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The Experiences of Post-ICU COVID-19 Survivors: An Existential Perspective using Interpretative Phenomenological Analysis

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Abstract

COVID-19 has highlighted the vulnerability of intensive care unit (ICU) patients and the negative sequelae associated with ICU treatment. While the potentially traumatic impact of ICU is well documented, less is known about the ICU survivor's subjective experience and how it influences life post-discharge. Existential psychology addresses the universal concerns of existence, including death, isolation, and meaninglessness, and offers a holistic view of human experience beyond diagnostic categories. An existential psychological understanding of ICU COVID-19 survivorship may therefore provide a rich account of what it means to be among the worst affected by a global existential crisis. This study employed interpretive phenomenological analysis of qualitative interviews with 10 post-ICU COVID-19 survivors (aged 18–78). Interviews were structured on existential psychology's 'Four Worlds' model that explores the physical, social, personal, and spiritual dimensions of human experience. The essential meaning of ICU COVID-19 survival was conceptualised as '*Trying to Reconnect with a Changed Reality*' and consisted of four themes. The first, *Between Shifting Realities in ICU*, described the liminal nature of ICU and the need to ground oneself. The second, *What it Means to Care and Be Cared For*, captured the emotive nature of personal interdependence and reciprocity. The third, *The Self is Different*, described survivors' struggle to reconcile old and new selves. The fourth, *A New Relationship with Life*, outlined how survivors' experiences shaped their new worldviews. Findings evidence the value of holistic, existentially informed psychological support for ICU survivors.

Keywords

COVID-19, intensive care unit, critical care, interpretive phenomenological analysis, existentialism, existential psychology, intensive care unit survivorship

Introduction

As of 13th January 2023, almost 3 years since the outbreak of severe acute respiratory syndrome coronavirus (SARS-CoV-2), 661,545,258 confirmed cases and 6,700,519 deaths have been reported globally (WHO, 2020). At the start of the pandemic, the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) suggested that 5–11% of those infected with the disease, known as COVID-19, would require admission to an intensive care unit (ICU) (Tingey et al., 2020). Data covering the first to fifth COVID-19 waves in Ireland indicated that 2356 COVID-19 patients were admitted to ICU by 10 January 2022 (HPSC, 2022). Thankfully, and largely due to the success of vaccination, the number of people admitted to the ICU due to COVID-19 has declined significantly from its peak in January 2021 (Ritchie et al., 2022). That said, however, ICU COVID-19 patients still represent a significant, vulnerable cohort (Vlake et al., 2021).

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Intensive care medicine has advanced considerably in the last 25 years (Inoue et al., 2019). ICU patients are now increasingly likely to survive, thereby shifting focus away from mortality to outcomes such as quality of life and preventing the long-term sequelae of critical care (Bein et al., 2019). Consequently, there is increasing interest in the ICU as a healthcare environment as well as the impact of ICU admission on patient outcomes (Kean et al., 2021). The term 'Post Intensive Care Syndrome' (PICS) is an umbrella term for a range of symptoms including pain, neuropathy, fatigue, and cognitive impairments that may arise following ICU treatment (Peach et al., 2021). ICU survivors may also experience depression, anxiety, and post-traumatic stress disorder (PTSD) (Dijkstra-Kersten et al., 2020; Hashem et al., 2016). Risk factors for PICS include duration of ICU admission, sedation and ventilation, age, premorbid conditions, and ICU delirium, which is an acute state of confusion associated with hallucinations and delusions (Da Costa et al., 2019; Stam et al., 2020).

High incidences of PICS have been documented in ICU survivors of previous respiratory disease outbreaks such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) (Jackson et al., 2016; Lee et al., 2007). By comparison, ICU survivors of COVID-19 are likely to have experienced even longer periods of ventilation and immobilisation, and higher levels of sedation, in addition to pandemic-related social restrictions (e.g. a ban on visitors). This is particularly true of ICU patients admitted during the first wave of COVID-19 (February–August 2020), before protocols for critical care practices such as mechanical ventilation were re-examined with a view to mitigating negative sequelae (Williamson et al., 2022). Given this confluence of a pandemic and a pre-existing ICU survivorship challenge, it is not surprising that the medical community declared PICS a potential 'Crisis after a Crisis' (Jaffri & Jaffri, 2020; Stam et al., 2020).

Emerging research into the psychological impact of ICU treatment for COVID-19 suggests a mixed picture of the levels of psychological distress during and after hospitalisation among survivors. A study of ICU COVID-19 survivorship in Italy found that 66.7% of participants reported mild to moderate depression and/or anxiety during hospitalisation but that 86.7% of participants had returned to normal levels following discharge (Piras et al., 2022). The study's sample of 15 was drawn from a population of survivors who had voluntarily shared their stories with the media, however, which potentially skews these results in favour of those less severely impacted by their ICU experience.

In a Portuguese sample of 56 ICU COVID-19 survivors, 29% and 23% reported depression and anxiety post-discharge, respectively. These symptoms were associated with cognitive difficulties, enduring pain, sleep problems, fear of catching COVID-19 again, and relatively younger age (e.g. median age = 63 vs. 68) (Martins et al., 2022). In highlighting the potential risk for PTSD among ICU COVID-19 survivors, Mongodi et al. (2021) reported that 40.4% of 47 survivors met criteria for acute stress disorder (ASD) at follow-up 55–92 days post-discharge. They speculated that an ICU patient's conscious awareness of their own condition, surroundings, and the suffering and death of others around them may be associated with higher levels of distress post-discharge. Similarly, Piras et al. suggested that a lack of understanding or awareness of the severity of their condition while in hospital might have been a protective factor for some ICU COVID-19 patients (2022).

From a psychological perspective, psychological trauma has often dominated the discourse regarding likely sequelae of ICU treatment (Bashar et al., 2018; Dijkstra-Kersten et al., 2020; Hauer et al., 2009). McGiffin et al. (2016) challenge the implication that ICU independently contributes to trauma beyond the traumatic effect of severe illness itself. They criticise the literature for sampling bias, lack of comparison groups, and lack of true prospective data. They also criticise the extant literature for failing to address the role of risk/resilience factors such as coping strategies, cognitive appraisal, and social supports, in predicting post-ICU outcomes. This raises questions of how we parse the psychological phenomena uniquely associated with ICU, made all the more germane in a post-COVID world. If we reduce the patient's experience to terms like depression, anxiety, and post-traumatic stress, do we risk overlooking important, but perhaps less tangible, concepts? Similarly, if we focus on ICU admission in isolation, do we preclude, as McGiffin et al. intimate, significant precipitating circumstances, and relevant personal, social, or even global factors that might better explain adverse psychological distress among ICU survivors? Indeed, there is a growing understanding that a 'whole episode of care' should be considered for a patient, over and above their time in ICU (Harvey & Davidson, 2016, p. 381).

Unlike other fields in psychology, existential psychology does not categorise people based on symptomatology, but rather considers the human experience across four dimensions, known as the 'Four Worlds' model – the physical, social, personal, and spiritual (see, for example, van Deurzen, 2014). It also describes the fundamental challenges in life as existential 'concerns' – life/death, connection/isolation, freedom/determinism, and meaning/meaninglessness (Bland, 2020; Greening, 1992). These provide a framework within which the individual's nuanced, multi-faceted experience of a crisis may be apprehended. Onrust et al.

(2022) adopted a multidimensional (though not explicitly existential) approach to study the physical, social, mental, and spiritual functioning of 56 Dutch COVID-19 ICU survivors 12 months post-discharge. This not only facilitated their reporting of tangible factors such as an ongoing need for follow-up physical care but also highlighted nuanced protective factors in the social dimension such as the significance of returning to work versus prioritising family or friends over work.

Onrust et al., 2022 also identified less tangible factors in the spiritual dimension, whereby the majority of survivors reported at least one 'spiritual need', as measured by the Spiritual Needs Questionnaire (SpNQ). The SpNQ's four subscales measure religious needs, existential needs, inner peace needs, and needs for positive confirmation. The authors noted that whilst only a few participants explicitly identified a role for spirituality in helping them cope with COVID-19, the fact that most reported needs in this domain suggests that 'spirituality' may be too ambiguous a term (Onrust et al., 2022). It also suggests that more may be done to explore patients' needs in this area by unpacking the various interpretations of spiritual and existential need and tailoring supports accordingly.

Taken together, the extant literature suggests that research allowing for a more multidimensional, existential understanding of ICU COVID-19 survival may inform a more nuanced, holistic approach to this complex issue. Specifically, there is a need to move away from strict adherence to pre-defined diagnostic criteria that, in Du Toit (2017) view, may deny survivors the existential nature of their traumatic responses, and 'thus stifle their ability to emotionally process their experience in purposive and meaningful ways' (p. 169). Moreover, an existential understanding of ICU COVID-19 survival may offer insight into which aspect(s) of post-ICU psychological distress individuals attribute specifically to their experience of the ICU. Accordingly, this study adopts an existential psychological approach to ask, 'what does it mean to survive ICU admission for COVID-19?'

Method

Interpretive Phenomenological Analysis (IPA)

Within health sciences, IPA has been used to explore a variety of subjects from an existential perspective, such as palliative nurses' experience of death proximity and patients' experience of chronic illness (Andersen et al., 2021; Vachon et al., 2012). The overlap between IPA and existentialism has been elucidated in an article that extends IPA's theoretical positioning and emphasises its 'concern with meaning-making on the part of both participant and researcher' (Smith, 2019, p. 1). Therefore, while the phenomenological approach theoretically encourages 'bracketing' of preconceptions on the researcher's part, they are by no means detached from the analysis and are recognised as engaging in the double-hermeneutic of interpreting the participant's interpretation of themselves (Pietkiewicz & Smith, 2014). Through close, transparent analysis of participants' words, the researcher subsequently invites the reader into the 'hermeneutic circle' (Nizza et al., 2021). This intersubjective approach is appropriate for research investigating how a pandemic, which affects all to a greater or lesser degree, has been experienced by some of those most severely impacted by it.

Participants and Procedures

Ten participants aged 18–78 were recruited from the patient group of ICU COVID-19 survivors at an Irish public hospital. The majority (70%) were in their fifties or sixties, three were female. Eight were Irish and two were English. The average length of ICU stay was 14 days (range 8–109 days), and participants were interviewed at 12–21 months post-discharge. The majority (70%) were ventilated during their ICU stay.

The study was open to all adult (18 and over) English-speaking patients treated for COVID-19 in the hospital's ICU. Psychology staff posted a brief study information leaflet to patients from this group and followed up with a phone call. If interested, patients could contact the first author directly using details provided on the leaflet or consent to their contact information being passed to the author by Psychology staff. Where such consent was provided, patients were contacted by the first author within 2 weeks and given the opportunity to discuss the study. If interested in participating, they were sent a detailed participant information sheet and consent form by email or post. Interview times were arranged on return of signed consent forms.

Data Collection

In-depth, semi-structured interviews were conducted using Microsoft Teams encrypted videoconferencing software between October 2021 and February 2022. To ensure a thorough, holistic exploration of the survivor experience, interviews adopted an existential psychology framework incorporating the 'Four Worlds' model of life dimensions and the existential concerns (Van Deurzen, 2012, 2014). These are the physical (life/death), social (connection/isolation), personal (freedom/determinism), and spiritual (meaning/meaninglessness).

Interviews took the form of a conversation, guided by a set of open-ended questions based on the Four Worlds model. For example, '*How have your relationships with people been different since your time in ICU, if at all?*' in relation to the social dimension and '*Would you say your time in ICU has changed your worldview?*' to invite exploration of the spiritual dimension. Interviews ranged from 45 to 80 minutes, and the majority were an hour long. Interviews were recorded on an encrypted device and transcribed within 4 weeks. Once transcribed, recordings were deleted. Transcripts were pseudo-anonymised through the removal of any identifying information such as names, locations, and job titles. Pseudonyms were used to report the findings below.

Ethical Issues

Ethics approval for this study was received from the relevant School of Psychology Ethics Committees and the relevant Hospital's Research Ethics Committee. Given the potentially emotive nature of the interviews, the primary ethical issue for consideration was the provision of support and signposting of follow-up services. As standard procedure, all participants were given a Debriefing Information Sheet after the interview, containing contact details for community and hospital-based psychological support.

Analysis

In accordance with IPA, each individual transcript was read in depth to produce a comprehensive descriptive, linguistic, and conceptual commentary on the data. The psychological essence of these comments were organised into experiential statements and grouped under personal experiential themes (PETs) through a creative process of abstraction and subsumption (Smith et al., 2022). This inductive approach honours the idiographic component of IPA, enabling the study to reflect the depth and breadth of participants' experiences (Smith et al., 2009). A table of PETs was created for each interview. These were compared to identify patterns across the data, which were summarised in a master table of group experiential themes (GETs). A GET was considered evidenced for the group if it meaningfully wove together PETs from each participant that either related to each other, built on each other, or contrasted with each other on some shared matter. Four GETs were thus developed that were reflective of both the convergent and divergent experiences of all participants. Nizza et al.'s (2021) four markers of high-quality IPA were used to guide the analysis. These are constructing a compelling, unfolding narrative; developing a vigorous experiential/existential account; close analytic reading of participants' words; and attending to convergence and divergence. To create a narrative across the breadth of material, the author devised additional guiding principles: (1) follow the emotional heat, (2) attend to 'stuckness', and (3) where are we in time?

Regarding the first principle, Smith (2019) notes that 'what makes an ongoing situation apposite for IPA is the presence of the hot cognition' as this flags mental and emotional engagement with the experience (p. 1). Additionally, van Deurzen (2014) emphasises how the 'lens of emotions' provides insight into an individual's values. She references Spinoza's observation that 'emotions are an expression of our values' (p. 81). Tracking the emotional heat in interviews, by noting any intensification of emotional expression and the subject matter associated with it, was therefore helpful in staying close to participants' essential experience both in terms of how they were processing it and what it meant in the context of their value system.

Similarly, points of 'stuckness', whereby participants repeatedly returned to a particular experience, question, or topic without prompting, were considered potential indicators of unprocessed material. In this way, seemingly innocuous or incidental material could gain significance in the analysis through the participant's returning to it over the course of the conversation, suggesting that there was an aspect of the matter with which they were grappling. While the assimilation of that material may be incomplete, the stuckness itself is a significant part of the lived experience, informing potential areas for support and intervention. Lastly, van Deurzen (2014) notes the dimension of time is a helpful indicator of how a person's thinking is oriented to their experience. She describes our ability to 'look back and create a different narrative depending on how closely to the actuality of the experience we can bring ourselves to be' (p. 79). Both points of stuckness and orientation in time were considered useful principles with which to balance the emotional lens, for perhaps a participant may avoid emotion by distancing themselves in time from its trigger, or repeatedly reference something significant they have as yet been unable to apprehend or process emotionally. By attending to these phenomena during the development of the GETs, it was hoped that a more authentic and respectful narrative of participants' true experiences would emerge.

Findings

The essential meaning of being an ICU COVID-19 survivor may be captured by the narrative 'Trying to Reconnect with a Changed Reality'. This not only speaks to the changed global reality that participants found themselves in following discharge but also captures how

individual survivors experienced the change brought about by ICU admission in different ways across the existential dimensions (i.e. physical, social, personal, or spiritual). Their changed realities in these dimensions informed their unique struggles to reconnect with life as ICU COVID-19 survivors. Reconnecting was an ongoing process for most participants in at least one dimension, often supported by their successful reconnection in another dimension. Starting from the experience of ICU itself, the four GETs help to unpack the different aspects of what it means to try to reconnect with a changed reality: (a) *Between Shifting Realities in ICU,* (b) *What It Means to Care and Be Cared For,* (c) *The Self Is Different,* and (d) *A New Relationship with Life.*

Between Shifting Realities in ICU

Almost all participants began their story with their admission to ICU. What emerged was a visceral impression of the ICU as a dualistic, liminal space where patients lingered between different states and shifted across thresholds such as consciousness/unconsciousness and delusions/reality. ICU delirium epitomises this duality as patients alternated between subjective and objective realities. This left an indelible impression on most who experienced delirium. Some still struggle to integrate their subjective memories with objective reality.

> It was very hard to differentiate ... when you ask me of my experience, I'm giving you this story that didn't happen but yet I'm recalling from memory. It's not fabricated. It's, as far as I know, it's what happened but then I also have to know it didn't happen. (Kevin)

Kevin struggled to integrate his subjective experience with the factual account his loved ones provided, leaving him with an unresolved feeling of not knowing which story was *his* story.

Others recalled seeking confirmation of their subjective experience in their objective reality.

> The cannula was ripped out and I still have a large scar in my arm to this day, but that was proof that I was dragged through the gates, the iron gates ... so I had *loads* of confirmation that I was in the right. (Sinéad)

Sinéad's description of the need for 'proof' and 'confirmation' of her delusional experience of being dragged against her will through gates highlights a desperate attempt to ground the self in some version of reality, to allay the terrifying events unfolding. Many found ICU frightening, and this served to blur the boundaries of reality. Vivid descriptions of ICU staff in lurid PPE and the distressing discomfort of medical interventions create an impression of delusions occurring as nightmares within a nightmare. Joe describes the distressing reality of having a breathing mask fitted.

> They put this like airtight mask over my face . . . and it was just, you know, screaming, crying, raving, all that shit . . . I often, you know if I'm in a bad place, you know, I see pictures of that in my head, all that stuff. (Joe)

Use of the continuous tense conveys how present this experience remains for Joe.

Another participant, Harry, unaware of the phenomenon of ICU delirium, hesitates to talk about his nightmares. His not knowing whether he was asleep or awake effectively portrays the shifting, untethered reality of ICU.

> The other thing is I, [little laugh] I don't know if you ever heard this before, but I actually thought, I mean, I was having these nightmares when I was awake, I suppose, well I thought I was awake. (Harry)

Halting speech and verification-seeking suggest a self-conscious uncertainty about Harry's experience. He wonders if the interviewer has heard of this before, demonstrating what a lonely and worrying psychological experience ICU can evoke.

Jane was able to rationalise her delusional experiences in order to process them.

> I was either physically restrained in some way or I was trying to escape somebody. They were the kind of, the two themes, but it was all about getting back to where I should be. (Jane)

Jane understands her experiences as psychological expressions of her feeling of displacement in ICU. Her phrasing 'getting back to where I should be' conveys a strong instinct to leave ICU and re-join the outside world.

Others found themselves pulled in a different direction as they experienced the ultimate liminal space, between life and death. In these two cases, familiar people from the person's life provide a reassuring link between one world and another, eliciting wonder and comfort that counteract the fear and uncertainty of ICU.

> An experience I had spiritually in, in ICU when I was on the ventilator . . . I saw all the people who were praying for me [shakes head]. It was an amazing experience. (David)

> My father passed 21 years ago. I could see Daddy, he was holding my hand. That was the *comforting* part. (Sinéad)

For some, the transition from ICU to a step-down ward was hardest of all, as the isolation of their new

environment compounded the distressing realisation of what they had just been through.

> Then I was moved into a private room and…that was the worst part. (George)

What It Means to Care and Be Cared For

Participants were most emotional when talking about others, rather than themselves. Unpacking these moments of emotion reveals a map of human interconnectedness that underlies every story. Several participants described how moving the experience of being cared for was.

> The level of care I got was unbelievable . . . It's probably the most emotional part for me when I'm thinking back. Uhm, you know, you're on your own. But you weren't. They made you feel you were part of their family [getting emotional]. (Kevin)

Kevin switches to talking about himself in the second person, perhaps attempting to distance himself from his emotions. He nonetheless becomes emotional when likening ICU staff to family, maybe because their caring gesture underscored the absence of his real family at the time.

Jane describes a reciprocal feeling of care and admiration between staff and ICU survivors.

> I said to her, 'you're just amazing what you do' . . . and she said [sits back and puts hand on chest, tearing up], this makes me emotional, she said, 'we think *you're* amazing, people like you who've come through this are amazing'. (Jane)

Jane is moved by her exchange with a nurse, perhaps because it contains both her appreciation for the care she received and validation of her own role in her recovery, but perhaps also because the nurse's humility reflects a quality of selflessness and caring she herself values.

These values come through in others' emotional accounts of how their illness impacted loved ones.

> I thought I was going to die. And I was concerned because [daughter] wouldn't have been able to come back from [abroad]. Uhm, [choked up] and then I was worried for my *other* girl who would have had to go through all of this on her own . . . it would have been traumatic for her. (Harry)

This father's love causes him, in the depths of his own suffering, to become preoccupied with the suffering of his daughters. Almost all participants alluded to how their loved ones' distress became their distress too.

> I have encouraged all mine to [gets a little choked up] write their own story of how they felt when [emotional] I was in hospital, and my daughter ... she sent me an email, and I cried when I read her email. (Mary)

Empathic connection is not limited to family contexts, and several participants describe the overwhelming sense of care and connection they experienced in their wider community.

> I had people that I don't know doing novenas for me ... whether you're religious or not, that means an awful lot. ... People. [Makes gesture of disbelief]. It's just amazing how it all ripples down and how people are connected by something like this. And that's why I get ... so angry with these people that, that deny [sighs]. (Jane)

This captures the dual nature of human interconnectedness. The mutual care and support that connection facilitates translates to mutual responsibility and power to cause harm through the same channels. In a pandemic, this elicits fear and anger. Jane is angry towards those who deny the dangers of COVID and may therefore put others at risk. Most participants describe a heightened awareness and frustration about this, and many fear catching COVID again.

> You were saying what way is your life affected . . . Number one I'm *terrified* of catching it again . . . I'm absolutely terrified. (Sinéad)

Some also report the reverse, whereby they feel others are avoiding them, as a result of having had COVID.

> I suppose when I first got out, you do feel kind of ostracised because, it's almost, you feel like a leper almost you know? (Kevin)

While the leper is a potent symbol of the contagious self, this was mainly referenced by those among the first to be hospitalised with COVID, before vaccination was introduced. Nonetheless, all are acutely aware of their narrow escape from death, and for some, the experience of witnessing those less fortunate is the interconnectedness they feel most of all.

> How come I got to walk out and the person opposite me, I don't think did, for instance. That kind of plays on your mind a little. And I found it quite distressing. (George)

Several others echoed George's experience of survivor's guilt, while also reporting a profound sense of how lucky they were to survive. 'Why me?' was a question asked by many.

The Self Is Different

Reflecting on how they were affected personally, almost all participants describe a change in their sense of themselves. For some, the physical repercussions of their illness have had a devastating effect.

> I was out every day. I worked Monday to Friday, went to the gym after work. Uhm, came home, walked the dog, full of energy, full of life. Always the life and soul of the party. And now I'm just lost! [voice quivers] . . . It's just not *me* [emotional].
>
> Interviewer: Your sense of yourself is…
>
> It's gone. (Sinéad)

Sinéad's identity as the life of the party has been lost through the impact of fatigue and other physical ailments resulting from COVID-19, a stark contrast to her former energetic self. It affects multiple areas of her life and creates a sense of being a stranger to herself.

Others also describe losing a part of themselves.

> I've lost a lot of things . . . and that is emotion as well. You know, I've kind of been drained so much of it. That it's kind of just [pause] left. It's just opened the door and gone, you know. (Joe)

This striking description conveys a sense of dissociation, whereby a part of the self disconnects in response to extreme stress. Joe described a distressing ICU stay, and the loss of self he experiences may be the challenging by-product of his natural survival response.

Other participants report the opposite scenario, as they are now experiencing more emotionality.

> The tears at night and the worry and the anxiety was just unbelievable. I had two or three visits with my GP over it, you know, which wouldn't have been the case prior to that . . . so, it's definitely changed me in that way. (Kevin)

There is a sense of loss of control of emotion for Kevin, which he experiences almost as a medical emergency. Yet, he appears to be coming to terms with it and has accepted this emotionality as part of a new, 'changed' self.

While some changes are embraced, there are aspects of the former self that many are not willing to relinquish. David is determined to reassert his autonomy, while feeling infantilized by others. His repeated use of the word 'power' suggests his ICU experience involved a loss of agency and identity, which he describes elsewhere as 'being brought to your own nothingness'.

> I found even trying to take back my own power again and empower myself was good as well. I found people talking to me like, "there you sit in there to that chair" and . . . treating you like a child, you know, and I had to say hold on, I says "I'm capable of driving again" . . . just regaining your power, I think that's an important thing. (David)

By contrast, two participants felt unchanged by their ICU experience. In both cases, they alluded to other challenging life events that preceded their ICU stay. While these events created a sense of pre-existing vulnerability for one participant, the other emphasised that COVID-19 had not impacted him significantly.

> I don't regard that the . . . experience of the COVID has had . . . a very *significant* effect on me. I don't consider it to be significant in comparison to the things I face every day, you know. (Barry)

Barry conveys a sense of resilience that almost minimises his serious illness in the context of other life challenges. Alternatively, he may not wish to reflect on his experience. Several others, however, enjoy talking about their experience and find it helpful. George describes how talking helps bring the experience to consciousness, which in turn helps him see how far he's come.

> I've enjoyed the conversation . . . you probably go around thinking about it subconsciously quite a lot. Uhm, but it's good to just . . . talk through, heighten your own awareness of where you're at. (George)

New Relationship with Life

For many, the change in self is at least partly attributable to a change in perspective. For those who identified as workaholics, their time in ICU has brought about a re-evaluation of what's important. There is a heightened awareness of time as a precious resource.

> Just, yeah, there's more to life than just having to work all the time. Now I spend more time with the wife and the family. (Jim)

George recalls making the decision to retire after imagining himself on his deathbed. This signifies a major shift in identity for him.

> I suppose the shift in focus . . . My favourite psychologist is Erich Fromm and existentialism and stuff like that . . . so I suppose I have been searching to find new meanings. New things to do. (George)

He describes a conscious redirection of his attention towards things that may bring new meaning to life. His referencing existentialism suggests this new meaning may be needed to offset the inevitable anxiety that a brush with death evokes.

Jim describes how facing death has also impacted his experience of time.

> But the fact that I was close to it . . . it's you know . . . in the back of the mind now. I don't think that will go away, it stays here. Like, sometimes I'll be sitting there thinking "hmm, how long, how long, how long?" And that just comes out of nowhere. (Jim)

He describes an almost intrusive anxiety about how much time he has left, which drives his new relationship with life.

This sense of the preciousness of time instigates change in other families too.

> Us as a family . . . have learned that life is too short. . . and to just get on . . . now we talk every day, which is lovely. So that's a *good* impact. (Sinéad)

Sinéad sees her enhanced family relationship as the silver-lining of her experience. Others also report that ICU has helped clarify what's important while 'stripping away' the superfluous.

> All that's stripped away, and you just see it comes down to, loving, how you love the people around you and the people you meet and how you treat them. And that's really, that's end game . . . The rest is only window dressing. (David)

David's choice of words powerfully portrays his new relationship with life, and death. ICU has separated superficial daily distractions from what he sees as fundamentally important, how we love and treat others, which to him is 'end game' – what remains as one enters the final stages of the game of life.

Most participants report less fear of death after ICU. For many, there is also a heightened awareness of the fine line between life and death, which evokes a new attunement with the world.

> It's probably subconsciously realizing how fragile life is and things I would never have noticed before. . . I also think it's part of me probably remembering how scared and how frightened *I* was and how fragile *I* was. (Kevin)

Taken together, these themes portray a striking narrative arc of participants being thrown into the disorientating and frightening shifting realities of ICU, experiencing profound empathic connection on both an individual and common humanity level, and emerging with a changed sense of self into a new relationship with a world that is also inexorably changed. From this position, participants are in the process of trying to reconnect – with their physical bodies, their social relationships, their sense of identity, or their values or beliefs.

Discussion

This study sought to understand the experiences of ICU COVID-19 survivors from an existential perspective. Findings suggest the meaning of ICU COVID-19 survival can be conceptualised as 'Trying to Reconnect with a Changed Reality'. This captures the sense of displacement, shock, or alienation survivors may experience in ICU and post-discharge, in any of the existential dimensions, as outlined by the Four Worlds model. This narrative of trying to reconnect is substantiated by the four GETs, which describe a need to ground oneself (*Between Shifting Realities in ICU)*, the importance of interdependence and empathy to feel safe in this changed reality (*What it Means to Care and Be Cared For*), reconciling the changed self with the old (*The Self is Different*), and a different perspective *(A New Relationship with Life)*. For many, 'reconnecting' is an ongoing process in at least one dimension. This not only refers to reconnection with a physical place or social group but also reconnection with the physical self, sense of identity, or a position of authenticity or belonging. In these dimensions, each participant may be facing a new reality, depending on their individual experience, and reconnection may therefore mean a process of negotiation, grief, rehabilitation, acceptance, celebration, and so on. It is at this point of trying to reconnect with their changed reality in a particular dimension that participants may most benefit from tailored support.

Participants elicited an impression of ICU as a liminal, dualistic space where they oscillated between consciousness/unconsciousness, delusions/reality, life/death, and isolation/connection. For many participants, 'reality' was a relative concept in ICU. The meanings they derived from their experiences in order to ground themselves and process what was happening often differed from the objective accounts of family and staff members. This echoes findings regarding the multidimensionality of ICU, and the dualistic worlds of ICU patients and families (Olausson et al., 2013; Page et al., 2019). Consistent with what was reported by many in this study, Page et al. (2019) noted an intra- and interpersonal duality emerging from patients' attempts to reconcile their subjective and objective realities. Their identification of survivors' need for 'reconciliation of self and body' also speaks to the struggle of

participants in this study to reconcile their new physical and/or emotional selves with their previous identities (Page et al., 2019, p. 612).

Egerod et al.'s (2015) meta-synthesis of ICU patients' experience describes ICU as the 'threshold' between life and death (p. 1359). This relates to existential psychiatrist Irvin D. Yalom's (1980) description of the 'boundary situation' as that which forces us into a confrontation with our existential reality, reminding us that 'existence cannot be postponed' (pp. 160–161). Following the boundary situation of ICU, participants in this study described a new relationship with life involving a changed sense of time and future, recognition of what's important, search for new meaning, and, for most, reduced fear of death. Some participants experienced these new perspectives as revelations, while others were actively seeking them to consolidate a new, meaningful worldview. Recently published qualitative research exploring experiences of Iranian ICU COVID-19 survivors shares similar themes in relation to the social and spiritual dimensions, wherein participants reported a changed perspective and enhanced spirituality following ICU (Nasrabadi et al., 2021; Norouzadeh et al., 2021). For these participants, spirituality may be synonymous with religious faith but, as Van Deurzen (2012) clarifies, the spiritual dimension in existential psychology simply refers to one's 'implicit worldview'.

As evidenced in this study, ICU brought participants into direct contact with their value systems and highlighted the value unanimously placed on human bonding, reciprocal care, interconnectedness, and love. This also revealed feelings of social responsibility, survivor's guilt, and vulnerability in relation to human connectivity during a pandemic. Mongodi et al.'s suggestion that conscious awareness of the suffering of others was associated with greater distress in ICU survivors was echoed by some participants in this study, who recounted their awareness of other patients' distress or death and expressed survivor's guilt in the form of 'why me?' (Mongodi et al., 2021). In their exploration of existential maturity and terror in a pandemic, Emanuel et al. (2021) liken the needs of a patient encountering death to the attachment needs of a child. They advocate for the provision of a 'holding environment' in which patients can safely experience feelings of death-related anxiety in the secure, attentive presence of another. In their view, existential maturity means 'being able to contemplate and experience absence with the knowledge of connection', which seems a poetic reflection of the ICU-based needs outlined by participants in this study (Emanuel et al., 2021, p. 215).

This relates to the idea of existential well-being, conceptualised as an 'internal coping resource whereby people draw upon their beliefs to cope with stressful situations' (Ownsworth & Nash, 2015, p. 2). Ownsworth and Nash (2015) report that the 21st century has seen an increased focus on existential well-being in the care of cancer patients. Psycho-oncological research has consistently associated greater existential well-being with reduced emotional distress and improved quality of life. Olsen et al.'s (2017) existential exploration of ICU survivorship reported psychological improvement among survivors, with some remaining emotional vulnerability, at 3 months post-discharge. Their analysis identified the theme 'Balancing between who I was and who I am', associated with gratitude, future-focus, and finding new meaning, and the theme of having one's individual differences seen and valued by hospital staff. Themes such as these, while highly significant in the minds of the patients, may not necessarily be addressed if patients' difficulties are viewed solely through the lens of conventional psychological nosologies. In particular, recognition of the individuality of survivors, as reflected in the heterogeneous coping styles, support systems, and beliefs identified in this study, must inform the development of support services if these services are to truly emulate the holistic 'holding environments' needed to assimilate an existential experience such as ICU admission.

Storli et al.'s (2008) exploration of living with memories of ICU 10 years after discharge concluded that it was not a question of how realistic or delusional a survivor's memory was, but rather the meaning of it that helped the individual process the memory. They found those who integrated these experiences into a new sense of 'who I am' expressed feeling more in touch with their being-in-the-world, even describing it as a positive experience. Thus, they noted that ICU was a place of 'torture' for some but a 'holy ground' leading to personal growth for others (Papathanassoglou & Patiraki, 2003). This speaks directly to the existential psychological conceptualisation of the trauma response, outlined by Du Toit as an opportunity to derive purpose and meaning from an experience (Du Toit, 2017).

The findings from this study lend support to the extant literature in suggesting that psychological services for ICU COVID-19 survivors should ideally be flexible in their approach. Returning to Harvey and Davidson's (2016) idea of a 'whole episode of care', this is likely to be different for each survivor, depending on their pre-ICU lives as much as their ICU experience. Many participants in this study reported getting a lot out of the research interview itself. This may be due to the existential frame of enquiry used. By inviting participants to explore the physical, social, personal, and spiritual aspects of their experience, the scene was set for those who felt inclined to reflect on a deeper level.

Strengths and Limitations

This is the first study to take an existential perspective on the experiences of post-ICU COVID-19 survivors in an Irish setting. The rich, in-depth data and wide range of participant ages, representative of the age range of the general adult ICU

COVID-19 population, are strengths of this study. The qualitative analysis presented goes beyond simple description of survivorship to offer an interpretation of the participants' accounts and, in keeping with the IPA quality guidelines, reflects both the convergence and divergence of their experiences (Smith, 2011). The inclusion of participants with diverse experiences, outlooks, coping styles, and support systems provides an authentic and varied account of ICU COVID-19 survivorship.

The study's voluntary, video-based design may be considered a limitation as it implies a certain level of self-selection in recruitment. In particular, lack of access or knowledge of the relevant technology may have precluded some potential participants. Others may have been reluctant to discuss their ICU experience due to ongoing difficulties or language barriers. These factors may be addressed by future research in the area.

Conclusion

This study is the first to add an explicitly existential perspective to the emerging body of research into the lived experience of post-ICU COVID-19 survivors. Findings outline survivors' experiences of displacement and change in the physical, social, personal, and spiritual dimensions against the backdrop of a changing global reality, captured by the narrative 'Trying to Reconnect with a Changed Reality'. In using IPA to explore this important topic, a detailed account has been provided of survivors' attempts to make sense of their experiences, and close attention has been paid to the ways in which individual experiences converge and diverge. The 'Four Worlds' existential psychological framework employed has allowed a multidimensional approach both broad and nuanced enough to honour the ways in which individual experience vary. These findings may inform the development of a flexible, existentially informed, holistic approach to the psychological support of ICU COVID-19 survivors.

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