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## From fear to fight: Patients experiences of early mobilization in intensive care. A qualitative interview study

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### ABSTRACT

**Introduction:** Early mobilization (EM) in intensive care is frequently used to prevent physical and psychological complications, with promising results. However, the patient's perception of EM has been sparsely investigated. **Purpose:** To investigate the experience of EM in patients treated in intensive care. **Method:** Nineteen former patients who had been treated in intensive care were interviewed. The interviews were analyzed using qualitative, inductive content analysis. **Results:** The analysis resulted in three categories; 1) Facing the impossible – a too demanding situation; 2) Struggling successfully on the way back; and 3) Need of having dedicated supporters. **Conclusion:** A considerable variety of experiences of EM were described in this study, both negative and positive. Prominent features were that pleasant emotions and great physical effort occurred simultaneously and that interaction and cooperation with the caregivers was paramount. To regain independence was another prominent feature, with EM considered to be of great importance in the recovery process. Moving to an upright position and ambulating appears to be beneficial to both body and mind. EM should therefore be among the first priorities in intensive care. EM should be practiced with respect and support, while encouraging and challenging the patient to strive for independence.

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## Introduction


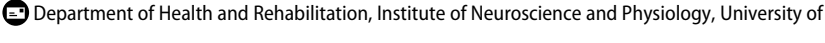
Survivors of critical illness often suffer from physical, cognitive, and mental health impairment. Intensive care unit-acquired weakness posttraumatic stress disorder, anxiety and depression have been reported (Karnatovskaia, Johnson, Benzo, and Gajic, 2015; Parker et al., 2015). These complications have recently been shown to persist several years after discharge, leading to an inability to return to work and increased health-care utilization (Hunter, Johnson, and Coustasse, 2014). This has led to increasing awareness of the need to prevent physical and psychological sequels in intensive care survivors (Karnatovskaia, Johnson, Benzo, and Gajic, 2015).

In ICU, both medical care and nursing traditionally require horizontal positioning, with patients held immobilized in bed and sedated for their comfort (Karlsson, Bergbom, and Forsberg, 2012; Stiller, 2013). The negative and potentially harmful cognitive, mental, and neuromuscular effects of sedation have become evident, with no or light sedation becoming common practice (Egeröd et al., 2015; Lipshutz and Gropper, 2013). The

concept of a bedridden patient is now being questioned and early mobilization (EM) more frequently used (Schweickert and Kress, 2011).

Recent research on EM conclude it feasible and safe to mobilize patients cared for in ICU, with adverse events uncommon (Fuest and Schaller, 2018; Nydahl et al., 2017). Studies have reported improved physical function, such as: increased walking distance measured by 6-min walking distance (Burtin et al., 2009); earlier return to independent functional status (Schweickert et al., 2009); improved psychological well-being (Hunter, Johnson, and Coustasse, 2014); decreased ICU and hospital length-of-stay (Arias-Fernandez, Romero-Martin, Gomez-Salgado, and Fernandez-Garcia, 2018; Cameron et al., 2015); lower rates of hospital readmission; and reduced mortality up to one year following critical illness (Schober and Thornton, 2013).

However, evidence of the beneficial effects of EM is still limited and some conflicting results exist (Fuest and Schaller, 2018). There are also some difficulties when comparing studies. EM is a complex intervention and

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there is little consensus regarding frequency, duration, and when to initiate. Questions about the long-term effects also require further investigation (Fuke et al., 2018). EM is still not a widespread practice due to the culture of the ICU, insufficient communication, and lack of resources (Barber et al., 2015; Engel et al., 2013). Some studies indicate that EM is best performed by multi-disciplinary teams, which include a physiotherapist, and using a protocol (Fuest and Schaller, 2018; Harris and Shahid, 2014).

EM is also not strictly defined, with Medical Subject Headings (MeSH) defining early ambulation as a: “Procedure to accelerate the ability of a patient to walk or move about by reducing the time to ambulation. It is characterized by a shorter period of hospitalization or of recumbence than is normally practiced.” In this study “early” is defined as soon as the patient is respiratory and circulatory stable, and “mobilization” refers to an increasing range of physical exercises starting with passive movements in bed, then active movements, followed by sitting on the edge of the bed, sitting in a chair beside the bed, standing, and finally walking (Stiller, 2013).

Over the past decades, a concurrently growing body of research has been reported concerning patients’ experiences in the ICU. Studies have described patients experiencing pain, agitation, anxiety, nightmares, communication difficulties and feelings of helplessness, lack of control, and insecurity (Bergbom-Engberg and Haljamäe, 1989; Karlsson, Bergbom, and Forsberg, 2012; Tingsvik, Hammarskjöld, Mårtensson, and Henricson, 2018). Perceptions of the body could be transformed and distorted during intensive care (Cutler, Hayter, and Ryan, 2013). The body has been described by patients treated in intensive care as an obstacle to daily life, strange, different, vulnerable, unreliable, and difficult to control, and even losing contact with the body and with reality has been reported (Egeröd et al., 2015). There is growing awareness for the need to prevent physical and psychological complications of intensive care, with EM now being more frequently used with promising results. However, the patient’s perception of EM is to our knowledge sparsely investigated. Thus, the aim of the study was to explore patients’ experiences of EM and upright position in ICU.

## Methods

### Design and setting

To deepen our understanding of patients’ experiences from ICU a qualitative exploratory design was selected. Semi-structured interviews were used, and data were

analyzed using qualitative content analysis (Hsieh and Shannon, 2005). The study was carried out in a county hospital in the southwest of Sweden. The participants had been treated in four different ICUs, from two different hospitals, one county hospital and one university hospital. They were recruited from either the rehabilitation clinic at the county hospital following intensive care, or in connection with the follow-up visit to the ICU.

### Participants

Patients who had been treated in an ICU for more than 24 hours and who had been mobilized early were purposefully sampled to participate in this study. The purpose was to invite both men and women of different ages, and with different reasons for treatment, in order to obtain variation and diversity in the collected material. Physiotherapists and ICU-nurses identified potential participants who were thereafter invited to participate in the study. The inclusion criteria were that the patient should remember parts of their first mobilizations sessions, be over 18 years, able to understand and express themselves in Swedish, and be positive and willing to share their experience in an interview.

The study was approved by the Regional Ethical Review Board of Gothenburg (Dnr 409–15). All participants received written information about the study, their rights and their freedom to withdraw at any time, assured that the data would be handled confidentially and asked to sign a written form to give their consent. This information was repeated at the beginning of the interview.

### Data collection

Semi-structured interviews were chosen, since they provide flexibility and allow the participants to freely describe their experiences and for the interviewer to ask follow-up questions, thus generating more comprehensive responses concerning the participants’ feelings, experiences, and/or behavior. An interview guide, including questions about the steps from sitting, to standing and walking, within the range of EM, was used (Table 1). The interviews were scheduled together with the participants for a suitable time, normally in connection with rehabilitation or follow-up care. Two interviews were carried out at the participants’ home. Before the interview the participants were encouraged to read their diary from the ICU, if they had received one. The participants were encouraged to speak freely and were reassured that the data would be handled confidentially.

**Table 1.** Interview guide.

(1) Can you begin by telling me the reason for you being treated in the ICU?
(2) Tell/describe how you felt when you first came up in semi-sitting /sitting/standing/walking
(3) Tell me how it felt after the first time
(4) Were there any differences between lying in bed and getting up?
(5) What was the most positive/negative? How do you think you came to have that/these thought(s)?
(6) Is there something important/some important experience I have not asked about?
(7) Do you have any good advice to health care professionals who are helping patients out of bed? Follow-up questions: Can you tell me more about ... ? Have I understood you correctly ... ?

**Data analysis**

Qualitative content analysis according to Hsieh and Shannon (2005) can be performed using inductive/conventional, deductive, and summative approaches. The inductive/conventional approach was chosen, since it is well suited for an area that has been sparsely studied and when variation in the material is desired. The analysis is done stepwise, and the categories are derived from the data (Hsieh and Shannon, 2005).

The transcribed interviews were first read several times to get a sense of the whole. Thereafter, a more structured stepwise analysis was followed where meaning units were identified, coded, and condensed into categories. This structured review was repeated several times and categories constantly compared with the research question and material generated through the interviews. During the whole process, reflections regarding codes and categories were noted and discussed among the authors. Similarly, the pre-understanding of the first author, who is an ICU physiotherapist, and this potential influence on the interviews and analysis was continuously reflected upon among the authors in order to avoid any preconceptions.

**Results**

A total of 19 people, twelve men and seven women, agreed to participate. Their age varied from 26 to 85 years, mean 57 years. Two were from countries outside Sweden. Seven were treated for a medical diagnosis, while six were subjected to emergency operation and six for planned surgery. Further data on personal characteristics are presented in Table 2. All interviews were conducted during 7 months and lasted for 13–118 minutes, mean 39 minutes. They were conducted, recorded, and transcribed verbatim by the first author.

From the analysis emerged three categories and eight subcategories that describe the participants’ experiences of being treated with EM in ICU (Table 3). The categories were 1) Facing the impossible – A too demanding

**Table 2.** Characteristics of the participants.

	Gender	Age	Cause of intensive care	Length of stay in ICU (days)	Time until interview (months)
1	M	70	Planned cardiac surgery	3	0.5
2	F	85	Planned cardiac surgery	1	1
3	M	61	Planned cardiac surgery	2	1
4	M	63	Sepsis due to abscess	5	3
5	M	48	Planned cardiac surgery	1	0.5
6	M	58	Planned cardiac surgery	3	1
7	F	53	Planned cardiac surgery	1	0.5
8	F	52	Heart failure, critical illness	18	24
9	M	33	Severe pulmonary engagement	35	5.5
10	M	52	Surgery due to cerebral hemorrhage	35	4
11	F	70	Surgery due to appendix rupture	26	2
12	M	66	Iatrogenic aortic dissection, multi-organ failure	27	2.5
13	M	31	Multi-trauma, anoxic cerebral injury	14	1
14	M	84	Sepsis, heart arrest, cardiac surgery	17	1.5
15	M	51	Surgery due to cerebral hemorrhage	4	5.5
16	M	72	Aortic rupture	28	1.5
17	F	27	Intoxication, pneumonia	10	3.5
18	F	26	Pneumonia	11	1.5
19	F	80	Postoperative septic shock	4	3

**Table 3.** Categories and subcategories derived from the data.

Categories	Subcategories
Facing the impossible, too demanding situation	Having a strange loss of control. Being fragile, in pain and exhausted Anxiety and fear Being dependent and misunderstood
Struggling successfully on the way back	Feeling more normal and less helpless. Pain and shortness of breath are eased Increasing control and independence. Hope for recovery and fighting spirit are spurred Gratefulness and human dignity
Need for dedicated supporters	Being given information, reassurance and support Being given encouragement and challenged

situation; 2) Struggling successfully on the way back; and 3) Need for dedicated supporters.

The participants’ first memories of being mobilized were often faint, and they had difficulties recalling if this had occurred in the intensive care unit or later, in the next ward. Hence, the experiences described by the participants could be derived from both the ICU and/or the ward shortly afterward. Many strong

feelings, both pleasant and unpleasant were expressed. When the participants were raised to an upright position, considerable support or full assistance was necessary initially, due to the vulnerability of the participants' body and their lack of body control. This resulted in a burst of emotions, a mixture of frustration and relief. Somewhat later in the recovery process experiences of more control, a will to fight on, gratitude for being alive, and regaining increased freedom were described. The following text uses quotes to illuminate the categories. The number appearing after the quotes refers to individual participant. The **sub-categories** are referred to in **bold**.

### *Facing the impossible – A too demanding situation*

To wake up in an ICU, lying helpless in bed was described as a very unpleasant experience. The participants said it was **strange** and odd, sometimes frightening and frustrating, to be totally **out of control**, helpless and incapable to move in bed. They described experiences of feeling very tired, **exhausted**, weak, and **frail**, unable to even talk or communicate. Being tied to and bound in bed was compared by one participant to being imprisoned, and was said to create feelings of powerlessness, with loss of hope and identity.

After a while I hated just lying in bed, the bed becomes like a prison ... you become so limited ... difficult to move yourself in bed ... for when one is just lying completely passive ... one is stripped of one's identity and you lose control completely then ... I was not myself at all (9)

Experiences of **pain** in different parts of the body were commonly reported. The body was injured, caused by either the trauma or the operation, making it difficult even to lie down. The lying position was said to make a painful thorax and backache. To be brought up to a sitting position resulted in a considerable effort and **exhaustion** and was sometimes described as a work-out.

Very tough!! I was extremely out of breath by sitting on the edge of the bed ... Yes, terribly hard, I didn't want to, I just wanted to lie down in bed ... yes, I was breathless, it was really tough (17)

Some participants reported great **anxiety and fear**, especially during the first mobilizations. They expressed feeling unprepared to take the next step as they felt insecure and unstable, and wondered if they could trust their legs.

But then I would try to get up and then stand up but it was impossible, everything just collapsed ... there was three or four people around me, so, I didn't have to be

worried about that, but I was anyway ... it's scary that you don't have control (11)

Some participants also reported frustrating experiences of **being dependent and misunderstood**. They had to face the fact that they were **dependent** on others like a baby. They needed help to wash, feed, to change their position in bed, and to get out of bed.

It was a little different, it's something you've never thought of ... being completely powerless, so you can't move, can't help yourself or anything ... didn't think it could disappear so completely, they had to feed me in the beginning ... there was nothing! And then you become a bit scared, wondering what is wrong with me? ... you have always managed before. And so being dependent on people all the time was actually the most difficult part (12)

One participant experienced the caregivers believing that she was unwilling and noncooperative, but she said this was not true and was unfair. She described not being listened to and at times being forced to do impossible things. She recounted an attempt to stand up:

Someone placed a hand on the lower part of my back and pushed me out, I realized that if I fall now, they can't stop me, I was panic-stricken ... I felt like they were trying to motivate me by making sure I had to, but I couldn't (8)

Another participant said he felt frustrated by not being able to move in bed, wishing that the physiotherapist had also performed bed exercises over and above sitting on the edge of the bed. When the physiotherapist did not include this, he started to practice himself, establishing small goals in this process together with his next of kin. The same participant also pointed out the importance of treating the patient as the person they were before being admitted to the ICU, identifying and encouraging the person to use their own resources and plan goals.

You lose your identity when no one asks who you normally are ... one should take note of what the person is good at, work with their resources ... give hope and ask what goals you have. (9)

### *Struggling successfully on the way back*

Several pleasant experiences of comfort were also described during early mobilization. The participants said they felt more alive, **more alert, and normal** when getting out of bed, gaining another point of view. It was good to change position, which sometimes **eased pain and shortness of breath**. EM seemed to bring a desirable change, despite fear, the strain, and breathlessness. The participants told of how they felt less bound to their beds, **helpless** and tired. Strong

expressions such as “enormously happy to be alive,” “wonderful to be in an upright position,” “a big step,” and “a sense of freedom” were sometimes used to describe some of their first experiences of moving to an upright position.

Yes ... if you laid down then you felt pretty helpless ... then you felt really ill when you were lying down ... when I had gotten up and then sat up as well, then I had a little more control of my body and felt like that I was ‘with it’ in a different way, with what was happening around me (5)

EM was reported to result in **increasing control** of the body. To be able to move in bed, to exercise and thus regain some control in the lying position was a pleasant experience and could reduce fear. Furthermore, the other positions gave a sense of control, of being capable of managing again, often expressed using very strong words such as amazing, wonderful, victory, courage to challenge, success, and proud of myself. EM was said to prevent one from getting stuck in oneself and thinking that everything is too difficult. The ability to get out of bed was said to promote the inner power and **hope for recovery** and to come back to every-day life. To be able to stand again **spurred their fighting spirit** and encouraged them to continue to strive for **independence**. Some of the participants found it useful to set goals for their rehabilitation and some found it better to “take the day as it comes” in order to avoid disappointment.

I am standing without holding on! ... It was a joy ... and it spurs you to fight on (16)

Their growing independence was sometimes linked to feelings of **gratefulness and of human dignity**, particularly being able to cope with basic locomotion and activities such as showering and managing toileting situations. Their increased freedom was greatly appreciated, with wheelchairs and walking aids often used giving more autonomy and independence.

Then I walked myself and it was really nice ... as I felt that I could do something myself, because that’s something I don’t like, being completely helpless ... but then you want to ... I can do it, just like children you know “can do it myself” ... there were little things that made such a difference, you felt worthy as a human being again when you managed those basic things (7)

### **Need for dedicated supporters**

This category describes the interaction between the participants and their caregivers, which the participants expressed as being very important. The participants described that the caregivers provided **information,**

**reassurance,** and **support.** Furthermore, they gave **encouragement** and at times **challenged** the participants, for them to move on in their recovery process. The participants explained consistently that they were pleased with the caregivers. Early in the process participants stated they understood the importance of getting up, even though it was stressful in different ways. The group that had undergone planned surgery explained that they had been thoroughly **informed** about both the operation and the importance of getting up soon afterward. Other participants reported how they were **informed** by the caregivers at an early stage in the process of mobilization. The information provided security and appeared to influence their experience of the early mobilization. In the case of one participant it also seemed to create a feeling of responsibility:

You recognized and had confidence in the person and thought “ok, I trust you, do your job, and I will do mine (7)

The participants also recounted how the caregivers gave them the necessary **support,** both mental and physical, to enable them to get through the EM. They emphasized the importance to feel safe, for example, through being **reassured** that there were enough caregivers and that appropriate equipment was available. It was especially important that the caregivers **informed** the participants what was going to happen and remained calm and confident when a patient failed, e.g. falling backwards. Receiving positive feedback regarding progress was also of great importance.

Then I was terribly afraid. But they sat on the edge of the bed and talked with me, that I should not be afraid, they were strong, and they supported and talked to me for a good while before I had the courage (11)

The **encouraging,** gentle, and humorous attitude the caregivers showed during the mobilizations strengthened and **challenged** the participants to progress. Since they seldom had the strength to push and **encourage** themselves, they needed someone else to do it, someone who was firm enough, while still cheerful. One participant highlighted the importance of not helping too much, but instead **encouraging** the person to use their own capabilities. To be mobilized early was described as very important. Many participants regarded EM as significant in their recovery-process, suggesting that caregivers should not let the patient lie in bed for too long. Instead, they felt that patients should be woken for mobilization as it promotes faster recovery and a feeling of becoming more normal again, which is mentally important.

They spurred me on in a good and sometimes playful way that made you try a bit more, dare more, strengthened ... it was just like they said, “come on, jump up, we are going out for a walk (12)

You need a kick in the butt, you are not so bright in the beginning ... for me it was good to get up and get going so that you felt that something was happening (15)

For participants who had been mobilized and treated by a physiotherapist, the physiotherapist became more important later in the process. The physiotherapists were appreciated for the same reasons as the other caregivers, e.g. their calmness, **encouragement, and information.**

Among the participants, one was a professional caregiver. She contributed with the reflection that she now knew she has been doing the right thing by mobilizing patients in her daily work:

I received confirmation that I'm doing the right thing when I am urging people to get up (18)

## Discussion

The findings of this study highlight that patients find EM both frustrating and stimulating. Despite having to exert great physical effort during EM, patients also experienced pleasant emotions. Interaction and cooperation with the caregivers were also paramount. Regaining independence was another prominent feature, with EM considered to be of great importance in the recovery process.

Pain and helplessness were frequently described and were often linked to lying in bed, with being tied and shackled to the bed compared to being imprisoned. This could be another aspect of the detrimental consequences of immobilization and a further reason to practice EM. The practice of allowing a person to stay in bed for the sake of their comfort should be reconsidered. The experiences of losing control, that the body is not working properly, and of frustration when being dependent on others, were common and have also been reported by Doroy, Bakerjian, Adams, and Apesoa-Varano (2016), Johansson and Fjellman-Wiklund (2005) and Lykkegaard and Delmar (2015). Hence, it is important when using EM in ICU to show patients respect while at the same time encouraging independence.

Experiencing relief and feeling more normal is also described in several studies within the field of ICU nursing, with patients referring to good care and treatment (Engström, Nyström, Sundelin, and Rattray, 2013; Karlsson, Bergbom, and Forsberg, 2012; Wählin, 2017). In this study, participants experienced feelings of relief and recovery as they started moving and mobilizing to

sitting or standing, even though this initially required great physical effort. This is similar to the results reported by Karlsson, Bergbom, and Forsberg (2012) who described how moving to a sitting position, on the edge of the bed or a chair was interpreted as a sign of improvement, not only physically, but overall. Fredriksen, Talseth, and Svensson (2008) also observed that when the body was taken from the bed to an upright and more interactive position, it was perceived as rediscovering and recovering the body, as well as being less restricted. To find the body again was an affirmation of life. Motion and strength appeared to be elementary conditions for nourishing hope. Likewise, Gjengedal (1994) depicted in her dissertation a patient whose turning point came and his hope was awakened after he was raised up on a tilt table. He could then begin to see the world and interact with it from an upright perspective. From this discussion, EM should be considered as a part of good care.

According to this study, it appears that the positive attitude of the caregivers affected the patients' experience of EM in a positive way, and the strenuous moments were easier to get through. The participants described how the success of the mobilization, and the support and encouragement from the caregivers spurred them to fight on. Providing information about the significance of EM may also have played an important part. Doroy, Bakerjian, Adams, and Apesoa-Varano (2016) described similar findings; to get up was overall viewed as a part of the care and healing process and, as in this study, most participants were very pleased with the caregivers and felt they could trust them. Ringdal et al. (2018) found that EM, including in-bed cycling, with continuous support from health-care professionals, gave a feeling of safety and hope for recovery. Strengthening the patient's fighting spirit was reported to be of great importance in the studies by Karlsson, Bergbom, and Forsberg (2012) and Wählin (2017). Furthermore, Karlsson, Bergbom, and Forsberg (2012) found that it is important to involve the patient as a companion in the process of recovery. Similarly, Tingsvik, Hammarskjöld, Mårtensson, and Henricson (2018) stated that the patient is not just a passive recipient of health care. To support and encourage, but also to cooperate with the patient during their recovery process is therefore of great importance.

In the study by Barber et al. (2015) some of the barriers to EM are identified. However, as indicated in this study, none of the barriers described were due to unwillingness of the patient. In contrast, the participants evidently considered EM to be very important in their recovery process, with them even taking some responsibility for their rehabilitation. Consequently, EM should

be among the first priorities in the team of professionals and patient in the ICU.

In the fight for independence, several participants commented that they had not been depressed, and that it was important not to become discouraged or downhearted. Hopkins, Suchyta, Farrer, and Needham (2012) found that physical activity helped to reduce anxiety and depression. EM may have the same effect, since EM can at times involve not only moderate, but also more strenuous physical activity. The relationship between body and mind can also be seen in the RCT-study by Schweickert et al. (2009) which showed a significant correlation between EM and the number of days with delirium in the ICU. Delirium is also an independent predictor of mortality (Schweickert et al., 2009) and duration of delirium is independently associated with long-term cognitive impairments (Hopkins, Suchyta, Farrer, and Needham, 2012).

Based on this reasoning it could be hypothesized that EM is not only favorable to the body, but also beneficial to the mind. The findings in this study also suggest this to be the case since mobilization of the body appeared to affect the mind in a positive direction. Another salient finding was that the interaction with the staff was very important. Both these findings are supported by the theories of the French philosopher Maurice Merleau-Ponty (Bullington, 1999; Rosberg, 2000; Storli, Lindseth, and Asplund, 2007). In his book *Phenomenology of Perception* Merleau-Ponty (1945) postulated that body and mind are indistinguishable from each other except by abstract thought. He also describes the concept of "being in the world," the body-mind always relates to a surrounding world. The body is necessary for the perceptions, and these perceptions are not casual but are directed intentionally toward something which has meaning. This directedness is not always conscious. Before the conscious act of thought, there is a more unreflected corporal relation to the phenomena. We are and act before we reflect. As a consequence of experiencing the world through the body, a rapid physical change, as being subjected to trauma and critical care, could change the perceived world (Cypress, 2011; Gjengedal, 1994). As physiotherapists and other caregivers in the ICU, we need to integrate this understanding into theory and practice (Bravo, Skjaerven, Sein-Echaluce, and Catalan-Matamaros, 2018), and thus need to consider the impact of EM on the mind, as well as, the body and the interaction with the patient.

### **Methodological considerations**

To interview persons who do not remember everything is a delicate task. Questions have been raised about how

much, and what part of their experiences have been recalled, as well as, how to ask follow-up questions in order not to bias the participants' description. Early in the data collection phase, it became evident that many people were not sure of where their first memories of EM had taken place, in the ICU or at the subsequent ward. This interfered with the interview process with the interviewee trying to remember where it happened instead of focusing on how it was experienced. After discussion in the author group, it was decided to focus more on how and less on where. Thus, some of the experiences described have taken place not only in the ICU but also at the ward shortly afterward. All the experiences described are seen from the patients' perspective, and as early experiences of mobilization. Four of the participants were interviewed more than 4 months after their ICU-stay. This may have influenced their ability to recall, but interestingly, these four participants were among those who contributed with lots of reflections. The participants may also have been influenced by feelings of gratitude for having survived and for the care that saved them.

Due to the recall-problem, more participants were recruited in order to collect as varied experiences as possible. The informants showed the desired diversity regarding admission diagnosis, age, sex, ICU, and length of stay. The use of qualitative inductive content analysis was applicable and appropriate as we aimed to describe a phenomenon, which has not been described before (Hsieh and Shannon, 2005). The authors therefore believe that the results are trustworthy and credible. Furthermore, under similar conditions, with patients experiencing positive interaction with the caregivers, the results could be transferable to others treated in ICU. This may also be the case for other groups of patients (e.g. those who have been seriously ill).

### **Conclusion**

A considerable variety of experiences of EM were described in this study, both negative and positive. Prominent features were that pleasant emotions and great physical effort occurred simultaneously and that interaction and cooperation with the caregivers was paramount. To regain independence was another prominent feature, with EM considered to be of great importance in the recovery process.

Moving to an upright position and ambulating appears to be beneficial to both body and mind. It should also be recognized that difficulties practicing EM are not due to unwillingness of the patient. EM should therefore be among the first priorities for the team of professionals, together with the patient, in the ICU. It is important for the professionals to acknowledge the patient's needs for



becoming independent. With this in mind, EM should be practiced with respect and support, while encouraging and challenging the patient to strive for independence.

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