



# Physiotherapy Theory and Practice

An International Journal of Physical Therapy

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

## Developing self-care in an interdependent therapeutic relationship: patients' experiences from Norwegian psychomotor physiotherapy

Tove Dragesund & Aud Marie Øien

To cite this article: Tove Dragesund & Aud Marie Øien (2021): Developing self-care in an interdependent therapeutic relationship: patients' experiences from Norwegian psychomotor physiotherapy, *Physiotherapy Theory and Practice*, DOI: [10.1080/09593985.2021.1875524](https://doi.org/10.1080/09593985.2021.1875524)

To link to this article: <https://doi.org/10.1080/09593985.2021.1875524>



© 2021 The Author(s). Published with license by Taylor & Francis Group, LLC.



Published online: 19 Jan 2021.



Submit your article to this journal [↗](#)



Article views: 66



View related articles [↗](#)



View Crossmark data [↗](#)

## Developing self-care in an interdependent therapeutic relationship: patients' experiences from Norwegian psychomotor physiotherapy

Tove Dragesund  and Aud Marie Øien

Department of Health and Functioning, Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, Bergen, Norway

### ABSTRACT

Factors causing and sustaining long-lasting musculoskeletal pain differ between patients, but must be identified in order to target treatment. During physiotherapy, there are multiple factors influencing the treatment outcome. The focus in the present study was to grasp patients' experiences of how social burdens influence the development and persistence of symptoms of muscle pain, and how the relationship with the physiotherapist influences the process of change during Norwegian Psychomotor Physiotherapy. A phenomenological, descriptive, and retrospective design was chosen. Data were collected through focus-group interviews. Eleven patients participated. They ranged in age from 34 to 67 years. The analysis was inspired by Giorgi's phenomenological method. The results identified a general, overarching structure; "Caring for others and developing self-care" and the two interwoven themes "Emerging awareness of overload" and "Receiving care from the physiotherapist." These themes describe the essence of the experiences from the treatment process. To be recognized by the physiotherapist, both through the hands-on treatment and verbal communication, appears to be crucial for patients to develop an awareness of the factors causing and sustaining their pain problems. This awareness seemed necessary for the process of change to take place and for the patients to take more responsibility for their own care.

### ARTICLE HISTORY

Received 19 February 2020  
Revised 21 September 2020  
Accepted 12 December 2020

### KEYWORDS



Norwegian Psychomotor Physiotherapy; relationship; long-lasting musculoskeletal pain; patient involvement

## INTRODUCTION

Long-lasting musculoskeletal pain is more common among women than men, and has a multifactorial etiology, including biological, psychological, and social factors (Malterud, 2010; Steihaug, 2005). Consequently, the examination and the treatment of patients with such pain problems is challenging and time-consuming. Factors causing and sustaining these problems differ between the patients, but it is mandatory to identify these individual risk factors in order to target the treatment. A phenomenological perspective of the body might be useful to identify sustaining factors and target treatment. According to this perspective our body, defined as subject, perceives the world. Social phenomena are understood from the subject's point of view (Merleau-Ponty, 2012). Our natural acceptance of our body is developed by experiencing the world with and through our body, and by reflecting on our encounters with the world. Experiences in life makes an imprint in and on the body as body habits, patterns, and movements (Merleau-Ponty, 2012).

In their clinical practice, physiotherapists often meet patients with long-lasting musculoskeletal pain. During

the treatment, there are multiple factors influencing the outcome (Hall et al., 2010; Laerum, Indahl, and Skouen, 2006; O'Keeffe et al., 2016). The interaction, both verbally and non-verbally, between the physiotherapist and the patient is of significance regarding the outcome. Evidence has emerged that a positive interaction might influence the patients' experience of physical disability (Ferreira et al., 2013; O'Keeffe et al., 2016). Patients and physiotherapists emphasize that physiotherapists promote positive interactions through sensitive listening, trust, and empathy (Gyllensten, Gard, Salford, and Ekdahl, 1999; O'Keeffe et al., 2016) and acceptance (Gyllensten, Gard, Salford, and Ekdahl, 1999). Other qualities emphasized include warmth, support, an ability to collaborate, handle negative emotions, and tailor treatment to the patient's needs (Gard and Gyllensten, 2004; O'Keeffe et al., 2016; Skjaerven, Kristoffersen, and Gard, 2010). According to Bjorbaekmo and Mengshoel (2016) touch during treatment, might enable a trustful and respectful co-existence between the physiotherapist and the patient. Through touch, physiotherapists implicitly invite their patients to participate in the treatment

**CONTACT** Tove Dragesund  [tove.dragesund@hvl.no](mailto:tove.dragesund@hvl.no)  Department of Health and Functioning, Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, Bergen, Norway.

© 2021 The Author(s). Published with license by Taylor & Francis Group, LLC.

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

process. The physiotherapist's ability to respectfully listen and guide the patient to explore their own bodily possibilities and limitations, further influences their co-existence.

In this study, we intend to grasp patients' experiences of factors influencing development and persistence of symptoms of musculoskeletal pain and how the relationship with the physiotherapist influenced their process of change during Norwegian Psychomotor Physiotherapy (NPMP). To the best of our knowledge earlier studies in the field have not focused on these aspects. Earlier studies in the field have explored aspects of change and the impact of interaction during treatment from the patients' and the physiotherapists' perspectives. Patients in the study by Ekerholt and Bergland (2004) emphasized the importance of both verbal and non-verbal interactions during the first encounter, and throughout the whole treatment process in order to enhanced relaxation as well as perception and reflection on own body (Ekerholt and Bergland, 2006, 2008). In these studies, patients felt that the relationship helped them to gain an insight into their symptoms. Furthermore, the patients emphasized the physiotherapist's ability to be present, to understand them and to see them during the treatment process. Trust, time, direct speech, as well as being respectfully listened to, were described as therapeutic preconditions by the patients during long term NPMP (Sviland, Martinsen, and Råheim, 2014; Sviland, Råheim, and Martinsen, 2012). These therapeutic preconditions were crucial for the patients' process of bodily changes. The patients in Dragesund and Øien (2020) described how enhanced embodied self-perception involving a sense of embodied ownership and agency seemed to be important both to be aware of own bodily needs and also to transfer changes from treatment into daily life.

In a study by Øien, Råheim, Iversen, and Steihaug (2009), the patients valued how the therapeutic relationship included encouragement of reflection on embodied experiences during the treatment process. The patients described how these reflections enhanced their self-perception and self-knowledge. From the perspectives of the physiotherapists, sensitivity and an ability to negotiate (Øien, Steihaug, Iversen, and Raheim, 2011), as well as self-awareness and being anchored in themselves (Dragesund and Øien, 2019) seemed to facilitate the further work in particularly demanding NPMP processes. The NPMP physiotherapists in Ekerholt and Bergland (2019) experienced that their own embodied knowledge supported them during their clinical practice. They described how this knowledge was crucial while facilitating the patients to explore aspects of body awareness in different social settings.

## THEORETICAL PERSPECTIVES

The theoretical perspectives in the current study are concepts from Norwegian Psychomotor Physiotherapy (NPMP) treatment, Schibbye's theory on relationships and interactions and Honneth's theory of recognition. We chose these three perspectives because they all include relationships and seem to complement each other and are related to the aim of this study.

In NPMP, the theoretical perspective is based upon the knowledge of the interactions and intertwined relationships between physical, psychological and social aspects in human beings (Ekerholt and Bergland, 2019). Influenced by Merleau-Ponty's (2012) phenomenology of perception, the treatment approach emphasizes the embodied nature of experiences of human subjects (Thornquist, 2006). Infant development theories (Stern, 1985), emphasizing that bodily contact and interaction are the earliest experiences and the primary level of contact, have influenced the hands-on aspect of the approach.

NPMP treatment is individualized, process-oriented and can be long term (Thornquist and Bunkan, 1991). Symptoms and local complaints are interpreted in the context of the body as an expression and regulator of the person's emotional life (Braatøy, 1947). The patient's social and historical context serves as frame of interpretation of symptoms. The aim of the NPMP approach is to facilitate change of the affected functions through movement exercises and massage. Regardless of presented local symptoms, the whole body of the patient is addressed in order to adjust posture and harmonize muscle tension, breath, and movements (Thornquist and Bunkan, 1991). NPMP is an approach that includes both non-verbal and verbal interaction between therapist and patient. Whether the communication is verbal or nonverbal, it can be seen as a dialog, allowing both to contribute to an intersubjective creative process on different levels (Thornquist, 2006). The interaction, embedded in the clinical encounter, depends on the participants' perception of signs through tactile and proprioceptive senses (Thornquist, 2006). Recognizing and sharing the patients' bodily experiences during the treatment, creates a process of focusing on the body as a source of knowledge (Ekerholt and Bergland, 2004). Subsequently, enhanced awareness of the body, including emergent feelings, might provide an insight into symptoms connected to earlier and present lived experiences, as well as to new ways of relating to them and handling them (Dragesund and Raheim, 2008; Øien, Råheim, Iversen, and Steihaug, 2009).

Schibbye's (2009) perspective on relationships and interactions, called the dialectical perspective of

relationship, is inspired by psychology, phenomenology, and existentialism. One aspect in this perspective is recognition, which includes respect for others as subjects and authority over one's own experiences. She describes recognition as a therapeutic intervention. Schibbye (2009) further claimed that recognition is an attitude or behavior, characterized at a practical level by listening, understanding, accepting, tolerating, and confirming the other person. The intertwined aspects of this attitude create a frame in the treatment session. Listening concerns being focused and active and open to the possibility of being emotionally moved. Understanding includes understanding the other person's experiences and concurrently retaining one's own field of experiences. Acceptance implies accepting the other person's right to his/her own feelings and being tolerant of these feelings. Confirmation is the ability to validate and understand the other person's feelings given the other person's point of view.

Based on Hegel's philosophical dialectic theory, Honneth developed a theory of recognition (Honneth, 1996). A main point in his theory is that recognition is a basis for healthy identity development (Honneth, 1996). He also underlines the reciprocity of recognition, meaning that we can only feel recognition from persons whom we recognize. He distinguishes between three forms of recognition, all acquired in different social contexts. The first form is love, an emotional recognition between people in a close relationship and the most basic form of recognition contributing to the development of self-confidence. The second form is rights (justice), which connects to formal rights and respect of the individual's autonomy and is crucial in the development of self-respect. Solidarity, the third form, is about societal recognition of personal characteristics, skill and lifestyle, and links to development of self-esteem (Honneth, 1996). According to Honneth (1996) there are three forms of disrespect, corresponding to the forms of recognition, which negatively activate feelings and identity. The three forms are: 1) humiliation; 2) deprivation of rights; and 3) degradation. The various forms of recognition and disrespect influence relationships to others and self.

## METHODS

The present study was guided by the perspective of phenomenology of perception, which states that our understanding is based on how our body defined as subject perceives the world (Merleau-Ponty, 2012). In order to explore this first-person perspective, we therefore chose a phenomenological, descriptive, and retrospective design. Phenomenology is both a philosophical

approach describing the internal meaning structures of lifeworld experiences, and a methodological strategy to achieve and explore empirical data (Giorgi, 2009).

We collected data through focus-group interviews that were well suited for exploring experiences of perceptions, feelings, and thoughts about selected aspects of everyday life. In addition, we collected qualitative data in a focused discussion. However, the richness of the interviews is highly dependent on the interaction in the groups (Morgan, 1997).

During the interviews, we sought a phenomenological attitude of openness by being sensitive and attentive to the patients' experiences of the NPMP treatment (Giorgi, 2009). We tried to hold back our preconceived ideas and theories and allow the meaning of the phenomenon to unfold in unexpected ways.

## Recruitment and participants

The patients received both verbal and written information about the study aim as well as a guarantee of anonymity. Those who volunteered and participated in the study also signed forms to give their consent. The study was approved by the Regional Committee of Ethics in Medicine and also registered at the Norwegian Social Science Data Service. Participants were selected for strategic reasons. To be able to capture a variety of process-related changes we wanted to recruit patients (both female and male) receiving NPMP treatment once a week for 3–12 months. Originally, the patients participated in a randomized controlled trial (RCT) which included two interventions: NPMP and Cognitive Patient Education (COPE-PT) in combination with active individualized physiotherapy. The intervention in the RCT reflected usual care and was conducted in physiotherapy clinics by five physiotherapists experienced in each of the two treatment approaches. The inclusion criteria in the present study were the same as for the RCT: 1) being employed in the Municipality of Bergen; and 2) having several short periods of sick leave during the last two years, or being on sick leave fulltime for longer than 6 months, or working despite long-lasting widespread musculoskeletal pain or pain located in the neck and shoulders. From this study, 25 of the 60 patients receiving NPMP in the RCT were invited to participate and 14 volunteered. Three did not show up for unknown reasons. A total of 11 patients participated, 10 women and one man. Patients ranged in age from 34 to 67 years. They all worked either in Health and Social Services, in a primary school or in a kindergarten. Among the patients, nine had completed the NPMP treatment

after 10–12 months and two were still receiving treatment for 3 and 6 months, respectively. The patients' pain problems were long-lasting, widespread ( $n = 5$ ), neck and shoulder ( $n = 4$ ) and back pain ( $n = 2$ ). Eight of the patients were working full time and three were partly on sick leave.

### **Focus-group interviews**

We conducted two focus-group interviews. The first was in October 2016 and involved seven patients; the second was in November 2016 and involved four patients. We prepared an identical interview guide for both interviews covering the following broad themes. How did you experience your health condition before the treatment? How did you connect your health condition to life occurrences? How did you experience the relationship with the physiotherapist during the treatment? How did you think that this relationship influenced the treatment process? We also prepared follow-up questions about concrete lived-through experiences to obtain richer descriptions.

In advance of the interviews, the themes were sent to the participants, giving them the opportunity to reflect upon them. Both interviews took place in a quiet meeting room at the first author's workplace. The interviews lasted for two and a half hours and were audiotaped. Initially, the moderator repeated the purpose of the study and encouraged the participants to describe how they experienced the interaction with the physiotherapist during the treatment sessions. Each participant was given approximately 10 to 15 minutes. Then, the participants commented and reflected on each other's stories and experiences. Both interviews ended by summing up the main points, allowing for additional comments from the participants (Kvale and Brinkmann, 2009). The second author and co-moderator wrote field notes during each interview, describing her experience of the non-verbal atmosphere of the interaction between the participants as well as keywords connected to the themes they discussed. The first author transcribed the focus-group interviews during the following days.

### **Analysis**

The further analysis of the transcribed focus-group interviews was inspired by Giorgi's (2009) phenomenological method. The aim was to reveal the patients' experiences at a more abstract level. Both authors participated in the four different steps of this analysis. Consensus during the different steps was reached by discussion. The field notes also contributed to give nuances and support to the analytic steps. The first

step started with both authors reading the interviews and field notes to get a global sense of the descriptions. In the second step, we established units of meaning and grouped them into subcategories related to the content. The keywords from the field notes were used during this step. In the third step, the meaning units were transformed into the researcher's voice (Giorgi, 2009). During this step, we considered and reconsidered the different aspects of the text to uncover and clarify the meaning of the experiences. Using our own experiences and knowledge during this process, we applied what Giorgi (2009) called free imaginative variation. In the fourth and final step, we searched for the general overarching structure of the patients' experiences. The transformed meaning units were the basis of the search (Giorgi, 2009). Both authors are NPMP physiotherapists and one is still working in clinical practice. Our previous experience in clinical practice might have influenced our preconceptions, but also contributed valuable insight during the analysis. However, we tried to keep an open-minded attitude and used our own experiences and knowledge in order to extract and understand the participants' expressions in the text.

## **RESULTS**

The analysis of the transcribed focus-group interviews resulted in the identification of a general, overarching structure which we called "Caring for others and developing self-care." The analysis revealed two themes in the descriptions of the essence of the explored experience from the treatment process. We have called these themes: 1) "Emerging awareness of overload during treatment"; and 2) "Receiving care from the physiotherapist." These two themes are interwoven and represent the essence of the patients' experiences. The first theme includes enhanced awareness of how burdens connected to relationships in their daily life had an impact on health. The second theme addresses how the relationship between the patient and the physiotherapist influenced the process of change during the treatment.

The general overarching structure will first be presented. The description of the two themes will then follow, including first the analytic text across the material then different examples and a number of quotations to highlight the variety and depth of the empirical material.

### ***Caring for others and developing self-care***

Most of the patients described how, over time at home and at work, they experienced burdens of responsibility as caregivers in their close relationships. During the



treatment, they gradually, both as a result of the hands-on and verbal interactions, became aware of how these burdens were a source of strain with a negative impact on their self-care and health. Furthermore, the patients described how the care from the physiotherapists enhanced their awareness of their own needs and facilitated a growing development of self-care. However, they maintained an ambivalence in terms of how much they should continue to care for others and how much they should care for themselves.

### **Emerging awareness of factors influencing the development and persistence of musculoskeletal pain**

All the patients described tasks of caring related to elderly relatives, sick parents, sick or disabled children and busy, demanding work situations with a high degree of social responsibility. Some patients were aware of how their demanding life situations contributed to their health problems. Others did not describe this kind of connection, either because they did not sense it or because they were not aware of this kind of connection. However, for most of the patients, the treatment process contributed to an increased awareness of the way that their burdens and caring tasks maintained or aggravated their musculoskeletal pain problems.

The patients described how, during the treatment, the physiotherapists observed their bodily reactions and shared their observations with them. This interaction gradually made them more aware of their own bodily sensations, reactions, and actions. Many patients described how they became aware of the fact that they tended to provide care for others beyond their own capacity (e.g. offering too much help to family members or accepting and taking too much responsibility at work or in their spare time). One patient described how, through the treatment, she gradually sensed that she tensed her jaw and hunched her shoulders when she pushed herself too far by taking on too much responsibility at work in addition to looking after her elderly father at home. She also discovered that she was too often willing to make an extra effort to help everyone else. She said:

*Now I notice how I clench my jaw and hunch my shoulders and hold my breath when I run around serving my colleagues coffee and generally making things nice for them – a responsibility I have taken upon myself. I am now more aware how this have an impact on my neck and shoulder pain.*

Another patient, a young teacher with long-lasting neck pain, described how, through the treatment, she became

aware of factors increasing her pain. Five years previously, she had been involved in a car accident and since then suffered from neck pain. Despite this, she still assumed a lot of responsibility and seldom refused when family members asked her for help. Over time, she gained a better understanding of the emergence of her pain. She said:

*Over time, I realised how different tasks like the heaviest lifting and vacuuming increased my pain.*

Another young patient, a teacher with long-lasting shoulder pain, shared similar experiences of enhanced awareness of factors that increased her pain. At the first treatment session, the physiotherapist commented on how she was sitting, leaning forwards in the chair, as if ready to leap. Being unaware of the position, the physiotherapist asked if this was her habitual sitting position. This made her reflect upon, not only her sitting position but also how she was ready to act in different situations both at work and at home. At work, she often worked extra hours as well as volunteering on committees. At home, she was trying to keep up with her partner's fast, efficient pace when shopping and eating, and other activities. Later in the treatment, she explored how much responsibility she ought to take. She realized that she had set off in an unfortunate direction and that this had to change. With a sigh, she said:

*It seems that for a long time, I have been adapting to everyone else. If my pain is to decrease, I have to make some changes and take better care of myself, and find my own rhythm and pace.*

A middle-aged patient with widespread pain, described a very stressful work situation. She shared her experiences of the treatment process. Early in her treatment, she noticed how during particularly busy periods she would tighten her muscles and experience pain in her neck and back. Later in the treatment process, she became more curious about this pattern of muscle tension and tried to explore how this influenced her experience of pain. She gradually became aware how she always eagerly met her colleagues' requests for help and favors. She realized that she had to change this pattern by saying no to colleagues or giving herself more time to fulfil her own tasks.

Several of the patients had extensive care responsibilities at home. Two patients had harrowing situations related to caring for mentally disabled children. They each described how their child's need for help and care took up most of their free time and defined their way of living. They set aside their own feelings and needs and ignored their bodily reactions. One of them explained:

*For many years, it was like there was a blockage at my neck. I had to ignore all the signals my body was sending about being tired or hurt or anything. Because there was nothing I could do about it anyway.*

Another patient, working as a preschool teacher, suffered from a stiff neck and breathing problems. She spoke about extensive strain due to her son's addiction problems. At work, her shame regarding this situation caused her to hide her problems from friends and colleagues. In addition, she felt very stressed and anxious and constantly hunched her shoulders causing her neck to lock. She exercised a lot, often with high intensity, hoping that this would relieve her pain. However, the tendency to overdo training resulted in increased pain. She gradually became aware of the connection between her breathing problems, her stressful lifestyle and worries for her son. Another patient struggled with her breathing and learnt how this problem was related to different life situations. Beyond her general tendency to be too energetic and to be in control of specific situations, she had for several years been responsible for the care of her mother who suffered from dementia.

In contrast to most of the other patients, one patient said that she had known for a long time that her pain, particularly the pain in her shoulder, was linked to earlier stresses in life, both privately and at work. However, she had addressed this and tried to heal her pain without any improvements. She therefore believed that there was little she could do to influence her pain. She explained:

*I have had three active children and know that my shoulder has been subjected to a lot of strain and other stressful life situations too. However, this is all in the past. Things are good now and much less stressful.*

### **Recognition and development of self-care**

The patients described how they valued the physiotherapists' ability to be present, their sensitivity during the hands-on and how they were listened to during the treatment. All the patients experienced a high degree of care in their treatment. In the first treatment session most of them established a good relationship with the physiotherapist. One of the patients, being skeptical about the treatment, described how the physiotherapist made her feel safe by taking her problems seriously. This approach was very important, as the patient had a great number of problems in her life during the treatment period. Because of the safe atmosphere and good relationship with the physiotherapist, she was able to open up and resolve many issues. For example, she discussed how to relate to family members and colleagues. She

believed this influenced her positive treatment outcome. She said:

*If I had not felt so safe, I probably wouldn't have opened up. It was very liberating to be able to explore feelings and experiences. For me, it was really good and I am not sure if the treatment had suited me so well if this had not happened.*

Several patients described how the switch between the verbal and the body-oriented approach in the treatment felt very natural. In some sessions, they spent a lot of time reflecting on different topics, while in others the body-oriented approach dominated. Generally, the physiotherapist initiated and steered what happened in the session. The patients were all surprised by how present, sensitive and aware the physiotherapists were during the treatment. They all felt that their needs were addressed. One patient, suffering from neck and shoulder pain for years, explained that she felt so confident in her relationship with the physiotherapist that she even dared to share an experience she never before had communicated to anyone else. In addition to neck pain and dizziness, the patient had weight problems and told the physiotherapist that she wanted to lose weight during the treatment period. The physiotherapist was supportive. Although the patient did not manage to fulfil her intention, she was nevertheless very grateful that the physiotherapist continued to meet her with acceptance. She said:

*I was very grateful to experience a non-judgemental attitude, even though I did not manage to attain my goals. I really felt being accepted.*

The patient continued describing how she gradually changed her attitude toward herself during the treatment process. One aspect of this change was taking more responsibility for her own care.

Several other patients also described how the care they experienced through both the verbal discussion and the body-oriented approach, helped them to become more in tune with their own body, feelings, and needs. As another patient said:

*The fact that someone saw me, was concerned about me, and did something good for me, meant a lot and made me act more kindly towards myself.*

Several patients valued the individualized NPMP approach. One patient, a teacher, described how important it was for her that the physiotherapist saw her as a whole person and not just as a painful back or knee. Like many of the other patients, she appreciated the physiotherapist's flexible and solution-oriented approach. She shared an example from her treatment process. Despite having a painful knee, she was

supposed to be going on a cycling holiday. The physiotherapist helped her find solutions to overcome the obstacles and take this holiday.

Many patients described the physiotherapists as acting directly and rather strictly. One young patient said that at the first session the physiotherapist asked her to remove her chewing gum because it negatively influenced her breathing pattern. The patient was a little surprised, but thought that at least the physiotherapist had expressed herself clearly, a characteristic that she valued. As she also sensed being met with both interest and openness, she felt a safe and trustful atmosphere develop. Over time, she herself became more able to talk in a direct way to the physiotherapist. She also sought advice with concrete questions. However, the physiotherapist never gave distinct advice, but rather answered her by returning her question. She put it like this:

*I might ask her a question about why something happened, and the physiotherapist responded by posing me another question, thus, stimulating my reflection*

She further explained that she gradually discovered how she was locked in certain patterns of movements, like always keeping a fast pace when carrying out a task. Several other patients attached importance to the way the physiotherapists asked questions. They experienced it as valuable and a useful way to make them aware of how to get in touch with their own thoughts, feelings and needs. However, one of the patients felt that the questions were probing for her problems. She was stuck with the notion that only a surgical operation could solve her health problems.

All the patients cited the value of having time and tranquility in the treatment. This gave them the opportunity to explore and become in touch with their body. Several patients further described how this enhanced body awareness helped them to change habits in concrete situations in daily life. Experiencing bodily what influenced their physical discomfort, guided them to decide whether it was a matter of saying no, slowing down or using less power. Gradually, they implemented these body-based experiences between treatment sessions. As one patient put it:

*Eventually, I was able to realise that I could slow down a bit, and the fact that this helped, meant that I kept on practising it more.*

Another described it thus:

*I have spent a lot of my time looking after everyone else. As I lay on the bench, I got in touch with my feelings and had a lot of thoughts, and I was a bit overwhelmed when I discovered that it can't go on like this any longer, because I have to look after myself as well.*

The same patient described how she changed her fitness routine from training a lot and very intensively to doing gentler forms of exercise such as yoga and Pilates. She also gave herself more time to relax and breathe.

Many of the patients described how the physiotherapists listened to them in a genuine, authentic and caring way. One of the patients attached particular importance to this. She found that health professionals rarely saw her situation as the mother of a mentally disabled son with extraordinary needs. In contrast, the physiotherapist showed great understanding of her situation. The care she received in the treatment paved the way for self-care and the ability to be present in the moment. Among other things, the physiotherapist recommended that she focus on the sensations in the soles of her feet when she was out walking. She said:

*I was supposed to practise focusing purely on the sensations in my feet when I was walking. It was incredibly good to limit my attention in this way.*

Several patients highlighted how the physiotherapist encouraged them to assume *responsibility for their own process of change*. They underlined how the physiotherapists' skill was required both in order to enter this process and to complete it. They valued the way that the physiotherapists engaged in their process, as well as cared for them without too many requirements and expectations. Several patients also appreciated how the physiotherapists confirmed their thoughts and feelings.

## DISCUSSION

The purpose of the present study was to grasp patients' experiences of how social burdens influence development and persistence of symptoms of musculoskeletal pain and how the relationship with the physiotherapist influenced their process of change during NPMP treatment. We will in the following discussion bring in the theory and perspectives of recognition, Norwegian psychomotor physiotherapy and previous research to provide a deeper understanding of our results abstracted in the two themes: 1) Recognition and relational life experiences; and 2) Recognition and developing self-care during treatment. Finally, we discuss the methodological aspects of the study.

### **Recognition and relational life experiences**

Many of the patients in the current study were not aware how their own experiences and burdens in life affected their health. Before receiving the NPMP treatment, they described how they had been living demanding lives with many burdens and activities. They seemed to cope



with these demands in different ways, for example, by trying to please others or by taking on too much responsibility at work and in their spare time. For some of the patients, these coping strategies might be seen as a kind of struggle for recognition because of fear for disrespect. Honneth (1996) explained that disrespect is an abusive behavior (i.e. humiliation, deprivation of rights, and degradation). It has a negative impact on identity and self-understanding and it influences health. He further claims that recognition cannot be taken for granted, but must be fought for. The starting point for the fight is fear of negative feelings triggered by not being recognized. In light of Honneth's theory, a patient's struggle might be linked to fear of negative feelings activated by disrespect, like the patient with the son with drug addiction who hid her family situation because of shame. The emotional content of shame is a kind of lowering of one's own feelings of self-worth. Feeling ashamed might include experiencing oneself as being of lower social value. Honneth (1996) held that individual development is socially acquired, and primarily take place in family, civil society, and the country.

Other patients might be influenced by the fear of lack of (self) respect and therefore choose to take on too much responsibility connected with care for colleagues and family members. Consequently, they have to neglect and suppress their own feelings and needs.

Patients' coping strategies seemed to influence their health condition in different ways. Musculoskeletal pain, however, emerged and gradually restricted their activities, making them search for treatment. According to Braatøy (1947), muscle pain might be explained as a consequence of sustained muscle contraction in order to suppress unpleasant feelings. As such, muscle contraction and pain seemed to contribute in the regulation of the patient's feelings and needs.

Recognition is a fundamental need and particularly when we get ill and are separated from one's normal experience of oneself (Schibbye, 2009). At the first encounter the patients experienced a safe and open atmosphere. Through the body examination, they discovered that the physiotherapist took their pain problems seriously. They also found, in line with Ekerholt and Bergland (2004), that the examination helped them to better understand their bodily symptoms. Throughout the treatment, they were satisfied with the care they received from the physiotherapists. Braatøy (1952) emphasized how care and respect for the patient is a meaningful therapeutic tool. The patients also valued the physiotherapists' presence and their sensitivity during the hands-on treatment and how they respectfully listened to them. The intertwined aspects of recognition (listen, understand, accept, tolerate, and

confirm), described by Schibbye (2009), seemed to create a safe and open atmosphere in the treatment sessions. In such a context, the patients became able to explore their pain problems. For example, through the touch and massage of painful body parts, the physiotherapist noted whether the patient tensed up or changed the rhythm of their breathing. The physiotherapists then gave a break to reflect on these reactions. Based on the reactions to touch, the patients were invited to participate in the treatment process in line with the study by Bjorbaekmo and Mengshoel (2016). In the current study, this shared experience through touch was crucial for the patient to become more connected with their own bodies. This is in line with Stern's (1985) theories emphasizing that bodily contact and interaction are the earliest experiences and the primary level of contact.

Gradually, the patients became in contact with areas of their body that they had previously been unaware of. Through this enhanced body awareness, they learned to understand themselves and discovered how external and internal events influenced their feelings and experiences. The emergent awareness of their own body reactions also made them interpret body sensations and signals differently. They seemed to connect them to their own feelings, personal style as well as their musculoskeletal pain problems. Like the young teacher gradually becoming aware of the connection between her long-lasting pain and how she copied the efficient pace of her colleagues and her partner. How enhanced bodily awareness influences self-perception and self-knowledge is described in other studies (Dragesund and Raheim, 2008; Øien, Råheim, Iversen, and Steihaug, 2009; Sviland, Råheim, and Martinsen, 2012). Once patients were more in touch with their own body, they also became more familiar with its reactions. They gradually became aware how they tended to provide care beyond their own capacity, like offering too much help to family members or accepting and taking on too much responsibility at work. They learned to recognize how these burdens were a source of strain with a negative impact on their own musculoskeletal pain problems. Honneth (1996) argued that the inevitable dependence on others for identity formation renders people vulnerable for recognition. As such, the relationship to others influences feelings about oneself and recognition is a crucial component in the creation of a good relationship. Furthermore, Honneth (1996) pointed out that recognition has a preventive or healing effect of the experience of not being recognized. In the light of love, rights and solidarity, the three aspects of recognition in Honneth's theory Honneth (1996), the patients experienced being appreciated by the physiotherapists. To be valued might

give hope that change is possible. Similar therapeutic pre-conditions are described by patients in earlier studies of NPMP treatment (Ekerholt and Bergland, 2004, 2006, 2008; Øien, Iversen, and Stensland, 2007; Øien, Råheim, Iversen, and Steihaug, 2009; Sviland, Martinsen, and Råheim, 2014; Sviland, Råheim, and Martinsen, 2012).

### **Recognition and developing self-care during treatment**

The patients in the present study valued the individualized NPMP approach and being seen as a whole person with a variety of obligations. In the safe and trustful atmosphere, they became more in touch with own bodies and feelings. Trust, time, open speech, as well as being respectfully listened to by the physiotherapist are valued elements in NPMP treatment (Ekerholt and Bergland, 2006, 2008; Sviland, Råheim, and Martinsen, 2012).

Through the enhanced awareness, the link between pain history and life events emerged and some of the patients in the present study shared life stories they had never told before. The experience of being listened to without judgment seemed to be a gift for them. According to Schibbye (1993, 2009), recognition means trying to understand and take the other person's perspective, but not to have the same opinion as the other. Furthermore, she emphasizes the relevance of focusing and appreciating the other person's inner world of experience and also to keep a professional distance to assess what is most adequate in a given situation.

The patients in the present study also expressed gratitude for the time they were given to explore relevant issues in order to improve contact with their own body. Honneth (1996) emphasized that without encouragement and affection (love) from others, one might not have the confidence to involve oneself fully in social settings. The experience of love through the intertwined NPMP approach of touch, movements and reflection, engaged the patients and involved them in the treatment process. This involvement included taking more responsibility for themselves.

The patients also experienced a sense of shared purpose with the physiotherapists, which further strengthened their involvement in the process of change. They found that the physiotherapists gave them enough space and permission to move forward in the process at their own pace. The sense of warmth and affection that the patients received from the physiotherapists also made them feel respected. In line with Honneth's (1996-) second aspect of recognition, rights, the patients seem to experience the physiotherapists' approach as respect

for their autonomy. Sensitivity, affection, and respect thus seemed to stimulate the patients' involvement in the treatment.

According to Honneth's theory Honneth (1996) recognition influences the relation to self. Through experience of friendship and love, self-confidence and an ability to love oneself and others develops. This development is a process, by which we individuate self distinctly from others (Honneth, 1996). Through the special relationship with the physiotherapists and their treatment approach, the patients seemed to become aware of their own uniqueness and formed a positive image of their own abilities. The patients changed their attitude toward their own body from neglecting its signals to using it as a source of knowledge. By listening to their body and gradually finding new ways to handle choices and change habits in their daily life, they implicitly took better care for themselves. Experiencing bodily what influenced their discomfort and helped them, whether it was a matter of saying no, slowing down or using less energy. As such, the sensed embodied experiences helped them to change habits in concrete situations in daily life.

According to Honneth (1996) an intersubjective recognition of one's own abilities and achievements is required in order to achieve a productive relationship with oneself. The process of being recognized by the physiotherapist and becoming more in touch with one's own body, might be seen as such a change. In light of Honneth's recognition theory Honneth (1996) these changes might be understood as self-realization, including being aware of one's own needs and utilizing one's own skills to realize personal goals. Again, recognition from others is a premise in order to develop this self-realization. According to Honneth (1996) self-confidence, self-respect and self-worth are the foundations of autonomy and agency. Through the relationship with the physiotherapists in the treatment sessions, they experienced that improved bodily sensation and contact made a difference by changing their relationship with themselves. Self-relation is gained from the experience of being treated as a mature person (Honneth, 1996). Thus, the care from the physiotherapists during the NPMP treatment gradually made the patients in this study take more care of themselves.

### **Methodological consideration**

The strength of the qualitative studies depends on the researcher's care and judgment. Malterud (2001) proposed reflexivity, validity, and relevance to be important properties in order to consider the quality of a study. Reflexivity concerns an attitude of attending

systematically to the context of knowledge construction. The researcher's influence on every step of the research process is especially important. As such, the attitude of a systematic approach might also be a way of coping with the researcher's knowledge in advance (Malterud, 2001). We tried to act with reflexivity through discussions and negotiations at every stage of the research process.

Most of the patients had positive experiences from the NPMP treatment and this might have influenced the findings. However, in the discourse within each focus-group interview, positive experiences from the treatment was not the focus of the analysis. The focus was to grasp patients' experiences of factors influencing development and persistence of symptoms of musculoskeletal pain and how the relationship with the physiotherapist influenced their process of change during Norwegian Psychomotor Physiotherapy (NPMP).

Focus-group interviews are well suited for exploring common experiences, but may also induce conformity (Morgan, 1997). It is also claimed that these interviews are more likely to empower the participants (Madriz, 2000). In that respect the number of participants and quality of interaction are essential. The number of patients in the two focus-group interviews in this study varied from four to seven. Spontaneous discussions and shared experiences were present in both groups. In the smallest group (four patients), however, the conversation was going deeper into each patients experiences. The limited range of total experiences discussed in the smallest group might have influenced the research material. For the same reason, the question can be raised whether individual interviews would have been more suitable. The interview material in this study, however, consist of shared themes quite thoroughly discussed, as well as of individual stories reflected upon by the other participants.

The internal validity was strengthened by aspects such as a good atmosphere, a willingness to share as well as the confirmation of the face validity of shared experiences present in both groups. The variety and nuances in the main themes point to richness in the material.

The fact that both researchers are NPMP physiotherapists with extensive clinical experience may have had an impact on the findings. However, this may also have added strength to the validity of the findings. Through the different steps of the study, we tried to hold back our preconceived ideas and theories by constantly returning back to the descriptions of the patients' experiences. As such, the results gave new insight about how the patients experienced to be stuck in demanding lives being less able to take care

of themselves. In an unexpected positive direction, the treatment extended their space of action followed by improved self-care. The content of the findings is limited to the participants in the study. However, the findings might be relevant to comparable therapeutic settings and should be evaluated to determine their value in practical use.

## CONCLUSION AND CLINICAL IMPLICATIONS

The clinical implication of this study emphasizes the relationship aspects between the patient and the physiotherapist during NPMP treatment. To be recognized and cared by the physiotherapists, both through the hands-on treatment and verbal communication, appears to be crucial for patients to develop an awareness of the factors causing and sustaining their musculoskeletal pain problems. This awareness seemed necessary for the process of change to take place and for patients to begin taking more responsibility for their own care. Thus, awareness and development of own relational skills as physiotherapists might be useful perspective in order to promote positive interactions and change during treatment.

## Acknowledgments

We thank the patients for participating in the study. The study was financially supported from the Norwegian Fund for Post-Graduate Training in Physiotherapy.

## ORCID

Tove Dragesund  <http://orcid.org/0000-0001-7576-9111>

## Declaration of Interest

The authors declare no potential conflicts of interest.

## References

- Bjorbaekmo WS, Mengshoel AM. 2016. "A touch of physiotherapy" The significance and meaning of touch in the practice of physiotherapy. *Physiotherapy Theory and Practice* 32(1): 10–19. DOI:10.3109/09593985.2015.1071449
- Braatøy T. 1947. *De Nervøse Sinn (The Nervous Mind)*. Oslo: Cappelen
- Braatøy T. 1952. *Pasienten og Lægen (The Patient and the Doctor)*. Oslo: Cappelen
- Dragesund T, Øien AM. 2019. Demanding treatment processes in Norwegian psychomotor physiotherapy: From the physiotherapists' perspectives. *Physiotherapy Theory and Practice* 35(9): 833–842. DOI:10.1080/09593985.2018.1463327

- Dragesund T, Øien AM. 2020. Transferring experiences of change from treatment into daily life. *Patients Experiences from Physiotherapy*. *International Journal of Qualitative Studies in Health and Well-Being* 15: 1735767
- Dragesund T, Raheim M. 2008. Norwegian psychomotor physiotherapy and patients with chronic pain: Patients' perspective on body awareness. *Physiotherapy Theory and Practice* 24(4): 243–254. DOI:10.1080/09593980701738400
- Ekerholt K, Bergland A. 2004. The first encounter with Norwegian psychomotor physiotherapy: Patients' experiences, a basis for knowledge. *Scandinavian Journal of Public Health* 6(6): 403–410. DOI:10.1080/14034940410029441
- Ekerholt K, Bergland A. 2006. Massage as integration and a source of information. *Advances in Physiotherapy* 8(3): 832–840. DOI: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. DOI:10.2522/ptj.20070316
- Ekerholt K, Bergland A. 2019. Learning and knowing bodies: Norwegian psychomotor physio-therapists' reflection on embodied knowledge. *Physiotherapy Theory and Practice* 35(1): 57–69. DOI:10.1080/09593985.2018.1433256
- Ekerholt K, Gretland A. 2018. Norwegian psychomotor physiotherapy, A brief introduction Probst MS, Skjærven LH, Eds. *Physiotherapy in mental health and psychiatry*. 51–58. Amsterdam: Elsevier
- Ferreira PH, Ferreira ML, Maher CG, Refshauge KM, Latimer J, Adams RD. 2013. The therapeutic alliance between clinicians and patients predicts outcome in chronic low back pain. *Physical Therapy* 93(4): 470–478. DOI:10.2522/ptj.20120137
- Gard G, Gyllensten LA. 2004. Are emotions important for good interaction in treatment situations? *Physiotherapy Theory and Practice* 20(2): 107–119. DOI:10.1080/09593980490452995
- Giorgi A. 2009. *The descriptive phenomenological method in psychology: A modified husserlian approach*. Pittsburg, Pennsylvania: Duquesne University Press
- Gyllensten AL, Gard G, Salford E, Ekdahl C. 1999. Interaction between patient and physiotherapist: A qualitative study reflecting the physiotherapist's perspective. *Physiotherapy Research International* 4(2): 89–109. DOI:10.1002/pri.156
- Hall AM, Ferreira PH, Maher CG, Latimer J, Ferreira ML. 2010. The influence of the therapist-patient relationship on treatment outcome in physical rehabilitation: A systematic review. *Physical Therapy* 90(8): 1099–1110. DOI:10.2522/ptj.20090245
- Honneth A. 1996. *The Struggle for Recognition: The moral grammar of social conflicts*. Translated by Joel Anderson. Massachusetts: The MIT Press Cambridge.
- Kvale S, Brinkmann S. 2009. *InterViews: Learning the craft of qualitative research interviewing*, 2. Thousand Oaks: CA Sage Publications, Inc
- Laerum E, Indahl A, Skouen JS. 2006. What is “the good back-consultation”? A combined qualitative and quantitative study of chronic low back pain patients' interaction with and perceptions of consultations with specialists. *Journal of Rehabilitation Medicine* 38(4): 255–262. DOI:10.1080/16501970600613461
- Madriz E. 2000. Focus groups in feminist research, In: Denzin NK, Lincoln YS (Eds). *Handbook of qualitative research*, (2<sup>nd</sup> ed), p. 835–850. Thousand Oaks: CA Sage Publications, Inc
- Malterud K. 2001. Qualitative research: Standards, Challenges, and Guidelines. *Lancet* 358(9280). 483–488
- Malterud K. 2010. Kroniske muskelsmerter kan forklares på mange måter [Chronic muscular pain is not unexplainable]. *Tidsskrift for Den Norske Legeforening* 130(23): 2356–2359. DOI:10.4045/tidsskr.09.0828
- Merleau-Ponty M. 2012. *Phenomenology of Perception*. London: Routledge
- Morgan DL. 1997. *Focus Groups as Qualitative Research*. Thousand Oaks CA: Sage Publications
- O'Keeffe M, Cullinane P, Hurle J, Leahy I, Bunzli S, O'Sullivan PB, O'Sullivan K. 2016. What influences patient-therapist interactions in musculoskeletal physical therapy? Qualitative systematic review and meta-synthesis. *Physical Therapy* 96(5): 609–622. DOI:10.2522/ptj.20150240
- Øien AM, Iversen S, Stensland P. 2007. Narratives of embodied experiences - Therapy processes in Norwegian psychomotor physiotherapy. *Advances in Physiotherapy* 1(1): 31–39. DOI: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. DOI:10.1080/14038190802315073
- Øien AM, Steihaug S, Iversen S, Raheim M. 2011. Communication as negotiation processes in long-term physiotherapy: A qualitative study. *Scandinavian Journal of Caring Science* 1(1): 53–56. DOI:10.1111/j.1471-6712.2010.00790.x
- Schibbye AL. 1993. The Role of “Recognition” in the resolution of a specific interpersonal dilemma. *Journal of Phenomenological Psychology* 24(2): 175–189. DOI:10.1163/156916293X00134
- Schibbye AL. 2009. *Relasjoner. Et Dialektisk Perspektiv på Eksistensiell og Psykodynamisk Psykoterapi [Relationships: A Dialectical Perspective on Existential and Psychodynamic Psychotherapy]*, pp. 57–256. Oslo: Universitetsforlaget
- Skjærven LH, Kristoffersen K, Gard G. 2010. How can movement quality be promoted in clinical practice? A phenomenological study of physical therapist experts. *Physical Therapy* 90(10): 1479–1492. DOI:10.2522/ptj.20090059
- Steihaug S. 2005. Can chronic pain be understood? *Scandinavian Journal of Public Health (Suppl)* 66 (66\_suppl): 36–40. DOI:10.1080/14034950510033354
- Stern DN. 1985. *The Interpersonal World of the Infant*: New York: Basic Books.
- 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. DOI:10.1007/s11019-014-9562-0
- Sviland R, Råheim M, Martinsen K. 2012. Touched in sensation - Moved by respiration: Embodied narrative identity - A treatment process. *Scandinavian Journal of Caring Science* 26(4): 811–819. DOI:10.1111/j.1471-6712.2012.01024.x
- Thornquist E. 2006. Face-to-face and hands-on: Assumptions and assessments in the physiotherapy clinic. *Medical Anthropology* 25(1): 65–97. DOI:10.1080/01459740500514489
- Thornquist E, Bunkan BH. 1991. *What is psychomotor physiotherapy*. Oslo: Norwegian University Press