The meaning of sport and physical activity as narrated by patients with depression during treatment: a pilot study

By Ida Damen (1722700)

April 2014

Supervisors Mulier Institute: Dr. Agnes Elling-Machartzki & Mirjam Stuij MSc.
Mulier institute Herculesplein 269 3584 AA Utrecht

Supervisor VU: Dr. Dirk Essink
Athena Institute for Research on Innovation and Communication in Health and Life Sciences
Faculty of Earth and Life Sciences. W&N building, U543

Master Management, policy analysis and entrepreneurship in health and life sciences
specialization Management and entrepreneurship, VU Amsterdam

VU

mulier instituut

Table of content

Summary

The objective of this pilot study was to investigate the meaning of sport and physical activity as narrated by people with depression during treatment. By providing different views on movement-related treatment and sports this study adds to a better understanding of the patient's perspectives. This can help healthcare professionals in tailoring the movement-related therapy, and thereby improve the outcome of movement-related treatment.

In recent years, there has been an increasing interest in sport and physical activity as an instrument to treat depression. There is, however, limited knowledge of the different ways people with depression give meaning to sport and physical activity during treatment. In order to fill this knowledge gap, this study seeks to address the following research question: *"What is the meaning of sport and physical activity for people with depression during treatment?"*

In order to answer this question an ethnographic case study was conducted at a psychiatric ward of a general hospital in the Netherlands. Data was collected by means of observations, informal talks and interviews during a seven-week fieldwork period. Five participants took part is this research and provided 'thick descriptions' on the meaning of sport and physical activity during their admission at the psychiatric ward of a general hospital (PAAZ).

These descriptions are presented in the results section as four narratives on the meaning of sport and physical activity. The narratives that will be presented in this research are: (1)*"The movement-related therapy is there just to do something – anything*", (2) *"Sport can provide distraction and mental relief"*, (3) *"Sport is good for your health, so therefor I ought to do it"* and (4) *"Trough sport and physical activity, I am confronted with my limitations*

The findings of this research offer valuable insights and have important implications for the development of future sport related treatments. The most significant implication of this study is that in order to improve the support of patients and enhance the movement-related treatment programmes it is important to take the variety of meaning on sport and physical activity into account. Furthermore, this research shows that the meaning of sport and physical activity can differ significantly between people with depression. It can provide positive as well as negative meaning, and is subject to numerous contextual factors.

The narratives that are presented in this research can be seen as a first step to broaden our perspectives on the different ways patients with depression give meaning to sport and physical activity. Limitations of this study include limited time, the unequal time distribution between participants and therapies and the noncommittal nature of the treatment setting. It is therefore recommended to extend the fieldwork period and reduce the intensity. Furthermore, future research is needed to build on this pilot study and expand our understanding of this neglected field of research even further.

Introduction

"Crazy? He, who does not move is crazy!" (Bakker, n.d.). This quote from the well-known Dutch psychiatrist Bram Bakker illustrates a common health and sport discourse in the Netherlands. People are expected to do sports, and playing sports equals a healthy choice (Notté, 2012). This idea is widely accepted by society, and Dutch health policy focuses increasingly on physical activity and sports (VWS, 2011). The Ministry of Health, Welfare and Sport (VWS) have placed an increasing emphasis on physical activity as an instrument to increase health in the Netherlands (VWS, 2011). With movement programs such as *'meedoen alle jeugd door sport'*[1] (VWS 2005) and *'Nationaal actieplan sport en bewegen'*[2] (VWS, 2007), the government attempts to increase sport participation, and thereby improve general health in the Netherlands.

Sport and physical activity are also emergent instruments to increase mental wellbeing, and more specifically treat depression. The latter is the focus of this study. Each year, 797.000 people suffer from depression in the Netherlands (Conijn & Ruiter, 2011). Treatment options for this substantial number of patients are numerous, and include drug treatments, psychological treatments and other sources of support.

In recent years, there has been an increasing interest in exercise as an instrument to treat depression. Running therapy is a well-known example of such an emerging movement-related treatment (Kruisdijk et al., 2012). The trend of these movement-related treatments is reflected by the growing number of studies on the therapeutic effects of physical activity on depression (Blumenthal et al., 1999; Brosse, Sheets, Lett, & Blumenthal, 2002; Craft, 2004; Faulkner & Biddle, 2004, Carless & Sparkes, 2007).

The vast majority of these studies, however, focus on the biological and medical aspects of exercise and depression. Furthermore, there is a clear tendency towards a positivistic scientific approach in sports research. This approach is based on the presupposition that there is an objective reality, which can be described in set patterns of cause-and-effect (Cohen & Crabtree, 2006). Within this positivistic approach, science is considered value-free and researchers are objective, neutral and rational beings (Green & Thorogood, 2004, p. 12). Often, there is no room for patients' perspectives in this type of

[1] MAJDS. *'Sport Participation for all youth'*
[2] Nationaal actieplan sport en bewegen. *'National plan of action for sports and exercise in the Netherlands'*

research. As a consequence, little is known about the way people give meaning to sport and physical activity during treatment of depression.

Since the recovery process is unique to each individual and depends on situational and contextual factors, it is of considerable importance to explore the different ways patients give meaning to sport and physical activity (Carless & Douglas, 2008). Adequate insights into this topic will result in a more in-depth understanding of sport and physical activity as part of the treatment for depression. It can help enhance the therapeutic effects of movement-related treatment and decrease dropout (Daley, 2002). Furthermore, a more detailed and broad understanding of the subjective nature of movement-related treatment will provide better guidance for medical professionals to differentiate between patients and tailor their care. Therefore, this pilot study will look beyond the biomedical effects of physical activity on depression and focus on the perception of patients.

The objective of this pilot study is to make a first step in filling the void in 'sport & depression' related research, by providing narratives of the meaning of sport and physical activity as narrated by people with depression during treatment. This paper will therefore explore different narratives by answering main research question: "What is the meaning of sport and physical activity for people with depression during treatment?"

This paper has been divided into six parts. This paper first gives a short background on depression and movement-related treatment. The second chapter lays out the theoretical dimensions of the research, and looks at the concepts of meaning and narrative. It will then go on to the methodology of this research, in which the setting, the participants and the data collection and analysis will be discussed. The results of this study will be discussed in the fourth chapter. The result section is divided into a background section on the setting and the participants, and five narratives on the meaning of sport and physical activity. The fifth chapter will give a brief conclusion, and is followed by the sixth chapter of this research. This final chapter will discuss the findings, the methods and the implications.

Background on depression & movement-related treatment

This introductory chapter provides a brief overview of the impact of depression. The impact of this illness will be discussed on a personal and a societal level. In addition, this chapter will give account to recent research outcomes on exercise as a treatment for depression.

Depression can be defined as a continuum of mental health problems, where low mood, absence of positive affect and associated emotional, cognitive, behavioural and physical symptoms are present for at least two weeks (NICE, 2007). According to the DSM IV-TR[3] at least one of two core symptoms have to be present, often accompanied by one or more other symptoms (table 1).

Core symptoms (at least 1)	**Other symptoms**
- Depressive mood the whole day/daily - Loss of interest in activities the whole day/daily	- Appetite/weight changes - Sleeping disorders (insomnia/ hypersomnia) - Agitation/restlessness of inhibition - Fatigue/loss of energy - Feelings of worthlessness/guilt - Concentration problems/ slow thinking/indecisive - Returning thoughts of death/suicide

Table 1. DSM-IV classification

People with depression typically have feelings of guilt, worthlessness and a clear reduction of interest and enjoyment in everyday life (NICE, 2009). Behavioural and physical symptoms often include tearfulness, social withdrawal and irritability (Gerber *et al.,* 1992). Other common physical symptoms are fatigue and diminished activity. Cognitive symptoms include reduced attention, poor concentration, mental slowing and rumination (Cassano & Fava, 2002).

Each year, 797.000 people suffer from depression in the Netherlands (Conijn & Ruiter, 2011). Once individuals have had a depressive episode they are at higher risk of having another episode. Chances of relapse within five years after a first episode are 70%.

[3] Even though the DSV V is out, this research uses the DSM IV classification, since diagnoses of participants are based on the DSM IV.

Furthermore, each additional episode increases the risk of another episode. Therefore, the chances on a fourth depressive episode are about 90% (Conijn & Ruiter, 2011). Additionally, persons who suffer from depression have a 1.65 times higher risk at a premature death compared to people who never suffered from depression (ibid).

In addition to the personal impact, depression can also have an effect at the population level. In the Netherlands, for instance, depression accounts for 8,2% of the work related absence. This makes it the number one reason of work absenteeism (Conijn & Ruiter, 2011). Moreover, depression is one of the more expensive diseases, with annual direct costs over 773 million euros (Meijer, 2012).

In order to cut these costs effective low cost treatment programs for depression are needed. According to Kruisdijk et al (2012) exercise and movement-related treatment could be such a treatment. Moreover, a growing number of reviews show a range of psychological and physiological benefits of movement-related treatment for people with depression (Blumenthal et al., 1999; Brosse, Sheets, Lett, & Blumenthal, 2002; Craft, 2005; Faulkner & Biddle, 2004, Kruisdijk et al, 2012). In addition to the possible cost reduction, movement therapy has minimal side effects compared to, for instance, drug therapy (Daley, 2007).

Furthermore, exercise may improve depression symptoms that traditional (drug) interventions, do not. These symptoms include fatigue and reduced cognitive function (Eriksen & Bruusgaard, 2004; Etnier et al., 1997), but also the reduction of cardiovascular diseases and improved weight management (Department of Health, 2004). In addition, studies by Fox (2000) and Taylor & Fox (2005) suggest that exercise can improve self-esteem and self-efficiency. Furthermore, physical activity can be a form of behavioural activation, which is seen as a key element of effective psychotherapy interventions for depression (Brosse et al, 2002).

According to these studies exercise could be a very effective and low cost treatment. The results suggest that movement-related treatment has mere positive effects. However, as was pointed out in the introduction to this paper, the vast majority of these studies only take the biomedical aspects into account. Previous studies of movement-related treatment on depression have not dealt with the perception of the patients. This despite the fact that a more detailed and broad understanding of the subjective nature will help enhance the therapeutic effects of movement-related treatment.

Methodology

Research method

As this study aims at providing narratives on the meaning of sport and physical activity, an ethnographic narrative research method is considered the best approach (Tesch, 1991). This approach is needed in order to seek people's stories and identify shared beliefs, values and identity (Tesch, 1991). The use of ethnographic fieldwork is especially suited to explore the real life situations that are studied in this research, and understand how the meaning of sports and physical activity is constructed in this context. By conducting observational fieldwork it is possible to identify multiple voices, in order to reveal the diversity of the expressed narratives (Finn & Waring, 2005).

Two scientific methods of data collection were used in this research to gain insights into the different narratives and the context in which the narratives were created. The two methods were (a) participant observation and informal talks and (b) semi-structured interviews. The section that follows will elaborate on these methods. In addition this chapter will discuss the setting, the participants and the narrative analysis.

Setting

This study focuses on a treatment setting, in which people with depression are admitted to the psychiatric ward of a general hospital (PAAZ) in the Netherlands. The PAAZ offers short-term treatments and crisis intervention for a variety of patients and pathologies (Hoogduin, 1984). The choice for this setting is based on the combination of the presence of patients with depression and the intensive treatment they receive. For this pilot study there was limited time to conduct ethnographic fieldwork, so therefore an intensive setting would serve useful. At the PAAZ it was possible to observe fulltime treatment programs, and follow the participants' entire stay at the hospital.

Participants

Six patients at the PAAZ were identified as possible participants and were asked for consent. Five participants were included in this research and one was excluded due to the lack of time spent with this patient. Excluding criteria for this research were: (a) High suicide risk and (b) treatment duration less then 2 weeks. The five included participants were willing to take part in the research and all were diagnosed with depression.

Although one of the participants only attended one movement therapy session, he was not excluded from this research. Not participating in movement therapy could provide a different angle to the meaning of sport and physical activity, which could further broaden the view of this research. Therefore, all five patients that were willing to take part were included in this study.

The participants were aged between 30 and 70 years old, and two participants were female and three were male. All participants received medication and were 'fulltime' residents at the PAAZ for three to six weeks. During the fieldwork period all participants were admitted and discharged from the hospital. In this research the participants are referred to by pseudonym, in order to provide anonymity.

Table one shows the (medical) characteristics of the participants. Age is given in categories according to the estimations that were given by the psychomotor therapist during the interview. The diagnoses of the participants were asked for during the fieldwork period and checked with the professional.

	Sex	**Diagnose**	**Age**	**Duration stay**
Willem	M	Recurrent depression, moderate	65-70	3 weeks
Wessel	M	Depressive disorder NOS*	50-55	4 weeks
Sophie	F	Recurrent depression, alcohol dependence	60-65	4 weeks
Mariska	F	Depressive disorder NOS*	30-35	5 weeks
Carla	F	Recurrent depression	50-55	4 weeks

* NOS = not otherwise specified

Table 1. Characteristics of the participants

Data collection

Prior to the fieldwork ethical clearance was obtained from the medical ethical committee of the Free University of Amsterdam. Following the approval of the hospital management, a seven week fieldwork period began were I immersed in the daily life of the psychiatric ward in a general hospital in the Netherlands. Here, I took part in the movement-related therapy as well as other therapy session and day-to-day activities such as lunch and day openings. In order to build trust and rapport, it was important to position myself as close to patients as could be.

Depending on what you want to know and the limitations of the field, you have to position yourself somewhere on the continuum of complete participant to complete observant (Boeije, 2005; Hammersley & Atkinson, 1995). I positioned myself in the middle of that continuum, as I did participate in the therapies, but did not express my life story as the participants did in therapy.

Furthermore, in order to get a full in-depth understanding of the meaning patients give to sport and physical activity I had to shift from insider to outsider, and be a 'professional stranger' (agar, 1996). Being a professional stranger entails constant questioning practices and the meaning of situations. I therefore had to shift constantly between a researchers' perspective and a 'patients perspective'.

Due to the severity of the participants' mental state, it was important to minimize risk of distress for the participants. Therefore, my presence had to have as little impact as possible, and not interfere with treatment. In practice this implies a friendly and cautious attitude. Also, I avoided asking 'therapeutic' questions, as this might distance myself from the participants.

Observations and informal talks

Over a period of seven weeks, I engaged in participant observation and 'informal talks' with the participants during movement-related therapy and daily activities at the PAAZ. I collected field notes and kept a logbook, in which I wrote notes of feelings and reflections on past activities. I observed not only what was said, but also how it was said and in what context (Sparkes, 2005). Furthermore, I observed the daily routine at the PAAZ and the individual day program of the participants.

During my observations I focussed on the four levels of the conceptual model and used a grounded approach to collect data. The field notes were written as soon as possible, and without the participant's presence. During the observations and talks the focus was not merely on the individual participants, but also on the interaction between them and with other patients and staff members.

Interviews with participants

At the end of treatment a single in-depth, semi structured interview was conducted with each participant. The interviews lasted between 30 and 45 minutes and were recorded and transcribed verbatim. The objective of this final conversation with the participants was to verify my observations and gather more data on the meaning of sport and physical activity during treatment.

The interviews were conducted at the end of treatment, because at that moment trust and rapport was expected to be established between the participant and myself. During the interview descriptive questions, structured questions and contrast questions were used to learn about experiences and to investigate specific details and check meaning and interpretation of experiences (Biddle et al, 2001). Questions such as *"Could you describe the movement-related therapy sessions at the PAAZ?", "You have mentioned that you played volleyball when you were young. How was it to play volleyball here?"* and *"Is there a difference in how you experience walking now and before your depression?"* were asked in order to get a complex and in-depth understanding of the participants individual experiences (Carless & Douglass, 2008).

The interview began with basic questions about the participant's experiences with sport. This topic was chosen because it is an 'easy' starting point that would allow the participant to sit at ease and talk freely. With the second topic we moved from the distant past to the sport participation prior to the depression. A third topic shifted to the participant's experiences at the PAAZ, and reflected on the period of treatment and my observations. Whenever possible the questions that were asked were personalised with previously acquired information.

Interview with therapist

During the final stages of data analysis a semi structured interview was conducted with the movement therapist. This interview lasted for 60 minutes. Notes were taking during the interview, and a summary was made afterwards. The objective of this interview was to present the preliminary results to the therapist and discuss the findings. This was done in order to verify and debate these findings and thereby increasing the reliability of the findings.

Narrative analysis and Interpretation

An inductive approach was used to analyse the data, in order to ensure openness to the participant's understanding of the world. The data is viewed within the context and social situation in which it is created. During the fieldwork the data was labelled according to the levels of the conceptual model. This 'coarse on sight labelling' served as a guideline for the data collection and ensured that all levels were taken into account.

The first stage of the analysis entailed reading and rereading the interview transcripts, reflective notes and verbal and observational field notes. This was an on-going iterative process that started at the beginning of the fieldwork period and continued throughout the writing of this rapport. By close rereading I immersed myself in the data, which resulted in progressive insights (Maykut & Morehouse, 1994).

The second stage of analysis involved an iterative process of open coding, axial coding and selective coding with the use of Nvivo 10 (Boeije, 2005). First all the data was coded with description codes. This process was repeated in order to check for misses. Thereafter, I started the axial coding, where the codes were related to each other, via a combination of inductive and deductive thinking. I made code webs in order to categories the codes and link them together.

The final stage of analysis entailed selective coding, in which I chose the core categories, and related all other relevant categories to that category, in order to construct the 'theme' that illustrated the meaning given to sports and physical activity by the participants. The core categories were chosen on bases of frequent occurrence and relevance to the research question.

With the core categories in mind I reread the data and the 'nodes' that I created in Nvivo. I selected quotes and observational data that reflected the core concepts and I began to write the narratives. I used the interview with the therapist to check the results and made adjustments if necessary.

After the construction of the narratives I sought out similarities and differences between the narratives and the literature in order to set the data in a more profound context. Furthermore, I gave my interpretation of the expressed narratives by discussing them in light of the four levels described in the conceptual model.

Theoretical approach

This chapter describes and discusses the theoretical approach used in this study. The first section will discuss the *narrative approach* and the key concept *meaning.* The second part moves on to describe the conceptual model. The conceptual model of this research is used to guide data collection and ensure that all factors that are involved in shaping the narratives are taken into account.

Meaning & narratives

The concept *meaning* is central to this study, and entails the way individuals try to understand their surroundings and everyday reality (Weick, 1995). Meaning can be seen as implied or explicit significance of phenomena to an individual. It affects the way people interpret their current truths, and also their future truths. In addition to time, meaning is also dependent on social and situational factors (ibid).

Individuals can present meaning through stories or narratives, as narratives can be seen as 'one of the fundamental ways people organize their understanding of the world' (Atkinson et al., 2005). Narratives represent the logic, ethical and behavioural assumptions that are significant to the creator of that narrative (ibid). Together, narratives construct our social world, shared values and priorities. Furthermore, they influence the way we experience things, and visa versa.

Narratives, and meaning, are subject to change as well as degrees of dominance (Gergen, 1982; Shoetter, 1984). They have to fit within the bigger frame in which a person has constructed his or her reality. This reality is a dynamic process in which other people play an important role. Within society different trends in reasoning can be found. These trends in reasoning are known as *discourses* and consist of a network of meanings in relation to each other. Discourses guide the construction of people's 'truth' (Weick, 1995).

Dominant sport related discourses within society play an important role in the way people express and create sport related narratives (Coakley, 2007). In this research sport and health related discourses are taken into account since they can reveal underlying assumptions about sports and physical activity. Furthermore, this research does not only focus on the 'individual stories' of participants that are told to the researcher. All interactions, either verbal or nonverbal, are included in this study.

Studying these interactions will help our understanding of the relationship between meaning, intention and action. In order to get a balanced and broad picture of the meaning

of sport and physical activity it is important to take all relevant information into account. Therefore, an open approach to meaning is favoured in this study. This open approach to meaning is needed to keep an open mind and provide a broad spectrum of narratives.

Conceptual model

Based on the background information and the theoretical approach a conceptual model was developed. The conceptual model entails the conceptual outlines of this research and is used to guide data collection and analysis. In the conceptual model all core concepts are intertwined, but shall be explained separately. The conceptual model is based on the levels of narrative analysis used by Murray (2000). Murray describes four levels of narrative analysis in his research on health psychology (Murray, 2000). The four levels are the personal level, the interpersonal level, the societal level and the positional level.

At the personal level people organize their perception of the world and their behaviour in that world. The personal function of the narrative is central to this level of analysis. These functions may include a form of self-care, but also the reconstruction of identity (Murray, 2000; Frank, 1995). *"The process of creating a narrative enables the person to give meaning to the constant change in his or her life, to bring order to disorder*" (Murray, 2000). At this level, the narrative is considered a way of *"getting to know the body and reorganize one's identity"* (ibid).

In contrast to the personal level, the interpersonal level considers the conversational context in which narratives are constructed. This level takes the interpersonal processes into account and portrays the narrative as one that is co-created in dialogue (Murray, 2000). Other patients, as well as the health care professional and the researcher will contribute to the creation of narratives. Furthermore, the narratives are also subject to the format of questions and observation (Mishler, 1986). Different types or formulation of questions may produce different stories, but also silences and responses influence the creation of narratives.

In addition to the conversational context, the social characteristics of interpersonal processes also play an essential role in the construction of narratives. These social characteristics of interaction are considered at the positional level. These characteristics extend the interpersonal level by considering differences in social position, which exist prior to the interaction (Doise, 1986, p 13). For instance, in this study the positioning of a healthy researcher versus a participant with mental illness could place the participant in a position of justifying his or her sickness (Radley & Billing, 1996). Also, social differences or

age differences contribute to the construction of narratives. It is therefore important to have an understanding of the positional context in which the narratives are constructed and get their function and meaning.

The fourth level that is considered by Murray is the ideological level. This level takes the society's ideas and beliefs into account (Doise, 1986, p. 15). Underlying assumption and generally accepted ideas can be found at this level. At this level the emphasis is on the sociocultural view on a certain phenomenon. According to Doise (1986) this sociocultural view can help examine how cultural assumptions and discourses permeate our society and our own identity.

Figure 2 provides a representation of the four levels that constitute the conceptual model of this research. The four levels all play a part in the construction of the narratives on sport and physical activity. Together, the four levels provide a collective representation of the meaning of sport and physical activity. Therefore, the narratives in this research will be presented as 'whole stories', in which all levels are integrated. However, some levels may be more prominent than others. That is why the narratives will be discussed as a whole as well as at the separate levels.

On the basis of this model the main research question *"What is the meaning of sport and physical activity for people with depression during treatment?"* is refined into the question: *"What types of narratives do people with depression use to give meaning to sport and physical activity during treatment, taken into account the personal level, interpersonal level, societal level and positional level of narratives.*

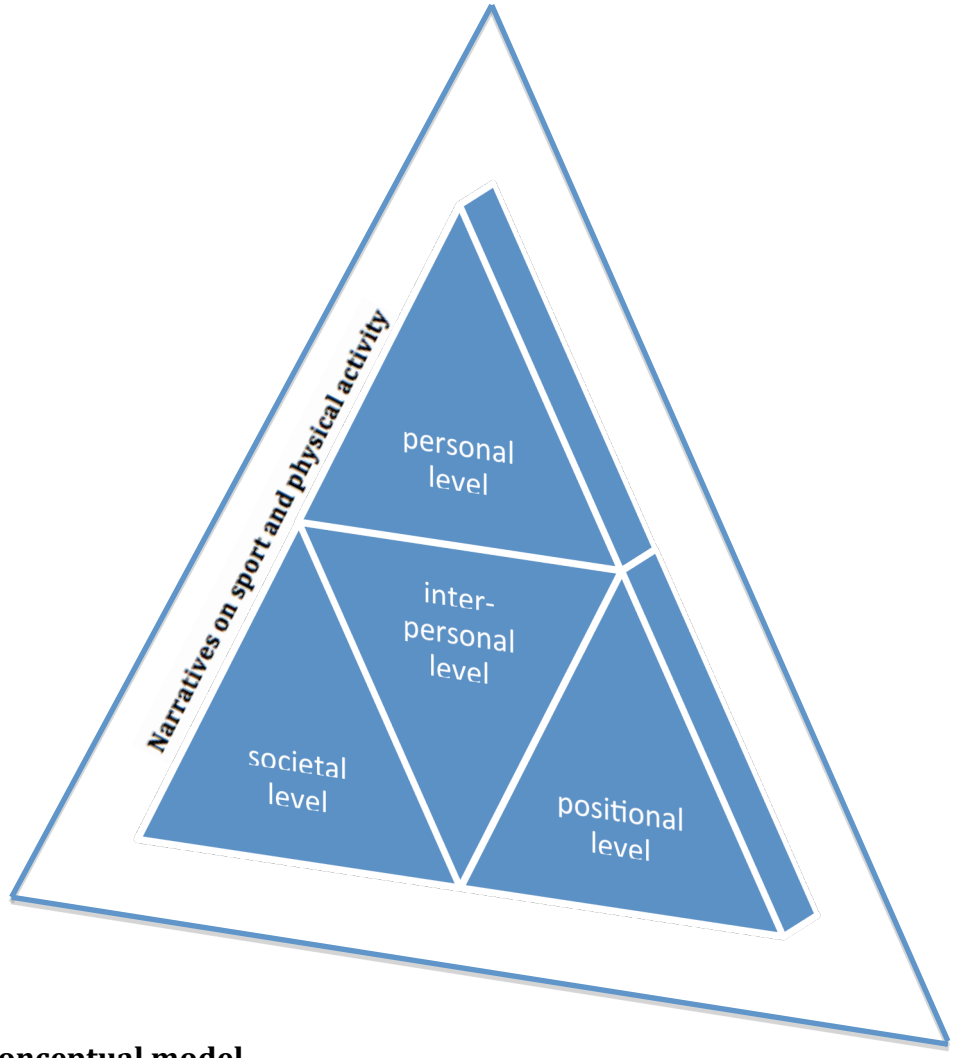

Figure 2. Conceptual model

Results

Background

The first section of the results includes a description of the setting and a personal background of the participants. This part serves as an introduction to the context in which the narratives are told. Furthermore, it provides a background on the participants in order to gain better insights into the narratives. The second part of the results will elaborate on the meaning of sport and physical activity as narrated by the participants.

Setting

During a stay at the PAAZ people live in a communal group up to twenty-four patients. There are some individual rooms, but the majority of the rooms are doubles. The ward has double entree doors with a bit key lock. People can come in only when they have the key, or if someone with a key opens and closes the door behind them. Alongside the double door is an office, were the staff sits between therapy hours. On the right there is a hallway with a table tennis table that leads to the main hall. This main hall is divided into three rooms, the group activity room with a large table, and a dining area with five small tables and one large table in the middle and a TV area with long chairs.

During the day there are approximately six to eight nurses, two therapists, one group activity leader, one team manager and one doctors assistant. This composition of staff depends on which day of the week it is (see appendix 1). There will also be one psychiatrist, whom you will rarely see. As a patient you can make an appointment with the psychiatrist, most of the time without a precise time or even date. But since patients do not have the key to go out and about, they wait (im)patiently for the psychiatrist to visit.

When patients are admitted to the PAAZ they receive an information brochure on the therapy and activity program and a brochure with general information concerning the ward. In this first brochure the aims of the different therapies are described. The goal of the movement-related therapy is described as learning to listen to your body via sports and play, dance and expression exercises and relaxation exercises. Furthermore, the therapy aims at increasing awareness of how you deal with situations, and work towards personal goals. In general the movement therapy is divided into four categories, namely

relaxation, dance, walking outdoors, and sports and play. Apart from the movement therapy there is running therapy, which is coached by a nurse.

Each morning at a quarter to nine all the patients and the staff meet in the dining area, and the staff elaborates on the program of that day. Depending on the liberties of the patients they can choose which activities they want to participate in. There are two activities before lunch and one in the afternoon. This 'free choice' mentality continued until my last week at the PAAZ. During the last week of fieldwork the therapists introduced a new system, in which patients in consultation with the therapist determined their (weekly) program.

Personal background of the Participants

Willem

Willem, a Dutch Caucasian male, was admitted to the PAAZ after an attempted suicide. He did not see any other way out. It is Willem' first admission at the PAAZ. His stay lasted for almost three weeks. Willem lives with his wife and has grownup children. When he told us (patients and me) his age, we did not believe this to be true. He looks quite a bit younger than 70. Willem likes to know here he stands and what is expected of him. He has a strong sense of responsibility and a set daily routine.

"It doesn't matter how good or bad I feel, I will always get up at eight a clock."

When Willem was little he played sports a lot, mostly volleyball. When he got older he stopped playing sports and he did not do any sport activities for many years. Some months ago he had to undergo hearth surgery, and afterwards he started working out at the gym on advice of his psychologist. He paid a weekly visit to the gym to do an hour and a half of cardio fitness.

During the first two weeks of his stay Willem expressed a very faint and physically weak feeling. He did not know what he would like to do, and does not recall ever really liking something. During his stay at the PAAZ Willem regularly participated in the movement therapy sessions, mostly sport and play activities. During the interview he said that he tried to incorporate one physically active moment in his program each day.

Wessel

Wessel is a Caucasian male of Dutch origin in his early fifties. Even though he has experienced depression before, this was his first hospital admission. Wessel attempted suicide and has been diagnosed with depressive disorder NOS (not otherwise specified). His stay at the PAAZ lasted for almost four weeks.

Wessel has a wife and a son, whom he lives with. In addition to the depression, he has a degenerative neurological disease, which results in a loss of function in his left arm. Furthermore, he has a loss of function in his left leg and therefore walks with a crutch. Wessel used to do a lot of sports when he was younger, such as table tennis, volleyball and soccer. The years before his depression he did not enter in any sport activities. Wessel finds it very depressing that he does not know how his neurological disease will progress. In his first week he said:

'It may sound cruel, but not knowing what I can expect is so extremely frustrating… that sometimes I say it would be better to just have it over with'.

During the first week of his stay Wessel attended the movement therapy sessions, but could not really engage in all activities. Nevertheless, Wessel wanted to participate in the next movement therapy session. However, the nurses and therapist advised him not to go. Wessel reluctantly agreed with the staff, and did not attend any more movement therapy indoor sessions. During the end of the second week Wessel said:

"I am not handicapped. I do not want to admit that I can no longer do things, but I have to accept that there are certain things that I can no longer do. I still have my ups and downs, but my death wish is gone".

Carla

Carla is a Caucasian woman of Dutch origin in her mid fifties and has been diagnosed with recurrent depression. During her last episode in 2004 she was also admitted to the PAAZ. This time her stay lasted for four weeks.

Carla lives with her husband and dog. In the past she engaged in sports such as yoga, recreational swimming and other moderate sporting activities. Carla proudly told me she has always been engaged in some sort of sport activity, especially when she was

depressed. Prior to her admission she would go for a walk or ride a bike if she felt depressed. During her stay at the PAAZ she frequently went to the movement therapy sessions. She also took part in the running therapy sessions.

Sophie

Sophie is a Caucasian female of Dutch origin in her early sixties. Several months ago she lost her husband and became depressed. She now lives alone, but sees her children often. After a first admission to the PAAZ earlier this year, she had a relapse and has been readmitted. Her second stay at the PAAZ lasted for four weeks.

When Sophie was little she did gymnastics and liked to go swimming. When she got older sports did not play a significant role in her life. There were periods were she didn't play any sports, alternating with periods of moderate sporting activities. In these periods she played badminton, went jogging or other individual sport activities. Furthermore, before Sophie got depressed she would go for a one-hour walk twice or three times a week with neighbours after supper. Prior to her admission she also joined an elderly gym club.

During her stay at the PAAZ Sophie participated in the movement-related therapy approximately two or three times a week. She preferred creative therapy to movement therapy, but favoured movement therapy often over 'talk'-sessions. Sophie said that she tried to incorporate one physically active moment each day. That moment could either be at the PAAZ or at home.

Mariska

Mariska is a Caucasian woman in her mid thirties, and is of Portuguese origin. Mariska has been diagnosed with depression and anxiety disorder. This is her first admission to the PAAZ, and her stay lasted for five weeks. Mariska grew up in Portugal and does not speak Dutch, but does understand a little Dutch. She has two children from her first marriage, whom still live in Portugal. She recently gave birth to her third child, whom she raises with her boyfriend (and father of the child).

When Mariska was young she was a very good gymnast, and trained to compete in the Olympics. She stopped doing gymnastics when she was fourteen. After that she did not do any sport activities for many years. There were brief periods were she would participate in individual sporting activities such as running.

During her stay at the PAAZ she attended one movement-related therapy sessions and two running therapy sessions. After her second run Mariska came back to PAAZ looking very pale and quiet. She had suffered from vertigo and nausea. After this she did not attend any movement therapy sessions.

Narratives on the meaning of sport and physical activity

This second part of the results consists of four narratives on the meaning of sport and physical activity. These narratives are: (1) *"The movement-related therapy is there just to do something – anything*", (2) *"Sport can provide distraction"*, (3) *"Sport is good for your health, so therefor I ought to do it"* and (4) *"Trough sport and physical activity, I am confronted with my limitations".* The narratives that are presented in this chapter are jointly constructed, but not all participants express each narrative.

1. The movement-related therapy is there just to do something – anything.

The first narrative that is expressed by multiple participants, in interaction with other patients, is the narrative that movement therapy as 'just' an interruption of the daily activities at the PAAZ. Sophie, Carla and Willem consider the therapy as being entertained. Furthermore, Sophie and Willem question the goals of the PAAZ program, including the movement therapy.

Willem expressed his doubts on the goals of the program at the PAAZ. During the interview he said that he does not get the philosophy behind the therapies. For Sophie and Willem movement therapy is seen as something that keeps you out of the street, a way to keep you busy. Although a lot of depressed patients express this narrative in a displeasing way, doing something and keeping your mind occupied can be seen as a relief. The hours in which there is nothing to do are considered the hardest hours of the day.

One Monday a patient expresses her dislike on the daily routine to Carla and me. *"The time between 12 and 13.30 are the toughest hours. Then, there is nothing to do, and you have to entertain yourself. Those are the hours I will not miss when I have left here".* Carla and another patient nodded in agreement to this statement. The next day during one of the weekly communal group meetings Sophie reiterated her discontent about the daily program. She told the staff how she felt about the hours after lunch, and that she would like to see the therapy hours extended. One nurse responded that she could do something by herself during these hours, and that it is just the way things are. Sophie did

not like this answer and glared at the nurses. At that moment the nurse did not address the importance of learning to do things on his or her own. The movement therapist shared this view with me later that day. She explained that once patients go home they will have to act on their own initiative.

The personal function of this narrative seems important in that it reflects some of the frustrations that Sophie and Willem have with the duration of the therapy sessions. This view is expressed mainly during the interviews and in one-on-one informal talks. Most of the time, these conversations took place after a therapy session on the way back to the ward, or during a 'therapeutic walk'.

Sophie and Willem expressed this narrative to the other patients and me, but not to the staff. This might be due to the fact that they did not see me as one of the staff members. Although Willem and Sophie may not see me as staff, Wessel did implicitly expressed that he did see me as 'one of them'. During the interview with Wessel I noticed that when he talked about the health care professionals of the PAAZ he addressed them as 'you guys'. This clearly shows that the experienced social position of the participants towards me differed among the participants.

2. Sport can provide distraction and mental relief

A second narrative that is expressed by some of the participants is about distraction and relief. Wessel, for instance, points out that for him it's not about the exercise itself, but it's about the distraction: "*when you do sports you do not mull and think of all the problems."* In response to this statement I ask him if that also applies to him. He replies with: "*yes, yes, yes, and that is the thing I miss. It is not the exercising itself, but the distraction [from depressive thoughts]".*

Not only Wessel, but also some of the health care professionals expressed this view. During my interview with the movement therapist she mentioned that distraction is one of the most important goals at the movement therapy. '*Patients need to learn that they can come out of their heads from time to time. [..] A lot of patients are constantly absorbed by their thoughts'.* Furthermore, during one of the running therapy sessions I asked one of the 'running therapy nurses' how he started with the running therapy. He answered with: *"Well, it is also very nice to start your work like this of course. And I am also getting older.. so before you know it ..[gestures getting fat]. And furthermore, when you walk you do not linger.*

This explanation was given in a matter-of-fact way, at which Sophie and another patient, whom were participating in the running therapy session that day, nodded in agreement. This talk provides a nice illustration of jointly constructed truths. Sophie could relate to the narrative that was expressed and expound upon it. She frequently repeated the nurses' statements on the distraction effects of running.

Sophie explained during the interview that for her it is not merely distraction. By exercising she is able to distribute her energy more evenly between her head and her body. *"At a certain point, I get tired [..] Than you are not plunged in negative thoughts all the time".* On a personal level Sophie expressed that distraction from negative thoughts is greatly dependant on contextual factors. She prefers competitive, and high intensity play. *"Only when I can really play fanatically, I am able to let go of my depressive thoughts".* This was clearly visible during the therapy sessions. Sophie seemed keen to play to full capacity.

Not only Sophie, but also the other patients seemed more vivid while playing competitive games. Especially Willem seemed to brisk up whenever we could smash the ball to the other side of the gym. During volleyball sessions Willem was more talk active, cheered and gave supportive comments to his team players.

This second narrative is one in which the interpersonal and positional level play a dominant role. As Sophie explained herself, she also exercises "*because all the professionals say it is good for you"*. The view that sport and physical activity can provide distraction is therefore co-created in dialogue with the professionals. Furthermore, because of the positional level it seems likely that the participants are receptive to this view, as the professionals have an advisory role towards the patients.

3. Sport is good for your health, so therefor I ought to do it [but it is hard to do it on my own]

That 'sport is something you ought to do', is a statement most of the participants can relate to. In the interview Sophie explains that she exercises because she's convinced it's is good for her, rather than enjoying the activity itself. *"It's terrible to start exercising, but once I do it, it's a real victory. I don't want to do anything, but I know in my mind that I have to get up and start moving",* according to Sophie. Furthermore, when asked how exercise made Sophie feel, she answered with: *"Well, I do feel satisfied because you know that it is good for you".*

Sport and physical activity, while depressed, is seen as an obligation or even a burden by most of the participants. According to Willem, Sophie and Carla, you have to force yourself to exercise. During the interview Willem said that he imposed himself to go to the gym every Wednesday. *Fortunately*, he said, *"there is always a way out"*. If he really did not want to go, he could always go tomorrow.

One moment during creative therapy Sophie and I were talking about her experiences with sport. Sophie started talking about her present sport activities:

S: … well, I started doing gymnastics again, but I really don't like it.

I: So what do you do there?

S: some ground exercises, but I really don't enjoy it.

I: So why do you do it then?

S: well, once I'm there it's all right, but when I have to go I constantly say to myself: pff, I have to go again [looks not amused]. But than it does feel like I have fulfilled my duty".

None of the participants expressed enjoyment in sports during depression, which lies in line with expectations considering the pathology. Just before the last running therapy session I asked Carla if she was looking forward to go running this morning. She responded with: *"I do not really think about it that way".* Carla also expressed that she knows exercise is good for her out of experience: *"I think it is because I have experienced depression before, than you know that you have to be physically active. You have to get up from that couch. I have to do something… and when you first experience this it will frighten you, and you would not understand what hit you".*

Although four participants expressed this obligatory view on sports, they also experienced a lack of motivation to move. This is inherent to their diagnoses, as one of the symptoms of depression is a loss of interest in activities. Some patients expressed a need for an external motivator to exercise or to be physically active. For instance, Carla explained that having a dog helps her to go for a walk. Furthermore, she said that that she started with the running therapy at the PAAZ because the nurses asked her. *'It was now or never.'* Carla was also motivated by other therapist since *'all the therapists give the advice to keep moving. And well, of course that is very hard, but if you are able to do that... ".* Willem also voices this external motivation from a professional. During the interview, he expressed that he had started the cardio fitness on advice of the psychologist.

In addition, apart from the direct advice from health care professionals there are also self initiated motivators. At the fourth running therapy session I saw that Carla was no longer wearing the PAAZ running shoes. I asked her if she bought new shoes at which she

replayed: *"Yes, I bought them this weekend. I thought to myself it would be best to just get them right away, otherwise I will probably not carry trough".* For Carla her new shoes had to serve as a big stick, for her to continue running.

When asked a question how Sophie puts herself to exercise she replayed with: *"Well, you have to be forced to do so, otherwise you will not do it".* This view is also shared with Wessel and Willem. Wessel argues that when he exercises *"there has to be some form of pressure. I have to have a jointly constructed planning [with for instance a fitness instructor], so I have to go."* For Willem it is also important to have a set date and time to do sports. If not, it is more likely that it will not happen.

According to Carla and Willem you have to be very strict and force yourself to do something. During the last running therapy session Carla compared running with depression. We were talking about going the extra mile when you run. She talked about the critical point when you would really want to give in and stop, but because someone or something is motivating you to take another step you try. "*That's what you have to do every day when you are depressed, a hundred times a day. Unfortunately by getting of the couch you do not get the satisfaction you get when you run".* Running, therefore, could be seen as a means to empower Carla.

Paradoxically, Carla expressed that being hard on yourself is dependent on whether or not you are depressed. When it comes to sport and physical activity she is less strict with herself when she is not depressed. During the interview she told me that before her depression if a 'swim buddy' cancelled on her, she would not go by herself. So, for Carla different sets of rules apply to her 'depressed self' compared to her 'normal self'.

In conclusion, four out of five participants expressed this third narrative. The dutiful view on sport is mostly given during the interviews, and in conversations between patients and healthcare professionals. Within this obligatory view the ideological level plays a dominant role since it is clearly linked to the cultural assumptions and discourses on sport. Also the positional level plays an important role in the construction of this narrative. The social position between patient and professional creates a 'teacher- pupil' relation in which the view of the healthcare professional is easily adopted. Furthermore, some patients seem to feel the need to explain and justify themselves or their illness.

Sophie portrays a good example of this phenomenon. Due to the depression Sophie had trouble getting out of bed. During the interview Sophie said she wouldn't go to bed during the day anymore. I asked her if this was a pitfall for her. She responded with: *"No! [..], I am not eighty years old!"* Only 30 minutes after the interview at 16 pm I went looking

for Sophie to say goodbye. I couldn't find her anywhere. At long last I heard from the nurses that she had gone to bed. Clearly, Sophie' story had a discrepancy between meaning, intention and action.

4. Trough sport and physical activity, I am confronted with my limitations

Mariska and Wessel expressed a narrative that can be described as "*Trough sport and physical activity, I am confronted with my limitations"*. Mariska expressed a confrontation with experienced limitations during the interview. She explained that she could not participate in the movement-related therapy. She tried, she said, *"but it was not possible"*. During her second session, Mariska had to stop with the running therapy. She was shaking and feeling dizzy. After that moment she did not attend any more running therapy and movement therapy sessions.

During the interview I asked Mariska how she had experienced the few movement therapies she attended. She responded with *"I was always an energetic person. And now I don't have any energy anymore. I wanted to rediscover my energetic personality [with the therapy]. […]But it didn't work out."* A little further in the interview she said: *"like I said, I was always an energetic person. I was always trying [..] I am not used to this [current situation of not being an energetic person]. At one time I was working so much, but I could still go to the gym. And from one moment to another it changed. Now I have the feeling that if I do something for myself, something bad is going to happen. I am also not sure of myself."* I asked her how it feels that she cannot do what she used to do. She said *"uhm It feels like.. I am not a valid person."*

The story of Mariska appears to be particularly significant at the personal level. She constructed a new type of identity through this narrative. Her 'depressed personality' is different from her healthy identity in regard to sport and physical activity. Furthermore, Mariska's current perception of sport is quite different from the way she perceived sports in the past.

In addition to Mariska's story Wessel also experienced a confrontation with his experienced limitations. In the first week of Wessel's stay he attended a movement therapy session on Monday. That Friday one of the nurses explained the program of that day and told the group: *"Everyone has to attend the movement-related therapy session today. Except if you cannot join in."* This subtle hint was lost on Wessel, as he raised his hand to participate in the movement-related therapy. In response, the movement therapist said *"well, Wessel… today, we will exercise more strenuous. You are welcome of course, but today is not very convenient"*. Wessel did not like this, and looked disappointed. During another

therapy session later that day he said: *"I am not handicapped. I do not want to admit that I can no longer do certain things, but I have to accept that there are things that I can no longer do."*

After this 'incident' Wessel only joined the 'therapeutic outdoor walks' in a wheelchair. During the interview Wessel explained: *"at a certain point I had to say to myself that it [movement-related therapy] does not work for me."*

I: "And why is that? That it does not work for you?"

W: "Well… You want to do more that you are able to. When we play with a ball, I want to play vigorous. But then, I have to make sure I do not lose my balance and fall, and cannot really focus on the ball. And at a certain point, that is going to work against you. At that point you have to say I have to quit, and start trying something else."

In the story of Wessel the interpersonal and positional level play a crucial role. Partly due to the interaction with the staff Wessel adopts the story that he is no longer able to do sports. During the interview he even internalised the choice of not participating in the movement therapy, even though this choice was made for him. Due to the differences in social position Wessel is probably more receptive of this view, and adapts his perspective on sport and physical activity.

Conclusion

The objective of this pilot study was to investigate the meaning of sport and physical activity for patients with depression. In this research the central question is: *"What is the meaning of sport and physical activity for people with depression during treatment?"* In order to answer this question the following study question was formulated: *"What types of narratives do people with depression use to give meaning to sport and physical activity during treatment, taken into account the personal level, interpersonal level, societal level and positional level of narratives.*

The purpose of the current study was to look beyond the biomedical effects of physical activity on depression and focus on the perception of patients. This subjective nature of sport and physical activity is translated into four narratives. Although this research was not set out to provide generalizable evidence, it does however provide insights in the way people with depression give meaning to sport and physical activity.

The most obvious finding to emerge from this study is that sport and physical activity is more than a mere means to treat depression. This research has shown that the meaning of sport and physical activity can differ significantly between people with depression. It can provide positive as well as negative meaning, and is subject to numerous contextual factors. Furthermore, the results of this research support the idea that the meaning of physical activity and sport are greatly dependent on personal, interpersonal, positional and ideological factors.

The four narratives that are presented in this research add to our understanding of the way people with depression give meaning to sport and physical activity during treatment. The narrative titles can be seen as general statements, "which are plausible because they rest on good reasons and the reasons are good because they are inferred from relevant information" (Bourdon, 1993). The four general statements that are presented in this study are:

-*"The movement-related therapy is there just to do something – anything*"

-*"Sport can provide distraction and mental relief*"

-*"Sport is good for your health, so therefor I ought to do it"*

-*"Trough sport and physical activity, I am confronted with my limitations*

These findings offer valuable insights and have important implications for the development of future sport related treatments. The findings of this research show that the meaning of sport and physical activity various amongst patients. Moreover, one person can adopt

several narratives, which are greatly dependent on personal, interpersonal, positional and ideological factors.

Furthermore, this study has shown that someone' sport history and the social context are important aspects in the creation of meaning. By providing different views on movement-related treatment and sports this study adds to a better understanding of the patient's perspectives. This can help healthcare professionals in tailoring the movement-related therapy, and thereby improve the outcome of treatment.

Discussion

Findings & future research

The first narrative that is presented in this research is: *"The movement-related therapy is there just to do something – anything".* This narrative on how movement therapy is something to keep you busy is somewhat similar to the action narrative of Carless and Douglas (2008). In this research they explored 'how sport and exercise may facilitate the reconstruction of a meaningful identity and sense of self in men with serious mental illness' (Carless et al, 2008). The action narrative resembles the narrative of this study in that it is portrayed as 'keeping busy' and 'doing stuff'.

Nevertheless, the action narrative of Carless and Douglas (2008) also tells the story of *taking action*, which is not expressed by the participants in this study. This could be due to the fact that these stories are constructed in different settings. Whereas the narrative of this research is presented at the PAAZ, the action narrative of Carless and Douglas is not constructed in a demarcated treatment setting. Their participants were patients at a weekly or daytime treatment setting, and where not hospitalized. Therefore, not taking action could be ascribed to the severity of the pathology in the current research group.

The second statement - "*Sport can provide distraction and mental relief*" - is one that is not only expressed by the patients in this research, but can also be found in the research of Notté (2012). There is strong consensus on the potential of sport and physical activity to provide distraction (Notte, 2012; Bahrke & Morgan, 1978; Gleser & Mendelberg, 1990). Of the four narratives, this is the one that is most expressed in conversations between the patients and the health care professionals. This could be due the fact that the health care professionals see distraction as one of the most direct and positive effects of sports and physical activity.

The third general statement that is presented in this research is: *"Sport is good for your heath, and therefore I ought to do it".* This statement resembles the 'sport equals a healthy choice' discourse that is presented by Notté (2012). This discourse is not only expressed by the participants, but also by health care professionals. Especially during the interviews a lot of the participants expressed their intentions to take up sport and often talked about sport and physical activity in future tense. This could imply a need for the participants to justify their illness and express their intentions to fit the desired image. At a positional level it is possible that the participants present this view because they believe

that it is the socially desired response. Something that I, as a researcher, would like to hear.

Moreover, the possible need of the participants to justify their illness and express their intentions to fit the desired image could also be the result of the timing of the interviews. As all the interviews were conducted at the end of the participant's admission, they might want to present a positive image of themselves. Therefore the timing of the interviews plays a role in the creation of this narrative.

Furthermore, my appearance can also contribute to the expression of this narrative. The fact that I am younger and have 'sporty look' according to the participants, will probably affect the way the narratives are constructed, even though I frequently explained that I am not investigating the biological effects, but that I am interested in the way that the participants give meaning to the matter.

The *'it is hard to do it on my own*'-part of this narrative is one that is not only expressed, but also observed during the fieldwork period. As stated in the result section, the expressed lack of motivation can be expected due to the participant's pathology. Nevertheless, the need for an external motivator is evident in current research. Although the need of external motivation is not new to field of depression, it is a research field that is somewhat neglected in respect to the movement-related treatment of depression. The motivational aspects of for instance drug therapy or cognitive behaviour therapy can be profoundly different from the motivational needs of movement-related treatment. Therefore, in order to improve this type of treatment, it is important to explore these motivational needs in future research.

The fourth and final narrative that is expressed can be summarised as *"Sport and physical activity can confront me with me limitations".* This narrative is endorsed by the research of Charmaz (2006). Charmaz shows that sport and physical activity can be " a guilty reminder" of what people can no longer accomplish (ibid). Although this narrative is likely to apply to a variety of people, in this research, the narrative is expressed by two participants with significant comorbidity. One of the participants had comorbid physical disorders, while the other participant had a comorbid phychological disorder. In both cases the participants felt that sport and physical activity confronted them with their former body and mind. Their former selves were able to do things that they could no longer do in present time. These findings suggest that comorbidity could have a profound impact on the meaning of sport and physical activity for people with depression.

However, further work is recommended to explore how comorbid conditions effect the meaning of sport and physical activity.

Methods and recommendation

Since this research served as a pilot study, the next section will discuss the methods and provide (practical) recommendations for future research. Practical implications for future research that need consideration are data gathering, time management, and the research setting. The first practical bump in this research was due to my ignorance on medical ethical requirements. For this type of research a medical ethical committee must give a 'non-WMO' statement before you can conduct the fieldwork. This 'non-WMO' statement entails that the research does not interfere with medical procedures and that the research does not infringe on the integrity of the subjects in any way. It is therefore advisable to keep this in mind, and also be mindful of the duration of this application process.

Secondly, the research setting has advantages as well as disadvantages. One disadvantage is that there was little discussion during the group therapies. Because I wanted to place myself close to the patients and not the therapist, I felt limited in questioning the patients.

Furthermore, at first I thought that the running therapy sessions would not provide a lot of useful data. I was under the impression that they wouldn't reflect and talk much, partly because the running therapy was not coached by a therapist. However, the running therapy sessions turned out to be a valuable data source, due to the talkative nurse who coached the running sessions.

Another disadvantage was the noncommittal nature of the program at the PAAZ. Because of this structure, I could not determine which therapy I would participate beforehand. I had to be very flexible, and decide on the spot whom I would follow. This resulted in an unequal time distribution between participants, but also therapies. Sometimes none of the participants would go to the movement therapy, and I was 'forced' to participate in other program activities. Most of the time, these hours were useful only to build trust and rapport, but would not provide relevant data.

It is therefore recommended to have a more extended and less intensive fieldwork period. Although it was probably the best fit in this research, the setting also proved to be an intense process, with little time to reread the collected data during the fieldwork period. It is, therefore, advisable to following one patient or a fixed group at a time. An

example of a fixed group, and a potential research setting is the 'Supportieve deeltijd' or 'Supportive parttime' treatment setting at the GGz.

Another methodological consideration for future ethnographical research is the role of the researcher. The role as researcher is a double role. You have to try to position yourself close to the participants in order to establish trust and rapport, but also to get a better understanding of their situation. On the other hand you have to be able to take a step back and constantly question practices and the meaning of situations. It is advisable to communicate your role as a researcher in a detailed way towards the participants, as well as the health care professionals. Furthermore, it is important to define your level of participation and make it known to the staff.

In line with the previous recommendation it is advisable to get acquainted with the setting prior to the actual fieldwork. By means of a 'taster day' you can get to know the daily routine and (some of) the staff before you start your participant observations. This can provide a more gradual introduction to the research setting. Furthermore, this can also help with the positioning as a researcher, because you can focus on the relation with the staff prior to that with the participants. It is therefore advisable to get to know the daily routine of a participant, without the (potentially) included participants present.

Other important practical recommendations that followed from this research are related to the data gathering. First, taking notes while patients are present is not advisable, as it could distance you from the patients. At some point during the fieldwork I wanted to write a quick note on my notepad. Although the participants knew I was doing research, seeing my notebook brought a certain distance between the participants and myself that was not helpful. In addition to that, it is advisable to drink a lot of tea. Then, you can go to the bathroom a lot, which might be helpful when you take notes of your observations.

Secondly, I would like to share some of the advice I picked up during the workgroup session with professor R. Rhodes at the University of Utrecht. He gave some practical recommendations and considerations on participatory observation. He explained that during the data gathering you have to keep an open mind, expect surprises, be an actor and be flexible. Furthermore, you should go where you are led and follow unanticipated leads.

A third possible limitation of this research that needs consideration is the presentation of the narratives. As explained in the background, narratives are dynamic and dependent on situational factors. Therefore, the meaning of sport and physical

activity can change during the admission, since treatment can be seen as a transformative process by which patients, in relation with the therapist and their surrounding, generate qualitative changes in their stories (Sluzki, 1992). The narratives in this study, however, are presented as static stories opposed to narratives as a process. The static nature of these stories is due to the fact that the treatment duration at the PAAZ was limited. Furthermore, there was no constant and evenly distributed data gathering. It is, therefore, recommended to increase the fieldwork period in order to take the dynamic nature of narratives into account.

In terms of strengths, the four narratives provide valuable insights into the ways sport and exercise can have meaning for people with depression during treatment. The findings of this research have important implications for the development of future sport related treatments. The most significant implication is that in order to improve the support of patients and enhance the movement-related treatment programmes it is important to take the various narratives into account. The narratives that are presented in this research can be seen as a first step to broaden our perspectives on the different ways patients with depression give meaning to sport and physical activity.

A further strength of this narrative approach is that it allows medical professionals to understand how movement-related therapy is construed as meaningful activity. Furthermore, this research provides a framework for factors that are relevant in the creation of meaning. Finally in regards to the ethnographical narrative research approach it is important to note that although participant observation has its limitations it is considered "*a rather uneasy combination of involvement and detachment, that is still the best method we have for exploring the complexities of human culture, so it will have to do"* (Fox, 2004).

Acknowledgements

I would like to thank Mirjam Stuij, Agnes Elling and Dirk Essink for their comments and guidance. Furthermore, I would like to thank Willem Damen en Dyon Schlebos for their 'layman's view' and the mental health professionals who facilitated this research. In particular, thanks to the participants for generously sharing their stories.

References

Agar, M. (1996) The professional stranger. Second edition. San diego: Academic press

Atkinson, (2005) Handbook of Ethnography. Sage, London.

Bakker, B. (n.d.). *runningtherapie.nl*. Retrieved July 16, 2013, from http://www.runningtherapie. nl/#!:wat-is-runningtherapie

Bahrke, M. S., Morgan, W. P. (1978). Anxiety reduction following exercise and meditation. Cognitive Therapy and Research, 2, 323–333.

Biddle, S., Markland, D., Gilbourne, D., Chatzisarantis, N., & Sparkes, A. (2001). Research methods in sport and exercise psychology: Quantitative and qualitative issues. Journal of Sport Sciences, 19, 777–809.

Boeije, H. (2005) Analyseren in kwalitatief onderzoek, Denken en doen, Amsterdam: Boom onderwijs.

Blumenthal, J., Babyak, M., Moore, K., Craighead, E., Herman, S., Khatri, P., et al. (1999). Effects of exercise training on older patients with major depression. Archives of Internal Medicine, 159, 2349–2356.

Brosse, A., Sheets, E., Lett, H., & Blumenthal, J. (2002). Exercise and the treatment of clinical depression in adults. Sports Medicine, 32(12), 741–760.

Bourdon, R. (1993) 'Towards a Synthetic Theory of Rationality', international Studies in the Philosophy of science 7 (1): 5-19

Carless, D., Douglas, K. (2008) Narrative, Identity and Mental Health: How Men with Serious Mental Illness Restory their lives through Sport and Exercise. Psychology of Sport and Exercise, 9 (5) September, pp.559-720.

Carless, D., & Sparkes, A. (2007). The physical activity experiences of men with serious mental illness: Three short stories. *Psychology of Sport and Exercise,* doi:10.1016/j.psychsport.2007.03.008

Cassano, P. & Fava, M. (2002) Depression and public health: an overview. Journal of Psychosomatic Research, 53 , 849–857.

Coakley, J. (2007), Sports in society: issues and controversies. McGraw Hill Higer Education: New York

Cohen D and Crabtree B, 2006, Qualitative Research Guidelines Project. http://www.qualres.org/ Last accessed December 2010

Craft, L. L., & Perna, F. M. (2004). The benefits of exercise for the clinically depressed. Primary

Care Companion to the Journal of Clinical Psychiatry, 6, 104–111.

Daley, A. J. (2002). Exercise therapy and mental health in clinical populations: Is exercise therapy a worthwhile intervention? Advances in Psychiatric Treatment, 8, 262–270.

Department of Health (2004). At least five a week: Evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer.

Doise, W. (1986). Levels of explanation in social psychology. Cambridge, UK: Cambridge University Press.

Ember, Carol and Melvin Ember. *Cultural Anthropology.* 2006. Prentice Hall, Chapter One

Eriksen, W., & Bruusgaard, D. (2004). Do physical leisure time activities prevent fatigue? A 15-month prospective study of nurses' aids. British Journal of Sports Medicine, 38, 331–336.

Etnier, J., Salazar, W., Landers, D., Petruzzello, S. J., Han, M., & Nowell, P. (1997). The influence of physical fitness and exercise upon cognitive functioning: A meta-analysis. Journal of Sport and Exercise Psychology, 19, 249–277.

Faulkner, G. & Biddle, S. (2004). Exercise and depression: Considering variability and contextuality. Journal of Exercise and Sport Psychology, 26, 3-18.

Finn, R., & Waring, J. (2005). The contribution of ethnography to patient safety research. In K. Walshe, & R. Boaden (Eds.), Patient safety: Research into practice. Buckingham: Open University.

Fox, K. (2000). Physical activity and mental health promotion: The natural partnership. International Journal of Mental Health Promotion, 2, 4–12.

Fox, K. 2004. Watching the English. The hidden rules of English behavior. London: Hodder and Stoughton.

Frank, A. (1995). The wounded storyteller. Chicago: University of Chicago Press.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture.

Gergen, *K., (1982). Toward transformation in social knowledge. New York: Springer- Verlag.*

Gleser, J., Mendelberg, H. (1990). Exercise and sport in mental health: A review of the literature. Israel Journal of Psychiatry and Related Science, 27, 99–112.

Green, J. & Thorogood, N. (2004). Qualitative methods for health research. London: Sage

Hammersley, M. and Atkinson, P. (1995) Ethnography: Principles in Practice, 2nd edn. London: Routledge.

Heider, Karl. *Seeing Anthropology*. 2001. Prentice Hall, Chapters One and Two.

Hoogduin, C.A.L., (1984) Directieve therapie en de PAAZ Tijdschrift voor Psychiatrie 23, 1981/4

Kruisdijk F.R., Hendriksen I.J., Tak E.C., Beekman A.T. & Hopman-Rock, M. (2012). Effect of running therapy on depression (EFFORT-D). Design of a randomised controlled trial in adult patients [ISRCTN 1894].]. *BMC Public Health 12*:50.

Maykut, P., & Morehouse, R. (1994). Beginning qualitative research. London: The Falmer Press.

Meijer, S. (RIVM). Depressie samengevat. Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid. Bilthoven: RIVM

Mishler. E.G. (1986). The analysis of interview narratives. In T. Sarbin (Ed.), Narrative psychology: The storied nature of human conduct (pp. 233-255). New York. Praeger.

Murray, M. (1997) A narrative approach to health psychology: Background and potential. Journal of Health Psychology, 2, 9–20.

Murray, M. (2000). Levels of narrative analysis in health psychology. Journal of Health Psychology, 5, 337–347.

National Institute for Health, Clinical Excellence. (2007). CG45 Antenatal and postnatal mental health. London: National Health Service.

Notté, R. (2012) Sport is goed, sporten is gezond, een sporter is aantrekkelijk. Ik sport niet. Unpublished master's thesis for master's degree. University of Utrecht, Utrecht,

The Netherlands.

Philipsen, G. (1992). Speaking Culturally: Explorations in Social Communication. Albany, New York: State University of New York Press

Radley, A., & Billig, M. (1996). Accounts of health and illness: Dilemmas and representation. Sociology of Health and Illness, 18, 220–240.

Reeves S., Albert, M., Kuper, A., Hodges B.D. (2008) Why use theories in qualitative research? BMJ 2008;337:a949doi:10.1136/bmj.a949

Rhodes, R.A.W. (2011) Everyday life in British government. Oxford: Oxford University Press

Shoetter, J., (1984). Social accountability and selfhood. New York: Basil Blackwell.

Sluzki, CE (1992b): "Transformations: A blueprint for narrative changes in therapy." Family Process, 31(3): 217-230, 1992.

Smith, B., & Sparkes, A. (2007). Sport, spinal cord injury, and body narratives: A qualitative project. *Health Psychology Update, 16(3)*, 26-33.

Sparkes, A. (2005). Narrative analysis: exploring the whats and the hows of personal stories. In: I. Holloway, (Ed.), *Qualitative Research in Health Care* (pp. 191-209). Milton Keynes: Open University Press.

Taylor, A. H., & Fox, K. R. (2005). Effectiveness of a primary care exercise referral intervention for changing physical self-perceptions over 9 months. Health Psychology, 24, 11–21.

Tesch, R. (1991) Qualitative research. Analysis types and software tools. New York, The falmer Press

Waring, J. (2009) Constructing and re-constructing narratives of patient safety. Social Science and Medicine, 69, 1722-1731

Weick, K. (1995). Sensemaking in organizations. Thousand Oaks: Sage.

Vermeulen, H. (2008). *Early History of Ethnography and Ethnology in the German Enlightenment: Anthropological Discourse in Europe and Asia, 1710-1808*. Leiden: Privately published.

Ministerie van VWS (2005) Programma Meedoen Allochtone Jeugd Door Sport, Retrieved June 13, 2013, from www.sportknowhowxl.nl/files/VWS%20%20 programma%20Meedoen%20Allochtone%20Jongeren%20door%20sport.pdf

Ministerie van VWS, (2007). Kaderstellende afspraken Impuls Nationaal Actieplan Sport en Bewegen, Retrieved June 13, 2013, from http://www.rijksoverheid.nl/ bestandendocumentenenpublicaties/convenanten/kaderstellende-afspraken-impuls-nationaal-actieplan-sport-enbewegen%2Fs-2840168b.pdf

VWS (2011). Gezondheid dichtbij. Landelijke nota gezondheidsbeleid. Den Haag: Ministerie van VWS.

Appendix 1

	Monday	Tuesday	Wednesday	Thursday	Friday
08.45-09.00	Day opening	Day opening	Day opening (for those not on leave)	Day opening	Day opening
09.00-10.00	Therapy / Activity	Therapy / Activity	Therapy / Activity	Therapy / Activity	Therapy / Activity
10.00-10.30	Pause	Pause	Pause	Pause	Pause
10.30-11.30	Therapy / Activity	Therapy / Activity	Therapy / Activity	Therapy / Activity	Therapy / Activity
11.30-13.15	Lunch	Lunch	Lunch	Lunch	Lunch
13.15-13.30	Afternoon opening	Afternoon opening	End of program	Afternoon opening	Afternoon opening
13.30-14.30	Therapy / Activity	Therapy / Activity	Individual therapy	Therapy / Activity	Therapy / Activity
14.30	End of program	End of program	Visiting hours (14.00 – 16.00)	End of program	End of program

Choices

	Monday	Tuesday	Wednesday	Thursday	Friday
	Group Activity			Group Activity	Group Activity
	Movement therapy	Movement therapy		Movement therapy	Movement therapy
		Creative therapy	Creative therapy	Creative therapy	
	Individual activity with nurse	Individual activity with nurse	Individual activity with nurse	Individual activity with nurse	Individual activity with nurse