

RESEARCH ARTICLE

Sheltering under a shield of love—A phenomenological-hermeneutic study of relatives' experiences in an acute neurological ward

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Abstract

Aim: To investigate the lived experience of being a relative to a patient admitted to an acute neurological ward to bring knowledge of what is essential to them.

Design: The study takes a phenomenological-hermeneutic approach.

Methods: Data were gathered through six individual semi-structured interviews with relatives from an acute neurological ward. A three-levelled analysis and interpretation inspired by Paul Ricoeur's philosophy was applied.

Results: Two main themes were identified: *To make yourself strong while feeling vulnerable inside* and *To live in a changed everyday life*. Within these themes, the connection between the relatives and the patients appeared to be a relationship of love. In this relationship, the relatives experience existential vulnerability. The lives of relatives undergo a difficult upheaval, which is challenged by deep emotional feelings. However, to be able to be there for their loved ones they are sheltering under a shield of love.

KEYWORDS

acute neurology, lived experience, loved ones, nursing, nursing care, phenomenological-hermeneutic research, relatives, Ricoeur, vulnerable

1 | INTRODUCTION

In neurology, relatives play an essential role because the symptoms associated with neurological diseases often involve cognitive, emotional and physical deficits that can affect the patient's ability to speak, eat and move, just as they may affect the personality and behaviour (Doser & Norup, 2016; WHO, 2006). Due to this wide and debilitating range of symptoms, a large proportion of neurological patients become dependent on care either temporarily or indefinitely (Doser & Norup, 2016; Khabarov, Dimitropoulos, & McGillicuddy, 2015; WHO, 2006).

Internationally, research has been focused on the responsibility and commitment that people experience when a close relative becomes ill (Engström & Söderberg, 2007; Martinsen & Norlyk, 2013; Mitnick, Leffier, & Hood, 2010). Although relatives take on the responsibility as a matter of course and largely wish to be involved, it is emphasized that this commitment poses an extensive burden (Doser & Norup, 2016; Eggenberger & Nelms, 2007; Faison, Faria, & Frank, 1999; Linnarsson, Bubini, & Perseus, 2010; Mitnick et al., 2010). Studies have demonstrated that relatives of ill people are at a greater risk of burning out or becoming ill themselves, and a high perceived strain due to caregiving is associated with increased

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mortality (Carretero, Garcés, Ródenas, & Sanjosé, 2009; Perkins et al., 2013). What is essential to these relatives is still unclear in the science of nursing.

2 | BACKGROUND

Neurological disorders largely lead to limitations in physical, cognitive or social capacity. In both the acute and chronic phases, there is often a need for not only close observation and care but also physical and mental support (WHO, 2006). According to the WHO, the burdens of neurological diseases and their sequelae are estimated to affect as many as a billion people worldwide and the number of people with neurological disorders is expected to increase considerably (WHO, 2006). In developed countries, there are, to a large extent, well-developed public service systems that aim to secure high-quality care and rehabilitation for people living with a neurological disease or a long-term disability. Nevertheless, the WHO notes that the welfare systems in developed countries still pose a heavy burden to the patient's relatives and network. The socioeconomic demands of care, treatment and rehabilitation put a strain on entire families, which affects their productivity and quality of life (WHO, 2006).

Research has been focused on identifying the needs of relatives regarding hospitalization. A need for clear and consistent information and communication with health professionals predominates; in addition, the need for involvement in care and decision-making are important for relatives to feel safe and secure. Unfortunately, those needs are often only partially met (Blom, Gustavsson, & Sundler, 2013; Khalaila, 2014; Laursen, Danielsen, & Rosenberg, 2015; Pinkert, Holtgräwe, & Remmers, 2013). Studies identify that most nurses find relatives to be a significant part of the patient's care and treatment as relatives contribute important knowledge about the patient's habitual state and provide encouragement and help to the patient in a situation where hopelessness is often prominent. However, in addition to these positive views on the involvement of relatives in nursing care, nurses also report finding relatives to be troublesome and demanding (Akroute & Bondas, 2016; Engström, Uusitalo, & Engström, 2011; Lindhardt, Hallberg, & Poulsen, 2008).

Studies have uncovered suffering among the relatives of patients, noting that being in the role of a close relative of someone who is seriously ill is associated with a continuous struggle to balance everyday life (Eggenberger & Nelms, 2007; Houldin, 2007; Martinsen & Norlyk, 2013; Pereira & Bothelho, 2011). Relatives must often keep both the patient and other family members in mind when trying to navigate life. To prevent the patient from feeling lonely, relatives tend to spend many hours at the hospital. However, studies identify that, at the same time, the relatives are longing for the life of their own (Eggenberger & Nelms, 2007; Houldin, 2007; Martinsen & Norlyk, 2013; Pereira & Bothelho, 2011).

Viewed in the context of development in industrialized countries, with aims of faster treatment in hospitals and a greater responsibility for primary care and informal caregivers (Grimmer, Moss, & Falco,

2004; Martinsen & Norlyk, 2013), it is important to care for, prepare and support relatives starting from the beginning of the acute phase of hospitalization. Insight into the experience of relatives is anticipated to form a sound basis for the care of relatives by nurses and other healthcare professionals. Therefore, this study aimed to investigate: how is it experienced to be a relative of a patient admitted to an acute neurological ward?

3 | THE STUDY

3.1 | Design

This study followed a qualitative approach with phenomenology and hermeneutics as a philosophical framework. Six semi-structured individual interviews with relatives from an acute neurological ward were performed. The interpretation theory of the French philosopher Paul Ricoeur (1976) inspired the analysis.

4 | METHOD

4.1 | Participants

Access to the participants was obtained through the head nurse. The relatives of patients who were hospitalized with a neurological disease or medically reasoned suspicion were included in the study. Participants were adults who were capable of speaking and understanding the Danish language. A purposeful sampling strategy was used to select information-rich participants who could describe with depth and richness the experience of being a relative in this setting (Polit & Beck, 2006). The recruitment process was continuous during the period when the interviews were conducted. Hence, the variation and nuances of the studied phenomenon guided the number of participants that were included. First author contacted potential participants when visiting patients, thereby ensuring the patient's acceptance of the participation of the relatives. Six relatives were invited, and none declined. Finally, four women and two men aged between 24–79 years were included (Table 1). Two of the relatives were spouses of the patients, one was a daughter, one was a brother, and two were grandchildren. All participants were either retired or students in higher education.

4.2 | Data collection

Data were collected by the first author during the period of March 2017–April 2017 at a neurological ward in a university hospital in the Capital Region of Denmark.

Semi-structured interviews. To gain insight into the relatives' lived experience, individual interviews were performed using a narrative-inspired approach (Fog, 2004; Kvale & Brinkmann, 2009).

TABLE 1 Participants interview

Participant	Relation to the patient	Age (years)	Civil state	Length of hospitalization
P1, Woman	Wife	79	Retired	Admitted 4 days
P2, Man	Brother	71	Retired	Admitted 6 days
P3, Woman	Grandchild	32	Unemployed	Admitted 2 days
P4, Woman	Wife	77	Retired	Admitted 5 days
P5, Man	Grandchild	24	Student	Admitted 5 days
P6, Woman	Daughter	34	Student	Admitted 10 days (discharged when interviewing)

Before the interviews, observation in the clinical department was conducted to provide in-depth insight and inspiration in relation to the questions in the interview guide. A position as a moderate participant in the field was chosen because it allowed the researcher to both observe and interact in the field where data could be obtained through invited or unsolicited participant reports (Hammersley & Atkinson, 2007; Spradley, 1980). The observations were conducted over the course of one day for approximately 8 hr total.

After pilot-testing, a semi-structured interview guide was developed. Open questions such as “Could you tell me what has made a special impression on you during the hospitalization?” were used to ensure that the participants narrated in their own words what was important to them. Accordingly, the participants were met with an open, engaged and curious attitude (Fog, 2004; Kvale & Brinkmann, 2009).

Participants were given the opportunity to determine the location of the interview. Four of the interviews took place in the hospital in a quiet setting. Two interviews were held outside the hospital, one in the relative's private home and another in an educational institution. The interviews were recorded on audio file, lasted an average of 41 min and reflected profoundly deep descriptions of the relatives' experiences.

4.3 | Ethical considerations

In accordance with the basic principles for research stated in the Helsinki Declaration and the Northern Nurses' Federation (Sykepleiernes Samarbeid i Norden, 2003), the relatives received written and verbal information about study purpose, their anonymity and the opportunity to withdraw from the study at any time. The participants were given time to consider their participation before written consent was given. According to The Danish Data Protection Agency, ethical approval was not necessary. Guidelines for safe data management were followed. The act of conducting interviews is a moral practice wherein the interviewer must be aware of the asymmetric relationship (Kvale & Brinkmann, 2009). For this reason, attentiveness and humbleness was strived throughout the interviews to avoid causing the participants any harm.

4.4 | Data analysis

The interviews were transcribed verbatim by the first author immediately after they ended. Ricoeur's philosophy of narrative and interpretation was used as inspiration for the method of data interpretation. The descriptive nature of phenomenology guided the analysis, and the hermeneutic part of the theory enabled the interpretation of the empirical material (Ricoeur, 1976). The interpretive phenomenological analysis consisted of the following three methodological steps: naive reading, structural analysis and critical analysis and discussion (Dreyer & Pedersen, 2009; Pedersen, 1999).

4.4.1 | Naive reading

It is an overall reading of the text and a first impression of the contents of the text. We were open-minded in this reading, absorbing the text and noticing what affected us. This first acquisition of the text contains an element of guessing. According to Ricoeur (1976), such first impression must be validated by further structural analysis.

4.4.2 | Structural analysis

It forms the basis for a deeper interpretation of the text's structures in a dialectical movement between understanding and explanation. An open division of units of meaning (what is said) and units of significance (what is being talked about) was made. To ensure credibility, the structural analysis was performed in collaboration between all three authors and, along the way, we compared units of meaning and units of significance with the naive reading. The structural analysis involves extracting themes, and this analysis is presented in the “results” section.

4.4.3 | Critical interpretation and discussion

Given the themes, the findings were further interpreted and discussed. This interpretation included the thinking of the Danish philosopher Soren Kierkegaard (2013), the theory of the Danish psychotherapist Marianne Davidsen-Nielsen (2010), the nursing

theorist Kari Martinsen (2012), and other research. Existing research was used to argue in favour of a suitable interpretation.

4.5 | Rigour

Within a phenomenological-hermeneutic research approach, it is essential to have an open-minded attitude towards the studied phenomenon (Dahlberg, Dahlberg, & Nyström, 2008); therefore, a continuous attention towards the researchers' pre-understanding was considered. During data collection and interpretation, all authors allowed their pre-understanding as nurses to be guiding their appropriation of data. The structural analysis was discussed with colleagues in the field to ensure conformability and credibility. According to Ricoeur (1976), structural analysis can serve as a validation. To provide transparency in this process, the description of the findings includes quotes from the data material.

5 | RESULTS

The overall impression from the naive reading revealed an existential experience wherein the relatives expressed a vulnerability that was deeply rooted in their love for the patient. The relatives referred to the patients with love and affection, thus expressing a relationship of love. Although the relatives felt existentially vulnerable, they did whatever it took to be a strong and resourceful support for the patient. Through a continuous struggle to balance everyday life, the relatives focused on the patient and hid their own difficult feelings behind a facade to protect the patients from any further burdening issues. The structural analysis resulted in the following two main themes: *To make yourself strong while feeling vulnerable inside* and *To live in a changed everyday life*.

5.1 | To make yourself strong while feeling vulnerable inside

The relatives composed themselves when they visited their loved ones in the neurological ward. Relatives built up a strength that appeared to be a facade. In a remarkable way, the relatives made an effort to hide their own sadness from the patients, to protect them from additional concerns. A granddaughter, who referred to the patient's strong physical pain, elaborated by saying: *I do not want to hurt her. I do not want her to worry. She has a lot on her mind right now given that she feels that way and I know that she hates being hospitalized.* (P3).

The relatives spoke about the patients as their ill loved ones and emphasized that the patients suffered due to the consequences of the disease and the need for hospitalization. The relatives clearly expressed that they had to restrict themselves even if it increased their vulnerability. The awareness of conveying strength in the presence of the patient was stated by a wife in the following quote:

I think it's terrible; it is a feeling of insecurity... when you walk through the door, you gather a lot of strength, because then you need to show something when you come up to an ill person, right? It is not useful if I come in crying, which I have done at home this morning. Then, you come in here and regain your composure. However, from the time you enter the door down there (referring to the main entrance) it is like this: "How does he look today? Is he doing well? What is he able to do?" An unrestrained unrest...

(P1)

Along with other statements, this quote illustrates how the relatives were challenged when illness and hospitalization became a reality in their lives. Relatives expressed a vulnerability that was perceived as living in constant anxiety and a renewable need to cry, even though they did not allow themselves to do so. A grandson illustrated how he suppressed his grief during the visit with his loved one:

The first time I visited her, I was there with my girlfriend and I completely collapsed when I got to the elevator after the visit. I collapsed three to four times before we returned to our bikes.... and I was very, very sad. (P5) *I want to be there for her and she should not see me crying.*

(P5)

This covers how the relatives wanted to demonstrate strength. This demonstration did not indicate that the relatives felt strong inside; rather, they forced themselves to appear strong for the sake of the patient. In the following quotation, it can be seen how the relatives' behaviour conveys strength, as a wife describes how her adult children come to her and say: *"Mom, you are healthy and you can walk and you can do this and you can do that and you are light-hearted" (...)* but no. *Deep inside you are not that at all.* (P1).

Nevertheless, the relatives also experienced a need to talk with someone other than the patient about how they felt. It was necessary to talk to someone about their feelings to be able to continuously handle the situation and preserve their strength. Mainly, the relatives turned to close friends and other family members when they needed to express their emotions. Clearly, speaking freely to others could help the relatives process what was difficult about their situation. However, they also experienced a dilemma when invited to open up and talk about how they felt because care from others could lead to a feeling of being exposed in an unpleasant way. One relative said: *Yes, I cannot help it, when someone ask me how I feel, I just try to say quickly: "I feel good," otherwise, I start crying (...)* I know I'm going to cry if I talk too much about it. (P4). This quote emphasizes how the relatives consciously tried to maintain the facade, not only towards their loved ones but also to others. On one hand, the relatives actively tried to keep the patient as the centre of attention and pushed themselves to the background. On the other hand, the relatives expressed that they themselves felt lonely and in need of care. Otherwise, they could feel neglected, which is illuminated in the following two quotations:

Nobody asks me how I feel; it is all about [name of the patient]. (...) I am hurting and I have an eternal unrest in my body - it is difficult to describe. (P3) You are carrying a lot yourself, you are very lonely, I think.

(P4)

5.2 | To live in a changed everyday life

The sudden placement into the role as a relative of an ill person caused the everyday lives of the relatives to immediately change. The relatives experienced a constant concern for what the future would bring. At the same time, the hospitalization of their loved ones affected their normal everyday lives because they could not maintain common everyday routines. One wife explains the impact on her usual hobby:

For example, I usually go to gymnastics every week, but I have not been there for weeks... Because then I have to leave him... so no, all my appointments I plan for him. I am here every day... my needs always come second (she looks at me with eyes that become wet and then tears fall down her cheeks).

(P4)

As shown in this statement, the relatives re-organized their lives to make the ill loved one the first priority. Such re-organization meant that they oppressed their own routines and needs. The wife continued: *Yes, you put everything aside... everything aside and then you only concentrate on the patient (P4)* and another relative explained it as follows: *She is the only thing on my mind, all the time (P3)*. The uncertain future, in particular, including insecurity about what could be expected, led the relatives to place the patient in the foreground, as clarified in the following statement:

Right now, this is my first priority... just to make sure he is doing well. However, because of his diagnosis, I might possibly lose him soon... For me it is simply important to spend time with him.

(P6)

This description is in line with other statements; the uncertainty about the course of the disease affected the relatives on an existential level because they were afraid of losing their loved ones. Love between the relatives and the patients made it an existential challenge to live with uncertainty and the fear that the worst, in terms of death, could happen. Moreover, a fear of the patient suddenly dying while they were not present made it difficult for the relatives to balance their everyday lives, as illustrated in the following quote:

I want to be there... it is probably that shitty balance, but I cannot just drop all my stuff. I am not going to have a guilty conscience for prioritizing my own things... but

what if she... just in one moment when I prioritize myself, it is over... so, it is always a balance between what I know is reasonable and what does not matter.

(P5)

The threatening death of the loved one was not the only concern that the relatives expressed about the future. They also feared that the patient would be forever changed due to the diagnosis and its symptoms, thereby affecting their relationship and shared life. One spouse said: *Is he going to be all right? Will he be able to come home and manage on his own and will he be able to walk? Because, if he cannot walk, I cannot take care of him. (P4).*

Existentially, it depressed the relatives not to know what to expect and the anxiety surrounding this uncertainty was prominent in several of the relatives' statements: *When I came home last night, I thought: "What happens? Do they call me? Do I have him tomorrow?" (P1)* and: *I carry two telephones around all the time while his is at the hospital. I am thinking, if they call and... (...) he was very ill and I thought: "Is he going to make it?" (P4)*. These quotes illustrate how the everyday life of the relatives was changed, not only according to routines but also due to existential feelings of worry, anxiety and unrest. The constant state of an inner existential unrest burdened the relatives' mental well-being and altered their previous state of being. Nevertheless, most of the relatives pushed themselves to be around the patient in the ward for many hours every day. One daughter elaborated:

I am sitting in this chair for many hours every single day. I might go to buy something in the kiosk and go for a walk outside, but then I will be sitting here again. You may not understand that you can get tired from just sitting, but when I get home, I'm ready to go directly to bed.

(P6)

Another relative stated: *I cannot let him down, you know, by saying: "Therefore, now he is in the hospital, he is in good hands, so I do my own things." No, I don't think I can do that, so of course I will be here (P2)*. The sense of responsibility was remarkable and was related to an obligation to be there for a loved one in need.

6 | CRITICAL INTERPRETATION AND DISCUSSION

The present study identifies two novel findings. First, it shows how relatives, regardless of the relationship to the patient, perceive the patients as their *loved ones*. Second, that the relatives put on a *facade* when they are around the diseased in the hospital.

In this material, it is illuminated that the relatives reflect their relationship to the patients as their *loved ones*. Several studies have addressed the experience of being related to someone with an illness, and the studies identify how relatives are broadly conceptualized, for example next of kin, significant other or informal caregiver (Blom et al., 2013; Houldin, 2007; Linnarsson et al.,

2010; Martinsen & Norlyk, 2013; Morphet et al., 2015; Pereira & Bothelho, 2011). The fact that our study illuminates how relatives perceive the patients as *loved ones* is valuable and new knowledge because it emphasizes the relationship of love. According to the Danish philosopher Soren Kierkegaard (1813–1855) (2013), love is a basic psychological state in humans. Love is, as Kierkegaard states, a dynamic movement, that is something that “is” and does not have to be proven. Kierkegaard emphasizes that what is interesting is not the existence of love but how it is and how it appears. When you love someone in a loving way, the love becomes self-denying and self-giving which, according to Kierkegaard, means that you do not act based on your own interests. Rather, you are what the love makes you. In this light, the relatives' behaviour from the present study can be considered a relationship of loving love. Relatives leap whole heartedly into the relationship of love and reflect themselves in this love. Thus, the illness becomes an existential matter for the relatives. This observation means that the relatives become self-denying and self-giving when they choose to prioritize the patient over themselves. In this view, the relatives change as human beings because of their love for the patients—not only in a practical sense but also existentially.

The Danish psychotherapist Marianne Davidsen-Nielsen (2010) is concerned with how life is grasped when illness and death affect people existentially. According to Davidsen-Nielsen, severe illness threatens normal existence, as shown in our study. Davidsen-Nielsen notes that people must change to live with existential threats; people need to be able to mourn. In grief, you can detach from what was and then relate to what is and this process changes people (Davidsen-Nielsen, 2010). This phenomenon can explain the changing lives of the relatives, wherein they change on an existential level in terms of the way they live and the way they are. Although it is similar to walking a tightrope and despite the vulnerability, they all accept the responsibility to be there for a loved one in need.

Our study highlights that being a *loved one* does not depend on the title of the relationship. Based on the existential vulnerability, the grandchildren in our study have a similar relation of love to the diseased as the participants who are a daughter, brother or wife. Currently, there is also a great focus on relatives and family patterns as a diverse group, wherein family ties are not the main decisive factor for determining the closeness of a relationship (Keim, 2011). Our findings support this focus. The existential vulnerability the relatives experience and the way it existentially challenges them are also reported in studies by Blom, Gustavsson, and Sundler (2013), Ågård and Harder (2007) and Christensen and Probst (2014), which are based on relatives of patients admitted to the ICU. The studies found that relatives experience an insecurity and uncertainty; moreover, relatives feel vulnerable both in relation to the patients' situation and to their own. From these findings, it can be concluded that relatives of acute neurological patients may be just as vulnerable and existentially challenged as relatives of patients in the ICU.

The second major finding in this study is that the relatives' existential challenge and the struggle to balance their life are hidden away behind a facade when they visit their ill loved ones. The relatives do not want to bother their loved ones with their own difficult feelings; instead, they try to handle the situation on their own, which leaves them with a feeling of loneliness. That relatives find it difficult to speak to the patient about their own existential thoughts and feelings and therefore, feel lonely, are supported by findings from other studies (Engström & Söderberg, 2007; Martinsen & Norlyk, 2013). However, it has not been previously described how relatives actively and deliberately put on a facade when they are present in the ward and thus refrain from talking about what is difficult. This finding indicates that the relatives try to protect themselves when they do not talk to their loved ones about their existential feelings. Accordingly, this study provides new knowledge by highlighting that the relatives try to protect their loved ones by hiding their own vulnerability behind a facade. Returning to the thinking of Davidsen-Nielsen (2010), she describes the phenomenon of *the shield of love*. The shield of love is to be considered a protective mechanism when something threatens a closely related group of people—in this case, when illness threatens one's life and function. The shield of love helps the group to maintain order and balance in the group or family “system” because it allows the system to function as usual, as if nothing has changed. However, at the same time, the shield of love leads to a shaken relationship that is characterized by distance, wherein openness and honesty are not prominent (Davidsen-Nielsen, 2010). Although the present findings illuminate how the relatives' vulnerable situations change the way they live and the way they fundamentally are, these findings also show that the relatives try to protect the relationship to their loved ones and maintain everything as it used to be. The relatives do not dare to be themselves, showing their existential vulnerability when together with the patient. A truer presence appears when you dare to be yourself, but in a changed way (Davidsen-Nielsen, 2010). Davidsen-Nielsen argues that development and change occur when you present your true self. By using the shield of love, the relatives oppose such change and even help create their own loneliness.

Seen in the light of Davidsen-Nielsen's theory, our findings emphasize that relatives should dare be themselves and show their vulnerability to undergo a necessary change in life. However, because of the relationship of love where the relatives invest something of themselves, at the same time, they must protect themselves and their loved one. The relatives are sheltering themselves under a shield of love to cope with the present, facing the challenges brought on by illness and symptoms. As Davidsen-Nielsen stresses, it is also important to be able to repress your own reality, but it is equally important to find the courage to face the reality (Davidsen-Nielsen, 2010). The Kierkegaard-inspired nursing theorist Kari Martinsen (2012) states, in regard to vulnerability, that being vulnerable is a fundamental part of our lives because vulnerability is a precondition for empathy for the suffering of others and an invitation to be cared for. From this point, she

underlines the strengths of human vulnerability. Seen in that light, the findings of existential vulnerability among relatives of patients in acute neurological wards are positive as long as the relatives receive the help they need to balance the existential challenges they face.

6.1 | Limitations

The present study illustrates how six relatives experience feeling existentially challenged when their loved ones are admitted to an acute neurological ward. Due to the phenomenological–hermeneutic character of this study, quantity was not the priority (Polit & Beck, 2006). Therefore, the findings are considered contextual (Polit & Beck, 2006; Ricoeur, 1976), which means that other interpretations are likely to be found in other contexts and settings. Our results, however, reflect lived experiences that may have relevance to a wider range of close relatives in acute and semi-acute neurology settings. It is important to be aware of the civil state of the participants. None of the participants were employed full-time in a workplace; rather, they were unemployed, retired or in school. Moreover, the age of the participants was categorized primarily as young adult or older. Further research may advantageously expand the existing knowledge by investigating relatives' experience across a wider range of civil states and ages.

7 | CONCLUSION

This study concludes that relatives of patients in acute neurological wards are emotionally vulnerable primarily due to a relationship of love to the patients. By sheltering themselves under a shield of love, the relatives find the strength to be affectionately supportive. This sheltering includes the development of a facade that hides the comprehensive upheaval in their lives. In secret, the relatives experience an omission of normal routines and a suppression of a wide range of personal needs. This situation is experienced as a demanding existential effort, which emphasizes a need for nurses to encounter the existential vulnerability when addressing relatives in the ward. Moreover, these findings emphasize the importance of recognizing the shield of love as a mechanism that can lead relatives to instinctively oppose the efforts of change that they are forced to face and experience a challenging loneliness. Thus, it is of great importance that nurses provide care that supports the relatives in appropriate ways as they navigate within the shield of love.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

LTH, MB, CS: conception and design; data acquisition, analysis and interpretation; drafting the manuscript or revising it critically for important intellectual content; final approval of the version to be published; and responsible for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

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