“Being somewhere else”—delusion or relevant experience? A phenomenological investigation into the meaning of lived experience from being in intensive care

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Abstract
Patients’ experiences of having been “elsewhere” during intensive care than in the intensive care unit (ICU) has traditionally been placed in a context with described pathological circumstances, such as brain dysfunction, and labeled with terms such as “unreal” and “delusional”. The aim of the study was to look more closely into this type of experience by turning to its meaning as reflected on by patients themselves. Through a phenomenological investigation based on follow-up and interviews with three patients, we found that the “delusions” were in fact filled with meaning. They mattered to the patients and were not to be dismissed as unreal because they were so inherently real in the lived body. The experiences were grounded in the patient’s lifeworld and could be interpreted as expressions of basic aspects related to being human in the world. The phenomenological term “lived mood” emerged as one such aspect to which intensive care patients appear to surrender more readily than man does in daily existence. The notion of “being somewhere else” as meaningful and relevant experience challenges the explanatory model whereby such experiences are placed in a context with brain dysfunction.

Key words: Delusion, intensive care, lifeworld, mood, patient experiences, phenomenology

Introduction
Patients admitted to an intensive care unit (ICU) share the common fate that the illness for which they are admitted is life threatening. Their stay in ICU may be lengthy and they may be in a critical condition for days or weeks. The patient normally requires assistance in breathing and in maintaining satisfactory functioning of the kidneys and heart. Throughout the treatment period, patients will receive analgesics and sedatives to alleviate discomfort and to enhance tolerance of organ-system support and nursing care.

Experiences from being in ICU as related by patients are highly diverse. They range from memories of procedures and dialogues to accounts of having experienced events that for both listeners and the patient himself/herself may appear strange. The experience of being under water may be seen as one such strange event.

I was under water and swam and swam to get to the surface… I struggled upwards… needed to have air! They say that it’s the medicine… or those drugs that do it, that one can have sort of hallucinations or delusions or whatever they call it… but I have thought about it as if I was actually on a journey through my own life. And I don’t really know what it is those drugs do, but it doesn’t get in through them… hallucinations like that, sort of getting shot into your veins… heh heh. . . . Nope, the way I see it, it’s more like they open up for my life to emerge, even though there’s so much craziness in all that I experienced. And if I think about it in that way, it’s not so crazy… then it’s simply quite normal! (“Henry”,
interviewed six months after his stay on the intensive care unit).

“Henry”, one of the patients upon whose reflections this article draws, illustrates through these comments the point that there are different perspectives from which to regard such experiences from intensive care units. His experience can be regarded as a delusion linked with some kind of dysfunction in the brain caused by pathogenic factors or perhaps, as “Henry” terms it, more as a normal phenomenon related to being human and to the patient’s life history. Before we ask “Henry” to elaborate on his reflection, we will try to offer a rationale for turning to the meaning of “being somewhere else” during intensive care.

**Background**

As early as the 1950s when the first intensive care units were established, it was noticed that some patients behaved and expressed themselves strangely in the recovery room (Bliss, Rumel & Branch, 1955; Nahum, 1965). Nahum (1965) calls it “madness in the recovery room” and McKegney (1966) “a new disease of medical progress”. McKegney was the first to give this “new disease” a label: The ICU syndrome. There is an ongoing discussion concerning what causes these reactions and which terminology should be used. The latest recommended concept for these kinds of problems is ICU delirium (Ely, Siegel & Inouye, 2001; Marshall & Soucy, 2003). ICU delirium is described as a brain dysfunction (Ely, Siegel, et al., 2001). Disorientation, hallucination, delusion and psychomotor agitation are some of the symptoms listed (Bergeron, Dubois, Dumont, Dial & Skrobik, 2001). The prevalence of reported delirium in ICU patients varies from 17–80% (Bergeron et al., 2001; Ely, Inouye, Bernard et al., 2001). There is a consensus that there may be a multitude of factors causing these reactions in the patient. The factors heretofore regarded as most important have changed over the decades (Granberg, Engberg & Lundberg, 1996). In the 1980s, psychosocial based models were presented (Easton & MacKenzie, 1988), while the “brain dysfunction model” represents a biologically based model wherein anatomic deficits and imbalances in the neurotransmitters are clues (Ely, Siegel, et al., 2001b). The observed state is viewed as a cerebral dysfunction similar to the failure of any other organ (Roberts, 2004; Ely et al., 2004). Common to the different models is that the patient is regarded to be in a pathological state when he/she shows signs that seem abnormal. There is something “wrong” going on inside the patient’s brain and which may inhibit recovery (Ely et al., 2002).

In the 1980s, there arose an increasing interest in patients’ experiences of intensive care. Describing and analyzing them, researchers made use of various categories. In an early study, experiences are divided into recollections, dreams and nightmares (Asbury, 1985). Later psychological terms were introduced. Hallucination as false sensory perception occurring without any external stimulus, and delusion as a fixed irrational belief are categories used to classify experiences (Easton & MacKenzie, 1988; Jones, Griffiths, Humphris & Skirrow, 2001). Another way often utilized to categorize what patients relate, is to use the terms “real” and “unreal” experiences (Granberg, Engberg & Lundberg, 1999; Russell, 1999; Roberts & Chaboyer, 2004). Unreal experiences, like hallucinations and delusions in the previously mentioned studies, are described as possible signs of the ICU syndrome/delirium (Granberg-Axell, Bergbom & Lundberg, 2001). The link between observed and experienced symptoms of abnormality is in this manner established and confirmed. Recently, however, there has been an increasing focus on the delusion not only as a sign of a syndrome or a state, but as one of the very factors causing problems.

It has been found that many former patients struggle with anxiety, flashbacks, psychological imbalance and depression (Jones, Macmillan & Griffiths, 1994; Perrins, King & Collings, 1998). In an increasing number of studies, these problems are regarded as symptoms related to the diagnosis post-traumatic stress disorder (PTSD), and a strong link between what the patients recall from the ICU and the development of PTSD has been identified (Stoll et al., 2000; Jones et al., 2001). Some patients seem to remember few factual events, a state which can be termed having “memory gaps” (Griffiths & Jones, 2001). Not remembering the factual events, but having delusions, has been identified as a causal factor (Jones et al., 2001; Griffiths, Cohen & Lawson, 2005). The main objective in preventing PTSD is to find ways of leading the patient to the realization that the delusion is not real (Jones et al., 2001).

The question as to why the patient experiences events that do not appear to belong to a common reality is, as we have seen concerning the observed state, examined from various perspectives. If such an experience is regarded as a symptom of delirium, the experience must be related to a dysfunction of the brain. The brain is influenced adversely by factors inherent in the situation (Jones, Griffiths & Humphris, 2000). The use of drugs reported to cause such symptoms, such as in the explanation “Henry” seems to have been given for what he
initially calls his “experiences of craziness”, is an example of a factor described as affecting the brain adversely. The experience of being under water can be regarded as a delusion caused by “external” factors. Nevertheless, Henry chooses to turn his attention toward his own life and toward aspects of meaning in his experience. In this way, he establishes the object of our investigation in this paper.

The investigation

Purpose

Patients were closely observed by the first author (SS) throughout their stay in intensive care. Having clues, then, concerning what these patients have been through, we encourage them not only to tell about their experiences, but also to reflect on the meaning of “being somewhere else” during intensive care. Proceeding in this manner, then, what can we expect to be revealed to us?

Perspectives and methodological approach

In order to discern and reveal the meaning of the lived experience of so-called delusions, we apply a lifeworld approach. This approach has shown to be useful in investigating intensive care patients’ experience (Storli, Asplund, Heggen, Bengtsson & Engelsrud, 2004). We aim at re-achieving contact, through reflective practice, with the world as immediately experienced. The term “lived experience” refers to experiencing the world while living it, a non-reflective type of consciousness preceding reflection (van Manen, 1997b, p. 9).

Our lifeworld approach and the phenomenological perspectives underpinning our study are primarily based in the work of Husserl (1970), Merleau–Ponty (1962) and the Danish philosopher Løgstrup (1997), but it also draws on the phenomenological movement as a whole as described in van Manen (1997b), Bengtsson (1999), Dahlberg, Drew & Nyström (2001), Martinsen (2003) and in Lindseth & Norberg (2004). Intentionality as a core concept in phenomenology indicates the inseparable connectedness of the human being to the world. When we experience something, it is experienced as something that has meaning for us (Merleau-Ponty, 1962). Merleau-Ponty states that the current of a person’s intentional existence is lived through the body, a lived body. Our intentional consciousness is experienced in and through our bodies. It is in a literal sense embodied. We can never free ourselves from this embodiment. We are our body and our body as lived is “a nexus of living meanings” (p. 151) that “inhabits space and time” (p. 139). In his latest work he speaks of the body as belonging to the flesh of the world, precisely in order to underscore the interconnectedness between the body and the world (Merleau-Ponty & Lefort, 1968).

Participants and methods

The three patients we meet in this paper participate in a larger study focusing on living with memories from intensive care. These three are chosen for presentation because we believe that through reflecting on what they have been living through, they have great potential for elucidating aspects of meaning in experiences of “being somewhere else”. The study took place in a Norwegian university hospital. The first author, who is an experienced intensive care nurse but no longer working in the hospital, followed the patients through intensive care and finally interviewed them about six months after discharge from hospital. The interviews had the form of conversational interviews as described in van Manen (1997b). They were tape-recorded and transcribed verbatim. The interview process was open, but disciplined by the focus on experiences and the informants’ reflections on experiences.

The nine-bed intensive care unit in the hospital in question has established a follow-up program in which these patients were included (Storli, Lind & Viotti, 2003). The aim of the program is to enable the patient to understand better what he/she has been living through by offering sources for understanding, such as a “diary” written by nurses, a follow-up conversation, and a return visit to the ICU. The diary is written bedside as a narrative or a “story of wonder” in which the patient might find recognition. The text is dialogic, addressing the patient even when he/she appears to be asleep and including photographs to support the text. The diary is offered to the patient after discharge from ICU and followed up by a conversation about perceived experiences and a return visit to the ICU. Through the entire program, the patient is encouraged to reflect on experiences. In this way, the program established a basis for the subsequent interviews. The first author was allowed to participate in the follow-up of the patients. The diary and the encounters with the patient will be exemplified later in this paper.

In order to have a reference for the patient’s experience and to obtain clues concerning what he or she went through in the ICU, each patient was followed by means of close observation as described in Dahlberg et al. (2001) and van Manen (1997b). The first author was at the bedside during sequences of their stay, sometimes assisting in basic nursing activities. Attention was especially focused on the patients’ bodily expressions in given situations. “I wonder whether you will retain any impressions from
this?’ was the point of departure for describing in field notes the situation and the patient’s expressions. The field notes were supplemented with data from medical and nursing documentation, from dialogues with nurses and from diaries in writing. Openness and sensitivity to the unpredicted and unexpected as basic attitudes (Dahlberg et al., 2001) and emotive involvement as a gateway (Martinsen, 2003) for spontaneously seeing opportunities and possible connections are cues describing the way of working.

**Ethical considerations**

The Regional Committee for Medical Research Ethics recommended the study, and the patients gave their informed consent to participate in it. They also gave their permission to use quotes from dialogues and interviews and to use excerpts from the diary. In addition, we received permission from the hospital administration and the relevant ICU. The identity of each patient is carefully disguised and “tripwires” are used in the descriptions. The expression “tripwires” indicates that diagnoses and circumstances are changed to a certain degree, but not in such a way that coherence is clouded. The names used, of course, are not the real ones. Great caution has been exercised to avoid identification of the patient, as stressed in Stake (2003), who discusses the risk of exposure in case studies.

**Descriptions and interpretation of meaning**

According to van Manen (1997b), the researcher may be seen as a collector of anecdotes. One has to recognize what parts of the “text” are significant for one’s study while it is happening, but it is often in hindsight that one can recover those living phrases and incidents that give the anecdote a cogent power or point. Here, the encounter with the patient’s lived experience during the follow-up program and in the interviews are what makes possible the recovery of such incidents in the field notes and, based on concordance between the various sources, makes possible the development of new anecdotes designed as comprehensive case descriptions. These descriptions aim at presenting each patient, context, experiences, and some of his/her reflections to the reader. Case descriptions were chosen as the point of departure for portrayal since in this respect; it provides the reader the opportunity to follow the events of lived experiences and encounter the “mantic” aspects of the text. van Manen (1997a) states that two types of meaning, cognitive and non-cognitive, are offered the reader in a phenomenological text. It is the mantic aspects of the text, its non-cognitive meaning, the evocative, expressive, transcendent, and emotional elements, that enable the text to reverberate with the reader, making us suddenly “see” something that enriches our understanding of life experiences. How the text speaks is an important issue in phenomenological writing. As authors, we have tried to write from the midst of life experience where meanings resonate and reverberate with reflective being.

Throughout the whole research process, interpretations are made. The way of working may thus be termed as hermeneutical with a ground in phenomenology (van Manen, 1997b; Dahlberg et al., 2001). In the case descriptions it was the patient’s wondering reflections that lead us further towards discovery. Wonder is not only a starting point for a phenomenological investigation, but it influences, and must be allowed to influence the entire way of working (van Manen, 2002). When we as authors together explored the individual texts, we encountered expressions that struck us as important and meaningful (Martinsen, 2003). These expressions are quoted in italics in the case descriptions. In a new integrated reading, with these expressions as clues, we strove to corroborate common elements between the texts. “Henry” related wonderfully his experiences as a journey within his own life. The same is true of “Erik”, one of the other patients we will meet, but his reflections were based on his lived experience and his life history. Using meaningful expressions as headings, we advanced from case descriptions to an attempt at a phenomenological description wherein the common traits of the three texts were allowed to corroborate and contrast with one another. van Manen (1997b, p. 122) stresses just such a description of the disparities among the possible similarities as a method by which to approach the “invariant” aspects of the phenomenon, allowing us to “see” the deeper significance, or meaning structures, of the lived experience it describes. Our description, however, does not appear as a pure account of lived experience, but rather as a phenomenological text on which we as researchers reflect on and interpret what gradually is revealed to us. The hermeneutic element is apparent, but according to van Manen (p. 26), such a text may still be termed descriptive. The text mediates between interpreted meaning and the phenomenon toward which the interpretations point. Even though meaning, in our perspective, is elucidated already in the case descriptions, the interpretative part of this paper may be considered as the main result. We have called that section “Reverberation”, a title that incorporates both the desire for a continued resonance in the reader as well as the intention to allow the individual texts to reverberate with one another. The main aspects of
meaning elucidated will then be summed up and discussed.
First, let us meet “Henry”, “Lisa”, and “Erik”.

Case descriptions

“Henry”

Henry, a man in his sixties, is received at the emergency ward due to a serious infection. In the course of only a few hours, he lapses into sepsis, with subsequent organ failure. Initially, he is awake, but because of rapidly developing respiration failure, he is intubated and transferred to the intensive care unit. Henry’s condition is critical over several days. After two weeks, however, sedative medication is discontinued and he gradually becomes capable of breathing on his own. The nurse writes in the diary:

You have had quite a struggle trying to breathe on your own again? We believe you have had a lot of help from your wife, who has sat by your side hour after hour? When she places her hand on your chest and ‘breathes with you’, it appears that this actually helps you to breathe? And today it seems as though you have found new strength? When your wife tells me that you are a strong person, then I think to myself: ‘I think you have what it takes to get through this ordeal, too!’

The entry is illustrated with a photograph of the couple, in which she is sitting close by his side. Four weeks later, he returns to the ICU for a visit. He brings the diary with him, and together with the nurse, he looks through the entries and photographs while sitting inside the screened-in section where his nurse, he looks through the entries and photographs brings the diary with him, and together with the

You feel it has something to do with my struggle for breath when I fell ill . . . and later, trying to breathe on my own again, that I was reminded of something . . . of suffocating . . . or of almost drowning. You see, as a youngster I did almost drown! I have thought about whether it might be some kind of old stuff that came to the surface, that it comes back to you when something happens . . ./ You know, I

was in my own funeral, at the chapel at home. I think, in a way, that I must have known how critical I was. I think one feels it even when one isn’t conscious. // But without my wife, I don’t think I would be sitting here today! I think it meant the world to me that she sat there and refused to let me give up! The thing that is so strange is that she, too, was part of all the chaos that occurred . . .

She was the one who pulled me up above the surface of the water . . . at least that’s how I experienced it! // And then we were tenting up on the Finnmark plateau . . . That’s the thing that I became so strongly conscious of when I heard the sound of that breathing machine on my visit back to the ward. // And believe it or not, we also were on a trip in the mountains! We stood at the top of Breitind, and I can just feel how it was to breathe in that wonderful summer air. It filled me with strength!

He reflects on the significance of what he calls “a strength that comes from inside oneself” in getting through an ordeal like critical illness. “It doesn’t help you to just take medicine,” he states, “—although I needed them, too, of course. But I think one has to have something inside oneself, too.” During critical illness such strength may be weak, but can, in the way Henry thinks about it, be supported. “Moving” to a place where he normally gathers energy provided such support for him, but he also reflects on the significance of human relations: “I think that the people around you can support that kind of strength, too . . . or, how should I put it, maybe awaken it!” He thinks about his wife as such an “awakener”, but he also indicates how he felt that the nurses really cared about him and supported. “My angels, I call them.” For him, the diary confirms what he is certain of having sensed in the situation. “Look here . . . the nurse that wrote here that she thought I had what it takes to get through the ordeal . . . and I believe that I sensed that, in a way; —that they believed in me!”

“Lisa”

Lisa, a woman in her thirties, comes to the hospital after a traffic accident. She is on her way to a conference farther south in the country when the car crashes into a mountain wall. Lisa is thrown out of the vehicle and is found lying on the rocky hillside after a traffic accident. She has compound fractures, lung injuries, and internal bleeding. She is stabilized in a shock bag at the accident scene, intubated, and then transported to the hospital. Her condition remains critical for the next few days. Her husband “Paul” sits by her bedside. When Lisa begins to awaken, her body is
generally restless, and on occasions, she “tosses” her head from side to side. The nurse enters in the diary:

Today you are so awake that you can keep your eyes open and look at us for several minutes at a time. // But there is something you want to say that we have tried very hard to understand. As I have told you, you can’t use your voice because of the tube in your throat between your vocal cords. We think you understand this, too, because you are getting better and better at forming silent words with your lips? But what is it that you want to say to Paul? It’s a long sentence that we weren’t able to understand at first. But then Paul understood some of your words. “I didn’t want to . . . I was forced to do it ...” We wonder what it was you were thinking about. Wonder what you have been experiencing during this time?

When Lisa begins to regain her strength, progress is rapid. Three weeks after the accident she is moved to the general ward. The nurse on the ward reports, however, that Lisa sleeps poorly at night. She does off, wakes up suddenly, and is clammy and perspiring. The ICU nurse brings the diary to her some days after her transfer. They open it together and they look at the photos and at excerpts from the entries. During the conversation two days later, she sits holding the diary in her hands. She points at the entry that is cited above. “I think it might be good to talk to someone who might understand some of this. This here is what bothers me so much. It comes to me when I close my eyes ...” Tears run down her face. “Paul says that it’s just a nightmare, because it didn’t happen . . . and I do realize that, in a way, but at the same time I feel it in all of me that it actually did happen anyway!” Slowly she begins to relate. “You see, I don’t remember anything about the accident.” But she does remember starting out on the trip south.

The crazy thing is that we arrived at our destination, and I was in the hotel room . . . And that’s where it happened! I can’t say so much about it, but I was abused, sexually abused!! And that is what I had to tell Paul! It’s what is here in the diary: That I didn’t want it to happen! That I fought against them! And I was convinced that I was in hospital because of the abuse!

Her account is intense. “How can it be that someone can experience something like this? That it’s so real, if it’s only a nightmare?” she says softly. The nurse’s thoughts go to the scene of the accident, where Lisa’s clothes were cut off and she was intubated and stabilized in a tight bag. “Could there be some connection here to what was in fact done with you?” the nurse wonders.

Returning to the ICU for a visit, she sits in the wheelchair for a long time, eyes closed. “That breathing, that panting . . . They were panting just like that . . . in the hotel room! And now I see that it is that machine that makes that sound!” Several months later, Lisa reflects on her experiences.

I have thought a lot about how these things could happen to me. Even now I catch myself thinking that the abuse episode actually happened, because it agrees with how my body felt . . . and how it still feels. The more I have thought about this here, the more I feel like I had these sensations from what really and truly happened! I was really abused, lying on that rocky hillside . . . more or less unconscious . . . and it continued with what was done to me in the ICU! I think it must be true that the body understands what it experiences in its own way in situations like this one when your head is ‘knocked out of the picture’! And it helps me not to think like that— that it was real. There were sounds and . . . or perhaps mostly a kind of atmosphere in the room that I could recognize, in a way! Now I know what it is when the feelings return . . . because they’re still there! // Otherwise it’s totally strange in terms of where I was . . . that I arrived at the place where the conference was supposed to be! But it is probably a case of one continuing on the course one starts, don’t you think?

“Erik”

Erik, a man in his forties, is admitted for scheduled thorax surgery. Postoperative complications occur and Erik is assigned a three-week long course of treatment on the intensive care unit. He is very restless when he starts to wake up. Respiration rate, blood pressure, and pulse are alarmingly high and he has to be sedated again. Two days later, he breathes well but is clearly uncomfortable. The nurse writes in the diary:

When I came here to you this morning, you were lying with your eyes open, but I still felt that I couldn’t obtain any contact with you. It seems as if you have stomach ache? You twist and turn in your bed and make faces. // I asked you if you had a stomach ache, but it wasn’t before I said ‘it’s not easy to tell where you are feeling discomfort’ that I saw I had made contact with you, because then you shook your head. Then I understood that it was the way things were.
During the afternoon on the same day, he retches violently during oral care, but towards evening he becomes more relaxed and breathes increasingly more easily on his own. The next day he is extubated and moved to a regular ward. Some days later, he asks to see his diary. In response to the question concerning how he has experienced the time spent on the ICU, he replies: “A long, long novel... All these strange events...” He is trying to sort it out.

Five months later, he reflects on these strange events. “You see all of this is connected with reality in some way or another...” He recalls how he alternated between being a patient and being his usual active self. Suddenly he is on his way toward one of the fishing lakes he knew as a child in order to prevent his brother from hurting another man in a fight.

He survived, and I could hear him lying next to me on the floor, breathing... We were back in the hospital again. But now I have decided that it was my own breath that I heard through the ventilator... it was delayed, wasn’t it? But at that time the sound meant to me that it was him lying there... and that he had survived!

He then reflects over “getting well” again. He knew that he had an operation. However, one point, he felt very sick and he was aware of the reason: The surgeon had put a cork in his spine, with a rubber band over it. “I knew that you can’t live with a cork in your spine!” He tells about how he decided to do something about it. “I managed to vomit it out, tried as hard as I could! Look here, they wrote about my stomach bothering me...” He is in no doubt that the vomiting represented a turning point for him. “But it was I alone who had to sort it out! I don’t know, maybe it was a part of my fight to get through this?”

Living alone, he is used to have to sort out his own life.

He also dwells on the phenomenon of living toward a future. “The strange thing is that I went into the future. While I lay there I had already come home and started exercising... I didn’t have time to be ill.” He remembers pouring cleaning liquid on the bathroom floor and that he exercised by swimming. He talks about how all these strange events still remain crystal clear in his mind and how in retrospect they seem to fit into his life.

The way I see it, it was like a long trip I was on—a trip lasting more than 40 years but completed in only a couple of weeks. In those weeks I went through my entire lifetime, with events from childhood and adulthood knitted into one another in a new kind of time... For me time is not chronological, everything is sort of woven together, and there is meaning in it... It has given me the opportunity to sort of understand my life and myself in a new way! But in order to come to terms with it, I think it’s important to come back... to sort of “feel” that room again!

Reverberation

In the further investigation, we allowed the voices of Henry, Lisa and Eric to converge in the light of possible common denominators. Through this effort, it became clear to us that we were touching on basic structures in human existence. In reflecting on the texts, we were inspired by van Manen (1997b) who recommends four fundamental existential themes as guides for reflection. These themes seem to pervade the lifeworlds of all human beings, regardless of their historical, cultural, or social situation: lived body, lived space, lived time, and lived human relation. Drawing on the phenomenological movement, he refers to these themes as “existentials”. Concerning lived human relation, we will especially point to the Danish philosopher Løgstrup, who vigorously elucidates how we as fellow human beings are interrelated and dependent on one another in our existence in the world (Løgstrup, 1997). Let us look more closely at what the existentials refer to, and under each existential include meaningful expressions drawn from the case descriptions that seem to be relevant. Subsequently we will proceed to description and, with the existentials as headings, aim at elucidating aspects of meaning relevant to the research topic by allowing the expressions and the individual texts to reverberate against one other, guided by an interpretive curiosity.

Lived body refers to the phenomenological fact that we are always bodily to the world. The subjective body is a living whole. We make our experiences as bodies and our bodies remember.

- It might be some kind of old stuff that came to the surface
- The body understands what it experiences in its own way
- I must have known how critical I was

Lived space goes beyond physical space. Lived space is felt space and is filled with meaning. Lived space is the existential theme that refers us to the world or landscape in which human beings move and find themselves at home.
It was my own breath that I heard through the ventilator.
A kind of atmosphere in the room.
I was actually on a journey through my own life.

*Lived time* is subjective time as opposed to clock time or chronological time. It is our temporal way of being to the world. The temporal dimensions of past, present, and future constitute the horizons of a person's temporal landscape. Whatever we have encountered in our past stays with us as memories that somehow leave traces on our beings. The future, the past, and the present are woven together in the movement of temporalization.

- Time is not chronological
- It is probably a case of one continuing on the course one starts

*Lived human relation* is the relation we maintain with others in the interpersonal space we share with them. Humans live in meaningful relationships. We are inter-related with one another in our being to the world. How we perceive and acknowledge one another in our human vulnerability is decisive for our lives.

- Without my wife, I don’t think I would be sitting here today
- But it was I alone who had to sort it out
- My angels, I call them

van Manen strongly emphasizes that these themes can never be considered independent of one another. They are interwoven, and one aspect always elicits other aspects. One clear example here is Henry's statement "I have thought about whether it might be some kind of old stuff that came to the surface" wherein lived body and lived time are represented as inextricably interwoven. However, let us begin the descriptions by looking at aspects of meaning in this statement in terms of lived body.

*Lived body*

Through the encounters with the voices of Henry, Lisa, and Erik, a deep seriousness is reflected. Their experiences matter to them. Henry's reflections on the meaning of what he has undergone during a period of critical illness are characterized by a wisdom gained through living.

It might be some kind of old stuff that came to the surface.
In his seeking to understand, Henry has turned his attention to his own lived life. For him it is entirely natural to have these thoughts. “They said so, the old folks, that you can’t get away from what you bear with you … and that it can come to the surface again when you least expect it.” He finds meaning in his struggle for air beneath the water’s surface by turning to a former experience. “I’m convinced that it can be brought out again … how should I say … ‘come to life’ again, when you feel something similar …” He regards this as if it is a bodily sensation that is felt once again in a new situation and then recognized. Through the relived sensation, the body is taken back to a situation in which the sensation was previously experienced. Could it be that this is also at the root of Lisa's reflections concerning whether the body understands in its own way?

The body understands what it experiences in its own way.
If we turn to the accounts of Lisa and Henry, meanings emerge that appear to have common traits. “I was more or less unconscious”, says Henry, “So I figure that my remembrance of the past is as much anchored in my chest as in my brain.” It is here that the reflections of Lisa and Henry connect with one another. The body is involved in the acts of remembering and comprehension. Moreover, when one's head is “out of the picture”, the body understands in its own way. In such a perspective, Lisa's experience may arise from some previously experienced abuse. Lisa, however, firmly denies a connection in her life between prior sexual abuse and the current experience. “I have never been involved in something like that before!” She does not consider it as one previously experienced event that resurfaces through recognition, but rather as experiences that belong to the realm of being human. As humans, we know pain as a phenomenon. We know sexuality as a phenomenon. Violation of the body in one way or another is something all of us have experienced in life. “And I believe that we live in a kind of premonition of how we will feel different situations in our bodies,” says Lisa. She understands that the sensation of being beaten in the accident and her clothes being torn off by the rescue team, may, through a lived premonition from a present occurrence, call forth the feeling of being mistreated and abused. Here, Lisa provides us with an opportunity to comprehend that such a feeling is not necessarily brought about by a prior experience of abuse. The initial feeling can then be amplified through increasingly new sensual impressions that “jibe” with the situation such as she experiences it.

It was sort of confirmed . . . . The nurse said, for example, that they put in a sort of tube . . . in my rectum, when I had such a bad case of
diarrhea. That's one of the feelings I recall... that something like that was done to me. But all this happened in the hotel room where I was kept captive... And that is something, too, the fact that I felt I was tied up... that I couldn't move. I guess I couldn't move... with all those tubes and plaster casts!

In a phenomenological perspective, the lived body holds inherent significance based on lived life. Perception is open; it leads us into a variety of circumstances. Comprehension is anchored in our lives. This is made clear by intensive care patients who are often in a situation where they do not have the opportunity to investigate closely “what I am hearing” or “what I am seeing?” Their heads are more or less “out of the picture” in terms of validation/invalidation of experiences. They are subject to a pre-reflective understanding based on the body’s premises. In the next paragraph, another question concerning the relationship between body, consciousness, and cognition is raised.

**I must have known how critical I was.** Henry wonders if it is true that one may recognize that the situation is critical without being conscious of it in a traditional sense. Erik also has an idea that in his struggle to return to life, he somehow knew that his condition was critical. “It was actually a struggle between life and death, just like it was in reality... and I think I somehow knew that.” Henry attended his own funeral and several times, he recounts the sight of his own coffin. “I don’t know, but I have a feeling that there and then I felt that... that I didn’t want to die! I have so much to live for...” he says tearfully. “I think I felt it inside... that I was on the threshold...” The expression “felt it inside” carries with it a reference to the body. The body that emerges through the descriptions is a lived body that represents a repository for previously lived experiences. It is not simply an object controlled by the mind, but our very way of being in the world. If we turn our attention towards the existential “lived space”, the phenomenon becomes even clearer.

**Lived space**

The body seeks meaning in its directedness out into the world. This emerges strikingly in the accounts. Lived space is felt space, but also a meaningful space.

**It was my own breath that I heard through the ventilator.** Erik explains how he has come to the realization that the breathing sounds that were for him the constrained breathing of the injured victim, were in actuality his own breathing delayed through the ventilator. Let us turn again to Henry, as he sits in the intensive care room and listens to the sound of the ventilator operating just behind him.

That sound is still with me... Oh, I can still feel how cold I was! We are in a tent on the Finnmark plateau, and I now realize that the pattern on the curtains around these beds reminds me of the tent we had 30 years ago when we went cloudberry picking up there... And it is my wife’s breathing that I recognize in the sounds... her breath as she lay keeping me warm!

He has brought his diary and has located the text and picture that he thinks are related to this experience. “Here one of you has written that it seemed as if my wife almost helped me breathe by placing her hands on my chest...” The intensive care room is for him a foreign room, but the sensory impressions are given meaning by what he is familiar with. In the same manner as Henry, Erik explains that the breathing sound provides meaning for him. It occurs in a meaningful circumstance. When he hears the constrained breathing sound, he associates it with the injured victim. The sound harmonizes with and confirms the experience. This is precisely what Lisa refers to when she says that what is done with her in the ICU fits into and confirms the events in the hotel room. It is a revelation to sit beside her at the moment she recognizes the panting from the hotel room. Her body is racked with sobs. “But now I know who ‘you’ are... you’re nothing more than a machine that stood above my bed!”

The human being seeks to understand and meaning emerges pre-reflectively. If we return to Lisa’s account, we see clearly how the existentials are interwoven. It is a case of a lived body inhabiting lived space. Sensory impressions in Lisa’s lived space combine in a meaningful context within herself, not by an effort on her part to discover “what it might be” through reasoning, but rather through a pre-reflective bodily comprehension.

**A kind of atmosphere in the room.** It is very interesting to consider the expression “atmosphere in the room”. Lisa repeats several times her awareness of this atmosphere that she was somehow able to recognize by being back in the ICU. In her retrospective thoughts about the event, it was precisely the half-hour she spent “feeling the room”, in Eric’s words, that was most important for her in the effort to cope with her traumatic experiences. “It is not only about the sounds, it’s sort of everything
The foreign room can make us feel vulnerable and lost. The feeling of being at home, on the other hand, represents a special experience of space for most of us, having to do with the fundamental sense of our being. We have a home that perhaps goes beyond the space of physical quarters. We have our lived places, as Henry so clearly illustrates for us. These are places that are in our existence and that represent a mood within us. What is described seems to be a kind of journey home from lostness to meaning and security—a homeward journey that has in itself both a power to mobilize strength in a situation and the opportunity to comprehend lived life in a new way.

Lived body inhabits lived space through time. The care-giving team operates through linear time via observation forms and goal-oriented actions. Through observations recorded from hour to hour, the parameters of the patient are registered and weighed as a basis for decision-making in terms of treatment. In the patient’s world, however, it appears that time takes on another form.

**Lived time**

The dimension of time that is associated with lived space and place has other distinctive features than the linear chronology of clock time. To repeat Erik’s introspection: “In those weeks I went through my entire lifetime, with events from childhood and adulthood knitted into one another in a new kind of time . . . For me time is not chronological . . . .” This is meaningful, interwoven time. Lived time is subjective time associated with the person’s being in the world. The temporal dimensions of past, present, and future constitute the horizons of a person’s temporal landscape. We have seen how temporality in remembrances and current sensation is inextricably tied to lived body and lived space. The past leaves traces in the body that may be actualized in the present and that affect comprehension of current sensation. A meaningful, interwoven complex emerges for us. Before we look at the dimension of the future in lived time such as it emerges from the material, we will dwell a little longer on Erik’s statement.

**Time is not chronological.** This is an item of interest. Erik’s time on the intensive care unit is disengaged from chronological clock time. For Erik, just as for the others, the time spent in intensive care has entailed a period of medicinally induced sleep. Such a period of sleep, as we have previously seen, has been traditionally considered a period of amnesia from which the patient has no factual recall. The patient has been unconscious, resulting in turn in a
black gap in his memory. A portion of clock time has been erased. However, here we see that time has not vanished, but has instead taken on other forms. The body continues to experience, even though consciousness is suspended. Memories continue to exist, but in a sequence other than clear, chronological order. The so-called black gap in memory is in actuality filled with lived experience. The bodily-lived time continues even during the lapse in the continuum that hospitalization on the intensive care unit represents, and it has a dimension of future in it, as Lisa’s account strikingly illustrates.

It is probably a case of one continuing on the course one starts. Might this also be a phenomenon belonging to humans’ being to the world? In the lived “now”, we are already on the path towards the future. We live towards a future which we already see taking shape. When Lisa continues her journey toward her destination, she sees it as an expression of movement toward the future triggered by preparations and focus on a task. “I had prepared myself so well! I was going to give a speech.” She has seen the future taking shape. She is already in what is to come when the accident or lapse in the forward continuum occurs. As we have seen, Erik has a similar experience. He swims and trains on the bathroom floor at home. He cannot afford the time to be ill. He experiences himself going forward into the future, but in contrast to Lisa, he takes the “interruption” along with him. His experience of illness accompanies him, and his athletic training is thereby placed in a meaningful context. For Lisa, the interruption is not initially present. She continues her journey unhindered, but she is accompanied by an experiencing body that she must cope with in her experience of the present.

There is, however, a further dimension in the lifeworld of humans. A relational dimension emerges clearly through the accounts. The human being lives in relation to other human beings.

Lived human relation

Lisa’s account in many ways represents the duality of intensive care treatment. Treatment is situated on the threshold between good and bad. Its intention is good: it is a matter of saving lives, but in its practical application, potential harms exist. The body is invaded with technical equipment, and the treatment may structurally represent a violation of the body. Lisa is violated, but she clearly realizes at the same time that the treatment saved her life. The way she retells the incident, she was alone in her struggle. She had no helpers. It is only after she comes to the hospital as a victim of the abuse that Paul becomes a part of her experience. Henry’s wife, on the other hand, is in his experience a constant companion who stands by him when he needs her most. “She was there when I needed her . . . But then, she has always been there.”

Without my wife, I don’t think I would be sitting here today. Henry returns several times to the thought that he believes there is a power in man that can be “awakened” and “supported” by people rallying around one during times of crisis. For Henry, his wife was one such source of support. She was present at his bedside and “came in” to Henry, regardless of where he was. She pulls him up above the surface of the water, she warms him in the tent, and she is at his side on the mountaintop. “And that is not hard to understand, we have been helping each other for forty years.”

Lisa’s husband also sat by her side day in and day out and was there while she slept and when she began to awaken. We may wonder why he didn’t “come in” to Lisa. Why didn’t he come to help her in the hotel room, in the same manner Henry’s wife came to help him when he needed her? What may lie behind this? Might it be a question of how relationships vary at the outset? Who is Paul as far as Lisa is concerned? Do they live their lives less intertwined or more independently of one another than Henry and his wife? If we reflect on our own lives, we understand that the quality of the relationship can have a significant effect in a vulnerable moment. However, might it also be a question of the “way” one is present at the bedside? In the field notes, the behavior and bedside manner of the two next of kin are described as very different from one another. At Henry’s bedside:

She has pulled the chair close into the headboard of the bed and is combing his hair. She talks about the snow melting in the flowerbeds in the garden and that the crocuses have begun to blossom. She takes his hand and massages it with lotion. He is lying with his eyes closed. No visible reaction, but she says that she can feel he squeezes her fingers from time to time.

At Lisa’s bedside:

He is sitting by the bed. She has begun to awaken. She blinks her eyes, chews on the tracheal tube, and tenses up in her body. But he turns to the nurse each time she moves. Does not touch her. The nurse says that he should try to talk to her. He
In caring for the patients, we
My angels, I call them.
his will to live and supported by human relations.
He mobilizes strength to survive, a strength based on
much to live for. His family means so much to him.
coffin, he then vows not to die, because he has so

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But it was I alone who had to sort it out. Erik has had
thorax surgery, but for him the problem is his spine.
A “cork” has been implanted in the spinal marrow,
but he sorts out his problems himself as he normally
does in his life. He mobilizes sufficient strength to be
able to expel the cork. The field note from the day
when he makes marked progress describes how he
 spit up violently during oral hygiene. Could this be
the time he experiences expelling the cork? Possibly,
but what is most interesting here is the description
he makes of having to mobilize all the strength he
had in his body in order to sort things out himself.
He describes it almost as a mustering of physical
force. Is this the same force that Henry speaks about
when he says that he thinks people have something
inside that can work together with the medicine
throughout the illness? He describes a force that
comes from within oneself, a kind of mental power
that is ancillary to physiological processes in the
body. Henry is convinced that when he sees his own
coffin, he then vows not to die, because he has so
much to live for. His family means so much to him.
He mobilizes strength to survive, a strength based on
his will to live and supported by human relations.

My angels, I call them. In caring for the patients, we
wish to do well. We wish to help, to support and to
make recovery as comfortable as possible. However,
what is so clearly revealed to us is the challenge one
faces in attempting to understand and help patients
who are experiencing painful and difficult circumstances. Lisa’s struggle in the hotel room and Erik’s
effort to expel the cork can only be understood in
retrospect. The signs that a patient is in discomfort,
however, are often present. The field notes from
Lisa’s period of sleep and initial awakening describe
several such sequences in which the nurses, through
their bedside manner, showed that they regarded her
as a perceiving person and not merely as an injured
physical body. Another note shows how challenging
it can be to remain attentive to the patient as a
feeling, experiencing person in complicated care
situations. The following note recorded during Lisa’s
routine care can serve to illustrate:

Four nurses at bedside, two women and two men.
Three to turn her on her side and to stabilize her
pelvis and leg, one to wash her. She lies with her
eyes closed, but her eyelids quiver. ‘Now we’re
going to turn you on your side.’ Talking to the
wall. What does the patient understand? The
turning is done rapidly (too rapidly?) and her leg
is stabilized. ‘Now we are going to raise your leg.’
Info. given after the leg was lifted. Lisa coughs
violently; the alarm on the ventilator sounds.
Tracheal suction. Resists. Tachycardy. Tries to
move her arm. Grimaces. Gets extra sedation. The
nurses discuss among themselves who will be the
first to take a break.

When we acquire insight into the world of
experience in retrospect, we understand that such a
situation can become part of the patient’s experi-
ence. But in this event, might a closer attentiveness
to the patient have made a difference in the patient’s
experience? In the case of Paul, could a different,
more qualitative presence have made a difference for
Lisa? We can hypothesize, but we cannot be certain.
Lisa was also cared for in a gentle, caring manner,
but without her world of experience being able to
absorb the kindness before she becomes “under-
standingly” present in the intensive care room. Can
it be, in Lisa’s case, that a mood has developed pre-
reflectively in her body whereby unpleasantness
overpowers pleasantness? The particular care situa-
tion described above, if we close our eyes and
imagine being in such a situation, can without a
doubt be perceived as a violation confirming the
mood she may live in at that time.

The human factors in the intensive care room are
significant for the patient’s being to the world, but
we are unable to avoid the fact that critical illness
and intensive care treatment will have to represent
change, encroachment, and technical invasion of the
patient’s body. Patients will also in the future have to
carry with them a multitude of chaotic experiences.
With this in mind, it is important to realize that the
diary and follow-ups can mean something good for
patients. When Henry speaks of “my angels”, it is in
continual reference to the diary and the meetings
with the nurses after his stay on the ICU. “It is worth
its weight in gold,” Lisa says about the diary. In
addition to opening for reflection and for finding
meaning in one’s experiences, the text may also be
significant in a relational context. “It tells me that
there were people that cared about me as a person,“
Erik states. Relationships may also emerge in retrospect.

People live in relationships. We are interwoven with one another in our being to the world. Through critical illness, relationships emerge as significant, but in different ways, as illustrated for us by Henry, Lisa, and Erik.

**Summing up**

What has then been revealed to us as authors through this investigation? We realize that the so-called delusional or unreal experiences of intensive care are not meaningless. In all their oddness, they are filled with meaning. These are experiences that matter to the patients and that may have an impact on their well-being in living with them. They may not be dismissed as unreal because they are so inherently real in the lived body. For the person striving with such peculiar and often fundamental, frightening experiences, it is a question of being given the opportunity to discover aspects of meaning in them, an acquired knowledge that in fact may hold a positive potential.

How may these types of peculiar experiences be understood? We have attempted to show that they can be considered to express aspects of existential themes such as lived body, lived space, lived time, and lived human relation. They may express phenomena related to being human in the world, an understanding that challenges an explanatory model based on pathogenic processes in the brain. In the reflection related to lived space, “mood” emerges as a significant factor both in the constitution of experience and in the process of searching for meaning. Odd experiences appear to express aspects of the patient’s feeling of mood in the situation in which he finds himself. A struggle for survival is clearly present as well, in which the phenomenon of “inner strength” is active and for which human relationships can make a difference. However, let us now try to place the insights gained into a broader context.

**Discussion**

van Manen, referring to Linschoten (1987), argues that the description, in order to be operative and moving in the reader, must be open. The researcher aims to be allusive by orienting the reader reflectively to that region of lived experience where the phenomenon dwells in recognizable form (van Manen, 1997a). Insight is achieved through making the text reverberate with the reader both because of its description of basic human phenomena that we recognize in ourselves, but also in the form of patients we have encountered who “come back to us”. In this respect, we become aware that what reveals itself to “me” may be different from what reveals itself to “you”. Validation of a phenomenological text, however, according to van Manen (1997b, p. 27), occurs by mutual recognition given by the “phenomenological nod” which says “Yes, that is an experience I could have”. Nevertheless, how can that be true concerning experiences like those related by Henry, Lisa, and Erik? The person is placed in such an extreme situation whereby his or her experiences may have no relevance beyond the situation itself, if they have any relevance at all. We argue, however, that the extreme situation that the person undergoes in intensive care treatment instead opens for an elucidation of basic phenomena belonging to the realm of being human in the world. Then recognition and validation are possible, precisely because of basic structures found in a commonly shared lifeworld.

“Then it’s simply quite normal,” Henry states in the introductory quote, and it is precisely this that contrasts so strongly with traditional professional explanations of experiences such as “being somewhere else” as a result of cerebral dysfunction, similar to the failure of any other organ (Roberts, 2004; Ely et al., 2004). There is something “wrong” going on inside the patient’s head that induces “false” and “unreal” experiences. However, as we have seen, such experiences, through a phenomenological perspective, can be understood as real in several ways. They are experienced as real, leaving traces in the body. “It agrees with how my body felt—and how it still feels,” Lisa says. In addition, they can be grounded in reality based on what the patient has actually been through both in the form of events and in the form of having been in a life-threatening situation. The sense impressions are real, but they align themselves via intentionality in meaningful contexts in the body creating subjective experiences (Merleau-Ponty, 1962). Moreover, we see that experiences may be understood as real based on the strong bonds to the person’s life and they can be interpreted through structures bearing meaning. They are real and relevant in the person’s lifeworld. Eric’s statement: “I went through my entire lifetime” is illustrative here.

There is undoubtedly something going on inside the patient’s head that may be related to changes in biological and physical circumstances. Opiates, for example, are reported to inhibit the release of acetylcholine in the brain and it is also found that the serotonergic systems have inhibiting effects on the cholinergic systems of the basal forebrain and the brain stem (Jones et al., 2000). However, what is going on does not necessarily lead to a failure
inducing “wrong” experiences that are to be dismissed. It is interesting to accompany Henry in his wondering about whether the result of the “causal factors” is actually to open up for lived life. Might some of what surfaces be what the controlled body strives to forget? We realize that what does come to the surface, pre-reflectively becomes interwoven with sense impressions through an experiencing body searching for meaning (Merleau-Ponty, 1962). Is it through such a perspective possible to understand what occurs, once again to borrow Henry’s own words, as “simply quite normal”? An interesting juncture here is the factor of “mood” that emerges so strongly from the description. The moods of the room, of the situation and of the patients are in an intense interplay in the constitution of experience. Merleau-Ponty illustrates this interplay by saying that “the body is in the world as the heart is in the organism” (p. 203). Psychoanalyst Binswanger, also of the phenomenologist tradition, offers a perspective that can facilitate understanding of the relationship between mood and the “delusional”. He claims that in what we regard as delusions as well as in dreams, we can “sense the pulse of existence” (Binswanger, 1963, p. 230). They are not, as Henry also states, “sort of getting shot into your veins”, but rather an expression of the situation in which the lived body finds itself. For Binswanger, mood is the total state of feeling which goes through a man and at the same time binds him to the world, and which underlies and influences all the movements of the soul. Man lives in moods (p. 243). We propose that for intensive care patients, in the extreme situation they find themselves in, lived mood pervades their lifeworld in a stronger sense that in man’s everyday situation. It pervades their lifeworld not only as an aspect of lived space, but as a fundamental existential that helps us, along with the other existentials, to understand the meaning of “being somewhere else” during intensive care.

A struggle for existence clearly emerges. Erik struggles to get the cork out and to prevent a murder at the lake, Henry swims, and swims toward the surface, pre-reflectively becomes interwoven with sense impressions through an experiencing body searching for meaning (Merleau-Ponty, 1962). Is it through such a perspective possible to understand what occurs, once again to borrow Henry’s own words, as “simply quite normal”? An interesting juncture here is the factor of “mood” that emerges so strongly from the description. The moods of the room, of the situation and of the patients are in an intense interplay in the constitution of experience. Merleau-Ponty illustrates this interplay by saying that “the body is in the world as the heart is in the organism” (p. 203). Psychoanalyst Binswanger, also of the phenomenologist tradition, offers a perspective that can facilitate understanding of the relationship between mood and the “delusional”. He claims that in what we regard as delusions as well as in dreams, we can “sense the pulse of existence” (Binswanger, 1963, p. 230). They are not, as Henry also states, “sort of getting shot into your veins”, but rather an expression of the situation in which the lived body finds itself. For Binswanger, mood is the total state of feeling which goes through a man and at the same time binds him to the world, and which underlies and influences all the movements of the soul. Man lives in moods (p. 243). We propose that for intensive care patients, in the extreme situation they find themselves in, lived mood pervades their lifeworld in a stronger sense that in man’s everyday situation. It pervades their lifeworld not only as an aspect of lived space, but as a fundamental existential that helps us, along with the other existentials, to understand the meaning of “being somewhere else” during intensive care.

A struggle for existence clearly emerges. Erik struggles to get the cork out and to prevent a murder at the lake, Henry swims, and swims toward the surface to get air and Lisa struggles against her aspirants in the hotel room. Granberg et al.(1998) also identify a struggle, but find it to be a fight to regain consciousness and wakefulness. We suggest that there is in fact a fight for survival going on; a fight that is an expression of the total state of feeling that goes through the patient. “I think I felt it inside... that I was on the threshold...”, says Henry in reflecting on his experiences. The form this struggle or fight takes is determined by who the patient is in his lifeworld.

Within lived relationship lie the possibilities for strength in the struggle. Let us look first at the aspect of strength. Inner strength, or the “something inside”, in Henry’s words, is described in several studies as a phenomenon in living with various states of illness (Dingley, Bush & Roux, 2001; Haile, Landrum, Kotarba & Trimble, 2002). A common element in these studies is a focus on inner strength as a factor of psychological health and spiritual well-being in the process of moving on. An interesting question to pose based on our study, however, is how such strength can influence the physiological processes in the body during the very struggle for survival? Bergbom and Askwall (2000) address this question and suggest that the patient’s courage may have an influence on the process of survival, while Morse and Carter (1995) state that a will to live is crucial to survival.

Henry regards his strength as coming out of a will to live, supported by close human relations. Løgstrup (1997) vigorously elucidates how we as fellow human beings are interrelated and dependent on one another in our existence in the world. In the human relationship lies a potential for a counterforce to the difficult and harmful. It is a matter of being received. The significance of close relations in supporting strength and the will to live in the intensive care patient has been identified by Bergbom and Askwall (2000). They argue that the “nearest and the dearest” can represent a “lifeline” for the critically ill and show that the mere presence of the loved ones is of the utmost importance to the patients in representing a counterforce to “giving up”, a factor that is also amply confirmed by Henry in our study. Our study, however, opens for interpretive curiosity about this “mere presence”. There are grounds to believe that it is also a question of quality of relationship and quality of presence. Both the phenomenon of inner strength in surviving critical illness and the impact that human relations via both loved ones and carers can have in reinforcing the strength call for further research.

Another interesting question that arises is whether what is going on actually may hold a positive potential? A journey through lived life provides possibilities for discerning meaning in life in a new way, such as our informants so clearly demonstrate for us. “It has given me the opportunity to sort of understand my life and myself in a new way!” Erik states. Panathanassoglou and Patiraki (2003) also maintain that there is a positive potential in dream-like patient experiences from being critically ill. They find that it is a question of the individual’s life in the world that carries with it a potential for better self-understanding and growth, a finding that stands in contrast to a view of this type of experience as adverse and inhibiting recovery (Jones et al., 2001; Ely et al., 2004). Panathanassoglou and Patiraki
(2003) also hypothesize that such experiences may be seen as heightened spirituality during the illness, thereby providing strength in the situation as well. This "trace" is supported by the sociologist Richman (2000) who suggests that he survived, having been in such a situation himself, only by having his soul elsewhere. Henry tells us convincingly that his mountain trip, and being comforted in the tent, gave him strength to go on. Escaping to a more pleasant place than the intensive care unit is also described by Granberg et al. (1999) and found to represent a kind of mental relaxation encouraging hope. Henry's reflection shows us that there may be more to it than that. Through journeying, not only as a soul but also as a living whole, to places that represent home, the patient may gain the strength to continue the fight for life. In lived space there are lived places where existential security and strength are to be found (Bollnow, 1961; van Manen, 1997b).

The accounts lead us to understand that people may find it difficult to cope with the burdens they take with them from their stay in intensive care. Henry and Lisa convey strongly to us how the drowning experience or the struggle against attackers is a type of troublesome experience. Lisa had symptoms clearly reconcilable with sub-PTSD developments during the time after her move to the ward. From a traditional perspective, Lisa was afflicted with delusions. She was not physically in the hotel room with her attackers. As we have seen, it is maintained that a way to prevent PTSD is for the patient to realize that the delusion is not real (Jones et al., 2001). However, our informants show us clearly that this is not helpful. Such experiences may not be dismissed as unreal because they are so inherently real in the lived body. It is rather a question of having the possibility to discover meaning in experiences that are real and relevant in life.

In a search for meaning, patient diaries and follow-up conversations may be helpful as also identified in earlier research (Bergbom, Kamsula, Svensson & Berggren, 1999; Combe, 2005). What warrants further research, however, is the significance of "feeling the room" in this search for meaning. The transformation process between chaos and meaning seems to occur in the individual over a lengthy period of time and having sources for finding meaning appears to be decisive in such a process.

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