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RESEARCH PAPER

Professional tools and a personal touch – experiences of physical therapy of persons with migraine

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Abstract

Purpose: The aim was to explore the lived experience of physical therapy of persons with migraine. *Method:* Data were collected by conducting narrative interviews with 11 persons with migraine. Inspired by van Manen, a hermeneutic phenomenological method was used to analyse the experiences of physical therapy which these persons had. *Results:* Physical therapy for persons with migraine meant making an effort in terms of time and energy to improve their health by meeting a person who was utilising his or her knowledge and skill to help. Being respected and treated as an individual and having confidence in the physical therapist were highlighted aspects. The analysis revealed a main theme, ''meeting a physical therapist with professional tools and a personal touch''. The main theme included four sub-themes, ''investing time and energy to feel better'', ''relying on the competence of the physical therapist'', ''wanting to be treated and to become involved as an individual'' and ''being respected in a trustful relationship''. *Conclusions:* The therapeutic relationship with the physical therapist is important and the findings of this study can increase awareness about relational aspects of physical therapy and encourage thoughtfulness among physical therapists and other healthcare professionals interacting with persons with migraine.

Keywords

Interaction, migraine, physiotherapy, therapeutic relationship

History

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➤ Implications for Rehabilitation

- Physical therapists use both professional tools and a personal touch in their interaction with persons with migraine and this article can increase physical therapists' awareness and encourage thoughtfulness in their professional practice.
- Being respected and treated as an individual and having confidence in the physical therapist are important aspects of the therapeutic relationship and indicate a need for patient-centred care.
- By making the effort of spending the time and energy required, physical therapy could be a complement or an alternative to medication to ease the consequences of migraine.

Introduction

Living with migraine means having a chronic disorder that causes attacks of severe headache, sometimes with associated symptoms such as nausea and phono- and photophobia [1]. Besides the attacks, life is affected by the uncertainty of future attacks and by lifestyle changes made to avoid triggering an attack [2,3]. The disability associated with migraine is substantial [4], and in 2001 the World Health Organization [5] listed migraine among the top 20 causes of disability.

In the guidelines for treatments offered to persons with migraine, medications are used primarily, but non-drug alternatives are also recommended [6]. However, the use of medication is not uncomplicated. Bigal et al. [7] found that overuse of pharmaceuticals was a common reason for migraine developing into chronic daily headaches. Moreover, earlier studies have described migraine sufferers' fear of becoming addicted and fear of the side-effects of frequent use of medication [3,8]. Among non-drug interventions, acupuncture has been found to be at least as effective as preventive medication [9] and cognitive behavioural therapy and bio-behavioural training (i.e. biofeedback, relaxation training and stress management) are promising treatments [10]. Physical therapy offers many of the recommended non-drug treatments for migraine, and a review has shown that a combination of physical therapy interventions was most beneficial in the treatment of migraine [11].

Physical therapy is concerned with identifying and maximising the quality of life and movement potential through promotion of health, prevention of illness or rehabilitation among persons, who need to develop, maintain or restore movement and functional ability [12]. An important part of physical therapy is the

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interaction between the physical therapist and the person who needs help and a good relationship can promote health and well-being [12]. Previous research has shown that a good patient–therapist relationship is likely to affect the outcome of physical rehabilitation positively [13,14]. The outcome seems to be affected by the physical therapist's sensitivity and ability to negotiate a common ground [15]. This might be even more important concerning persons with migraine, since both Brandes [2] and Edmeads [16] have stated that effective patient–therapist communication is a key factor in migraine prevention. Further, several studies [17–19] have reported that persons with migraine have frequently experienced not being taken seriously by healthcare personnel. Examples of the complaints were that physicians lacked sympathy and dismissed migraine as an insignificant disorder or just prescribed a medication without listening to the needs of the persons with migraine. Consequently, it is important to explore their experiences of health care further. Apart from a study showing the experience of acupuncture of women with migraine who had been given such treatment by physical therapists [20], there is to our knowledge no study showing how persons with migraine experience physical therapy.

To improve physical therapy, Potter et al. [21] emphasised the importance of physical therapists having an awareness of their part in the intervention and the interaction with the patient, and they concluded that more research was needed, especially from the patient perspective. Therefore, this study aims at exploring the lived experience of physical therapy of persons with migraine.

Method

Design

To fulfil the aim of the study, we chose to use a qualitative research design with a phenomenological approach. According to van Manen [22], phenomenological research begins in the lifeworld, and he relies on Husserl's epistemology in arguing that phenomenology means understanding the meaning of lived experiences and of being in the lifeworld. According to Drew [23], researchers as residents of the lifeworld are creative co-contributors together with that world and understand phenomena from the perspective of their particular situatedness. Their pre-understanding and beliefs contribute to their perception of the phenomena under study and cannot be suspended or bracketed [22]. In addition, Drew [23] emphasises that self-awareness is the foundation of objectivity in phenomenological research, and therefore researchers must give clear information about how they are connected to the phenomena under study. The present authors have different experiences of being health caregivers: one of us as a physical therapist in primary care (Stina Rutberg), one as a nurse (Kerstin Öhrling) and one as a health consultant (Catrine Kostenius). Moreover, we have experiences of being patients receiving physical therapy, although none of us has a lived experience of having migraine.

Ethical considerations

Permission was obtained from the relevant healthcare managers before a number of physical therapists were contacted and asked for their help in communicating information on the study to their patients. After being informed about the study and having been told that they could change their mind about participating at any time without having to provide an explanation, a number of persons with migraine gave their informed consent to participation, and full confidentiality was assured. The Regional Ethical Review Board at Umeå University in the city of Umeå in Sweden approved the study (reference no. 08-182M).

Participants

Physical therapists at 38 primary care clinics in the northern part of Sweden were contacted by phone and asked if they at that point in time were treating any persons diagnosed with migraine. At nine of those clinics there were physical therapists treating at least one person with migraine. Information about this study was sent to the therapists at these clinics by post and they handed out information about the study to their patient/patients. To be included in the study, the participants were required to be at least 18 years old, to have been diagnosed with migraine, to be receiving physical therapy from a physical therapist for their migraine and to be able to speak Swedish.

Eleven persons, nine of whom were women and two were men, answered and agreed to participate in the study and they were between 20 and 69 years old. Nine persons had had their migraine diagnosis for 9–59 years, and two persons had had their symptoms and diagnosis for about 1 year or less. The number of migraine attacks varied as follows: 3–8 attacks per year for two persons, 1–4 attacks per month for 7 persons and 5–8 attacks per month for two persons. Four persons were attending their first period of physical therapy and two persons were attending their second period. Five persons have been attending physical therapy for different periods during the previous 3–20 years. The participants had experience of many different physical therapy interventions, e.g. exercises, stretching, relaxation training, stress management, acupuncture, massage, working on posture change and ergonomics and learning strategies for how to stay healthy.

Data collection

The persons interested in participating were contacted by phone and given additional information about the study, and the time and place of an interview were decided. Six interviews took place at the home or workplace of the participant, and five interviews were conducted at Luleå University of Technology, all of them held in an undisturbed room. Interviews with a narrative approach were performed by the first author. To capture the participants' experience of physical therapy, the interview started by inviting them to tell their story: ''Please tell me about your experience of receiving physical therapy for your migraine''. To encourage the persons to elaborate their narratives, the interviewer asked questions like ''How did you feel then?'' and ''Can you tell me more about . . .?''

The participants were asked to draw a picture of their experience of physical therapy when the interview reached the point when they did not have any more information to add to their stories. Thereafter the interview continued with narrations about the picture, starting with the questions, ''Could you please tell me about your drawing?'' and ''What feelings and associations do you get when you look at your drawing?'' Nine of the 11 participants chose to draw a picture. The interviews held before and after drawing the picture lasted about 40 min each. They were tape-recorded and transcribed verbatim with indications of non-verbal pauses and emotional expressions.

Data analysis

Inspired by van Manen [22], the process of analysis involved the interrelated phases of seeking meaning, theme analysis and interpretation with reflection, all of which considered both the parts and the whole of the text. The analysis phases were not performed in a stepwise fashion, but rather were a movement back and forth to reach understanding of the phenomenon. The analysis started with a verbatim transcription of the recorded interviews, after which the text was read several times to obtain a sense of the collected meaning or meanings in all the experiences described by

Table 1. Our evolved pre-understanding.

- A healthy life is the equilibrium of physical, psychological, emotional, social and existential well-being.
- Physical therapy is both an intervention and an interaction between the physical therapist and patient. The effects of the intervention and the interaction are intertwined and affect each other.
- Physical therapy aims primarily to treat the human via the body, and it has the potential to promote health and well-being.
- There are no stereotypes for ''the good/bad physical therapist''; rather the experience of receiving ''good/bad physical therapy'' depends on the patients' experience of how their needs are met.

the persons with migraine. During the phase of theme analysis, the entire text was reread and phrases and sentence clusters that seemed to be thematic were marked as meaning units. Motivated by a sincere desire to explore our own pre-understanding, suppositions and assumptions, we adopted Drew's [23] suggestions for structuring pre-understanding in the following steps. The search for our pre-understanding started with an exploration of our own feelings and motives steering our choice of meaning units. We wrote down statements about the meaning units, producing a text that revealed something about our own understanding, and we tried to capture the questions which the statements were answers to. We added our own experiences of the written statements, particular situations where we were a patient and a caregiver, and the feelings connected to these experiences. The questions and the summations of the statements provided knowledge about our collective understanding and presumptions. To elucidate the point of departure of our understanding, we have made a summation of our collective pre-understanding and presumptions in this study (Table 1).

The data analysis continued thereafter with a return to the text and meaning units and we asked ourselves the following question concerning each meaning unit: ''What does this meaning unit reveal (thematically) about the lived experience of physical therapy?'' In the data analysis, we remained true to van Manen's [22] (p. 34) description of the ''inventive thoughtful'' attitude. First, we reflected on the data that we had started writing down and then we alternated between reflection and rewriting in a back-and-forth movement, to illuminate the meaning of and the meaningful interconnections between all the data. The preliminary themes were discussed with research colleagues who had experience of physical therapy or other healthcare professions. Moreover, some of these colleagues had experience of working with qualitative methods, including hermeneutical phenomenology. This procedure supported reflection and provided new understanding which resulted in some minor changes in the names of the themes and in part of the text changing its position. During the procedures of analysing and reflective writing, our understanding evolved and the final structure emerged.

Findings

The analysis revealed one main theme and four sub-themes, which captured the lived experiences of physical therapy of persons with migraine (Table 2).

Meeting a physical therapist with professional tools and a personal touch

The analysis resulted in an understanding of the fact that physical therapy meant making an effort to improve one's health by meeting a person who utilised his or her knowledge and skill to help and by participating in an intervention. One interpretation was that the physical therapists used several professional tools and their personal touch in the interaction with the persons with migraine, which had the power to strengthen both the persons with migraine and the therapeutic process. The professional tools were understood to be the therapist's competence in physical therapy, communication skills and ability to build a trustful relationship and meet individual needs. Our understanding was that the personal touch applied by the physical therapist in his or her interaction with the persons with migraine comprised both actually touching them physically and, more metaphorically, treating them in a personal manner. One highlighted aspect was being treated as an individual and examples of that were occasions when the persons with migraine were seen and acknowledged, which was communicated through dialogue and touch. The therapeutic relationship with the physical therapist played an important role in the experience of the persons with migraine and, in this connection, being able to trust and feeling trusted were crucial components. Even if the intervention was a tool for reaching alleviation, the satisfaction with the intervention rather referred to the persons' experience of the competence of and the relationship with the physical therapist. Together, the intervention, the relationship, the expertise of the physical therapist and the persons' with migraine own efforts composed the crucial parts of physical therapy. The following metaphor is one example of the lived experience of physical therapy.

> [It is as if] the physical therapist is a watering can, and the flower is actually us coming together and our feelings . . . first the exterior is happy and brightly coloured . . . then you have roots that are just painful and black–red, yes the pain . . . and the physical therapist tries . . . to water or take care of that ugly little black–red . . . [like] a helping hand . . . a watering can that can help the flower to grow . . . it [the flower] is the interaction, but it is also me . . . and here are some black details, because the bad things are always there, but the main thing is that the watering can [the physical therapist] wants this bud to grow . . . and be able to flower . . .

Table 2. Overview of the main theme and sub-themes.

Main theme	Meeting a physical therapist with professional tools and a personal touch
Sub-theme	Investing time and energy to feel better
Sub-theme	Relying on the competence of the physical therapist
Sub-theme	Wanting to be treated and to become involved as an individual
Sub-theme	Being respected in a trustful relationship

Sub-themes in this main theme were ''investing time and energy to feel better'', ''relying on the competence of the physical therapist'', ''wanting to be treated and to become involved as an individual'' and ''being respected in a trustful relationship.''

Investing time and energy to feel better

Engaging in physical therapy for persons with migraine meant investing time and energy to abort or ease the consequences of migraine. The desire to decrease the intake of medication was a strong motive for engaging in physical therapy and, in cases when medication did not work, physical therapy was considered a possibility of reaching alleviation. Physical therapy was experienced as being a way for the body itself to heal or alleviate pain

and not as something that was added to the body, like medication. ''. . . one should not become too dependent on or take too much medicine; this [acupuncture] is actually also a form of medication, it releases something in the body that is preventive, but compared to medicine it feels natural . . .''

The outcome of physical therapy could mean, besides the alleviation of migraine, increased awareness of one's own body, relaxation and a feeling of increased energy and strength. When the outcome meant decreased suffering from migraine, it was experienced as a relief in the psychological and existential areas as well. ''I have really been helped by this [the physical therapy], I can still get a migraine . . . but this acupuncture treatment was a boost, it is as if I have entered a new phase in life . . .'' However, sometimes it was difficult to know what was influencing the migraine attacks and if the relief from migraine was due to the physical therapy or something else.

The persons with migraine highlighted the importance of the physical therapy interventions providing the reward of improved health and decreased pain. When the symptoms of migraine were a burden, it was considered worthwhile to take the time required for a visit to a physical therapist. The time spent on physical therapy meant not only an interruption in the daily activities and could be experienced as frustrating, but also as an opportunity to spend time and focus on oneself. ''. . . sometimes I can feel that it is an annoying feeling if I am stressed and have much to do, that it is hard to lie still, but . . . I try to make it a positive moment, having time for myself . . .''

Relying on the competence of the physical therapist

The importance of the skill and knowledge of the physical therapist was emphasised by the persons with migraine. Having confidence in the physical therapist meant decreased worry and fear and could make it possible for the persons with migraine to have the courage to try something which they would normally not try, such as acupuncture. The persons with migraine expressed that receiving acupuncture treatment was a special situation where they felt vulnerable, since acupuncture had the potential to be harmful. In these situations it was crucial that the person with migraine should have confidence in the physical therapist to create a feeling of security. The confidence felt in the physical therapist also influenced the perceived appraisal of the intervention.

> . . . she knows exactly what I need and I felt that it gave results, everything we did, it was so obvious, but oh God . . . [first] I thought that it couldn't help, but it did . . . you know, me clenching my teeth at night, which can also be a reason why my neck is so tense, and then she thought of a method I could use to relax when I am sleeping, so she has answers to everything . . .

Confidence in the knowledge of the physical therapist was mediated through the individual physical therapist's personal manner, i.e. way of acting, touching and treating the person, as well as through his or her communication skills. Equally important as or even more important than communication skills was the fact that the persons with migraine sensed that the physical therapist knew what he or she was doing, as recognised in his or her touch. A skilled physical therapist's touch felt professional and mediated a feeling of knowledge and security. ''. . . it's quite amazing too, he [my physical therapist] feels . . . just by feeling, that there is the right spot [acupuncture spot] . . . I have complete trust in him; I could almost be unconscious and still be there, I totally trust him''. However, experiencing being touched by someone who felt unsure and was somewhat clumsy mediated the feeling that this was an inexperienced physical therapist. It was difficult for a physical therapist to compensate for a lack of practical experience, even by demonstrating theoretical knowledge. When a physical therapist found and confirmed a person's tender spots, trust in his or her knowledge increased. Accordingly, it seems that knowledge of and skills in performing the intervention were more important than knowledge of the disorder. ''She knew I was searching for help for my migraine, but she talked more about tension headache actually, but that is not what I have . . . but I thought; well okay . . . she was good anyway because I got better . . .'' Experiencing a positive outcome from physical therapy increased the person's confidence in the physical therapist. However, when the intervention was considered to be effective, some persons perceived the physical therapist as being less important.

Wanting to be treated and to become involved as an individual

Going to a physical therapist meant engaging in a therapeutic relationship and to some extent being dependent on another person for the treatment of one's migraine. The persons with migraine embarked upon physical therapy with individual needs and their needs changed sometimes during the therapeutic process. They wanted to be treated by a physical therapist who was interested in them and tried to meet their needs. Sometimes they wanted someone who could provide them with knowledge and teach them how to manage their migraine on their own in the best possible way. In some situations they needed to be taken care of, for example, when they felt vulnerable or ill. The physical therapist's ability to meet these individual needs influenced the person's satisfaction with the intervention.

> . . . you have to struggle on by yourself too; no one is telling you to go and do your exercises and that's all up to me, but the physical therapist is a good tool to get you started and to guide you in doing the right things, so that you don't go and make things worse . . . they can explain how your body functions, and in that way you are learning all the time . . .

It was found that the persons with migraine considered it important to be treated with individual approaches, and not to have an intervention performed by routine. ''. . . she [my physical therapist] is really good . . . she cares about me and makes me feel that I'm not only one in a crowd, she asks me how I feel today . . . and if we shall insert the needles . . .'' Involvement in the therapeutic process and the decision-making was understood to be a part of the individual care. At the beginning of a period of physical therapy, the physical therapist was usually considered as being the one in charge and the involvement in decisions of the persons with migraine mostly concerned answering questions and being informed and tutored. Persons who had been undergoing physical therapy for a long time often experienced that they could be more involved in the decisions and they had clearer perceptions of what was good and effective for them. However, when the level of trust in the physical therapist was high, this meant that it was more natural that the physical therapist should make suggestions and choose interventions, even though it was preferable that collaboration should take place with the persons being treated.

> I trust him completely . . . he knows what he is doing; I have seen that it gives results and when he asks me if I would like to try something, I say of course I will, I will do anything that can help me.

One important aspect of being involved was the availability of the physical therapist. The persons with migraine expressed

feelings of vulnerability when they did not know how available the physical therapist was, and a woman with migraine expressed her worries as follows: ''I do not dare to think about what would happen if I was not able to go to the physical therapist anymore''. When availability of the physical therapy was assured in advance, for example when the physical therapist had said, ''Just call me if you get worse'', this gave a sense of comfort and security. By knowing that there was help to be obtained if necessary, the persons with migraine felt that they were able to cope better. In addition, being able to make an appointment quickly when calling the physical therapist gave the feeling of being prioritised and taken seriously by the physical therapist.

> It [being able to call if I get worse] gives me a sense of security, knowing I can come and get this help, which she is so good at, and that I can get better if it starts all over again.

Being respected in a trustful relationship

Feeling important and respected was highlighted by the persons as a valued aspect in their therapeutic relationship with the physical therapist. It was crucial to the persons with migraine to be treated by a physical therapist who believed in them and showed a commitment to providing help. A sense of being understood was a key factor in the communication with the physical therapist and a pre-requisite for their ability to share everything concerning their disorder and how it affected their life. In addition, feeling free to speak about everything was expressed as a liberating experience.

> . . . I feel that I'm not being neurotic or anything like that . . . [I can tell her about] the smallest pain I feel and she can say that the reason is this or that, and this is what you can do . . . I understand that it is probably not so bad after all . . . but [it is easy for my physical therapist] to think . . . that [I] should be able to tolerate some pain and so on, but with her I never feel like that, she understands and tries to help me as much as possible . . .

A sense of being respected was mediated not only by communication, but also through the physical therapist's actions, for example by the physical therapist showing caution and being attentive to the reactions of the person with migraine. When the physical therapy included undressing, which was sometimes experienced as causing discomfort and a sense of being exposed, it was crucial that the person with migraine should be treated with respect.

> . . . one has to take off so much of one's clothing [in the physical therapist's consultation room] and I can feel that sometimes that . . . is not so nice; I know I must do so . . . he would never . . . do anything that would make me feel uncomfortable and that is important; I feel secure . . . but I feel quite naked when I'm there . . . but I feel cared for too, having a soft pillow . . . and a towel over me, then I feel less . . . vulnerable . . .

Several persons with migraine had had previous experiences of not being taken seriously by healthcare professionals, and they described this as being made to feel invisible and sometimes worthless and a waste of the staff's time. On occasions like these, it was easy for them to hide and understate the severity of their own symptoms.

> [A good reception] is to be treated with . . . curiosity, perhaps not curiosity . . . but . . . at least not being greeted with ''What are you doing here?'' and not having a feeling that you are not being believed, compared to my physical therapist, who really listens to me and understands and tries to help and explain . . .

When the physical therapist remembered previous expressed needs, requests or personal information, which did not necessarily need to be linked to the intervention or disorder, a feeling of being seen and important arose among the persons with migraine. When the physical therapist was well acquainted with the person and knew the history of his or her disorder, it was considered hard to start all over again with a new physical therapist and to have to retell the whole of one's case history. ''[My physical therapist] knows my background and everything [about my illness]. We usually talk a lot about stress and stress management and he notices when I am stressed . . . it is extremely valuable that he knows all about me . . .''. When the person with migraine sensed that he or she had got to know the person behind the role of the physical therapist, the therapeutic relationship was strengthened as long as the roles were intact; for example, it was not acceptable for the person with migraine to feel sorry for the physical therapist. A prolonged intervention period often meant mutual sharing of personal experiences between the person with migraine and the physical therapist. The persons with migraine expressed a satisfaction when they could offer the physical therapist advice in areas where they were experts. They also felt valued when the physical therapist shared his or her personal experiences in other areas than health care. ''. . . we talk quite a lot . . . and when she had been away . . . [and said,] 'I must tell you about . . . 'I felt so, it was amazing what she shared with me, we have a good connection''.

Discussion

This phenomenological study has attempted to illuminate the lived experiences of physical therapy of persons with migraine and our interpretation of the narrated experiences has revealed one main theme, ''meeting a physical therapist with professional tools and a personal touch''. Meeting a physical therapist meant a possibility of improving one's health, but demanded an effort involving time and energy on the part of the person with migraine. The physical therapists possessed an array of professional tools which consisted of communication skills, the ability to instil confidence in their competence and the ability to build a trustful therapeutic relationship and meet individual needs, and they used these tools in their interaction with the persons with migraine. Our understanding also reveals that the persons with migraine were treated with a personal touch, which comprises both being treated in a personal manner and actually being touched physically. The use of the professional tools and the application of a personal touch were interlaced and constituted crucial components of the therapeutic relationship with the physical therapist.

Our findings indicate a need to establish a trusting therapeutic relationship built on good communication and confidence in the physical therapist. The physical therapist's personal manner and communication skills influenced the persons' confidence in the physical therapist and their feeling of being respected, involved and individually treated. The importance of the physical therapist's ability to communicate has been emphasised in several earlier studies on patients' perceptions of physical therapy and the qualities of a good physical therapist [24–27]. Slade et al. [27] concluded that a willingness to listen and communicate effectively may improve the patients' satisfaction with care. Further, Cooper et al. [25] stated that communication is the most important dimension of patient-centred physical therapy. Our understanding is further that the relationship with the therapist

was strengthened when the person with migraine got to know the person behind the role of the physical therapist, for example by sharing experiences beyond the issues of physical therapy. According to Tickle-Degnen [28], the therapist and the patient should bond and develop a friendship, which is useful for communicating respect. However, this friendship is not equivalent to a social friendship.

The persons in this study highlighted a need to be respected and, most of all, not to be perceived as someone who is just complaining. It is possible that the need for a trusting therapeutic relationship is more explicit among persons with migraine, since, as Rutberg and Öhrling [3] have found, they live with the fear of not being believed. Further, Cottrell et al. [18] has reported that several persons with migraine have experienced being dismissed by healthcare services and that they desire a collaborative therapeutic relationship, to improve the understanding of the person with migraine before treatment is offered. However, the need to be trusted by the physical therapist is not an isolated experience for persons with migraine. Persons with chronic low back pain have stated that healthcare personnel have sometimes not taken them seriously and that they want a confidence-based partnership with their physical therapist [27]. Further, persons with musculoskeletal problems have stated that they want the physical therapist to make them feel understood and respected and demonstrate empathy [26].

Confidence in the physical therapist has been emphasised in this study and, when the persons with migraine had confidence, this meant having a lower level of worry and fear and affected their appraisal of the intervention. This is similar to the findings of Kidd et al. [26], who further argued that, within a good therapeutic relationship, the physical therapist's expertise and self-confidence can create a confident patient who can be self-directed after a certain period of treatment. The physical therapists' knowledge of migraine was not one of the factors highlighted by the persons in this study; rather, the physical therapists' competence was considered to consist of their skill in performing interventions and their knowledge of the interventions and the body, as mediated through communication and a skilled and experienced touch. This differs from the studies of Cooper et al. [25] and Slade et al. [27], where persons with low back pain perceived the physical therapist as an expert on their diagnosis, and their confidence in their physical therapist related more to his or her ability to communicate his or her expertise.

The findings of this study have revealed that the persons with migraine embarked upon physical therapy with individual needs which were not constant, but instead changed during the therapeutic process. The physical therapists' ability to meet these individual needs affected the persons' satisfaction with physical therapy. Potter et al. [24] concluded that, by actively seeking patient input, physical therapy can be more patient-centred and beneficial. Being treated as an individual was in this study understood to be closely connected with being involved in the therapeutic process and decision-making. The importance of being involved in rehabilitation was emphasised by Cott [29], who found that persons with chronic illness and disability regarded patient-centred care as the equivalent of being actively involved in managing their health care and their rehabilitation process. In addition, May [30] described how patients receiving physical therapy wanted to be listened to and involved, and to have treatment which could be seen as a consultative process, which met their individual needs, rather than treatment given as a prescriptive process. In this study, the desire of the persons with migraine to be involved in decisions varied, depending on where in the process they were and how much confidence they had in the physical therapist. This differs to a certain extent from the findings of Cooper et al. [25], which showed that patients generally did not want to be involved in decisions as long as they received good explanations. One important finding in this study was that comfort and security could be obtained through a pre-arranged availability of physical therapy and that the persons with migraine were able to cope better merely by knowing that help was available. Access to physical therapy has been highlighted as an important dimension in patient-centred physical therapy [25]. Therefore, our proposal is that the physical therapist should offer persons with migraine the opportunity to be involved in the physical therapy process. In addition, we suggest that the process would benefit from the physical therapists using both perceptiveness and adaptability to meet their individual needs.

The findings of this study show that the outcome of physical therapy for persons with migraine could extend beyond physical relief, by giving relief in the psychological and existential areas as well. This mirrors the finding of Rutberg and Öhrling [20] that women who received acupuncture treatment for their migraine, given as a physical therapy intervention, felt that they could live life to the fullest when the migraine decreased in severity. A strong motive for engaging in physical therapy was the possibility of decreasing the intake of medication, and sometimes it was used as an alternative to medication. Even though physical therapy was considered a way for the body to heal itself, the strongest motivator for continuing was the fact that physical therapy resulted in the reward of increasing the person's feeling of health and well-being. As many of the non-drug interventions recommended in research for migraine [9–11] are performed by physical therapists, it is surprising that persons with migraine only visited nine of the 38 clinics that we contacted. We have not found any research showing how common it is for persons with migraine to attend physical therapy, but this seems to be a low number considering the fact that about 13% of the population in Sweden suffer from migraine [31]. One reason for this could be the time and energy which a person with migraine has to invest in treatment, but further research is needed to explore why they do not attend physical therapy to a greater extent.

Although we did not explicitly ask the persons with migraine participating in this study about their experience of the therapist or their relationship with the therapist, the major part of the findings relates to that. Our understanding is that their accounts concerning satisfaction with the physical therapy treatment related to the confidence which they had in the physical therapist and his or her ability to meet their individual needs and to build a trusting relationship. This can be compared with the findings of Hush et al. [32], which showed that the key determinants of patient satisfaction were the attributes of the physical therapist and the process of care. In addition, May [30] concluded that satisfaction is a reflection of the quality of care and the care process, besides being an important measure of the outcome. The findings of this study reinforce the importance of paying attention to the patient–therapist relationship in physical therapy, which is a factor that previous research has suggested as being important for the outcome [13–15]. The effectiveness of interventions versus interaction in physical therapy has been discussed, and Miciak et al. [33] argue in favour of common factors in physical therapy affecting the outcome, like therapist qualities, relationship elements and client characteristics. According to Tickle-Degnen [34], research on the therapeutic relationship can provide important information and shape an evidence-based practice in rehabilitation.

Methodological considerations

Hermeneutic-phenomenological research has the potential to deepen the personal insight of persons who are open to change, and thereby enhance their ability to act with more thoughtfulness

and tactfulness towards others [22] (p. 7, 23). Since the aim of this study was to explore the lived experience of physical therapy of persons with migraine, it was important that the data collected should contain rich information and a broad variation of experience. The persons with migraine participating in the study had experience of a wide range of different interventions and some of them had attended physical therapy only four times, while others had 20 years' experience of physical therapy, which indicates both a richness and a variation of experience. To facilitate the interviews and deepen the narration, we asked the persons with migraine to draw a picture of their experience of physical therapy when they did not have anything more to add to their initial narration. The pictures made it possible for them to recall and express further their experience of physical therapy, as well as to summarise the experience that they had previously narrated. We chose to use only the narration about the picture in the data analysis and not the picture itself. According to Guillemin [35], drawing pictures is a process of knowledge production and, when the participants in a study make their own interpretation of their drawing, this validates the drawing further as a research method.

The finding of a phenomenological study is not only based on the empirical world, it also derives from the researcher's consciousness of the empirical world [36]. Therefore, the constructed truth value of the study depends on how rigorously and effectively the researcher's subjective experience of the phenomenon is explicated and recognised as a contributor to the phenomenon [36]. To meet this criterion of quality, we spent a great deal of time exploring our own pre-understanding and assumptions, as well as our experience of being a patient, a healthcare professional and a researcher, in a structured way. To challenge our pre-understanding further and to enhance the quality of the study, we presented the preliminary findings and discussed them with fellow researchers who had experience of qualitative research methods and health care. We used our pre-understanding as a point of departure and we tried to evolve our horizon of understanding. Even though complete self-understanding is not possible [23], we have attempted to explicate our self-understanding to give the reader an understanding of our influence on the research.

A possible limitation of this study may be that having a positive experience of physical therapy could have enhanced the willingness of the patients contacted to participate in the study, but, even if this is so, our findings still present a wide range of experiences comprising both positive and negative aspects.

Conclusions

When persons with migraine were asked about their experiences of physical therapy, their narrations mostly related to their experience of and therapeutic relationship with the physical therapist. In the patient–therapist interaction, it was important to be respected and to be treated as an individual, as well as to have confidence in the physical therapist. This indicates the importance of physical therapists being conscious of how they use their professional tools and their personal touch. The findings in this study can increase awareness and encourage thoughtfulness among physical therapists and other healthcare professionals interacting with persons with migraine.

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Declaration of Interest

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