“Crawling Out of the Cocoon”: Patients’ Experiences of a Physical Therapy Exercise Intervention in the Treatment of Major Depression

Louise Danielsson, Birgitta Kihlbom, Susanne Rosberg

Background. Although the effectiveness of physical exercise for depression has been studied for many years, few studies have described patients’ experiences of what exercise means to them, beyond the biological focus. Moreover, exercise as a treatment for depression is rarely explored in a physical therapy context.

Objectives. The purpose of this study was to explore a physical therapy exercise intervention, as experienced by people with major depression.

Design. This study had an inductive approach and used qualitative content analysis.

Methods. Semistructured interviews were conducted with 13 people who participated in physical therapist-guided aerobic exercise in a randomized controlled trial. All participants were diagnosed with major depression according to the Diagnostic and Statistical Manual of Mental Disorders. Data were collected and analyzed in an inductive manner using qualitative content analysis according to Graneheim and Lundman.

Results. Four categories emerged: (1) struggling toward a healthy self, (2) challenging the resistance, (3) feeling alive but not euphoric, and (4) needing someone to be there for you. The participants experienced that although the exercise intervention was hard work, it enhanced the feeling of being alive and made them feel that they were doing something good for themselves. These feelings were a welcome contrast to the numbness and stagnation they experienced during depression.

Limitations. The study was conducted in Swedish primary care. Transferability of results must be viewed in relation to context.

Conclusions. Exercise in a physical therapy context can improve the patients’ perception of their physical ability and create a sense of liveliness, improving their depressed state. The therapeutic relationship is essential for supporting the patient’s vulnerability and ambiguity in an empathic and perceptive way.
The positive effects of exercise on depression were documented as early as 1905. A common definition of exercise is a planned, structured, and repetitive physical activity to increase or maintain physical fitness (eg, aerobic capacity). Several methodologically robust trials have supported the antidepressant effects of exercise, although other trials concluded that exercise is not more effective than standard care or active controls. Guidelines propose that exercise, preferably aerobic, can be used for depression, in addition to other treatments. The working mechanisms are as yet unclear, but research proposes biological mediators related to neurotransmission, neurogenesis, and growth factors. Most recently, attention is being given to the communication between muscle and brain through activation of skeletal muscles’ protein expression, which, in turn, influences neuronal plasticity. Beyond this attention, the antidepressant effects of exercise also seem to be mediated by psychological mechanisms such as self-efficacy.

Despite the growing attention to exercise as a treatment for major depression, studies involving patient’s perspective are sparse. Searle et al concluded that patients with depression mainly perceive exercise as an acceptable treatment. They associated the enhanced mood with both biochemical changes and seeing exercise as a source of distraction from ruminating thoughts, as well as with having a sense of purpose. Low motivation and a lack of confidence are strong barriers to physical activity, and the authors proposed that initial medication can help to start and maintain activity. Perceived important facilitators for exercise are suggested to involve the relationships with health-promoting professionals, the rise in self-confidence resulting from participation, and the tailoring of exercise to suit individual circumstances. Addressing the concepts of variability and contextuality, Faulkner and Biddle emphasized that it is fundamental to consider the wider context of participants’ lives in the quest for understanding how exercise relates to psychological well-being.

In this study, the focus of exercise for treatment of depression moves beyond the structural and biological definitions. To deepen the understanding for what lived experiences of exercise mean to persons suffering from depression, a more holistic perspective is needed, where exercise is also viewed as an example of human movement. Some physical therapists promote human movement as an expression of the whole person and his or her life, with the healthy and the aesthetic dimensions of movement closely connected. This underpinning is a common ground for physical therapists in Sweden who specialize in working with patients having mental health problems. Internationally, there is an increasing number of countries, primarily European, with physical therapists specialized in working with movement from a mental health perspective. Although the suitability of physical therapists for promoting and delivering physical activity in psychiatric populations has been highlighted, exercise in a physical therapy context is still sparsely explored in research on depression.

Here, the theoretical perspective was inspired by the phenomenological concept of the lived body, as described by Merleau-Ponty. Our lived bodies are our means to engage in the world as participants; we perceive, feel, talk, think, relate, and act through our bodies, but, at the same time, our bodies are also objects through their organic and physical qualities. The lived body is intentional—it is constantly relating to the world around us, but simultaneously already immersed into it. This perspective acknowledges a natural, meaningful connection between subjective experiences and the physical body, overcoming the Cartesian mind-body split that underpins biomechanical views of body and movement.

Prior to this study, our research group conducted a randomized controlled trial, presented elsewhere, concluding that aerobic exercise has antidepressant effects. In the trial, the exercise intervention was guided by physical therapists using a person-centered approach. This approach meant that each person’s program was individually tailored, taking into account the patient’s expectations and previous experiences. It also meant a strong emphasis on the therapeutic relationship.

We wanted to go on to deepen our understanding of this exercise intervention as a wholeness involving both the experience of exercise itself and the context of the particular program. We wanted to grasp what the exercise intervention meant to the participants and how they experienced it in order to gain insight into important factors. The purpose of this study was to explore a physical therapy exercise intervention, as experienced by people with major depression.

Method

We used qualitative content analysis, as described by Graneheim and Lundman. The research approach in this method is inductive in the sense that it is committed in a curious and open way to the research task, rather than approaching the data with conceptualizations beforehand, such as a predefined coding scheme. The purpose of qualitative content analysis is to identify and describe similarities and differences in the data, expressed in categories. The level of abstraction in the analysis can differ, but the method acknowledges that all qualitative data involve both a manifest meaning (ie, a descriptive content close to the text) and a latent meaning (ie, that which is said to be “between the lines”). The method assumes that the generation of data is co-constructed between participants and researcher and is context-bound in the sense that it must be viewed in relation to the participants, to the researchers’ subjectivity and understanding, and to the research settings.

The preunderstanding at hand in our research group involved our previous studies exploring the embodiment of depression in a phenomenological framework. We had long clinical experience of working as physical therapists in the fields of primary care and psychiatry. Subjectivity in qualitative research is always a challenge, which we specifically addressed in 2 ways. First, we
attempted to practice a state of “persistent curiosity” in both the interviews and the analysis, that is, to approach the participants’ experiences with a genuine and wondering openness, an eagerness to be surprised, and a desire to see something new. Second, to hold back and “bridle” our own preunderstanding, we used a reflexive journal in which we continuously made explicit, reflected on, and challenged our assumptions during the study.

Participants and Procedure
The criteria for inclusion were: (1) a diagnosis of major depression according to the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)* criteria, determined with the Mini-International Neuropsychiatric Interview, and (2) participation in the exercise intervention of the trial mentioned above. Criteria for exclusion were: (1) suicidal tendencies, as judged by a psychiatrist in the research group, and (2) inability to speak Swedish.

During May to December 2013, 15 people from 2 cycles of the exercise intervention (one cycle during 10 weeks [March–May] and the other cycle during 10 weeks [September–November]) were invited to participate in the present study. Two of the invited people declined, one for reasons of time constraints and one who did not respond to the researcher’s attempts to schedule an interview. Thirteen participants were included (Tab. 1).

We used an iterative sampling procedure, meaning that the process of data collection and preliminary findings inform subsequent data collection, both regarding purposiveness and the size of the sample. One essential aspect was to include participants with both a beneficial outcome and a poor outcome in the depression assessment, as measured with the Montgomery-Åsberg Depression Rating Scale (Tab. 1). In this way, we attempted to include the “negative cases” to contribute to a richness and variation of experiences.

Exercise Intervention
Initially, the participants took part in 2 individual sessions with one of the 2 physical therapists working with the intervention. They had long experience (10–25 years) of working with people with mental health problems, both in psychiatric settings and in primary care. During these individual sessions, each participant’s program was developed using both physiological assessments (the Borg Perceived Exertion Scale and the Astrand Submaximal Test for Cardiovascular Fitness) and the person-centered approach described below. A pulse watch was used during the development of the programs to reflect on the perceived effort and to refine each person’s program further. During the following 8 weeks, the participants trained in small groups of a maximum of 8 par-

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measurement</th>
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<tbody>
<tr>
<td>Age (y)</td>
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<tr>
<td></td>
<td>Range 24–62</td>
</tr>
<tr>
<td></td>
<td>24–44 7</td>
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<td></td>
<td>45–62 6</td>
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<tr>
<td>Sex</td>
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<td></td>
<td>Male 2</td>
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<td></td>
<td>Part-time work 3</td>
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<td>Full sick leave 4</td>
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<td>Student 1</td>
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<td>Marital status</td>
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<td></td>
<td>Single 7</td>
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<td>Children living at home 3</td>
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<tr>
<td>Depression severity before intervention (MADRS)</td>
<td>Median 23</td>
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<td></td>
<td>Range 15–29</td>
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<tr>
<td></td>
<td>Mild depression 3</td>
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<td></td>
<td>Moderate depression 10</td>
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<tr>
<td>Depression severity after intervention (MADRS)</td>
<td>Median 12</td>
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<td>Range 2–28</td>
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<td></td>
<td>Mild depression 9</td>
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<tr>
<td></td>
<td>Moderate depression 4</td>
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<tr>
<td>Time from intervention to interview</td>
<td>&lt;2 wk 6</td>
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<td></td>
<td>2–8 wk 3</td>
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<td>9–14 wk 4</td>
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*a* Measured with observer-rated Montgomery-Åsberg Depression Rating Scale (MADRS). Scores are generally interpreted as: <20 points = mild depression, 20–35 = moderate depression, >35 = severe depression.
endure moments of anxiety. Another with the participant to help him or her to mean that the physical therapist stayed during training. Occasionally, it could and talk for a while; and for others, it participations, this support could mean closer support was called for. For some participants, this support could mean to sit and when he or when a participant had ideas for developing his or her program, these ideas were considered in a respectful way. Finally, the physical therapist tried to promote a warm, friendly atmosphere that would facilitate group coherence. The climate would open for interaction between members, but with no demands for it, such as pair openness for interaction between members.

We emphasized 3 factors in the physical therapist’s approach: support, collaboration, and atmosphere. The physical therapist was to support the anticipated ambivalence among the participants, which meant perceptiveness to when he or she needed to be guided more actively and when to stay more in the background. It could be through instructions about how to carry out the exercises, but, more importantly, it concerned perceptiveness to when and how emotional support was called for. For some participants, this support could mean closer guidance; for some, it could mean to sit and talk for a while; and for others, it could mean to be left more to themselves during training. Occasionally, it could mean that the physical therapist stayed with the participant to help him or her to endure moments of anxiety. Another part of the support was to promote acceptance and a “good-enough” attitude if someone felt especially low or fatigued. As for collaboration, the participants’ own ideas were encouraged, which meant that if or when a participant had ideas for developing his or her program, those ideas were considered in a respectful way. Finally, the physical therapist tried to promote a warm, friendly atmosphere that would facilitate group coherence. The climate would open for interaction between members, but with no demands for it, such as pair exercises.

Interviews

Semi-structured interviews were conducted, the initial 5 interviews by the second author (B.K.) during spring 2013 and the remaining interviews by the first author (L.D.) about 6 months later. We used a thematic interview guide with open-ended questions, including 4 topic areas: (1) direct and indirect changes following the intervention, (2) previous experiences of exercise, (3) views on exercise during depression, and (4) barriers and facilitators. The interview guide was approached in a flexible manner so that the course of the interview followed each participant’s narration. As more interviews were conducted, the interviewer introduced thoughts from previous interviews to elaborate on these reflections with the informants. This way of introducing the interviewer’s reflections grounded in data and connecting interviews with analysis was a way to foster trustworthiness and the validity of results. For example, content about identity connected to exercise was brought up, which we had not anticipated. Subsequently, we asked the question “How do you see yourself as an exerciser?” in the interviews that followed. This approach made more nuanced data emerge about recognizing something healthy about oneself or feeling sad about being different or outside of a healthy society.

The interviewer recorded the interviews using a digital audio voice recorder and transcribed the audio files verbatim shortly after each interview. In addition, the interviewer took notes during the interviews, which were added to the overall textual data material. The interviews lasted between 29 and 65 minutes, with a mean length of 42 minutes.

Data Analysis

In accordance with procedures in qualitative content analysis, we began by reading all of the textual data to achieve immersion with the data and to grasp a sense of the whole. Each transcript was then systematically and closely read, deriving exact statements from the transcripts that appeared to carry a meaning relevant to the purpose. These statements constituted the meaning units for the analysis, which were condensed by shortening the text while still preserving the core. The condensed statements were then coded in a way that captured the meaning but allowed the data to be seen in a new way. For example, a statement of how “the body feels stiff, but more alive” was coded “vitalization,” which allowed the underlying meaning of new and richer sensations to be interpreted as signs of health and life.

As a strategy for validation, we independently coded the first 5 interviews. The coding schemes were compared and discussed until a consensus was achieved. Codes were then clustered on the basis of their content to form subcategories that reflected the commonalities and nuances of meaning. This clustering

![Figure 1. General structure of a physical therapy exercise intervention for depression explored in a qualitative study reflecting patients’ experiences.](https://academic.oup.com/ptj/article-abstract/96/8/1241/2864887)
meant moving back and forth between meaning units, codes, and groups of codes, trying in different ways to structure the content in a way that would capture the participants’ experiences. The subcategories were then abstracted into categories. This phase involved further reflection on the latent meaning connected to each subcategory (see Tab. 2 for examples). Latent meaning emerged more clearly in this last step of moving from subcategories to categories, relating the categories to each other and to the data as a whole.

The interviews and the initial phases of analysis were conducted in Swedish. However, in the phase of grouping the codes and describing the emerging subcategories, we worked with both Swedish and English expressions. The reason for this approach was to maintain rigor and sensitive closeness to the data,28 in terms of translating the meaning and cultural nuance from Swedish into English, which we chose to initiate during the analysis. In this way, we tried out ways to translate the descriptions and headings of the subcategories while still in the phase of moving back and forth between the parts and the whole of the data. This procedure enabled a comparison of the meaning of the translated expressions with the empirical data. The translations in the draft of the study were then checked with a bilingual professional translator.

Ethical Considerations
None of the participants had suicidal tendencies or current thoughts of self-harm as assessed by the trainee psychiatrist using the Mini-International Neuropsychiatric Interview.29 Participants were encouraged to contact the research group after the interview if they had questions or felt emotional distress. The flexible and collaborative interview approach was chosen partly from an ethical point of view, aiming at letting the participant choose the course of the conversation. The participants gave their informed consent to participate, which included ensured confidentiality and that participation was voluntary, with the right to withdraw from the study at any time.

Role of the Funding Source
The study was financially supported by regional funds from Västra Götaland, the University of Gothenburg Centre for Person-Centred Care, and the Renée and Henry Eandi Fund, Sweden.

Results
The participants’ experiences of the exercise intervention emerged as 4 categories, reflecting qualitatively different yet connected meaning. The meaning of each category is presented below, including direct quotes to illustrate the described experiences. Figure 2 illustrates the categories with their respective subcategories.

Struggling Toward Your Healthy Self
This category reflects the participants’ experiences that the exercise intervention sparks a sense of being capable, as physically active people, in contrast to feeling entrapped in their depressed state. They described that they wanted to lead a more active and healthy lifestyle, feeling like outsiders because “everybody else” around them was physically active. For some participants, this involved the experience that exercise is not for them, which did not change during the intervention. Relating to the intervention, the participants described a certain pride in being able to tell friends and family that they have been working out. Struggling with their exercise programs reconnected participants to their healthy selves, making them feel a bit “good and healthy in body and mind.”

For some participants, previous physical activities that used to be a source of joy got lost along the way as a result of mental illness or life circumstances. These participants talked about exercise as a means to reapproach oneself as the person you want to be and want to see yourself as. Parts of the person’s self-image and identity can be restored via exercise:

Since I’ve been exercising, like, always...then to suddenly not being able to,...it’s like you don’t really know who you are. So it’s this thing about trying to find myself again, I think.

Challenging the Resistance
This category captured the experience of exercise as a challenging act of doing, understood both as a possibility and as a barrier, relating to depression’s resistance and vagueness. It is not the wanting to do things that is failing, it is the ability to carry them out, as explained by the participants:

Right now, when I’m feeling low, it’s hard, even though people say, “Pull yourself together and just go to the gym.” It’s not that hard. Get off your lazy ass. But if you’ve tried to get off your lazy ass for months, then you just can’t anymore. Doesn’t matter how much people nag you.

Some participants felt that the exercise intervention was boring and reminded them of the physical education in school. Exercise like this is not for fun, it is something you just force yourself to do, “like physical education but for adults,” said...
Table 2
Examples of the Interpretative Process Going From Participants’ Statements to Categories in a Study Exploring Experiences of an Exercise Intervention for Major Depression

<table>
<thead>
<tr>
<th>Examples of Meaning Units</th>
<th>Codes</th>
<th>Analytic Reflection</th>
<th>Subcategory</th>
<th>Analytic Reflection</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>It feels like I’m coming back to myself, both body and mind. I’m taking them back so to speak.</td>
<td>Recognition</td>
<td>Recapture and return to a vital and healthy self</td>
<td>Taking back a lost active self</td>
<td>This reflects a feeling that if you are not physically active, you are strange and outside of the healthy society. Different “exercise identities” to strive for. An effort to be more healthy is better than no effort.</td>
<td>Struggling toward your healthy self</td>
</tr>
<tr>
<td>I’m not one of those who go to the gym all the time. I feel exposed when people watch me.</td>
<td>Vulnerable</td>
<td>Awkwardness and possibly also self-doubt Feeling estranged and not belonging</td>
<td>Feeling like an outsider</td>
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<tr>
<td>I felt so good about doing this type of training that you do for your health.</td>
<td>Able to</td>
<td>A sense of ability to take care of one’s own health</td>
<td>Something rather than nothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To stretch my limits, really work hard, I believe it’s good for me … to go a little longer and faster.</td>
<td>Work hard</td>
<td>The strain and challenge makes something happen</td>
<td>Challenging oneself</td>
<td>The resistance in depression is paralyzing, and even more so regarding physical exertion, but pushing oneself can be rewarding, facilitating actions and feeling proud of oneself.</td>
<td>Challenging the resistance</td>
</tr>
<tr>
<td>It’s something you do to get more strength or stamina, but not for the fun of it. I mean, you don’t go there because you just love being on a cross-trainer.</td>
<td>No fun</td>
<td>Exercise is boring, just to regain health Makes resistance harder</td>
<td>Exercise is not for fun</td>
<td></td>
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</tr>
<tr>
<td>I feel like I’ve done something, that I’ve achieved something even though it was so hard.</td>
<td>Achievement</td>
<td>Pushing through the resistance makes you feel pleased</td>
<td>Pleased to power through</td>
<td></td>
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</tr>
<tr>
<td>I notice that my body softens and that I feel more alive, more in contact with my body.</td>
<td>Vitalization</td>
<td>A feeling of “sparking” signs of life, going from stiff to soft, awareness</td>
<td>The numb body awakens</td>
<td>This reflects an enlivening experience, but they had hoped for more. Depression is still there, suppressing joyous feelings and expressions.</td>
<td>Feeling alive but not euphoric</td>
</tr>
<tr>
<td>I felt my muscles were tired, but it was a “Yeah!” kind of tired.</td>
<td>Good tired</td>
<td>A positive tiredness that connects to activity, rather than the usual fatigue</td>
<td>A different kind of tired</td>
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<td></td>
</tr>
<tr>
<td>I was hoping to feel some moments of euphoria, but there was nothing like that.</td>
<td>Unhappy</td>
<td>Expected strong emotions failed to arrive</td>
<td>Less joy than hoped for</td>
<td></td>
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<tr>
<td>It was good that we had scheduled appointments.</td>
<td>Appointments</td>
<td>Importance of structure, but “appointment” also means someone waiting, frames, and stability</td>
<td>Supportive structure</td>
<td>This reflects the importance of relationships connected to the exercise, to make exercise at all possible. To make it happen, someone else is needed, expecting you—with concern and empathic support—to make it seem worth trying.</td>
<td>Needing someone to be there for you</td>
</tr>
<tr>
<td>You need someone to practically drag you there. If no one waits for me there, how could I make myself go?</td>
<td>Motivator</td>
<td>Needs a motivating and supporting person Support needs to be active, an act of doing together</td>
<td>Someone to make it worthwhile</td>
<td></td>
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<tr>
<td>I wouldn’t do it just for me. I’ve tried before, and it just doesn’t work. Some days I go just for her [the physical therapist’s] sake.</td>
<td>Dependent</td>
<td>Resignation? Going for the sake of oneself is not enough</td>
<td>Oneself is not purpose enough</td>
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<tr>
<td>It’s not like I would hang with these people outside of the gym. But it still feels nice, to be someone who relates to others, in a way.</td>
<td>Being with</td>
<td>A group can be positive or negative, but raises thoughts on how one relates</td>
<td>Feeling part or apart</td>
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one woman. Even though resistance can be a paramount feeling, the participants said that the concreteness of challenging their bodies in strenuous movements provided a feeling of actually carrying something out:

At first, I feel very slow; it takes a while before I get into...before I feel any drive at all. I feel like, no, I don’t want to do this. I can’t be bothered. I don’t have trust that my body has the strength. Really, it’s an enormous slowness. But then you get up, you get going, and the body wakes up. I feel good; when I move, I feel much better, I’m doing something that feels great, carrying it out.

The participants described an unusual feeling of being pleased with themselves after an exercise session. They claimed that, when many things in life fail, momentarily breaking through the resistance and powering through the program can have a large impact on one’s self-esteem.

Feeling More Alive but Not Euphoric

This category had to do with the direct physical responses and sensations of exercise, described as various expressions of vitality. The experiences represented a contrast to the numb and fatigued feeling in depression. The participants described a change of increased alertness, softness, mobility, and energy:

I notice that my body softens and that I feel more alive in my body, more in contact with my body. If I’m just sitting like this, I don’t really feel my body in the same way; it’s more uncomfortable. But when I start to move, I kind of turn more alert, happy, and strong in a way. I walk differently, there’s more energy to it. It’s not just about fitness and stamina, but more about how I feel, like the energy inside. Because it was totally gone.

To sense the vigorous, moving body in exercise felt great:

I’m really happy with my body, it’s like I have a solid foundation, my body responds much quicker than my mind. . . . I have problems with some parts, my inner organs, . . . but my muscles and my skeleton...they feel great...the very shell of me... so great to really sense them.

For most participants, exercise lifted something about the overall spirit, which they described was visible even to friends and family. However, some participants were disappointed that exercise did not bring about the strong, euphoric sensations that they had expected:

To be honest, I was hoping to feel some moments of euphoria, but there was nothing like that.

I get absolutely no kick out of exercising! It does nothing for me! Those chemicals, I just have to assume that they’re not being released!

Needing Someone to Be There for You

This category concerned the participants’ experience that exercise is something that they could not do by themselves during depression. Exercising for your own good is not purpose enough, they say. For many, this barrier was what had kept them inactive. They claimed that they did not need information about exercise. Advice from professionals or their families can result in a stronger resistance when they did not feel acknowledged in their difficulties. They described that the physical therapist is an important ally, as a supportive person “setting the pace” and increasing their motivation both by being attentive and by suggesting strategies to come around barriers such as pain. They described that depression makes them stuck with tunnel vision, unable to come up with ideas or to see possibilities. Therefore, they valued the process of working together and trying out different exercises with the physical therapist. It also can mean developing a more balanced view of exercise:

It’s not so much that you exercise really hard and perform perfectly. It’s rather about the feeling that you’re on the way. It doesn’t have to be so much,... and it helps you, if you’re with a PT [physical therapist], it helps you to think not so much about exercise as competition.

The participants felt supported in knowing that they had an appointment and someone waiting for them. They emphasized the importance of not being blamed by the physical therapist if they needed to cancel their appointment, stressing that the therapist needs to “read between the lines” and understand things intuitively. Some participants felt that the intervention has prepared them to continue exercising, but others said...
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that they would quit without the physical therapist’s context.

Most participants appreciated training in a group with others who share the same problems. Just knowing that others might feel similar is a nice feeling, according to another participant:

Feels great to be in a group here... I don’t really know who the others are or what problems they have, but it’s easy to imagine that they are like me, think the same way I do, and they don’t mind me doing things my way. We’re just like everybody else. They wondered where I was if I didn’t show up. Sometimes they asked, “Where is she, how is she?” Someone actually cares, and you come here, and you become someone who is cared about by someone else, and that feels pretty great.

Other participants had opposite feelings about being in a group:

I absolutely need support from somebody, but I don’t like big groups, don’t like to be one of many. I don’t like the forced social interplay with people just randomly pushed together.

Discussion

Our results, particularly the first 2 categories, illuminated descriptions of enhanced possibilities to experience oneself as capable, carrying out intended actions and taking care of one’s health. In this way, exercise can be understood as setting something in motion, beyond the pure physical movement, promoting a sense of capability. The enhanced capability can be related to the psychological constructs of self-efficacy and self-determination theory, previously pointed out as a suitable framework for understanding and promoting exercise in mental health. It can be thought that the experience represents a powerful possibility to view and apprehend oneself differently, as someone who is capable of exercising even though depression debilitates many other dimensions of life. In a similar way, previous research has described experiences of increased self-confidence following exercise.

In our study, the participants described that the enhanced capability transcended the task of exercise and facilitated relational and practical concerns in their daily lives.

Our findings also can be related to the concept of movement, as described by Wikström-Grotell and Eriksson. The authors understand movement as a complex, inter- and intradynamic concept that can be categorized into 4 aspects: (1) movement as an absolute value, (2) movement as a personal value, (3) movement as a means, and (4) movement as a sensation in body and mind. Our categories “struggling toward your healthy self” and “challenging the resistance” connect to the aspect “movement as a means” by enhancing participation and ability, and they also connect to the aspect “movement as a personal value,” in terms of feeling proud and more like oneself again. Relating to the same study, our category “feeling alive but not euphoric” carries a meaning connected to the aspect “movement as a sensation.” Our findings suggest that the exercise intervention can mediate a sense of revitalization—in simpler terms, to feel more alive again. Although a full range of sensations and joyful emotions did not shine through, the results point to exercise as a way to sense something more, as a contrast to the feeling of deadlock in depression. Previous phenomenological analyses have described this deadlock as perceived numbness, stiffness, and encapsulation, which interrupt the person’s intentional acts and keep him or her from engaging in life. Elaborating on a phenomenological perspective of exercise for depression, previously pointed out as a knowledge gap, can deepen the understanding of the existential perspective of exercise and movement. This perspective is still under-explored in physical therapy.

Similar to previous research, we found that the therapeutic relationship, including individual tailoring of the program, was essential for the participants. In line with this finding, recent studies investigating the therapeutic relationship in physical therapy showed that it modulates the treatment effects on chronic pain. The authors interpreted this relationship as going beyond good communication to include empathic support and a multidimensional dialogue of touching, caring, and listening. The supportive role of the physical therapist has been previously emphasized when treating people with mental health problems. Recently, the impact and quality of the therapeutic relationship also have been discussed in a physical therapy intervention to increase physical activity for people with multiple sclerosis and in physical therapy for people with migraine. The relationship is proposed to depend on both the physical therapist’s “professional tools,” which make the patient feel safe and confident of the therapist’s competence, and a “personal touch,” which involves a mindful, respectful approach toward the patient as a unique person.

In our data, we noticed a dimension of the therapeutic relationship that means that the physical therapist, in order to guide the patient further and to convey trust, needs to be sensitive to the part of the communication that is embodied. Recently, this embodied dialogue between physical therapist and patient has been suggested to vastly contribute to, and to a large part, constitute the clinical reasoning process. Our results support the importance of this embodied dialogue in terms of a perceptive approach that includes empathic observing, mirroring, and moving together. The physical therapist’s challenge in the present study involved an attunement to the patient, being with and guiding the patient through the perceived ambiguity and resistance. Elaborating on this embodied dialogue can deepen the understanding of less articulated elements in physical therapist practice.

Strengths and Limitations

To enhance credibility, we used a thorough clinical assessment ensuring a well-defined study sample from which we selected patients with variations of depression severity, age, sex, and depression outcome following the intervention (Tab. 1). In this way, we aimed for different experiences, leading to more nuanced understanding of the phenomenon.

Another issue for credibility is to extract suitable meaning units. Units that are too broad are likely to contain several
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meanings, whereas those that are too narrow can lead to fragmentation of the narrations. We worked with this issue by having 2 researchers code the data, followed by a continuous dialogue among all 3 researchers. A detailed illustration of the process, from meaning units to categorization, was included to enhance transparency of the analysis (Tab. 2).

In qualitative research, results are context-dependent. Our results gave examples of how a particular intervention conducted in Swedish primary care was perceived by patients with major depression. For other rehabilitation settings in diverse cultures and societies, transferability must be viewed in relation to the specific context. To facilitate the reader’s judging of transferability, we put effort into describing the setting, the intervention, the participants, and the process (Tabs. 1 and 2, Fig. 1). We sought for a rich presentation of the findings, including quotations, to enhance the reader’s ability to value the results.

It should be noted that the sample was homogeneous with regard to ethnic, cultural, and geographical background. Future studies on the subject of exercise for depression could preferably seek to address a more diverse sample. Because this study was limited to a Swedish context in terms of language and health care organization, the results need to be cautiously interpreted from an international physical therapy perspective. More research is needed to explore the field of physical therapy in the treatment of depression and other mental health problems. Promising initiatives of collaboration are currently being developed through international research groups and the International Organization of Physical Therapists in Mental Health, which was recently formed as an official subgroup to the World Confederation for Physical Therapists.

Although we included negative cases, an active recruitment of participants who had dropped out would have contributed to the understanding of barriers to exercise. Another limitation of the sample is that it included people who had voluntarily approached a trial evaluating exercise for depression. They were likely to be more positive to exercise than depressed people in general. Our results should be interpreted with regard to this limitation.

The researchers’ experiences of the research subject enhance credibility, but, paradoxically, it can be a limitation that all 3 authors are physical therapists. Different professions could have given a richer interpretation of the data. We addressed this limitation by reflecting on the results together with other health professionals, with other patients with depression, and by checking the results with the participants.

Implications

The study described how an exercise intervention was experienced by patients with major depression treated in Swedish primary care. These results can inspire clinicians to reflect on exercise for depression in their respective contexts. Moreover, the results supported the role of physical therapists in mental health to promote and guide exercise. In particular, this role regarded the therapeutic approach and embodied dialogue, acknowledging the patient’s need for empathic, active support to endure ambiguity and resistance.

All authors provided concept/idea/research design and data analysis. Mrs Danielsson and Mrs Rosberg provided writing. Mrs Danielsson and Ms Kihlbom provided data collection and participants. Mrs Rosberg provided consultation (including review of manuscript before submission). The authors thank the participants for generously sharing their experiences.

The regional ethics review board approved the study.

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