

Phenomenological Inquiry as a Methodology for Investigating the Lived Experience of Being Critically Ill in Intensive Care

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Received: February 01 2016; **Accepted:** February 03, 2016; **Published:** February 10, 2016

In the Cartesian driven high tech environment of ICU were patients are objectified and reduced to anatomical and biochemical entities, phenomenological inquiry can bring a touch of humanness and holism to the care of critically ill patients. When discussing critical illness from a phenomenological lens, the word intentionality comes to the foreground. Therefore this paper begins by discussing intentionality as the centre of perception and existence in the world. It then discusses the place of phenomenology, phenomenology and nursing, the existentials and then phenomenology as a way of investigating the experience of critical illness".

Intentionality is the way the body communicates with the world [1]. It is the awareness of the world in the space and the objects that people find themselves. The unconscious patient's intentionality is fractured because their perception of the world is severed they cannot perceive or communicate with world. On the other hand, the semiconscious patient's intentionality is distorted because their perception of the world is unclear. Unconsciousness in the phenomenological sense is a *horizontal* element of the lived body, lived space and relationality [2] and temporality [3]. Both the unconscious and the semiconscious patients experience memory problems because the unconscious patient cannot remember what they did not experience and the semiconscious patient's memory is unclear because their experience is unclear. Yet the memory of our past experience forms our style of existence, which is the basis upon which we perceive the world. This is our situated context [4]. For the purpose of this paper, memory is defined as the totality of dispositions of perception and behavior mediated by the body and sedimented in the course of earlier experience [2]. This is a fundamental element of existence that continually affected in critical illness survivors and yet are left unnoticed in empirical research. Phenomenological research on the other hand, seeks to tend to such matters of existence as this in order to reunite the critical illness survivor to their original world.

The Place of Phenomenology

Phenomenology tends to hidden things of existence such as facets of awareness like intuition and feeling [5]; which can often be overlooked when absorbed in the anatomical and biochemical

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Citation: Tembo AC. Phenomenological Inquiry as a Methodology for Investigating the Lived Experience of Being Critically Ill in Intensive Care. J Intensive & Crit Care 2016, 2:1.

aspects of the patient. These things can only be realized through phenomenological awareness. Phenomenology unveils original experience and its meaning. In so doing, phenomenology offers a deeper understanding that can bring about enhanced praxis in intensive care nursing and medicine.

Phenomenology foregrounds human experience and brings a holistic approach to human treatment [6]. Contrary to the objectifying and reductionist nature of empiricist research methods that reduce people to five senses, phenomenology seeks to understand human experience from an individual's perspective [5]. Phenomenological inquiry portrays the patient as a whole human being [5] with needs other than the illness they present with [7].

For years, the experience of intensive care has been documented as mostly traumatic in nature by critically ill patients [8-10]. Despite the innovations in ICU practices including the advancement of technology in ICU the experience of ICU has not changed [11, 12]. Many patients report memory problems after ICU hospitalization thus increasing the evidence that there are numerous patients who experience biographical disruption resulting in poor health related quality of life (HQoL).

However, the phenomenologist is concerned with understanding

human behaviour from the actor's own frame of reference [5, 13, 14], the phenomenologist examines how the world is experienced, for him or her, the important reality is what the people imagine it to be [3].

Phenomenology and Nursing

The ontological, epistemological and axiological tenets of phenomenology resonate with the cornerstone of nursing philosophy that is based on the holistic, individualistic view of a person [14]. This is evidenced in the fact that from the first year of training, the nursing student is introduced to person centered care, which purports that the patient is an individual who must be treated as such. Phenomenological work is unique. It aims at influencing health care staff to execute their care of critically ill patients in a more meaningful and caring way.

Phenomenology allows nurses to gain a deeper understanding of the life-world of nursing. It gives nurses the avenue to uncover patients' veiled emotional world, which can only be uncovered through phenomenological inquiry. The inner things of the mind and heart are concealed from the intelligible world of empirical science and scholarship because the logical eye cannot see beyond what is given to it as Dilthey put it:

"All science and scholarship is empirical but all experience is originally connected, and given validity, by our consciousness...it is impossible to go beyond consciousness, to see, as it were, without eyes or to direct a cognitive gaze behind the eye itself...From this point of view our picture of the whole of nature stands revealed as a shadow cast by a hidden reality; undistorted reality exists for us in the facts of consciousness given by inner experience" Dilthey, in Moustakas [15].

Because experience does not reveal itself to outsiders, phenomenological inquiry tends to the things that hide such as experience, consciousness, writing and language. Therefore, the phenomenological writer writes to discern the quality of human reality thus, making phenomenological writing a phenomenological gaze [16]. The phenomenological writer writes in the midst of life's experience and writes to draw both the writer and the reader into the text by writing in such a way that the text resonate meaning and reverberate with reflective being [16].

To this end, the phenomenologist gets into the thick of things so much so that he or she draws into, or lives the experience with the people that are experiencing the phenomenon thus uncovering the veil of human experience [16] which is embedded in the basic elements of being in the world known as existentials from which the unconscious patient is severed.

Existentials

Existentials help us develop as approach of exploring lived experience of particular interest such as we exist in the world in relation to time, space, body and relationship with other humans [3]. Our life worlds change depending on the time of the day such as the lived world of work, school and the lived world of home [17]. Human existence comprises four fundamental thematic structures known

as "existentials" [3]; namely spatiality, corporeality, temporality and relationality. As important structures of the life world [1], existentials are important in the formulation of phenomenological question composition, reflecting and writing Van Mannen [3]. They help us to know how we can go about finding out what we are curious about such as the lived experience of ICU and what meaning is attached to it. For instance, the critically ill patient is dislocated to the space of ICU. Hence one of the questions would be "how does the critically ill patient interpret their critical illness experience in the space of ICU?" To help us understand the relevance of space as an existential, we need to know what spatiality is.

Spatiality (Lived space)

Spatiality in phenomenology is defined as felt space [3]. Felt space affects our experience of the world Manen [3]. Lived space is the existential theme that refers us to the world or landscape in which human beings move and find themselves at home. It is a category for enquiring into ways we experience the affairs of our day-to-day existence and uncover more fundamental meaning dimensions of lived life [3]. The mood in which we encounter lived space can influence the way we experience and interpret the particular space be it our home or a hospital. For instance the space of home gives us a special experience of being profoundly safe and by ourselves Van Manen [3] whereas the felt space of ICU can be strange and frightening. However, while our home can offer a sense of protection and security, it can also change and be frightening depending on the circumstances under which we encounter our home such as loneliness [16]. The ICU becomes the felt space for the patients while they are hospitalized in ICU. If the felt space has an influence on how we feel, how does the ICU being a strange environment, full of strangers make our patients feel? How can we fully or begin to understand how these patients feel? We can only do so by asking them because they alone know how they feel and it is from their narratives that we can delve deeper into their feelings and learn from them perhaps to better execute our services next time. The felt space is experienced through the lived body.

Lived body (Corporeality)

The lived body is our pivot of existence. From the phenomenological lens, corporeality means that we are always bodily in the world [3, 18, 19]. We do not only have a body but we essentially exist in and with the body [1]. It is in the body that we meet other people through their bodies. Our physical or bodily presence, reveals something about us and in spite of ourselves, (unconsciously/not deliberately) we are always concealing something at the same time [3].

When the body is the object of one's gaze, it may lose its naturalness or it may appear to grow enhanced in its modality of being [3]. Therefore depending on how we feel about someone, their appearance may be distorted to suit our thoughts. In the same way, the ICU environment can be perceived differently depending on the way we look at it whether it is from the patients' point of view or the nurses' point of view. For the ICU patient, their body does not exist in the ICU room but it lives the room. Hence, the body's senses perceive the ICU room with its ability to influence its environment thus providing information

about its condition when it meets the room [19]. For instance patients from a phenomenological study conducted by Tembo [12] felt like they were in a prison upon discovering themselves in ICU without the ability to talk or move. More often than not, the body meets the room in a horizontal position thereby changing its interpretation of the room. This means that the light instead of being perceived as a source of light in the room becomes a stressful shining object in the eyes, which may make it difficult to distinguish night from day [19].

When we are in good health, we tend to “pass our body over” because we experience our body in a state of near self - forgetfulness and thus, take it for granted [20]. Critical illness threatens the taken for granted state of our existence with our body. Being ill or being in pain or discomfort draws our attention to the body and this can evoke feelings of alienation from our body and disrupt the way we experience our world. By drawing our attention to our body, critical illness also makes us know the object - like aspect of our body [20]. Critical illness does not only disrupt a person’s self – forgetful and passed – over relation to their body but also changes the way they experience the existentials viz a viz time, space and lived relations with the people around them.

In response to critical illness, the body produces among other things, catecholamines that can perpetuate the critically ill patient’s disruption, brokenness and or indeed, disturbance of relationship with their body [20]. This phenomenon puts stress on the patient and further interferes with the way they live with their body and thus, further distorts their world. Often the patient fails to make sense out of their experience [18, 19]. However the experience becomes embodied and can become alive when a person is confronted by similar situations [21] such as stress.

Stress, in an intensive care patient can be due to sleep deprivation [22]. Sleep gives a healing effect on the body and it is the body’s self-regulating mechanism. From the phenomenological point of view, sleep is the means through which the body shuts the senses down (keeps the world out) and renews itself [23, 24]. However, the procedures and the noise around the patient’s room deprive the patient of sleep. When the lived body is deprived of sleep, it is forced to perceive the ICU space differently and possibly misinterpret it. This has been reported by patients from several phenomenological studies such as Parker [8]; Tembo [11]; Zeilani & Seiyomor [10].

Stress arises from unrelieved pain causing feelings of alienation of the psychological from the physical being, fear and makes the patient feel they have lost control of the situation [19]. However pain and fear are means through which the body expresses changes and reactions that cause stress and this experience is embedded in time.

Lived time (Temporality)

Temporality is subjective time as opposed to clock time. It is the way time seems to speed up when we are enjoying ourselves or slow down when we are bored [3]. It is our temporal way of being in the world – as a young person with the future becoming or as an old person recollecting memories from the past. We get

to know people by learning what constitutes their past, present and future as these represent horizons of their landscape [3]. Embedded in time are encounters of the past that always remain as memories, or as near forgotten experiences that somehow leave their traces on ones being, such as their mannerisms, the words they speak and the language that ties them to the past [3]. The temporal things of the past determine the present and the future perceptions of the world. For instance, past experiences such as trauma, culture and spiritual beliefs can affect the way one interprets their time in ICU. However, the present pressures and influences may also change the past. In the same vein the past changes itself as we live toward a future which we already see taking shape or the shape of which we suspect as yet a mystery of experiences that lie ahead in store for us [3]. Hopes and expectations give us a perspective on life to come whereas desperation and lack of will to live may result in loss of such perspective [3]. Similarly, ones experience of ICU may affect their perspective of the future. If their ICU experience was traumatic, the memories of ICU may make them not wish to repeat their ICU experience. This is evidenced by many phenomenological studies [8-11]. An example of this is one participant from Tembo’s [12] study who said; “I wouldn’t like to relive that experience, not in reality or otherwise”.

Temporality in relation to perception of objective time is affected by unconsciousness in the critically ill. This is evidenced in Tembo’s [12] phenomenological study where all twelve patients who underwent DSI failed to remember the time they were in ICU before they regained consciousness. For example, one participant described her distorted perception of objective time as follows: “Time I was there. I thought it was three days but it was five days”

In addition, unconsciousness robs people of subjective time and disrupts their continuity of existence (biographical disruption) as evidenced by a critically ill patient who referred to her failure to know what happened to her while she was unconscious as “lost time” [12].

Nevertheless time in ICU is not spent in a vacuum. It is spent in the midst of other people albeit strangers who have a bearing on the experience of ICU.

Lived other (Relationality)

Relationality is the lived relation individuals maintain with others in the interpersonal space that they share with them [3]. We meet other people in a corporeal way such as handshakes or by gaining an impression of the way they represent themselves to us. All life revolves around being and dealing with relationships [23]. Equally the critically ill patient present to ICU in their bodily state and meet the ICU staff in this manner. At the same time critical illness and ICU hospitalization bodily separates patients from their family leading to feelings of loneliness and possibly a distorted perception of self and ICU staff. One patient described the ICU staff as people who had robbed her of her speech because they had stitched her lips together with red cotton only to realize upon reflection that they were nurse and doctor who just wanted to help her get better and that her lips were not stitched together and that the ETT was actually preventing

her from talking. Feelings of vulnerability also led to mistrust of ICU staff and affect relationships between patients and ICU staff *“you see people smiling at you and you don’t smile back at them because they are strangers and you don’t trust them”* [12].

Relationality is affected by spatial dislocation and corporeal severance from family due to the nature of critical illness. In this state, patients mostly perceive ICU staff as strangers and relate with them as such. In Tembo’s [12] study, feelings of vulnerability and the perception of ICU staff as strangers heightened agitation in patients. Patients described calming down in the presence of family members as narrated by one participant:

“I was trying to pull that thing out (ETT) because I couldn’t breathe and she (nurse) was telling me to stop and I thought who are you? I don’t even know you. It was only when my mum came round that I calmed down.” If this is the case the presence of a family member might help alleviate fear and therefore agitation. In so doing, the problem with relationality can be meaningfully addressed.

Discussion

Phenomenological inquiry gives insight into how patients interpret their lived experience in ICU. While the empiricist provides numbers of survivors or people how efficiently new practices or technological advancements are working, the phenomenologist provides meaning and understanding of people’s experience of ICU. Phenomenology allows people to give interpretive accounts knowing that there are variations in the way individuals describe the same lived experience because of their situated context such as culture and language [16]. In this way phenomenology enhances holism and caring. Similarly, caring and holism are fundamental to nursing as nurses deal with individuals with various physical and psychological needs [5]. The fact that people have given various narratives and the meaning they gave to their ICU experience reverberates the philosophy of phenomenology. Using existentials to understand experience not only uncovers the phenomenological tenets but consolidates the landscape of existence and how critical illness in ICU affects the whole person and their perception of ICU and its objects. For instance the patients who perceived ICU staff as strangers have given us insight that while we perceive ourselves as pedagogical care givers, the patient perceives us otherwise and therefore does not trust us. Armed with this knowledge, we then can ask ourselves, what does it mean for me to be at the bedside of an agitated critically ill patient? Is my presence here as a total stranger to this patient who is in a strange place evoking fear which is contributing to the agitation? If this is the case can the presence of a family member help alleviate fear and therefore agitation? In so doing, the problem with relationality can be meaningfully addressed.

Phenomenology uncovers corporeal problems and the meaning the patient attaches to the corporeal disconnection they experience in ICU. For example the patient who described lips being sewn with red cotton, can no longer be treated as having

hallucinations because phenomenologically we understand the meaning the patient attaches to that. Our role then would be to restore the patient with their body through legitimation and explanation of their corporeal disconnection. Embedded in this particular exemplar of lips being stitched together is the problem of speech. Although we meet and relate with other people in a corporeal way, we need speech to make our intentions known. Equally, the patient’s disconnection with her lips was a yearning for speech as echoed by George who needed to ask questions about discovering himself in ICU.

The narrative about discovering himself in ICU which he (George) called a strange place elucidates the problem of spatiality. Understanding that the space we occupy becomes our world would enable us to understand the spatial dislocation the patients suffer by discovering themselves in the strange high tech lived space of ICU where they often lose track of objective time as evidenced by participants not knowing how long they been in ICU. In addition spatial dislocation severs the patient from their familiar lived other and space leading to feelings of isolation and negatively impacting on the experience of subjective time.

Phenomenology highlights the problem of temporality as evidenced by the patient who narrated that time spent in ICU seemed like three hours yet it was five days and the one who attested that the failure to recall events that happened while she was unconscious was “lost time” amount to biographical disruption. The meaning of misperception of time would not have been realized had phenomenology been not used to explore this lived experience. This is difficult to understand by an intelligible person who is in tune with their world but for the critically ill patient who is out of tune with their world, it makes perfect sense.

Therefore for those of us who are in tune with our world, for whom it is hard to understand how being out of tune with the world feels like, we may not be able to care for those who are out of tune with the world in the way that is meaningful and thoughtful. We need phenomenological inquiry which allows us to get into the thick of experiences – the world of the people that are out of tune with the world in such a way that we get so close to them that we start speaking and listening to their language, experience their pain as if it was our pain, make their hopes our hopes so much so that we read and write in such a way that we pay attention to the phenomena that gets them out of tune with the world Van Manen [25] so we can execute our work thoughtfully and meaningfully. Indeed, gaining a deeper understanding of the mechanically ventilated critically ill patients is like entering a new world which care givers or Gnostic beings have never trodden before, but which they have only seen and may be even taken for granted.

It is hoped that through phenomenological inquiry, ICU staff who are both Gnostic and pathic pedagogical beings will execute their duties to these kind of patients with more thoughtfulness as they embark on their job as critical care health professionals to restore a livable relationship of the patient with their body.

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