

Overcoming existential loneliness: a cross cultural study

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Abstract

Moving into a long-term care facility (LTCF) can alter the way older adults see themselves and reduce their ability to engage in meaningful experiences and roles. They experience a shrinkage in their social network when they move away from home, a reduction in the frequency of their social contacts and the number of people from whom they receive emotional support. These changes and losses can lead to feelings of loneliness. However, the loneliness these older adults experience may be more than having the difficulty with expressing the feelings of loneliness or the loss of social roles, as common examined in the loneliness literature. Rather, this loneliness stemmed from the intolerable emptiness and lack of meaningful existence attributed to all the losses they have experienced (i.e., existential loneliness (EL)). The aim of this qualitative study was to describe the experience of EL in older adults from Eastern and Western cultures who were living in LTCFs and how they dealt with the experience. Methods: Open interviews were conducted with 13 Chinese and 9 Swedes living in the LTCF about the experience of EL. A qualitative study using Thorne's (2004) interpretive description (ID) was conducted and data were analysed using thematic analysis. Results: The core theme "overcoming EL" captures the participants' experience of EL. It describes a combined process of "feeling EL" and "self-regulating". The study affirms that EL, was triggered as a common human condition in our study when the Chinese in Hong Kong, China and Swedes in Malmo, Sweden faced with life boundaries and crisis such as losses, frailty and mortality. Conclusions: EL is a very stress-inducing human phenomenon. Our study demonstrates that EL experience affects the fundamental structure of the 'self' unfolded by the experience of loss of control, isolation and meaningless in life. However, being EL allows the older adults of these two ethnics groups reaping the benefits that a 'clearer' sense of self provides, ranging from spirit of contentment to decreased distress. Thus, early and clear counselling support addressing the searching and meaning ascribed to EL should facilitate overcoming and better coping with the experience.

Background

Many older adults reside in long-term care facilities (LTCFs) because they require assistance in their daily activities [1]. By 2050, the world population will be 1.5 billion people aged 60 and older, comprising 16% of the world's population [2-3]. Such a steep trend towards ageing demands an increasing need for professional care in LTCFs [4]. Recent data showed that proportion of those aged 65-74 who live in LTCFs ranges from less than 15% in developed countries (e.g., Sweden) to 50% in developing countries (e.g., China) [5-6]. With many residents live for many years in LTCFs, it is critical to ensure that they experience the highest quality of life as possible [7-8].

The purpose of LTCFs is to support their residents in their daily activities, while maintain their basic rights, freedom, choice and dignity [7-8]. However, moving into a LTCF can alter the way older adults see themselves and reduce their ability to engage in meaningful experiences and roles [7]. Furthermore, many older adults experience a shrinkage in their social network when they move away from home, a reduction in the frequency of their social contacts and the number of people from whom they receive emotional support [7-8]. These changes and losses can lead to feelings of loneliness [9-11].

However, this loneliness these older adults experience may be more than having the difficulty with expressing the feelings of loneliness or the loss of social roles or the shrinkage of one's social network, as common examined in the loneliness literature [12-14]. Rather, it may stem from the intolerable emptiness and lack of meaningful existence attributed to all the losses they have experienced (i.e., existential loneliness (EL)) [15-16]. Because EL has been linked to serious psychological outcomes (e.g., suicidal ideation [17]), every effort should be made to better understand EL and provide effective psychosocial support of those who experience it.

While EL has been described as a universal human experience in studies involving people from Western cultures [18-19], it is unclear if it holds true among individuals from eastern cultures. Even if people from Eastern cultures experience EL, it may be manifested or managed differently because there are variations in how people in Eastern and Western cultures experience, express, and respond to universal experiences such as emotions [20]. For example, Eid and Diener found that Chinese and Taiwanese participants reported experiencing lower intensity of negative emotions than the Western participants [21]. Another study suggested the regulation of negative emotions were more prominent in people from Eastern cultures than those from the Western cultures [22]. Thus, to address the gap in the literature, the current study described the experience of EL in older adults from Eastern and Western cultures who were living in LTCFs and explored if there were any differences in dealing with the experience.

Methods

Research questions and study design

This study aimed to answer the following questions: (a) How did older adults describe their experience of existential loneliness? (b) How the older adults dealt with these experiences? (c) What were the cross-cultural similarities and differences in the EL experience? A qualitative study using Thorne's interpretive description [23] were conducted. Thorne's methodology was used to allow the research team to examine how the study participants construct their shared experience within the context of their society and culture [24-25].

Participant recruitment

Chinese (proxy for people from Eastern culture) and Swedes (proxy for people from Western culture) were purposively sampled from a government-sponsored, municipal-level LTCF in Hong Kong, China and Malmo, Sweden, respectively using the researchers' clinical networks. These two facilities were chosen because they are the type of LTCFs that are most accessible to Chinese and Swedish older adults due to their low fees. They also provide comparable level of care (e.g., personal and basic nursing care to dependent older adults in a communal living setting).

To identify and recruit participants, the researcher team contacted the administration at the selected LTCFs to introduce the study. Once the LTCFs approved the study, nurses who most often provided care at these facilities reviewed residents' charts and administered the screening tools (described below) which

were used in the routine assessments to identify 20 eligible residents from each site. All eligible residents were then invited to an information session, led by one of the authors (BC in Hong Kong and JO in Malmo), during which information about the study was presented, questions were answered, and consent to participate were solicited.

Inclusion criteria for recruitment included: (a) aged 65 or over, (b) had been living in a LTCF for more than a year at the time of recruitment, (c) require moderate and/or high level of assistance in activities of daily living i.e. score 4 or below in Katz Index of Independence in Activities of Daily Living (ADL) [26], (d) had been diagnosed with at least one of chronic diseases that require regular medical follow-up and daily drug treatment, and (e) were mentally competent (i.e., made 2 or less than 2 errors in the Short Portable Mental Status Questionnaire (SPMSQ) [27]). Exclusion criteria included those who: (a) were aphasic, (b) have profound hearing loss or other communication barriers, (c) are cognitively impaired (i.e., made more than 2 errors in the SPMSQ), and (d) have other emotional conditions that may confound with the experience of EL (i.e., scoring more than 2 on the Geriatric Depression Scale (GDS-4) [28]).

Data collection

Participant recruitment and data collection and analysis occurred concurrently and continued until a redundancy ('data saturation') of patterns was achieved. Two series of in-depth semi-structured interviews, six months apart, were conducted using an interview guide between The interview guide was pilot-tested on a Chinese and a Swedish participant, which led to only slight rephrase to one question for clarity

The one-on-one, in-person interviews were conducted by the authors (BC in Hong Kong and JO in Malmo) in Cantonese and Swedish, respectively. During the first interview, participants were asked the following questions, "Please tell me your idea about loneliness?" "We are especially interested in a deeper sense of loneliness in life, do you have any experience on that?" "Can you recall an occasion when you felt that way?" "Can you tell what a day looks like when you have this feeling of existential loneliness?" Prompts were used to further explore their responses and how they handled the particular experience. At the end of each interview, the interviewer summarized the participant's responses.

Interviews were audio-taped and translated into English after each interview. The translated interviews were not necessarily verbatim because the goal was to capture the entirety and emotions involved in the experience of EL. In addition, the interviewers wrote reflective notes during and within 24 hours of each interview to capture the contextual characteristics, atmosphere, and relevant non-verbal expressions of the participants.

Data analysis

Data analysis occurred concurrently with data collection. The analysis was conducted by the four-member research team that had extensive cross-disciplinary and experiential knowledge of aged care and existentialism research. Analysis began with independent coding of three transcripts by two team

members (BC and JO). Following the analytical methods of Thorne's interpretive description [24, 29], the coding described and compared pieces of data within and across the interviews and noted similarities and differences of the ideas about the experience and coping with EL. The analysis of the first three transcripts helped to establish the initial descriptive comprehension and synthesis of patterns. Next, critically-oriented questions were used to further probe the data for example, the following questions were asked: , "You just said sense of EL gave you time, what does it mean?, "In what way did EL help you to reflect?" This questioning process enabled further in-depth exploration of meaning [30]. The two research team members met via Skype after each transcript was analyzed and discussed the codes and patterns until consensus was achieved. We compared commonalities and constructed categories, and then an interpretative account with themes. Analytic strategies were reflective memo writing, re-examination of each transcript, and mapping of the codes and categories. These analytic strategies assisted the researchers with inductive imagining and interpretive insights during analysis [31]. As a result, a rigorous analytic process was ensured by navigating within and beyond the preliminary analytic framework with at least three researchers at all times.

Once the coding framework was derived, all transcripts were coded using the QSR NVivo 11 data management software by the first and second author. The research team then conducted thematic analysis to further the interpretation of the data by identifying related codes and putting into themes that reflect the experience of existential loneliness in LTCFs. Finally, the team finalized the themes and subthemes to provide a coherent set of constructs, where their relationships were examined. Data analysis continued until a coherent interpretive description of participants' experiences was rendered. The quotation in the findings section presented in English was back-translated by adopting a reflexive approach to shed light on the complexities involved and to ensure equivalent meanings[32]. Two additional Chinese older adults (one woman and one man) and one Swedes were recruited to help further explore or understand certain aspects of the findings around the adaptive process of EL. When the research team agreed that there was theoretical saturation of the analytical categories, data saturation was deemed achieved [33].

Rigour

Rigour was established by adhering to three central tenets of qualitative research: credibility, plausibility and transferability [34-35]. Credibility was established through repeated and prolonged engagement with the interview transcripts, investigator triangulation (when forming the initial coding structure), and respondent validation of preliminary results (i.e., two Chinese and one Swedish participant were involved in confirming the findings from the first series of interviews). This validation not only did not change the data interpretation, but also confirmed the findings, providing clarity of and elaboration to the ideas [35]. Moreover, reflexivity and validation by research team members were used to ensure the credibility of the interpretations. Reflexivity was ensured through the researcher's process of questioning (e.g., "why is this?" and "what does it mean?"). Writing reflexive notes allowed the tracking of the decision-making process to develop a more coherent analytical framework with others. Plausibility was established through data saturation and multiple investigator perspectives (i.e., experienced aged care clinicians and

researchers) and by maintaining an audit-trail with reflective notes and a research journal to record analytic decisions. Transferability was attained through comparison of findings across empirical literature.

Ethical considerations

Ethical approval for this study in Hong Kong was obtained from the Human Subject Ethics Subcommittee of the Hong Kong Polytechnic University (HSEAR20170510001), while the approval in Sweden was provided by the Regional Ethical Review Board in Lund, Sweden (20176/781). Ethics was also cleared in the two LTCFs to conduct interviews with the older adults. All participants were informed of study requirements, the voluntary nature of participation, and their right to withdraw from the study at any time. The research team obtained written consent from all participants prior to study participation. Confidentiality was ensured through use of pseudonyms in the reporting.

Results

Participant description

Among the 40 eligible residents identified in total, 13 Chinese and nine Swedes consented to participate (See table 1 for description of the participants' demographic characteristics).

The mean age of the Hong Kong and Swedish participants was 82.6 years (ranged from 75 to 92) and 92.4 years (ranged from 83 to 96), respectively. The Chinese participants have lived at their LTCF on average for 10.5 years (ranged from five to 18 years), while the Swedish participants lived at the LTCF for a shorter period, on average, 3.8 years (ranged from one to 14 years). Eight Chinese and five Swedes were widow or widower. On average, each participant had 2 children.

Nine of the Chinese were diagnosed with cancer such as lung, brain or colon, three had a stroke, and two were bed-bound. Most of the Swedes suffered from the age-related health issues such as heart conditions, lung diseases, and mobility problems. All participants lived with their family before moving to the LTCF because of their poor health and increasing need for assistance in daily activities.

Thematic overview

The purpose of this study was to describe EL as experienced by Chinese and Swedish older adults living in LTCFs and the way they dealt with it. The overall theme that described both Chinese and Swedish older adults experience was "overcoming EL", which consisted of two themes: "feeling EL" and "self-regulating". As the participants faced functional decline (e.g., frailty, illness) and their consequences (e.g., inability to care for oneself, perception of impending death), they realized the inevitability of these experiences and admitted it was part of the ageing process similar to that of death and dying. Illnesses, frailty and the ageing experiences represented challenges to both groups of older adults in this study and heightened their awareness of the self. This struggle engendered spiritual and existential distress among them. Their experiences were captured in these four sequential themes: loss of control of life, failure to be

understood, experience a sense of isolation, and inability to identify meaning in their lives. Recognizing that little can be done to change the trajectory of their decline, the participants opted to accept and adjust how they feel about their situation. This act of self-regulation involved four steps: accepting the reality and reframing, reflecting the self, quest for meaning and redefining the success in life. The process of self-regulation makes the older adults adapted and reduced the intensity of the sense of meaningless and being existential lonely. Figure 1 shows all the key themes and subthemes identifying in this study and below is an elaboration of the themes.

Theme 1: Feeling EL

In overcoming EL, the participants must first experience it. Both Chinese and Swedish participants reported feeling worried, frustrated, and depressed as familiar roles and life goals were disrupted. Some participants were in despair because their life was nearly coming to an end. They had accomplished their life's tasks when they were younger, and now they felt useless because others or even they themselves assumed they could no longer contribute. For example, because their children were independent and able to manage their own lives, the Chinese participants no longer felt they were contributing to their family. As a result, they felt a profound sense of loneliness despite having family and friends around. They felt deserted and helpless because the experience of EL led to emotional instability, insecurity, and negativity. This experience was characterized by the loss of control of their life, failed to be understood by others, a growing sense of isolation, and failure to identify meaning in their lives.

Loss of control of life

Both Chinese and Swedish participants felt they were losing control over their own lives as they experience physiological decline. The feeling of powerless took over, and they felt vulnerable.

...I cannot do what I really would like to do because of my poor health, I am forced to be sedentary for most of the day...I can't control. (Swedish participant 5)

I am old. Life is never be the same as before... with my poor health, I am unable to bathe by myself, not saying to go shopping, it is a great loss to me, ...I have to depend on the aids here...Being immobilized, I even can't go to the toilet by myself and I wear napkins all the times, I have no say, no control at all... (Chinese participant 6)

For some participants, they felt that they have lost the right to make choices about their lives when others, like caregivers or family members, would assume control and made decisions for them.

Sometimes I want to take a nap but they [nursing aids] say I am not allowed to... because I couldn't fall asleep at night if I slept too much during the day! But what is there to forbid me to do things at my choice? (Swedish participant 2)

They [the nurses] take charge of everything, they decided when and what I should eat, when I should get up and sleep, when I should void, when I should bathe, they decided everything... I lost myself... I would

question myself who I am? (Chinese participant 6)

Failure to be understood

Most Chinese and Swedish participants explicitly referred to various forms of negative affect, including feeling down, miserable, or sad, because they felt like no one understood them, which made it impossible to feel connected to others.

Have you ever been in a situation when you felt like your words couldn't get through, not being understood even talking to your own children and to your close relatives? Like you were expressing yourself over and over again, yet you were being misunderstood by your loved ones?... I was miserable, upset, woke up at four in the morning and looking at the ceiling. (Chinese participant 1)

The loneliness, I don't want to show it my friends much as they don't understand, I feel bad to let them know that I have the feeling of uselessness, of course, to them, this is it, this is life, they say, 'Don't cry ,don't cry... don't be sad,' and then so what?... they don't understand, I am still on my own, I am sad. (Swedish participant 3)

Experience a sense of isolation

Both Swedish and Chinese participants felt isolated and distanced from others and questioned where they belong.

My husband and two of my sisters do not live any longer. It is sad. They have gone. ...and I feel sorry for myself sometimes being the last one left in the family ...There is nowhere to belong. (Chinese participant 10)

My children all have their own families and all managing on their own... I had two best friends when I was young but they are all gone leaving me alone. I feel lonely in the sense that nobody needs me... I am alone, it should be the time for me to go now... (Swedish participant 9)

In a few cases, Chinese participants felt depressed despite the fact that they still have opportunities to spend time with their children.

"I have to take care on my own well while I am here. If anything gone wrong... it would be the burden to my daughter. She doesn't visit me often..., she has two kids at home. She has her own job and her own family to look after... but I valued the time when she visited me with her children...sometimes I think when I have nothing that I can do for her... even make her a cup of tea, that means she doesn't need me any longer..." (Chinese participant 13)

While some Swedes felt lonely and ashamed of having no friends.

My children always comment on my lack of friendships and do not make new friends... feel lonely that my best friends died and I have nobody to talk to. I would like to get away from everything. Close my

eyes and get myself away and rest from everything. I don't want to be here anymore. I saw the gate of heaven, I saw it. Let me in. No, they didn't let me in. (Swedish participant 1).

Inability to identify meaning in their lives

Some of the Chinese and Swedish participants have lost the life meaning. Their vision of the reality and the future were uncertain and darkened. And they seemed to "see" the reality was how little, unworthy and insignificant they were.

I know I'll end up in the hospital...no future at all... Well, I don't have to think about my children and grandchildren as I couldn't help much in the family, I am useless now... I doubt about my ability to do anything more for them ... My life is over (Chinese participant 9)

I am old. Life is never be the same as before... it is different. With my poor health, it seems I have lost my self, being old is of no use... no meaning at all (Swedish participant 7)

It is pointless, no meaning at all... there is nothing that I can do for myself... getting up every morning and there is nothing to do, but there are things that the others told you to do... (Swedish participant 9)

Both Chinese and Swedish participants in our study exemplified EL as a human condition and revealed similar properties. Both groups experienced EL that others were unable to understand, resulting in feelings of loneliness and loss of meaning in life. These experiences varied with cultural and life contexts, in which the sense of meaningful existence for the Chinese participants tied to kinship and to the families while the individual self as a unit was valued for the Swedes and linked up with friendship. Next, the ways in which the Chinese and Swedish participants coped with EL will be highlighted.

Theme 2: Self-regulating

When our participants' sense of EL intensified, they began to challenge the meaning of their life and their identity. They felt anxious when they reflected issues related to purpose in life or self-identify. This was especially common when they experienced physical, emotional, or spiritual instability. As the older adults found that it was something that couldn't be changed and beyond their control like their aging process, they found that they have to deal with it. The process of self-regulation occurred as the older adults experience EL and decided to accepting. This was the time when the older adults learned about EL and developed strategies to cope with it.

When I feel lonely, I often tend to beat myself up and think that something is just wrong with me. The more alone I feel, the more I start to have thoughts of not belonging or of feeling rejected by others... These thoughts further provokes my own criticism of being useless. Is that all in my life?...I think it is my internal enemy that making me unhappy... The more unhappy I am, the more I avoid others and the more I isolate myself and in a lonely state...but it can't help me out. I have to do something... (Chinese participant 13)

This is the fact that I am old and sick..., something I can't control...why not shifting to the things that I can do for myself now, not to think about the past nor the future... Just live in the moment. (Chinese participant 3)

Most of the Chinese and Swedes were struggling with their identity and were searching for a core sense of themselves.

I realized my inadequacy when I am old and asked who I am? (Swedish participant 4)

When the participants decided they would no longer suffer from EL but live with it, the process of self-regulating occurred, where the participants began to accept and reframe the experience, examine oneself and one's life, quest for meaning, and re-define the success in life. This process led the participants to unfold their life experience and re-examine themselves, where they looked from within and see their 'clearer self', thus enabling them to develop a sense of well-being.

Accepting and reframing the experience

Most of the Chinese and Swedish participants coped with their experience EL by accepting their own limitations, weaknesses, and loneliness, and that change was needed. They paid attention to the present moment rather than being trapped in the past and worried about the future. They accepted EL in a new way by recognizing it was unavoidable and appreciated its positive aspects and reframing EL as opportunities. They were then able to experience life more fully and to become a more whole human being.

I am old... Life will never be the same as before, this is it, I have to accept this is the "present me", it always be different from the "past me"... It seems that I have lost my world as a rubbish when depending on others.... but when my grandkids called me grand-pa... I am excited, I am still their grandpa, I didn't lose my identity as a grand-pa...I should enjoy every moment with my grand-kids. This is me I enjoyed it. (Chinese participant 3)

The loneliness is sometimes hard to cope especially in the evenings, I know I would end up at the hospital...Well, I am by myself here. It can be positive of being myself here. I am alone to think through my own life... It is very good to get these 'quiet' times and think through who I am. (Swedish participant 5)

I have to endure and live with what cannot be changed. (Swedish participant 8)

Examine oneself and one's life

Being alone has been reconsidered as an opportunity to not only reflect about the past and the future, but also examine their own thoughts and feelings and reflecting on what they meant to them.

I think being alone might be a chance for me to reflect, to think about the past and redefine my life purpose, not just sit there and wait for nothing,... I went to the Hong Kong Museum of Coastal Defense to recapture my old days. I am proud to tell my grandson that I was a soldier in the Chinese Civil War in the

1940s. I am satisfied with my past accomplishment and my grandson said, my grandpa fight in war. (Chinese participant 8)

It can be a sense of positive loneliness. The positive thing is that I can be alone and think through life. It is very good to get these times and think through about who I am(Swedish participant 5)

I think this might be a chance for me to reflect, think and plan my remaining days...in which I have nothing more to lose. (Chinese participant 11)

Quest for meaning

Several Chinese participants found ways to feel satisfied and regain meaning to their lives. As they reflected on the experience, they recognized that EL was unquestionably challenging, and they shared that it created a time for personal reflection. The participants learned to accept their EL and their feelings toward it. In doing so, the participants regulated their negative emotion and made meaning.

I found it is no use to linger on the anger or get depressed, sad to being old and lonely. To me, to make my daughter worrying about me is a sin... I should focus my days on the things that I could do... it is more meaningful to me to live in a moment. (Chinese participant 13)

I let myself be alone but not lonely. Letting myself be this way doesn't mean hiding from pain, loss or misery. It just means I go with the present experience and make meaning for my existence. When the sad things came, I opened up to them and let them in—to face it. I would choose to get out of here and it is my new way of control (Chinese participant 12)

The Chinese participants took the form of self-appraisal and exploration of self-worth through acknowledging their effort of contribution to their families and others. While the Swedes searched their meaning through their own self and socializing with friends.

I work in the support groups here. I hope to help the others go through the experience, sadness, happiness, sorrow, hoping what I have used to support myself in those days might help them too, we have to accept we are old and have to be by ourselves. It is meaningful that I am not useless... still I can contribute... despite I don't know how big the contribution is... it doesn't matter. (Chinese participant 4)

I wake up every morning and thinking I am glad that I can get up and make myself a cup of coffee. It is good enough for myself now. (Swedish participant 8)

I do not feel lonely because I have friends around me here when having dinner for example and we have activities as well and it is nice and worth to spend time with friends, their presence was my support. I found my own meaning of life is to find happiness with friends (Swedish participant 1)

Being able to ascribe meaning to the experience not only helped them to identify their new reason for living, but also give them back control of their own lives. This, in turn, reduced their sense of EL.

Re-defining the success in life

Finally, the participants saw that it was time to redefine success in their own terms. For many participants, their 'life-is-good' perspective was entrenched within memories of past success and the present challenge.

I come to the realization that unless there is something positive, um, "life-is-not-so-bad", that I have to just go on with what I have. There are still times that I have down days of course. That's life. (Chinese participant 1)

In particular, the Chinese participants defined their success beyond the sense of their own and found comfort in the success with their family and to the others.

I know I'll end up in the hospital...no future at all... Well, I don't have to think about my kids and grandchildren in fact they are doing well on their own. I established the family by my own pairs, not very well-off though, it is my success, I define my success is not only to my own but to my whole family. I don't take the negative so seriously. What is far more important is love and my family... I can't afford to lose more... (Chinese participant 7)

I spent considerable time in the groups such as Christian group, not always depended on others. I think "something good has to come from this experience". Actually, I didn't know what good it would be, but the idea that I could share my experience, so that others who joined this group do not have to go through the same thing as I did in the past, this experience gave me considerable comfort, it make senses of my worth. In a way, it is my success. (Chinese participant 9)

While some Swedes interpreted their success from an the 'individual' lens.

I know that my time is short... even if I am stroke and am alone here...No, I don't see the experience as a bad thing because, it, what I had in the past was nothing. I was nothing before then, you know. Then, why bother! I want to make clear that my acceptance does not mean giving up or being passive. It is my success to think good about myself(Swedish participant 7)

Discussion

This study portrays the EL experiences of Chinese and Swedish older adults living in LTCF and highlights nuanced cultural similarities and differences on how Chinese dealt with EL, as compared to the Swedes. While the study took place in Hong Kong, China and Malmo, Sweden, the findings represented similar ideas from the review by Kitzmüller and her research team (2018) about older adults' voices and their meaning of the existential human core of loneliness in old age [36]. In our study, this was characterized by having the life nearly to an end, disrupting familiar roles and unattaining life goals, having sense of useless because others or even themselves assumed they could no longer contribute, being dependent and being unable to manage their own lives. Their narratives conveyed a felt gap between meaningless life they now experienced and the sense of 'fullness' they craved in the past. These experiences are

consistent with EL arising from an emptiness and disconnected with actual life of the frail elderly, advanced cancer patients, dying persons and terminally ill patients [37-39]. However, unlike Kitzmüller et al. (2018) review, both Chinese and Swedish older adults in our study made the distinction of “overcoming” rather than “being trapped”, (whether the older adults were male or female), though they also depicted EL as a devastating condition connected with negative emotions (i.e., hopelessness, losses, meaningless, see no purpose in life and no value in continuing to live [36]).

Consistent with the findings reported for dying and cancers patients[40-41], our findings agree with Vehling & Kissane and Bovero et al., showing that the suffering of EL was accompanied by a disrupted sense of identity. Experiencing EL exposed our participants to a psychologically and existentially painful situations that was likely to impact on their “self”. The change in identity was particularly well-demarcated in our Chinese participants whose identity changes due to shifting role relationships in the families. This possible “shattered self” alerted the older adults that something was at stake and prompted them to reflect [42]. This was important because EL created a “moment” in which older adults develop a stronger sense of self who they were through self-discerning reflection. This path to re-examining and clarifying the self can be obscured when only living in life full of strivings and was stuck in everyday busyness of life.

Similar to patients coping with terminal chronic illnesses, like cancer, neurodegenerative disorders, and multiple morbidities, our study reported the older adults’ capacity to overcome EL originated from their own capacity to regulate emotion and re-prioritize goals to concerns when living in the moment in recognition of that loneliness experience could not be changed [43-45]. In our study, participants held an adaptive attitude towards EL. Our findings demonstrated the older adults were active agents who could overcome EL, thereby regulating or controlling the negative consequences on their existential and emotional health. Given the initial interruptions imposed by EL forced the older adults to accept, reflect and re-define as functions of changes along the EL trajectory. Similar to cancer patients, dying individuals and bereaved persons [46-47], acceptance of EL did not mean giving up or passivity for both ethnic groups in our study. It did require that these older adults openly recognized and confronted their limitations and the dark side of the human condition of being existential lonely. Being able to accept and quest for meaning of EL were predictors of coping among the older adults [46]. It also meant that the older adults needed to learn how to adapt and transform the experience that are unavoidable. This transformed experience of EL from a threat causing negative emotions and pathological outcomes to a challenge creating ‘moment’ for older adults to reflect and engage in a quest for meaning in life. In doing so, older adults tended to make sense and meaning of EL and were concerned with their overall well-being. Without this, the focus on “trapped” experience can leave the older adults question their meaning of life, as one counter to a normalization of “growing old” [47].

Meaning comes from various sources in people’s life [48]. In our study, the sources of meaning of life differed among the Chinese and the Swedes. Our findings showed that most important sources of meaning in life for Swedes were participation in friendship and leisure activities, personal accomplishment and meeting their own basic needs. These findings fit Lykes and Kemmelmeier’s

individualistic accounts that characterize the personal self in terms of self-enhancement and personal growth in the West [49]. Nevertheless, our Chinese participants have reported that collective self was obtained from family and mutual development in the family as a whole. It appears that its meaning is framed in relational based within the families in the Chinese context. This is consistent with the Chinese collectivism values focusing more on social and family roles like being a grandparent or being a witch, obligations toward children and grandchildren, and moral behavior[50]. Indeed, knowledge of how to reengage in other meaningful goals and activities support these Chinese and Swedish older adults, may enhance clinicians' capacity to work with them and facilitate identifying their potential self-help strength.

Further to resisting the negativity of EL, older adults' creation of positive moments when experiencing EL was generated by reflecting and engaging in a quest for meaning in life congruent to their individual or collective values to the Swedes and the Chinese. A process of transformation follows theoretical ideas introduced by Wrosch and Freund's [51] and Park and Folkman's [52] studies about self-regulation and coping. This process appeared to transform the experience through infusion of positive meaning for the creation of enduring memories and living in the present moment, and moreover, is posited to have generated the older adults' capacity to overcome EL.

Strengths and Limitations

This is the first qualitative study we know of that described and compared how Swedish and Chinese older adults make sense of EL experience. Nevertheless, this study has some limitations. While there was diversity in participants' experience, negative cases of older people remained vulnerable and threatened were limited. Hence the experience of overcoming may not be transferable to those whom whose sources of meaning of life could not be identified.

Conclusions

Existential loneliness can be very stress-inducing human phenomenon. Our study demonstrates that EL affects the fundamental structure of the self by reflecting what life meaning is. It allows the older adults to reap the benefits that a true sense of self provides, ranging from spirit of contentment to decreased distress. Thus, early and clear counselling support addressing the searching and meaning ascribed to the experience should facilitate better coping with EL. Yet not all older adults go through the same process. The clinicians should integrate the existential dimension into person-centred care and be aware of self-regulating and coping strategies among older adults. A process of transformation facilitated by clinicians (e.g. nurse-led) in identifying preferred sources of life meaning may enlighten and support older adults' self-worth, self-help abilities and resilience.

Declarations

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Availability of data and materials.

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Authors' contributions

BC, JO, FW, MR conceptualized the study. BC, JO performed interviews. BC, JO performed the initial analysis of the qualitative data and continued discussed with the analysis with all authors. BC was major contributor in writing the manuscript. JO, FW, MR made revisions to the manuscript. All authors read and approved the final manuscript.

Ethics approval and consent to participate

The project was approved by the Human Subjects Ethics Committee of the Hong Kong Polytechnic University (HSEAR20170510001) and the Regional Ethical Review Board in Lund, Sweden (20176/781). Ethics was also cleared in the two LTCFs to conduct interviews with the older adults. The participants were aware that we were going to use their anonymized data and a written informed consent was obtained prior to data collection.

Consent for publication

All participants gave permission to use their anonymized data for publication purposes.

Competing interests

All authors declare that they have no competing interest.

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Tables

Table 1: Chinese Participants' demographic characteristics

| Name (pseudonym) | Gender | Medical problems/comorbidity | Years of staying in the care homes |
|------------------|--------|--|------------------------------------|
| 1. Eddie | M | Lung Cancer | 11 |
| 1. John | M | Colon Cancer | 12 |
| 1. Lee | M | Stroke and bedridden | 11 |
| 1. Bing | F | Lung Cancer | 9 |
| 1. Faith | F | Brain cancer and hypertension | 7 |
| 1. Angela | F | Stomach cancer, poor control diabetes and bedridden | 11 |
| 1. Kwan | M | Hypertension, chronic pain | 15 |
| 1. Uncle Lam | M | Pancreatic cancer | 11 |
| 1. Grace | F | Stroke and poor diabetes control | 18 |
| 1. Mazy | F | End-stage breast cancer | 13 |
| 1. Keung | M | Hyperlipidemia, Poor controlled hypertension and poor diabetes control | 5 |
| 1. Sam | M | Lung cancer | 7 |
| 1. Kei | F | Ovarian cancer | 8 |

Table 2: Swedish Participants' demographic characteristics

| Name (pseudonym) | Gender | Medical problems | Years of staying in the care homes |
|------------------|--------|-------------------------------|------------------------------------|
| 1. Anna | F | Arthritis | 1 |
| 2. Bella | F | Heart diseases | 2 |
| 3. Klara | F | Chronic lung problem | 2 |
| 4. Bo | M | Heart and lung diseases | 3 |
| 5. Britta | F | Scoliosis | 3 |
| 6. Bengt | M | Macula of retina, amputee leg | 4 |
| 7. Ture | M | Heart disease | 3 |
| 8. Signe | F | Hypertension | 3 |
| 9. Nils | M | Stroke | 14 |

Figures

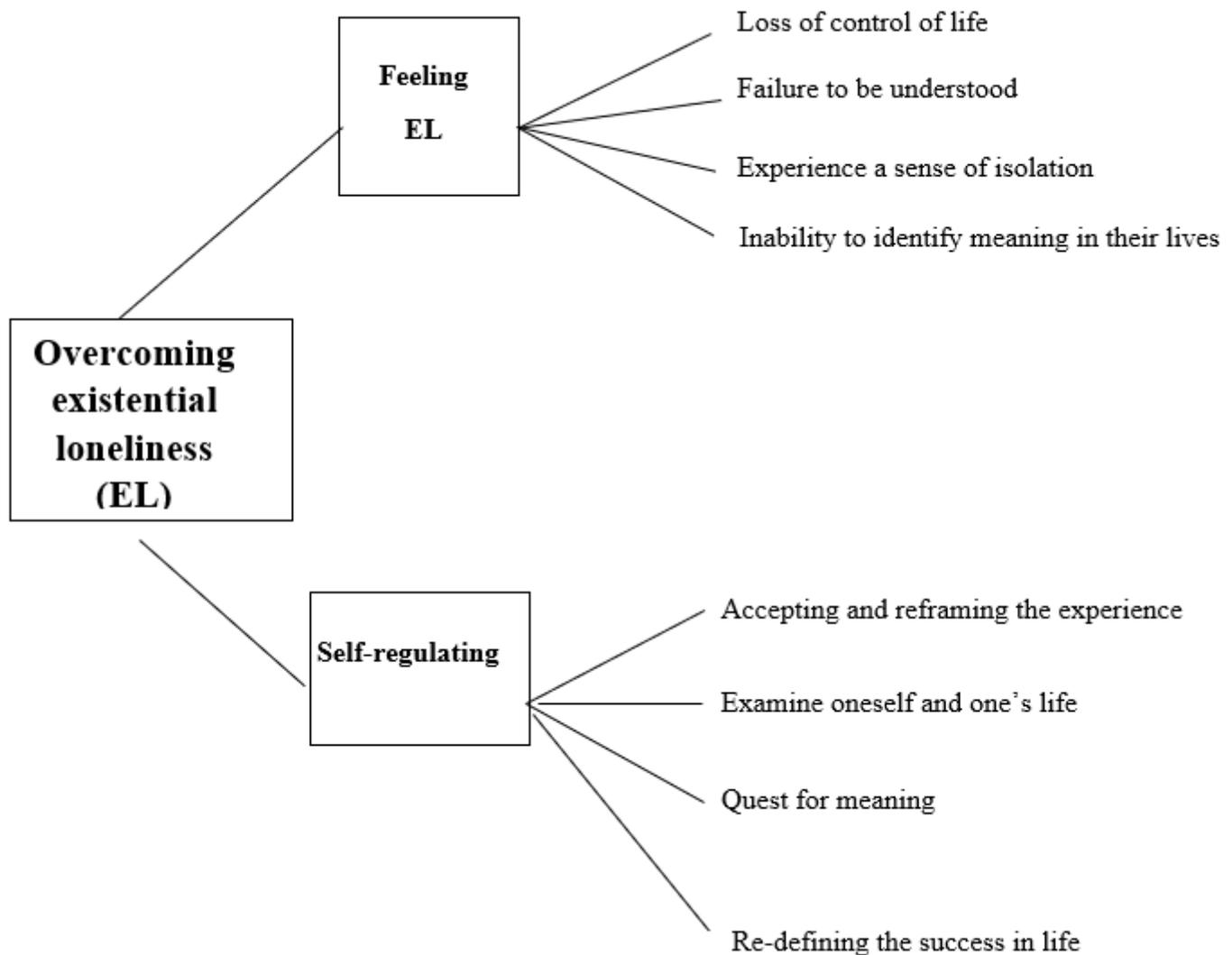


Figure 1

Framework of Key Themes and Subthemes