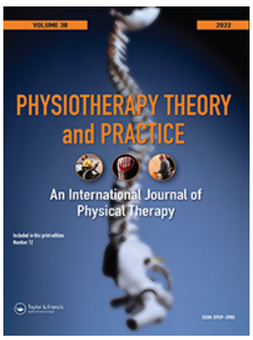

Taylor & Francis
Taylor & Francis Group

Physiotherapy Theory and Practice
An International Journal of Physical Therapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/iptp20

Identifying contrasting embodied voices of identity: a qualitative meta-synthesis of experiences of change among patients with chronic musculoskeletal pain in long-term physiotherapy

Aud Marie Øien & Tove Dragesund

To cite this article: Aud Marie Øien & Tove Dragesund (2022): Identifying contrasting embodied voices of identity: a qualitative meta-synthesis of experiences of change among patients with chronic musculoskeletal pain in long-term physiotherapy, Physiotherapy Theory and Practice, DOI: 10.1080/09593985.2022.2100298

To link to this article: https://doi.org/10.1080/09593985.2022.2100298

Published online: 14 Jul 2022.

PHYSIOTHERAPY THEORY AND PRACTICE
https://doi.org/10.1080/09593985.2022.2100298

Taylor & Francis
Taylor & Francis Group

Identifying contrasting embodied voices of identity: a qualitative meta-synthesis of experiences of change among patients with chronic musculoskeletal pain in long-term physiotherapy

Aud Marie Øien PhD, PT[a] and Tove Dragesund PhD, PT[b]

[a]Department of Welfare and Participation, Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, Sogndal, Norway; [b]Department of Health and Function, Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, Bergen, Norway

ABSTRACT

Background: The aim is to identify and synthesize qualitative research findings about patients with chronic musculoskeletal pain in long-term Norwegian psychomotor physiotherapy, in connection to their voices of meaning of embodied experiences of change and the possible influence on their identities.

Methodology: We systematically searched for qualitative studies in English in ten databases: AMED, Cinahl, Cochrane, Embase, Medline, PsychInfo, Scopus, SportDiscus, Svemed, and Web of Science. We included and analyzed nine publications using meta-ethnography. Bachtin's polyphonic voice perspective influenced the analysis.

Results: Three overarching themes emerged: 1) voices of body and mind as disconnected and connected; 2) ambiguous voices in the therapeutic relationship; and 3) identification of embodied voices of constraint and freedom influence identity.

Conclusions: The patients' polyphonic voices of ambiguous and contrasting expressions of embodied sensations and the therapeutic relationship in inner and external dialog seemed to facilitate the choices of change and the creation of new identities. In practice, the physiotherapists' consciousness of the patients' concurrent polyphonic voices may improve change in treatment.

ARTICLE HISTORY
Received 25 June 2021
Revised 13 7 2022
Accepted 5 July 2022

KEYWORDS
Qualitative meta-synthesis; Norwegian psychomotor physiotherapy; patient perspective; chronic musculoskeletal pain; new identities; Bachtin's polyphonic voices

Introduction

Targeted treatment to patients suffering from chronic musculoskeletal pain is both challenging and time-consuming. Patients describe that living with chronic musculoskeletal pain is a long and lonely struggle for examination, diagnosis, care, and treatment (Gjengedal et al., 2019). A new classification system is suggested, where chronic pain, such as nonspecific low back pain, may be conceived as "chronic primary pain" that requires special treatment (Treede et al., 2019). Chronic pain is defined to persist more than three months (Treede et al., 2019). A need of adapted and rewarded approaches of treatment appears related to the increasing knowledge of the reasons of chronic musculoskeletal pain. Identified predictors of poor prognosis of chronic musculoskeletal pain comprise female gender, severe burden of symptoms, lack of social support, poor physical function, vitality, mental health, insomnia, experiences of physical abuse during childhood, and current stressful life circumstances (Aili et al., 2021; Lamahewa et al., 2019; Sørensen, Jensen, Rathleff, and Holden, 2019).

In general practice of medicine and in physiotherapy, a large group of patients seeks help for chronic musculoskeletal pain with no objective findings, so-called medically unexplained symptoms (Malterud and Aamland, 2019) or subjective health complaints (Ekerholt and Bergland, 2021). General practitioners in medicine diagnosed patients with severe subjective health complaints, as having multimorbid problems, and most frequently they referred them to psychotherapy or a combined psychological and physical approach (Maeland et al., 2012). The involved professionals seemed to exceed the discrepancy between the variety of reasons to chronic musculoskeletal pain and the lack of objective findings.

In contrast to the biomedical perspective, the phenomenological perspective of perception emphasizes no separation between objective findings and subjective embodied experiences, but that of simultaneously being and having a body (Merleau-Ponty, 1945/2012; Wifstad, 2018). Basically, our body by being present toward the world is defined as a body subject, a lived body, in contrast to an object among other objects (Merleau-Ponty, 1945/2012; Wifstad, 2018).

CONTACT Aud Marie Øien Aud.Marie.Oien@hvl.no Department of Welfare and Participation, Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, , Bergen 7030 N-5020, Norway

The treatment, Norwegian psychomotor physiotherapy (NPMP), that bridges the gap between symptoms of psychologic, social, and somatic distress (Braatøy, 1947, 1952; Thornquist and Bunkan, 1991) is the context of our current article of qualitative meta-synthesis of published primary studies of patients with chronic musculoskeletal pain. The treatment originated from the collaboration between the physiotherapist Bulow-Hanssen, and the psychiatrist Braatøy in the middle of the twentieth century. Their knowledge of orthopedics, neurobiology and psychoanalysis influenced the development of the approach. The last decades, also knowledge of the phenomenological perspective of perception contributed to the field (Øien, 2010). The NPMP perspective emphasizes how physical, psychological, and social burdens over time disturb the dynamic flow of the reciprocal influence between movement, balance, rhythm of breathing, and expression of feelings and words (Braatøy, 1947, 1952; Thornquist and Bunkan, 1991). The NPMP examination emphasizes the patient's illness narrative, and the ability to sense and vary functions of moving and breathing. The individual patient's social and historical contexts serve as an interpretation frame of health complaints and constrained functions (Thornquist and Bunkan, 1991). The NPMP approach aims to reduce chronic musculoskeletal pain by enhancing awareness and change in the affected functions by way of individually adapted movements for relaxation and balance, tailored massage to improve embodied sensation, and reflection to build connections between pain and past and present lived experiences of burden (Thornquist and Bunkan, 1991). Patients seeking NPMP, who are mostly women (82%), suffer predominantly from chronic musculoskeletal pain, emotional symptoms of depression and anxiety, fatigue, insomnia, and reduced quality of life (Breitve, Hynninen, and Kvåle, 2008). Studies of treatment processes and outcomes within the NPMP context comprise themes of therapeutic relationships and changes. From the perspective of physiotherapists specialized in NPMP, change in treatment is seen as reciprocally dependent on the use of tools of movement, massage, and reflection, and on the quality of the dialog and/or interaction between the physiotherapist and the patient (Dragesund and Øien, 2019; Ekerholt and Bergland, 2021). From the perspective of patients, development of self-care depends on the quality of the therapeutic relationship (Dragesund and Øien, 2021).

When scrutinizing treatment outcomes of studies of quantitative methods, findings indicate that NPMP has the potential to reduce the symptoms of subjective health complaints, depression, anxiety, insomnia, and fatigue, and to improve health-related quality of life and self-esteem (Bergland, Olsen, and Ekerholt, 2018; Breitve, Hynninen, and Kvåle, 2010).

In sum, outcomes of improved embodied functions and self-care take place in the juxtaposition between the use of tools of movement, massage, and reflection, and the therapeutic relationship. Further, outcomes of studies using quantitative methods included reduced symptoms of subjective health complaints, and improved quality of life, and self-esteem. These findings, implicitly, point to a transformation of self-perception that seem to influence the patient's identity. Personal identity is defined as a sense of oneself (Keesing, 1985) and builds on our self-experience or self-perception (Binder, 2018).

Within the context of NPMP, in contrast to studies of quantitative methods, studies of qualitative methods of observation and interview of change during and after treatment explore in details patients' own experiences. In line with Malterud (2019) we anticipate that analyzing the meaning of findings across previously published primary studies may expand knowledge developed from each study. In general, our intention is to explore change of embodied complaints from the perspective of the patients during and after treatment. Specifically, our aim is to identify and synthesize qualitative research findings of patients' voices of meaning of embodied experiences connected to change in treatment, and the possible influence on their identities.

Theoretical perspective – building a polyphonic world of polyphonic voices

As physiotherapists with extensive experience of Norwegian psychomotor physiotherapy practice, education, and research, we share an interest in improving our understanding of the voices of patients suffering from chronic musculoskeletal pain. Seeking to explore knowledge from patients' own voices in a meta-synthesis across primary studies, we decided to use Bachtin's perspective to support our inductive interpretative analysis. This perspective originated in the dialogical perspective of Dostoyevsky's poetics and builds a polyphonic world through polyphonic voices (Bachtin, 1972/1991). The polyphony of voices consists of a multiplicity of independent and separated voices of equal consciousnesses. The voices are embodied in the entirety of the human being's lived voice. Further, each consciousness is connected to its own world and incorporated in the performance of a unity of a certain action (Bachtin, 1972/1991). The dialog of open expressed voices between subjects is connected to internal dialogs within subjects (Bachtin, 1972/1991, 2003). The construction of self takes place in relationship to some other, *"whether that other be another person, or parts of the self, or the individual's society or culture"* (Bachtin, 1986).

From the practice of physiotherapy, we found ourselves familiar with how different voices of embodied experiences, such as not sensing and sensing muscle tension, take place in the dialog between and within the patient and the physiotherapist. Bachtin (1972/1991) emphasized that the dialogic structure encompasses an entirety of co-existence of the internal interactions of many separated consciousnesses. Every thought is a person's point of view (Bachtin, 1972/1991). Grasping the world includes thinking about all content as concurrent and guessing its internal relationships within the same moment (Bachtin, 1972/1991). Sensing the ambiguity in every phenomenon includes looking for the moment of ambivalence in every voice, expression, and gesture. In this perspective, the person's position of interpreting and reflecting upon themselves and their world is important (Bachtin, 1972/1991). We emphasize that what the world is for the patient, and what the patient is for themselves, includes the significance that these phenomena have for the patient, or the function of their self-consciousness (Bachtin, 1972/1991). In the discussion, we apply concepts of polyphonic voices to elaborate the results of our meta-analysis.

Methodology

Our selected qualitative meta-synthesis, which is based on meta-ethnography, an inductive method of analysis, belongs to the interpretative paradigm and entails reciprocal translation relating the studies to each other (Malterud, 2019; Noblit and Hare, 1988). We analyzed and synthesized qualitative studies from the context of Norwegian psychomotor physiotherapy in the effort to develop new knowledge by systematically interpreting previous research. Synthesis implies the transformation of second-order concepts dealing with related issues into an overarching third-order concept (Malterud, 2019). We applied the seven-phase model developed by Noblit and Hare (1988) to systematically analyze the second-order concepts across the findings of our nine primary studies.

Search strategy

First, we defined the aim of the study (step 1) and included criteria for the inclusion and exclusion of primary studies for re-analysis (step 2). Second, the first author and one research librarian, systematically searched the databases between 25 October and March 17, 2020. We used the search phrases "psychomotor physiotherapy" and "Norwegian psychomotor physiotherapy" in peer-reviewed journals within the following ten databases: AMED, Cinahl, Cochrane, Embase (Ovid), Medline, PsychInfo (Ovid), Scopus, SportDiscus(Ebsco), Svemed, and Web of Science. We used the selected phrases as a strategy to focus on the most relevant issues and avoid searching too widely. Following example illustrates our search strategy: We identified, March 3, 2013 records in Medline database by using the search phrase "Norwegian psychomotor physiotherapy," and March 16, 2021 records by using the search phrase "Psychomotor physiotherapy." See Table 1 for search strategy across databases.

Table 1. Search strategy across databases.

	Results	Search strategy, 3-March 16, 2020
AMED (Ovid)	9	
Cinahl (Ebsco)	20	TI psychomotor physiotherapy OR AB psychomotor physiotherapy OR MW psychomotor physiotherapy
Cochrane	7	
Embase (Ovid)	29	Database: Embase <1980 to 2020 Week 11>Search Strategy: --- 1 psychomotor physiotherapy.mp. (29) 2 "psychomotor physiotherapy".ab,ti. (27) 3 psychomotor physiotherap*.ab,ti. (27) 4 "norwegian psychomotor physiotherapy".mp. (19) 5 "norwegian psychomotor physiotherapy".ab,ti. (19) 6 1 or 2 or 3 or 4 or 5 (29)
Medline (Ovid)	21	
Oria (Norwegian academic libraries)	106	
PsycINFO (Ovid)	9	
Scopus (Elsevier)	29	(TITLE-ABS-KEY("psychomotor physiotherapy") OR TITLE-ABS-KEY ("norwegian psychomotor physiotherapy"))
SportDiscus (Ebsco)	15	
SveMed+	17	
Web of Science	14	
Total	276	

Process of reviewing and selecting potential primary studies

Initially, we, the first author and the librarian, identified 106 publications by applying the search phrase "Norwegian psychomotor physiotherapy," and 170 publications by applying the phrase "psychomotor physiotherapy" for 276 publications in total. We deleted 212 duplicates both electronically through End Note, and manually. We ended up with 64 publications in a combined file for a further review of relevance. Independently the two authors screened the relevance of these hits (i.e. title and the abstract) within the framework of our inclusion criteria of primary studies of qualitative methods written in the language of English. We then independently assessed the full text of the publications in the light of our research question, which included experiences of change within treatment

in the context of Norwegian psychomotor physiotherapy in outpatient clinics from the perspective of patients with chronic musculoskeletal pain and with or without psychosomatic disorders. Hence, we emphasized publications that presented experiences of change through NPMP treatment as explored through individual interviews, focus group interviews, self-reflection notes, video recordings, and observations. We included publications on the therapeutic relationship and/or communication with descriptions from the perspective of the patient. Furthermore, we included publications presenting findings from NPMP examinations in following treatment sessions.

In contrast, we excluded editorials, congress papers, theoretical papers, and book chapters. By emphasizing subjective phenomena of the meaning of experiences of change, we excluded primary studies and systematic reviews of quantitative methods. In highlighting the perspective of patients, we excluded publications on findings of experiences of change from the perspective of physiotherapists. We excluded publications presenting findings solely from Norwegian psychomotor physiotherapy examination. In the light of the inclusion and exclusion criteria, our assessment of the relevance of publications scrutinized in full text resulted in ten potential publications for systematic review. See Figure 1 for assessment flowchart.

Systematic critical assessment

In the last step of the selection process, the authors, independently, read the ten potential publications in depth and assessed their quality in line with a checklist of guidelines for qualitative studies developed by Malterud (2001). The chosen guidelines encompassed evaluation of aim, reflexivity, method and design, data collection and sampling, theoretical framework, analysis, presentation of findings and discussions.

We appraised and excluded one publication due to the absence of any methodological discussion of the strengths and weaknesses of the study. Accordingly, we included nine publications in the development of our meta-synthesis. See Table 2 for features of the nine studies included in the analysis.

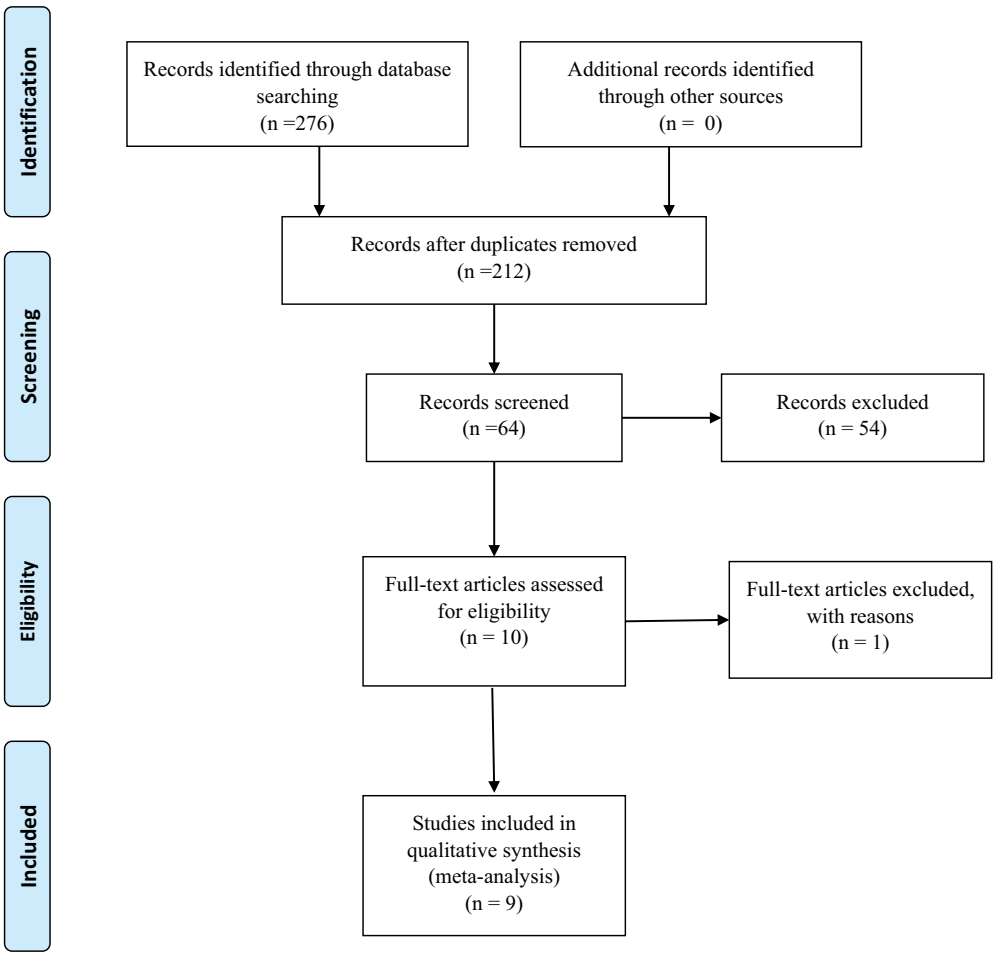

Figure 1. Flow diagram.

Characteristics of the selected primary studies

We conducted a reanalysis of the findings of the nine empirical primary studies in the context of Norwegian psychomotor physiotherapy, carried out in outpatient clinics in Norway, and published in international journals between 2006 and 2020. In the studies, the authors recruited patients through physiotherapists specialized in NPMP and working within the Norwegian public health system. Altogether 84 patients participated, including 71 females and 13 males. The samples ranged in size from one to seventeen. Participant ages ranged from 22 to 69.

The participating patients were the same in the two studies by Ekerholt and Bergland (2006, 2008), but aims and research questions varied. The two patients participating in the study by Øien, Iversen, and Stensland (2007) and the nine participants in the study by Øien, Råheim, Iversen, and Steihaug (2009) also participated in the study by Øien, Steihaug, Iversen, and Råheim (2011). The single patient in the study by Sviland, Martinsen, and Råheim (2018) was one of the 17 participants in the study by Sviland, Martinsen, and Råheim (2014). In addition to the diagnoses of chronic musculoskeletal pain and/or psychosomatic disorders, some of the patients suffered from symptoms of anxiety, depression, dizziness, numbness, sleeping disorders, cardiac insufficiency, stroke sequelae, and post-traumatic stress.

The findings in the nine studies were generated from different data sources and perspectives in time. Two studies used open in-depth individual interviews (Ekerholt and Bergland, 2006, 2008); three used focus group interviews (Dragesund and Øien, 2020; Dragesund and Råheim, 2008; Sviland, Martinsen, and Råheim, 2014); and one used a focus group interview, in-depth individual interview, and autobiographic text (Sviland, Martinsen, and Råheim, 2018). In these studies, the participants described their experiences retrospectively. The three studies using multiple data sources consisting of video-recorded and observed treatments, individual interviews, and personal notes over time (Øien, Iversen, and Stensland, 2007; Øien, Råheim, Iversen, and Steihaug, 2009; Øien, Steihaug, Iversen, and Råheim, 2011) included a prospective perspective. In our study, we emphasized the patients' perspectives on embodied experiences of change from NPMP treatments, including their experience of the reciprocal interdependency between the changes and the interaction between the patient and the physiotherapist. The nine studies included rich material on the complexity of patients' hopes for and experiences of change in treatment. Variations in the patients' hardship as these related to life, and the duration and complexity of symptoms influenced the time and range of change.

Analysis and synthesis

In line with Noblit and Hare (1988) we applied step three by reading the full text of the primary studies, placing particular emphasis on relevant themes and metaphors throughout the results of the primary studies. Noblit and Hare (1988) defined metaphors as key words and crucial terms used by the authors of the primary studies (metaphoric reduction). We intended to search the patients' expressions and meanings connected to their embodied reactions and experiences in treatment. We chose an index study with rich metaphors and relevant themes from ongoing long-term treatments (Øien, Råheim, Iversen, and Steihaug, 2009) as our starting position for comparing similarities and differences across the studies. Key findings of each primary study are presented in Table 2. Examples of identified metaphors in the index study were being and not being in touch with ways of moving and breathing.

In step four (Noblit and Hare, 1988) intending to examine how the findings were linked together, we organized relevant themes and metaphors from each primary study in vertical columns in a matrix, as suggested by Malterud (2019). In this step, we scrutinized the texts of the result sections. Moments of ambiguity and ambivalence in the patients' embodied expressions and speech caught our attention. In step five, we searched for similarities and differences in expressions by systematically comparing themes and metaphors across studies in the horizontal rows of the matrix. This was the most challenging step, where we recurrently considered the different aspects of the text to clarify the meaning of the experiences. Preliminary thematic groups of multiple voices appeared, such as being and not being in control of pain, experiencing the body and the mind as separated and/or integrated, being in touch with the body and being detached from the body. See Table 3 for preliminary themes and supporting quotes from included studies. In step six we synthesized the translations. Synthesizing the findings, we emphasized the meaning of embodied experiences of change in interdependence with the therapeutic intersubjective dialog. In step seven we developed three themes, third-order concepts which are presented as headlines in the results.

Table 2. Features of the nine primary studies included in the analysis.

Source	Title	Data collection	Sample origin	Participants	Key findings
Dragesund and Råheim (2008)	Norwegian psychomotor physiotherapy and patients with chronic pain: Patients' perspective on body awareness	Focus groups	Patients with chronic muscle pain on waiting lists or in treatment in outpatient clinics	Thirteen patients, eight females and five males, between 26 and 68 years.	Themes of body awareness: 1) Being aware of one's own body 2) Associations about one's own body 3) Feelings for one's own body
Dragesund and Øien (2020)	Transferring patients' experiences of change from the context of physiotherapy to daily life	Focus groups	Patients with long lasting musculo-skeletal pain, in and subsequent to treatment in outpatient clinics	Eleven patients, ten females and one male, between 34 and 67 years.	Overarching structure: To develop embodied ownership of oneself over time Themes: 1) To get an embodied grip on oneself through treatment 2) To give oneself space in daily life
Ekerholt and Bergland (2006)	Massage as interaction and a source of information	In-depth interviews	Patients with psychosomatic or long lasting musculo-skeletal pain after end of treatment in outpatient clinics	Ten patients, nine females and one male, between 41–65 years.	Core category: Massage as interaction and source of information Categories: 1) The ambiguity: Pleasure and provocation 2) The ambiguity: Losing control-gaining control 3) The intra- and interpersonal dialogue
Ekerholt and Bergland (2008)	Breathing: A sign of life and a unique area for reflection and action	In-depth interviews	Patients with psychosomatic or long lasting musculoskeletal pain after end of treatment in outpatient clinics	Ten patients, nine females and one male, between 41 and 65 years.	Categories: 1) Breathing: An incomprehensible and disparate phenomenon 2 non 2) Breathing: Access to meaning and understanding 3) Breathing: Enhancing feelings of mastery
Sviland, Martinsen, and Råheim (2014)	To be held and to hold one's own: Narratives of embodied transformation in the treatment of long-lasting musculoskeletal problems	Focus groups	Patients with psychosomatic or long lasting musculoskeletal pain after end of treatment in outpatient clinics	Seventeen patients, fourteen females, and three males, between 26 and 69 years.	Narrative core themes: 1) Time and trust: To be the main character 2) Embodied identity: Finding one's own voice 3) To speak out 4) The paradox of control
Sviland, Martinsen, and Råheim (2018)	Toward living within my body and accepting the past: A case study of embodied narrative identity	Focus group, in-depth interview, autobiographic text	Patient with psychosomatic or long-lasting musculoskeletal pain after end of treatment in outpatient clinics	One female patient, 30 years old	A narrative of Rita 1) Coercive hospitalization – corroborative distrust 2) Going to Norwegian psychomotor physiotherapy – chaos and discoveries 3) Struck by a droplet – reminiscences in sensation 4) Anger shifting direction – blaming the responsible 5) Revelation of embodied tranquility – hope for a future 6) Compassion – coming to herself in the eyes of the others 7) Ready for love – time to harness the process 8) Life as it is – a new way of being in the world

(*Continued*)

Table 2. (Continued).

Source	Title	Data collection	Sample origin	Participants	Key findings
Øien, Iversen, and Stensland (2007)	Narratives of embodied experiences – Therapy processes in Norwegian psychomotor physiotherapy	In-depth semi-structured interviews, observations, video-recordings, reflective notes	Patients with chronic muscle pain in treatment in outpatient clinic	Two female patients, between 33 and 40 years.	A narrative of Gina 1) Physiotherapy for the whole person 2) Being divided in body and mind 3) The treatment sessions – Reflection and physiotherapy 3a) My back as a tortoiseshell 3b) I'm not to be blamed 3c) Breathing more deeply 3d) My legs – My "stepchildren" 4) Reflecting on the treatment course – My body was asleep
Øien, Råheim, Iversen, and Steihaug (2009)	Self-perception as embodied knowledge. Changing processes for patients with chronic pain	In-depth semi-structured interviews, observations, video-recordings, reflective notes	Patients with chronic muscle pain in treatment in outpatient clinics	Nine patients, eight females and one male, between 22 and 47 years.	Two step procedures 1) Identified patient groups of limited and considerable change 2) Identified patterns of change 2a) To move restricted and non-restricted 2b) To breathe restricted and non-restricted 2c) To reflect in a non-exploring and exploring way 2d) To not transfer and transfer experiences from treatment to daily life 2e) To be detached from and to be in touch with the body
Øien, Steihaug, Iversen, and Råheim (2011)	Communication as negotiation processes in long-term physiotherapy: A qualitative study	In-depth semi- structured interviews, observations, video-recordings, reflective notes	Patients with chronic muscle pain in treatment in outpatient clinics	Eleven patients, ten females and one male, between 22 and 47 years.	Identified main pattern of communication 1) Seeking for common ground – demanding negotiating process Identified episodes of interrupting challenges 2) The pattern of ambivalence and uncertainty 3) The pattern of impatience and disagreement

Results

Analysis of the patients' voices of embodied experiences of change during NPMP resulted in an overarching theme of voices of the body and the mind as disconnected and connected. This all-embracing theme appeared closely entwined with the themes of ambiguous or contrasting voices in the therapeutic relationship and of identification of embodied voices of constraint and freedom of functions of movement, breathing, and emotional expressions. The multiple voices of contrasts and ambiguities emerged in ongoing moments of treatment and in retrospective reflections during and after treatment. The multiple voices and identity appeared to influence each other reciprocally.

Voices of body and mind as disconnected and connected

The analysis across the studies of NPMP treatment, disclosed that the patients indirectly and directly expressed sensations of disconnection and connections between their body and mind (Dragesund and Øien, 2020; Dragesund and Råheim, 2008; Ekerholt and Bergland, 2006, 2008; Øien, Iversen, and Stensland, 2007; Øien, Råheim, Iversen, and Steihaug, 2009; Øien, Steihaug, Iversen, and Råheim, 2011; Sviland, Martinsen, and Råheim, 2014, 2018). In the early phase of NPMP, many patients revealed voices of embodied disconnection and connection when they shared their aims for healing by reducing the symptoms of pain and

anxiety, and their hopes for a better life in the future. They requested to be regarded as an integrated or a whole person, in contrast to being defined as a patient suffering from musculoskeletal pain only. The desire to be considered as an integrated person co-existed and contrasted with experiences of sensing oneself as separated in mind and body. Some identified themselves with their mind, or their cognitive control in contrast to their body, which they defined as a thing to discipline, or carry around (Dragesund and Råheim, 2008; Øien, Iversen, and Stensland, 2007; Sviland, Martinsen, and Råheim, 2014). However, the meaning of the body as a thing to carry around, included concurrent voices of expressing itself as normal and healthy and constraining embodied expressions of anxiety. Hence, the equivocation of feeling detached from the body as a thing of no expression, and in touch with the body as a phenomenon of expression and action existed.

The analysis indicated that during treatment, the voices of sensing the body and mind as disconnected and/or connected appeared intertwined with the process of becoming conscious of various embodied reactions and actions. In the light of their past and present experiences of burden of complaints, the patients expressed new voices of understanding themselves. Voices of becoming more in touch with the body, facilitated emergence of their reasons for detachment, such as actively ignoring embodied messages of tiredness and pain in challenging situations of care and work. Critical experiences of abuses, injustices, and lack of care over time indicated obstruction and delay of emerging voices of embodied connections. In sum, the analysis indicated that voices contributing to develop connections between the body and the mind depended on negotiations between the participants in the therapeutic relationship, and on a detailed step-by-step process of getting in touch with and identifying their embodied functions of breathing and moving.

Ambiguous voices in the therapeutic relationship

In all of the studies, the patients emphasized experiences of change embedded in the dialog of the therapeutic relationship. They expressed verbally and nonverbally a multiplicity of ambiguous and contrasting voices in and about the therapeutic relationship. In moments over time, themes of distrust and trust reappeared (Øien, Steihaug, Iversen, and Råheim, 2011; Sviland, Martinsen, and Råheim, 2014, 2018). In early treatment, some shared experiences of skepticism due to past occurrences of not being helped by physiotherapists and due to their own reluctance to engage in intimacy (Øien, Steihaug, Iversen, and Råheim, 2011). For a year a young student suffering from pain, anxiety, and trauma, distanced herself from the physiotherapist by taking her seat on the floor. Retrospectively, she formulated her ambiguous attitude of distrust and hope for developing trust toward the physiotherapist over time (Sviland, Martinsen, and Råheim, 2018). In moments over time, many patients learned to trust the physiotherapist by exploring and reflecting on the painful tensed muscles and the meaning of their symptoms connected to their context (Øien, Steihaug, Iversen, and Råheim, 2011; Sviland, Martinsen, and Råheim, 2018). However, feeling detached to one's own body, the process of becoming in touch with or sensing embodied functions of moving and breathing appeared as challenging.

Voices of dependence and independence on the physiotherapist emerged. In early treatment, voices of dependence dominated over voices of independence. Many patients depended on the physiotherapists' observations and interpretations of their functions of moving, breathing, and expressing themselves. In both the prospective and retrospective studies, patients shared that the physiotherapist read their reactions the moment they appeared. Some indicated that the physiotherapists knew them better than they did themselves (Ekerholt and Bergland, 2006; Øien, Iversen, and Stensland, 2007; Sviland, Martinsen, and Råheim, 2018). Hence, voices of independence and dependence appeared closely to voices of participation and non-participation. Many patients found it challenging to give voices to non-sensed embodied reaction of movements, breathing and emotions (Øien, Steihaug, Iversen, and Råheim, 2011). Hence, they cleared the ground for searching and negotiating common experiences. The moment the patients expressed that they did not sense tensed muscles and restricted ways of breathing, the physiotherapists shared their perceptions of the patients' reactions. Their contrasted voices created a nascent dialog about the patient's self-perception. By allowing space to explore the functions of movement, breathing, and emotional reactions, the patients became more in touch with their embodied reactions. Consequently, they depended more on their own perceptions. Voices of independence and responsibility for one's own change emerged (Ekerholt and Bergland, 2006, 2008; Øien, Steihaug, Iversen, and Råheim, 2011; Sviland, Martinsen, and Råheim, 2018).

Identification of embodied voices of constraint and freedom influence identity

Across the studies, findings pointed to the patient's effort to exceed the perception of the disconnection between the mind and the body, by developing embodied ownership of oneself by getting an embodied grip on oneself, and by giving oneself more space in daily life (Dragesund and Øien, 2020). Thus, the patient's embodied identities

Table 3. Preliminary main themes and supporting quotes.

Preliminary main themes	Selected supporting quotes from included primary studies
Body and mind disconnected and connected	*"I wish someone could help me as a whole person to experience less pain, and less anxiety and insecurity, and to manage to look forward to the future"* (Øien, Iversen, and Stensland, 2007, p. 34). *"I am my mind, and I have a body I just have to carry around. It is hard to be at work and talk to people when you are anxious because the body has to express itself as normal and healthy."* (Øien, Iversen, and Stensland, 2007, p.34) *"I kind of disappeared mentally from my body"* (Ekerholt and Bergland, 2006, p.140). *"For many years I have been using my power of will, I've tried to control my body, which seem to be a bad idea. If symptoms are to abate, I think you have to learn to listen to your body"* (Dragesund and Råheim, 2008, p.248). *"Very much, my son's needs determined my movements and daily routines. For years I had to ignore my bodily signals of tiredness and pain. In treatment I enjoyed becoming in touch with my own body again"* (Dragesund and Øien, 2020, p.4). *"It became important to keep an untouched face. I learned to feel extremely sad inside without letting my family see how hurt I was"* (Øien, Iversen, and Stensland, 2007, p.34) *"Nothing started happening, until I made contact with my body and breathing. The body as well as the mind sort of let go – opened up again. More positive thoughts started taking root"* (Ekerholt and Bergland, 2008, p.836). *"I live within my body, instead of living beside myself. I live with my history instead of within my history, I don't live in the feelings that I had, but I live with them"* (Sviland, Martinsen, and Råheim, 2018, p.368)
NPMP change: Being detached from and being in touch with functions of moving and breathing	*"Occasionally, I can feel myself standing or sitting in a painful way"* (Øien, Iversen, and Stensland, 2007, p.35). *"Being aware of my diaphragm makes a difference. I am not out of breath, I stand more relaxed"* (Øien, Råheim, Iversen, and Steihaug, 2009, p.125). *"When thinking of change during therapy, what means the most to me is being in contact with the ground and breathing properly. Before treatment started, I felt like I was walking on pillows of air. To become aware that muscle tension in my stomach is causing me to breathe high up, to be able to sense that I am tense, and to try and loosen up. When I get dizzy and lose touch with everything, I don't need to be afraid, I know it's because of muscle tension."* (Dragesund and Råheim, 2008, p.247). *"I was always locked in my jaws, I was breathing in a sort of tube. Everything felt so stretched that I was completely tied up"* (Ekerholt and Bergland, 2008, p.835). *"I learned to dare to react; it loosened up tension, I could breathe more freely. I finally dared to try. I'm still not very good at expressing my feelings or letting go of my aggression, but I'm much better. I don't get those physical reactions so frequent any more"* (Ekerholt and Bergland, 2008, p.836).
Becoming in touch with embodied feelings	*"My back was extremely painful afterwards. Maybe because I felt so angry"* (Øien, Iversen, and Stensland, 2007, p.35). *"I understood that my tension may be related to what I have experienced earlier in my life and what I experience today"* (Ekerholt and Bergland, 2006, p.139).
The body as source of identities	*"To have good contact with my own body, helps me, and the foot is essential to get better contact with my own voice. What do I want now? I simply know more about who I am"* (Sviland, Martinsen, and Råheim, 2014, p.8). *"Who can tell us who we are if not the body"* (Sviland, Martinsen, and Råheim, 2014, p.9) *"Being a body is being oneself"* (Sviland, Martinsen, and Råheim, 2014, John p.14). *"Who am. I Who is Johanna? This has to do with my legs"* (Sviland, Martinsen, and Råheim, 2014, p.9). *"I feel less passive, I feel angry and ready for action. I returned a kick"* (Øien, Råheim, Iversen, and Steihaug, 2009, p.25). *"The treatment benefits me, I have learned a lot about myself. Now, I can sense how I am straightening myself up too much, pulling myself together. I was not aware of that before"* (Dragesund and Øien, 2020, p.4).
Dependency between change of embodied functions and the therapeutic relationship	*"I couldn't have gone through the process without help; it's important to feel supported"* (Ekerholt and Bergland, 2008, p.836). *"It feels so strange, I sense my legs at a distance compared to my shoulders. I only sense them when you touch them"* (Øien, Iversen, and Stensland, 2007, p.35). The physiotherapist: *"Do you perceive that you restrict your breathing?"* The patient: *"Oh, no, I don't notice anything or may be sometimes I do, when you point it out"* (Øien, Steihaug, Iversen, and Råheim, 2011, 57). *"The touch of the therapist's hands sort of drew my breathing along the spine and down to pelvis and to my stomach. It was a new feeling. I had to concentrate, had to be mentally present. It was a little bit scary, but it felt good"* (Ekerholt and Bergland, 2008, p.835). *"Her hands just touching me were enough, and I would start crying, something I could never do unless I was alone. It was embarrassing, but I was given time and support. It felt good."* (Ekerholt and Bergland, 2006, p.140).
The therapeutic relationship: trust and distrust	*"In a subconscious way, I may have felt that this particular person could be trusted, with time"* (Sviland, Martinsen, and Råheim, 2018, p. 366).
The therapeutic relationship: dependency and independency	*"If I tensed my muscles, the physiotherapist said, "Let your breath go""* (Ekerholt and Bergland, 2006, p.140). *"I feel she responded to my body. I didn't have much contact with my body. When I spoke, she saw where I was, from seeing my body, she took the body as point of departure, so this was where we started"* (Sviland, Martinsen, and Råheim, 2014[, p.10).

appeared to be at stake. However, the subject of identities was more outstanding in some of the studies. Findings from one study indicated that listening to the body enabled patients to answer questions about identity, voiced by a patient as *"Who can tell us who we are if not our body?"* (Sviland, Martinsen, and Råheim, 2014).

In all the studies, the patients indicated that the flexible use of the multiple tools of touch in massage, guided hands-on movements, self-initiated movement, and reflections on past and present embodied actions and emotional experiences, all served to contribute to identify perception and variation of ways of moving, breathing and emotionally expressing oneself. The ambiguous and/or contrasting voices of perception, being detached from and/or being in touch with the body appeared as the core element of change. In moments over time, the patients carefully learned to identify and partly vary between relaxing and tensing specific and general groups of muscle, between restricting and releasing breath, and between holding back and expressing emotions. The ambiguous and/or contrasting voices of feeling detached from and/or feeling in touch with the body did exist over time, but the domination of the voice of being detached from the body subsided (Øien, Iversen, and Stensland, 2007; Øien, Råheim, Iversen, and Steihaug, 2009; Øien, Steihaug, Iversen, and Råheim, 2011; Sviland, Martinsen, and Råheim, 2014, 2018). Analysis of findings across the studies indicated that improved embodied self-perception influenced the development of varied embodied identities. The patients gave meaning to their body as a source of identity. At the end of treatment, one patient emphasized *"I simply know more about who I am"* (Sviland, Martinsen, and Råheim, 2014). In moments of ongoing treatments, the subject of embodied identity emerged but apparently without any particular attention from the patients, such as the one, who did not sense her constricted breathing. She whispered with uncertain voice *"what do I notice?"* (Øien, Steihaug, Iversen, and Råheim, 2011). In learning to perceive and know themselves in new ways, the patients' embodied identities; who or what a person is were at play.

Discussion

Identifying a polyphony of embodied voices makes choices for change possible

In our meta-synthesis, grounded on expectations and experiences shared in dialog during or after treatments, patients expressed multiple voices of aims of reducing pain, anxiety, and uncertainty, of hope for improving quality of life, and of desires to be met as integrated persons. The patients' expressions of voices of feeling some sort of separation between body and mind were common. Their voices of embodied sensations varied, but they all shared voices of both being in touch with and being detached from embodied functions, included emotional reactions. Entangled in the voices of embodied sensations, there were voices of trust and distrust, dependence and independence directed toward the physiotherapist and/or themselves. A joint feature of the topics of the dialogs in and about treatment is the concurrent existence of multiple voices of ambiguity and/or contrast. Bachtin's (1972/1991, 2003) concept of dialog points toward a language practice of contextually embedded expressions of concurrently existing voices unfolding extensively in space in temporal singularity. In our meta-synthesis, the concurrently existing voices of sensing connection and/or separation between body and mind, sensing or not sensing variations of embodied functions of movement, breathing and emotional reactions, and the variety of voices in the therapeutic relationship indicated that the steps of change appeared as challenging.

Mainly in early treatment, the patients' voices of experiences of connection and disconnection between the body and the mind came to the foreground through their multiple voices of how they perceived the body, such as the mechanical expressionless body, the healthy body, and the anxious body. Bachtin (1972/1991, 2003) emphasized that the polyphony of fully worthy voices consists of a multiplicity of independent and separated expressions of equal consciousnesses, embodied in the entirety of the human being's lived voice, gestures, and mimic movements. Thus, exploring each lived voice as a different expression of oneself seems to be important in the process of acquiring self-knowledge. Each voice is an autonomous carrier of one's own individual perspective on the world, and includes the self in the world (Bachtin, 1972/1991, 2003). The different voices described above suggest different but interrelated worlds of existence. Within social contexts, the voice of feeling anxious appeared to be connected to the voice pretending to express health and normality. In line with the NPMP perspective, the patient as an embodied subject may conceal embodied emotional reactions of anxiety by restricting rhythm of breathing, tensing muscles, and hyperextending body posture (Braatøy, 1952). Thus, the voice of looking healthy, and the voice of constraining emotional expressions existed in close connection with the voice of the mechanical body. Interactions between multiple but not united consciousnesses take place (Bachtin, 1972/1991). In line with this, Ahlsen, Mengshoel, and Solbrække (2012) interviewing men in general physiotherapy practice found that their stories of chronic musculoskeletal pain, concurrently

included voices expressing rational reasoning, control, and vulnerability. In our meta-synthesis, the patients in early treatment did not seem to be in touch with the connection and/or the interaction between the contrasting multiple voices. However, dialog and consciousness influence each other reciprocally (Bachtin, 2003). By exploring the variations in the embodied voices, the patients created possibilities of choice to further investigate voices of disconnection and connection between the body and the mind.

In the meta-synthesis, the patients facilitated change of movements by reiterating variations between tensing and relaxing muscles. However, they expressed polyphonic voices of feeling detached from or in touch with their body. These equivocal voices appeared as inner dialogs with themselves, and as external voices shared in dialogs with the physiotherapist. The polyphonic voices of sensing and not sensing the body in specific moments of movement and reflection appeared to be entangled with unclear voices of dependence on oneself and the physiotherapist. Neither sensing embodied reactions of pain nor restrictive rhythms of breathing and muscle tensions, the patients depended on the physiotherapists' expressions of their observation and interpretation. Consequently, voices of nonparticipation and participation emerged. Further, this polyphony of voices seemed to be intertwined with voices of trust and distrust toward the physiotherapist and themselves. In accordance with Bachtin (1972/1991), each consciousness is both connected to its own world and incorporated within the performance of a unity of a certain action.

In order to facilitate change in NPMP, the polyphony of clearly and unclearly expressed voices and the connections between the voices needs to be taken into consideration. In a comparable medical clinical dialog, the connection between polyphonic voices of inner and external dialogs (Bachtin, 1972/1991), are taken into consideration. A physician successfully relieved a distressed patient who had recently been diagnosed with "subarachnoid hemorrhage" by exploring the patient's internal voices of worry about family members (Frich, 2010). Correspondingly, our findings indicated an urgent need to search for the constrained internal and external voices that are critical to further treatment. In the field of family therapy, findings from examinations of the dialog emphasized that listening carefully in the service of polyphony by giving voice to and fostering polyphony is the primary transformative condition (Olsen, Laitila, Rober, and Seikkula, 2012). In our study, exploring a polyphony of ambivalent and contrasting voices of embodied sensations and emotions facilitated the patients' freedom to choose healing actions. Thus, actions of future significance, defined as actions of freedom, occur on the basis of contrasts or ambivalences among co-existing powerful voices (Bachtin, 1972/1991, 2003).

Improving self-perception and participation creates new voices of connection and identity

In the meta-synthesis, in the juxtaposition of the patients' multiple voices, decisive moments of choice of action appeared that facilitated moments of sensing the body as the self or as a source to the self. In sequences of treatment over time in the retrospective and the prospective studies, findings of change in self-perception and identity emerged through the exploration of a polyphony of ambiguous embodied voices. The conception of self as being connected to self-perception, self-understanding, self-knowledge and self-ownership suggests something being appropriated as opposed to being given once and for all (Zahavi, 2005). The self appears as an open-ended construction in constant revision (Bachtin, 1986; Zahavi, 2005). Thus, the multivocal self is dynamic with future capabilities (Bachtin, 1986).

In the meta-synthesis, the patients' voices of identifying vaguely sensed embodied reactions and feelings appeared as challenges. Still, in dependence on the physiotherapist, capturing their ambiguous voices of being in touch with or being detached from embodied reactions and feelings, a space was opened in which new identities could unfold. In accordance with Bachtin (1986) the construction of self takes place in relationship to another person. Experiencing this type of identification as challenging can also be apprehended in accordance with the understanding that the person, the embodied self, is simultaneously unchanged and in a state of change. Struggling with the polyphonic voices of being in touch with or being detached from embodied reactions and feeling, the healing process seemed to be held in suspense.

However, in evolving treatment sequences of polyphonic embodied voices, the patients in line with Zahavi (2005) involved themselves existentially, by actively improving their embodied self-perception, self-ownership and self-agency. Being an evolving self is to be existentially involved (Zahavi, 2005). Constructing identities includes the embodied self, creating connections and giving itself positions of choice (Binder, 2018). Bachtin (1986) stated that the construction of self takes place in relationship to some other, such as another person, or parts of the self. In our meta-synthesis, the patients appropriated new identities or constructed their selves by creating meaningful voices of connections between muscle tension, rhythm of breathing, and emotional reactions to past and present experiences of pain,

strain and/or trauma, such as transforming voices of expressions from "what do I sense" to "being a body is being oneself." Findings of change from different physiotherapy contexts emphasize the development of new identities. By rebuilding functions in rehabilitation, patients with chronic muscle pain, also linked treatment to (re)building the self (Ahlsen, Bondevik, Mengshoel, and Solbrække, 2013; Ahlsen, Mengshoel, and Solbrække, 2012). The NPMP body assessment of individuals with anorexia nervosa suggests that interventions with proprioceptive information to restore muscular function and postural stability may generate a more coherent experience of the body and the self (Kolnes, 2017).

Strengths and limitations

We found the approach of qualitative meta-synthesis relevant to contributing to further development of knowledge by building on the knowledge acquired through earlier qualitative research studies in the field of NPMP treatment into patient experiences of change. Relevance is a standard of qualitative research (Malterud, 2001). Our meta-synthesis included the analysis of nine qualitative primary studies that used different designs and methods of data collection. In selecting studies for inclusion, we emphasized reflexivity, a common criterion for qualitative research (Malterud, 2001). In the inclusion process, we improved the quality of our study by applying guidelines for authors and reviewers of qualitative studies developed by Malterud (2001). Thus, we enhanced the transparency of our reflexivity. The findings from the primary studies were built on data from single or multiple data sources of individual in-depth interviews, focus group interviews, observations, video-recordings, and texts of experiences from patient perspectives during and subsequent to NPMP treatments. The heterogeneity of the designs and the data generating methods encompassed by the studies revealed experiences and actions in practical moments over time. Thus, our sampling enhanced internal validity: whether a study investigates what it is meant to investigate (Malterud, 2001). In an effort to interpret knowledge from second-order concepts and develop them into third-order concepts (Malterud, 2019), we used a rigorous meta-ethnographic approach consisting of seven steps (Noblit and Hare, 1988). By inductively analyzing the results of the primary studies (i.e. second order concepts) we became aware of multiple voices of meaning as a common feature connected to embodied change in self-perception and identity. Consequently, we decided to let the perspective of polyphony (Bachtin, 1972/1991) influence our analysis. In evaluating the external validity and the relevance of the knowledge produced (Kvale, 2007; Lyons and Coyle, 2007; Malterud, 2001), we discussed the findings with physiotherapists within the context of NPMP; the physiotherapists found the findings of concurrent ambiguous voices and the influence of identities recognizable. Extending the experiential knowledge to physiotherapists beyond the NPMP contexts, we tried to undertake what Yin (2003) referred to as "analytical generalization." Analytical generalization develops when empirical results are discussed and compared with findings reported from other relevant studies and previously developed theory. The mutual influence between embodied identity and multiple voices of inner and external dialog appears within the field of NPMP and across limited fields of physiotherapy. In general, physiotherapists may be more in touch with ambiguous voices of motivation prerequisite to change in contrast to power of change in treatment. Hence, a meta-synthesis built on published primary studies from NPMP contexts might limit the use or facilitate reflection on involved issues.

Conclusion and clinical implications

The present meta-synthesis of primary studies of NPMP treatment of patients with chronic musculoskeletal pain describe improved variation in self- perception and identity. In treatment the patients got into touch with concurrently expressed ambiguous and contrasting voices of being detached from or in touch with embodied functions of balance, muscle tension, rhythm of breathing, and emotional expression. In the therapeutic relationship, the patients expressed experiences of ambiguous and contrasting voices of trust and distrust, dependence and independence, nonparticipation and participation. Steps toward change became possible through identifying and varying embodied reactions and feelings in the juxtaposition of the multiple voices of ambiguity and contrast within the patient and the therapeutic relationship. The patients' ongoing involvement in sorting out and choosing to emphasize voices of getting in touch with the body created connections between the body and the mind, and enhanced freedom to vary and enrich their embodied identities. In practice, we suggest that physiotherapists assist change by exploring, identifying, and recognizing the patient's polyphony of internal and external voices that are connected to the patients' aims of treatment, embodied self-perception, and therapeutic relationship.

Capturing significant moments of choice of change, may enable patients to more freely choose new ways of moving and acting. Hereby, the patients have the possibility to expand their identity.

Acknowledgments

We are grateful for the support of the academic librarians Gerd Vik and Lise Vik-Haugen, at the Western Norway University of Applied Sciences, Sogndal, Norway.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

ORCID

Aud Marie Øien PhD, PT http://orcid.org/0000-0003-3085-4640
Tove Dragesund PhD, PT http://orcid.org/0000-0001-7576-9111

References

Ahlsen B, Mengshoel AM, and Solbrække KN 2012 Shelter from the storm; men with chronic pain and narratives from the rehabilitation clinic. Patient Education and Counseling 89(2): 316–320. 10.1016/j.pec.2012.07.011

Ahlsen B, Bondevik H, Mengshoel AM, Solbrække KN 2013 (Un)doing gender in a rehabilitation context: A narrative analysis of gender and self in stories of chronic muscle pain. Disability and Rehabilitation 36(5): 359–366. 10.3109/09638288.2013.793750

Aili K, Campbell P, Michaleff ZA, Strauss VY, Jordan KP, Bremander A, Croft P, Bergman S 2021 Long-term trajectories of chronic musculoskeletal pain: A 21-year prospective cohort latent class analysis. Pain 162(5): 1511–1520. 10.1097/j.pain.0000000000002137

Bachtin M 1972/1991 Dostojevskijs Poetik [Dostoevsky's Poetics]. Uddevalla: Anthropos.

Bachtin M 1986 Speech genres and other late essays. Austin: University of Texas Press.

Bachtin M 2003 Latter og dialog [laughter and dialogue]. Oslo: Cappelen Akademisk.

Bergland A, Olsen CF, Ekerholt K 2018 The effect of psychomotor physical therapy on health-related quality of life, pain, coping, self-esteem, and social support. Physiotherapy Research International 23(4): e1723. 10.1002/pri.1723

Binder PE 2018 Hvem er Jeg? Om å Finne og Skape Identitet [Who Am I? Finding and Creating Identity]. Bergen: Fagbokforlaget.

Breitve MH, Hynninen MJ, Kvåle A 2008 Emosjonelle symptomer og helseplager hos pasienter som oppsøker psykomotorisk fysioterapi [Emotional symptoms and health problems for patients seeking Norwegian psychomotor physiotherapy]. Fysioterapeuten 75: 19–26.

Breitve MH, Hynninen MJ, Kvåle A 2010 The effect of psychomotor physical therapy on subjective health complaints and psychosocial symptoms. Physiotherapy Research International 15(4): 212–221. 10.1002/pri.462

Braatøy T 1947 De nervøse sinn [The nervous mind]. Oslo: Cappelen.

Braatøy T 1952 Psychology versus anatomy in the treatment of "armneuroses" with physiotherapy. Journal of Nervous and Mental Disease 115(1): 215–245. 10.1097/00005053-195201000-00020

Dragesund T, Råheim M 2008 Norwegian psychomotor physiotherapy and patients with chronic pain: Patients' perspective on body awareness. Physiotherapy Theory and Practice 24(4): 243–254. 10.1080/09593980701738400

Dragesund T, Øien AM 2019 Demanding treatment processes in Norwegian psychomotor physio-therapy: From the physiotherapists' perspectives. Physiotherapy Theory and Practice 35(9): 833–842. 10.1080/09593985.2018.1463327

Dragesund T, Øien AM 2020 Transferring patients' experiences of change from the context of physiotherapy to daily life. International Journal of Qualitative Studies on Health and Well-being 15(1): 1735767. 10.1080/17482631.2020.1735767

Dragesund T, Øien AM 2021 Developing self-care in an interdependent therapeutic relationship: Patients' experiences from Norwegian psychomotor physiotherapy. Physiotherapy Theory and Practice 1–11. Online ahead of print. 10.1080/09593985.2021.1875524

Ekerholt K, Bergland A 2006 Massage as interaction and a source of information. Advances in Physiotherapy 8(3): 137–144. 10.1080/14038190600836809

Ekerholt K, Bergland A 2008 Breathing: A sign of life and a unique area for reflection and action. Physical Therapy 88 (7): 832–840. 10.2522/ptj.20070316

Ekerholt K, Bergland A 2021 Embodied knowledge - The phenomenon of subjective health complaints reflected upon by Norwegian psychomotor physiotherapy specialists. Physiotherapy Theory and Practice 1–12. Online ahead of print. 10.1080/09593985.2021.1920073

Frich JC 2010 Dialogue and creativity - Narrative in the clinical encounter. Stene-Johansen K, Tygstrup F Eds Illness in context, 37–50. New York: Rodopi.

Gjengedal E, Sviland R, Moi AL, Ellingsen S, Flinterud SI, Sekse RJ, Natvik E, Råheim M 2019 Patients' quest for recognition and continuity in health care: Time for a new research agenda? Scandinavian Journal of Caring Sciences 33(4): 978–985. 10.1111/scs.12696

Keesing RM 1985 Cultural anthropology. A contemporary perspective 2nd. New York: CBS College Publishing.

Kolnes LJ 2017 Exercise and physical therapy help restore body and self in clients with severe anorexia nervosa. Journal of Bodywork 21(3): 481–494. 10.1016/j.jbmt.2016.09.005

Kvale S 2007 Doing interviews. London: Sage Publications.

Lamahewa K, Buszewicz M, Walters K, Marston L, Nazareth I 2019 Persistent unexplained physical symptoms: A prospective longitudinal cohort study in UK primary care. British Journal of General Practice 69(681): e246–e253. 10.3399/bjgp19X701249

Lyons E, Coyle A 2007 Analysing qualitative data in psychology. London: Sage Publications.

Maeland S, Werner EL, Rosendal M, Jonsdottir IH, Magnussen LH, Ursin H, Eriksen HR 2012 Diagnoses of patients with severe subjective health complaints in Scandinavia: A cross sectional study. International Scholarly Research Notices 2012: 851097.

Malterud K 2001 Qualitative research: Standards, challenges, and guidelines. Lancet 358(9280): 483–488. 10.1016/S0140-6736(01)05627-6

Malterud K 2019 Qualitative meta-synthesis. A research method for medicine and health sciences. Oxon: Routledge Focus.

Malterud K, Aamland A 2019 Medically unexplained symptoms: Are we making progress. British Journal of General Practice 69(681): 164–165. 10.3399/bjgp19X701885

Merleau-Ponty M 1945/2012 Phenomenology of perception. London: Routledge.

Noblit GW, Hare RD 1988 Meta-Ethnography: Synthesizing qualitative studies. Newbury Park, CA: Sage.

Olsen ME, Laitila A, Rober P, Seikkula J 2012 The shift from monologue to dialogue in a couple therapy session: Dialogical investigation of change from the therapists' point of view. Family Process 51(3): 420–435. 10.1111/j.1545-5300.2012.01406.x

Sviland R, Martinsen K, Råheim M 2014 To be held and to hold one's own: Narratives of embodied transformation in the treatment of long-lasting musculoskeletal problems. Medicine, Health Care and Philosophy 17(4): 609–624. 10.1007/s11019-014-9562-0

Sviland R, Martinsen K, Råheim M 2018 Towards living within my body and accepting the past: A case study of embodied narrative identity. Medicine, Health Care and Philosophy 21(3): 363–374. 10.1007/s11019-017-9809-7

Sørensen L, Jensen M, Rathleff M, Holden S 2019 Comorbid insomnia, psychological symptoms and widespread pain patients suffering from musculoskeletal pain in general practice: A cross sectional study. British Medical Journal Open 9: e031971.

Thornquist E, Bunkan BH 1991 What is psychomotor physiotherapy? Oslo: Norwegian University Press.

Treede R, Rief W, Barke A, Aziz Q, Bennett M, Benoliel R, Cohen M, Evers S, Finnerup NB, First M, et al. 2019 Chronic pain as a symptom or a disease: The IASP classification of chronic pain for the international classification of diseases (ICD-11). Pain 160(1): 19–27. 10.1097/j.pain.0000000000001384

Wifstad Å 2018 Vitenskapsteori for helsefagene [theory of science in health science]. Oslo: University Press.

Yin RK 2003 Case study research: Design and methods 3rd. Thousand Oaks, Ca: Sage Publications.

Zahavi D 2005 Subjectivity and selfhood. Investigating the first-person perspective. London: The MIT Press Cambridge.

Øien AM, Iversen S, Stensland P 2007 Narratives of embodied experiences - Therapy processes in Norwegian psychomotor physiotherapy. Advances in Physiotherapy 9(1): 31–39. 10.1080/14038190601152115

Øien AM, Råheim M, Iversen S, Steihaug S 2009 Self-perception as embodied knowledge - Changing processes for patients with chronic pain. Advances in Physiotherapy 11(3): 121–129. 10.1080/14038190802315073

Øien AM 2010 Change and communication. Long-term Norwegian psychomotor physiotherapy treatment for patients with chronic muscle pain. Doctoral Thesis, University of Bergen.

Øien AM, Steihaug S, Iversen S, Råheim M 2011 Communication as negotiation processes in long term physiotherapy: A qualitative study. Scandinavian Journal of Caring Sciences 25(1): 53–61. 10.1111/j.1471-6712.2010.00790.x