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Being acknowledged by others and bracketing negative thoughts and feelings: Frail older people's narrations of how existential loneliness is eased

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Abstract

Aims and objectives: The aim of this study was to describe how EL was eased, as narrated by frail older people.

Background: Existential loneliness (EL) is an unavoidable part of the human condition. It is a complex phenomenon that has been described as disconnection from life. If EL is acknowledged in the care of older people, the experience of EL can be reduced.

Design: In this qualitative study, we used an exploratory and descriptive design.

Methods: The study was based on 22 narrative interviews with frail older people, 76 to 101 years old, who were receiving long-term care and services. We analysed the data using conventional content analysis.

Results: Being acknowledged by others, that is, being the focus of others' concern, eased the experience of EL, as did encountering intimacy and having meaningful exchanges of thoughts and feelings. Further, EL was pushed into the background and eased when participants could bracket negative thoughts and feelings, that is, when they could adjust and accept the present situation, view life in the rear-view mirror, be in contact with spiritual dimensions and withdraw and distract themselves.

Conclusion: Existential loneliness can be eased by experiencing meaningful togetherness with others and oneself when something else comes to the forefront, pushing EL to the background. Frail older peoples' opportunities to ease EL may be facilitated by health care staff (HCS) providing person-centred care and create possibilities for solitary time and meaningful togetherness.

Implications for practice: If frail older people's ongoing processes of adjusting and accepting their situation are understood and confirmed by people in their environment, for example, by nurses, family and friends, the experience of living a meaningful life can be supported, which, in turn, can ease EL.

KEYWORDS
content analysis, existential loneliness, experiences, frail older people, home care, palliative care, residential care facilities

1 | INTRODUCTION

Old age can bring bodily weakness, which may influence everyday life (Rowe & Kahn, 1987) and compromise independence (Fillit & Butler, 2009; Strandberg, Norberg, & Jansson, 2003). The impact on independence limits freedom and self-determination and increases the risk of loneliness in general (Strandberg et al., 2003). Research shows that loneliness is increased among people over 80 years of age (Yang & Victor, 2011) and among older people living alone (Dykstra, van Tillburg, & de Jong-Giervald, 2005). Older people living with losses of various kinds, such as physical limitations and the loss of partners and friends through death, are vulnerable and at risk for loneliness in general and existential loneliness in particular.

Different forms of loneliness are described in the literature. According to Weiss, Riesman, and Bowlby (1973), *social loneliness* is a consequence of a lack of social networking and engaging contacts while *emotional loneliness* is a feeling of lacking close and intimate relationships. *Existential loneliness* (EL) is intertwined with, and affected by, social and emotional loneliness, but is described to run more deeply (Ettema, Derksen, & Leeuwen, 2010; Mayers & Svartberg, 2001). EL can be understood as "the immediate awareness of being fundamentally separated from other people and from the universe, primarily through experiencing oneself as mortal, or, and especially when in a crisis, experiencing not being met at a deep human (i.e., authentic) level" (Bolmsjö, Tengland, & Rämgård, 2018, p. 5). In old age, the existential human core of loneliness has been described as an experience of being trapped in an "empty waiting room" (Kitzmüller, Clancy, Vaismoradi, Wegener, & Bondas, 2018). EL could thus be understood as the essence of loneliness.

Existential loneliness is a state or mode characterised by the deepest level of insecurity and despair, but it is possible to move beyond that state to the creation of meaning (Frankl, 1985). A conceptual analysis by Ettema et al. (2010) argued that being aware of and accepting EL could lead to positive results and internal growth. Moreover, such awareness and acceptance can, according to Mayers, Naples, and Nilsen (2005, p. 106), serve as "a turning point in one's life and an impetus to a meaningful and authentic existence".

EL has been studied empirically from different perspectives by examining different populations, such as patients with cancer in end-of-life care (Sand & Strang, 2006), patients with aphasia (Nyström, 2010) and women with HIV (Mayers et al., 2005), as well as frail older people (Sjöberg, Beck, Rasmussen, & Edberg, 2017) and their significant others (Larsson, Rämgård, & Bolmsjö, 2017). Among frail older people, EL meant being disconnected from life and being trapped in a deteriorating body. The experience of EL was aggravated when individuals were met with indifference, had no one with whom to share life or lacked purpose and meaning (Sjöberg et al., 2017). One of the few studies describing coping with EL was conducted among young women infected with HIV (Mayers et al., 2005). The results showed that interactions such as sharing the experience of their illness with their children helped

What does this research add to existing knowledge in gerontology

- The importance of meaningful togetherness with others in pushing experience of existential loneliness into the background.
- The importance for frail older people having the opportunity to withdraw and engage in activities distracting thoughts about EL.

What are the implications of this new knowledge for nursing care with older people

- Health care staff (HCS) may facilitate frail older peoples' opportunities to ease EL by providing person-centred care.
- Knowing the frail older peoples' experiences of EL may help HCS to create possibilities for solitary time and meaningful togetherness.

How could the findings be used to influence policy or practice or research or education

- By the development of tools that HCS can use to discover and ease EL among frail older people.
- By placing a greater emphasis on the relationship between physical deterioration and existential loneliness in nursing education

them overcome the experience of EL and turn it into a meaning-giving experience (Mayers et al., 2005). It is reasonable to assume that outlooks on life and death differ between youth and old age. Therefore, these results cannot easily be transferred to frail older people. Such knowledge is of utmost importance to enable health care staff (HCS) to support older people coping with EL. As EL is described mostly in negative terms, being connected to loss and death, it seems important to ascertain how experiences of EL can be eased. Thus, the aim of this study was to describe how EL was eased, as narrated by frail older people.

2 | METHOD

2.1 | Design

This qualitative study had an exploratory and descriptive design (Polit & Beck, 2012) in which the data consisted of narrative research interviews (Kvale & Brinkmann, 2014). Data were analysed inductively using conventional content analysis (Hsieh & Shannon, 2005).

2.2 | Context

In Sweden, approximately 10% (850,000) of the population is 75 years or older (Statistics Sweden, 2017). Among people being

75 years or older, 12% receive long-term care or service at home, while 5% live and receive care in residential care facilities (RCFs) (National Board of Health and Welfare, 2016; Statistics Sweden, 2017). The health care system is financed primarily by taxes, and the user must undergo a needs assessment before moving to an RCF or receiving home care service. The provision of long-term care and services for older people is within the remit of the municipalities, while the County Councils are responsible for primary health care centres, some of them specialised for older people, as well as hospitals and specialised palliative care (SALAR, 2017). In municipal care, the healthcare staff (HCS) for older people consists of registered nurses and nurse assistants who work around the clock with the support of an on-call physician at the primary health centre.

2.3 | Participants

To understand how EL is experienced among older people in need of long-term care, living at home or in RCFs, we employed a purposeful sampling strategy aiming for heterogeneity in care settings. Participants were strategically selected from one primary health care centre specialised for older people ($n = 2$), municipal home care ($n = 4$), RCFs ($n = 7$), hospital wards ($n = 2$), specialised palliative home care ($n = 7$) and specialised palliative inpatient care ($n = 1$) in southern Sweden. The criteria for inclusion were frailty and an age of 75 years or older. In this study, we used an umbrella definition of frailty for the target group—"being in need of long-term care or service due to health problems"—to capture the criteria for frailty as suggested by Fried et al. (2001). According to Fried et al., frailty is "a clinical syndrome in which three or more of the following are present: an unintentional weight loss, self-reported exhaustion, weakness, slow walking speed and low physical activity" (Fried et al., 2001). Furthermore, participants were required to have the ability, both cognitive and linguistic, to participate in an interview in Swedish and were required to have experienced EL. A designated contact person at each care unit identified candidates who met the inclusion criteria and provided oral and written information about the study. If interest was expressed about talking about EL, the contact person informed the first author (MS), who then contacted the participant and again provided oral information about the study. In total, 22 participants who in a previous study expressed that they had experienced EL (Sjöberg et al., 2017) were included, comprising 12 men and 10 women, aged 76 to 101 years (median 85). Six were widowers, and nine were widows; 18 lived in single households, and four were cohabiting.

2.4 | Data collection

Data were collected through individual narrative interviews (Kvale, 2007), for which the time and place were chosen by the participants. The interviews were performed between February 2015 and July 2016 by two of the authors (MS and IB) working together, using open-ended questions. The interview started with an initial open question about loneliness in general to open the way for the questions in focus, and thereafter, the participants were asked to narrate (a) their experiences of EL (a deeper feeling of loneliness) and (b) how these experiences could be eased. To deepen the discussion about EL, additional probing questions related to the participants' narrations such as "Can you tell us more about this?" were asked, along with echo-probing questions intended to deepen the narratives and summary statements to confirm the interpretation of what had been said. The interviews took place in the participants' usual housing, in the residential care facility or in a specialised palliative care ward. The interviews lasted a median of 61 min (range 36–147) and were digitally audio recorded and thereafter transcribed verbatim by a secretary and validated by the first author (MS). The data collection was considered completed when no new information about EL appeared in the interviews. The results from the first part of the interview (a) have been presented elsewhere (Sjöberg et al., 2017), and only the interview data from those who experienced EL were selected for this study.

2.5 | Analysis

The text was analysed by using inductive stepwise conventional qualitative content analysis, as described by Hsieh and Shannon (2005). The analysis started with all four authors' independent first readings of the interview text to achieve an overall understanding of when EL could be eased. They then came together to discuss and compare their initial understanding of the text as a whole. In the second step, meaning units related to the aim of the study were identified in the text and coded for their content, sorted and grouped into meaningful clusters by two of the authors (MS and IB). In the third step, all authors reread the codes and meaning units in each cluster and compared them, searching for similarities and differences, which formed the basis for developing subcategories and categories. Internal variations were identified as subcategories. Citations from participants are referred to by number in the results.

2.6 | Ethical considerations

The study was performed in accordance with the principles of research ethics (Beauchamp & Childress, 2013; World Medical Association, 2013) and approved by the Regional Ethical Review Board in Lund, Sweden (2014/652). This study involved vulnerable and frail older people, and the interviewers strove to be sensitive, respecting the participants' integrity and endurance. The participants were followed up with a phone call the day after the interviews to ensure their well-being.

3 | RESULTS

Two categories and seven subcategories emerged from the analysis: being acknowledged by others with the subcategories *being the focus of others' concern*, *encountering intimacy* and *having a meaningful exchanges of thoughts and feelings*; and bracketing negative thoughts

and feelings with the sub-categories *adjusting to and accepting the present situation, viewing life in the rear-view mirror, being in contact with spiritual dimensions* and *having the opportunity to withdraw and distract* (Table 1).

3.1 | Being acknowledged by others

Being acknowledged by other people such as family, friends or health care professionals (HCS) meant receiving attention from people who perceived them as unique persons and "came in between", interrupting a boring everyday life, which pushed the experienced EL away temporarily. Examples of receiving attention were when others confirmed, noticed and spent time with them. The experience of being acknowledged by others occurred *when participants were the focus of others' concern, when participants encountered intimacy* and *when they had meaningful exchanges of thoughts and feelings*.

3.1.1 | Being the focus of others' concern

EL was described as being pushed into the background when the participant was the focus of others' concern. For example, family, friends or HCS paying attention to them; being kind, forthcoming and willing to help; and spontaneously coming and talking to them without any obvious reason was described as the highlight of the day. Additionally, displays of willingness to help, such as offering help even without being asked, induced a positive feeling. As a participant who received care in a specialised palliative care ward said,

> When I was there [at the palliative care ward], then they worked together and helped each other... always came and looked, even though you had not called for them, they looked in and asked how it was and if I needed something... So you would feel welcome and not... think you bothered them. They were thus a step ahead. (16)

Furthermore, participants reported being the focus of others' concern when health care professionals were available and gave the

TABLE 1 Overview of categories and subcategories describing older people's experiences of how EL was eased

Categories	Subcategories
Being acknowledged by others	Being the focus of others' concern
	Encountering intimacy
	Having a meaningful exchange of thoughts and feelings
Bracketing negative thoughts and feelings	Adjusting to and accepting the present situation
	Viewing life in the rear-view mirror
	Being in contact with spiritual dimensions
	Having the opportunity to withdraw and distract

time needed. Their availability presented opportunities for meaningful conversations and the chance to talk about existential issues, such as death and dying. The participants further emphasised the importance of not being blamed or criticised because of their frail bodies, for example, for unbalanced cups or glasses that ended up on the floor, which HCS cleaned up without any negative comments. Living in a caring environment was important to endure a life dependent on others. Participants also felt acknowledged by being the focus of others' concern when supported by relatives in situations when they experienced EL, for example, when relatives stayed with them, brought them home or came to share a meal.

The participants described EL as being related to feelings of uncertainty. When HCS met them with sincerity, the experience of EL was eased, for example, when HCS gave them honest information about their health condition and when they received information about possible treatments. Such discussions opened the way for conversations and enabled participants to take control and make important decisions, for example, concerning cancer treatments or resuscitation, questions that might have become sources of EL if not discussed.

3.1.2 | Encountering intimacy

The experience of EL was eased when participants encountered intimacy with family, friends and HCS. Intimacy involved not only the close physical contact that they received from other people but also the intimacy they gave to other people, for example, by hugging someone, holding another person's hands or stroking someone's cheek. One way of encountering intimacy was described as "a speech of hand contact" when no words were needed. Examples from residential care were described as, for instance, when other residents came and sat next to them and took their hands or warmed their hands through massage. Other examples were when HCS hugged them or laid their arms around them, which the participants experienced as feelings of well-being. A man confined to a wheelchair and unable to move from one place to another said,

> It happens quite often that somebody cries, but then a nurse comes and puts her arm around them... very nice staff... they have put their arms around me many times... they have put their arm around me and wanted to comfort me, when they've seen that I've reacted... been sad inside myself. (7)

3.1.3 | Having a meaningful exchange of thoughts and feelings

Meaningful exchange of thoughts and feelings with other people also eased EL. Such exchanges could concern anything from everyday life situations to existential issues. When the participants shared their thoughts and feelings about life and the world outside their own space, it was a break that was experienced as meaningful. The conversation

could concern thoughts and feelings about news on TV or stories from daily life told by family, friends or HCS. Some participants used familiar terms to describe HCS with whom they had meaningful exchanges, speaking of them as if they were close relatives. A woman living in an apartment who could not go outside on her own said,

> I think it's nice if you have read a book or if you read for each other... or talk about your life stories, I think that is interesting to hear. Everyone has different experiences and different ways of looking at things. (1)

The participants, however, reported that they sometimes did not want to share thoughts of death and dying with close family members with whom they otherwise shared matters of importance. For example, a woman who was cared for in her apartment described one of the HCS as her close friend and said, "I feel I can talk with her about everything; she knows me." It seemed easier to share thoughts about their own death with a friend in whom they had confidence but to whom they were not emotionally bound.

3.2 | Bracketing negative thoughts and feelings

The experience of EL was eased when participants could bracket negative thoughts and feelings by holding onto life and their remaining time on earth. They described having an inner dialogue to turn negative thoughts into positive thoughts. Some participants expressed how they acted out to release some of the "steam" in order to endure and move on. Participants had the experience of bracketing negative thoughts and feelings *when adjusting to and accepting the present situation, when viewing life in the rear-view mirror, when in contact with spiritual dimensions* and *when they had the opportunity to withdraw and distract themselves.*

3.2.1 | Adjusting to and accepting the present situation

In the moments where the participants could adjust to and accept their situation, the experience of EL was pushed away. They faced an ongoing process of adjusting to, and accepting, life with a deteriorating body that made them dependent on others in everyday life.

> I have to accept. I'm totally dependent on help from others. But that is not a reason for me to just be lying here, crying. (12)

Instead of being "paralysed" by their ponderings, they tried to make use of their remaining time on earth and not to worry in advance but to find positive aspects in everyday life. For example, they accepted being dependent and used downward comparisons as a strategy, that is, thoughts such as, "there are others who are worse off"; alternatively, they imagined the HCS as friends. Some participants expressed that they had "lived their life" and that the goal was to make the best of what was left. Previous experiences of difficulties in life had taught them to proceed and accept the situation.

Adjusting to and accepting the present situation could also concern the inevitable approach of death, such as planning for the funeral and bequeathing things of importance. Written documents with wishes for the coming funeral were used to ensure that their important possessions would be cared for, which eased the experience of EL. Another way of adjusting to and accepting the eventuality of death was to think positively about death itself as a relief and as a possibility for reunion with loved ones who already had passed away.

> I have come to terms with the fact that it's about to end soon... I'm absolutely not afraid of what is coming. No, absolutely not... I do not think I'll be alone when I die. I think my wife is waiting on the other side. So there is no problem. (18)

3.2.2 | Viewing life in the rear-view mirror

Viewing life in the rear-view mirror was described as summarising life, a process that eased EL. This was primarily positive but also as negative experiences; for example, when remembering and viewing life from childhood to the present, including thinking of their parents, siblings, other relatives and friends of importance, participants recalled both aspects. Viewing life in the rear-view mirror also meant bringing back experiences of a vivid life that had given them the ability to "stand with both feet on the ground" when they encountered difficulties. In that sense, they received strength from their own life experiences, which was a factor that could ease EL.

> It was many years since I looked at them [photos]... they are from the time when the kids were young. But to be able to look back, that was when this happened, and remembering different places where we had fun... it might sound banal, but it helps. (17)

Pleasant and positive experiences and memories from the past could be awakened by photos or TV programmes, which presented occasions for daydreams in which they returned to places they liked to visit and activities that they had previously performed. Some participants held onto dreams that, even though they were not possible to fulfil, induced positive feelings, such as becoming an engine driver or moving back to their own house. Others were reminded of people from their past in dreams at night. Furthermore, the participants emphasised the importance of their children and grandchildren having a good life, a positive feeling that eased EL.

3.2.3 | Being in contact with spiritual dimensions

When participants were in contact with spiritual dimensions, the experience of EL eased. Participants described this contact as occurring in different ways, for example, via thoughts of dead people who had been of specific importance to them, fantasies of another

life or contact with nature. A sense of spiritual contact with people of importance was experienced when visiting the cemetery, a place where they could talk to deceased friends and loved ones. Although this sense of communion was usually described as something that could ease EL, it sometimes evoked feelings of sadness and sorrow. Other ways of maintaining spiritual contact included continuing life as usual, talking and acting as if the dead person were still there.

> I have to admit that I talk to her sometimes [the deceased wife]... about what is happening, what I am doing, if I have been shopping, what we are going to eat, and if I have bought the newspaper, etc. I often buy her flowers that I put in a vase in the living room.
> (20)

Experiencing the sensation of a dead loved one sleeping next to them during the night was described as a good feeling that pushed away EL. Singing religious songs or praying to God also awakened a sense of belonging. Thoughts about a coming life in heaven constituted another spiritual aspect.

The participants described how they sometimes preferred to have an inner dialogue with themselves, with dead relatives or with God and simply ponder. Such dialogues could occur when participants were searching for answers concerning deeper questions about life and death, questions they felt that no one else could understand or answer. Experiences of being in contact with nature were also described as having a spiritual dimension. Contact with nature could consist of visiting the woods, watching the fields or going to the seaside. The participants described how they enjoyed sitting outside when the sun was shining, listening to the birds or looking through the window and daydreaming. Simply going outdoors and experiencing something other than the four walls they were accustomed to seeing was experienced as easing EL.

3.2.4 | Having the opportunity to withdraw and distract

The experience of EL was reduced when participants could withdraw from situations in which they felt uncomfortable or excluded and instead could engage in activities distracting their thoughts about EL. When participants could withdraw to a peaceful place, for example, their own apartment or their own room, they could distract and divert themselves with activities and interests that felt meaningful to them, such as handicrafts, reading, writing, watching TV, listening to music or simply lying on the bed and dozing, which was described as enjoyable. Women who perceived that no one took them seriously stated things such as the following:

> Then it is more peaceful when nobody is here... Then I would rather read a chapter in a book or listen to music.
> (1)

> I can take my walker and go into my room. I think that it is much nicer to be here on my own and do some needlework.
> (11)

Additionally, having the opportunity to withdraw and to write down their feelings on paper, for themselves alone, was described by participants as a relief. It was important to participants that nobody else be able to read what was written; therefore, the paper was torn into pieces and thrown away.

4 | DISCUSSION

Our result showed that meaningful togetherness with relatives, friends and health care staff (HCS) could ease existential loneliness (EL) as could situations when the older people, themselves, had the possibility to bracket negative thought and feelings. In other words, experiences of EL can be eased when something else comes to the forefront, either during solitary time and/or in encounters with others, a result that is of high importance for gerontological nursing.

Participants achieved relief from EL by being acknowledged by others and in situations where they could bracket negative thoughts and feelings. Such relief can be understood in light of the "model of shifting perspective", described by Paterson (2001) as a process of shifting between experiences of illness and wellness. Which perspective occupies the foreground depends on, for example, the environment, which either can facilitate or hinder the shifting of perspective. Older people's experiences of EL (Sjöberg et al., 2017), that is, a negative experience of being disconnected from life, can be understood as having the illness in the foreground. Given that EL is described as an experience characterised by the deepest levels of insecurity and despair (Frankl, 1985), it is reasonable to assume that people need a reprieve from it and need to move beyond it in order to be able to create meaning into their life. HCS in the care of older people thus have an important responsibility to support older people in shifting perspective when necessary.

For frail older people, EL can be eased by encountering others who see them as unique and valuable. This phenomenon was seen in the results when, for instance, participants were the focus of others' concern or were met with intimacy. Studies in other contexts confirm the importance of caring encounters for the promotion of well-being (cf. Halldórsdóttir & Hamrin, 1997; Custers, Westerhof, Kuin, & Riksen-Walraven, 2010). In the framework of person-centred practice, being sympathetically present is an important part of the person-centred process (McCormack & McCance, 2017). When sympathetically present, the nurse recognises the uniqueness and value of the person and is available when the person wishes to talk. Mutuality and a positive attitude are needed to make a person feel special and valuable (Holopainen, Nyström, & Kasén, 2017). A sympathetic presence can be regarded as communication on a "deeper level" and requires self-awareness (Lannie & Peelo-Kilroe, 2017). Such an interaction resembles Buber's (1970) description of an I and Thou dialogue relation, an encounter that is fundamentally genuine.

If one is not absolutely present, the other becomes an object. Even if nursing theory and practice describe genuine relations and interactions to be fundamental, and where the other is seen as unique and equal, earlier research has shown that this is not always possible. In the care of older people, HCS themselves describes the difficulty to be able to focus on "being" in a work environment that is primarily focused on "doing" (among others, Beck, Törnquist, Broström, & Edberg, 2012). A cultural change thus seems to be urgently needed, involving staff as well as leaders, in order to be able to meet older peoples' existential needs.

Being in an environment that supports seclusion and the creation of meaning is significant for easing the experience of EL. In our results, individuals achieved such relief when being able to bracket their negative thoughts and feelings, that is, when viewing life in the rear-view mirror, when having contact with spiritual dimensions and when given the opportunity to withdraw and distract themselves. Tornstam (1999) describes older peoples' needs of withdrawal and the need to be alone, as gerotranscendence. In this ongoing process, older people reflect on meanings in life and re-evaluate the world and their own place within, as well as their approaching death. Tornstam (1999) describes this process include a decline in fear of death and may lead to maturity and wisdom. This is in line with previous research, showing that telling someone about one's life, involving both looking backwards and looking forwards (Coleman, Ivani-Chalian, & Robinson, 1998), create meaning and preserve a sense of social identity (Robertson, 2014). As having a sense of meaning in life is fundamental for people (Frankl, 1985), supporting ongoing processes of reflecting on experiences in life seems to be of utmost importance, especially for older people who need help managing basic needs and moving from one place to another. According to Tuan (2001), place and space are connected, where the place is where people feel safe, while the space is where they feel free. Therefore, there is a reason to believe that older people sometimes want to retreat to a safe place to have the space to be able to ease EL. Most frail older people find it challenging to do so, as physical limitations hinder them from moving from one place to another without support. This is so especially in RCFs, where older people themselves have described the importance of having a space for themselves to live a meaningful daily life (James, Blomberg, & Kihlgren, 2014). Thus, nurses caring for older people need to pay attention to their need for a space for themselves and places in which they feel safe, as well as support them in transferring to such places and provide opportunities to having meaningful exchanges.

For frail older people, meaningful togetherness and voluntary solitude are of importance to ease EL. This is in difference to studies concerning loneliness in general among older people that have shown that interventions to maintain social contact (Tsai, Tsai, Wang, Chang, & Chu, 2010) or to create new contacts (Bouwman, Aartsen, van Tilburg, & Stevens, 2017) have a positive effect. However, these studies have focused mainly on the social aspects of loneliness rather than the existential and spiritual dimensions. In line with our results, the study by Mayers et al. (2005) among young women infected with HIV, showed that meaningful togetherness with their children could overcome experiences of EL. Our study shows that both meaningful togetherness and voluntary solitude are of importance for frail older people in pushing experiences of EL into the background. However, the balance between togetherness and solitary time may be highly individual. Thus, in the specific context of caring for older people, the challenges for nurses are to pay attention to, and understand when, an old person wants to be alone or be together with others. Thus, our results can provide the basis for interventions to help nurses interact with older people experiencing EL including the development of tools for HCS that can be used to discover and ease EL among frail older people.

4.1 | Strengths and limitations

The process of analysis followed the steps of Hsieh and Shannon (2005), strengthening its credibility (Shenton, 2004). Concerning confirmability (cf. Shenton, 2004), all four authors were involved in the analysis, constantly challenging the interpretation of the data and thus reducing the risk of a biased interpretation. There is, however, always a risk that the findings may be coloured by the authors' perspectives. As all the authors are women and registered nurses with a research focus on older people, the analysis was continuously discussed in the LONE research group, including researchers in the fields of ethics and human ethnography, and with a reference group composed of stakeholders. Concerning transferability (Shenton, 2004), the participants were perceived as representative of frail older people in different care contexts. However, as a contact person at each unit identified the participants, there is a risk that some eligible people may not have been asked to participate.

5 | CONCLUSION

Frail older peoples' experiences of EL can be eased when something else, such as experiences of meaningful togetherness with others and oneself, comes to the forefront, pushing EL to the background. Frail older peoples' experiences of EL may be prevented by health care staff (HCS) providing person-centred care and creating possibilities for solitary time and meaningful togetherness. If older people's ongoing processes of adjusting and accepting their situation in the last period of life is understood and confirmed, for example, by nurses responsible for their care and by family and friends, the experience of living a meaningful life can be supported and can, according to the frail older people themselves, ease experiences of EL.

6 | IMPLICATIONS FOR PRACTICE

- If frail older people's ongoing processes of adjusting and accepting their situation are understood and confirmed by health care

staff, the experience of living a meaningful life can be supported, which, in turn, can ease EL.

- Health care staff may facilitate frail older peoples' opportunities to ease EL by providing person-centred care.
- Knowing the frail older peoples' experiences of EL may help health care staff to create possibilities for solitary time and meaningful togetherness.

CONTRIBUTIONS

AKE, MS, BHR and IB contributed to the design. MS and IB collected the interview data. The qualitative analysis was made by MS, BHR, AKE and IB. MS wrote the initial draft of the manuscript and BHR, AKE and IB commented critically and contributed substantially to the manuscript. All authors read and approved the final manuscript.

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