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Existential Loneliness in Residential Care Homes for Older Adults: A Qualitative Exploration of Lived Experiences

Soledad existencial en residencias de personas mayores: una mirada cualitativa a las experiencias vitales

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ABSTRACT

This study seeks to understand existential loneliness among people living in residential care homes for older adults through an exploration of their lived experiences. Using a deductive approach – based on a topic guide developed a priori – and a reflexive thematic analysis, 34 semi-structured interviews were conducted with residents of publicly managed care homes in Seville to explore their biographical narratives in depth. Existential loneliness emerged as a recurring feature of everyday life and was linked to factors such as awareness of the proximity of death, the normalisation of the end of life, the absence of a sense of future purpose, the experience of vicarious happiness through family relationships and the existential void left by the loss of significant others. Enhancing the emotional and existential well-being of people living in residential care settings requires fostering meaningful relationships and experiences both within and beyond the care home.

KEYWORDS: existential loneliness; emotional well-being; residential care homes; older adults; life trajectories; end of life; interviews.

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RESUMEN

Este trabajo busca comprender la soledad existencial de personas que viven en residencias de personas mayores por medio de sus experiencias vitales. A través de un planteamiento deductivo –con un guion con temas a priori– y mediante una aproximación temática reflexiva, se analizaron 34 entrevistas semiestructuradas a personas que vivían en residencias públicas de Sevilla para así explorar en profundidad sus narrativas biográficas. La soledad existencial emergió como parte de su cotidianeidad, y se enlazó con aspectos como la consciencia ante la cercanía de la muerte, la normalización del final de la vida, la falta de proyecto vital, la vivencia de una felicidad vicaria a través de la familia y el vacío existencial que dejan las pérdidas de personas del círculo cercano. Para mejorar el bienestar emocional y existencial de las personas que viven en residencias de mayores es necesario facilitar relaciones y experiencias significativas dentro y fuera de la residencia.

PALABRAS CLAVE: soledad existencial; salud emocional; residencias; personas mayores; trayectorias vitales; final de la vida; entrevistas.

1. Introduction

Against a backdrop of population ageing and increasing longevity, residential care homes play a vital role in supporting the health and well-being of older adults, particularly those requiring specialised care (Miralles and Rey, 2015). At the same time, these settings face a range of challenges related to adaptation, isolation, loneliness and depression among residents (Zhao *et al.*, 2018). Such issues have become increasingly pronounced and visible in the wake of the COVID-19 pandemic (Ho *et al.*, 2021; Simard and Volicer, 2020) and are also associated with the very nature of residential care homes as total institutions (Goffman, 1961/2001). Living in a care home is often associated with a high prevalence of poor physical and mental health, frailty (Rico-Uribe *et al.*, 2016), dementia, cognitive impairment and sensory disabilities (Lara *et al.*, 2019), alongside the considerable emotional demands that such circumstances may entail (Kitzmüller *et al.*, 2017). Furthermore, evidence indicates that, compared with older adults living in their own homes, care home residents are more likely to experience loneliness – particularly severe loneliness – and social isolation (Simard and Volicer, 2020; Smith *et al.*, 2023). Indeed, feelings of loneliness are highly prevalent in residential care settings for older people in Spain, with reported rates approaching 70% (Molas-Tuneu *et al.*, 2023).

The literature offers an extensive body of theoretical and methodological work on the conceptualisation of loneliness and its multifaceted nature (de Jong Gierveld, 1998). Within this diverse landscape of perspectives and experiences, it is important to clarify both the definition of loneliness and its various dimensions. Loneliness is defined as a subjective feeling of dissatisfaction arising from a discrepancy between an individual's actual and desired levels of social connectedness (Lapane *et al.*, 2022; Peplau and Perlman, 1982). It is generally understood as a multidimensional

experience comprising two principal dimensions: social loneliness, which relates to the quantity of social relationships and is associated with social exclusion and isolation; and emotional loneliness, which concerns the quality and closeness of meaningful relationships and is associated with feelings of abandonment and emptiness (de Jong Gierveld *et al.*, 2018). In later life, a third dimension emerges: existential loneliness. This ontological form of loneliness is linked to the end of life and prompts reflection on life's meaning and one's personal life course (Bolmsjö *et al.*, 2019).

2. Existential Loneliness in Residential Care Homes for Older Adults

Although there is a wide range of operationalisations and definitions of existential loneliness (Gil Álvarez *et al.*, 2023), the conceptualisation most commonly used in the context of older adults and residential care refers to a sense of separation from the world, from other people, from one's former self and, ultimately, from human life itself, regardless of the size or quality of one's social network (Bolmsjö *et al.*, 2019; Yalom, 1980). This creates a gulf between the individual and others that may come to be perceived as insurmountable and incomprehensible to those around them (Larsson *et al.*, 2024).

The transition from one's home to a residential care setting – most often prompted by health problems, vulnerability or widowhood, which frequently intersect (Hajek *et al.*, 2015) – can give rise to existential questions for which residents find no answers, either on their own or through those closest to them, whether family members, caregivers or their newly formed social networks within the care home. Later life is often accompanied by existential reflections on the past, present and future (Sjöberg *et al.*, 2018). These reflections are shaped by circumstances of dependency and care needs, as well as by the experience of living in a standardised environment specifically designed for the provision of professional care. Consequently, residents contend with existential challenges such as emptiness, loneliness, loss of identity and awareness of approaching death (Sjöberg *et al.*, 2018; Sundström *et al.*, 2018), which may become deeply embedded in everyday life and affect other dimensions of health and well-being.

Existential loneliness is associated with the human experience itself, encompassing the search for meaning in life, a sense of purpose, the sharing of everyday experiences, the maintenance of hopes and aspirations, the ability to confide one's worries and joys, as well as experiences of isolation, disconnection from reality and alienation, among other circumstances (e.g. *Bolmsjö et al.*, 2019; Ettema *et al.*, 2010; Larsson *et al.*, 2017). It may manifest as an awareness of being separated from others, expressed through an experience in which social, emotional and existential dimensions are closely intertwined. Moreover, this occurs within an environment where daily life is necessarily shared with other residents and staff members, where external social support and occasional visits from family and friends may be available, and where the institution itself operates according to the characteristics of a total institution (Goffman, 1961/2001). Existential loneliness therefore refers to a condition inherent to the human experience, yet one that is shaped to a considerable extent by both

structural factors – demographic, social and political, among others – and individual factors such as age, gender, health status and family circumstances.

To understand the different layers of loneliness experienced by older adults living in residential care, it is essential to listen to their own accounts within the environment in which they reside. The literature reviewed suggests that themes emerging from experiences of existential loneliness often reveal a tension between negative and positive feelings. Individuals may, for example, maintain hope for the future while simultaneously accepting the proximity of death (Carr and Fang, 2023; Larsson *et al.*, 2024). They may experience profound feelings of abandonment and isolation while continuing to derive meaning from relationships with family and others (Larsson *et al.*, 2023, 2024). They may also experience an ongoing process of grief following the loss of loved ones, while accepting such losses as an inevitable part of life (Paque *et al.*, 2018). More broadly, their experiences often encompass both resignation to living apart from the wider world and a sense of peace regarding the future and a life perceived as having been well lived and now approaching its end (Barbosa-Neves *et al.*, 2019; Larsson *et al.*, 2024).

Given that most studies have focused on estimating the prevalence of loneliness and analysing associated factors, research into the lived experiences of loneliness among people residing in care homes remains relatively recent (e.g. Barbosa-Neves *et al.*, 2019; Jansson *et al.*, 2021; Paque *et al.*, 2018; Prieto-Flores *et al.*, 2011; Victor, 2012). Qualitative studies examining existential loneliness are particularly scarce (e.g. Carr and Fang, 2023; Jansson *et al.*, 2023; Larsson *et al.*, 2023, 2024; Misiak *et al.*, 2024). The principal contribution of the present study lies in the fact that no previous research in Spain has explored existential loneliness in residential care homes for older people. In addition, it introduces an innovative methodological protocol based on a qualitative research design grounded in the social sciences.

3. Objective and Methodology

3.1. Objective

The aim of this study is to explore and gain a deeper understanding of the experiences of existential loneliness among people living in residential care homes for older adults.

3.2. Research Design and Ethics

A cross-sectional qualitative design was employed using semi-structured interviews. The research protocol received approval from the Research Ethics Committee of the Universidad Pablo de Olavide (reference code 23/8-1). All participants provided written informed consent prior to taking part in the study. Institutional support and authorisation to conduct visits to the care homes were granted by the Directorate-General for Older People, Active Participation and Loneliness of the Regional Government of Andalusia.

3.3. Sampling and Participants

Sampling was conducted in two phases. In the first phase, the three publicly owned and managed residential care homes for older people operated by the Regional Government of Andalusia in the province of Seville were selected through convenience sampling (Saumure and Given, 2008). These centres formed part of the fieldwork undertaken for the broader research project within which this article is situated. In the second phase, residents from each care home were selected to form the final sample through purposive sampling (Schreier, 2018), following a three-stage contact and sampling protocol. First, the management of each care home was contacted by email and telephone to provide information about the project and request an in-person meeting. Second, centre staff assisted in compiling a list of potential participants who might meet the inclusion criteria. Third, a preliminary interview was conducted with each potential participant to verify strict compliance with the inclusion criteria. This involved administering a brief questionnaire and consulting once again with professionals at each centre.

The inclusion criteria were willingness to participate in the study, being aged 60 years or older, having lived in the care home for at least three months, and obtaining both a positive subjective assessment of sensory abilities and a positive objective assessment of cognitive functioning (Mini-Mental State Examination score ≥ 24/30 for participants with primary or higher education, and ≥ 21/30 for participants without formal education [Folstein *et al.*, 1975; Escribano-Aparicio *et al.*, 1999]). In addition, once the research team had completed its assessment, each resident who met these criteria was individually reviewed in consultation with specialised staff at the respective care home (psychologist and/or social worker) in order to minimise screening errors. The sole exclusion criterion was failure to meet any of the above conditions.

All residents who met the inclusion criteria were selected, resulting in a potential sample of 44 individuals, of whom 34 were ultimately interviewed. At Heliópolis, located in the municipality of Seville, 17 residents were interviewed. The care home had a capacity of 168 places and accommodated a population in which 90% of residents were considered at risk of vulnerability or social exclusion, primarily due to homelessness or housing insecurity. At Huerta Palacios, located in the municipality of Dos Hermanas and with a capacity of 134 places, 10 residents were interviewed. At Marchena, which had a capacity of 56 places and primarily accommodated individuals with care dependency needs, seven residents were interviewed. Table 1 provides an overview of the sample characteristics.

Table 1
Sample profile

Variable	Category	n	% / Mean
Care home	Heliópolis	17	50
	Huerta Palacios	10	29
	Marchena	7	21
Age	*Mean (years)*	34	*77.4*
	60–69	7	20
	70–79	15	44
	80–89	8	24
	90+	4	12
Gender	Male	14	41
	Female	20	59
Marital status	Single	12	35
	Divorced	8	24
	Widowed	14	41
Time since widowhood or divorce	*Mean (years)*	24	*18.8*
Education	No formal education	12	36
	Primary education	11	32
	Secondary or higher education	11	32
Mini-Mental State Examination	*Mean (score out of 30)*	34	*24.6*
Previous residence in a care home	Yes	21	62
	No	13	38
Length of stay in current care home	*Mean (years)*	34	*6.1*
Total time spent in care homes	*Mean (years)*	34	*7.9*
Main reason for admission	Health	16	47
	Loneliness	5	15
	Vulnerability	9	26
	Other	4	12

Source: own research.

3.4. Data Collection

Participant recruitment and fieldwork were conducted between December 2023 and June 2024 by a research team with extensive experience in qualitative research involving older adults.

Drawing on previous experience of interviewing older people (García-González and del Rey, 2021), the interviews followed a philosophy of 'kind science' or 'caring science', characterised by two key features. First, given the emotional intensity of encounters with residents, fieldwork was scheduled so that each member of the research team conducted no more than one interview per week. Second, a dual-interviewer system was employed, consisting of a primary interviewer and a secondary interviewer. The

primary interviewer led the conversation, while the secondary interviewer took notes, monitored the emergence of topics from the interview guide and contributed to the discussion when necessary. This approach enabled the primary interviewer to focus exclusively on the conversation, while the secondary interviewer captured nuances in both the verbal interaction and participants' non-verbal communication, as well as observations relating to the surrounding environment. This organisation also facilitated a more balanced distribution of the emotional demands associated with conducting in-depth conversations on emotionally sensitive topics.

The interviews were conducted face to face in private areas of the care homes, ensuring both the confidentiality of the process and the participants' ability to speak openly about their experiences. Interviews lasted approximately 60–70 minutes and were structured around a semi-structured thematic guide comprising seven topics related to loneliness and emotional well-being: life trajectories prior to admission to the care home; reasons for admission and the adaptation process; family relationships and bonds; social networks within and beyond the care home; identity and existential reflections; health and autonomy; and the residential care home as a total institution. All interviews were audio-recorded and transcribed verbatim by members of the research team with experience in transcribing interviews with older adults. To ensure data quality and fidelity to the audio recordings, the transcripts were reviewed by the same researchers who had conducted the interviews.

3.5. Interview Analysis

A reflexive thematic analysis was undertaken (Braun and Clarke, 2006, 2021, 2022). Given the limited body of research on existential loneliness, the complexity of the concept, the difficulty of accessing the study population, and the highly subjective, stigmatised and socially sensitive nature of the topic – which meant that loneliness was rarely discussed explicitly during interviews but instead emerged in multiple ways, primarily as a latent category – a deductive approach to data analysis was adopted (Green and Thorogood, 2018). This approach allows researchers to draw on theoretical frameworks previously developed in the literature, thereby facilitating the interpretation of complex and sensitive phenomena such as existential loneliness. From this perspective, the analytical categories were identified on the basis of the themes included in the interview guide, theoretical and conceptual frameworks relating to loneliness, and prior research experience.

The interview process and thematic analysis were closely intertwined, focusing on the existential, emotional and family-related experiences reported by residents that might be associated with their emotional well-being and everyday life within the care home. Although the main themes had been identified *a priori*, an open-coding approach was also adopted to enable the identification of emerging themes relating to existential experiences (Thornberg and Charmaz, 2014). Following the principles of reflexive thematic analysis (Braun and Clarke, 2021), a flexible approach was employed, allowing adaptation to different theoretical frameworks and particularly well suited to the study of subjective experiences. Accordingly, Braun and Clarke's (2006) analytical process was adapted from six to four stages: (1) reading and familiarisation; (2) initial manual

coding of the transcripts; (3) developing and refining the content and meaning of themes and categories; and (4) writing up and interpreting the findings. Although the sample included residents with diverse profiles (Table 1), all 34 interviews were analysed as a single dataset. The authors initially conducted independent analyses, which were subsequently compared and discussed in order to develop, refine and interpret the analytical categories and select the verbatim quotations presented. Following the analysis, saturation was achieved both theoretically and at the sample level.

4. Findings

This study focused on understanding existential loneliness among people living in residential care homes for older adults. In residents' narratives, existential loneliness emerges as a pervasive and multifaceted experience linked to the sense of self, identity, one's relationship with time, awareness of the proximity of death and a symbolic disconnection from the surrounding environment and the people within it. Rather than simply reflecting a lack of companionship in either quantity or quality, it constitutes a form of subjective dislocation in which the world no longer holds the same meaning or interest for the individual, and the narrative continuity of life appears to have been disrupted. Existential loneliness is rarely expressed directly. Instead, it surfaces through silences, learned resignation, memories that are mentioned but not elaborated upon and everyday routines. Four themes were identified as shaping this phenomenon: awareness of mortality and the finitude of life, the absence of a sense of future purpose, the role of family and the creation of vicarious sources of meaning and hope, and unresolved significant losses.

4.1. Awareness of Death and the Finitude of Life

Awareness of death emerges as a constant, normalised and accepted presence, experienced as an ongoing process: dying is not viewed as a discrete future event, but rather as something already unfolding. Death itself is not generally feared, although it prompts reflection, often expressed through humour, resignation, spirituality or silence.

The following excerpts illustrate how residents develop an indirect awareness of their own mortality through the deaths of their mothers and project their own relationship with death through a perspective marked by humour and resignation. This familiarity lends an almost domestic quality to death, normalising what is ultimately inevitable. At the same time, a powerful combination of resistance to death and humorous acceptance emerges, which may itself constitute an existential coping strategy: defusing the gravity of death in order to live more peacefully with oneself.

> Resident [R]: I used to say to my mother: 'Mum, you're getting so old. You'll be dying soon, won't you? Aren't you afraid?' And she'd say, 'Bloody hell, how should I know? How could I possibly know whether I'm afraid of death or not? It doesn't bother me.'
>
> Interviewer [I]: Would you say you're afraid of death?

R: Well, I don't know where I'm going. [...]

I: You don't want to die.

R: No, I don't want to die, but then again, I won't feel anything, just like everyone else. I don't know, who wants death? I always say: 'Once I'm dead, do whatever you like.' They ask me whether I want to be cremated or buried, and I say: 'With how burnt out I already am, am I really going to get any more burnt?' [Woman, 78 years old].

R: The future? Dying [laughs]. [*I: No...*] [Continues laughing] Dying with my boots on. The future I see is dark, very dark.

I: Do you have negative thoughts about what lies ahead?

R: No, not negative. Positive. [Man, 83 years old].

Furthermore, death is not dramatised because it has become integrated into everyday life and experience. Certain underlying certainties run through these narratives: companionship alone is not enough, and as life draws to a close, death is envisaged as a peaceful and welcome transition. The existential significance of death extends beyond how one wishes to die. Residents also speak about how they wish to live until the end and how they hope that end will unfold: without suffering, without violence, with meaning, dignity and companionship.

I: Are you worried about death?

R: Death? It doesn't frighten me. No, it doesn't worry me at all. If I become very ill, they already have written instructions about what to do with me: not to prolong my life, not to try to make me better. Like my mother, my mother died very peacefully. [...] That's what I ask God for – that I die the same way my mother did. Happy. [Woman, 95 years old].

I: How do you see your future?

R: I think I'm going to die very soon. [...] That's what I think, that I'll die very soon. And that's that. My family always gets upset when I say things like that. [Woman, 91 years old].

These testimonies reveal a way of relating to life that incorporates death without turning it into a tragedy, normalising it and making it part of the everyday fabric of existence. Death, as an inevitable end, gives rise to a profound form of loneliness, but it also fosters an ethic of living in the present. Knowing that everything comes to an end – and expressing a wish to die without truly desiring death itself – can lead either to hopelessness or to a form of emotional lucidity in which humour, irony and faith function as mechanisms of resilience. It is within this ambiguity that the strength of these narratives resides, as affirmations of life in which existential loneliness remains latently embedded.

4.2. Absence of a Sense of Future Purpose

The routines and rhythms of residential life often lead residents' personal life projects to fade into the background, with meaning and fulfilment increasingly experienced vicariously, primarily through family members. The absence of a sense of future purpose is reflected in the perception that each day is much the same as the one before: there are few significant events, changes or personal decisions through which time is structured. This way of inhabiting the present, without direction or desire, results in a diminishing of life's forward momentum: rather than building towards something, one simply exists. Accordingly, the absence of a sense of future purpose is often expressed through everyday statements marked by resignation.

> I: Do you do anything in those moments [when you feel sad] to feel better or lift your spirits?
>
> R: I'm always the same. I don't have... better days or worse days. Just the same. [Woman, 76 years old].
>
> I: Is there anything that makes you want to keep living?
>
> R: No. At my age, you think about how old you are and what you're doing... and you understand that something has to happen.
>
> I: What do you expect from the future?
>
> R: What am I supposed to expect? Death, that's all. What can I expect here in the care home? You lose your enthusiasm for everything. [Man, 79 years old].

For many residents, the future contains neither hope, nor personal projects, nor the prospect of meaningful change. There is often no visible trauma, only a sense of disconnection associated with a loss of motivation to engage in activities and, ultimately, a diminished desire to continue living.

> I: What do you expect from life?
>
> R: To die.
>
> I: Do you want to die?
>
> R: Very much. Very much. If there were something to sign, I'd sign it right now. I really want to go... and the thing is, I'm comfortable here! But I still really want to go.
>
> I: Have you thought about why?
>
> R: Well, I don't know why. I just don't feel at peace inside myself [...] And when you reach my age, if you remember me – and you will remember me – you'll see and say, 'How right [name] was.' You lose the desire to go out, to come in, to laugh, to do anything. [Woman, 82 years old].

In many cases, existential loneliness manifests itself through the disappearance of long-term hopes and aspirations. As a result, moments of happiness become concentrated in the short term, emerging from the simplest and most everyday aspects of life within the care home. Small sources of satisfaction, such as watching television or receiving occasional visits from family members, assume a central role in residents' daily lives. To cope with this loneliness, individuals often adapt, almost by necessity, to a reality in which expectations have gradually diminished.

> I: Are there things that still bring you a sense of anticipation or excitement?
>
> R: The telly. I like watching it, yes.
>
> I: And what brings you joy?
>
> R: When my nephew comes to visit. That's what brings me joy. [Woman, 94 years old].
>
> R: Excitement? The television. If there's something good on, I enjoy it.
>
> I: But... in life, is there anything that excites you, anything you look forward to?
>
> R: No, that's what I'm telling you. [Man, 83 years old].

4.3. Family and the Generation of Vicarious Sources of Hope

Residents often experience happiness and hope vicariously through their families, closely linked to the visits they receive, which are imbued with both positive meaning (when visits occur) and negative meaning (when they do not occur or are perceived as insufficient). Thus, in the absence of a clear sense of future purpose or meaningful prospects, residents tend to hold on to what has provided continuity and meaning throughout their lives and continues to do so in the present: family. In many cases, residents describe the presence of their children and grandchildren as one of their principal sources of hope and encouragement. This may be understood as an attempt to anchor their sense of self in their closest interpersonal relationships. Interaction with family members, even when infrequent or brief, remains one of the few sources of genuine happiness in daily life, a reality that becomes particularly significant within the context of residential care.

> I: What kinds of things do you look forward to?
>
> R: Being with my daughters and my grandchildren. When you're here, that's what you want. [Woman, 76 years old].
>
> R: What do I look forward to? Oh, life. Life, life! May God give me the strength to carry on as I am and to see my children and my grandchildren [...] They're young people, sometimes they come and sometimes they don't, but you have to forgive them and leave it at that. [Woman, 83 years old].

When residents say that being with their daughters and grandchildren is 'what I want', they underscore the importance of these emotional bonds in maintaining a sense of belonging and personal worth within a residential context that might otherwise be experienced as alienating. This form of hope, grounded in affection and family relationships, becomes a source of emotional support in the face of a growing sense of existential loneliness. There is, therefore, a reaffirmation of identity through family ties.

Family thus plays a dual role. On the one hand, these relationships may be instrumental and, at times, fragile. On the other, they remain a profoundly positive presence despite their increasingly limited place in the resident's day-to-day life. Residents' narratives frequently combine resignation – regarding physical distance, infrequent visits and relatives who seemingly 'disappear' once a person enters residential care – with acceptance: not wanting to be a burden, recognising that family members have 'their' own lives, acknowledging that 'my' life is now here in the care home, and deciding that 'I'm not going to cry any more'.

> I: When you first came to live here, did you expect people to visit you more often?
>
> R: I expected my eldest daughter to come. That would have been the greatest joy in the world. [...] I cried a lot, but in the end I said to myself, 'I'm not going to cry any more'. That's just how it is, and this is what I have to accept, because it is what it is. [Woman, 68 years old].

Accepting what one has rather than what one hopes for reflects a form of emotional resignation in response to the realities of ageing and residential life. This reinforces the idea that family, although often absent in terms of regular physical presence, remains a crucial source of emotional support and continuity, particularly when interactions are characterised by trust and a sense of emotional affirmation. These accounts illustrate how family, as a central source of identity and belonging, continues to provide meaning and comfort despite the constraints imposed by the care home as a total institution and the growing awareness of approaching death.

> R: What do I look forward to? To be honest, right now... for my children to come and visit, to have a little chat. You become somewhat resigned to the fact that life is coming to an end [laughs]. [Man, 64 years old].
>
> I: How often does he [your nephew] come to visit you?
>
> R: Every week. We go and have a coffee together and he spends a long time talking with me. I talk to him.
>
> I: You prefer talking to people you trust.
>
> R: Of course. Apart from him, I hardly talk to anyone. [Woman, 94 years old].

These narratives reveal a need to preserve emotional bonds even when they have weakened. They also unfold within a framework of separation created by the care home itself – through its physical boundaries, institutional rules and, in some cases,

the lack of direct means of contacting family members. Residents often adopt resigned yet understanding perspectives towards life 'outside' – almost as though referring to what they perceive as 'real life'. In doing so, they justify both geographical and emotional distance, even as something appears to fracture within relationships that were once deeply meaningful when they still lived at home.

> I: Do your children and grandchildren come and visit you here?
>
> R: Yes, they do. Every couple of weeks. Or once a month. Well, whenever they can come. Because they can't always. 'Grandma, we're…' And it's true, they're working. [Woman, 87 years old].
>
> R: [My son doesn't come] because he has to work and be with his family. Be at home and all that.
>
> I: How do those moments make you feel, [when they come to see you]?
>
> R: Wonderful. And they can tell. They know. They know I'm happy when I'm with them. [Woman, 88 years old].

Feelings of being a burden intertwine with a sense of no longer having a place, yet at the same time there is a degree of resentment arising from the lack of time available for visits or even telephone calls. A sense of guilt emerges from the inability to maintain the emotional bonds that once existed, leading to a form of existential disconnection from a family within which the resident had previously occupied a central and organising role.

> R: […] And my daughter has her own life. And she can't come. So that… makes me very sad.
>
> I: You miss…
>
> R: You do miss your family. Even a phone call, because my daughter doesn't even call me. She's not the kind of person who says, 'I'll call my mum and see how she's doing'. But a phone call… people don't realise what it means when someone calls you. A phone call opens something up inside you. I don't know, it makes that day feel different. But in the end, you adapt. What else can you do? They're young. They have their lives, and I have to have mine here. [Woman, 76 years old].
>
> I: Do you have a mobile phone?
>
> R: No, I don't. […] I had one before I moved into the care home. But when I arrived here, my daughter asked me what I needed it for… [Woman, 76 years old].

4.4. Unresolved Significant Losses

The participants described the loss of children and other loved ones as a permanent biographical rupture. What is expressed explicitly – the fact of death itself – is accompanied by what remains unspoken yet clearly implied: the difficulty of accepting the loss, the impossibility of forgetting and its enduring impact in the form of an existential void.

> I: And are you happy with your life?
>
> R: Well... sometimes family deaths come back to me... Thinking about them, the people who are gone, the way they left... That's how it is, this thing about family deaths.
>
> I: And when you feel like that, when you feel down remembering family deaths... do you talk to anyone about it?
>
> R: No, no, no. Then it passes... it comes and then it goes. [Sighs]
>
> I: You keep those feelings to yourself, don't you?
>
> R: [Silence] [Man, 73 years old].

In the voices of the participants, one hears a grief process that has never been fully resolved. These losses are past events, yet they also remain emotional experiences that continue to resonate in the present. The deaths have not been fully integrated into their life narratives and continue to shape the way they experience and make sense of the present.

> I: I had four children, but two of them died. My daughter died ten years ago, when she was forty. She left behind two children, a boy and a girl. [...] And I brought them up myself. [...] Five years after my daughter died, my husband passed away. [...] And then my son, nearly three years ago. [...] When my son died, I suffered terribly. I cried so much. [Woman, 87 years old].

Beyond the pain itself, what underlies these narratives is a profound disruption to personal biography. The people who have died formed an integral part of the residents' identity, and their absence deepens the loss of self that life in a residential care home may already have weakened. This experience is particularly acute when the loss is perceived as contrary to the natural course of life, as in the case of younger family members, and especially the death of a son or daughter. The love that was given and the companionship once shared remain present even though the other person is no longer there. It is here that existential loneliness intensifies: in grief, when the other person continues to occupy a place in one's heart but no longer occupies a place in the world, a profound sense of emptiness may emerge.

> R: My daughter died two years ago... And since then, for me... my life has been over. When you lose a child... Because a mother dies, a father dies, a sister dies, a husband dies. That's normal. But the death of a child is not normal. A mother is not prepared for that. And since my daughter died, I haven't been the same. And what can I do? If God sent this to me. [...] It's something immense. You have to go through it yourself to understand. What can you do? If He wanted to send me that, He must have had His reasons. I've come to accept it. I've come to accept it. [Woman, 82 years old].

Emotional losses associated with degenerative illnesses such as dementia and Alzheimer's disease also leave a trail of existential loneliness. Although death itself may be accepted, far more complex is the experience of watching someone become invisible or unrecognisable while still alive – of having their mind erased and no longer being able to remember them as they once were.

> I: Is there anyone you miss in your day-to-day life?
>
> R: Of course, I miss my children and my grandchildren. And my great-grandchildren. And I miss my sisters-in-law as well. I have a brother-in-law and a sister-in-law who both have Alzheimer's. I went to see them the other day, but I won't go again. My children say to me: 'Mum, I'll take you to see Auntie.' But I don't want to see her like that. I want to remember her as she was.
>
> I: How does it make you feel when you miss these people?
>
> R: I feel... overwhelmed. A little emotional, as I say. Because I miss them. And my mother, and my children. [Voice breaks] Every day I pray for them. That's all I have left. [Woman, 87 years old].

5. Discussion

The aim of this study was to explore how existential loneliness is connected to the life course, everyday experiences and the 'institutionalised' lives of people living in residential care homes for older adults. The existential loneliness emerging from residents' experiences is associated with four key dimensions: (1) awareness of death and the finitude of life; (2) the absence of a sense of future purpose; (3) the role of family and the generation of vicarious sources of hope; and (4) unresolved significant losses.

The findings are consistent with those of other recent studies (particularly those conducted following the COVID-19 pandemic) that have explored existential loneliness in residential care settings using qualitative designs (e.g. Carr and Fang, 2023, in the United Kingdom and Australia; Jansson *et al.*, 2023, in Finland; Larsson *et al.*, 2017, 2023, 2024, and Sjöberg *et al.*, 2018, 2019, in Sweden). Overall, older adults spoke about being aware of, or even wishing for, the proximity of severe ill health and death; fearing abandonment by their families; worrying that they might be forgotten by loved ones or even by themselves; resigning themselves to the loss of the life they had before entering residential care; and accepting their new life circumstances (Barbosa-Neves *et al.*, 2019). Taken together, these experiences help us understand the processes through which existential loneliness, understood as a sense of disconnection from the world, emerges within residential care settings.

The transition from living in one's own home to a residential care home entails, first and foremost, a cognitive shift and a narrowing of the sources of meaning upon which individuals have relied throughout their adult lives, particularly their role as

central figures within their families (Larsson *et al.*, 2024). Second, admission to a care home often results in a significant transformation in individuals' self-perception and personal identity (Goffman, 1961/2001, within the framework of the theory of total institutions). As a result, many of the activities and decisions that once fostered a sense of agency are lost, and within this institutional framework residents have few, if any, opportunities to exercise control over the decisions that shape their current lives.

This residential and life transition is also accompanied by a transformation in both the quantity and quality of family relationships. In general, these relationships become weaker, more instrumental and more routinised, particularly from the perspective of older people living in residential care and receiving visits or contact from family members (Larsson *et al.*, 2023). While some residents maintained close relationships with their children and relatives, others experienced feelings of abandonment or detachment due to a lack of visits or an inability to sustain regular contact. This phenomenon is widely documented in the literature on older adult care, which suggests that residents' expectations regarding family involvement can have a significant influence on their emotional well-being (Sörensen *et al.*, 2002; Larsson *et al.*, 2023). Families play a fundamental role in providing emotional support that can mitigate the impact of existential loneliness among residents (Saarelainen *et al.*, 2020; Sjöberg *et al.*, 2019).

The experience of feeling ignored, rejected or perceived as a burden because residents believe that their families visit out of obligation rather than genuine desire can be deeply painful and may contribute to profound existential loneliness (Sjöberg *et al.*, 2018). Conversely, feeling seen, valued and appreciated contributes to the creation of meaningful existential experiences. Indeed, any experience in which individuals feel cared for, empowered and supported by those around them – whether family members, friends, fellow residents or care home staff – can act as a buffer against existential loneliness and foster hope in everyday life. Attachment theory (Bowlby, 1982) is particularly relevant in this regard. It suggests that the continued presence of our closest relationships, most commonly family members, serves as a central protective mechanism against feelings of emptiness and existential loneliness, whereas their loss or weakening deepens a sense of existential disconnection. Residents' narratives indicate that any form of contact can help alleviate the monotony of routines and institutional regulations. However, it is regular in-person visits, particularly those that allow residents to spend time outside the care home, that appear to have the most beneficial effects (Saarelainen *et al.*, 2020). This observation is consistent with theories of comfort contact (Playfair, 2010), which suggest that face-to-face encounters and opportunities to spend time outside with others can help restore a sense of belonging to the world and thereby prevent social death (Borgstrom, 2016). This concept is closely linked to perceptions of no longer belonging to reality and of life having already run its course and therefore no longer being worth living (van Wijngaarden *et al.*, 2015). These short-term future-oriented relationships in later life within residential settings are associated with having a sense of purpose, experiencing life as meaningful and preserving a sense of self and identity (Mansfield *et al.*, 2021). In this way, they help prevent individuals from becoming, in existential terms, *nobody* (Yalom, 1980). The participants' accounts

reveal a form of biographical pain (Carr and Fang, 2023; Johnson, 2013), reflected in a final stage of life in which there is ample time to reflect on past traumas and failures, painful memories, experiences of grief, unfulfilled promises and other aspects of life that can no longer be changed, all of which may deepen existential loneliness.

Over the course of life in residential care, and likely as a consequence of previous bereavements and losses within their close social circles, as well as transitions towards ill health, the end of life and death increasingly move to the forefront of everyday experience (Paque *et al.*, 2018). The emotions associated with these losses – sadness, loneliness, denial and grief – particularly in cases involving younger family members, are likely to be linked to residents' wishes to die. In some cases, emotional exhaustion, a sense of having no further reason to continue living and persistent boredom also appear to be important factors in perceiving death as something both imminent and, to some extent, desirable (Wijesiri *et al.*, 2019). This gives rise to a sense of waiting in loneliness (Jansson *et al.*, 2021, 2023), or even of sitting alone in a waiting room for death (or heaven) to arrive (Forbes, 2001; Kitzmüller *et al.*, 2017). There is, therefore, a more or less explicit sense of vulnerability, understood as an awareness of one's own mortality and fragility, associated with the perception of having limited social support from one's closest social network (Sanchini *et al.*, 2022).

6. Methodological Limitations

This study has four main limitations. First, it adopts an ecological design conducted in three publicly managed residential care homes within a single province of Andalusia. These centres represent only a small proportion of the residential care sector in Andalusia and Spain as a whole, and one of them accommodated a particularly high proportion of residents experiencing social exclusion. Second, the stringent inclusion criteria resulted in a relatively small sample and may have introduced a degree of selection bias. Third, owing to the complexity of the topic, the interview guide did not explicitly address existential loneliness, although this dimension was implicitly embedded throughout the interviews and emerged naturally during the conversations. Fourth, although existential loneliness is often expressed differently by men and women, the study did not specifically adopt a gender perspective. A more detailed analysis of these differences, as well as of other individual characteristics such as age, educational level, social class or reason for admission to residential care, would require further research.

7. Conclusion

The principal contribution of this study is that it helps address one of the gaps in the Spanish literature on loneliness in residential care homes for older adults through the application of a qualitative methodology. Through the analysis of 34 in-depth interviews, our findings provide evidence that existential loneliness, although expressed implicitly, may coexist with the everyday lives of older people living in residential care settings. This form of loneliness is rarely articulated directly. Rather, through the biographical interview

approach, we infer that it is rooted both in residents' previous life experiences and in their day-to-day lives within the care home. Moreover, it is evident across a wide age range, reinforcing the processual nature of the development of existential loneliness. Existential loneliness is shaped, first, by individuals' life trajectories; second, by the changes in habits, relationships and family dynamics associated with the transition from living at home to living in residential care; and third, by the everyday routines and constraints inherent to life within a total institution such as a care home. Taken together, these three dimensions illustrate how individuals, throughout the transition into and experience of residential care, become increasingly vulnerable, with vulnerability understood as a condition of human exposure in which existential loneliness may emerge.

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