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Health-promoting conversations – A novel approach to families experiencing critical illness in the ICU environment

Concise title: Health-promoting conversations

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Summary box

What does this paper contribute to the wider global clinical community?

-Families with a member who has a critical illness face an emotionally challenging life situation that threatens the normal functioning of the family.

-Through health-promoting conversations family members can share and understand each others feelings related to the critical illness.

-In order to gain a better understanding of family adaptation and the family as a unit, the experience of each family member needs to be acknowledged.

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ABSTRACT

Aims and objectives

The aim of this study was to identify and describe the outcomes of a nurse-led intervention, “Health-promoting conversations with families,” regarding family functioning and well-being in families with a member who was critically ill.

Background

Families who have a critically ill family member in an intensive care unit face a demanding situation, threatening the normal functioning of the family. Yet, there is a knowledge gap regarding family members’ well-being during and after critical illness.

Design

The study utilized a qualitative inductive–descriptive design.

Methods

Eight families participated in health-promoting conversations aimed to create a context for change related to the families’ identified problems and resources. Fifteen qualitative interviews were conducted with 18 adults who participated in health-promoting conversations about a critical illness in the family. Eight participants were patients (6 men, 2 women) and 10

were family members (2 male partners, 5 female partners, 1 mother, 1 daughter, 1 female grandchild). The interviews were analyzed by conventional content analysis.

Results

Family members experienced strengthened togetherness, a caring attitude, and confirmation through health-promoting conversations. The caring and calming conversations were appreciated despite the reappearance of exhausting feelings. Working through the experience and being confirmed promoted family well-being.

Conclusion

Health-promoting conversations were considered to be healing, as the family members take part in sharing each other's feelings, thoughts, and experiences with the critical illness.

Relevance to clinical practice

Health-promoting conversations could be a simple and effective nursing intervention for former intensive care patients and their families in any cultural context.

KEYWORDS: Critical illness, family support, health, intensive care, family.

INTRODUCTION

Advanced treatment of critical illness during intensive care has enabled an increasing number of patients to survive (Oeyen *et al.* 2010). Approximately 17-48% of patients who survive experience post-discharge consequences, such as symptoms of post-traumatic stress, anxiety, depression, sleep problems, nightmares, and hallucinations (Davydow *et al.* 2009, Myhren *et al.* 2009), up to 18–24 months after discharge (Paparrigopoulos *et al.* 2014). Impairments that occur during post-intensive care and have been described as new or worsened health problems include physical, cognitive, and mental health difficulties, and have been defined as part of a “post-intensive care syndrome” that may also affect close family members (Elliott *et al.* 2014).

Surviving patients report a need for varying information related to the course of their recovery, highlighting the necessity to develop different support methods. Patients may not be able to understand the information given during intensive care or at discharge; therefore, family members may also need individualized and understandable information (Elliott *et al.* 2014).

Different methods and rehabilitation services have been developed for patients and their family members or caregivers, but their application remains limited. Patient diaries are cost-effective interventions that demonstrated a positive influence on psychological complications in a review of 22 studies (Ewens *et al.* 2015). However, in a recent review, Ullman *et al.* (Ullman *et al.* 2015) found minimal evidence from three randomized controlled trials (RCTs), reporting neither benefit nor harm for patients or their family members when using diaries during intensive care.

In addition, the evidence for nurse-led follow-up clinics after discharge from an intensive care unit (ICU) is contradictory. Two reviews reported that nurse-led follow-up clinics are associated with patient satisfaction, lasting up to 6 months after discharge in one

review based on the results of 17 studies (Jonasdottir *et al.* 2016), and reducing symptoms of post-traumatic stress disorder 3 to 6 months after discharge in two out of five reviewed studies (Jensen *et al.* 2015). On the other hand, results from a recent multicenter RCT identified no difference between patients receiving nurse-led follow-up and those receiving ordinary care in terms of quality of life, sense of coherence, anxiety, depression, or post-traumatic stress disorder (Jensen *et al.* 2016). Similarly, Lasiter *et al.* (Lasiter *et al.* 2016) reported a continuing lack of strong evidence for follow-up clinics in their review of 20 studies, partly because many of the published studies (15 of 20) were difficult to compare given the variable methods and focus. These authors called for rigorous studies aimed at developing standardized follow-up for the growing number of patients surviving intensive care and their families.

Background

Patients and family caregivers express that the need for information varies across the care continuum (Czerwonka *et al.* 2015). Fear and worries exist when families are unsure of what to expect during intensive care and after discharge. The patient's transition from dependence to independence is also related to the patient's mental well-being and can affect relationships, which can be frustrating for all parties. Thus, families with a member who has a critical illness and is in an ICU face a demanding, emotionally challenging life situation that threatens the normal functioning of the family (Jones *et al.* 2012, Linnarsson *et al.* 2010). Family members who experience this overwhelming situation often suffer from anxiety, depression, and post-traumatic stress disorder to a greater extent than a patient who is critically ill, and these symptoms are reported to persist among family members for up to 3 months (Fumis *et al.* 2015). Memory loss, isolation, and negative emotional reactions, such as bitterness have also been reported among family members who ask for support when facing the future

(Frivold *et al.* 2016). When asking patients and their families what matters during critical illness, 85% find spirituality to be of great importance (Aslakson *et al.* 2016). Consequently, as acknowledged in two reviews, interventions aiming to improve families' involvement during critical illness may facilitate the families' well-being and, thus, needs to be improved (Mitchell *et al.* 2016, Olding *et al.* 2016). As family members have valuable experience related to the patients' needs, participation in the care of the patient has been shown to improve emotional well-being, as well as communication with the nurses, when using the family-centered care model (Mitchell & Chaboyer 2010). The newly published guidelines for family-centered care during critical illness support and conclude that there is still a need for further research aiming to identify ways to strengthening communication with family members (Davidson *et al.* 2017).

To meet family members' needs, interventions have been developed based on the Calgary Family Assessment and Intervention models (Wright 2009c) and the Illness Belief Model (Wright 2009b), both of which aim to support families' well-being and health by creating a context for change. The possibilities for change are created by family interactions in which family members listen to one another's thoughts about the illness the family is facing. This approach may ease life for family members affecting their well-being, as a few recent studies have suggested (Benzein *et al.* 2008, Duhamel *et al.* 2007, Wacharasin 2010). Furthermore, health-promoting conversations inspired by the above models (Wright 2009a, Wright 2009b) have been developed by (Benzein & Saveman 2008) in Sweden and used in clinical practice with promising outcomes suggesting an improvement in family well-being that promotes positive family relations (Benzein *et al.* 2008, Benzein & Saveman 2008). Families who have experienced stroke in the family and participated in health-promoting conversations express that they have improved their relationships within the family and experienced a decrease in the sense of being alone, which may be transferable to family in

other vulnerable situations (Ostlund *et al.* 2016). In addition, an integrative review of 17 empirical studies describing outcomes from family nursing interventions, such as health-promoting conversations, in different contexts reported that the interventions improved family members' understanding of one another, improved their caring behavior within the family, and facilitated emotional engagement and feelings of closeness in the family, which may be considered to be significant for family interaction and well-being (Östlund & Persson, 2014).

To gain a better understanding of family adaptation and the family as a unit after critical illness, the experience of each family member needs to be acknowledged. Yet, a knowledge gap exists regarding the family members' well-being during and after critical illness. As health-promoting conversations are described as being successful in families who, through the conversation, can identify, solve, and use their experience as a resource (Beinzein *et al.*, 2008), they may be one way to support patients and their families after critical illness and intensive care. To the best of our knowledge, health-promoting conversations in families with experience in critical illness have not yet been evaluated. Thus, the purpose of this study was to identify and describe the outcomes of a nurse-led intervention, "Health-promoting conversations with families," regarding family functioning and well-being in families with a member who was critically ill.

METHODS

Design

A qualitative inductive–descriptive design was considered appropriate to obtain deep insight into the effect of health-promoting conversations with families after critical illness (Hsieh & Shannon 2005). Qualitative research is a flexible method for developing knowledge about the human experience of health and illness. Conventional content analysis was chosen to expand

current knowledge of family function and well-being after critical illness and discharge from intensive care (Hsieh & Shannon 2005).

Setting

The study was conducted at one university hospital and one county hospital in southern Sweden. Family members were welcome to visit their critically ill family member at any time at the ICU but were asked to leave the room when nursing or medical procedures were performed. Family members were also encouraged to participate in the care but would usually just be present and sit by the bed.

Data collection

Sample

Adult patients (>18 years of age) who had been cared for in an ICU for at least 72 hours during 2015 or 2016 were included in this study if they had at least one family member (>15 years of age) who participated with them in the ordinary post-intensive care follow-up clinics with the patient. Both parties had to be interested in taking part in health-promoting conversations. Eligible families received a request to participate from an intensive care nurse responsible for the recruitment of participants, but she was not involved in caring for participating patients or the data analysis. Three weeks after discharge from the ICU, the families received a study information letter containing a description of the study, a description of the voluntary nature of the study, a consent form, and a postage-paid return envelope via the mail. Eight families gave informed consent to participate.

Intervention

The families who agreed to participate were invited to take part in health-promoting conversations. The intervention consisted of three health-promoting conversations 4–8 weeks after discharge with intervals of 2 weeks and a closing letter after the last conversation. Two intensive care nurses led the health-promoting conversations. One nurse took major responsibility for the conversation, and the other nurse served as a co-participant, acting as an observer of metacommunication, keeping track of the time, and monitoring the technical equipment. The health-promoting conversation was based on an interview guide, and each family member was asked to narrate their own experience and the family's actual situation (Benzein & Saveman 2008).

The aim of the conversations was to create a context for change related to the families' problems and resources. The conversations started with a discussion of the aim of the conversation series and the families' and nurses' expectations about the conversations and each other's roles. All family members were invited to participate in telling their story and in listening to one another's stories of their experiences. The three conversation sessions focused on topics that the families considered important, and the dialogue and questioning intended to identify resources within and outside the family (Wright 2009a). At the end of each conversation, the nurse offered a short reflection on how the family members had experienced the session.

A closing letter was sent to the family 2 to 3 weeks after the last conversation to summarize further possibilities for reflection. The letters were based on the stories told during the conversations and did not contain interpretations or value judgments. To standardize the intervention, all participating research nurses completed formal theoretical education and practical training in health-promoting conversation (Ahlberg *et al.* 2015).

Interviews

The intervention was followed up by interviewing families that had participated in the health-promoting conversations. Interviews were performed 3 and 12 months after the last health-promoting conversation. An interview guide was developed based on the Calgary Family Assessment and Intervention models (Wright, 2009a). The families were asked to narrate as freely as possible their reflections and the significance of the conversations to family functioning and well-being. The following questions were used to guide the interview: (1) Would you please tell me how you experienced the health-promoting conversations? (2) Have the conversations influenced you? If so how? (3) What meaning did the conversation have for your family? (4) Was there anything specific in the conversation that was of special value for you? (5) What in the conversation had greatest meaning for you?

Probing questions (e.g., “Would you please tell me more about that?” “What do you think?”) were used when suitable. One pilot interview was performed to test the interview guide; this interview was included in the analysis.

The interviews were conducted by two intensive care nurses/researchers experienced in the qualitative method (GHF, IW). These two nurses did not lead the conversations. The interviews were performed in the families’ homes, except for five that occurred in a small conference room at the hospital.

Demographic characteristics, such as sex and relationships, were collected at the beginning of the interview. All participants had taken part in the ordinary post-intensive care follow-up clinic and health-promoting conversations and had received a closing letter.

Fifteen interviews were performed with 18 individuals from eight families participating in the follow-up study; 8 participants were patients (6 men, 2 women) and 10 were family members (2 male partners, 5 female partners, 1 mother, 1 daughter, and 1 female grandchild). The mean participant age was 60 ± 19 years. Five participants had university

education, six had high school education, three elementary school or less, and the education level was not reported for four participants. None of the participants were health professionals and one former patient had been an ICU patient several times before. All participants had equal information and understanding of the health-promoting conversations. Each interview lasted 20–60 minutes, was audio-recorded and transcribed verbatim by a secretary, and treated confidentially.

Analysis

The data were analyzed using conventional content analysis to obtain information about family function and well-being after critical illness. Conventional content analysis provides a subjective interpretation of the content of the text through a systematic classification process that involves coding and identifying patterns (Hsieh & Shannon 2005). The two interviews (at 3 and 12 months) were analyzed together because the family function after discharge was seen from a comprehensive perspective because the participants' own experience participating in health-promoting conversations was regarded as one experience (Hsieh & Shannon 2005).

The analysis was a back-and-forth process involving four steps. The goal of the first step was to get a sense of the whole, so the first author read the transcripts several times. Next, the authors discussed the text and reached agreement about the content. During the second step, meaning units relevant to the aim and interview guide were identified. The third step involved a condensation of the meaning units to reduce the text while keeping the meaning of the content. The fourth step was a coding process in which the condensed meaning units were categorized into subcategories and categories based on the agreement of all of the authors.

Quotations are used as illustrative examples in the presentation of the findings to give the reader an opportunity to evaluate the consonance between the interviews and the

categories (Hsieh & Shannon 2005). Together, these techniques support the trustworthiness of this qualitative study.

Ethical considerations

Permission to carry out the study was granted by the Regional Ethical Review Board in Linköping (Dnr 2013/228-31) and conducted in accordance with the Declaration of Helsinki. All participants were invited to contact the first author or the post-intensive follow-up clinic if they felt distressed after the interview.

RESULTS

The results of the analysis of the two interviews are presented from a comprehensive perspective because the family function after discharge was seen as holistic, and the second interview did not add any new elements. Three categories (strengthening togetherness, a caring attitude, and confirmation through the health-promoting conversations) and five subcategories were identified (Figure 1).

Strengthening togetherness

Strengthening togetherness was related to the two subcategories ‘showing feelings’ and ‘support’. Some families became closer through their experience with critical illness in the family and worked through their emotions together during the health-promoting conversations.

Showing feelings

Having the opportunity to talk about and show the other family members one’s own feelings during the conversation was experienced as positive:

“How I felt ... and getting to tell my dad and nn. Nn was asked the same questions and then she got a chance to tell us what she has felt and experienced. It then became emotional and we cried together and got closer to each other.” (1)

In some families, these feelings were not easy to talk about with the family member who was critically ill:

“You put on a brave face ... as parents we try to be strong and nn (the former patient) tries to toughen up ... but then you got to show each other how you felt.” (2)

However, after the first meeting, some participants felt that the conversation had revived feelings that were already addressed. Some had talked a great deal with all family members about their feelings and already had the chance to work through their feelings:

“We brought this up again after it had subsided a bit.” (3)

Although some families had talked a lot, they still cried together, especially after the first conversation. Largely, they cried out of thankfulness, not sadness, and the family member who had been critically ill was very thankful for still having their life and family. One patient felt that the second interview was too emotional and interrupted it after 5 minutes.

Support

Some adult children were astonished at the understanding and support their parents had received through the conversations. In addition, some participants looked forward to the conversations and the relief that they might offer:

“I almost looked forward to these appointments because they were so uplifting.” (4)

The conversations contributed to family members being better informed and more conscious about how critically ill their family member was and what had happened. Having the opportunity to discuss one’s feelings in more detail, which not was possible with people who had not experienced critical illness, was viewed as supportive. Without this opportunity, the

participants would have not had the support and been more alone with their own thoughts. After discussing the experience of critical illness, it was easier to leave it behind and move forward.

There were also opinions about the conversations not being supportive. One family member said that it was nice to meet the nurses but that the conversation did not give him anything in particular:

“Just some general chit chat about all this, and it was very enjoyable.” (6)

That said, he appreciated that his wife, who had been critically ill, was positively influenced and much calmer after the conversations; therefore, he was influenced as well. In addition, the conversations had supported his wife in making fewer demands on herself, which was positive for the family:

“The family works as before ... she has even changed a little ... not as obstinate and dominating ... a little bit more humble.” (6)

In this way, the family function was positively supported by the conversations influencing their togetherness.

Caring attitude

The caring attitude, to be invited to talk about one's thoughts and feelings, was a positive experience. Confidence in the nurses responsible for the conversations was established immediately.

Engagement

Participants found it to be very important to have the chance to explain how a family can be influenced by a family member falling critically ill. This sentiment was especially expressed by a family who had had many experiences with critical illness and ICU care. Respondents

appreciated that someone was interested and listened with engagement to their individual experiences and, though there were a lot of tears and crying, there was also laughter:

“I am incredibly impressed by your help and consideration.” (4)

Engagement with and caring for a person over 80 years of age was especially pronounced. The feeling of getting information and feeling cared for was positive and contributed to a sense of satisfaction, though life was sometimes depressing when symptoms reminded the participant of the critical illness:

“You had someone to talk to ... they listened.” (4)

In families in which the grown children had participated, the parents were very happy that the children had the opportunity to talk about and process their feelings. It was also expressed that doing this study meant an unexpected engagement from health care, a sign that someone was interested in the deeper meaning of the health-promoting conversations.

Intervention structure

The health-promoting conversations were appreciated and performed in an easy-going atmosphere rooted in well-prepared, structured questions that allowed all persons present to talk freely. However, some participants had been doubtful about participating in the health-promoting conversations before they decided to take part.

Offering three opportunities for health-promoting conversations was positive because the first conversation was experienced as intense, and it was valuable to have a closing conversation and leave the hospital with a sense of calm. Knowing that it was possible to make contact with the nurses again if new thoughts or reflections arose related to the critical illness was considered security:

“I constantly worry that something is going to happen to him, and I feel that I need someone to turn to ... because we don't have any children.” (7)

The health-promoting conversations facilitated the sorting of one's own thoughts while not having to be alone with them. One participant who had been critically ill expressed the opinion that the conversations should be required instead of voluntary:

“It shouldn't be voluntary, it should be compulsory. I think that everyone who has been under general anesthetics has thoughts and questions.” (6)

The only way to understand and sort things like this out was to get help from nurses who had cared for a critically ill person. Participants also expressed the importance of having a favorable mental attitude and being receptive from the beginning.

Confirmation

Being able to discuss the meaning of being critically ill was calming. In addition, the possibility of expanding one's knowledge about the medical condition and treatment was valuable and contributed to a sense of confirmation. The caring and calming conversations were appreciated even though exhausting feelings re-emerged. Furthermore, working through the experience again and being confirmed promoted the family's well-being.

Insight

The health-promoting conversations facilitated understanding of the patients' and family members' different experiences during the critical illness; the person who was ill gained insight into how the family members experienced their time in the ICU, which is one reason the health-promoting conversations were appreciated:

“It took some time before it dawned upon me that your experience was completely different from mine.” (8)

On the other hand, some family members gained insight into the seriousness of the critical illness during the conversation, which was difficult to bear. Seeing a partner who had been

critically ill feel relieved during the conversation gave one wife a sense that it was easier to talk about it at home afterward. It was valuable for a professional to express something:

“It has been good to be there and talk to them for a while, and then move on ... I suppose it’s that confirmation again.” (3)

The transcripts also confirmed that episodes of depression, nightmares, and hallucinations are normal during recovery, which participants experienced as relieving:

“I don’t know why these conversations were so important to nn (a former patient), but they were, so therefore they’re good.” (6)

The conversations meant getting answers to reflections that had not been expressed earlier; thus, they supported increased well-being.

DISCUSSION

The outcomes of health-promoting conversations resulted in strengthened family functioning and well-being through strengthened togetherness. Other outcomes were related to the supportive nature of health-promoting conversation, with the experience of a caring attitude mediating confirmation.

In some families, the conversation reawakened feelings that they had already worked through. Nevertheless, participants expressed the need to discuss their experiences again, noting that during the second conversation, they found it meaningful and relaxing to express their feelings with the family again. Some feelings that came up were related to the insight that the critical ill family member had received qualified intensive care and was thankful for still having their life and family. A previous study found that partners who participated in group communication with other partners of former intensive care patients benefited from sharing their feelings with others with similar experiences of being an onlooker in intensive care. Once the shared experience was discussed, it was easier to leave it behind and move

forward (Ahlberg *et al.* 2015). Sharing emotional experiences within the family or with strangers who have had similar experiences are two different situations satisfying different needs, and such conversations may not be substituted for one another. Perhaps both conversational methods are needed to leave behind the emotional feelings related to intensive care.

Some contradictory opinions were expressed about whether the health-promoting conversations were supportive. Although one participant was very critical in the beginning, he ultimately concluded that, because he and his wife had shared and discussed their experiences during the conversations, he could see that the family function was supported by a positive influence on family togetherness. In another study, conversations with families living with chronic illness who could reconsider their perspectives by listening to the other family members' thoughts and understanding of the situation also resulted in a new communal understanding (Persson & Benzein 2014).

The health-promoting conversations were characterized by a caring attitude, and someone being interested and listening with engagement to the individual experiences was especially valued. The invitation to participate in health-promoting conversations was received as an unexpected engagement from health care. Gill *et al.* (Gill *et al.* 2016) previously indicated the need for a family navigator with knowledge about the long-term effects after intensive care. Patients and family members in that study were unsure about a primary care clinician's knowledge of long-term effects and were hesitant to consult their primary care physician.

Surprisingly, one participant expressed that the health-promoting conversations should be required for all intensive care patients because critically ill patients have a lot of unresolved worries. Participating in group communication was also highlighted by Ahlberg *et al.* (Ahlberg *et al.* 2015); in their study, partners recommended group conversation to all

partners who had experience with critical illness and intensive care. In the current study, participants expressed that an intensive care nurse with adequate experience and knowledge of caring for critically ill patients is the most optimal resource for health-promoting conversations. One issue regarding supportive interventions for families after critical illness and intensive care is determining the optimal time for support. This is a challenge because some families may be ready for conversations and reflections earlier than others. If the conversations are offered too late, after the emotional feelings have already been worked through, family functioning may be disturbed by awakening these feelings again. Similarly, the optimal time for conversations differs among families with chronic illness (Benzein *et al.* 2015). This issue is also reflected in the newly published guidelines for family-centered care during and after critical illness and ICU care (Davidson *et al.* 2017).

The health-promoting conversations increased family well-being, as confirmed during and after the meetings. Confirmation was experienced through both listening to the family members' thoughts about the critical illness period and mediated knowledge that the experienced psychological symptoms were normal. Approximately half of former intensive care patients have cognitive impairments (e.g., difficulties with concentration, reading/understanding, and/or memory loss) based on a 3-year follow-up after discharge from the ICU (Fonsmark & Rosendahl-Nielsen 2015). In addition, receiving confirmation that their feelings about the demanding situation at home or existential thoughts were normal provided relief among partners during group communication. Through reflection, they could continue their lives in a new family situation (Ahlberg *et al.* 2015). Being required to accept a new life situation with limited physical ability due to chronic illness has also been discussed and interpreted during family health conversations, resulting in a renewed communal understanding of how to solve problems together (Persson & Benzein 2014).

Nurses require a specialized course on health-promoting conversation. In Sweden, a 5-week course is offered at two universities. The nurses performing the health-promoting conversations in this study had taken this specific course.

Methodological issues

The sample size of eight families could be considered small, but more than one family member was present at every interview, allowing 18 family members to be represented in the analysis, which was considered a reasonable selection. To strengthen the credibility of the findings, the persons performing the interviews with the families had not participated in previous conversations with them. Furthermore, truly following and giving a clear description of the method enhanced the dependability of the findings. Together, these techniques support the trustworthiness of this qualitative study.

Having two interviewers may be seen as a limitation, though both were experienced in interviewing, the application of qualitative methods, intensive care. Another limitation may be that the participants were interviewed twice due to expectations that the second interview would yield new information about the effect of the intervention. However, during both the second interview and the analysis, it was clear that the participants' thoughts about the health-promoting conversations had not changed since the first interview.

During the interviews, some participants had difficulty staying on the topic of health-promoting conversations because the whole caring period in the ICU was in focus. In addition, some found it difficult to separate the caring period in the ICU from the post-intensive care follow-up. This conflation occasionally required the interviewer to intermittently clarify the aim of the interview and bring the discussion back to the health-promoting conversation, which may be seen as a limitation.

CONCLUSION

Health-promoting conversations are suggested to be healing, as the family members took part in hearing and understanding one another's feelings, thoughts, and experiences with the critical illness. Working through the experience of critical illness and being confirmed by family members promoted family well-being.

RELEVANCE TO CLINICAL PRACTICE

Nurses need a specialized course to perform health-promoting conversations that aim to identify problems and resources in the families and encourage them to talk and listen to one another. Thus, health-promoting conversations could be a simple and effective nursing intervention for former intensive care patients and their families. Furthermore, the health-promoting conversations may be performed in other cultural contexts, as families' experiences with critical illness could be transferred to any cultural context.

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Contributions to the manuscript

All authors (GHF, IW, LO, and SÅ) contributed to the conception and design of the study.

Data analysis and interpretation was performed by GHF and IW.

The article was drafted by GHF and revised critically for important intellectual content by IW, LO, and SÅ.

All authors approved the final version of the manuscript.

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