



PEER-REVIEWED ARTICLE

RE-IMAGINING 'HOW' COMMUNITY DANCE AFFECTS THE HEALTH AND WELLBEING OF OLDER ADULTS

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ABSTRACT

We are currently experiencing unprecedented population aging worldwide, with people over 65 projected to outnumber youth for the first time in human history. As such, the need to support this demographic's health and wellbeing has never been more acute. There is a growing recognition that engagement with dance and arts provides numerous benefits for the health of older people, with existing research existing primarily within a biomedical model of efficacy. Driven by the primary research question "*how does dance affect the health and wellbeing of older adults*", we reflect on the potential insights gained by returning to the root of research aims and methodologies. Sitting in conversation with dance and health scholarship and leaning into critical gerontology debate, this article broadens discourse to consider not only how evidence is articulated, but as importantly, how it is being asked. Through a series of exploratory "*how*" questions that critically engage with literature from practitioner, participant, and sector perspectives, we consider elucidating the origins of research enquiry as fundamental to broadening and deepening our understandings of the benefits of community dance for the health and wellbeing of older adults.

Keywords: *Dance, health, aging, qualitative, worldview.*

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Introduction

In recent years, there has been growing recognition that engagement with the arts carries with it a number of positive impacts (Gordon-Nesbitt, 2017). This is particularly true as we age, with arts engagement evidenced to support a range of health domains including social inclusion (Atkins et al., 2019; Cruwys et al., 2014; Lewis, 2016); quality of life (Heiberger et al., 2011); and balance, gait, strength and dynamic mobility - the key risk factors for falls (Fernández-Argüelles et al., 2015). We are currently experiencing unprecedented population aging worldwide, with people over 65 projected to outnumber youth for the first time in human history (World Health Organization, 2007). As such, the need to support this demographic's health and wellbeing has never been more acute.

The construction of aging as a period of life marked by “the bleakness of disability, dependency, decline and social disengagement” (Pack et al., 2019, p. 2086) is increasingly countered by theories, policy and media that encourage “successful ageing”. Through examining discourses attached to “successful ageing” (Rowe and Kahn, 1997) that emphasize activity, individualism, and productivity as ideals in old age (Katz & Marshall, 2018; Martinson & Halpern, 2011), activities such as dance can be conceived as a means to reach normative ideals of health rather than as an artistic activity with its own intrinsic benefits (Krekula et al., 2017). This is clearly illustrated in the increase in evidence based studies, systematic reviews, and frameworks employed to directly assess dance interventions in relation to health outcomes for older people (Fernández-Argüelles et al., 2015; Merom et al., 2016; Predovan et al., 2019).

Many dance-based studies involving the health and wellbeing of older adults focus on the functioning of the body. Examples include, but are by no means limited to: aerobic dance shown to improve physical function, quality of life, balance, and mobility (Shigematsu et al., 2002); contemporary dance showing increased functional performance and physical activity levels (Keogh et al., 2009); Argentine tango improvements in physical function and balance (McKinley et al., 2008) and traditional Greek dance for enhanced static and dynamic balance (Sofianidis et al., 2009). Compared to activities such as exercising, walking, or playing an instrument, dance has been cited as having an advantage as a result of its combining sensory, motor control, and musculoskeletal systems (Bennett & Hackney, 2018). These studies exemplify ways of knowing through epidemiology. That is to say, within these studies how dance affects health and wellbeing as a research focus concerns itself primarily with the biomedical model of health, which reifies Western rationality and assumptions of empirical observation, positivism, and a Cartesian epistemology (Powell & Owen, 2005).

Drawing on a range of literature from Finland, Lehtonen (2017), argues that “how” the role of the arts in elderly care is articulated “depends on the particular interpretative repertoires and discourses that provide justification statements for their argumentative leverage in the contexts where they are addressed” (p. 1). Following this observation, we take this article as an opportunity to broaden discourse to consider not only how evidence is articulated, but as importantly, how it is being asked. Driven by the primary research question “*how does dance affect the health and wellbeing of older adults*”, we reflect on

▶ the potential insights gained by returning to the root of research inquiry and examining how the benefit of health and wellbeing efficacy is researched.

This article is structured into three sections. In the first, we draw from the discipline of critical gerontology and in particular “healthism” (Crawford, 1980) discourse to draw attention to the framing and evaluating of dance and health for older adults. In the second, we turn to questions of epistemology, attending to existing research both within and beyond the biomedical frame, exploring assumptions and premises driving literature in this field. In the concluding discussion we consider the more general problem of assessing benefit from a community dance perspective.

Stemming from an Interpretive paradigm, we hold that “all knowledge is humanly situated” (Longino & Murphy, 1995, p. vi). The centrality of interpretation and qualitative evidence speaks to the authors experience within community dance that values participation and inclusion of all people within dance activities. Valuing diverse dancers’ lived experience as evidence for analysis and interpretation opens opportunities to examine meanings of wellness for elderly dancers. With regards to the research question posed by this paper, paying attention to the history of “*bow*” we ask questions, existing hierarchies of knowledge (Daykin et al., 2017), the models we subscribe to and whose perspectives are championed can be seen to illuminate a political issue surrounding the framing and interpretation of the benefit of dance to health for older adults.

As a spring board into this discussion, we shall first attend to three key definitions as employed by this article; these being *aging*, *community dance*, and *health* and *wellbeing*. In keeping with the questioning spirit of this paper, we draw attention to the historical, social and cultural roots of these constructs, so that we may walk backwards into the evolving future of dance for health research and practice (inspired by the Māori proverb “Ka mua, ka muri” - “walking backwards into the future”).

Definitions

Aging

In short, there is no complete or universally agreed upon age at which one becomes “old”. As New Zealand based researchers and dance practitioners, we draw from Statistics New Zealand who refer to older people as those “aged 65+”¹. There is no mandatory retirement age in New Zealand, though people can claim Superannuation (pension equivalent) from the age of 65². At the moment, the UN agreed cut off is 60+ years when referring to the older population. Brooke and Jackson (2020) point out that for some vulnerable populations, 50+ is more likely to be considered “old”. As is well established, poverty tends to have a “highly deleterious impact on aging” (Gordon-Nesbitt, 2017, p. 62), making ill health more likely at an earlier age. ▶

¹ www.stats.govt.nz

² www.govt.nz

- ▶ In line with both Age Concern New Zealand and People Dancing “the UK development organisation and membership body for community and participatory dance” (People Dancing, n.d.) when using the term “older adult” in this article, we are referring to individuals over the age of 65.

Community Dance

Dance and health takes place in hospitals (Amans, 2017), residential homes (Horne, 2016), at home (Brierley, 2014), and community centres (Cooper & Thomas, 2002). Noting the lack of exposure afforded the community-based field compared to the significant body of literature emerging from the medical and scientific community concerning the arts in health care (Putland, 2008), reference to dance interventions for community dwelling older adults are the focus of this paper.

Amongst the myriad of dance based studies, we make explicit that we speak from the “evolving” field of community dance (Butler et al., 2016). Rather than the teaching of a specific dance style, community dance champions diversity of dance forms as it seeks to engage with people from all walks of life and levels of ability and training. Within the context of this research, community dance is a process guided by a set of values and principles. Values such as inclusive practice, collaborative relationships, a focus on participants, positive participation and learning, and celebration of diversity are integrated into dance experiences (Amans, 2008). In this way, it can be understood that the nature and function of community dance, as representative of a particular ethos, is defined by its concern with an agenda that has at its heart “a belief in the potential of dance to effect personal growth and change” (Akroyd, 1996, p. 17).

Taking this as a central tenet, questions concerning “*how dance affects health and wellbeing for older adults*” broaden the focus from the isolation of the body (or indeed body parts), and into the domains of emotional, spiritual, cultural, and communal wellbeing. In linking back to this article’s primary focus in examining how the benefit of health/wellbeing efficacy is researched, we consider that embedded values of community dance as cited above, cannot but shape scholarship from this field. As Bresnahan (2019) iterates, different dance philosophers will choose a different research focus, ask different questions, employ varying methodologies and interpret what constitutes valuable data depending on their epistemological leanings.

Health and Wellbeing

How we understand health is central in “the philosophy of medicine and the sociology of health and illness” (Broderick, 2011, p. 97). However, in contemporary Westernized societies, there are many different understandings of what constitute health and wellbeing (Barbour et al., 2020). Amongst these understandings is recognition that health is a multi-dimensional concept including physical, emotional, psychological, spiritual, and social dimensions (Card, 2017; Durie, 2004; Engel, 1977). Whilst often attended to as separate concepts in the literature, we conceptualise health and wellbeing as “closely connected with a complex network of interrelated factors” (Harris & Hastings, 2006 in Karkou et al., 2017, p. 1). In line with the WHO definition, *wellbeing*

as used in this paper is not a separate concept but a crucial aspect of health (Sheppard & Broughton, 2020).

Health and wellbeing is “not fixed, measurable or contained” (Broderick, 2011, p. 106); rather, it is a vague, subjective term. Whilst writing this, we in New Zealand have suddenly returned into Covid-19 induced lockdown; leaving us with a void in our practice and space to consider how we search, and re-search what is considered important to staying well. Definitions of *health* may very well now be located in relation to not having the Corona virus (Covid-19), or having had the vaccine, or wellbeing located in the hug of loved ones or in staying two metres apart. As defined by Huber et al. (2011), health as “the ability to adapt and to self-manage” (p. 237) seems increasingly relevant as we navigate these unusual times.

Modern medical care and research remains largely based on a paradigm known as the biomedical model, which assumes health to be fully accounted for by measurable biological variables (Engel, 1977). In his seminal paper “*The need for a new medical model: A challenge for biomedicine*”, Engel traced the history of reductionist beliefs back to the Church. According to Engel’s teachings, over five centuries ago, Christian thinking reduced the body to a “weak and imperfect vessel for the transfer of the soul...” (p. 131). This separation, Engel maintains “may be considered largely responsible for the anatomical and structural base upon which scientific Western medicine eventually was to be built.” (p. 131).

Engel’s concern with the limitation of the biomedical model stemmed not only from the assumption of mind-body dualism, but as importantly from the notion that health could be reduced to an “objective physicality” (Buetow, 2020, p. 49). Speaking from a psychiatrist’s perspective, Engel proposed that any conceptualisations of health must necessarily consider the psychological and social elements, alongside the biological, in order to create a “whole” system of health (Gask, 2018, p. 548). It is now generally accepted that illness and health are the result of an interaction between biological, psychological, and social factors (Wade & Hallington, 2017, p. 995).

In as much as its broadening has paved the way for research into extended conceptualisations of health and what they might mean subjectively and socially, the limitations of framing arts interventions within Western oriented, pre-ordained categories is still apparent. The following examples highlight the experiential, intersubjective aspects of dance which have been voiced by dancers but find no defined health domain to “map” onto.

Lima and Vieira’s (2007) study of ballroom dancing and its benefits for sixty Brazilians aged over 60 reported varying subjective meanings of dancing as iterated by participants, including its connection to culture. Dunphy and Ware (2018) examined the relationship between dance and quality of life for Aboriginal and Torres Strait Islander Australians, highlighting the importance of concepts of health which allow for relationship to “culture, land and spirituality” (p. 11). Whilst Murcia et al. (2010) revealed the spiritual

benefits of dance for older adults, claiming “dancing makes one feel spiritual love” (p. 157). For Indigenous populations and those from non-Western cultures, the wider determinants of dance and health are unaccounted for through either the biomedical or biopsychosocial model.³

The National Arts and Health Framework, set up in 2014 and endorsed by Australia’s Health Ministers and Cultural Ministers (Davies et al., 2016) acknowledges that “arts initiatives have a place in our health system and a role in contributing to the health and wellbeing of all Australians” (p. 304). As guided by the biopsychosocial model of health, three “pathways” are identified in the framework—residing in the physical, mental, and social health domains. However, prior to this Gee et al. (2014) identified the domains of: connection to: body, mind and emotions, family and kinship, community, culture, country or land, and connection to spirit, spirituality and ancestors as being important for the wellness of the Indigenous people of Australia (p. 57). We thus raise consideration of the historical domination of the Western “epistemological landscape” (Borell et al., 2019, p. 198) and the way it has undoubtedly shaped the dance for health field to date. Indeed, Sheppard and Broughton’s (2020) systematic review revealed that “there were no studies that looked at the benefits of music and dance to Indigenous peoples or communities” (p. 15).

We regard that in order to open to the multiple worldviews that reflect the global aging population and to further prevent health domains that cannot be explained (and are therefore excluded) through existing models of health and wellbeing warrants methodological extension. Chappell et al. (2021) address this in their systematic review about the aesthetic, artistic and creative contributions that dance makes to health and wellbeing. They identified seven contributions beyond the biological – embodiment, identity, belonging, self-worth, aesthetics, affective responses and creativity. We maintain that we cannot fully articulate the benefits of dance to health and wellbeing for any population until we have expansive definitions of health which can account for them.

Sitting at the T-Junction of Gerontology, Dance and Health

The following section aims to develop a critical account of the rhetoric and positioning of older adults in society in order that we may consider the backdrop against which research on dance, aging bodies, and health is produced and circulated.

Healthism, as first described by political economist Robert Crawford (1980) “represents a particular way of viewing the health problem” (p. 365). He goes on to posit that within Western interpretations of health and illness, “healthism” positions the problem of health and disease at the level of the individual. Healthism discourse focuses on the merit of discipline and effort and is underpinned by the unspoken assumption that health can be “achieved” (Crawford, 2006, p. 402); referred to by Harrington and

³ Whilst a full account of Indigenous health models is beyond the remit of this article, we make reference to Sodi & Bojuwoye (2011) for an in-depth consideration of the ways in which health and illness are culturally embedded and epistemologically different.

- ▶ Fullagar (2013) as the “active living imperative” (p. 1). In considering the context of a society permeated by healthism discourses, we make theoretical links to the ways in which dance is framed as a solution to the “problem” of aging as exemplified by reviews which aim “to understand whether dance in older adults is an effective adjunctive treatment for the healthy aging” (Gronek et al., 2021, p. 903).

A question of epistemology

We consider it pertinent to return to “the meta-philosophical question” (Bresnahan, 2019, p. 3) of epistemology and ontology in guiding both the methodology and the focus of a dance and health inquiry. Epistemology is essentially concerned with the philosophy of knowledge, prompting us to question how we know what we know (Crotty, 1998). Brough (2013) argues that without an epistemological self-awareness, the act of investigating the health of others may not only be culturally invalid but also illustrates “only one way to imagine or respond to health” (p. 36). Ontology is a means of understanding how we come to be (Koch, 1999). We refer to the two main ontological positions--relativists who believe that multiple realities exist (Guba & Lincoln, 1994) and realists for whom the world exists independently from human action and observation (Blaikie, 2007).

As Houston (2011) puts it “a methodology that works on the belief that things are knowable through a system of empirical testing of cause and effect is likely to think of dance as a thing that is knowable through the same system” (p. 331). In her paper “The Methodological Challenges of Research into Dance and Parkinson’s”, Houston questions whether by fitting dance into standardised measures we are in fact removing it from its ontological roots as an artistic practice and giving it a new ontology in the process--an ontology spoken through the language of science. From this ontological root, dance as phenomena is external and separate from the dancing body. We consider that by ascribing the belief system of realists onto the belief system of relativists, we may be denying that the lived body as subjectively felt may differ from the living body as objectively defined.

Fernandez (2020) draws on the philosophy of phenomenology, particularly the concept of Leib and Körper - the “lived body” and the “corporeal body” - to reflect on embodiment and objectification within a healthcare context. In acknowledging these two perspectives on the same body, Fernandez (2020) reminds us that whilst our body is perceiving and engaging with its environment (the lived body) it is, at the same time, a physical object within this environment (the living body). In coming from an understanding that “we do not have our bodies, but we are our bodies” (Fernandez, 2020, p. 4405), it is accepted that questions, observations, and reflections stemming from the living body link to the “constructed and contextual nature of human experience” (Thorne, 2004, p. 3). This approach’s ontology stems a relativist stance.

Originating from the realist perspective, we cite an investigation by Keogh et al. (2009) on the physical benefits of dance for older adults which reviewed 18 studies using systematic review. In order to be included, studies had to have been published in peer-

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reviewed journals and involved healthy older adults (no prior diagnosis of medical conditions) aged over 60 years old. Aerobic power, muscle endurance and strength, and static and dynamic balance were the most commonly assessed outcome measures. Their results indicated that dancing can improve aerobic power, lower-body muscular endurance, strength, flexibility, balance, agility, and gait speed. We can ascertain from the research question inclusion criteria and stated outcomes that Keogh et al. (2009) are employing the biomedical model to validate the benefit derived from dance. In framing research findings in this way, we understand the epistemology of this study to be grounded in the belief that “phenomena can be reduced to their constituent parts, measured and then causal relationships deduced” (Baum, 1995, p. 461). As a systematic review Keogh et al.’s study (2009) illustrates that much research on dance and health for older adults espouses an objectivist approach.

The issue of evaluation

“The value of community dance is revealed when the participants pay attention to the qualities present and desired, and engage in the moment in the processes of working with others” (Buck & Barbour, 2007, p. 157). Turner’s (1969) concept of *communitas* expresses that it is the processes of community, indeed the processes of forming relationships, that encourage personal growth. Such process based articulations highlight one of the founding values of community dance—that is a celebration of the process of participation (Kuppers & Robertson, 2007).

Such experiential, intersubjective experiences are not easily explained using a biomedical discourse. Extending into the biopsychosocial we could conceivably map onto the social domain of the model. However, in doing so we fundamentally miss crucial acknowledgement of the process driven, relational aspects of dancing together into health. Chappell et al. (2021) consider that “notions of capturing complexity, reflecting dance’s embodied qualities and emphasizing process over outcome are at the heart of necessary future methodological developments in this area” (p. 12).

Exploring suitable methodologies and frameworks that can accommodate the more processual aspects of dancing alongside meeting the requirements of “demonstratable rigor” (Daykin et al., 2017, p135) from health funders sits beyond the remit of this article. Our research aim is to elucidate the foundational assumption that the viewing of participants as older bodies in ill-health requiring intervention is a worldview away from facilitating older dancers in motion. Daykin et al.’s (2017) year long study into the challenges of evaluation with a wide range of UK based arts and health stakeholders attends to this in further detail.

As we are noting, attempts to know dance as phenomena, verified through direct observations or measurements can prove to be problematic when considering dance’s ephemeral nature (Bresnahan, 2019). Problematic, as used in this article means that for us as practitioners it spurs a host of other connected considerations, including issues around what constitutes benefit and who that benefit is for. Any ethics procedure

- ▶ rightly questions whether an intervention may have negative impact on participants, a consideration all the more pertinent in the face of progressive conditions such as Parkinson's. How do we ethically consider the impact of measurement? What are the implications for participants' health and wellbeing if the numbers represent decline in functional outcome?

In returning to the lived and living body (Fernandez, 2020), we relay a personal experience of evaluation. As part of data collection for a research project on dance for people living with Parkinson's (Hills, 2019), video observation as research method was employed. Upon witnessing the video footage at a later date, one participant became visibly upset, commenting "I didn't realise I looked like that". In talking further, she relayed that she had felt her posture was better, that she felt stronger and more confident. The video footage in her eyes showed otherwise. The subjective dancing body as "felt" was juxtaposed by the dancing body as objectively witnessed--a poignant moment for researchers and practitioners to fully appreciate the impact of objectification of the body with its implied connotations of improvement or lack thereof; the antithesis of the "emotionally safe and positive experience" (Butler et al., 2016, p. 1936) that we strive to foster through our community dance practice.

"I guess what happens is that for a moment, the social ... what has been given us from society disappears and what is saved is the reality of ourselves together" (Pethybridge, 2014, p. 184). These are the words of dancer and choreographer Giulio D'Anna, who through personal contact with Pethybridge (2014) articulates that contact improvisation with his Parkinsonian father, whilst entirely embedded in the physical, also refers to a mode of communication that goes beyond reductive definitions of either dance or health. In speaking of "selves together", D'Anna's words speak to considerations of how dance, as a corporeal experience has facilitated a transcendence for him, serving to illuminate other aspects that biomedical explanations may be leaving behind.

Houston (2015) addresses this very issue in her paper, "Feeling Lovely: An Examination of the Value of Beauty for People Dancing with Parkinson's." Houston's interviewee, Carol, insists that "the feeling of being beautiful" (p. 30) during the session holds unequivocal value for her. From the perspective of this paper, the answer to the question "*how does dance benefit your health and wellbeing*", would be answered by reference to Carol's articulation that it "makes you feel lovely" (p. 27). However, as attended to through the "the idea of feeling lovely does not figure in any assessment; even the well-used Parkinson's disease quality of life questionnaire, PDQ-39" (p. 30), leaving us to question whether "feeling lovely" should be considered irrelevant because it does not fit into externally imposed outcomes?

We are therefore left with questions pertaining to "*how*" we evaluate our community dance practice? What, if any, are the intrinsic mechanisms of our practice that cause an effect on particular health outcomes? How do they shape session content and influence practice principles? Should we position, advertise and talk about our dance practice as a means to "achieve" a healthier self? For we are dancers, not healthcare practitioners. ▶

- ▶ And, in line with the International Association for Dance Medicine & Science definition of Dance for Health “...we engage people as dancers, rather than patients...” (Chappell et al., 2020, p. 3) The “*how*” as asked from a practitioner perspective highlights pragmatic concerns surrounding how these multiple, varied perspectives shape not only practice but our research inquiries.

In reviewing the literature on dance and older adults for this article, only a handful of studies addressed the issues of facilitation. Amans’ tome, *Age and Dancing* (2012) is an oracle of practical information and insights from experienced practitioners for anyone thinking about or already working in community dance practice with older adults. There are various training and professional development programmes available to artists internationally, and a Google search will bring up numerous activities and ideas for ways to engage with older adults. However, what is missing in the literature is attendance to *how* the “proposed mechanisms of the various components of an artistic activity” (Fraser et al. 2015, p. 725) are understood, interpreted, and incorporated into session structures.

In a chapter titled “Moved to Dance: Socially Engaged Dance Facilitation”, Houston (2014) examines how teaching artists engage participants living with Parkinson’s. Delving deep into the values driving this work, specifically the meaning and application of person-centred practice and the issues and challenges faced by facilitators, Houston (2014) postulates that working with a Parkinson’s population cultivates specific attitudes and values of community dance artists. She states, “Dance that is socially engaged brings a particular outlook to dance teaching that takes the work beyond the dance studio and beyond the work itself” (p. 150). We employ “outlook” as referenced by Houston to suggest a return to questions of an epistemological nature. What do we, as practitioners and researchers consider to be measureable? How do we evidence benefit that reflects our worldview? And furthermore, how we apply these learnings in our community dance practice? The answers to these questions lie beyond the remit of this article but are raised here to highlight the importance of bringing to the foreground the “*how*” of practice mechanisms.

Conclusion

The intention for this paper has been to tease out and question some of the larger contextual questions surrounding dance and health, aging and health and wellbeing. As “a process of creative questioning” (Durocher et al., 2020, p. 38) this article has discussed existing literature surrounding the role of dance in facilitating health and wellbeing in older adults. The need to understand the mechanisms of health and wellbeing that underpin the physical aspects of dance have to date constructed a solid foundation on which other constructions of dance and health can be built (Jola & Calmeiro, 2017). However, the very physicality of dance means it has a hard time navigating a world that primarily functions around the fact that, “things are knowable through empirical testing of cause and effect” (Houston, 2019, p. 87). In trying to evaluate our older adults’ dance practice in the language of the bio-medical, we consider that there will be aspects of the relationship between dance and health which risk being lost in translation. This ▶

article can therefore be understood as being driven by a belief that qualitative ways of knowing are integral to offering different perspectives essential for the development of evidenced based practice and research pertaining to “how” dance can benefit the health and wellbeing of older adults.

This article is one of many (e.g. Braun & Kotera, 2021; Broderick, 2011; Houston, 2011; Wakeling; 2015, Raw et al., 2012; White, 2004) that questions whether dance and health can successfully be conveyed through the same language. We have illustrated how different constructions of health problems, interventions, and funded solutions result from differing worldviews, shaping the research questions asked, methods used, data collected, and the conclusions drawn.

Dance as art, as social activity, as creative expression, or as a way to keep fit necessarily requires pluralistic perspectives in order to offer a well-rounded, evidenced answer to the question most often posed by policy makers, governments, and funders concerning *how dance can benefit the health and wellbeing of older adults*. In questioning who the research is for and how we ask the research question, we have explored some of the theoretical landscape from which dance and health scholarship has emerged. We hope that in unpacking the discourse surrounding *how* we successfully convey benefit, we have stimulated a critical questioning of why we are employing certain models, whose interests are being served and what knowledge may be gleaned from considering the imperative of *how* dance and health for older adults is accounted for.

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