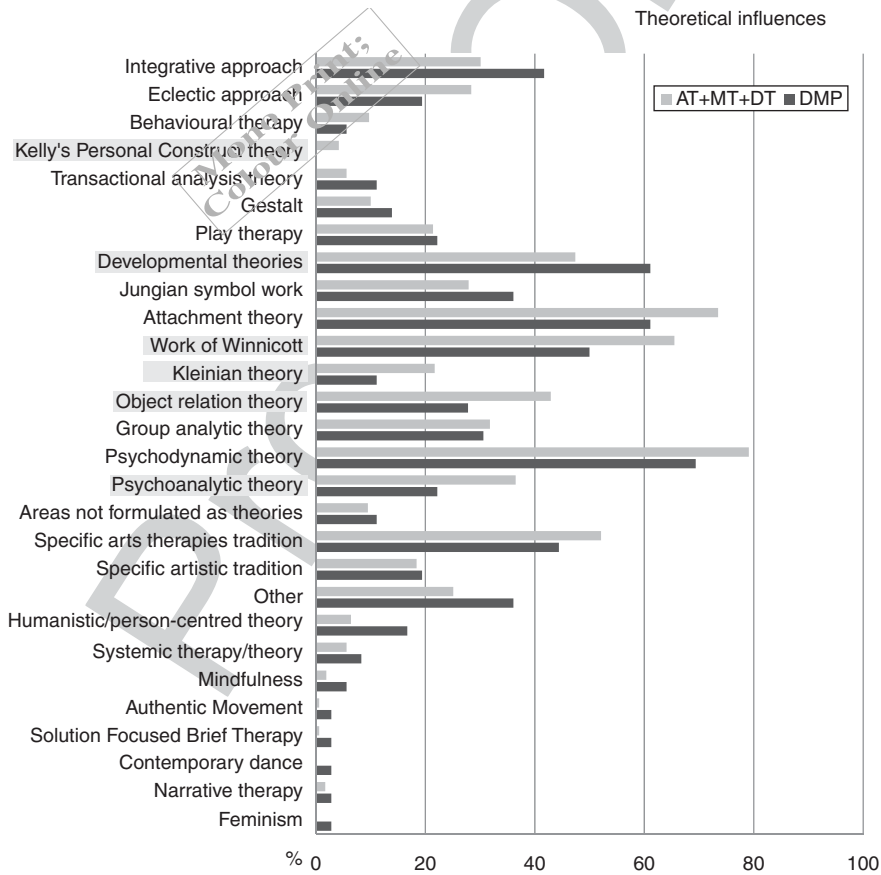

Figure 4. Theoretical influences in two groups of arts therapists. Note: Highlighted areas of statistically significant difference, last seven influences listed by therapists who chose option 'other'.

on DMP practice in particular, the DMP group was compared to the group consisting of other arts therapists (AT + MT + DT). While data appeared to indicate similarities in both groups, with the strongest influence reported in psychodynamic theory, statistical analysis was performed to determine any significant differences. Analysis of proportions revealed that dance movement therapists were significantly more often influenced by developmental theories than other arts therapists ($z = 2.2$ at 95% confidence interval). Conversely, group AT + MT + DT was more prone to be influenced by psychoanalytic, object relations and Kleinian theories as well as the work of Winnicott (z between 1.8 and 1.9 at 90% confidence interval) and Kelly's personal construct theory ($z = 4.0$ at 99% confidence interval).

In additional comments, dance movement therapists also shared other theories, not listed in the questionnaire, that they considered inspirational. Some of these additional influences were mentioned by more than one respondent and therefore it seemed important to include them in the analysis. Of these self-reported influences, humanistic/person-centred approaches were mentioned most often (16.7% of respondents). For comparison, occurrences of similar theories were sought in responses of therapists of other disciplines (AT + MT + DT) and were included in Figure 4.

Assessment and evaluation of practice

Certain items of the questionnaire addressed the areas of practice related to: (i) assessment of client suitability for therapy on offer and (ii) the determinants on which therapists evaluate their practice.

Figure 5 gathers dance movement therapists' responses to the listed criteria for assessing clients' suitability for treatment. The most popular methods of assessment, chosen by 75% of therapists, included: a feeling that 'we can work together', client's struggle to find words for his/her feelings and client's communication problems. A need for emotional outlet was also considered a popular criterion (nearly 70% respondents – see Figure 5). Some therapists chose to suggest other criteria and the ones mentioned by at least two respondents included: referral from the team/treatment plan and an inclusive belief that all clients are suitable: 'all clients are suitable in my fields of work as it is what we all do – move' (R24), 'anyone can benefit from art therapies, just in different ways' (R28).

Figure 6 gathers indicators that help practitioners evaluate their therapeutic work with clients. Some of the evaluation methods were particularly popular among dance movement therapists. Changes in behaviour were mentioned most often (nearly 89% of therapists in the DMP group), followed by verbal/non-verbal communication (86.1%), engagement with therapy process (83.3%) and emerged themes (80.6%). Among other indicators enabling evaluation, the respondents mentioned increased flexibility (both psychological and physical), reduction of distress and individual or group shifts/changes, including physical and cognitive aspects. One of the respondents highlighted that 'evaluation is collaborative and on-going' (R6) in her/his practice, possibly referring to work within multidisciplinary teams.

Therapeutic principles

Dance movement psychotherapists' preference for specific therapeutic approaches (six factors identified by Karkou in 1998) was measured and the results in the DMP

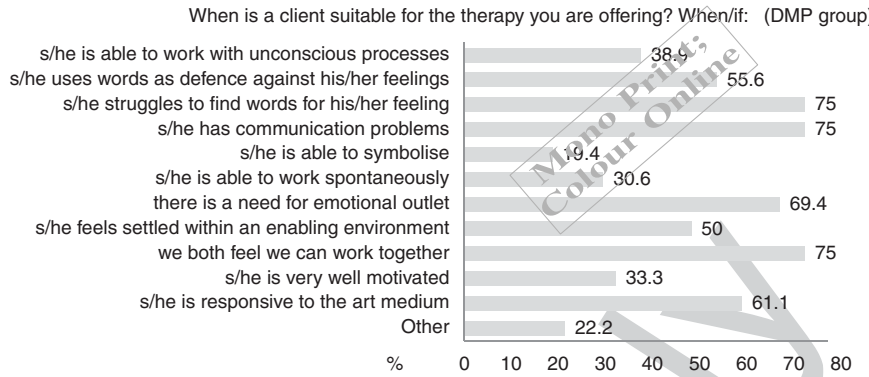

Figure 5. DMP therapists' responses indicating client suitability for the therapy they offer.

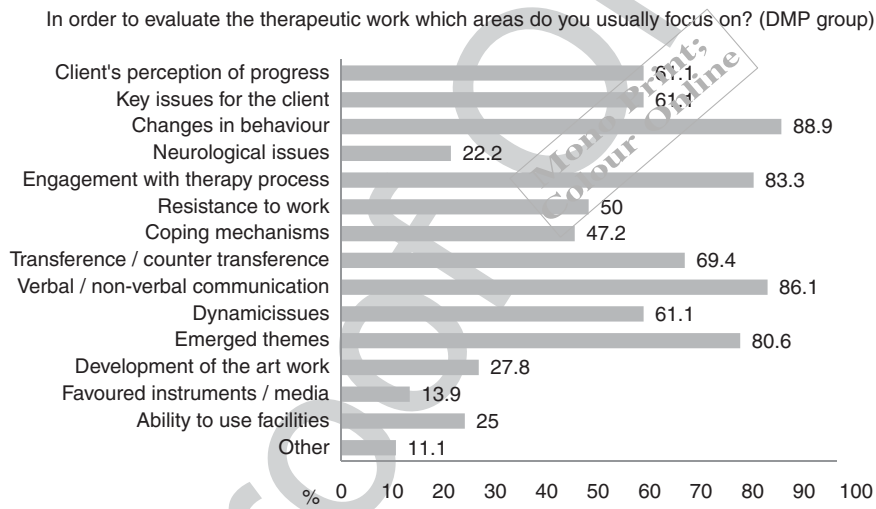

Figure 6. DMP therapists' responses indicating determinants for evaluation of the therapeutic work.

group were then compared to the AT + MT + DT group to determine whether arts therapists of different disciplines differ in their chosen approach. Table 3 lists therapeutic principles in order of preference for the DMP group; humanistic principles were the most popular, followed by integrative/eclectic approach. (Note that lower means indicate higher level of agreement, on a five-point scale, where 1 = strongly agree and 5 = strongly disagree.) Active/directive approach was the least common among dance movement therapists.

An independent samples *t*-test revealed statistically significant differences between the DMP and the AT + MT + DT groups in preferred therapeutic principles. Dance movement therapists agreed with humanistic principles more strongly than other arts therapists ($t = -3.8$, $df = 392$, $p < 0.05$). Moreover, although active/directive approach was the least preferred among dance movement

Table 3. Comparison of two groups of arts therapists (DMP and AT + MT + DT) in relation to the six factors – in order of preference for DMP group.

Therapeutic principles	Discipline	N	Mean	SD	Std. error mean
Humanistic	DMP	36	1.8254*	0.49500	0.08250
	AT + MT + DT	358	2.1899*	0.55391	0.02927
Eclectic/integrative	DMP	36	2.1083	0.71768	0.11961
	AT + MT + DT	356	2.1695	0.60049	0.03183
Psychoanalytic/	DMP	36	2.3778	0.68591	0.11432
psychodynamic	AT + MT + DT	356	2.2600	0.58503	0.03101
Artistic/creative	DMP	36	2.4583	0.55259	0.09210
	AT + MT + DT	358	2.5162	0.55491	0.02933
Developmental	DMP	36	2.5000	0.69857	0.11643
	AT + MT + DT	353	2.3763	0.66312	0.03529
Active/directive	DMP	36	2.5444*	0.73073	0.12179
	AT + MT + DT	353	2.7893*	0.55202	0.02938

*Significant difference indicated by t-test, $p < 0.05$.

therapists, it was still more popular among these practitioners than among arts therapists of other disciplines ($t = -2.45$, df = 387, $p < 0.05$).

Apart from quantifiable items, one of the open-ended questions asked therapists to comment freely on any aspect of their therapeutic practice. Some respondents used this opportunity to share what in their opinion constitutes the essence of the therapeutic process or how different theoretical approaches were used to best respond to clients' needs. In the comment below, possible benefits of DMP were highlighted and core areas for potential improvements through therapy were being revealed:

> I work a lot on encouraging integration, empowerment, communication, individuals making choices, developing social skills, being part of a process, exploring their own creativity. Working towards reaching ones full potential – drawing on individuals abilities. Exploring safe ways to express feelings and emotions. (R15)

It is apparent that the respondents expressed their willingness to adapt their approaches according to client population they work with. The flexibility in practice extends to theoretical backgrounds, with certain approaches more suitable to particular client groups. One respondent described how she/he worked with clients suffering from dementia and explained the core focus of this type of intervention:

> When I worked with adopted and fostered children, I referred a lot to attachment theory (. . .) With people affected by dementia I take a very different, more person-centred approach, and (. . .) the therapy work is much less about process and more about being in the moment and enabling expression and communication [and about] helping people to live as well and as fully as possible at whatever point they are. (R34)

Work with depression

In addition to the characteristics presented above, the survey collected data on arts therapists' practice with depression in particular. Specific items in the questionnaire allowed for identification of those therapists who worked primarily with depression, those who encountered depression among their clients and those who did not work with the condition at all.

Figure 7 illustrates the commonness of client depression among DMP practitioners. Over 80% of respondents encountered depression in their practice; among them there were therapists who specialised in working with the condition (8.3% of the DMP group). A relatively low percentage of therapists did not encounter depression in their practice (19.4%).

While the results appear to suggest that depression was a common condition among clients of DMP practitioners, it seems that working with the condition was even more frequently undertaken by other arts therapists (group AT + MT + DT). A total of 17.8% of the latter group specialised in working with depression and only 7.5% reported not to have depression among their clients. The differences in the frequency of working with depression between the DMP and the AT + MT + DT group are statistically significant (with $z = 1.9$ and 1.7, respectively, at 90% confidence interval).

Although a thorough qualitative analysis may not have been undertaken due to the small number of responses to open-ended questions, comments from DMP practitioners on their work with depression revealed the complexity of the condition and highlighted its co-morbidity with other mental health issues. Two of the respondents noticed the connection between depression and dementia: 'Dementia and depression often occur together, so many of my clients experience depression at some point in their illness' (R34). One therapist shared that 'in acute ward admissions many patients are depressed but it is unlikely that this is the reason for their admission' (R10) and commented on her/his practice with refugees among whom the condition is common. Another respondent noticed how depression among clients with learning disabilities might at times be attributed to purely behavioural presentation and further commented: 'I am ever mindful of the potential for this client group to become depressed or to be suffering from depression and I pay a lot of attention to my embodied somatic responses in relation to my clients' (R16). One dance movement therapist shared that 'the medium [dance/movement] can help to find antidote' for depression and that she/he approached the condition by allowing clients 'to express how they are, and be seen/heard' (R6).

Limitations

Although efforts were made to reach all therapists practising in the UK, the distribution of advertising through Arts Therapies Associations could only partially be controlled by the researcher and therefore it was not possible to assess the exact number of therapists,

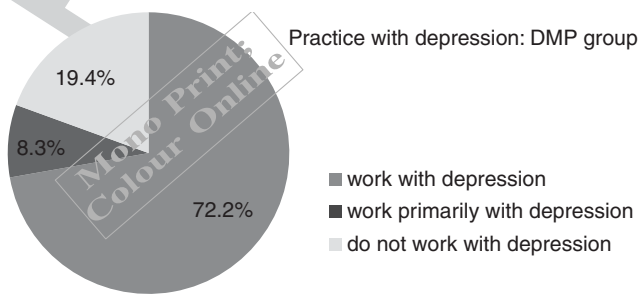

Figure 7. Practice with depression among therapists in the DMP group.

who received an invitation to take part in this study. This may possibly account for the relatively small number of respondents practising DMP. Should the survey be replicated, it would be valuable to receive more information from the Associations about the means they used to circulate relevant information and the total number of people their distribution lists consisted of. Additionally, adverts in relevant professional journals would potentially increase the number of respondents.

The current study described DMP practice in relation to other arts therapies disciplines. However, the professions of art, music and dramatherapists were considered one group for the purpose of this project and therefore the findings need to be interpreted as a comparison between the practice of dance movement psychotherapists and other arts therapists in general, rather than comparisons with separate professions.

While the current survey did not collect data on the cultural backgrounds of the therapists, such information would be especially valuable for any comparative international studies. Obtaining cultural data is thus recommended in any similar forthcoming surveys.

Discussion

Arts therapies are relatively new professions in the UK but the steadily growing number of therapists, an interest in training in the disciplines and progress in arts therapies research suggest that the field is rapidly developing. The findings of the current study, concerning dance movement psychotherapists, additionally seem to confirm that these practitioners represent a particularly young and fast growing discipline (Karkou & Sanderson, 2006) with a relatively young age of therapists and a fairly short average time in practice. While arts therapies are generally female-dominated disciplines, dance movement therapy seems to include an even larger proportion of female practitioners.

Further research may possibly explore what leads to relatively your age of DMP practitioners. It is possible that the reason lies in the actual young age of the discipline or, alternatively, dance movement practitioners might tend to leave the profession after a certain age, similarly to dance professionals.

The environments in which dance movement therapists work include a wide range of settings and working arrangements. Practice alone and within teams seems equally common. Interestingly, even though registration of dance movement psychotherapists with the HCPC is still pending, health settings are the most popular working environment for these practitioners. It is possible that the finding that the health setting is an even more common working environment for other arts therapists is a reflection of the 'anomaly' in the professional registration of arts therapists in the UK. Other usual work settings include private practice and educational institutions. It is worth noting that the survey undertaken by Karkou in 1996 clearly identified education as a main working environment for dance movement therapists, while for other arts therapists health setting was the primary place of practice (Karkou, 1998). The current study, therefore, suggests that over the last 15 years there have been significant changes to the work settings of dance movement therapists, whose most commonly offered practice has by now moved from educational to health settings to resemble a general tendency in the whole field

of arts therapies. Since health settings still remain significantly less common working environments for dance movement therapists than for respondents of other arts therapies disciplines, a trend for DMP to be practised more often in health settings in the future may be predicted. However, for a sustainable expansion of arts therapies, and dance movement psychotherapy in particular, in the health sector, a number of conditions would need to be met. These may include: (1) growth of high quality research evidence, (2) further development of links between the NHS and the universities and support for trainee placements and (3) registration of the DMP profession with HCPC or possibly UKCP. Time may seem right for dance movement practitioners to negotiate their presence in the National Health System, despite economic difficulties, while increasing attention to the body through mindfulness programmes is evident. In light of the current situation in the NHS, the above is certainly a particularly interesting finding that would need to be further clarified through future studies, which may, for example, explore attitudes of the NHS and other agencies to employing DMPs and their understanding of what arts therapies may offer.

Although dance movement therapists work in all therapeutic configurations, including group, one-to-one and family therapy, practice with groups is most common in comparison to other arts therapies disciplines, in which individual therapy is offered most often. Although the current study does not offer further clarification on this subject, it may be assumed that there is an existing tradition of dance movement therapy being facilitated in groups as a direct reference to how dance as a social and art form is commonly delivered, or that this is what is most often required in the settings where the therapists work. No other studies that could relate to this finding are known to authors and further research is recommended.

The fact that arts therapies in the UK are offered to diverse client populations has been explored by Karkou and Sanderson (2006) and is evident in the registers of practitioners from the different professional associations. Numerous informal accounts from the therapists and published literature confirm that the practice is relevant for people of different ages and experiencing a variety of difficulties. The current study identifies main client groups in DMP practice and suggests that certain client difficulties are equally common across arts therapies disciplines, with mental health problems being predominant.

Among the theories that influence DMP practice, humanistic, psychodynamic, developmental and attachment ideas seem the most popular. It is important to mention that the survey offered a direct opportunity to declare theoretical influences and additionally measured the actual behaviour through levels of agreement with the six therapeutic factors. The respondents were more likely to indicate psychodynamic principles when choosing from the ready-made list, but revealed stronger agreement with the humanistic principles measured through factors. It is possible that the training determines a more psychodynamic thinking among the therapists, but the actual practice follows more humanistic ethos. It might also be worth noting that humanistic theory was not directly mentioned in the given list and it may be assumed that, should they be listed, humanistic principles would have been chosen often and possibly more often that the currently leading psychodynamic theory.

Therefore, although all of the above mentioned approaches are influential in arts therapies in general, humanistic and developmental theories seem to have a particular impact on dance movement therapy practitioners. This finding is not different from findings from the survey of 1996 (Karkou, 1998; Karkou & Sanderson, 2006). Furthermore, when it came to overall therapeutic trends, the authors of the 1996 survey concluded that, in comparison to other arts therapists, DMP practitioners placed higher value in humanistic ideas, a feature of DMP practice that appears to remain the same 15 years later. Also, although an active/directive approach is not common among arts therapists in general, dance movement therapists are more likely to use active/directive interventions than other respondents. This, again, may reflect the nature of dance as a medium as well as existing training and practices. It is interesting that in the latest survey reported here, the active/directive nature of the work is statistically different from other arts therapies in the UK, in a way that was not apparent in the survey of 1996 (Karkou, 1998; Karkou & Sanderson, 2006). Finally, willingness to adapt own practice and to utilise various theoretical perspectives in order to best address client needs is apparent. A strong agreement among DMP practitioners with eclectic/integrative approaches has already been commented on by Karkou and Sanderson (2006) and appears to be suggested again in this more recent study.

The core criteria indicating client suitability for treatment offered by dance movement therapists included communication problems and difficulties with finding words for expressing feelings. The choice does not seem surprising given the nature of DMP practice, which offers clients an opportunity to communicate outwith verbal channels. This unique feature of arts therapies has been widely discussed against verbal psychotherapy approaches (Odell-Miller, Hughes, & Westacott, 2006; Thyme et al., 2007). Moreover, a mutual feeling that working together is possible seems a crucial criterion for client suitability for therapy, while spontaneity, motivation, ability to symbolise and work with unconscious processes seem less important. Similar findings were suggested by Karkou and Sanderson (2001) and the current survey confirmed the significance of certain suitability criteria in dance movement therapy.

Communication (both verbal and non-verbal) and behavioural changes were highlighted by dance movement therapists as the most popular means of therapy evaluation. Emergent themes often assist in assessment and engagement in therapy process has also been identified as crucial. Exactly the same areas of therapeutic work were considered most important in evaluation of practice in the previously undertaken survey (Karkou & Sanderson, 2001) and the current findings seem to confirm that evaluation routine is fairly established among dance movement therapists. It is important to note that the current findings do not mention of standardised outcome measures or systematic movement observation (e.g. Laban, 1975; Loman & Merman, 1996) in the evaluation of treatment. Since these may be expected in DMP practice, further research into evaluation of the therapeutic work, including more specific methods, is recommended.

Previous study has shown that work with depression was relatively most common among art therapy and dramatherapy practitioners, while dance movement therapists most often stated that they do not encounter depression in their clinical practice (Zubala et al., 2013). However, it needs to be highlighted that, although less

common than in other arts therapies, depression is a hugely popular condition among clients of dance movement therapists and attempts to evaluate DMP for the condition have been made (Meekums, Karkou, & Nelson, 2012). In addition, the current study offered high quality comments on therapists' practice with dementia suggesting that knowledge and expertise in the condition seems to be particularly strong among dance movement therapists. A more thorough description of DMP with dementia would add to relatively modest in scope literature currently available (e.g. Coaten, 2009; Hill, 2009; Kovarzik, 2006).

Conclusion

This study reveals the wide scope and flexibility of dance movement therapy practice, which is undertaken in a variety of settings and utilising a range of therapeutic principles in a creative way in order to best address complex difficulties of diverse client populations. In relation to the general population of arts therapists, dance movement practitioners tend to work more often with groups, with clients presenting other than mental health difficulties and adopting approaches stemming primarily from humanistic and psychoanalytic/psychodynamic traditions in eclectic/integrative way.

While the current work offers a degree of understanding of the principles and other aspects of therapeutic work of DMP practitioners in the UK, further research in the area would be advantageous. Since dance movement therapy is a young and fast growing profession, a repetition of the survey in the future could likely provide a larger number of responses and explore the directions in which the DMP practice in the UK develops. Additionally, further comparative studies in other parts of Europe currently underway (Karkou et al., 2011) would potentially allow for a more universal understanding of the field.

The presented findings refer to the general principles of the therapeutic practice and, since only the work with depression was more thoroughly explored, it certainly remains recommended that future studies focus on more in-depth explorations of practice with specific client populations or within specific settings. Since mental health problems were identified as a main client presentation, what conditions in particular are common in dance movement therapy practice and how they are approached in therapy would be worth exploring. More qualitative data, gathered possibly through interviews with therapists, would strengthen the understanding and may potentially offer meaningful clinical guidance to the interested practitioners. Further high quality research on DMP practice with depression is highly recommended to complete already initiated work (Meekums et al., 2012; Zubala et al., 2013). Moreover, while certain ways of working with dementia have been highlighted by participants in this study, further research on this subject seems especially relevant.

On a final note, it is worth mentioning that once the current DMP practice is thoroughly understood and described, its effectiveness may then be meaningfully explored in research utilising rigorous randomised controlled trial designs. The need for such studies has to be acknowledged for different reasons. For one, they can directly contribute towards professional recognition. At the same time, studies of effectiveness with rigorous designs can make a potential contribution towards

clinical practice that draws upon research evidence and upon a comprehensive understanding of what may be effective (Ritter & Low, 1996). Mapping the field appears to be a first step in this direction. Once we are clear about what we are doing, we can start finding out which elements of our work are indeed useful for our clients and what may be worth changing.

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