Co-funded by the
Erasmus+ Programme
of the European Union

ALONE

2019-1-PL01-KA202-064933

LIMITATIONS IN CARING OLDER PERSONS

RELATED TO EXISTENTIAL LONELINESS ENCOUNTERED BY HEALTHCARE PROFESSIONALS

INTERNATIONAL REPORT

IO2 INTERNATIONAL REPORT

LIMITATIONS IN CARING OLDER PERSONS RELATED TO EXISTENTIAL LONELINESS ENCOUNTERED BY HEALTHCARE PROFESSIONALS

AUTHORS: Manattini, A., Trogu, G., Modrzejewska, D., Renn-Żurek, A., Woźnicka, E., Pintilie, L.L., Popovici, S., Beck, I., Edberg, A-K., Virbalienė, A., Žebrauskaitė, A.

This work has been funded by the Erasmus+ Program of the European Union, project „Innovative Health Professionals Training Program on Existential Loneliness among Older People", project no. 2019-1-PL01-KA202-064933.

TABLE OF CONTENTS

1. INTRODUCTION

ALONE project pursues the goal to meet the needs of development of high-quality work-based VET in healthcare and social sector, facilitating the approach of professionals working with older people experiencing existential loneliness. This project has the main objective to create tools to support professionals detecting and recognizing existential loneliness among older people and to improve their abilities facing loneliness in general and existential loneliness in particular.

The present report introduces the findings of researches conducted in each partner country on perception and resources by health care professionals and social workers to face existential loneliness among older persons. In accordance with objectives of ALONE project, a study of health care and social professionals' understanding, perceptions and experience of existential loneliness in older people was carried out. The aim of this empirical research is to reveal challenges and limitations encountered by healthcare and social professionals working in home care, nursing home care, palliative care, primary care, hospital care, or pre-hospital care, underlining their educational and support needs and the skills to deal with existential loneliness among older persons.

A qualitative approach has been used for this study, through the use of focus groups and individual interviews, in order to gain a large amount of data regarding opinions, perceptions and expereinces.

The transferability of the output consists in the fact that report findings will be the basis of curriculum elaboration for training health professionals and social workers in the most effective way related to existential loneliness.

2. METHODOLOGY OF RESEARCH

During this phase of the project, research activities have been carried out in each partner country using a qualitative approach in order to detect health care and social professionals' opinions, experiences and needs to face existential loneliness among older persons.

The focus group method has been selected as a way of collecting qualitative data, but also as a technique for gaining a large amount of data regarding opinions and attitudes in the shortest amount of time. It relies on group processes and encourages interaction between group members, resulting in deeper exploration of the subject under study[1]. Focus group, through focused discussions, allows the researchers to study the topic of interest in depth, involving a selected group of people according to the study's aim. As far this research within ALONE project, has been chosen in each partner country different health care and social professional profiles, also employed in the same work setting, and has been collected general data about participants (gender, age, level of education and professional path) through a demographic questionnaire submitted at the beginning of each focus group. During the focus groups participants had discussed their similar experiences and shared common characteristics. The discussion had been facilitated by the figure of moderator that used a semi-structured interview guide to invite participants to deepen specific issues. Participants had been encouraged to freely express their feelings, ideas, agreements or disagreements in a non-threatening environment. Furthermore, discussions stimulated memories and facilitated the exchange of ideas and opinions, leading to a more in-depth study of the research topic.

As far the research conducted in Sweden, the following information and data reflect the results of a previous study carried out in 2018 and 2019 by Swedish partner with the aim of explore existential loneliness among older people from the perspective of health care professional (HCPs), involved in 11 focus groups. Below you will find specific reference to Swedish studies:

- *Encountering existential loneliness among older people: perspectives of health care professionals. International Journal of Qualitative Studies on Health and Well-being - Sundström, M., Edberg, A-K., Rämgård, M. & Blomqvist, K. (2018)* (indicated in this report with [1])
- *The context of care matters: Older people's existential loneliness from the perspective of healthcare professionals-A multiple case study. International Journal of Older People Nursing - Sundström, M., Blomqvist, K., Edberg, A-K. & Rämgård, M. (2019)* (indicated in this report with [2]).

These studies carried out in Sweden have inspired the creation of the semi-structured interview guide used by moderators to lead the researches within ALONE project. Same topic and issues have been discussed and deepened both in Sweden studies and in ALONE research.

Focus groups has been organized in each partner country, except in Italy, with 6-8 participants in each group, involving professionals from different settings (i.e., hospital, residential care, community…). In Italy, due to Covid-19 health emergency, it has not been possible to gather experts simultaneously in the same place, not allowing to implement focus groups. In this particular case, the individual interview method has been used to collect their contributions and inputs. The same demographic questionnaire

[1] Bowling A. (2014) Research Methods in Health: investigating health and health services 4th ed. Open University Press, Berkshire

and semi-structured interview guide, used in the other partner countries, have been submitted to health care and social professionals involved.

3. DEMOGRAPHIC DATAS OF PARTICIPANTS

In order to collect information about experiences and limitations in caring older persons related to existential loneliness, encountered by health and social professionals, different focus groups and interviews have been carried out in the countries involved in ALONE project. In particular 18 focus groups and 9 individual interviews have been carried out:

- 2 Focus groups in Poland
- 2 Focus groups in Lithuania
- 3 Focus groups in Romania
- 11 Focus groups in Sweden
- 9 individual interviews in Italy.

The focus groups and the interviews, carried out in the different countries, involved a total of 139 health and social professionals: 9 in Italy, 18 in Lithuania, 12 in Poland, 39 in Romania and 61 in Sweden.

The following demographic data have been collected through a questionnaire that participants filled in prior the beginning of the focus group or interview.

3.1 Gender and age

The majority of professionals involved were women: 127 out of 139 (91,4%). In the diagram below (*Figure 1*) you can see the number of males and females involved in the different countries:

- Italy: 3 Men and 6 Women;
- Lithuania: 2 Men and 16 Women;
- Poland: 1 Men and 11 Women;
- Romania: 0 Men and 39 Women;
- Sweden: 6 Men and 55 Women.

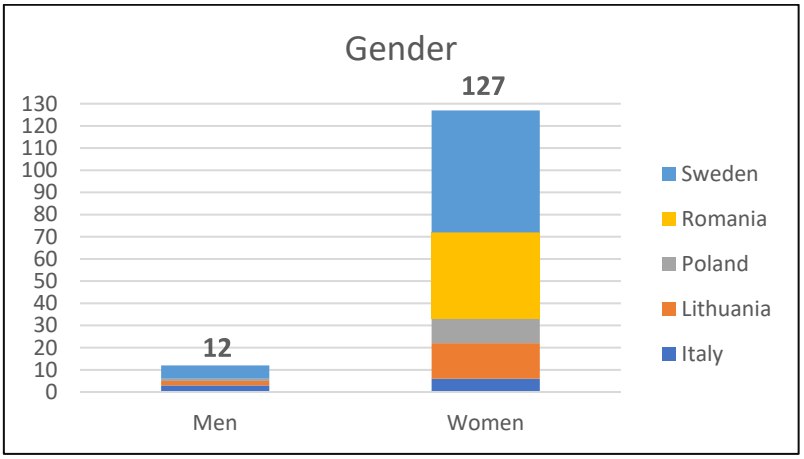

Figure 1. Gender and Age professionals involved

The average age is 50 years old, the youngest is 26 years old while the oldest is 70. Below you can find information on the ages of professionals involved in the different countries:

- Italy: 40-67 (Mean 53);
- Lithuania: 34-70 (Mean 55);
- Poland: 31-58 (Mean 49);
- Romania: 26-60 (Mean 42);
- Sweden: 26-68 (Mean 49).

3.2 Professional Profiles and experience

A wide range of professional profiles have been represented: nurses (n=93: 71 registered nurses and 22 nurse assistants), social workers (n=25), physicians (n=6), occupational therapists (n=4), physiotherapists (n=3), social counsellors (n=3), psychologists (n=2), educator (n=1), social health worker (n=1) and speech therapist (n=1).

As you can see in the diagram below (*Figure 2*) the vast majority of professionals involved were Nurses (67%), followed by Social workers (18%), Physicians (4%), Psychologists and Physiotherapists (2%) and Occupational Therapists (2%).

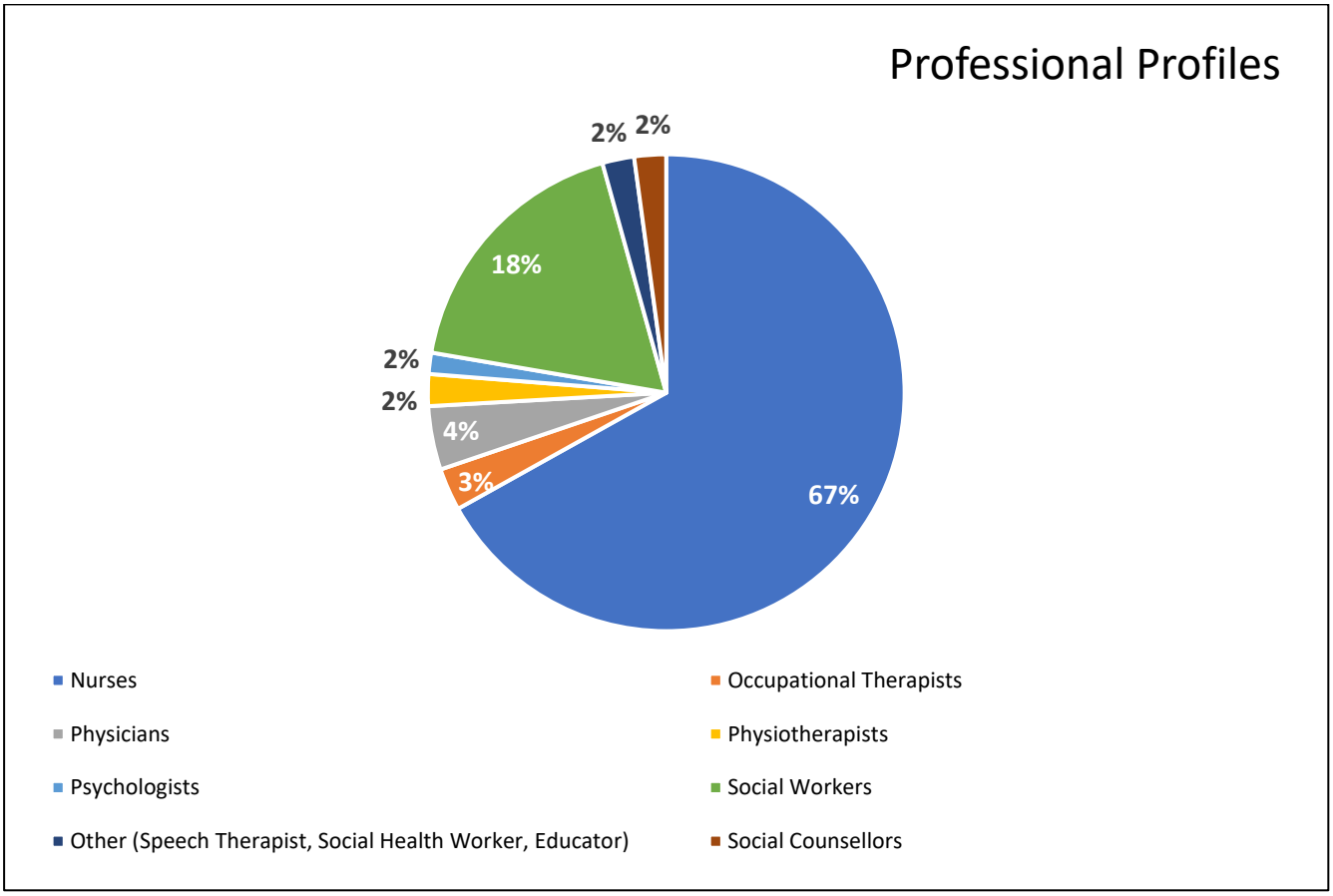

Figure 2. Professional Profiles

The diagrams below (*Figures 3,4,5,6,7*) show professional profiles involved in each country.

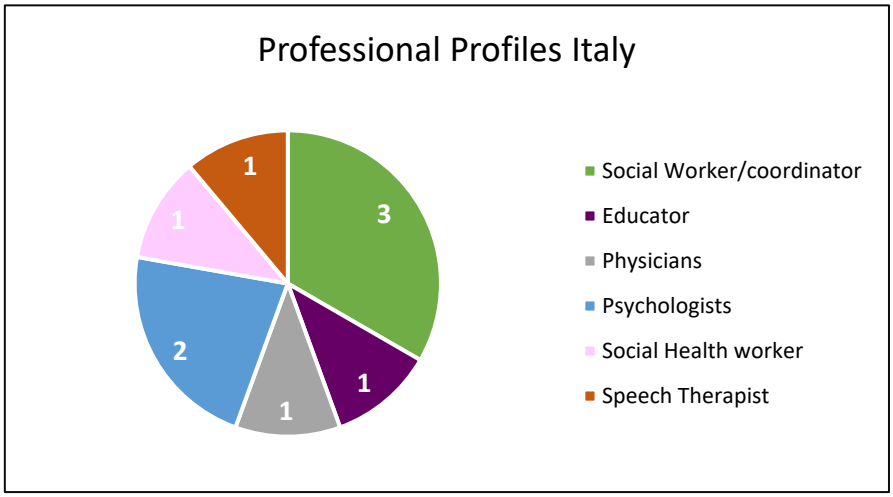

Figure 3. Professional Profiles Italy

Figure 4. Professional Profiles Lithuania

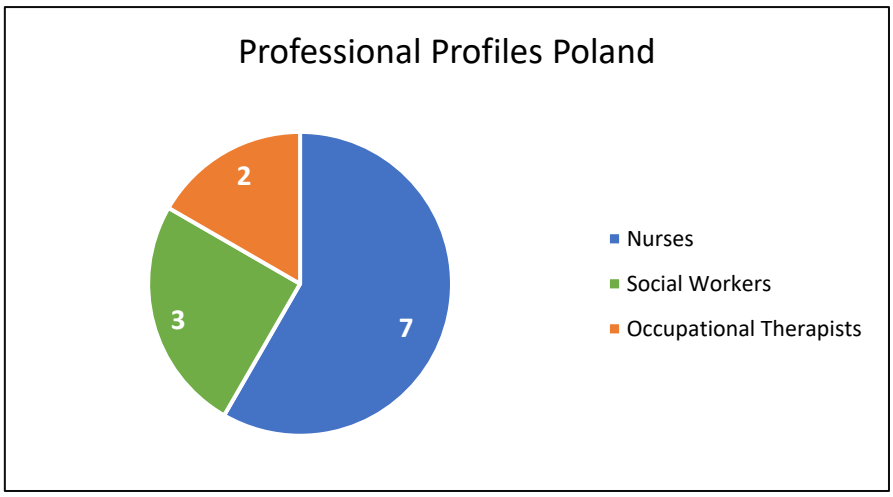

Figure 5. Professional Profiles Poland

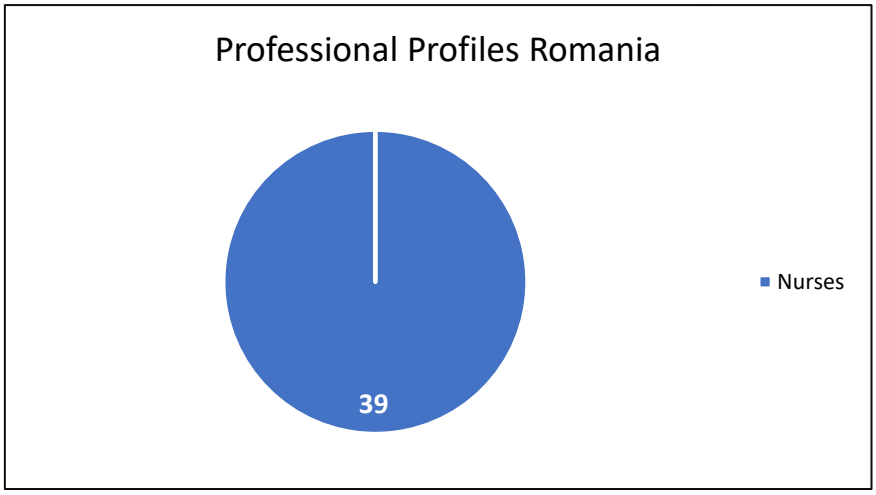

Figure 6. Professional Profiles Romania

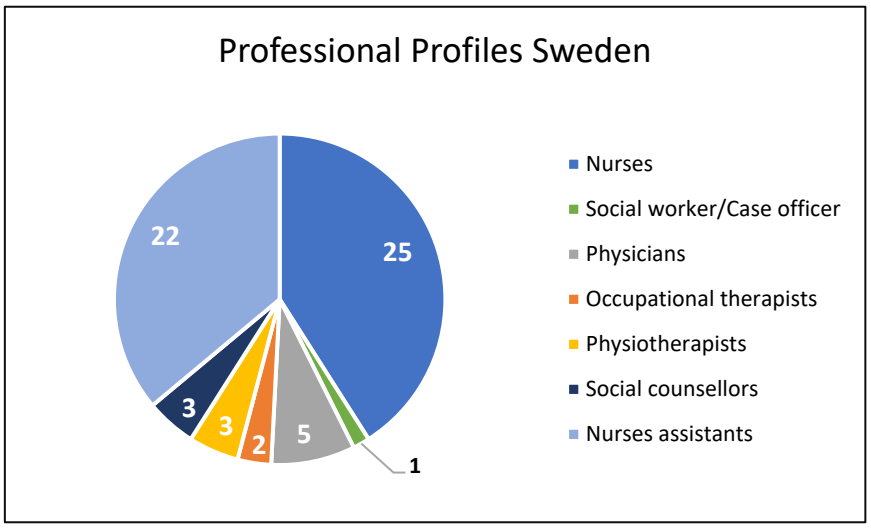

Figure 7. Professional Profiles Sweden

Their professional experience in health care range from 1 year and 8 months to 43 years, with an average of 19 years. Below you can find information on the professional experience of professionals involved in the different countries:

- Italy: 10-40 years (Mean 27);
- Lithuania: 6-40 years (Mean 24);
- Poland: 7-20;
- Romania: 1 year and 8 months-36 years;
- Sweden: 4-43 (Mean 19).

3.3 Level of education

For what concerns the level of education the majority of participants have the high school diploma. As you can see in the diagram below (*Figure 8*) 74 of them have a high school diploma (53%), 29 have a bachelor degree (21%), 34 have a master degree (25%) and 2 have a Phd (1%).

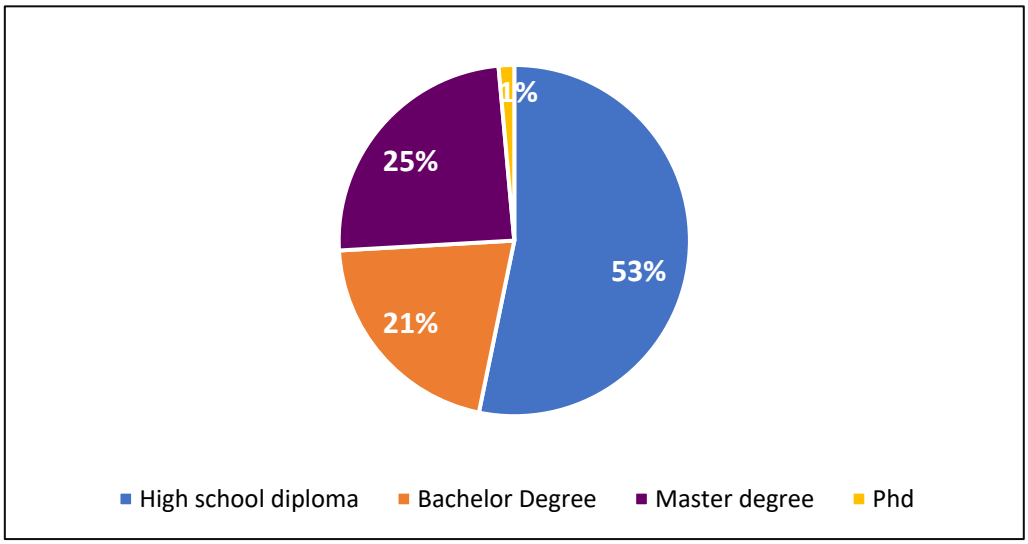

Figure 8. Level of education professionals involved

3.4 Social and Health Care contexts

Professionals interviewed work in 7 different social and health care contexts: Home care (n=42; 30%), Nursing/residential homes (n=26; 19%), Primary care (n=27; 19%), Hospitals (n=21, 5 of which working in pre-hospital care; 15%), Palliative care (n=21; 15%), Social Service (1%) and Voluntary Association (1%) as represented in the diagram below (*Figure 9*).

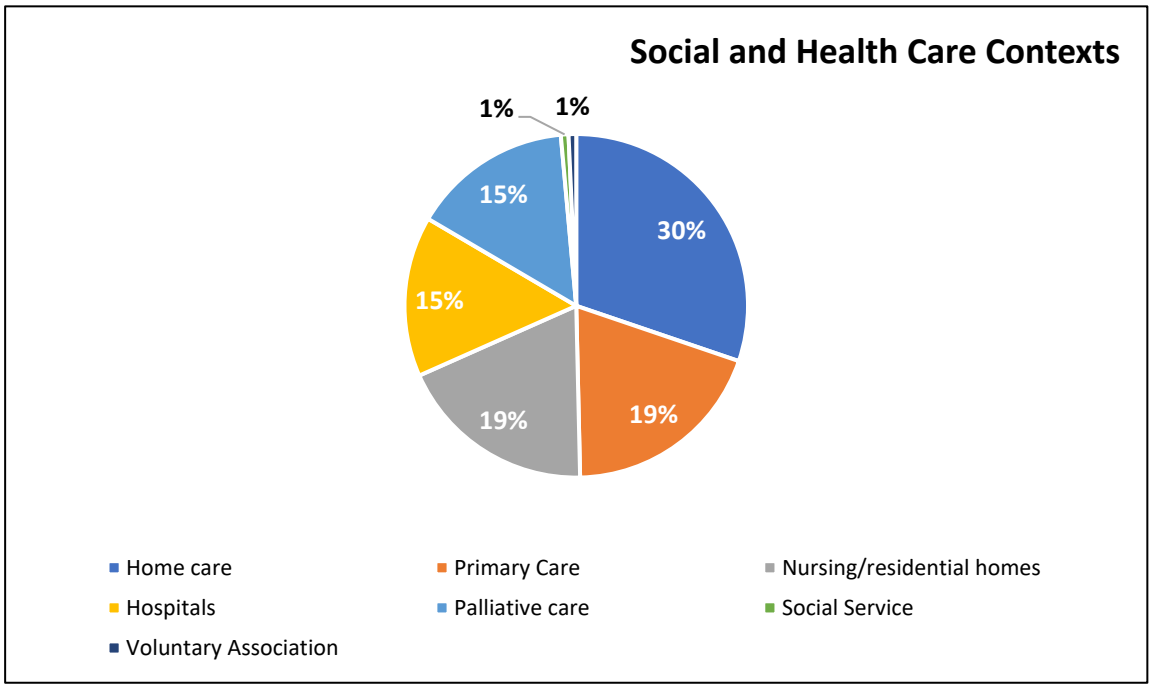

Figure 9. Social and Health Care Contexts

3.5 Training on Loneliness

At the end of the questionnaire participants were asked if they had ever attended any training on the topic of loneliness. Except 3 professionals (an Italian educator, who attended 2 hours training about loneliness among young people, a Polish and a Lithuanian professional) the other professionals involved in focus-groups and interviews have never attended a training on this topic.

4. PART 1: EXPLORE HEALTH CARE PROFESSIONALS' UNDERSTANDING, PERCEPTIONS AND EXPERIENCE OF EXISTENTIAL LONELINESS AMONG OLDER PERSONS

4.1 Loneliness in general

In order to explore health care professionals' and social workers' understanding, perceptions and experience of existential loneliness among older persons, during the research they were asked to share their considerations and experiences about loneliness in general and in their daily work with older persons. This allows to put in evidence similarities and differences in the perception of loneliness between professionals.

Experience of loneliness among older persons

ITALY

In Italy most of professionals interviewed refer that everyone, at least once in their life, has experienced loneliness and recognize at least 2 different aspects of it: a positive one, due to the fact that loneliness is sought and wanted, a sort of intimate need; and a negative one in case of a loneliness that it is forced and that causes suffering. They all share the idea that one can feel lonely even if he/she is surrounded by many people. It also arises the idea that loneliness is not only about a lack of relationship with other people but it concerns also a lack of relationship with own self, a sort of „desert" characterized by a lack of contact with one's own history and values.

Loneliness is also seen in relation to the feeling of not being understood, this feeling seems to push people to detach from other people; or when personal expectations are disappointed. In some cases, also dealing with people that try to prevaricate, can make you feel lonely. They also recognize loneliness as a way of protecting oneself from the outside world. One of the professionals interviewed sees loneliness as a complete lack that doesn't allow you to take care of yourself and to respond to your basic needs as well as a lack of people interested in your well-being.

All Italian professionals encountered many loneliness situations during their professional activity. Due to the variety of professionals interviewed and the different contexts in which they are working and living, their professional experiences of loneliness among older people show a great variability.

In small communities they seem to encounter less situations of loneliness, meaning with this term a condition both physical than emotional, maybe because they are mitigated by the more frequent social relationships such as neighbourhood, family, associations and volunteering.

In residential homes for elderly people it happens that they show they feel alone, or even they verbalize this feeling that, sometimes, seems to be connected with the perception of not being

understood or that other people (for example their children) don't care about their feelings. Residential homes for elderly people try to contrast loneliness promoting socialization (proposing different activities in group) and, at the same time, promoting the maintenance of family bonds.

Memory impairments seems to make things worse because people forget that, maybe few minutes before, had contacts with their relatives and they feel lonely again. Besides it also complicates actions that can be taken: „if one day I found a way to breach their feeling of loneliness, the day after they don't remember it and the potential positive effect went away".

Even when loneliness seems to be sought, it can hide a deep malaise, like a psychological disorder, maybe not recognised before (depression, anxiety, compulsive accumulation.). Frequently loneliness in elderly people is related to the loss of the partner; the situation seems to worse in case of couples closed on themselves that had few contacts with other people. In some cases, these elderly people have children, that maybe live nearby and that are present in their lives, but this doesn't prevent them from feeling lonely.

In some cases, loneliness seems to be related to an objective physical isolation (for example elderly people who live in the old part of the city that can be reached only by foot, or live far from the inhabited centre, or don't have the possibility to use ICT - Information and Communication Technology - to be connected with other people...). These situations seem to exacerbate the feeling of loneliness. Loneliness can also be related to family problems or the end of friendships due to misunderstanding or offenses. Sometimes it can be due to the fact that people find difficulties in approaching the illness of their loved ones.

Dementia seems to be related to different kind of loneliness: loneliness experienced by the person with dementia and loneliness experienced by carers. There is a loneliness that the person with dementia perceives and he/she is conscious of and a loneliness that we don't know if the person perceives but that his/her behavioural symptoms can be the expression of. There's also the loneliness of carers, sometimes, after their relative's diagnosis, they isolate themselves from contexts they used to attend before. Sometimes this seems to be due also to the fact that they don't have information about possible help and they feel alone in facing this situation. Other times this loneliness is due to a real lack of help from people close to them. Finally, carers can experience loneliness due to the fact that their loved one is no longer the person they met and with whom they used to share their lives.

In elderly people there is also a loneliness related to how they lived their life (the interests they had, the propensity to social contacts, the way they faced difficulties). Loneliness seems not to be related to the tragic events in life, but to the way people faced them, to the ability to rebuilt themselves and maintain relationships.

POLAND

Polish nurses that participate to focus group, agreed that loneliness is a huge problem among older people. Often, Polish families are not multigenerational, causing a very painful experience of loneliness for older people that have to live on their own. Moreover, an important problem in Łódź is related with architectural barriers which discourage older people from attending social life. This situation makes the city and its structure a place and a promoter of a sense of loneliness.

In Poland women live longer than men, in fact there a lot of lonely women. The other problem is that there is also the lack of sense of connection between neighbours, as it used to be some time ago, is another cause of sense of loneliness and it's a problem that has been reported during the focus group in Poland.

According to the focus group with social workers, loneliness means lack of relations with people and it can affect anyone. It could be also the case related to the loss of relatives, making it very hard to recover by the loss. Finally, they put in evidence, that social services are not prepared enough to support older people.

SWEDEN

The health care professionals' views and perceptions of loneliness in general were that the experience, and the way loneliness is expressed, differs between people. Older people sometimes want to be alone, but can also feel lonely at times. Many older people are content in their own apartment/room and it is important to find out if they want more social contacts or not. It is therefore important to listen to the older person's wishes and needs. There are older people who are lonely and want to have more social contacts, but do not have the strength or will to seek new friends. It is probably harder to get new friends when you are older. In nursing homes there are some people that seldom receive visitors, and some never have visitors, no family or friends. "When they compare themselves to others that have visitors every day – they must feel very lonely". Older people might refrain to talk about that they feel lonely as this can be experienced as shameful. The norm in society is that you should have your family and many friends around you.

The health care professionals (HCPs) expressed that older people who have different impairments (vision, hearing, speech) or that speak another first language could face a challenge situation that makes them feel lonely due to the fact that they can't express their thoughts and feelings. Moreover, older people with cognitive impairment or dementia, can experience loneliness for different reasons as they might feel unfamiliar in an environment with people they do not know. Further, the HCPs expressed that loneliness has to do with losses; loss of bodily strength, loss of partner and/or friends, loss of identity etc. They report that this feeling of loneliness has to do with the sense of emptiness, getting the sense of an empty space that cannot be filled with someone or something else.

Moreover, the HCPs point of view was that loneliness cannot be alleviated through social contacts with people you have nothing in common with (for example gathering the residents in a nursing home, thinking that they will feel less lonely when being together). Older people can feel lonely even if there are a lot of people around they can talk to. "If you can't share deeper thoughts you are still alone".

The HCPs' view was that at the end of life there is a different kind of loneliness – you must face death by your own. No one can share that experience.

LITHUANIA

According to the results of the study, it can be stated that social workers, working in a care institution with the elderly, cannot assess older persons loneliness because they think that older persons, could face some challenges on perceiving loneliness, due to a lack of cognitive and mental abilities: "They are happy to be in the place they are and they don't care about anything else". Social workers summarize the status of older people as disoriented, suggesting that many social workers work with people with dementia.

It has emerged that stereotypical attitudes of some social workers towards mental disorders in older people prevail and higher needs are not identified. Employees feel that older people in institution are not lonely because they have enough social activity and their own hobbies and abilities. Many of them dance, sing, make music, thus realizing themselves. According to employees, loneliness begins to manifest as those abilities begin to fade. By denying the loneliness of their clients, social workers place more emphasis on communication and care, thus not acknowledging the possibility of their loneliness.

External circumstances also contribute to the increase in loneliness. For example, when an institution is quarantined for the flu, most residents feel depressed, not in the mood to embrace gloomy thoughts. Those people who have a lot of diseases choose this condition of loneliness not voluntarily, but because of diseases that lead agony, pain, etc. Poor health (inability to walk) becomes an obstacle to meet the need to communicate, participate in community events.

Loneliness is related to the longing of loved ones, frequent talking about them, waiting for them. Moreover, some of them feel lonely due to the death of their children. Professionals involved in research report that sometimes people living in a care institution present addiction issues, as an attempt to alleviate the sense of loneliness. After drinking alcohol, they call social workers and talk about their feelings, problems that are related to loneliness. In some cases, addiction can be considered a cause of loneliness because relatives did not tolerate that a loved one's drinking, so they were placed in a care home.

Workers sometimes feel that older people come up with loneliness when they get angry with friends or have problems and thus get attention from the social worker. However, in this episode, the need for individual conversations can be seen. Most workers perceive loneliness just in a physical meaning and try to help residents by pointing out the presence of other people around them (workers, specialists, residents, animals).

Often loneliness of the elderly is due to the deaths of loved ones. In addition, the experience of loneliness intensifies in cases of deteriorating health. As the environment of the care institution itself limits communication and social networks, old people often live in longing, when personal hobbies, and interests seem to no longer exist. Their world is shrinking a lot. On the contrary, some older people no longer feel lonely when they enter a care institution, because when they meet other guests with whom to make relations, they reveal themselves, communicate and forget their problems.

Loneliness is most felt during the holidays, especially when other residents are visited by loved ones. Many workers argue that the loneliness of older people is instantaneous, influenced by conflict with those around them, competition. In some cases, loneliness is equated with social isolation, rejection.

According to employees, those who live alone experience loneliness more than those who live in care homes**.**

ROMANIA

Elderly feel lonely in case of the life partner`s death, when, in most cases, they get depressed, uncommunicative and isolate themselves from other people. They become more nervous and sometimes selfish in their relationships with others. They don`t pay any more visits, they talk to children or other relatives less and less, decreasing communication with the neighbours, authority representatives and community members. However, there are also cases in which the exact opposite happens, elderly feel "liberated" after partner`s death. Usually in these cases the relationship between spouses was not bringing them comfort, real communication and help. In such rare cases, and it is women cases most often, their life changes trajectory and they begin to enjoy life more than before, they become more active, and live life without constraints.

Loneliness also occurs when elderly have the children in a different town or, most often, abroad and the relationships are not close and communication is rare or absent. The child-parent relationship has generally a very special importance. In fact, often children undertake in helping and caring their parents, taking care of them until their death through different kinds of support. The elderly complain that they are rarely visited by the family. Some old people are too proud and do not ask for help from anyone, not even from the family.

Participants mentioned that in rural areas, in many cases, young people, generally men, become alcoholic and forget to look after their parents and check how they are and see if they need help. This fact reported by the interviewed health professionals is sustained by the high scores registered in the recent WHO alcohol consumption for Romania: 67% of men and 31% of women are registered with excessive alcohol consumption[2].

Loneliness also arises from the differences in mentality between young and old, and the increasingly advanced technology deepens this differentiation.

Loneliness can occur when older persons are hospitalized in nursing homes, as they have no one to care for them at home and most of the time they have to pay all their income for the care provided. Elderly feel blocked in these institutions with people they cannot talk to. Total or partial immobilization is a source of loneliness even if elderly live in their homes, in nursing homes or in hospitals. The fear of illness, helplessness, of death makes them feel very vulnerable. Elderly feel more alone because they consider themselves useless. They wish they could do the same activities as before, but, unfortunately, they no longer can.

Many older persons do not feel loneliness due to their religious engagement and practices, as they feel protected by God and know that if they feel lonely or have problems there is a superior force that cares, protects and comforts them.

Summary

All professionals involved in research encountered many loneliness situations during their professional activity. They recognize mainly 2 different aspects of it: a positive one, as loneliness sought and wanted, a sort of intimate need, and a negative one in case of a loneliness that it is forced and that causes suffering. The feeling of loneliness among older persons is very common in all partner countries, often related to the to the deaths of loved ones, with a worse situation in case of couples closed on themselves that had few contacts with other people. Loneliness can be related to an objective physical isolation and has been referred that sometimes the architectural structure of cities not help to improve socialization and mobilization. The lack of relationship with the families and neighbours, as well as family problems or the end of friendships due to misunderstanding or offenses, could raise a sense of loneliness, felt mainly during the holidays when other elderly are visited by loved ones. However, in some cases also if elderly people have adult children and families close to them and present in their lives or if they are surrounded by many people, they can experience a sense of loneliness because this doesn't prevent them to feel lonely. It has been noticed that loneliness cannot be alleviated through social contacts with people who you have nothing in common with, especially because loneliness has been related to the impossibility expressing personal thoughts and feelings. Loneliness doesn't seem to be related exclusively to the tragic events in life, but also to the way people faced them, to the capacity to rebuilt themselves and maintain relationships.

An important issue arose during the research is the loneliness of carers, who sometimes, after their relative's diagnosis, isolate themselves from contexts attended before. Loneliness has been related also to the fact that people find difficulties in approaching the illness of their loved one.

[2] WHO (2018) Global Status Report on Alcohol and Health 2018:284;. https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1

4.2 Existential loneliness

With the purpose of revealing challenges and limitations encountered by healthcare and social professionals in caring for older persons experiencing existential loneliness, the research further explored their understanding of this type of loneliness and their work experience in relation to existential loneliness among older persons.

During the empirical researches in each partner country, it has been asked to participants if they had ever heard about existential loneliness and what was its meaning for them. Asking to healthcare and social professionals about their professional experience, how they had noticed that it was a situation of existential loneliness, as well as if they had any idea of the causes and what did they have done, their suggestions and strategies were detected. In addition, it has been explored the reactions and the management by the participants facing these situations of existential loneliness, considering the feelings that these events evoked in them, how they had handled this kind of situations and how they could have handled the situation differently.

Understanding of existential loneliness

ITALY

In the study 7 professionals out of 9 refer to have heard about Existential Loneliness. All professionals describe Existential Loneliness as a deep and pervasive sensation that you can experience even if you are surrounded by other people, even if there is someone willing to listen and take care of you. It is described as a sensation that can be present in all ages, „an unbridgeable void that at some point does not allow you to stay here and now, and that prevent you to feel life so that you can just fly over it in a detached way". A professional links existential loneliness with the perception that a person has about existence and own self in relation to it; while another one links it to the lack of reference points. Some professionals convey the idea of something chronic that prevents you to overcome isolation and difficult situations.

POLAND

Some nurses that participated to the interviews have never met the term of existential loneliness and they do not distinguish existential loneliness from the other types. They described several situations in their work with elderly people, especially situations of loneliness despite there were close people and families. The nurses involved in research empathise that older people justify their families when they do not visit them in the hospital or not take care of them. In such situations older people become more demanding: they expect extra support from the country and social services, not only to receive practical care, but also to be supported in their emotional needs.

Instead, Polish social workers involved define the existential loneliness as a loss of the sense of life, that cause a falling into depression and the feeling of abandonment.

SWEDEN

After the presentation of the concept of existential loneliness all professionals (n=61) recognized it in older people they met, even if, at that time they didn't know it was existential loneliness. The result showed that the HCPs experience was that older people with bodily limitations were not able to escape from the feeling, and meant being able to see what is going on around them but not being able to take part in, it i.e. living in a world of their own [1].

LITHUANIA

The term "existential loneliness" was first heard by many professionals in the Lithuanian study. According to one participant, this should be related to existence. Participants referred that they can see the nature of existential loneliness in elderly people grief reactions: anger, denial, sorrow or pity. The fact that the population experiences existential loneliness can be predicted from the actions representing deep depression and the need for emotional closeness, "they want to be patted, talked to, hugged… just want warmth".

Older people tend to experience negative emotions within themselves because they have not been taught to reflect on feelings. Therefore, after reporting the loss of a loved one, manifestations of existential loneliness can only be observed, but they are not named. On the other hand, employees do not encourage residents to reflect on their feelings and experiences, because they face some challenges doing it and they react trying to coming up with strategies to overcome the problem on their own, due to the lack of tools and knowledge on managing these issues.

ROMANIA

Participants have never heard about the concept of existential loneliness. They seemed very interested about it and it seems something quite new.

They assimilate it with the need for interiorization and reflection over the meaning of their life or the remembrance of the fact we are all dying human beings, especially when they lose someone important in the family or they realise they get older and time is irreversible.

Experiences of existential loneliness

ITALY

After the presentation of the concept of existential loneliness all professionals interviewed recognized it in older people they met, even if, at that time they didn't know it was existential loneliness. Sometimes this feeling is verbally expressed by elder people, but most of the time, it is unsaid and it is just perceived by professionals. Their experiences with existential loneliness vary a lot: in some cases this deep sense of loneliness was related to the perception of having done nothing important in life, in other cases it was related to the loss of loved ones, in other ones it appears in conjunction with changes in life (i.e. retirement) when it is difficult to reorganize own life. Existential loneliness in many cases seems to be connected to the fear of death and the fear of losing loved ones. One professional refers that, based on his experience, sometimes economic problems can elicit this feeling; another one links existential loneliness with a lack of hope and faith. In some cases of people experiencing existential loneliness the social support offered has been rejected. This can be linked to the fact that often professionals recognize existential loneliness starting from the fact that the help and support that you offer seems to be never enough. In some cases, a deep pain is visible and it is clear that the person needs to unload one's emotions even if he/she refuses to talk and asks to be left alone. Some professionals refer that in case of people experiencing existential loneliness there's often a sort of resignation, the idea that nothing can make him/her feel less lonely, none can help and the situation can't change. Probably they would feel lonely even if they were in company. Other professionals refer that they recognize existential loneliness by some behaviours: frequent pleas for attention (obsessions about the clinical situation, continuous request to have someone to talk to), becoming more silent,

lost in thought and locked up in own self, recurring thoughts and behaviours, physical isolation, apathy, refusal to communicate and lack of appetite.

One professional points out that sometimes elderly people tell you that they feel lonely and, based on her experience, this happens when they perceive that you are not afraid and are willing to face these emotions.

For what concerns the possible causes of existential loneliness, professionals interviewed had different points of view but they all agreed about the fact that it is not possible to trace common causes, it is possible to experience existential loneliness for many reasons. Most professionals relate existential loneliness with a loss (i.e. loss of loved ones, loss of autonomy, loss of personal roles) and changes in life (i.e. changes in health conditions or economic conditions). Two professionals wondered if at the base there is an unrecognized and untreated depressive state. Sometimes existential loneliness seems to be caused by thoughts concerning drawing conclusions about own's life (regrets, remorses, sensations of having left many things to do) or concerning future (fear of death, sensations of still having things to do in this world but fear of not having time).

Two psychologists interviewed related existential loneliness with subjective elements concerning the structure of family origin, education received, affection and attention received in childhood. Based on their experiences, sometimes existential loneliness can have its roots in a family absence, people grow with the feeling of being alone and destinated to be alone, feeling alone seems to become a sort of „state of being".

A participant states that many elderly people come from a poor childhood so they grow up trying to satisfy material needs, once reached them they realize to have not dealt with spiritual ones. This lack of attention to spiritual needs can be related to existential loneliness.

In other cases, existential loneliness can arise from objective causes like being left alone by other people.

Professionals interviewed implemented different actions dealing with existential loneliness:

- Talking to the person who was experiencing existential loneliness about the emotions he/she was feeling in that moment.
- Staying with the person who was experiencing existential loneliness keeping company, letting him/her know that there is someone willing to listen to him/her.
- Having conversations about his/her life focusing on what he/she did, evoking memories.
- Shifting the attention to something else, for example focusing attention to topics that can let him/her feel better, to beautiful episodes of their life. In these cases, it is really important to know the person, his/her interests, his/her story, knowing how to get through to him/her.
- Listening to him/her trying to understand the experiences and the reasons behind these feelings.
- Activating, if possible, family network.
- If needed activating external services or professionals (psychiatrists, social workers, neurologists).
- Promoting participation in associations that offer activities for elderly people.
- Creating aggregative groups for elderly people.

In case of physical isolation, the first thing professionals did was verifying that the person wasn't in a dangerous condition and that he/she was able to take care of him/herself (for example taking medicines, eating, living in hygienic conditions.). Then, in case of need, there was an activation of services (for example meals delivery) and associations.

In general professionals point out the importance, as health and social operators, not to be afraid of facing these emotions, approaching these topics in a delicate and respectful manner.

In many cases actions implemented gave positive results: increasing self-confidence and interest in some activities; relief from suffering; improving mood and, consequently, wellbeing. In some cases, interventions proposed have been positively accepted by elderly people, in other cases professionals met strong resistances: the idea that accepting help made them be less independent, the fact that talking about own feelings can be unpleasant and difficulties in bringing out the emotions felt.

Two professionals referred that in case of existential loneliness the intervention implemented, but maybe any intervention, seemed to be more effort than it's worth and always not to be enough to make the person feel better.

Coming in touch with existential loneliness in elderly people made professionals experience a range of feelings: deep sadness, sorrow, pain, helplessness, sense of loss and desolation. One professional referred that she felt the same emotion the other person was feeling but to a different extent, she empathized with the person who was experiencing existential loneliness. For some professionals getting to know these kinds of situations pushed them to be more present with patients. In some cases, seeing existential loneliness in other people, evoked personal experiences of loneliness, memories and constituted an occasion to reflect on own self and personal story.

Professionals handled this kind of situations in different ways: being empathetic, spending time for listening, inviting the person to speak or involving him/her in activities, keeping company without saying a word, using creativity, focusing on what you have done instead of what you have lost, looking for support (professionals or services, involving the family), validating the emotions felt and working on personal strengths.

One professional referred that the most important thing in handling these situations is not being afraid of facing these emotions but accompanying the person through his/her pain and that can be done only if you have faced your own existential void instead of avoiding it. If you avoid yours, you will avoid also other's ones.

All professionals agreed on the fact that the situation could be handled differently: maybe not being impulsive but taking time to have more information, or taking time to listen, to see things through the person's eyes, instead of trying ways to fix a situation that can't be fixed.

Some professional stated that they would need a greater preparation in facing these situations.

POLAND

Nurses claimed that sometimes there are situations in which an older person lives with a family but is locked in a small room, excluded from family life and that in some cases older people are treated as a source of income (economic violence occurs). They observed that generally, an elderly person is negatively perceived by the environment and that the topic of old age and death is ignored. There is no respect for elderly people, lack of relations in families and problems in understanding that older people should participate in family life.

All the nurses noticed that it is important in their work to talk with the patient, even to drink tea with him/her (in the situation of home care delivered by nurses). Elderly people wait for these situations and even if they talk about the same situations from their life they want to be listened to, feeling that there's time dedicated to them. Quoting an observation of a participant "loneliness is a suffering and we accompany them in this suffering". Some of their patients are reconciled with old age, but others are not and someone else are reconciled with old age but in a negative way. Many of them don't have

any plans for the future. Patients don't talk directly about their loneliness, because it could give a negative opinion about their families, but nurses can read about it among words.

Social workers that participated to the research observed that elderly people that live in Social Welfare Home experience loneliness. However, they got used to the situation. Some of them lost the sense of doing anything and they isolated themselves, saying at the beginning of stay that "I came here to die". Professionals noticed that they need more attention from the staff. They noticed that there are people who can cope with the situation of living in Social Welfare Home. They meet new people, they can talk to the staff (nurses, priests, social workers) and develop their hobbies, etc.

The other problem raised by participants is related to the lack of contacts with families and friends.

SWEDEN

A potential expression for existential loneliness, turned out to be older people's seeking for contact. Seeking contact in vulnerable situations and recurrently seeking for help was interpreted as a way for searching for human contact. Other signs described were when older people distanced themselves from close human contact or showed signs of anger. Other signs described were: looking lonely despite being together with other people, focusing their weakness and decline, smoothing things over, apologizing, and hinting about feelings of shame. Existential loneliness was also described to be characterized by sadness, homesickness, anxiety, anger, and fear of death or dying alone. Also, expressions of guilt, regrets of choices in life and feeling useless, not being significant to others, and feeling alienated from society [1].

HCPs experienced that possible causes of older peoples' existential loneliness could be connected to feeling of invisibility and being forgotten. Further, the difficulty for older people to maintain their routines and independence was another idea of the origin of existential loneliness. HCPs experienced older people to have difficulty in starting new relationships. The HCPs perceived that older people were often occupied by reflections over the life they have lived, the imminent death, feelings of guilt, and regrets [1].

However, the HCPs ideas of the causes of existential loneliness differed between the different contexts [2].

The home care professionals "perceived that the origin of older people's experiences of existential loneliness was related to missing their previous life, no longer feeling needed, being unable to live independently and meaningfully in their own homes and feeling that their children had no time to visit" [2]. Further, the result showed that the experience also perceived to arise when the older person no longer had someone from their own generation to share important life events with. The HCPs perceived existential loneliness to be associated with death [2].

The residential care professionals "perceived that the main origin of existential loneliness in older people was the painful loss of important people in their lives. These professionals also felt that poor relationships between older people and their relatives could lead to existential loneliness, and existential loneliness was associated with feelings of alienation." [2] Another idea of the origin was that the older persons felt like strangers to themselves when they were no longer able to do what they previously enjoyed or when they could not cope with everyday situations. The HCPs perceive existential loneliness to be associated with the approaching death [2].

The hospital care professionals "did not reflect on the origin of existential loneliness or ask older patients about their existential concerns." [2] Further, they perceived that older people did not have any urgent need to talk about loneliness, existential concerns and situations in the hospital. The HCPs

perceived existential loneliness to be related to the end of life and that the feeling of existential loneliness was difficult to talk about [2].

The palliative care professionals "thought the origin of existential loneliness was primarily linked to death, and they described existential loneliness as an inescapable feeling that comes from within. Palliative care professionals highlighted the importance of hope and consolation in times of uncertainty at the end of life" [2]. Further they perceived that existential loneliness at the end of life was not so common among older people and that they seemed to be more content with life compared to middle-aged people. The HCPs also perceived lack of physical contact and a sense of being abandoned to be origins of existential loneliness [2].

It emerged that HCPs experienced difficulties to meet older people who experience existential loneliness. The HCPs perceived four main barriers in the encounter:

- insecurity when trying to interpret and understand the older persons needs and desires,
- reluctance to meet demands and needs they perceived as insatiable,
- insecurity about how to break through the older persons personal shield and
- fear and difficulty in encountering existential issues.

However, some HCPs managed to overcome the obstacles and their uncertainty, but not all [1].

Home care professionals rarely talked about death with the older people in their care. Even though the HCPs believed that communication about meaningful matters could relieve existential loneliness, they had to prioritise among tasks and among the individual needs, wishes and requirements. However, the result also showed that the HCPs expressed that encounters about meaningful matters need not necessarily be long, and some time there were time and such conversations were possible [2].

Residential care professionals referred that it was important to address existential loneliness to meet the older person as a person instead of as a resident i.e. a meeting person to person. HCPs described the importance of showing the older person respect and to build relationships, and touch was perceived valuable to creating relationship. However, the results also showed that some HCPs tried to redirect existential conversations as they felt uncomfortable with such conversations, while others said such conversations were important. Some HCPs emphasized the importance of continuing to ask questions to understand, but they also described trying to change the subject when death or dying came up. HCPs also often tried to pair residents to ease their loneliness, but this was not always appreciated by the older persons [2].

Hospital care professionals experienced that existential loneliness among older people was related to the end of life and that feelings of existential loneliness were hard to put into words. Questions from the older persons relatives relating to death i.e. about how long time was left for the older person, was usually answered with standard phrases. The HCPs believed that it was important for the older person to have someone by their side when they died. Further, HCPs described that older patients expressed that they do not want to live anymore and was interpreted as a sign of existential loneliness. Some of the HCPs wished that it was more natural to talk about existential issues. They described that their ability to support older people in existential matters was limited [2].

Palliative care professionals providing home care expressed that they tried to understand and learn about the older persons life, interests, and relations with significant others. To do so they used different tools i.e. photographs, paintings and books. The results showed that the HCPs who provided care to older people at hospice shared thoughts and feelings about meaning and guilt, as they thought it could help relieve existential loneliness. Further, empathetic curiosity was used to open up for

existential conversations to alleviate existential loneliness. Moreover, HCPs used themselves in the encounter, for example being present, listening and having the courage to talk about existential matters. Others thought talking about existential issues were something private and therefore avoided such conversations. To open for existential conversations HCPs also used physical touch or just being silent [2].

Home care professionals experienced that conversations about meaningful matters could relieve existential loneliness. Residential care professionals emphasized the importance of continuing to ask questions to understand. However, they also changed the subject when death or dying came up and the older persons therefore might not get the possibility to talk about matters of importance. Trying to pair residents to ease older persons loneliness were not experienced as successful. Hospice care professionals experienced that sharing thoughts and feelings about meaning and guilt could help relieve existential loneliness. Empathic curiosity and being present, listening and having the courage to talk about existential matters was of importance. To open for existential conversations physical touch and being silent was used [2].

Encountering existential loneliness made HCPs feel insecure, inadequate, and powerless, but in some cases, also compassionate. The felt inadequacy when not being able to reach the older persons or interpret their needs and desires. In contrast, the experience of a mutual understanding was considered as significant moment. Encountering older person's existential loneliness was also characterized by feelings of frustration, stress and feeling drained when HCPs could not satisfy the older person's needs. Further, the HCPs experienced insecurity when they perceived that the older persons distanced themselves but also fear and difficulty in encountering existential loneliness. It could also evoke existential concerns within themselves. However, the events also evoked positive feelings among HCPs for example when the older persons chose to trust them and allowed them to break through their shield, which made the HCPs feel happy and grateful [1].

HCPs feelings of insecurity, inadequacy and powerlessness were probably handled by avoiding exposure to meetings that involved conversations about existential issues. This in turn increase the risk that older people who need such conversations, are not having their needs met [1].

The professionals reflected over the importance of prioritizing conversation and talking about death and dying before it was too late. They would probably have handled the situation differently if they had access to emotional and practical support. Such support could have encouraged them to meet older people's thoughts and feelings about existential loneliness and existential issues and to prioritize these conversations to the same level as other tasks. But also, an awareness of the needs and wishes among the older persons themselves, for example wanting to be alone, i.e. the importance of asking the person what s/he needs and wants.

LITHUANIA

Experts empathize that firstly it is necessary to put in evidence that institution places, the field of research in which the interview takes place, already in themselves create a condition of existential loneliness, because after moving to live in an institution, all people experience significant existential changes. They think, in fact, that all older people that live this situation experience what is called existential loneliness in psychology, due to the fact that limiting their space and movements, life is limited too.

The second specificity of this study is that social workers work with people with exclusively complex disabilities, like dementia, schizophrenia, depression and more. This represents a challenge for

healthcare professionals, especially in the process of eradicating stigmatization to meet the higher needs of these people.

Employees do not essentially identify existential loneliness. This is evidenced by their nonverbal language during interviews: swollen eyes, long pauses during interviews, confusion in concepts, directed language. Existential loneliness can be identified in fragments in the lives of older people by assessing their emotional and physical states or symptoms: lack of constant appetite, behavioural changes, intuitive feeling that something is wrong, lack of security, unfounded anger, apathy, often speechless, boredom. Frequently mention when talking to social workers that they do not want to be visited by their loved ones because they feel angry at being left behind. This feeling of anger towards their loved ones, can mean existential loneliness, related to the fact that they feel abandoned and left alone in a care home, so that even if they suffer for it they prefer not to meet their loved ones. For someone, the characteristics of existential loneliness are attributed to personality character traits which according to the study participants, are impossible to change.

Sometimes economic aspects could bring a sense of existential loneliness. It has been said by participants that it could be hard for older persons to accept not have control over all their money (i.e. social benefits and pensions received) and give it to care homes. Probably they feel that are losing control on their property and they are not happy to spend money that they would like to use buying things they want.

ROMANIA

After the presentation of the concept of existential loneliness professionals mentioned that they rarely recognise it in their patients.

Nurses mentioned elderly suffering of existential loneliness feel sad. Elderly communicate rarely, feel alone in the world, loose their appetite, their joy for life and very often they don`t express their malaise in situations in which others do.

Professionals involved add that patients who suffer from loneliness, need more attention from the medical staff, they talk very little, communicate their needs very poorly, this is why they need to questioned about their condition, their state of mind. Nurses and the other staff need to make additional efforts to integrate them, to make conversation, to make them participate in the activities. Usually they ask them about their life experiences in order to stir their desire to talk. The elderly sometimes become capricious and grumpy, even if they are visited by relatives or medical staff and want to be left alone. Patients are no longer active, they become melancholic and have the nostalgy of their youth or good times.

The pensions that the elderly benefit from are quite small, in most cases, so that pensioners cannot afford too many activities compared to those in other countries (such as: trips). They are sad for not having the chance to enjoy a richer and more beautiful life. However, nurses also mentioned that elderly that were accustomed to work and be active all the time do not feel loneliness, they continue to work and resign themselves to dying and reaching a better world.

Elderly people who are brought by the family in the nursing homes feel depressed, consider themselves useless and abandoned by their families. There are cases in which elderly come and ask for help on their own initiative from home care providers present in the urban environment, because they do not get help from the family. Elderly patients hospitalized sometimes feel powerless in relation with their family as they care them too much and tend to suffocate them with too much treatment, too much food and things they do not want, thus spoiling the patient's self-confidence. On the other

hand, some elderly people prefer to come to the hospital because there is someone to help them instead of being alone in their home.

Summary

The research carried out in the different partner countries put in evidence that not all professionals involved have heard about existential loneliness or know its meaning. However, professionals who already know this type of loneliness, describe existential loneliness as a sensation that can be present in all ages. They define it as a deep and pervasive sensation that you can experience even if you are surrounded by other people, even if there is someone willing to listen and take care of you as well as a loss of the sense of life, that causes a falling into depression, feeling of invisibility and being forgotten and the feeling of abandonment. The home care professionals think that the origin of older people's experiences of existential loneliness was related to missing their previous life, no longer feeling needed, being unable to live independently and meaningfully in their own homes and feeling that their children had no time to visit. Further, the results showed that existential loneliness seems to arise when the older person no longer had someone from their own generation to share important life events with and often it is associated with death.

Healthcare and social workers described several situations in their work with elderly people and their experiences with existential loneliness vary a lot. They met this feeling even in situations in which there were close people and families. They identified some possible signs of existential loneliness: feeling lonely despite being together with other people, focusing their weakness and decline, smoothing things over, apologizing, hinting about feelings of shame, sometimes economic problems can elicit this feeling, it can appear in conjunction with changes in life (i.e. retirement) and can be related to the perception of having done nothing important in life or with subjective elements concerning the structure of family origin. It was observed that elderly experiencing existential loneliness decrease communication, feel alone in the world, loose their appetite, their joy for life and very often they don`t express their malaise in situations in which others do.

Professionals interviewed said that they implemented different actions and strategies dealing with existential loneliness, such as staying with the person who was experiencing existential loneliness, talking and listening to her/his emotions, evoking good memories, creating aggregative groups for elderly people and increasing communication about meaningful matters. These actions seemed to relieve existential loneliness.

However, encountering existential loneliness could made healthcare and social workers feel insecure, inadequate and powerless, but in some cases, also compassionate. Professionals could perceive four main barriers facing insecurity due to elderly existential loneliness: trying to interpret and understand the older persons needs and desires, reluctance to meet demands and needs they perceived as insatiable, insecurity about how to break through the older persons personal shield and fear and difficulty in encountering existential issues. Because of that it could happen that workers do not encourage older persons to reflect on their feelings and experiences but, due to a lack of specific knowledge or tools, they may react by coming up with improvised strategies to overcome the problem themselves.

5. PART 2: EXPLORE HEALTH CARE AND SOCIAL PROFESSIONALS' EDUCATIONAL AND SUPPORT NEEDS IN ORDER TO FACE EXISTENTIAL LONELINESS AMONG OLDER PERSONS

5.1 Training needs

Recognizing existential loneliness among older people is the first step to understand this phenomenon, but it's also important to support professionals facing existential loneliness, answering to their educational and support needs. With the purpose to explore the professionals' situation in the different partner counties, the educational and support needs of health care and social professionals dealing with existential loneliness in elderly have been investigated.

During the focus groups and the interviews, we faced the theme of their training needs. On one hand, we explored their support needs in relation to existential loneliness, asking them if they had ever received any support in their work places, what kind of support they received or would like to receive and what are the difficulties in encountering older people's existential thoughts. On the other hand, we examined in depth the skills needed to deal with existential loneliness, asking to participants if they have ever seen ways of dealing with a situation of existential loneliness and what skills have been put in place, as well as what skills should they have. This information allowed the partnership to identify existent good practices and lacks in work settings with elderly and considering them as a basis to create training materials to support professionals.

Support needs of professionals in relation to Existential Loneliness

ITALY

During the interviews, 4 out of 9 professionals declared to receive support to deal with existential loneliness, through recurring supervisions with a psychologist, peer supervisions, moments of exchanges with colleagues and support by the service manager. Professionals that don't receive any kind of support to deal with existential loneliness referred they would like to have the chance to share experiences with colleagues and external professionals, as well as to participate to a specific training about loneliness in elderly people and to have a better collaboration with other services.

The psychologist interviewed, who works in a residential home for elderly people, referred that she would consider beneficial a recognition of the value of these psychological aspects and therefore the constant implementation of projects addressed to psychological wellbeing.

The possible obstacles in encountering elderly people's existential thoughts, highlighted by professionals, can be divided into different groups:

- Available resources (for example time and spaces): sometimes you don't have enough time to spend empathizing with patients or listening to them because of time pressure; or there isn't a private space in which people can talk about personal and intimate issues.
- Professional preparation: not being able/not having the proper preparation to give the support needed, not being able to detect/recognize loneliness situations or patients' needs, not being able to have real contacts with elderly people or to use the right approach to talk and listen to them, being judgmental.

- Professional expectations: if the professional thinks, through his/her intervention, to be able to get to a resolution of the patient's emotional state, this can be considered an obstacle because the risk is that the professional lives an experience of ineffectiveness, frustration and failure. Another limit concerns the idea that it's enough to cheer up the patient at that moment, not considering that, maybe, it can be sufficient spending time talking to them.

- Patients difficulties: in particular in the case of cognitive impairment, it can happen that patients don't remember what it has been said or done the day before, for example they can't remember that they have met their relatives and feel that none care about them. Another obstacle concerns the resistance, from patients, in showing what they feel, as they consider it a sign of weakness.

Professionals agree on the fact that it is important to be aware of these limits in order to not taking more than you can face.

LITHUANIA

Participants to the research have reported that existential loneliness is a very recent theme, so that employees rely on their personal strengths and self-help to address existential issues.

Anyway, they put in evidence that loneliness among older people is a real problem and it can happen that employees in residential home try to solve problems of users loneliness, facing the dilemma of balancing their time between family and work, especially during significant holidays, when they leave from loved ones to provide help to the users.

Social workers admit that they experience emotional fatigue themselves, without being able to distance themselves from work, from users about whom all thoughts revolve. They give the example of death of resident in homecare as a challenge, because funerals also take place on weekends, when they have to give up all and attend the funeral ceremonies of the residents of the care home.

The specifics of the work of social workers do not allow them to have long contacts with clients, because their main work is limited to filling out documents. Therefore, social workers cannot fundamentally delve into the existential problems of clients.

Summarizing the participants' statements, we can see that professionals certainly need support, that probably could be provide through activities of supervision, training and coaching meetings.

POLAND

Nurses involved in the focus groups declared that there are no special trainings dedicated to the problem of existential loneliness. They empathize that is not provided any psychological support for nurses, so they don't feel psychologically prepared to deal with existential loneliness. Additional to this, nurses report that during their work day they are very busy and have a lot of work, so it is very hard to have the proper time to spend talking with patients. Moreover, some nurses have stated that they do not want to continue working with older people.

Social workers that participate to research report that work team employed with elderly face some challenges on communication with older persons. These problems are specifically related to some challenges faced by older people, such as lack of trust, isolation, misunderstanding of the situation and not being willing to talk.

ROMANIA

Participant nurses mentioned that they have not received any specific training for dealing with existential loneliness, they learnt from personal experience or other colleagues experience.

Healthcare staff feel emotionally charged in working with the elderly. At the beginning of the discussion, a nurse spoke about the medical conditions of elderly they need to address, later on the discussion deviates to the emotional aspects of their professional activity such as when they need to listen, to participate and offer counselling when the elderly talk about their problems, that they feel abandoned by the family and that they need to talk to someone and feel important for other people.

Sometimes nurses make efforts to help their elderly patients that get isolated, refuse to talk about their thoughts and problems saying they could not understand them and set barriers to all communication. If nurses do not succeed in motivating the elderly, they feel frustrated and have the feeling they haven`t done enough and maybe someone else would do better, even if they did their best. Nurses mention that introvert persons remain the same in old age, and do not accept to see medical staff and do not accept medical treatment as easily.

At the same time nurses working in the palliative or geriatrics ward in the hospital are burdened with the experiences they live in the hospital. They get emotionally attached to their elderly patients and at the moment of their eventual death they suffer, so they need to learn how to overpass this situation by themselves.

Nurses talk to elderly patients for a limited time, as the number of patients is much too high for the number of staff. Therefore, nurses also need to politely shorten too long discussions and avoid elderly get upset for not providing them the expected attention.

Some nurses learnt from psychologists, in facilities where they work, how to discuss and offer counselling to elderly. However, in the geriatric wards generally there are no psychologists. Nurses feel chronical exhaustion from work, due to the work schedule and discussions or problems encountered in relation with the elderly.

Nurses has reported there is a need for textbooks and continuous professional development courses for nurses to help them understand better and communicate better with the elderly. They mentioned the need to focus more on working with elderly, especially the ones who are experiencing existential loneliness, from the faculty or postsecondary school, at theoretical, as well as during clinical practice.

SWEDEN

The support that the Health Care Professionals (HCPs) received differed depending on the care context they worked in. HCPs working in home-care, residential care, and hospital care setting did not receive any regular or organized supervision, while, HCPs working in palliative care settings were offered regular clinical supervision and organized meetings for reflections [2].

The HCPs experienced a lack of time and resources to support the older people in their care. They particularly needed support in how to meet older people who expressed thoughts of death and a wish to die, and when it was timely to discuss existential issues [1].

It was difficult for the HCPs to interpret older people’s needs and desires and to get through their barriers of bodily impairments and connect. Further, it was difficult for them to have the strength to remain and endure in the encounter. It was difficult for them to overcome their insecurity and find a way to get contact with some of the older persons without threating the older persons private sphere and integrity. It was also difficult for them to overcome their fear in encountering older persons existential issues i.e. to talk about life, death, meaning, guilt and regrets and to share what was important for the older person [1].

Skills needed to deal with existential loneliness

ITALY

In Italy 4 out of 9 professionals have seen different ways of dealing with existential loneliness. The competences put in place were different: active listening, understanding, empathy, ability to involve elderly people, to let them feel at ease in order to feel free to express their feelings and the ability to use different approaches on the basis of the person characteristics and needs.

Professionals identify several skills and characteristics that are needed to deal with existential loneliness:

- Managing emotions (in particular loneliness and depression) and not being afraid of approaching difficult emotions;
- Being able to recognize existential loneliness and give support;
- Sensitivity;
- Humility;
- Empathy and compassion;
- Humanity;
- Respect;
- Authority;
- Non-judgmental attitude;
- Curiosity (getting to really know other people, a true interest towards others);
- Listening skills (and also having and spending time to do it);
- Being able to stimulate conversation (talking about the past, the present and future);
- Good self-knowledge;
- Technical preparation on the topic (psychological skills but also having the appropriate lexicon about loneliness that helps to enter the world of loneliness and make the person feel better);
- Paying attention to own nonverbal communication (for example approaching with a gentle smile, gestures, proxemics) and appearance (having a welcoming look);
- Being willing to step back if I realize I'm not able to satisfy a specific need (for example a person can feel more at ease sharing his/her emotions with a colleague he/she feels more in tune with).

Professionals agree on the need to attend trainings on this topic that give them information on existential loneliness, how to deal with it, help them to understand what people feel, through real examples, and the opportunity to discuss and exchange ideas with other professionals.

LITHUANIA

In Lithuania focus groups revealed that residents of care homes long for religious practices, such as rosary speaking or chanting the litany in local communities. Social workers seem not to be able to meet these spiritual needs. They tend to respond to these needs making use of conventional problem-solving techniques, regardless the nature of the problems or involving them in employment. This actions seem to exacerbate the problem of the loneliness of these people.

Summarizing the interview datas, in the training of social workers different areas need to be improved: the holistic concept of human presence, the medical approach that needs to be changed, the theoretical insight into human strengths, nonverbal communication skills to interact with people with dementia. The focus groups revealed a lack of dignified palliative, person-centered care; lack of supervision, clear vision, strategy and a lack of faith in ownself. Besides social workers interviewed

reffered to have no knowledge of how to deal with burnout syndrome, how to learn to distance ownself from customer problems.

POLAND

In Poland nurses involved in the focus groups reffered that they would like to attend workshops/trainings dedicated to existential loneliness in order to be able to deal with particular, practical situations. These type of workshops could be a good opportunity to expand the nursing education system. In their opinion supervisions could be important because nowadays they don't have any support in dealing with emotions and stress experienced at work. They suggest that the training included a psychological module dedicated to existential loneliness among elderly people.

All Social Workers interviewed agreed on the fact that in their work with elderly people different soft skills are required. Other skills needed to deal with existential loneliness are: knowledge about the topic, empathy, understanding, consistency, trustworthy, involvement and encouragement.

ROMANIA

In Romania nurses involved in individual and group discussions, provided positive examples, life stories and successful solutions about how it can be possible to overcome existential loneliness. For what concerns skills and knowledge needed to deal with existential loneliness nurses interviewed mentioned:

- a deeper understanding of the elderly psychological mechanisms;
- psychological and religious counselling skills;
- knowledge and skills to deal with depression and fear of death;
- empathy (how showing it without being emotionally affected);
- knowing how to offer consolation to patients in severe pain and near-death patients (mentioned by nurses from palliative care);
- knowledge and skills to preserve and enhance a positive attitude in relation with elderly people.

Nurses involved highlighted the fact that also burnout prevention and coping are a serious professional issue in dealing with elderly people, that needs to be taken into consideration. Moreover, specialization in individual and group therapy for existential loneliness as well as occupational therapies are considered very helpful in working with elderly people especially in facilities where there is not a psychologist.

SWEDEN

In Sweden professionals involved in focus groups referred that it was important to have abilities such as being empathic, compassionate, courageous, curious, and being open-minded to overcome various barriers in the encounter with older persons experiencing existential loneliness. It was important to be able to listen, reflect and to be able to switch to the perspective of the old person's life world. It was also important to have knowledge about the person's past and present life to be able to understand the older person's situation. The results also showed that it was important for health professionals to have knowledge of their own norms, preferences. The lack of knowledge of the ageing process could represent a barrier in encountering existential loneliness [1].

The skills put in place differed among health professionals, most of them seemed to be aware of older peoples' experience of existential loneliness. Encountering and dealing with older peoples' existential loneliness was meaningful but also challenging for them, they struggled to overcome barriers in the encounter [1].

For what concerns skills needed to deal with existential loneliness, health professionals interviewed identified different aspects:

- knowledge about the ageing body, life and death;
- courage to engage in existential conversations to meet older persons' needs;
- being able to create trustful relationships to the old person;
- being empathic, compassionate, courageous, curious, and open-minded to overcome barriers in the encounter;
- being able to understand the old person's situation [1].

Summary

According to the findings from different partner countries, it has been put in evidence that professionals involved in research have not received any specific training for dealing with existential loneliness and sometimes they learnt from personal experience or other colleagues experience. They declare to feel stressed and unsatisfied to not be able to deal with loneliness among older persons, having important repercussions on their personal life and on their emotional sphere. Main challenges and difficulties reported on facing existential loneliness are: insufficient available resources, lack of proper time and spaces, inadequate professional preparation on this topic, professional expectations and patients' difficulties. It could be difficult for workers to overcome their fear in encountering older persons existential issues, for example to talk about life, death, meaning, guilt and regrets and to share what was important for the older person

Professionals agreed on the fact that it is important to be able to understand what they are facing and to be aware of their limits, as well as to receive needed tools and supports to be able to work more comfortably and efficiently as possible with elderly. Participants suggest that probably it could be helpful to provide support activities to employees such as training, coaching meetings, recurring supervisions with a psychologist, peer supervisions, moments of exchanges with colleagues and support by the service manager.

The research carried out in the different partner countries put in evidence that many skills are needed to deal with existential loneliness among elderly people. In addition to a thorough knowledge on the topic (that gives professionals tools to recognize existential loneliness), on aging and elderly people psychological mechanisms many other interpersonal skills need to be developed or increased such as: empathy, listening skills, the ability to create a trustful relationship and to involve elderly people, verbal and non-verbal communication skills, the ability to manage emotions and to be supportive, psychological and religious counselling skills. Other skills and characteristics that professionals found to be important are: being courageous, curious, open-minded to overcome possible barriers, sensitive, respectful, having a non-judgmental attitude and a good self-knowledge.

Health professionals involved recognized the importance of these skills, the fact that they have not acquired some of these skills or that some skills need to be improved and that they are not always able to respond to elderly people needs. For these reasons they agreed on the need to attend trainings on this topic in order to have more information on existential loneliness, learn how to deal with it and being able to satisfy elderly people needs.

They also recognized the importance of psychological supervisions, the importance of being supported in dealing with these situations and the emotions that can arise in order to prevent burnout syndrome.

6. CONCLUSIONS

ITALY

All professionals interviewed encountered many loneliness situations in their professional activity. Most of them have heard about existential loneliness and describe it as deep and pervasive sensation that you can experience even if you are surrounded by other people. All of them recognized it in elderly people they met and their experiences vary a lot: in some cases this deep sense of loneliness was related to the perception of having done nothing important in life, in other cases it was related to the loss of loved ones, in other ones it appears in conjunction with changes in life. Often professionals recognize existential loneliness starting from the fact that the help and support that you offer seems never be enough. Actions implemented by professionals to deal with these emotions were different and concerned on one side actions toward the person who was experiencing that emotion (talking, staying and listening to him/her) and on the other side actions on the context (activation of services, professionals, family network...). Coming in touch with existential loneliness in elderly people made professionals experience a wide range of feelings: deep sadness, sorrow, pain, helplessness, sense of loss and desolation. One aspect that seems to play an important role is not being afraid of facing these emotions but accompanying the person through his/her pain and that can be done only if you have faced your own existential void instead of avoiding it.

Half of professionals receive support to deal with existential loneliness through recurring supervisions with a psychologist, peer supervisions or moments of exchanges with colleagues.

Possible obstacles in encountering elderly people's existential thoughts can concern available resources (for example time and spaces), professional preparation and/or expectations and patients' difficulties. Dealing with existential loneliness seems to require different personal skills (i.e empathy, non-judgmental attitude, respect, sensitivity, listening skills…) as well as a technical preparation on the topic. Professionals agree on the fact that to acquire all these skills they would need to have training on this topic that gives them information on existential loneliness, how to deal with it, help them to understand what people feel, gives examples and the opportunity to discuss and exchange ideas with other professionals.

LITHUANIA

The concept of existential loneliness seems not to be known among professionals working in care institutions. However existential loneliness is present in the lives of the residents of the care home and recognized by professionals in elderly people daily activities, in moments of communication, in outbursts of emotions.

In general, social workers tend to respond to loneliness denying this phenomenon or considering it as a temporary problem caused by external stimuli. However sometimes social workers recognize this distress and react empathetically to the needs expressed by elderly people, trying to understand the possible causes of their problems.

Professionals involved pointed out that most residents experience loneliness during the holidays, when other residents are visited by relatives.

Recognition of existential loneliness seems to be hindered by the prevailing negative attitudes in society about the needs of the elderly. Basic and medical needs are most recognized, while the existence of higher needs, such as the spiritual ones, is often ignored.

Social workers interviewed find difficulties in identifying existential loneliness, and its components, as a phenomenon. There is a weak perception of existential loneliness and its impact on professional activity. This leads to negative consequences in professional activities such as burnout, denial of problems, protection and maintenance of stereotypical attitudes. For these reasons a specific training on psychology of the elderly, nonverbal communication and dementia as well as recurring supervisions are needed.

POLAND

Participants agreed that in Poland loneliness is a huge problem among older people and social services are not enough prepared to support them.

Majority of the participants have never heard about existential loneliness. Nurses interviewed don't distinguish these terms while some occupational therapists define existential loneliness as a loss of the sense of life.

Participants described several situations they met during their professional activity related to existential loneliness. They often encountered loneliness situations among close people and families.

Professionals involved pointed out that in our society elderly people tend to be negatively perceived by the environment, the topic of old age and death seems to be ignored. Professionals involved in research report that it is important to care about personal relations working with elderly people, especially due to the fact that elderly people don't received the proper respect and due to the lack of relations in families and involvement of elderly people in family life.

Both groups agreed that there are no special trainings dedicated to the problem of existential loneliness. Nurses are not psychologically prepared for dealing with these situations and, additional to this, during their professional activity have a lot of work to do and few times to spend talking to patients.

All participants would like to attend a training dedicated to existential loneliness. They would like workshops/training that can help them developing soft skills like: empathy, understanding, consistency, trustworthy, involvement and encouragement.

ROMANIA

Existential loneliness is not known among health professionals involved in the focus groups, however they seem very interested about this concept.

The most frequent situations of existential loneliness among elderly people, identified by nurses involved, concerned the loss of life partner, having no family or being isolated from the family, children and other relatives living abroad, being immobilized in bed at home or in the hospital/nursing home. Professionals found that elderly people living in nursing home experience loneliness.

Nurses interviewed pointed out that many elderly people they met in their professional activity don't experience existential loneliness, even if they are in situation of physical loneliness. The reasons, identified by participants, are that they are still active persons and spend their time doing different activities, they have a large group of acquaintances to communicate and interact with, they find relief in religion and are able to enjoy their new life stage.

During individual and group discussions professionals involved provided positive examples and life stories in dealing with existential loneliness.

Nurses mentioned that the skills and knowledge needed to deal with existential loneliness are: deeper understanding of the elderly psychological mechanisms, psychological and religious counselling skills,

knowledge and skills to deal with depression and fear of death, empathy, positive attitude and burnout prevention skills. They also pointed out the fact that specialization in individual and group therapy for existential loneliness and in occupational therapy for elderly, as well as focusing on dealing with existential loneliness during the bachelor studies, master's degree and CPD, could be very helpful for professionals working with elderly patients.

SWEDEN

Health Care professionals involved in the focus groups in their professional activity encountered older persons who experienced existential loneliness. They referred that encountering existential loneliness affected them and their own feelings. It was challenging for them to overcome barriers that obstructed existential conversations with older persons. However, even if they experienced it as a challenge, they found meaningful to encounter older people who experienced existential loneliness. Health care professionals working in home care, residential care and hospital care referred a lack of regular and organised supervision focused on their own feelings and ways of working; they also stated that the support need to be tailored on the basis of their needs and the context of care in which they are working.

FINAL CONCLUSIONS

The empirical researches carried out by partners have revealed a general lack of specific knowledge about existential loneliness by professionals involved in almost all partner countries. However, after the explanation of this phenomenon, it was possible to notice that they often encountered elderly people experiencing existential loneliness during their professional activity. The observation of this type of loneliness among older person is heterogeneous depending on the country professionals come from, as well as on the context they are living and working. Living in small communities has been considered a reducing factor of feeling existential loneliness and professionals encounter less situations of loneliness, probably due to the fact that social relationship with other inhabitants of the town or neighbourhood are more frequent. On the contrary, living in isolated areas could increase the sense of loneliness because there are less opportunities to meet people and share moments of socialization. This challenge adds up to the possible difficulty of creating new bonds in old age, due to a lack of strength or the will to look for new friends.

At the same time, it has been pointed out that the presence of someone is not necessarily a way to prevent or eliminate the sense of existential loneliness, which can actually get worse when you are surrounded by people with whom you don't feel affinity, don't feel you have anything in common or feel unable to understand your deepest thoughts and feelings. Several times during the various researches carried out in the partner countries, participants highlighted how existential loneliness is very frequent also in elderly care institutions, despite the occasion for socialization and sharing. According to what reported by some professionals, existential loneliness is something that goes very deep, bringing with it a sense of emptiness cannot be filled, because it is attributable to a sense of irrecoverable loss of something or someone that is considered very important, as a partner, a loved one, personal identity and physical or mental well-being. This sense of emptiness is however due to something that goes beyond the objective lack, but it can instead be connected to how the elderly person reacts to certain events. Consequently, existential loneliness doesn't seem to be related exclusively to tragic events in life, but also to the way people faced them, to the capacity to rebuilt themselves and maintain relationships.

From a psychological point of view, existential loneliness can also be traced to elements concerning the structure of family origin, education received, affection and attention received in childhood.

Sometimes existential loneliness is not a recent perception but can have its roots in a family absence, people grow with the feeling of being alone, perceiving the loneliness as a destiny and state of being. The deep sense of ordinary loneliness can therefore lead the older person to isolate himself and refrain from cultivating relationships or refusing communication with others.

However, some professionals involved report that during their professional experience they have noticed how older people share their feeling of loneliness when they perceive that person with whom they are talking to is not afraid and is willing to face these emotions. It's therefore evident that among the various skills that a professional working with older persons must possess there is the ability to offer empathic and non-judgmental listening and attitude.

Professionals should be able to observe and detect all signs that may be the manifestation of the need to express their emotions, even if the person refuses to talk and asks to be left alone. When talking about existential loneliness, it is important to highlight that sometimes the person himself is unaware of feeling this sense of loneliness and feels a malaise and a sense of dissatisfaction that can be due to various factors, including detachment from one's own emotions and needs. In this sense, the worker must be able to deal with meaningful matters, managing any barriers and difficulties he/she may encounter in dealing with existential loneliness of the elderly and increasing awareness of one's own limits in expressing and facing existential loneliness. It has been reported that is significant to consider burnout syndrome prevention and coping, that is a serious professional issue in dealing with elderly people. In fact, it is reported how sometimes dealing with existential matters could make professionals feel insecure, inadequate and powerless, bringing them to not encourage older persons to reflect on their feelings and experiences and to avoid situations of conversations about sensitive issues.

It is therefore important to offer healthcare and social professionals the tools and knowledge to develop these skills so that it is possible to observe and interpret older people's challenges, needs and desires. It is fundamental to elaborate individual strategies to handle different situations in a more effective and professional way, without threating the older persons private sphere and integrity and avoiding the necessity of implementing improvised strategies to overcome the problem on their own.

It would indeed be central to offer professionals the chance to share experiences with colleagues and external professionals, to participate to specific training about existential loneliness among older persons and to have a better collaboration with other services, as well as to have moments of support to deal with existential loneliness, through recurring supervisions with a psychologist, peer supervisions, moments of exchanges with colleagues and support by the service manager.

According to interviews findings, a training proposal on this topic can satisfy the healthcare and social professionals' need to have information on existential loneliness, how to deal with it especially under a psychological, communicative and relational aspect, in order to help them to understand what older people feel and how to support them. Participants report that it could be interesting and helpful a training focused on improving knowledge about the aging body, life and death, as well as skills such as empathy, understanding, compassionate, open-minding, active listening and managing emotions, also submitting real and practical examples. It has been underlined the importance of an interactive training, that favors opportunities of discussions and exchange of ideas with other professionals.

Finally, the recent Covid-19 health emergency, that has struck the entire world on 2020, has seen the need to introduce a protocol for the containment of human contacts and social distancing, implemented through the invitation, or obligation in some countries, to remain at own home for a certain period, as well as the suspension of visits by relatives or friends to the elderly living in residential homes. In an extraordinary situation, like this case of forced isolation, it has become even

more evident the importance of recognizing and dealing with existential loneliness among older people, by healthcare and social professionals.

The information included in this report will be the basis for the creation of the learning contents and training materials in the next steps of ALONE project.