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Being disconnected from life: meanings of existential loneliness as narrated by frail older people

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ABSTRACT

Objectives: This study illuminated the meanings of existential loneliness (EL) as narrated by frail older people.

Method: Data were collected through individual narrative interviews with 23 people 76–101 years old receiving long-term care and services. A phenomenological hermeneutical analysis was performed, including a naïve reading and two structural analyses as a basis for a comprehensive understanding of EL.

Result: Four themes were identified related to meanings of EL: (1) being trapped in a frail and deteriorating body; (2) being met with indifference; (3) having nobody to share life with; and (4) lacking purpose and meaning. These intertwined themes were synthesized into a comprehensive understanding of EL as 'being disconnected from life'.

Conclusion: Illness and physical limitation affects access to the world. When being met with indifference and being unable to share one's thoughts and experiences of life with others, a sense of worthlessness is reinforced, triggering an experience of meaninglessness and EL, i.e. disconnection from life. It is urgent to develop support strategies that can be used by health care professionals to address older people in vulnerable situations, thereby facilitating connectedness.

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Existential loneliness; frail; older people; interviews; phenomenological hermeneutical method

Introduction

Discovering and addressing existential loneliness (EL) among older people are challenges for health care. Research demonstrates that older people in general (Broström, 2014; Hallberg, 2004), older people receiving municipal care during the last period in life (Andersson, Hallberg, & Edberg, 2008), and severely ill people at the end of life (Ågren Bolmsjö, 2002) need to talk about existential issues. Talking with others about existential issues is important, but several studies indicate that doing so is difficult for health professionals (Adelbratt & Strang, 2000; Beck, Törnquist, Broström, & Edberg, 2012; Lundmark, 2006). The need to talk about existential issues is not always clearly expressed by care recipients and might therefore remain unknown to care staff (Strang & Strang, 2001), meaning that frail older people risk being left alone with their thoughts. When existential needs are not recognized and addressed, this can lead to feelings of EL that in turn affect health and well-being.

Being older and in the last period of one's life often involves a complex of symptoms and problems (National Board of Health and Welfare, 2011), increasing one's vulnerability and frailty. Frailty is defined in several ways, usually as a progressive age-related decline resulting in decreased reserves of capacity and an increased risk of adverse health outcomes (Fried et al., 2001; Rockwood, 2005). Being old and frail likely affects a person's life situation in terms of dependency on others and can, according to a conceptual analysis by Ettema, Derksen, and Leeuwen (2010), trigger experiences of EL. EL is one of several types of loneliness described in the

literature. Loneliness is a complex concept that relates to physical aspects (Queen, Stawski, Ryan, & Smith, 2014), especially needs for closeness and touch, and to social aspects (Cacioppo & Patrick, 2008), such as needs for human relationships. Both aspects can appear throughout the life course, but are more often present as people age and their social networks shrink (Dykstra, van Tilburg, & Gierveld, 2005). Loneliness in its existential form is described in the literature as EL. EL runs much deeper than simple loneliness and is described as an unavoidable condition of humanity (Mijuskovic, 1979; Moustakas, 1961; Yalom, 1980). EL is usually described in association with death, dying, and cancer (Sand & Strang, 2006; Sand, Strang, & Milberg, 2008) when questions about the meaning of life come to the fore. Yalom (1980) describes EL as existential isolation, arguing that, despite interpersonal relationships, there is an insurmountable gap when human beings are totally alone (Yalom, 1980). EL has also been described as existential suffering, including fear of death and of being alone (Sand & Strang, 2006). Most research into EL has concentrated on theoretically understanding the concept itself (Ettema et al., 2010), while empirical research into EL has emphasized end-of-life care, especially among patients diagnosed with cancer (Sand & Strang, 2006; Sand et al., 2008). There is thus a need for better knowledge of older people's experiences of EL. A concept analysis (Ettema et al., 2010) of EL emphasizes that it is a multifaceted condition of human existence, as one is always and fundamentally separate from others, i.e. there is a total absence of relatedness. Ettema et al. (2010) further describe EL as a process in which negative

experiences can be confronted and thereby transformed into positive experiences (Ettema et al., 2010). However, EL is mostly described in negative terms such as suffering, even though its outcome might lead to positive experiences that can contribute to maturity and inner growth (Brown, 1996) and be constructive if recognized and validated by others (Browall, Henoch, Melin-Johansson, Strang, & Danielson, 2014). Several researchers (Andersson, 1998; Boston, Bruce, & Schreiber, 2011; Ettema et al., 2010) have identified a need for clarity concerning EL, so that patients' experiences can be better understood. Affirming older people's existential thoughts and questions might lead to strengthened health processes (Luo, Hawkey, Waite, & Cacioppo, 2012) and contribute to an experience of meaning in life. Our knowledge of frail older people's experience of EL is limited, and improving this knowledge could guide the development of supportive measures by health care professionals. The aim of this study was, therefore, to illuminate meanings of EL as narrated by frail old people.

Methods

Design

The design of the study was descriptive, inspired by Ricoeur's (1976) interpretation theory and by the phenomenological hermeneutical method of Lindseth and Norberg (2004). Understanding a text, here a frail older person's narratives about EL, entails following the text from what it says to what it talks about (cf. Ricoeur, 1976). The process of interpretation implies dialectic movement between three steps: naïve understanding, structural analysis, and comprehensive understanding.

Context

About 10% (850,000) of the Swedish population is 75 years or older (SCB, 2016), 45% of whom, especially women, live in single-person households. Of the population 75 years or older, 12% receive municipal home support and 5% live in residential care facilities (RCFs) (National Board of Health and Welfare, 2016; SCB, 2016). Three-quarters of all deaths in Sweden occur at age 65 years or older (National Board of Health and Welfare, 2015), the vast majority in hospitals and RCFs (Håkanson, Öhlén, Morin, & Cohen, 2015). Older people's children and other family members commonly live far away. Sweden is described as among the most secular and individualistic societies in the world (Inglehart, 2015). The Swedish health care system is financed primarily by taxes. The provision of long-term care and services for older people is within the remit of municipalities and is preceded by needs assessments. This study included participants from different contexts in Southern Sweden; primary health care center specializing in older people, municipal home care, RCFs, one hospital ward, and specialized palliative care either in-home or in-patient care. This study is part of the LONE study (Edberg & Bolmsjö, submitted).

Participants

In all, 23 people participated in individual interviews. The inclusion criteria were being 75 years or older, frail, and capable of and interested in participating in an interview

Table 1. Characteristics of the informants.

Characteristics	<i>n</i> = 23
Men/women	12/11
Age, years, median (range)	85 (76–101)
Widowers/widows	6/10
Single households/cohabiting	19/4
Care context	
Outpatient primary care center	2
Homecare	4
Residential care	8
Hospital	2
Specialized palliative home care	6
Specialized palliative ward	1

in Swedish. As the common criterions for frailty, i.e. 'a clinical syndrome in which three or more of the following are present: un intentional weight loss (10 lbs in past year), self-reported exhaustion, weakness (grip strength), slow walking speed, and low physical activity' (Fried et al., 2001), could not be operationalized in our study, we used the umbrella definition 'in need of long-term care or services due to health problems' to capture the target group. The participants were identified by a designated contact person at each care unit who provided the participants with oral and written information about the study. If the potential participants were interested, the contact persons informed the researchers, who then contacted the participants; if they were still interested, the participants determined a time and place for the interviews. In addition, one person volunteered to participate when researchers visited the RCF. The characteristics of the participants are presented in Table 1.

Data collection

Data were collected through individual narrative interviews (Kvale, 2007) conducted in the participants' ordinary housing, RCFs, or specialized palliative care ward. The interviews were conducted between February 2015 and July 2016 by two of the authors (MS and IB) working together, using open questions and probes to stimulate narration. After initial conversations that allowed the participants and interviewers to get acquainted, the participants were asked to narrate experiences of loneliness in general. We then made this statement, 'We are particularly interested in your experiences of a deeper feeling of loneliness, called existential loneliness, a feeling that can come and go and be more or less intense', followed by the question, 'Could you please describe a situation when you experienced existential loneliness?' Additional probes such as 'Can you tell us more about this?' were used to deepen the narratives, and summary statements were made to confirm the interpretation of what had been said. The interviews, which lasted a median of 61 minutes (range, 36–147 minutes), were digitally audio recorded, transcribed verbatim by a secretary, and validated by the first author. After each interview, reflective notes were taken (Polit & Beck, 2013). These notes focused on the interview settings, disturbances during the interviews, and the interviewer's impressions and thoughts about the interviewee's appearance and reaction to the interview as a whole. For this study, data concerning the participants' experience of EL were selected for analysis; data concerning strategies for managing EL will be treated elsewhere.

Data analysis

The data analysis process followed the steps described by Lindseth and Norberg (2004), i.e. naïve reading, structural analysis, and comprehensive understanding.

Naïve understanding

Interviews and field notes were first read several times to grasp their meaning as a whole, i.e. the naïve understanding of meanings of the EL phenomenon. The narrated experience of EL varied between participants and was difficult to express explicitly, but surfaced in described situations of, for example, meaninglessness and helplessness. The naïve understanding was that being unable to share thoughts and feelings with others as well as experiences of powerlessness and meaninglessness triggered experiences of EL, as did experiences of losing freedom and being dependent on care, as the lived body became frail with increasing functional losses.

First structural analysis

Informed by a naïve understanding of the texts, the first structural analysis was performed in which the texts were systematically analyzed. The first structural analysis concentrated on the content of each interview, inductively exploring dominant themes in the participants' narrated experiences of EL, i.e. stories or descriptions of various lengths having a beginning, middle, and end (Riessman, 2008). In each interview, meaning units concerning experiences of EL were identified, coded, and sorted into tentative themes. This analysis was conducted separately by all four authors, who then came together to discuss their understandings of the texts. Several themes were identified as recurrent in several participants' narratives (e.g. 'I feel trapped by physical limitations'), while other themes were articulated by only a few participants (e.g. 'I feel that no one is interested in my cherished possessions'). In one interview (8), no dominant theme related to experiences of EL could be identified (Table 2).

Second structural analysis

The tentative themes identified in the first structural analysis guided the second structural analysis. In this analysis, the meaning units from all interviews about EL relating to (1) the body, (2) sharing experiences, and (3) meaningfulness were merged into a new text. This step was conducted by all four

authors, first separately and then together, who reflected on and discussed what the text talked about. This analysis focused on meanings of EL, applying a more interpretive approach and identifying four themes.

Ethical consideration

As this study involved vulnerable and frail older people, the interviewers strove to be sensitive, respecting the participants' integrity and stamina. The participants were followed up by phone the day after the interviews. The study upheld research ethics principles (Beauchamp & Childress, 2013; WMA, 2008) and was approved by the Regional Ethical Review Board in Lund, Sweden (2014/652).

Author perspectives

The first author (MS), a doctoral student, has work experience in specialized palliative care. The second author (IB), a PhD, has work experience in specialized palliative care and a research focus on general palliative care for older people. The third author (BHR), a professor, has work experience in palliative hospice care and a research focus on specialized palliative care. The fourth author (AKE), a professor, has work experience in geriatric nursing and a research focus on care of frail older people and palliative care. All authors were women and registered nurses and thus had a nursing perspective. The analysis was continuously discussed in a wider research group and with a reference group of stakeholders.

Trustworthiness

The phenomenological hermeneutic method requires that the trustworthiness of the study is considered within a naturalistic approach (Lincoln & Guba, 1985). One such aspect concerns the quality of the interviews. To ensure interview quality, the interviews were conducted by one PhD student working with a PhD experienced in interviewing. There is a risk that the analysis and findings may be colored by the authors' perspectives. To counteract this possibility, the analysis was continuously discussed by the authors, in a research group comprising researchers in the fields of nursing, ethics, and human geography and in the reference group of stakeholders. The interviews were conducted within a relatively

Table 2. Dominant themes in the individual interviews

Themes
• I feel trapped by physical limitations (1, 2, 3, 4, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23)
• I am lacking a meaningful everyday life (2, 10, 12, 13, 14, 17, 19, 20)
• I feel left out of community (1, 2, 4, 7, 12, 14, 16, 23)
• I miss someone to share my thoughts and interests with (1, 2, 5, 7, 13, 15, 16)
• I feel betrayed by people of importance (1, 3, 4, 10, 13)
• I feel left behind (4, 5, 15, 18, 20)
• I feel that no one sees me as a unique person (1, 7, 10, 23)
• I don't feel at home (7, 10, 21, 23)
• I feel exposed to others (1, 10, 13)
• I long for spiritual contact (2, 9, 16)
• I long for intimacy (7, 9, 18)
• I am tired of waiting for someone to come (2, 7, 10)
• I fear what will come (6, 7, 15)
• I feel useless/helpless (10, 21, 23)
• I feel that no one is interested in my cherished possessions (1, 16)
• I feel emptiness and loss (10, 12)
• I am done with life (12, 18)
• I am ashamed of and feel guilty about the person I have become (17, 19)

Note: The numbers (1–23) refer to interviews in which the themes were significant.

Table 3. The experience of existential loneliness as narrated by frail older people.

Overarching theme	Themes
Being trapped in a frail and deteriorating body	Being met with indifference Having nobody to share live with Lacking purpose and meaning

short period (18 months) using open-ended questions designed to stimulate narration as a basis for all the interviews.

Findings

The meaning of EL as narrated by frail old people was understood as (1) being trapped in a frail and deteriorating body; (2) being met with indifference; (3) having nobody to share life with; and (4) lacking purpose and meaning. The first theme was considered an overarching theme due to its close interrelatedness with the other three themes (Table 3).

The themes should be seen as inseparable and not mutually exclusive, so the experience of EL may encompass more than one theme simultaneously. For clarity, the themes will be presented under separate headings. The quotations presented below are translated with pauses, faltering, and repetitions removed, to improve readability. In the text, the words of participants are presented in italics. All participants are given assumed names.

Being trapped in a frail and deteriorating body

In narratives about EL, many of the situations described concerned experiences of living with and being trapped in a frail and deteriorating body. Caring for one's basic needs, moving from one room or place to another, visiting family and friends, and going outdoors had become impossible without assistance from family and/or health professionals and using assistive devices. Consequently, most of the time was spent indoors, in isolation. Being dependent on others, in turn, limited the ability to preserve autonomy and control over life and increased feelings of helplessness and vulnerability. Bodily changes such as losing abilities to hear, see, and talk, inability or lack of energy to establish new relations, or participate in events not adapted for the use of assistive devices, as well as loss of close friends and relatives, were closely related to feelings of isolation. Increasing loss of abilities increased the fear of being a 'package', leading to the realization that death is inevitable and might be a relief. When what used to be meaningful in life became impossible, due to lack of energy or opportunities to develop new interests, or irrevocable and irreparable past choices were regretted, experiences of EL moved to the forefront.

Being met with indifference

Narratives about EL concerned experiences of being treated with indifference, such as not being included or treated seriously, not being listened to, and/or being ignored or treated as non-existent. Most such situations related to health care staff, but some involved relatives. Being treated with indifference was said to evoke feelings of worthlessness and abandonment.

The described situations could involve information about one's own health and care being withheld and health care

professionals or others 'taking over' and deciding what to do. This was experienced as hindering one's decisions about life as a whole. As Ove, sitting in a wheelchair following a fractured hip, said:

P: ... It annoyed me ... if there is something that is not done properly, I tell them ... I: Don't they listen to you then? P: ... No, not at all ... They take it for granted that you are already 'lost' when you come here ... (23)

Being met with inappropriate cheerfulness and not being taken seriously were also experienced as expressions of indifference. Other such situations included being addressed impersonally and disrespectfully by those who were expected to offer help and support; for example, Sally felt that she was invisible and not seen as valuable by her relatives:

They are so stressed ... but when they eventually come, they never say 'Is there anything you need help with?' ... and I mean, they can obviously see that I am in a wheelchair ... I think it is more peaceful when they are not here. (1)

Experiencing the body as being invaded by intrusive care evoked feelings of being just an object. As Ulla, who experienced shortness of breath, dizziness, and fatigue, and felt that she was an object, said:

I don't think ... that they can say 'you can get out of bed before we come and start in the bathroom' ... I then have to stand there and wait ... And they did not help me to shower, because it takes too long. I am so sad that I cry ... You are not regarded as a human being, but as ... a thing to 'make up' and then leave again. (13)

Having nobody to share life with

EL surfaced in situations of being alone and having no one with whom to share daily activities, interests, thoughts, and feelings. In addition, lack of physical intimacy, such as receiving or giving bodily closeness, was described as evoking feelings of sadness, sorrow, emptiness, and abandonment.

The text revealed reduced opportunities to share significant aspects of life, as friends had died and family members, staff, and fellow residents seemed uninterested in listening to individual life stories. Finding new friends was not an option in the present context. As sharing seemed fundamental to life, feelings of not wanting to continue living were expressed. As Inge, bedridden and nearly blind, said:

Yes ... I feel really lonely sometimes ... like being the only person in the world ... having nobody ... feeling ... useless, so to say. Then, again, I think about leaving ... leaving this present life ... Oh, what a relief, I think. (2)

Having nothing in common with people in one's surroundings resulted in eating alone or withdrawing from other people, as this reduced feelings of loneliness. Donald, who could not move without help and was forced to sit in the dining room, said:

When I am in the dining room I don't hear anyone ... the only voices I hear are the staff's and what they are talking about ... They are sitting talking with each other about their own interests ... and that is nothing that interests me ... I have never been as lonely as in this place. (7)

The text contained descriptions of a desire to share inner thoughts and feelings about death and dying. Sharing these experiences seemed difficult, however, especially with close family members. Gerth, who does not believe that he will live much longer, said:

... there is no return, I cannot talk about it ... I just cry ... It sometimes happens that I think that it has been quiet for too long, and then I call my sister ... But then it is difficult, it ends up with me crying. This makes for an odd end to the conversation, as there is much more to talk about... It is difficult to handle emotions... (16).

EL was also experienced when no one was interested in or willing to take care of significant personal valuables, i.e. requests to family members were ignored. This was described as a lack of control over how and by whom personal valuables would be taken care of when one is no longer in the world.

Lacking purpose and meaning

A lack of purpose and meaning surfaced in the narratives about EL, for example, when there were no longer any life purposes to fulfill and when one did not belong to a community or was no longer a valuable member of society. This lack of purpose and meaning was described as existence in a 'vacuum' that evoked feelings of being lost, of being in 'the waiting room' for, and looking forward to, death.

The described situations related to experiences of being lost in life, as former purposes and meanings no longer had any value, as meaningful aspects of life were successively cut off. Dear ones had disappeared and the body lost more and more abilities. What remained was a boring and meaningless everyday life comprising either no activities at all or participation in activities of no interest simply to fill the day. Robin, with incurable cancer, said:

I interfere in every small damn thing ... And my wife says, hell, you have never cared about this before ... I ask her if she has tried another dishwasher detergent as it seems cheaper than the other ... but I know myself ... often it is just because I have nothing else to do ... something sensible ... what the hell am I going to do today? (19)

Boredom and having nothing to look forward to, constantly waiting for someone or something to relieve the gloom, were closely related to a wish not to continue living and a view of death as a relief. Ruth, who had had both legs amputated and spent most of her time in bed, said:

I don't want them to revive me if something happens ... this is enough ... I can't see any meaning in that ... lying in a bed staring at the walls, what's the meaning?... No one comes out of here alive ... it's the waiting-room for death (12).

Although a lack of purpose and meaning led to thoughts of death as a relief, unexpected situations or events could restore meaning to life, making it worth living again. For example, staff members saying or doing something positive or providing unexpected support, or family members visiting, could restore interest in life for a moment, placing feelings of EL in the background.

Discussion

The comprehensive understanding was based on the researchers' pre-understandings, the naïve understanding, and the themes validated in relation to the literature (cf. Lindseth & Norberg, 2004). The comprehensive understanding of EL among frail older people was 'being disconnected from life', an experience of at least momentary abandonment, being left to one's destiny and living a meaningless life. Feelings of being both disconnected from life and marginalized emerge when one lacks connectedness, characteristically in situations of vulnerability and purposelessness. EL among

older people comprised primarily negative dimensions, in line with previous research involving other target groups (Avieli, Mushkin, Araten-Bergman, & Band-Winterstein, 2016; Mayers & Svartberg, 2001; Sand & Strang, 2006).

Bodily frailty and physical limitations were pervasive threads in the narratives about EL. These characteristics limited access to the world ('life had come to a standstill'), leading to increasing isolation and dependence on others to meet basic needs – an experience far from that of normal life. Merleau-Ponty (1968/2002) emphasized the body as a 'lived body' where all aspects of existence are intertwined, enabling communication with others. Being frail and old communicates vulnerability and dependency, in turn reinforcing an unrecognizable self-image. According to Merleau-Ponty (1968/2002), the body is the personality made manifest, creating and conveying meanings, emotions, memories, and thoughts. As the 'lived body' is the basis of being, a frail and dependent body could lead to a sense of disconnection. The lived body allows access to the world, but when threatened by illness and physical limitation, it limits access to the world, i.e. threatening human existence.

Frankl (1959/1987) described the feeling of purposelessness as an 'existential vacuum', an inner empty space created by an absence of meaning. When humans lack meaning in life, they confront this empty space and existential questions such as 'What is the purpose of my life?' According to Tillich (1952/2000), this threat to existence, i.e. meaninglessness, causes anxiety. In such situations, humans need courage to affirm themselves and strength to overcome anxiety. According to Frankl (1969/2014), humans have a drive to find meaning. Meanings of life are tied to specific individuals and specific times and life situations (Frankl, 1969/2014). In the present study, the older people were aware of their own vulnerability and expressed feelings of helplessness and worthlessness. Someone had to help them 'move on' to experience meaning in their new life situation. As Løgstrup (1956/1997) noted, we as people are interdependent. Disconnection from life was experienced in reaction to inability to come close to and influence or be influenced by another person's life. Being met with indifference and not being able to share one's thoughts and experiences with others reinforced the experience of EL (Figure 1).

The older persons' frail bodies lacked strength, resulting in vulnerability to others' willingness and opportunities to give care. This appeared in the findings as a sense of being trapped in a frail and deteriorating body, being isolated from the outside world. Frailty also made the participants dependent on health care professionals and relatives. Being dependent for care implies, according to Strandberg, Norberg, and Jansson (2003), being exposed and subjected to others' ability and benevolence, and not being in a position to choose between good and bad care. Instead it is a struggle for survival (Strandberg, Åström, & Norberg, 2002), a struggle about the value of oneself as a person, i.e. identity and proving oneself deserving of care. This insight is supported by the present findings: being met with indifference reinforced the experience of being worthless, in turn impairing the sense of dignity and triggering the experience of disconnection from life.

The absence of a sense of being valued and of importance can lead to a desire for life to end. This was seen in the findings as a lack of purpose and meaning in life, death being described as a relief. van Wijngaarden, Leget, and Goossens (2015) investigated the phenomenon 'life being completed

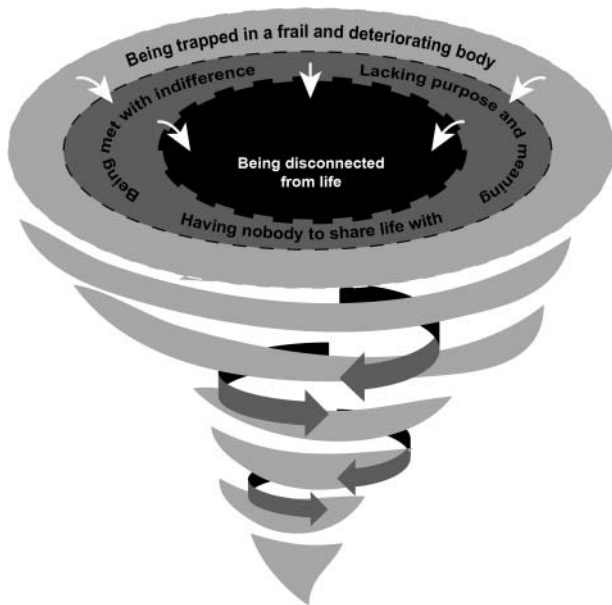


Figure 1. The meaning of existential loneliness.

and no longer worth living' among older people. The phenomenon was understood as 'a tangle of inability and unwillingness to connect to one's actual life'. The present findings indicate that the experience of EL was related to a restricted life situation, triggered by the environment. On the one hand, life was seen as meaningless; on the other hand, incidents and people could intervene, returning light to life for a moment and displacing EL. This is in line with Paterson (2001), who noted that people with chronic illness hover between illness and wellness perspectives, i.e. foreground and background. When someone or something intervenes, unexpectedly or not, it is possible to shift perspective (Paterson, Thorne, Crawford, & Tarko, 1999). It seems to be an important challenge for health care professionals and relatives to reinforce the wellness perspective and a sense of connectedness, while paying attention to older people's thoughts and beliefs about death and dying (cf. Hallberg, 2004). This could be accomplished using a holistic approach based on the needs of the specific person, for example, in a model of person-centered practice (McCormack, Dewing, & McCance, 2016) based on knowledge of the person's beliefs and values.

Sharing significant aspects of life with others seems difficult especially when one is old, frail, and dependent. This appeared in the findings as having nobody to share life with, since family members and friends were absent and staff and fellow residents seemed uninterested. Furthermore, sharing experiences about existential concerns is emotionally difficult. The findings indicate that it was easier to talk to people who were not personally emotionally connected, such as care staff. However, several studies find that health care professionals have difficulties talking about existential concerns (Adelbratt & Strang, 2000; Lundmark, 2006), and that conversations about death and dying are experienced as unnatural and emotionally demanding (Beck et al., 2012). However, EL apparently does not primarily concern death in itself, but rather an awareness of being vulnerable and mortal as a human being (Carter, 2000; Mijuskovic, 1980). If EL is acknowledged and addressed, it can lead to existential growth and meaning, so it is important for health care professionals to develop support strategies based on knowledge of older

persons' own strategies to reduce EL. This matter merits further elucidation in future research, which could use the present findings as a basis.

Strengths and limitations

The interviews were performed by two researchers working together but with different roles, one being responsible for the conversation and the other for taking notes and, when necessary, asking questions to deepen the conversation. This procedure can be seen as both a strength and a limitation. The researchers' roles were determined in advance, but were flexible depending on to whom the interviewee turned. Although this procedure strengthened the study's credibility, there is a risk that the interviewees might have experienced a power imbalance. To ensure that the interviews had no negative effects on the interviewees, all participants were phoned the day after the interview. Other strengths of the study are that the interview text is rich (cf. Kvale & Brinkmann, 2014), illuminating various aspects of EL, and that quotations from the transcribed interviews are provided, making the basis of interpretation evident to the reader (Lincoln & Guba, 1985). All authors agreed that the findings represent the most trustworthy understanding of the text. From the readers' perspective, it is also important that the findings convey insights and meanings that are understandable and applicable in their own practice in a new and expanded way (Lindseth & Norberg, 2004).

Concerning transferability, there is a risk that the participants might not be representative of frail older people in general. The contact person at each unit identified eligible participants, so there is a risk that some eligible people may not have been asked to participate. As this study included only people who were interested in and capable of sharing their experiences, the findings must be interpreted with caution. The inclusion criteria included being able to participate in an interview in Swedish, leading to the low representation of older people with immigrant backgrounds. Contextual factors must, therefore, be considered when transferring the results.

Conclusion

This study demonstrated that the threatening of the lived body by illness and physical limitation affects access to the world, i.e. human existence is threatened. Being met with indifference and being unable to share one's thoughts and experiences of life with others reinforces a sense of worthlessness, triggering an experience of meaninglessness and EL, i.e. disconnection from life. These results recall those of earlier research into EL in end-of-life and cancer care, but add knowledge of the experiences of older people who do not have directly life-threatening conditions. The results highlight that these aspects are important when one is in need of care and services, being dependent on others and having limited freedom of choice. There is a need for further research into how older people themselves can alleviate EL, as this seems to be an important factor contributing to experience meaning of life. This could in turn add important knowledge constituting a basis for developing support strategies for use by health care professionals to address older people in vulnerable situations, thereby facilitating connectedness.

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