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# Older persons' experiences of Reflective STRENGTH-Giving Dialogues – 'It's a push to move forward'

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## Older persons' experiences of Reflective STRENGTH-Giving Dialogues – 'It's a push to move forward'

### Abstract

**Rationale:** Experiences of the innovative method Reflective STRENGTH-Giving Dialogue (STRENGTH), which is grounded in a lifeworld perspective and developed to improve quality of care, is described in this study. Innovative thinking in developing health and social care, which may include digital solutions, is required to ensure a meaningful and dignified life in old age.

**Aim:** The aim of this study was to describe experiences of the intervention Reflective STRENGTH-Giving Dialogue from the perspective of older persons living with long-term health problems.

**Method:** Individual qualitative interviews were conducted with 27 older persons who participated in the intervention. The older persons wrote notes from each dialogue in booklets, and the booklets became part of the study data, analysed with a Reflective Lifeworld Research approach.

**Results:** STRENGTH is experienced as an opportunity to reflect upon life and identify small and large life projects. Dialogues that lead to change in thoughts and actions influence the older persons' well-being, sense of balance, joy and meaning in life. There is an experience of STRENGTH as a starting point and a push to move forward in an effort to experience joy and meaning in life when living with long-term health problems.

**Conclusions:** STRENGTH has the potential to contribute to quality improvement in person-centred care and enhance meaning in life for older persons living with long-term health problems. However, the use of a digital tool in this particular context poses challenges that must be considered.

**Keywords:** dialogue, digitalisation, intervention, long-term health problem, older person, person-centred care, phenomenology, qualitative research, reflective lifeworld research, STRENGTH.

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## Introduction

Ageing is associated with long-term simultaneous health problems causing dysfunction, difficulties and dependence that influence older persons' daily living and well-being (1, 2). Cardiovascular diseases, cancer, diabetes, hearing loss, cognitive impairment and painful musculoskeletal conditions are prominent in old age and may affect the experience of health and well-being (3, 4). Lack of individual and holistic support in the context of one's own home is highlighted as a problem that needs to be addressed in today's healthcare system (5–7).

Demographic changes, with a growing proportion of older persons living with long-term health problems, challenge today's ways of working in health and social care (1, 2).

Several psychological methods are used to guide individuals in need of support. Methods that focus on changing behaviours to cope with symptoms such as anxiety are cognitive behaviour therapy (CBT) (8) and acceptance and commitment therapy (ACT), a form of CBT (9). Motivational interviewing (MI) is another method, originally developed to treat patients with alcohol problems (10). These traditional methods were invented by psychologists and are used mostly in the context of primary health care (11, 12), and their use among older adults (65+) has not been fully explored and evaluated (13, 14). Additionally, few clinicians are trained to use CBT with older persons (8). As earlier noted, the focus in

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these methods is on changing behaviours or on management of health problems per se, rather than holistic orientation of the persons in their living contexts. Interventions to promote a meaningful and dignified life in old age are needed (15, 16). Available resources need to be utilised more efficiently (17), and innovative thinking is required in developing and renewing health and social care.

The development of mHealth – mobile wireless technologies, such as apps for tablets and smartphones – has increased and may, properly managed, be a support or complement in health care (18). At the same time as the government of Sweden aims to be a world leader in using the potential of digitalisation (19), a large group of residents, mainly in the 65–85 age group, are nonusers of digital technology (20). Impairment of memory, vision, and physical function (21, 22), as well as lack of motivation and social support (22, 23), increases the digital divide (23). A shift in orientation needs to take place in health and social services to increase health promotion and person-centred efforts to meet the needs of community-dwelling older persons (24).

Healthcare professionals, who are the primary contacts and providers of health care, are calling for the development of holistic methods grounded in caring science to be used in the older person's home. In caring science, the subjective experience of health entails the sense of well-being and the ability to balance rhythm, pleasure, courage, meaning and strength in life. It also includes being able to carry out small and large projects that are important to the person in life (25, 26). In order to provide individual and holistic guidance, the innovative Reflective STRENGTH-Giving Dialogue (STRENGTH) (27) method was developed to guide and support the individual in ways that increase a sense of well-being, joy, strength and meaning in life. STRENGTH was used with good results in a previous study with older persons living at home with long-term musculoskeletal pain. Research showed that the method has the potential to improve quality of care when implemented in the context of health and social services in communities (28). STRENGTH in this present study is used in the provision of community health and social care in order to meet the older persons' needs in an often-complex situation when living with multiple long-term health problems. The experiences of STRENGTH are described in this study.

#### *The method: Reflective STRENGTH-Giving Dialogue*

STRENGTH (27) is a method that is ontologically and epistemologically grounded in a lifeworld perspective (29–31). The method was developed by Gillsjö (32) and Berglund (33), based on research findings, in an effort to holistically meet individual needs in the context of health and social care. Central to this method is that the

dialogues are based on the patient's lifeworld, that is the person's experiences, questions and problems, and not on a single health problem (27).

In the present study, 12 healthcare professionals (three physiotherapists, four nurses and five occupational therapists) participated in an educational programme (27), carried out by the authors. STRENGTH aims to strengthen and support older persons' ability to deal with their situation when living with long-term health problems. It was used during 10 dialogues in an effort to enhance the sense of meaning, health, and well-being in carrying out small and large life projects that bring joy and meaning in life. The healthcare professionals used a tactful, didactic attitude grounded in a holistic perspective to state the situation and challenge the person's understanding of one's situation and actions (27). Since a relationship evolves, in which the person's life situation as a whole comes to the forefront (not the disease itself), STRENGTH can be viewed as a way to apply person-centred care (34).

Concepts suggested to deepen reflection, such as health, well-being and suffering, together with analog tools such as pictures and booklets, were available to be used when suited to the dialogues. The pictures were of landscapes and people in different stages and contexts. In the booklets, the older persons could write notes from each dialogue and reflect upon the past, the present and the future in the form of a time line, often with the support of the healthcare professional. Furthermore, by using the image of a weigh bowl in which positive and negative aspects are valued, the older person was able to reflect on the advantages and disadvantages regarding choices in life. A digital tool, SelfSTRENGTH, has been developed to be a part of the dialogues, and it is used in this present study. In SelfSTRENGTH, the focal point is to note the emotion of the day by choosing one of eight faces (smileys) that symbolise different emotional states, for instance happy, satisfied, tired, worried, sad, angry and neutral, which are also labelled in text. The digital tool is also used to engage in goal setting that is significant to the older person's experience of health and well-being. Strengths and difficulties in relation to the goals can be entered, and goals being set, cancelled or fulfilled can be visualised. The goals should be the participants' own and not suggested or controlled by the healthcare professionals.

The method Reflective STRENGTH-Giving Dialogue (27, 28) is illustrated in Fig. 1.

#### *Aim*

The aim was to describe experiences of the intervention Reflective STRENGTH-Giving Dialogue from the perspective of older persons living with long-term health problems.

| Reflective STRENGTH-Giving Dialogue: |  |
|--------------------------------------|--|
| <b>S</b>                             | <b>State the current situation</b>   |
| <b>T</b>                             | <b>Transition from "One to I" and Take charge in the situation</b>                               |
| <b>R</b>                             | <b>Reflect upon possibilities and choices</b>  |
| <b>EN</b>                            | <b>Engagement in fulfilling small and large life projects that gives joy and meaning in life</b> |
| <b>G</b>                             | <b>Get inner strength and courage</b>  |
| <b>T</b>                             | <b>Tactful and challenging approach</b>  |
| <b>H</b>                             | <b>Holistic perspective</b>  |

**Figure 1** Reflective STRENGTH-Giving Dialogue, key dimensions.

## Method

The study has a phenomenological approach (30, 31). Data collection and analysis were carried out according to Reflective Lifeworld Research (RLR), in which the overall aim is to gain an extended and deepened understanding of a phenomenon through description and clarification of lived experiences (35).

### Settings and participants

The STRENGTH intervention was used in a community in the western region of Sweden in autumn 2017 and spring 2018. Inclusion criteria for participation in the study were the following: 65 years or older; living with long-term, persistent, or regularly recurring health problems (such as dizziness, mobility problems, and pain) for at least the past 6 months; and receiving services from home care. Additionally, the participants had to be able to understand and answer questions in Swedish. Contact information for 37 older persons who consented to participate in the study or agreed to be contacted for additional information was provided by the development manager. The older persons were then contacted by phone by the first author. Three of the older persons declined participation in the study due to illness or not feeling in need of dialogue. In total, 34 older persons agreed to participate in the study; however, eight participants ended their participation before the start of intervention or during the intervention due to illness or moving. One participant declined further participation after six dialogues as she did not feel she needed additional dialogues, but she still wanted to be included in the data collection after the intervention. Characteristics of the participants are described in Table 1.

Ten dialogues with each of the 27 participants ( $n = 270$ ) in the data collection were planned to be carried out over a period of 14 weeks. Given the above circumstance with declined participation and additional factors as the older persons' health situation and the healthcare professionals' schedules needed to be

**Table 1** Characteristics of the study participants (before  $n = 34$ , after  $n = 27$ )

| Characteristics                      | <i>n</i> before | <i>n</i> after |
|--------------------------------------|-----------------|----------------|
| Gender                               |                 |                |
| Female                               | 23              | 20             |
| Male                                 | 11              | 7              |
| Age                                  |                 |                |
| 65–74                                | 2               | 0              |
| 75–84                                | 9               | 8              |
| 85+                                  | 23              | 19             |
| Living situation                     |                 |                |
| Single                               | 32              | 26             |
| Cohabiting                           | 2               | 1              |
| Housing situation                    |                 |                |
| House                                | 10              | 6              |
| Apartment                            | 14              | 12             |
| Independent living in senior housing | 5               | 5              |
| Assisted living facilities           | 5               | 4              |

prioritised, the actual number of dialogues carried out in the study was 186.

### Data collection

Data were collected from 27 older persons within 2 weeks after the intervention through interviews conducted in the participants' homes at their request by the first author, a district nurse with experience in community health care. Data consisted of digitally recorded face-to-face interviews, carried out according to the principles of RLR (35), lasting an average of 37 minutes. The opening question, 'Would you please tell me about your experiences of Reflective STRENGTH-Giving Dialogue?' was asked to direct the participants intentionality towards the phenomenon. The interviewer intended to stay curious, open-minded and pliable to the phenomenon by questioning and responding to the participants in order to support and encourage their attempts to reflect on the phenomenon. The verbatim-transcribed interviews,

together with the booklets in which the older persons could write down notes from each dialogue, were part of the analysed data.

### *Phenomenological lifeworld analysis*

In the RLR approach, unreflected lived experiences related to the natural attitude can be examined and conceptualised through reflection, leading to an increased awareness and a deeper understanding of lifeworld experiences and phenomena in the analysis (35). Openness and bridling are the researcher's guiding tools in striving towards a scientific reflective attitude, which involves shifting focus from the natural attitude and being sensitive to the phenomenon and its meanings and open to several possible understandings (36). The analysis was conducted to illuminate the essence or core aspects of the phenomenon on an abstract level, and all its variations and nuances on a concrete level; these elements are termed constituents (37). The data were read repeatedly to create familiarity with the whole content. Units of meaning related to the phenomenon, Reflective STRENGTH-Giving Dialogue, were identified. Subsequent reading was focused on understanding the meaning of every unit, with an attitude of openness and bridling (36). The temporary pattern of clusters emerged, consisting of units of meaning that seemed to be related. The clusters were useful in delineating the essence, the structure of essential meanings that explicate the phenomenon. The analysis continued in order to describe all nuances that constitute the essence. These nuances are illustrated in the study's four constituents, which are illuminated with quotes to present the findings.

## **Result**

### *Essence*

Reflective STRENGTH-Giving Dialogue is characterised as a starting point, a push to move forward and an effort to focus on things that bring joy and meaning in life while living with long-term health problems. The dialogue is characterised by reflection that moves across life as it is, has been and to identify small and large life projects for the future. A prerequisite for the dialogues is a trusting relationship and that the content in the dialogues is based on the older person's life context and needs. The direction of the dialogues is guided by the healthcare professional's ability to challenge the older persons' understanding through questions and tools supporting reflection. As the reflection in the dialogues deepen, the opportunities to summarise life increase, and the focus shifts from obstacles to opportunities in life. When thoughts and actions are foremost stated and confirmed instead of being challenged, a lack of in-depth reflection

needed for the dialogues to be experienced as energising and life confirming occurs. Reflective STRENGTH-Giving Dialogues that change thoughts and actions are of significance for sense of well-being, balance and joy in life.

### *A relationship built on trust and continuity*

A trusting and continuous relationship with the healthcare professional is central in Reflective STRENGTH-Giving Dialogues, since it is of significance for the older person's ability and willingness to open up for dialogues of a deeper nature. 'If you do not like the person who comes, it does not work at all. Then, it turns black'. The importance of the healthcare professionals' ability to be sensitive, listen, show an interest and be able to understand the older persons' situation is described as more valuable than an established relationship. The sense of trust is further gained when the continuous dialogues are carried out with the same person in strict confidentiality. The continuity also allows the dialogue to reach a deeper level since it can be resumed where it ended the last time.

In a relationship built on trust and continuity, the dialogues can serve as a method to break loneliness. They are described as a positive break in everyday life, are yearned for and enjoyed, and help to shift focus from health problems in a way that puts the body in a sense of balance: 'If I have been a little down when she comes, I have been cheerful when she's been leaving'. STRENGTH dialogues, carried out in one's own context at home, are experienced as contributing to an increased understanding and holistic approach regarding the older person's life situation. The relationship is strengthened when the participant is involved in deciding the time for the dialogues and has the freedom to easily cancel the dialogue if it feels too demanding or strenuous.

### *Reflection moves between being shallow and being in depth*

Reflective STRENGTH-Giving Dialogues are from the starting point of the person's life story, experienced as vacillating between being shallow and being in depth. Dialogues that affect one's own existence are described as 'another kind of conversation' that differs from everyday conversations that do not lead to either improvement or worsening of the situation, also described as cold talks. STRENGTH dialogues that stay on general topics, or not are in depth and responsive to the older person's life situation and needs, are experienced as entertaining and exciting which to some extent satisfy needs, but inefficient in conveying inner strength. 'I enjoyed chatting and laughing although it's only superficial, nothing in depth in regard to where I am in life, that's what I think'. The opportunity to reflect upon life with long-term health problems, one's own needs and desires,

worries and grief, as well as what gives joy and meaning in life are areas that are otherwise neglected but have been addressed in a satisfying way through STRENGTH. 'They go very close to me and my life, like no other conversations'. 'We have talked so much about me and no one has ever done that before'. Close relatives are described as having difficulties talking about existential issues.

The acquaintanceships diminish with increasing age, and conversations with other older persons during social activities are not always experienced as satisfying the required need for depth or focus on the individual's situation. Lack of time, priorities, and continuity of healthcare providers can result in superficial conversations that are usually carried out at the same time as an existing intervention is provided. STRENGTH dialogues offer an opportunity to feel valuable and listened to and are experienced as both relaxing and strenuous. 'It can be exhausting to talk this way since one goes so much deeper into oneself than one usually does'. The content of the dialogues is oriented towards the older person's needs, while the seriousness and depth are achieved through the healthcare professional's tactful and challenging approach to support reflection and challenge the older person's understanding. 'I did most of the talking, but she guided me in such a way that she made me talk'. In dialogues in which the content has moved towards a deeper level, the reflection has continued, especially at bedtime and when waking up in the morning.

#### *Obstacles and opportunities in using tools supporting reflection*

In the Reflective STRENGTH-Giving Dialogues, tools supporting reflection are experienced to challenge the understanding and reflection upon existential issues influencing older persons' sense of meaning in life. Possibilities and choices related to the future have emerged, which is experienced as valuable and supportive for the feeling of joy, safety and well-being. The opportunity to use tools supporting reflection facilitates the ability to summarise life in the dialogues and state the actual current situation. 'I think I've gained self-awareness. So this is me, who I am, this I can do, this I can't. Then I need to put demands on myself accordingly'. The focus is shifting from past to present and future, which is found to be more difficult, but valuable, to talk about since 'there is a background to a life and there is a future in life'. Weighing alternative courses of action against each other in the weigh bowl is an opportunity and support in making decisions and reaching 'balance' in life. In one specific case, an older person used the weigh bowl to reflect upon the advantages and disadvantages of moving to an assisted living facility and, through that process, came to an insight about what felt right and made a decision.

Pictures evoke memories in life, support reflection through association, and facilitate the ability to later remember the content in the dialogue. 'You have to sit and think a lot but the pictures were very good, I can recommend it.... It can bring back memories of both this and that'. The use of one's own photographs and mementos is a way to support reflection in participants with difficulties making associations with pictures provided in the STRENGTH dialogues. Writing down goals and feelings for each day in SelfSTRENGTH are experienced to increase the impact and facilitate the planning and implementation of meaningful life projects. On the other hand, written text can be embarrassing if it ends up in the wrong hands, and a digital tablet can steal focus from the dialogues. 'You may use [the tablet] when you are alone...instead, take the opportunity to talk to somebody when you are given the chance'.

The use of SelfSTRENGTH is experienced as a fun break, but its use is hindered by an unwillingness or a fear of not having the strength to learn new technology. Other obstacles are not seeing the benefit, the smileys not feeling real, and lack of support in using the tablet and the digital tool. The health problems themselves, such as vision impairment, memory loss, and reduced hand motor skills, are also experienced as obstacles in using tools to support reflection.

#### *A starting point and a push in finding new meaning*

STRENGTH dialogues are experienced as support for formulating realistic goals and a starting point in changing the life situation. Targeting goals in the dialogues leads to growing thoughts and ideas and an increased desire, willingness, and inner strength to do things that give meaning in life. 'I feel that I want to do more than I have done before. That's what I got out of this'. When goals and meaning in life are followed up in the continuous dialogues, a feeling of being positively 'accelerated' is described. The dialogues are described as giving a 'push' forward in the right direction regarding carrying out issues that the older person had intended to do but had not done. This push provides an opportunity to find a way back to fellowship and context, such as arranging invitations, baking, looking at photo albums, and keeping one's home in good shape. Participants describe finding new meaningful projects, such as going on excursions, visit one's hometown or childhood home, and borrowing books from libraries. The dialogues lead to establishment of new contacts that provide support for life with long-term health problems. The support may be having someone read the newspaper, a housing adaptation that makes it easier to move about more independently in the home, or increased participation in one's own health care. For one older person, the STRENGTH dialogues resulted in scheduling a care planning meeting in which

the person stated that he wants to remain at home until the end of his life. This relieved his concern about having to move, decreased his suffering, and increased his well-being.

## Discussion

The older persons in the present study felt that STRENGTH, carried out with the starting point in their life story and needs and conducted in their own context of home, was a satisfying opportunity to holistically reflect upon life with long-term health problems, areas that otherwise were neglected by both relatives and healthcare providers. This address the need for today's mainly disease oriented healthcare system, to shift focus to a person-centred approach in which the person's will, knowledge and own inherent resources are promoted (38). A previous study concerning STRENGTH (28) focused on older adults living with long-term pain and was experienced by the participants as a new way to talk about life with pain. To support older persons living with long-term health problems, the healthcare providers need to meet them in their lifeworld and in their everyday lives (39). The context of the present study—older persons living with multiple long-term health problems—establishes the importance of having the opportunity to talk and be listened to with regard to one's own entire life situation. The results demonstrate the importance and need of providing holistic person-centred care grounded in caring science rather than traditional psychological methods such as CBT or MI, which foremost are used to deal with one specific health problem at a time (8, 10).

Similarly to the previous study (28), STRENGTH has created support for formulating and fulfilling realistic goals by enabling the older person the inner strength and courage needed to push forward in fulfilling meaningful activities. Previous research defined inner strength as having the courage to continue to strive to find life meaningful (40). Awareness among healthcare professionals about the importance of feeling inner strength and how it is achieved could increase older persons' ability to use their resources in living a meaningful life. Analog tools supporting reflection, along with the healthcare professionals' ability to ask questions, have been useful in this process. The use of SelfSTRENGTH has been found to facilitate the fulfilment of meaningful life projects; however, the older persons have not used the digital tool to the full extent as intended. Obstacles similar to those described in the use of SelfSTRENGTH are confirmed from previous studies (21, 23), revealing that individual characteristics may be an obstacle in using digital technology, and the desire to use it differs. Research also shows that older persons are driven to use technology when it matches their individual needs and wishes (41),

which should be considered when implementing a digital tool in health and social care. If older persons with long-term health problems, especially vision impairment, are to be included in digitalisation, further technological adaptation is needed to reduce the digital divide.

The results confirm that STRENGTH differs from everyday conversations when they reach a deeper level and affect one's own existence. As existential issues are crucial aspects of the provision of health and social care to meet the needs of human beings (42), the dialogues must be in depth for the older person to be able to start a process of reflection. Earlier research established that courage is needed when initiating a reflective process as a healthcare professional (43). Healthcare professionals may also be challenged by conversations that require taking a step back and listening instead of conveying the answers themselves (44). Training communication skills is not systematically developed or regulated in nursing education; thus, communication is essential in the provision of health care (45). Knowledge and competence, together with continuity in care, are improvements required in order to support older persons and increase the quality of care provided (5). Healthcare professionals' education and supervision prior to conducting STRENGTH (27) may respond to these requirements and be beneficial in increasing the well-being of the older persons' receiving Reflective STRENGTH-Giving Dialogues.

## Conclusions

The results address the importance of in-depth dialogues in health and social care in order to promote and preserve individual and holistic guidance and to support and increase the sense of well-being, joy and meaning in older persons' lives. Few interventions are grounded in this context in caring science. New methods, possibly supplemented with digital solutions, need to be developed and studied in the provision of health and social care. Innovative initiatives such as STRENGTH, with a holistic approach based on the person's entire lifeworld rather than on a single health problem, have the potential to be implemented in clinical praxis. This intervention can contribute to improve the quality of person-centred care and enhance the meaning in life for older persons living with long-term health problems. However, use of a digital tool in this particular context poses challenges that must be considered.

### Study limitations

Reflective STRENGTH-Giving Dialogue might be considered a complex intervention as it consists of several interacting components (46). To understand the effectiveness and how the intervention was experienced, both

quantitative and qualitative data were gathered in the project. The extended time needed for the infirm group of informants to contribute to data collection could have affected the length of the interviews in this present study. For the result to be generalised, as suggested by the originator of the RLR approach, the sample should achieve variation of experience and data rich in meaning of the lived experiences of the phenomenon (35). The interviews were carried out, oriented towards the phenomenon, by the same researcher both before and after the intervention, which could enhance the trustworthiness. The variations in gender and housing situation were most prominent; most informants were over 85 years old and lived alone.

The booklets facilitated the analysis of data in cases where the older person failed to remember specific content in the dialogues. In cases where notes were taken by the healthcare professionals, the data were reviewed with great caution as the material consisted of the older persons' experiences that were analysed. Evaluations of complex interventions are often undermined by difficulties of compliance and delivery of the intervention (46). All STRENGTH dialogues may not have reached the depth and quantity as suggested in the approach, and the reflection tools have not been used to the full extent. Nevertheless, the result provides valuable knowledge of how STRENGTH is experienced by older persons, barriers and possibilities that appear, and potential improvements for further development and implementation of the intervention.

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## Authors' contributions

All the authors (CÅ, MB, JH, CG) designed the study and participated in data collection. The interviews were carried out by the first author. All the authors analysed the data, prepared the manuscript for submission, and read and approved the final manuscript.

## Ethical approval

The study was carried out in accordance with the principles in the Declaration of Helsinki (47) and approved by the Regional Ethical Review Board (No. 295-17). Both written and oral information were provided stating that participation was voluntary, confidentiality would be maintained, and participation could be withdrawn without explanation or consequences. Informed consent was obtained from each participant.

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## Conflict of interests

The authors declare no conflict of interest.

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