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ORIGINAL ARTICLE

Body, strength and movement—intensive care patients' experience of body

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Abstract

This study is about intensive care patients' experience of strength, body and movement during critical illness in an intensive care unit. The aim of the study is to inquire and understand the ways the body and its experience appear when the phenomena of strength and movement are altered. The data were collected through in-depth interviews with seven patients and analysed from a phenomenological-hermeneutical point of view. The findings showed a body that refuses to cooperate and is often marginally able to cope with the situation at all. It showed relational bonding between the patients and health personnel and/or significant others where the patients were overlooked and at the same time dependent on the same persons. They were wavering between life and death through dimension of existence, which is contrasted to earlier experiences. They showed feeling responsible for the family through a role in to reduce their fears. At the same time, they are in a continuous struggle for life in which they balance between vague hope and a situation so challenging that the only thing left is grim humour. They showed progressing and expectations where the slightest changes in the situation in a positive direction create a hope in them.

Key words: *Phenomenology, hermeneutics, body, strength, movement, intensive care patients*

Introduction

Critical illness often changes a person's life situation in a dramatic way and brings with it extraordinary experiences and reactions. The patient's life changes from the constant calm of everyday life to the drama of life-threatening conditions where vital bodily functions are at risk or have ceased to function. This altered and vulnerable position leaves the patient with loss of control of the body due to a dramatic change of conditions within the body. The body's ordinary potentialities—representing all its opportunities—can from one moment to the next be lost and/or come to represent its limitations (Roberts, 1976; Leder, 1990; Merleau-Ponty, 1994). A person has the capacity for strength and movement, as well as the loss of strength and limitation of movement. Strength and movement refer to the potential or actual ability of an individual

to influence the situation and/or interpersonal relationships and are related to how the individual influences, causes, or prevents changes in condition, attitudes, behaviour and emotions. How strongly the body is influenced by these two physical elements usually refers to experiences of success and failure with efforts useful to or efficient in the situation (Roberts, 1976). Illnesses affect the body and the body's potential for strength and movement becomes redirected. This refers to the existing degree of potential but also the limitations imposed on the body in terms of loss of freedom to apply strength and movement (Cheever, 1999). Strength and movement are also limited by physical and emotional stress related to illness (Richman, 2000). Previous scientific research into these phenomena has mostly been from the perspective of the natural sciences, where strength is viewed in terms of energy or it

represents physical capacity, or strength and movement have been classified in terms of biomechanics and development of motor activity (Engelsrud, 2001). Research has been conducted within several medical fields and focussing on various diagnoses (Freigang & Rudolf, 2004, Folpe et al., 2005; Wall & Kristjanson, 2005). Some research includes conditions and strategies for treatment related to the elderly population (Topp, Ditmyer, King, Doherty & Hornyak, 2002; Cirio, Piaggi, De Mattia & Nava, 2003; De Jonghe, Shaarshar, Hopkinson & Outin, 2004; Barry & Carson, 2004; Wiles, 2005; Thomson, 2005; Biggs, 2005). There are also studies focusing resilience, stamina and inner strength, but few of them focus on patients in intensive care (Labyak, 2002; Jansen & Keller, 1998; Chao, Chen & Yen, 2002; Haile, Landrum, Kotarba & Trimble, 2002; Bays, 2001).

However, strength and movement are also in focus within a quite different tradition: the phenomenological-hermeneutic one. According to this tradition, the body, with its presence in the world, can be seen as being in the world (Heidegger, 1962). Being in the world with one's body creates proximity to things and to life itself. This proximity makes phenomena physically observable and allows us see them in context (Merleau-Ponty, 1994). Since a person is inextricably linked to the body, the body becomes the centre and point of departure for sensing, reflecting on and comprehending one's situation in the world (Benner & Wrubel, 2001). The consciousness of the phenomenological body appears through the body's experience and learning from situations. Within the phenomenological-hermeneutic tradition, little research has been conducted on how the phenomena strength and movement manifest themselves in the body, particularly in the context of intensive care. It is important to question patients, who experience strength and movement, how they experience that particular situation in, and with, the body. Hence, the research question, How do intensive care patients experience the phenomena strength and movement? The aim of the study is to inquire into and understand the ways the body and its experience appear when the phenomena strength and movement are altered.

Method

This study applies a phenomenological-hermeneutical method inspired by Ricoeur's philosophy and developed by Lindseth and Nordberg (Ricoeur, 1976, 1982; Lindseth & Nordberg, 2004). The method is in use at the universities of Tromsø (Norway) and Umeå (Sweden) (Sørli, 2001; Talseth, 2001). The hermeneutic approach presupposes

that the researchers' interpretation and understanding is based on their pre-understanding (Heidegger, 1962). The unconscious part of the interpreters' pre-understanding consists of a part of a person's culture, language, history, which though taken for granted still influence the interpretation of the text (Heidegger, 1962; Malterud, 1996). This subjectivity can be counteracted by application of a strict method of interpretation (Ricoeur, 1976). This method focuses upon understanding and interpreting the meaning of phenomena of lived experiences. Ricoeur (1976; 1982) describes interpretation of a text as a dialectic process from understanding to explanation, and then from explanation to comprehension understanding.

Subjects

The informants in this study are five females and two males between the ages 34–82. Apart from one woman, all informants had been connected to a ventilator. Two of the women had been treated for chronic lung disease with complications, one for heart surgery with complications and one for infectious disease with complications. One male was treated by orthopaedic surgery with postoperative complications while the other one had an acute infectious disease with complications. The period of treatment in intensive care varied from ten days to three months. Four of the female informants were treated two or more times in the intensive ward. The time span recorded covers the total treatment in the ward.

Data collection

Written permits were collected from three hospitals in Northern Norway regarding contacting former intensive care patients. Staff nurses distributed an inquiry of participation to informants selected on the following inclusion criteria:

- women/men
- 18 years +
- five days or longer in intensive care (excluding postoperative patients)
- patients connected/not connected to a ventilator (including both kind of experiences)

The informants' written consent to participate in the study was returned directly to the first author (STDF) who made the initial contact with the informants, made appointments for interview dates and collected the data. Data were assembled through seven in-depth interviews (from 47 min to 1 h 45 min). The informants were interviewed in their

homes. Since intensive care can be traumatic for patients, the data collection was carried out within a timeframe of six months post hospital discharge. The interviews were carried out by way of narrative where the information rendered became the premises for the content of the interview. Initially all informants were asked the following question, "How did you experience your body when you were seriously ill and committed to the intensive care unit"?

Analysis

The interpretation process was to some extent informed by the first author's (STDF) capacity as an intensive care nurse and the pre-understanding and experience this involves. The analysis was performed in a dialectic process, consisting of three phases; naïve reading, structural analysis and in-depth interpretation (Lindseth & Nordberg, 2004). The first phase, naïve reading, included several readings of the text with an open mind in order to gain an overall impression of the meaning of the text as a whole, which provided ideas for the forthcoming analysis. The second phase, structural analysis, was directed toward the structure of the text. The text was divided into meaning units, i.e. one or more sentences or whole paragraphs connected with their meaning content. The meaning units were condensed and abstracted into key descriptions of each unit. These key descriptions were then reflected on for prominent relationships, as well as regular patterns and variations, and organized into sub-themes. The subthemes were then clustered, based on their similarities, and then organized in themes. The interpretation was conducted in the following way. The first and second authors read and re-read the interviews, and developed the meaning of what the text said semantically, and what meanings it represented. These meaning units were then further reflected on and put into context. The second and third authors followed the first author's thoughts and asked questions about what had been done and why. Through this process, the first author's mind was opened up to possible and alternative interpretations of findings, and made sure that the findings were grounded in the data (Ricoeur, 1982). In the third phase, the text was considered as a whole while taking into account the naïve reading, the structural analysis, the researchers' questions and pre-understanding, and the literature for the purpose of gaining a deeper understanding of what the text as a whole indicated. This in-depth interpretation is presented in the discussion section of this paper.

Research ethics

The study was approved by the National Committee for Medical Research Ethics, Health region 5, (8 November 2004), as well as by the Norwegian Social Science Data Service (27 October 2004).

Findings

The findings will be presented according to the two first phases in Lindseth and Nordberg's method naïve reading and structural analysis. The findings will then be analysed in-depth and discussed.

Naïve reading

The naïve reading gave us (authors) to understand that the informants' narratives focus on what they experienced in the situation. The informants described their dependency on care providers but also how they felt objectified in their condition as critically ill. They tried to act responsibly from their hospital beds by shielding themselves and their relations from extra stress by implementing limitations and structure. In spite of their difficult situation, the informants referred to some incidents, which promoted their will to fight and lighted their spark to search for opportunities in a situation very much characterized by limitations.

Structural analysis

With the naïve reading as the basis for understanding, the three themes emerged from seven sub-themes: (1) Losing the body, strength and movement; (2) dealing with the loss of body, strength and movement, and (3) reclaiming the body, strength and movement. The structural analysis resulted in seven subthemes and three themes as shown in the Table I.

Table I. Results of structural analysis identifying subthemes and themes.

Subtheme	Theme
The body refusing to cooperate Relation bonding between health personnel and significant others Waving between life and death	Losing the body, strength and movement
Feeling responsible for the family Dissociating and protection Struggling for life	Dealing with the loss of strength, body and movement
Progressing and expectations	Reclaiming the body, strength and movement

The first theme: Losing the body, strength and movement

The intensive care patients perceived their bodies as unfamiliar because strength and movement were lacking or very reduced as compared to having control of the body. They were in relationships with both relatives and health care professionals that had a very negative or dramatic influence on their strength and movement in the situation; they also experienced relationships, however, which they perceived positively in the situation. The informants were in such an existentially difficult situation that they were often only marginally able to cope with the situation at all.

The body refusing to cooperate

The informants experienced with a body thoroughly different where both distance and bodily control was concerned. They told about a condition where the body completely or in part lacks the capacity to move. They were in a kind of duality where they saw and learned what happened to the body at the same time as being in a state where they did not recognize or feel the body.

... I noticed they moved my feet, but in my mind my feet were facing straight forward although I could see them being moved to the side ... I could see them move but I couldn't feel anything ... and it was a pretty strange experience since I knew what they had done (female, 34 years).

Strength and movement were recognized as decisive for the sensorial precision of the body. The informants met with considerable limitations in fine sensorial nuances as coordination became restrained, hampering not only their strength and movement but also the bodily forms of expressions. They told that the elements strength and movement appeared to be mutually intensifying or restricting since they both provided the opportunity for bodily expressions and they limited the same capacity:

“... I was unable to move my arms ... to a certain extent I felt I could move my head to indicate a ‘yes’ or ‘no’ ... and I also found it difficult to speak ... because the fine motor ability was destroyed” (male, 82 years).

The intensive care patients found that they were unable to move and consequently were made aware of the loss of control of the body and the situation that had been brought about by the reduction of movement since movement is often necessary to communicate. They also found that not being able to

move put them in a situation different from the one where they control body and action. This went against the world they knew:

“... one could hardly lift one's head and turn it. Help was required for everything else, and that ... you know I've never been used to asking for help for just turning or moving a limb ... it was a totally new experience (male, 64 years).

Relation bonding between health personnel and significant others

The informants felt that they were set aside and not taken into consideration in addition to the indignity felt by not being seen or taken care of. They also felt being dependent on personnel, both humanely and for treatment. The situation they were in they felt traumatic because they were overlooked by personnel and at the same time dependent on the same persons:

“... and then it was awful lying there for five hours ... and having them questioning me again and again and again ... these candidates ... so one could actually die there I guess” (female, 53 years).

The patients wanted to contribute by assisting themselves in situations and they asked nurses to make arrangements so that they by means of strength and movement could manage. Despite the difficult and complex situation they were in they wished to cooperate and be in charge:

“... then I asked them to give me one of the long syringes and fill it with water and rest it on my shoulder or chest so that I could push some water through the tube and wet my mouth” (female, 34 years).

Being treated instrumentally is like being in a kind of vacuum and the intensive care patients felt excluded from having any influence on their own life and their own situation. Being treated like this was like being in a kind of void that could not be described:

“... I felt they treated me like I was a practice doll ... only thing was I was alive ... yes ... to describe the feeling is quite difficult ...” (female, 68 years).

The informants found that nurses were involved and expressing compassion both by being

continuously present and above all by being aware. They also found this as a genuine engagement, a mental presence and empathy always present with nurses:

“... they shared my feelings ... they sat there ... watched ... watched out for me all the time ... I felt there was a strong good will in everything they did ...” (male, 64 years).

Nurses caring and the effects of nursing efforts often were by the patients found as a state of well-being. They felt that nurses acknowledged their situation and improved their conditions with dignity. The patients became important when having the attention of and when being treated by numerous nurses.

... but then I remember a man coming into the room ... an elderly man ... a nurse ... professional nurse, he came in ... then he stroked my chin and then he said that ... poor (informant's name) it's wet and awful for you now ... then he lifted me up into his arms and then he moved to a chair ... and moved me there ... because my bed was so wet ... and then he called for help so others came and changed my bedclothes and all ... and then I remember there was someone who prepared soap water ... and you know he washed me and ... it felt so good (female, 73 years).

The informants found that their contact with family was a contrast to all that was not experienced as essential aspects of the situation. They also found that survival and belonging became life's most important values:

“More than anything I wanted permission to live ... permission to live with my family. It was so ... all material things became irrelevant and unimportant ... really” (male, 64 years).

They felt a strong conflict between being in contact with the family and at the same time taking care of themselves in a difficult situation. They almost felt forced to making choices they did not want to make but which were necessary to survive. To allow worries about relational concerns would make their situation and choices even worse.

... it was a huge strain and very hurtful to have to push those problems away ... I had to ... just had to decide that I couldn't let them be a part of my life at this moment in time, and it was really

painful to make the decision that I couldn't let it affect me just now (female 34 years).

Some informants felt a strong connection to their relatives and this represents a wish, an urge, a motivation and hope as well as a confirmation of the strength of these ties: “I remember saying to my wife on the phone that if I survive this we'll really celebrate our 50th wedding anniversary this summer” (male, 82 years).

Waving between life and death

Patients found themselves in a reality far beyond what they perceived from their life experiences. They found themselves in another dimension of existence where reality was unknown and strongly contrasted to the life they had experienced. Their sense of existence was so intrusive that being in the body was experienced as being so difficult and intense that they dissociated themselves from their own bodies.

... and during the time I was lost to this world I was in America and we were at a hotel in Mexico or on the border ... then I got it all confused again ... America and some rogue state next to it ... and then the other daughter and her family joined us ... I even brought my brother and a cousin with me and we stayed at a very big hotel (male, 64 years).

The informants experienced and became conscious that something had happened to them. They also believed that some important part of life had disappeared while they were unconscious. They found that they were unable to find what was lost and how to find it. This loss of content made them reflect on something which might help them to explain life and death:

“... well yes I began to think ... at first I wondered what had happened to me ... but when I regained full consciousness I realized it had had to be something important” (female, 75 years).

In less lucid states of consciousness, informants perceived brighter colours. They found that colours changed from having a specific distinctness to getting vaguer as they came to. They experienced that the colours were important to them and that the colours were connected to their present situation.

It affected my perception that the colours were so vibrant ... just in this room ... I almost said I interpreted the colours in my own special way ...

when I could sense things more clearly it wasn't like that, it was more brown ... it was anonymous (female, 68 years).

Some of the intensive care patients felt a spiritual enlightenment through the power of light. They experienced that the spiritual light changed their vital power and the strength of vital power, a kind of power, which encouraged the will to get back to life. They were surprised that the power could be observed as something that was materialized in the body and not only as a bodily impression.

...and I remember that for some time I saw light ... I saw the light ... it was orange ... red and there was a lot of power in it ... and I remember it well because I had not anticipated that there would be anything to see ... and my friend told me that she had prayed for me ... that they had thought about me every day and they had talked and ... they had sort of ... I knew there was a power there that they had conveyed to me because I gained so much more desire to come back (female 34).

The second theme: Dealing with the loss of strength, body and movement

The informants did not just have to take responsibility for their own situation, but also had to take responsibility for and manage family members. They were so exhausted that in order to cope with treatment and procedures, they had to distance and/or protect themselves from various circumstances in the situation. At the same time, they were in a continuous struggle for life in which they balanced between a vague but clear hope and a situation so challenging that the only thing left was to use grim humour.

Feeling responsible for the family

Bodily restrictions were experienced by the patients and in this difficult and vulnerable situation, they told their families how they were. They felt a joint responsibility associated to family tasks and engagements: "I felt quite helpless and there wasn't much else I could do than to try and express some soothing phrases on how I felt" (female, 34 years).

The informants found that they had a special role in the family and it was very important for them to keep their families safe and to reduce their fears. When they chose to be with certain family members this could be felt as a way of safeguarding the family in terms of mastering the situation:

"... I felt I had to tell them I was fine so that I could make them relax more ... and I saw that in spite of my illness I felt I was ... I almost said ... the boss in the family" (female, 34 years).

There were individual variations among family members in terms of requirements. Responsibility for spouse and children was considered more important than anything else: "Yes ... I felt a different responsibility towards him (husband's name) and my children than I do for my parents" (female, 34 years).

The informants found themselves divided between their own feelings and the need to have company on the one hand, and the emotional burden from family members on the other hand.

When they had to choose between their own needs and the strain on relatives, they often chose to take the burden on themselves:

"... I really felt bad ... I was bone tired and almost crying and didn't want to see them leave, yet I also wanted them to leave so that they wouldn't feel burdened" (female, 34 years).

Dissociating and protection

In order to tolerate care and procedures the intensive care patients felt that they were exposed to, they needed to alienate themselves from the pain these activities involved. This denial of pain may be seen as a coping strategy. They found that they had to shift the focus from the body to somewhere outside the body or keep it limited within the body to gain a distance and be able to endure. They also experienced that they dissociated themselves from the body by not claiming it as their own body. Patients just observed a body, which had to be cared for, but which was not related to them.

... I had to create a zone or a space when they came to do this ... I searched for a spot on the wall or a thought I could hold on to ... and then they did what they had to do and finished with it (female, 34 years).

A common experience was to have to shut the strain out to sustain the strain on the body and in the situation. They managed to escape the situation and the body with its thoughts and emotions by moving the pain to a different time-dimension. The situation was conceived as so all-including and threatening that they dissociated themselves from it by mentally taking refuge in a time period ahead where they could look back on the situation as something in the past.

...I only needed to be somewhere quiet where there was no pain...I didn't have any thoughts...I didn't think of the disease...I didn't think at all...my only thought was that that was then (female, 53 years).

The informants experienced that to be critically ill, with the challenges this situation posed, was a very stressful experience. They felt the situation so stressful that they were unable to face the challenges. They shut off information they were given to avoid dealing with it.

... they gave me a lot of painkillers so that I slept and woke up and fell asleep again so the information they gave me...I just pushed it aside and said...okay...fine, but I didn't give it more thought (female, 34 years).

The way relatives were permitted to visit functioned well for the patients. They found that arrangements were based on providing for families as well as their own need for closeness and distance. Putting the family in the relatives' room was a way of relieving themselves.

...it was nice that the hospital had a homely ambience to it...I had my own room...with a sofa, table and chairs and slowly it took the shape of somewhere my relatives could visit me, and if I hadn't had this I think it would have been exhausting to be there (female, 34 years).

Surviving the initial acute illness involved a sense of having been under protection, which some intensive care patients experienced as linked to the spiritual dimension. They wondered what kind of preference they had been given to be alive after a critical illness. At the same time, they were grateful to be alive.

... it was strange that I should be spared... after all I'm 68. Younger people than me have been placed in such a... I don't know if they felt like me, but they were all very ill and had had cardiac arrest (female, 68 years).

The patients who were parents found a need to protect their children from the overwhelming impressions of their parent situated in the context of the equipment and instruments which the intensive care unit contain. They were strongly against their children being allowed into the intensive ward because impressions from such visits may mar them for life.

...all the tubes and apparatus that surrounded me...connected to me...lying on the bed... and I really didn't want them to see this...that this should stick in their memory...so the kids didn't see me much in ICU. ... (female, 34 years).

Struggling for life

For the patients there were sometimes experiences of a big difference between material world and living. When critically ill, when life is at risk and all power and movement were reduced to a minimum they felt that life's "being" became the priority. They found themselves at a crossroad where existence itself got urgent and where existential conditions got more important than material ones.

...I've always been struggling and working for money to buy things, and there were always something we needed...and it suddenly became irrelevant. It was unimportant...the important thing was to stay alive and get my health back (male, 64 years).

Grim humour was important in their misery, for instance referring to the helplessness the informants experienced. Once they realized how bad their situation was grim humour became the only motive force: "When I felt how I lay there and comprehended what the situation was like I used grim humour to push myself...to get there... (male 64).

They often found the situation extremely important bringing about a state of profound despair where both strength and movement were absent. They felt that being deprived of every opportunity to act or to express one's thoughts using language made them lose heart: "...I was so depressed it was unbearable...I think we focus too much on things...like you know...death and such...negative" (female, 68 years).

Having lost the ability to eat was experienced as traumatic since this is the most basic function in man's existence and eating is fundamental for basic survival. Not being able to eat puts you on the lowest possible level. Loss of strength was a sort of bodily void, which put you in great danger. To get out of this void you needed assistance.

... and I couldn't eat or anything...I was at the minimum level in everything...I think one of the doctors realized this because she came to me and said...I think we need to make some changes in your life now (female, 34 years).

The informants had reached a state where they were on the brink of giving up. They experienced a

situation so demanding and body potentials so marginal and the difference between the two dimensions so enormous that they emitted small messages that they could not stand it any longer. This was observed by relatives who registered that the informant were about to let go.

...at a certain stage I mentioned several times that I couldn't take it anymore, I don't want any more of this ...and then they came to see me more and tried to make me think of other things because they realized I was drained (female, 34 years).

Despite the difficult situation, informants at times experienced that they had some hold on life. In the middle of despair and distress, there were a will and determination deep down to manage. This will to succeed was extremely important in order to master the present situation.

The patients experienced that they needed to have some kind of grip on life to master the situation, and had this focus not been present they might not have stayed alive: "... if I hadn't managed to cling to the idea that I would survive this I wouldn't have been where I am today I'm sure" (female, 34 years).

The intensive care patients found the situation in relation to their own capacity and time, but fought it by limiting it to the here-and-now. They experienced their stamina as a source of power to move away from the situation as critically ill. They felt a drawing towards abandoning life but decided against it and made life their leading idea. They possessed a will to live limited in time but the will was still there.

... when I was in ICU I sometimes thought I was hanging on by the skin of my teeth ... yes ... I thought so many times ... but still I struggled ... I realized it wasn't time for me to go yet (female, 73 years).

When the situation was difficult and the pain was almost unbearable and the body did not function, the patients' despair was transformed to anger. They experienced a kind of frustration and despair by being locked in a position in life they might not get out of and which became increasingly importunate. In this state of anger and despair they were aware that they allowed their frustration to affect innocent persons and they found this most distressing.

...I felt desolate and abandoned ... horrible pains and ...I don't know why I was so angry ... and I was angry with them all ... and no one of them had caused me any harm (female, 68 years).

The informants at times summoned their resources to object to certain decisions. Their defiance helped them protect themselves as well as being a boost towards bettering their situation:

"...I don't think there's much hope ... we need to switch off the machine When she (name) was about to leave me I opened my eyes Oh no, you don't!" (female, 68 years).

The third theme: Reclaiming the body, strength and movement

The informants re-discovered the body when being removed from the horizontal position. The slightest changes in the situation in a positive direction created a hope in them. When the health care professionals challenged them, they experienced it as problematic; still, it created a motivation as regards the future. When the situation gradually became more positive, they also changed their attention from being turned inwards to carefully being turned outwards.

Progressing and expectations

The patients described the experience of being brought back to a vertical and interactive perspective after having spent long intervals in a horizontal position. They found a kind of reclaiming the experience of body. They felt that the body was in a position less limited and where they could register what took place around them. Their body was strange but in a new mode which induced hope. This was registered as getting back the body they experienced before.

It was almost the biggest thing that had happened to me when they helped me get up in that chair, they supported me ... to that chair that was there and everything seemed upside down ... only so that I could sit and see what was happening around me ... and it was almost ... although I didn't have any strength ... the arms were just lying there and the feet were propped up ... yet still I felt that now ... something was happening which made ... that thing with the chair is one of the greatest things that have happened to me actually (male, 64 years).

Even the smallest positive changes in their condition the patients experienced as personal progress, and this enhanced their personal motivation. They felt that this changed their view of life from hopelessness to taking a more positive view. The new attitude made them acknowledge progress and it

added energy. This motive power triggered the will and thus encouraged the functions of the body.

I did feel that I was gaining control with the situation ... something's happening now I'm getting better now this thing ... now it's getting much better ... and then my motivation came back (male, 64 years).

The staff had great expectations from the patients during treatment or rehabilitation activities. The patients sometimes felt that the body resources were so limited that they could not meet with the minimum of activities suggested by staff and they thereby registered a gap between expectations and their own condition. They were often unable to comply and protested.

... tomorrow we want you up and walking. Oh no you don't because I can't. Oh yes you can. You are not expected to really walk, but you'll take a step or two and then we'll put you in a chair (male, 64 years).

The staff also motivated the intensive care patients to work on concrete bodily functions. The patients experienced that this encouragement was meaningful in terms of its focus on the concrete and its limitations in terms of the totality critical illness involves: "And then she said we'll manage this because it's a human right to be able to scratch your own nose" (male, 64 years).

The informants at times questioned why they were permitted to live on and what life would have to offer in the future. They found themselves in a state where they looked both inwards and outwards while awaiting progress that would give them reason to look ahead.

... I don't want the rings ... deep in my heart I wasn't sure. ... It was a strange sensation ... then I began to think ... what does this mean ... and the doctors had done an amazing job that ... oh I had an angel next to me (female, 68 years).

Walking and being active and achieving tasks were significant and meaningful to the intensive care patients' lives. They, and specially the male informants, experienced that wanting to achieve something became a motive force to get the body going.

... I felt a burning desire to be able to walk again and to get back to work ... work may be the wrong expression when you're in the eighties, but we have this park we work on and two guys in particular motivate us a lot (male, 82 years).

To have an intact body created expectations towards personal abilities to achieve and to see opportunities the future may hold. The patients felt that finding the body and bodily functions intact together with being in touch with your own body brought a confirmation of life (and the wonders of life). Knowing that the body was not lost was a strong and decisive turning point.

... then I thought ... this went really well and I tried with my feet and arms and everything ... that I could move and I wasn't a vegetable ... no not that ... and I really found out quickly (female, 73 years).

Some informants with a religious faith experienced a hopeful expectation towards God. They found that the expectations they might have of the future would depend on the comprehension of their spiritual dimension: "... I thought of Jesus a lot ... if He would help me now or if He had left me ... I had just been saved and baptised" (female 73 years).

Comprehensive understanding

The findings of this study described the patients' experiences when the phenomena strength and movement are altered. Three themes were found to describe and characterize the intensive patients' experiences: (1) Losing the body, strength and movement; (2) dealing with the loss of body, strength and movement; and (3) reclaiming the body, strength and movement. There were no apparent differences arising from patients' gender or the context in which the narrated story took place. To be critically ill means being caught up in a situation in life where one's body is completely exposed and vulnerable to the loss of strength and movement. When the intensive care patients referred to strength, they did that in an awareness of the distinction between strength and the lack of strength. Having strength means being able to perform physical tasks in everyday life without being aware of it. Body and strength are symbiotic. One conditions the other giving the body form and potential for activity and movement. Strength implies being able to perform tasks with your whole body and/or certain parts of the body. These activities are intentionally purposeful and the body is used to performing them in a more or less advanced way. The opposite of strength is weakness. It represents a body that completely or partially has lost the potential of activity through loss of strength. Such a reduction of the body's ability to sustain activity is particularly visible during critical illness.

Intensive care patients suffer major challenges in terms of strength and movement. This includes the loss of body, strength and movement, coping with and reclaiming body strength and movement from critical illness. These patients felt locked in a situation where they had lost all control and where their bodies were incapable of drawing on resources strength and movement would have given them for even the simplest tasks. In this situation the patients lived in an absolutely marginality where potentials hardly could be found. In spite of all this, the patients coped by shutting off emotions when situations became unbearable. With gradual improvement, the patients drew resources from minute progress and used their expectations to maximize the potential for reclaiming life-opportunities.

Discussion

The intensive care patients emphasized the loss of strength, but also the grief when they realized that their body did not respond the way they were used to. The narratives from the intensive care patients referred to this grief as an overwhelming sense of disempowerment. The potential for action was lost. The body existed without strength and capacity to move and the patient lost control over the situation (Fredriksen & Ringsberg, 2006). In an intensive care unit, the patient is forced to accept living with this situation. The phenomena strength and movement converge in the body's experience of the situation. The situation's limitations and openness in view of the environment becomes essential (Merleau-Ponty, 1994). In this meeting between body and situation, the separate phenomena strength and movement become one existential condition. This condition challenges the lifeworld of experience and history, and the lifeworld becomes alien and filled with contradictions (Storli, Lindseth & Asplund, 2007). The awareness experience provides us with is not converted to something beyond the body, but remains the experienced body's encounter with the world, thus making the body's possibilities and limitations clearer. When experiencing this particular situation the intensive care patient gradually accepts the different aspects of the situation the person is in. This is a condition where man understands his/her being in the world through, in Heidegger's words, his/her decisiveness (Heidegger, 1962). The decisiveness calls upon the opportunity for being. The situation's transparency creates awareness of the reality it represents for the patient. The perception of reality in the situation provides a connection to the world by the clarity the conceptual understanding of body, strength and movement provides. For intensive care patients, it involves

connections to the world through the sharpness, which emerges in a form of structural understanding of the body, strength and movement. This also involves how the body of intensive care patients functions with regard to the potentials and limitations (Fraleigh, 1987). When intensive care patients find that their body, strength and movement is altered this initiates a new realization of the condition they're in, but also new information towards understanding the self. This understanding is the foundation for opening up a new path. Moreover, to a limited degree, it permits the intensive care patient to get a grip on his life from there onwards (Nicolaisen, 2003).

How the intensive care patients deal with body, strength and movement and the level of challenge it represents can be seen when the potential is at its lowest (Strandmark, 2004). They deal with their body's struggle for life with their intentional consciousness as a driving force (Strandmark, 2006). They express intentional consciousness by boundaries or motivation depending on the relevance to the situation. It is based on impressions their consciousness opens up to and becomes aware of (Husserl, 1992). In doing so, the patient opens his/her consciousness to make it available as well as purposefully shutting out impressions. Self-preservation means creating distance to someone or something, or receiving protection from someone or something. The patients' choices express a vast discrepancy between resources they possess and the outside pressure. Their narratives express self-preservation through physical distance but also self-preservation through emotional distance. Coping strategies are based on the challenges the patient has to face and the degree of loss of strength and movement (Nyman & Sivonen, 2005). The strategy has to be meaningful in terms of assessment of the total situation. Often the critical health situation implies seeking opportunities derived from a marginal potential or hope of survival. This life-and-death drama is a struggle for survival with only a marginal opportunity to affect the outcome. The contradiction between intentionality, which drives the patient forward, and the loss of access to strength and movement creates resignation. Resignation drowns the urge to act for shorter or longer intervals. The strength and the urge to move are basic forces in man's efforts to move forward and an elementary precondition for nourishment of hope. The occasional resignation counter effects hope and affects the sense of meaning in life (Nyman & Sivonen, 2005).

Intensive care patients who have reclaimed their bodies emphasize the gradual emergence of life-opportunities and understanding of being in the

world (Heidegger, 1962). The new understanding of life is characterized by strength and movement as progress and expectations. They refer to the importance of reclaiming a vertical perspective of life and visual access to the room by being in a vertical position. These revelations, or movements, are not singular discoveries in the condition but also a motivating source of improvement. The gaze becomes focused outwards instead of inwards at a sick body, and into a space and a future (Leder, 1990). The future holds uncertainty and expectations as well as opportunities. Faith and hope are particularly visible among those patients who have spiritual faith and who question whether God has left them or not. To be able to apply body, strength and movement in actions, and in spiritual actions, is a positive expectation among the intensive care patients. These are communal actions as well as individual in maintenance of personal body and survival (Hupcey, 2000; Fagerström, 1998). Renewed discovery of the body and its potential also renews expectations to the future. It also encourages the search for new strength and new movements. These expectations represent the phenomenological body's search for a kind of wisdom that involves context and recognition of meaning (Merleau-Ponty, 1994).

What clinical implications can be drawn from this study? Making oneself familiar with the experiences of intensive care patients is significant for care providers since these experiences represent insight critical to the lives of patients. Particularly since the situation might be one of "to be or not to be" for the patients, and minor changes to body, strength and movement may cause the scales to tip. Experience based knowledge is not only a supplement to objective knowledge but also represents the sensibility and life-opportunities within the critically ill patient. The knowledge of intensive care patients' experiences includes knowledge of the phenomenological body's conditions as being critically ill. This means that the precondition for seeing, comprehending and meeting the patient's physicality in strength and movement must be given consideration.

Care providers need to be trained in and taught the subjective and sensuous knowing gaze. Such training would first and foremost involve learning and understanding the essence of the phenomenological body and embodied skills. In addition, training must include sensing the body's tone and tuning to body, strength and movement. The sensuous perceptive knowledge should be emphasized in teaching programmes as well as in educational policies since it touches on subjects that are important to the ontology and epistemology of the health sciences.

References

- Benner, P., & Wrubel, J. (2001). *Omsorgens betydning i sygepleje* (The primacy of caring). Copenhagen: Muunksgaard.
- Barry, B. K., & Carson, R. G. (2004). The consequences of resistance training for movement Control in older adults. *The Journal of Gerontology Biological Sciences and Medical Sciences*, 59(7), 730–754.
- Bays, C. L. (2001). Older adults' descriptions of hope after a stroke. *Rehabilitation Nursing*, 26(1), 18–20, 23–27.
- Biggs, S. (2005). Beyond appearances: perspectives on identity in later life and some implications for method. *The Journal of Gerontology Biological Sciences and Medical Sciences*, 60(3), 118–128.
- Cirio, S., Piaggi, G. C., De Mattia, E., & Nava, S. (2003). Muscle retraining in ICU patients. *Monaldi Archives for Chest Disease*, 59(4), 300–303.
- Cheever, K. H. (1999). Early enteral feeding of patients with multiple trauma. *Critical Care Nursing*, 19(6), 40–53.
- Chao, C. S., Chen, C. H., & Yen, M. (2002). The essence of spirituality of terminally ill patients. *Nursing Research*, 10(4), 237–245.
- De Jonghe, B., Sharshar, T., Hopkinson, N., & Outin, H. (2004). Paresis following mechanical ventilation. *Current Opinion in Critical Care*, 10(1), 47–52.
- Engelsrud, G. (2001). Bevegelse som kunnskapsområde i fysioterapi (Movement as an area of knowledge in physiotherapy). In G. Stokkenes (Ed.), *Fysioterapi på terskelen* (Physiotherapy on the brink) (pp. 101–117). Kristiansand: Høgskoleforlaget.
- Fagerström, L. (1998). The patient's perceived caring needs as a message of suffering. *Journal of Advanced Nursing*, 28(5), 978–987.
- Folpe, A. L., Mentzel, T., Lehr, H. A., Fischer, C., Balzer, B. L., & Weiss, S. W. (2005). Perivascular epithelioid cell neoplasms of soft tissue and gynecologic origin: A clinicopathologic study of 26 cases and review of the literature. *American Journal of Surgical Pathology*, 29(12), 1558–1575.
- Fraleigh, S. H. (1987). *Dance and the lived body*. Pittsburgh: University of Pittsburgh Press.
- Fredriksen, S. T. D., & Ringsberg, K. C. (2006). Living the situation—stress experiences among intensive care patients. *Intensive and Critical Care Nursing*, 23(3), 12–31.
- Freigang, B., & Rudolf, J. (2004). Results achieved in the treatment of patients with vestibular schwannoma. *Otolaryngologia polska*, 58(1), 53–59.
- Heidegger, M. (1962). *Being and time* (Sein und Zeit). New York: Harper & Row.
- Haile, B. L., Landrum, P. A., Kotarba, J.A., & Trimble, D. (2002). Inner strength among HIV-infected woman: nurses can make a difference. *Journal of the Association of Nurses in AIDS Care*, 13(3), 74–80.
- Hupcey, J. E. (2000). Feeling safe: the psychosocial needs of ICU patients. *Nursing Scholarship*, 32(4), 361–367.
- Husserl, E. (1992). *Ideas pertaining to a pure phenomenological philosophy—first book*. Dordrecht: Kluwer Academic Publishers.
- Jansen, D. A., & Keller, M. L. (1998). Identifying the attentional demands perceived by elderly people. *Rehabilitation Nursing*, 23(1), 12–20.
- Labyak, S. (2002). Sleep and circadian schedule disorders. *Nursing Clinics of North America*, 37(4), 599–610.
- Leder, D. (1990). *The absent body*. London: The University of Chicago Press Ltd.
- Lindseth, A., & Nordberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences*, 18(2), 145–153.

- Malterud, K. (1996). *Qualitative method in medical research*. Oslo: Tano Aschoug AS.
- Merleau-Ponty, M. (1994). *Kroppens fenomenologi* (Phénoménologie de la perception). Oslo: Pax Forlag.
- Nicolaisen, R. (2003). *Å være underveis. Introduksjon til Heideggers filosofi* (Being under way. Introduction to The Heideggerian philosophy). Oslo: Universitetsforlaget.
- Nyman, A. C., & Sivonen, K. (2005). Livsmening som vårdvesenskapelig begrep (Courage of meaning as a caring concept). *Vård i Norden*, 25(4), 20–24.
- Richman, J. (2000). Coming out of intensive care crazy: Dreams of affliction. *Qualitative Health Research*, 10(1), 84–102.
- Ricoeur, P. (1982). In J. B. Thompson (Ed.), *Hermeneutics and the human sciences: essays on language, action and interpretation*. New York: Cambridge University Press.
- Ricoeur, P. (1976). *Interpretation theory: discourse and the surplus of meaning*. Fort Worth Texas: Christian University Press.
- Roberts, S. (1976). *Behavioral concepts and the critically ill patient*. London: Prentice Hall International.
- Storli, S. L., Lindseth, A., & Asplund, S. (2007). “Being somewhere else”—delusion or relevant experience? A phenomenological investigation into the meaning of lived experience from being in intensive care. *International Journal of Qualitative Studies on Health and Well-being*, 2(3), 144–159.
- Strandmark, M. (2004). Ill health is powerlessness: a phenomenological study about worthlessness and suffering. *Scandinavian Journal of Caring Sciences*, 18, 135–144.
- Strandmark, M. (2006). Health means vital force—a phenomenological study on self-image, ability and zest for life. *Vård i Norden*, 26(1), 42–47.
- Sørli, V. (2001). *Being in ethically difficult care situations: narrative interviews with registered nurses and physicians within internal medicine, oncology and paediatrics*. Umeå: Umeå University.
- Talseth, A. G. (2001). *Psychiatric care of people at risk of committing suicide: narrative interviews with registered nurses, physicians, patients and relatives*. Umeå: Umeå University.
- Thomson, W. M. (2005). Issues in the epidemiological investigation of dry mouth. *Gerontology*, 22(2), 65–76.
- Topp, R., Ditmyer, M., King, K., Doherty, K., & Hornyak, J. (2002). The effect of bed rest and potential of rehabilitation on patients in the intensive care unit. *American Association of Clinical Issues*, 13(2), 263–276.
- Wall, D., & Kristjanson, L. (2005). Men, culture and hegemonic masculinity: understanding the experience of prostate cancer. *Nursing Inquiry*, 12(2), 87–97.
- Wiles, J. (2005). Conceptualizing place in the care of older people: the contributions of geographical gerontology. *Journal of Clinical Nursing*, 14(8B), 100–108.