

Transformations of self: a phenomenological investigation into the lived experience of survivors of critical illness

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SUMMARY

- Based on the hermeneutical, phenomenological perspective, this study explored the lived experience of individuals with a past hospitalization in an intensive care unit, with focus on their dreams. The purpose was to explore how it is to have been critically ill
- Dreams are the language of the unconscious and can symbolically convey meanings
- Eight participants recounted their experiences with critical illness through semi-structured phenomenological interviews and dream-telling. An interplay between the 'factual-external' world and the 'internal' world appeared to be the basis of their perception of the situation. Participants' narratives were immensely rich in symbols of *transformation*, *transcendence* and *rebirth*. Transformations in perception, in lived-body, and in lived time and space were some of the themes emerging as part of both conscious and dreaming experiences. Attitudes towards death were altered, and elements of heightened spirituality were evident in the aftermath of critical illness
- Critical illness was conceptualized as a 'cocooning phase' leading to transformation of self, spiritual arousal and personal growth. Nurses may be able to alleviate suffering by supporting this process while in the ICU, as well as after discharge

Key words: Critical illness survivors • Heidegger • Hermeneutics • Jungian theory • Lived world • Symbol analysis

INTRODUCTION

Critical illness is an intense life event, entailing physiological, psychological and cognitive aspects that have a profound effect on being (the self). Little is known about the long-term imprint of critical illness on the holistic self in survivors. Based on the interpretive phenomenological perspective and hermeneutics, the present work aimed to explore how it is to have been critically ill and to bring forth the meanings that individuals with a past critical illness perceive in life, in relation to their past acute health condition. Additionally, we attempted to present pieces of their

experience that were still significant despite the time lapse. Researchers have pointed out that dreams and illusions are a major part of patients' recollections from the ICU, while recall of actual events may be hindered (Rundshagen *et al.*, 2002). Therefore, themes dreamt of while in ICU, and later, may be very instructive for deciphering the lived world of these persons. Dreams are the language of the unconscious and they convey meanings through symbolic content (Jung, 1974). Dream symbols may simultaneously entail factual data, as well as personal, collective and cultural symbols (Jung, 1964; Dombeck, 1993).

The interpersonal caring relationship with nurses (Holland *et al.*, 1997) and simple psychosocial interventions (Hwang *et al.*, 1998; Jastremski and Harvey, 1998) are reported as effective means for the alleviation of suffering and stress in critical care. Meanings and feelings are essential building components of the lived world of hospitalized individuals, and these may continue to evolve in the discharge period affecting

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functional and growth processes of a person. Expanding consciousness and insight into the individual at the receiving end of care is a potent tool in structuring a therapeutic interpersonal environment in acute care settings.

With the expanding confidence of the nursing community in qualitative research, studies on the lived experience of critical illness are increasing. Granberg *et al.* (1998; 1999) described experiences of acute confusion, fear and unreal experiences in relation to ICU syndrome. Compton (1991) and Hupsey and Zimmerman (2000) focused on patients' feelings and thought processes, whereas Maddox *et al.* (2001) investigated psychosocial recovery after discharge, and Todres *et al.* (2000) contributed a phenomenological case study on coping with critical illness. Wong and Arthur (2000) compared patients' and nurses' perceptions regarding patients' feelings and needs, while Burfitt *et al.* (1993) investigated patients' perceptions of nursing care. Additionally, Jablonski (1994) described the experience of being mechanically ventilated.

METHOD

Theoretical framework

The theoretical framework is based on the existential ontology of Heidegger, Parse's theory of human becoming, and Jung's theory and methodology of dream analysis. Parse emphasizes that humans create their reality by free choice of meaning, and thus they may transcend their current circumstance and grow (Parse, 1981; 1995). Therefore, a therapeutic potential may be inherent to the interpretive work through unveiling meaning.

The most influential contribution of Heidegger's philosophy is the notion of '*Being-in-the-World*' ('*Dasein*') and the ensuing '*lived world*'. *Dasein* implies the situatedness of humans in the world negating the dualism between body and mind/soul. Individuals are self-interpreting beings, intricately interrelated with factors traditionally deemed external to human existence (time, space, others, culture and language) (Heidegger, 1976). Moreover, language is an important means of interpreting one's own existence. Language becomes a set of symbols providing a primordial interpretation of being and reinforcing 'communal recollection' (Kearney, 1984). Human beings share a 'background familiarity' that allows them to have shared-collective as well as individual interpretations of the world. Therefore, any act of interpretation presupposes unveiling the shared understanding. These views are in line with the Jungian theory of dreams, and the 'collective unconscious', as the bearer of 'latent memory traces... and archetypical images inherited from [humans'] ancestral past...' (Jung, 1971a).

Jung considered the dream as an expression of the self-regulation of the psyche, aiming to achieve a point of psychological balance (Jung, 1964). Jung's methodology of dream symbol analysis is based on unveiling both the 'collective' meanings through extensive review of cultural and mythological symbols (Jung, 1991) and private meanings. Symbols are the language of the unconscious. Dream symbols may have multiple layers of interpretation (personal, cultural, conditional and collective). It is the dialectic between the personal and the communal that may sufficiently reveal the importance of each particular symbol (Jung, 1974).

Design

Interpretive phenomenological design stemming from hermeneutics.

Participants-procedures

Eight participants (five women and three men) were recruited to the study. All had experienced a critical illness, which required hospitalization at an ICU, and they were accessed through a community network. The cut-off criterion for inclusion was an ICU discharge period of 1 year or longer. Four participants had been discharged between 12 and 24 months ago, and four between 4 and 6 years ago. Three interviews of 1 to 2h in duration were conducted. The first two were consecutive, spaced 1 to 2 weeks apart, while the third interview was conducted after the initial phase of analysis for verification with the participants. On some occasions, short follow-ups by phone or by mail – initiated by either the investigator or a participant – were also conducted. Two of the participants were North American, three were American but of Greek descent and the rest were Greek.

Interviewing and dream reports

The phenomenological interviews were semi-structured with open-ended questions and were undertaken over a 2-year period, in English or in Greek. The participants were free to relate anything they considered important in relation to their ICU experience. Emphasis was given to the respondents' dreams. Dreams remembered from their hospital stay, subsequent to their discharge to home, and current or recurrent dreams were included. Smith's (1984) methodology with three open-ended questions was used for dream reporting: (a) '*Tell me your dream in detail, as much as you can remember*', (b) '*This is your dream, telling something about you. What do you think this dream tells you?*' and (c) '*Run through the dream once more. What else comes to mind?*' A fourth question, originating from Jung's (1974) methodology, was used to grasp diffuse feelings:

'Now I would like you to carry this dream further. Use your imagination and add to the dream. What do you see?'

Interpretive phenomenological analysis

The phenomenological analysis and the hermeneutical cycle of interpretation with active participant input evolved concurrently with the interviews, to be intensified after the interviews were transcribed. The participants were prompted to reflect on the meanings of their experiences and dreams. The transcribed narratives were coded and cross-coded for emerging symbols and themes. They were analysed as text and then as a whole. Particular emphasis was given to symbolism, according to the method introduced by Jung, and also applied in the dreams of patients with organic diseases (Welman and Faber, 1992; Dombeck, 1993). The analyses of Jung (1964; 1974; 1991), Cirlot (1996), Eliade (1964; 1994), as well as cultural and mythological sources (Diel, 1975; 1980; Cooper, 1998) were considered for symbol analysis. Mythological symbols often integrate cultural and collective symbols, describing discrete dimensions of human experience (Fromm, 1974; Cirlot, 1996). Such archetypical images may often come up as themes in dreams, succinctly expressing one's context and state of mind (Jung, 1974).

Both investigators carried out the analysis independently, and, subsequently, this was discussed, extended and validated by them in long focused sessions. The results of these sessions were brought back to the participants for validation. This process of parallel analysis was employed to assure analytical rigour.

FINDINGS

A constant interplay between the 'factual-external' world and the psyche – the 'internal' world – appeared to be the basis of participants' perception of the situation. Dreaming and illusionary experiences during their hospitalization, or even during their recovery at home, often could not be distinguished from reality, at the time. Common themes emerging from participants' narratives of their experience were: (a) transformations of perception, and of lived-body, time and space; (b) aloneness; (c) death-rebirth; and (d) transformations of life.

Transformations of perception

Descriptions depicting altered and unreal perception of the self were very frequent in reports of their critical illness trajectory. Participants described their experience as being 'out of it' and being 'out of myself' which was an unreal but often a peaceful sensation.

... It just feels so unreal. I was so out of it. [...] Nothing really mattered. Like being out of myself.

The experience of 'being somewhere else' was common, and it was related to a sense of an altered association between their psyche and the physical body, which, also, was evident in their vivid descriptions of where they 'might have been'. They related images of hovering in the midst of space, floating, flying or finding shelter inwards. Images of flying also came up in dreams. Flying is a universal symbol of 'transcendence' (Jung, 1971b; Diel, 1975; Cirlot, 1996), of the release of spirit from matter. Images of descent were also given. The theme of moving inwards and downwards was common.

... I kept sinking deeper and deeper, for hours I just kept sinking into myself.

Falling or sinking inwards is a general symbol of 'incarnation' of the return of the spirit to matter (Jung, 1971b; Cirlot, 1996), and it may denote a distortion (or even recapturing) of embodiment.

Transformations of body

Distorted perception of body and bodily sensations was also experienced by the respondents, whilst in the ICU. The participants described how they felt their bodies taking strange shapes, being in continuous motion or swinging sideways, or upwards-downwards, repeatedly:

... as if I had no body, only head – a big huge ball! This nurse poked me in the arm, [...] and I begun to sense my body... I was in great pain... I only wanted to go back into my head and hide.

I felt swollen, huge and very heavy... once they moved me and I felt like they were plucking a whole house out... My fingers felt enormous and stiff like gas pipes...

The metaphors for the body in the first narrative – ball (sphere) and head – are overall symbols of the mind/spirit/soul, and although they may be otherwise associated with the notion of wholeness (Jung, 1964; Cirlot, 1996), they may also highlight a disrupted embodiment. The sensation of being 'huge' also points to altered somatic perception. The analogy of the house – a symbol associated with the human body – points to the same direction, while the fingers, greatly exaggerated in the narrative, are intuitive symbols of one's grasp of the world and a mythological symbol of the link to the subconscious (Diel, 1980; Jung, 1991). Overall, it was evident that participants experienced their body as a medium with inner spatiality, in which movement was possible. This is dramatically different

from the everyday lived experience of the body. The perception of the head as a hideaway and the following analogy of the pipe, offered by another participant, further illustrate this point.

I was at the end of a very narrow pipe and from there I could hear everything... the pipe was I.

Here, again, the experience of the body as an instrument of sound transmission replaces the everyday, naturally embodied perception of sound.

Sensations of swinging and of spontaneous abrupt movements to any direction, as if floating on water, were common. Participants viewed them as a sign of imbalance. A sense of orientation is another embodied perception, which appears to have been disrupted during their critical illness and for sometime after.

Transformations of time and space

Descriptions of an altered perception of time were common.

There is no time, no passage of time. Like being on vacation somewhere.

This unreal experience also extended to the perception of space. Space seemed to be condensed around them, in a way that they felt disturbed even when nurses cared for others, and they felt they could hear everything too loudly. However, space could also extend to infinity.

There were no walls, as if they were from rubber and they were extending to infinity – everything was there at once, I could see everything.

... I thought I saw my husband sitting at the family lounge. I could see he was worried... I believed I could see him even when he was not next to me.

A similar theme was also noticed in the dreams of one participant who did not report any such experience from his hospitalization.

There were no walls. Everybody was there, [...] all my life.

The participants appeared to describe a perceived collapse of time and space. Time and space are intricately related embodied notions, which make up self-consciousness (Newman, 1976). Although perception of self, excluding these attributes, may be beyond the cognitive ability of humans, participants appeared to have had retained a strong self-awareness independently from the inconsistencies in their lived time and space.

The symbol of the 'centre' which came up in the narrative of one participant, who described a sense of

being 'the whole world' and being 'the centre point', provided a useful summary symbol. It intuitively evoked the idea that participants sensed themselves at the centre of things, at a central motionless point from which access to time and space was possible without the limitations of linearity. Indeed, the concept of the 'centre' was viewed by the participants as an insightful description of their experience. As a symbol, 'the centre' is regarded as a 'spaceless and timeless point, the origin of creation' (Eliade, 1964). In religious symbolism, the journey to the 'centre' is a mystical one, allowing the flight to 'heavens' (Eliade, 1994). It is worth exploring whether such altered perception of time and space may also bear traces of spiritual experiences.

Aloneness – transcendent pause

Feeling alone, even when the participants had sensory contact with their environment, was another interesting experience.

I could hear them talking about me – but I was alone, like suspended in space.

This sense may have been carried on during their recovery period, and it also came up as a theme in dreams. A participant described a recurrent distressful dream:

... I am alone in this big huge area, where there is nobody and nothing!... (a) kind of a desert, a vast brown empty thing.

The impression of emptiness is apparent in the recurrent dream of another participant, which, however, was interpreted by the dreamer as peaceful.

... everything is so dark, no light, ... just black. There is nothing, no sound, like under water. I could not do anything, even if I wanted to. I was still ...

In another recurrent dream, described as peaceful, the same dreamer paints with black paint on a black canvas, and even though she keeps on putting black onto black, she did not favour any negative connotations for the 'darkness' in her dreams.

The isolation and abstraction expressed in these narratives and the symbols contained therein evoked the notion of 'coming to a pause'. An emptiness of space, an extraordinary and possibly transcendent 'nothingness', was described. Jung argues that darkness and 'black' are archetypal symbols for the origin of life, for the primordial state of being. Hence, he categorized them as symbols of rebirth and transformation. Alchemists viewed black as the first in a series of four colours leading to the mystical transformation of matter to spirit (Jung, 1974), and they regarded it as the 'prime matter', in which all potential lies (Poisson,

1999). When the notion of 'prime matter' was presented to one dreamer, it was intuitively very meaningful, and she emphasized that her interpretation, also, was that she needed time to become her true self. The notion of the 'transcendent pause', which was intuitively evoked during the interaction with the participants, got to be meaningful, at first by mere virtue of its contrast to the ICU milieu. It was an intriguing idea that, in the midst of all the trauma, of the stress and preoccupation of practitioners, a transcendent pause could ever occur. It became very meaningful to us as investigators, and it represented an intuitive tool for expanding our perception into the lived world of the critically ill.

Death–rebirth

Having contemplated on death and its meaning while in the ICU and after their discharge was common for all participants. Two said they had felt that 'death was near' during the acute phase of their illness, and five of them reported dreams with death-related themes, of whom only one perceived them as nightmares. They referred to death as an experiential state or even as a personified entity:

They said... I would die... I was not afraid. I knew exactly what death was... He was there with me and I was not afraid. From that point on I am not afraid of death. I wish I could tell others – it is really so simple.

Dream themes of sinking underground, saying good-bye and being put in a black box were described.

I was sinking and I felt very peaceful – at the same time a part of me was thinking: this is death, I am dying. I was saying good-bye in my own way...

An interesting finding was that death anxiety was not common. Only one participant described being scared. In recurrent dreams, he was very fearful to be confronted with his dead self. One participant related that dreaming about death during her immediate recovery period evoked such peacefulness that she never got fearful:

...it truly has taken away my fear of death, so incredibly! It was such a peaceful feeling, it was just NOTHINGNESS [...] it was just a peaceful feeling.

The participant's choice of the word 'nothingness' to describe a peaceful feeling brings to mind the eastern notion of *nirvana* as absence of conflict, rather than a state of absolute negation. Symbolically, death stands for liberation, the end of something, and for transformation. Death is also the source of rebirth (Jung, 1971a). Both notions 'transformation' and 'end' were meaningful to the participants. In their perception,

a period in their life (their pre-ICU life) had come to an end; for others, their self as they knew it was no more.

It would appear that dream images of babies were common amongst these participants. These were intriguing, favourable and even joyous dreams. When asked what these dreams meant to them, they mostly related them as expressing something of the future, or of their need to be children again, or of new responsibilities. A participant, who had recurrent positive 'death dreams', also described feeling like 'a newborn' or a 'baby' during her recovery.

Apart from being a symbol of the future, the baby or child, Jung argues, is a symbol of transformation of the personality and of the inner man (person) (Jung, 1971b). Jung describes cases of the child symbol appearing in the dreams of individuals who experience a change in the sphere of the spirit (Jung, 1971b). Therefore, the child is, for Jung, one of the symbols of rebirth. These views were particularly meaningful to the participants.

Another notable dream image with particular intensity recalled by three of the participants from the acute phase of their illness was that of a river:

I was watching the waterfall and I drunk water from it.

I needed them to hold my hand. I thought this was the only way to remain on the surface and not get swept along in the river I felt beneath me.

I could hear a river close... I wanted to turn around and drink. I was very thirsty, but at the same time [I thought] keep going, don't stop, walk!

In Greek mythology, it is through river *Acheron* that the dead are carried to the underground kingdom (*Ades*) (Diel, 1980). It is worth mentioning that the participants who presented the common 'river' theme are all women of Greek descent. The river can equally be a symbol of death as well as one of birth. In dreams, pregnancy and birth come up with water images (Jung, 1971b). From this viewpoint, the river symbol seemed to summarize the death–rebirth experience, which the participants expressed in other literal or metaphorical ways, as described previously.

Transformations of life

The aftermath of critical illness seems to permeate all aspects of participants' life. Their sensitivity to the joy of life and their love of family and others appeared heightened in their narratives.

I look out from the window and I see people walking and I cry out of joy, because I am alive [...] and I had never realized that before...

For others, however, interpersonal relationships may have changed dramatically. This included a change in their perception of the future. They valued the present and concentrated less on the future. Although they realized that their 'being' was transient, this, rather than being a source of anguish, prompted them to live a fuller life.

I try to cram in as much living as I can, because it could all end tomorrow...

Their sense of purpose in life appears heightened. For some, life is more 'meaningful' and a sense of purpose is also accentuated. Purposeful movement towards a goal also came up in dream content. A woman related a recurrent dream in which she is on a road moving towards an elusive destination. Another, described taking off into the air to embark for a destination that he really yearned to reach.

SYNTHESIS AND DISCUSSION

Participants offered a combination of past and present experiences and dreams as a way of explaining what being critically ill meant to them. Several months after the acute hospitalization, sensory and extrasensory experiences as well as dreams from their ICU stay were still essential in recounting their experience and its implications. Moreover, several current dreams were considered by some as residual to their ICU stay. The long-term effect of critical illness appeared to be more of an existential nature rather than traumatic. In accordance to the findings of others (Maddox *et al.*, 2001), the participants negated being psychologically traumatized by their experience. Instead, they emphasized feelings of personal rebirth, joy and awe to the wonder of life. Notably, although participants remembered being in pain, these experiences were no longer meaningful to them, in contrast with reports of participants who have been interviewed soon after discharge (Todres *et al.*, 2000; Wong and Arthur, 2000).

Reports of awareness of inner events entailing altered bodily perception, as opposed to awareness of the external environment, were ample. This state has been termed 'inner consciousness' by Lawrence (1995), which is probably very appropriate to describe experiences significant to the participants, however, undetectable to others. Although participants may have had scant recollections of the events of their hospitalization, as reported by others also (Granberg *et al.*, 1999; Wong and Arthur, 2000), memories of dreams and inner consciousness experiences were more coherent. Granberg *et al.* (1998; 1999) have also described patient experiences of altered perception of body, time and space. They also reported similar findings of alienation, emptiness and darkness, as those

extensively described by the participants in the present study. Interestingly, participants involved in Granberg *et al.*'s (1999) study also recounted experiences of extrasensory perception beyond the physical limits of walls and of transformations of space. The distortion in time is also in accordance with Newman's Model of Health, which predicts that one's time increases when one's space is decreased, as by either physical or social immobility (Newman, 1980).

The existential nature of participants' perceptions and meanings in life in relation to their ICU experience was immediately evident. Maddox *et al.* (2001) described similar themes of being a 'different person' and of having a 'positive outlook' of critical illness. An obvious explanation for this is the natural tendency of humans to wonder about the meaning of life after surviving life-threatening situations. Moreover, dream and symbol analysis in themselves may have given an existential twist to the results. Dream-telling has been reported as a means of enhancing spiritual awareness (Dombeck, 1995); however, the participants reported of being more spiritual and 'aware' of life's meaning after their illness.

At a more abstract level, an additional set of outstanding similarities in these experiences was evident. As it will be discussed, participants appeared to employ a more 'magical' way of reasoning, bearing similarities to what anthropologists termed '*savage thought*'. Additionally, parts of their lived world while in the ICU may have been so extraordinary that they evoked the impression of '*hibernation in a cocoon*' and of an '*ontological mutation*'.

Savage thought

During critical illness and recovery, participants' perception of reality was affected by the content of their dreams and hallucinations, in such a way that their reasoning was often 'magical' rather than what is commonly considered 'rational'. The participants were fully aware of this fact. It is possible that critical illness caused participants to experience the encounters of their psyche as concrete sensory experiences. This may have been a lived experience of the 'holistic' self, with no boundaries between the somatic and the psychological. The images embedded in their narratives, rather than mere abstractions, appear to be lived symbols. Here, there may be an analogy with what has been termed 'mythical (savage) thought' by ethnologists, meaning the ability to employ symbols as a means to convey simultaneously the tactile and the inner aspects of experience (Strauss, 1977). This ability is prevalent in the primitive person but may have been partially lost in the modern westernized man (Fromm, 1974). However, stress and shock may

revert the individual to more 'savage' modes of thought.

Cocooning and spiritual awakening

The compound image of 'hibernating in a cocoon' emerged spontaneously during the interaction with the participants, and it was further developed through analysis and verification (Figure 1). During the acute phase of critical illness, the self lays in dormancy, yet fast healing and evolutionary processes, come about at the mind–body–soul. At the end of the cocooning cycle, the meanings in life of the emerging self may be transformed. The 'new' person may realize that he/she is a transient being, moving purposefully through life, appreciating the joys of life and seemingly coming to terms with death. Death in the participants' experience is perceived as much more imminent but nonetheless not frightening. The image of the cocoon got to be very meaningful for the participants as a means of reflection on their experience. The metaphor of the cocoon has been successfully used to enhance meaning in grief (Kubler-Ross, 1969). Therefore, it may be a proper tool to alleviate critical illness trauma as well. The mostly positive connotations of death in these narratives are in line with previous findings on death experiences (Sabom, 1982). Participants' stories appear to outline what Heidegger termed '*being-towards-death*'. According to Heidegger, humans may live authentically when assuming responsibility for their being towards death (Heidegger, 1976).

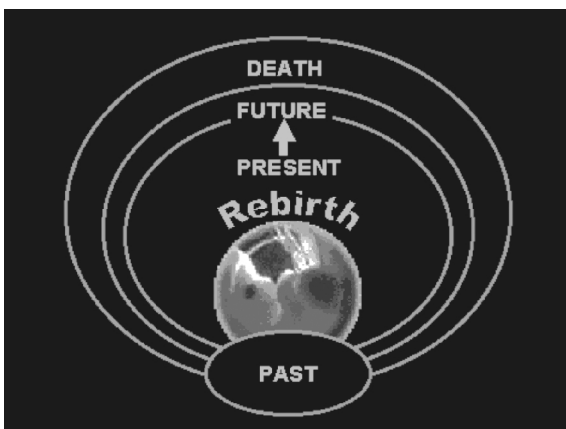


Figure 1. Transformations of self. Critical illness conceptualized as hibernation in a cocoon. During the acute phase of critical illness, the self lays in dormancy, yet fast healing and evolutionary processes come about at the mind–body–soul. At the end of this cycle, the meanings in life of the emerging self may be transformed. The 'new' person may realize that he/she is a transient being moving purposefully through life, appreciating the joy of life and seemingly coming to terms with death.

The sense of peace, the awareness of life purpose, the awe at the wonder of life and the recognition of one's own finite presence are all elements of a heightened spirituality (Dossey *et al.*, 2000). From this perspective, the critical illness experience may have been a means of spiritual 'awakening'. Although the association between spirituality and disease progression and recovery has been explored (Morris, 2001; Westlake and Dracup, 2001), the effect of illness in bringing about changes in spirituality is not sufficiently studied.

Ontological mutation

Specific elements are common to the human experience, regardless of race, gender, culture or age. Perception of three-dimensional space, bodily perception, and sense of movement, of time passage and of the connectedness with others are such elements. These participants revealed that during the acute phase of their illness, perception of even these basic elements was overruled. As if an 'ontological' mutation occurred, and they temporarily lost contact with those experiential aspects that connect all humans. Subsequently, from the phenomenological viewpoint, their 'being' is originally unfamiliar and foreign to us. We cannot comprehend their situation by casually contemplating on what they must be going through. Therefore, symbolism, metaphors and dream images, by virtue of their immediacy and powers of communication, may be unique tools for discerning the lived experience of critical illness.

Issues of reliability and validity

The portrayal of participants' perspective, unfounded by the views of the investigators, and concurrently the attainment of a shared meaningful understanding are criteria of rigour in interpretive phenomenology (Benner, 1994). Therefore, throughout the study, we engaged in a process of analysing and then suspending our own beliefs for the situation to be investigated – the technique known as *bracketing*. Both of us being nurses and having extensively dealt with suffering expected to come across themes of pain and death. The study, however, took a separate route.

Interpretive analysis of symbols is an intricate task requiring a stance of unawareness and, at the same time, deep understanding and extended knowledge of symbolic function and meanings. Characteristically, Jung recommended to learn as much as one can on symbols and then forget everything (Jung, 1964). Therefore a symbol-driven hermeneutic analysis, as this attempted herein, may be awash with personal and cultural nuances. Furthermore, owing to the multiple levels of symbolic function, participants may overemphasize specific interpretations because of

transpersonal factors. This subjective formulation, however, is desirable in hermeneutics, as 'interpretation always presupposes a shared understanding and therefore has a threefold forestructure' (Heidegger, 1976). Every effort was made to ensure the rigour of symbol analysis, by pertaining to participants' views and by studying extensively diverse material on symbols. We felt that this process contributed to bracketing by confounding our own cultural interpretations, therefore increasing our 'openness' to the data.

An additional challenge to ensuring the rigour of this analysis is the lack of specific validity and reliability criteria for hermeneutical studies. Therefore, Burns' (1989) four criteria and Munhall's (1994) 11 criteria for phenomenology were applied. However, this study is a preliminary work aiming to inform future investigation.

CONCLUSIONS AND IMPLICATIONS FOR NURSING

These narratives revealed an intense and rich experience, with strong elements of spirituality and of personal transformation. Both participants and we, as investigators, were daunted by the findings and by the therapeutic potential of our interactions, for both sides. The participants' and our personal views on critical illness shifted. For us, it taught us about the necessity of the 'transcendent pause' in caring for the critically ill, and they led us realize that each time nurses approach an ICU patient, they step on 'holy ground'. This study can be viewed as a descent to the 'prime matter' of being, which we found to be more glorious than expected.

Inasmuch as such studies raise awareness about the critical illness experience, it is possible that they may also have clinical implications, especially as healing may be hindered when caring in critical care does not become a 'shared mutual process' (Burfitt *et al.*, 1993). The following are some clinical considerations:

- Critical illness may entail psychological (inner consciousness) processes, and it may stimulate individual growth, instead of being merely a profoundly unpleasant state through which we need to navigate the individual preferably at a sedated state. In that case, supporting such growth processes may be of interest for critical care nursing. Conceptualizing the ICU setting and the ICU bed as 'holy ground', where physical recovery, personal development and spiritual arousal take place, may be a useful balancing view for the mostly mechanistic ICU environment. Additionally, such views may cause many critical care nursing practices to be re-examined.
- The critically ill may be in various stages of sleep and experiencing a range of dreams. Is there a therapeutic function or potential in these dreams? Does dream content associate with specific events of their illness or care?
- Despite the urgency of their clinical status, at the level of psyche, patients may 'pause'. It may be helpful for ICU nurses to 'pause' too, in order to consider comprehensively the needs of their patients. Moreover, the participants in this study offered a 'forgiving' vision of death. These views may be valuable to nurses when dealing with patients with ominous prognosis.
- The experience of the critically ill may be so extraordinary that empathizing with them may be a very complex process, demanding validating insights into patients and extensive reading on the accounts of critical illness. Moreover, enquiring patients about their experience and dreams may have a significant therapeutic potential for both patients and nurses.

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