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Lived experiences of hypertensive older adults living alone in Kendari City: a phenomenological aprroach

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ABSTRACT

Introduction: A decline in the function of the cardiovascular system organs among older adults can be due to age risk factors such as living alone and reporting feelings of isolation or loneliness, thus increasing the prevalence of hypertension. However, their lived experiences including health changes, coping mechanisms, and healthcare needs are largely underexplored. This study aimed to explore lived experiences as evidence-based in developing health services for hypertensive older adults living alone.

Methods: This study employed a qualitative phenomenological approach, with in-depth and semi-structured interviews of hypertensive older adults living alone in Kendari City Southeast Sulawesi. Purposive sampling was utilized. 15 participating older adults, predominantly female, and with ages ranging from 61-80. Data were collected from April until July 2022, and Colaizzi's steps were used to guide the data analysis.

Results: Three themes were identified: 1) health changes in the older adults living alone consisting of physical, emotional, social, and spiritual changes; 2) coping mechanisms consisting of emotion-focused coping, biobehavior-focused coping, social-focused coping, and spiritual-focused coping; and 3) healthcare needs consisting of health information needs, regular health checks, group activities, and spiritual activities.

Conclusions: This research highlights the needs of hypertensive older adults living alone to adapt to their health changes and requiring holistic hypertensive care as well as regular health services. Recommendations in this study include developing a holistic hypertensive care program consisting of physical, psychological, social, and spiritual activities. Further research needs to explore the effectiveness of holistic hypertension care on blood pressure, stress, coping, and quality of life of older adults with hypertension by comparing older adults living alone with older adults living with family, and qualitative research using ethnographic methods to determine the adaptation process of the older adults living alone according to culture.

Keywords: coping mechanisms, healthcare changes, healthcare needs, holistic care, hypertensive older adults, living alone, qualitative study.

Introduction

Hypertension in older adults is caused by changes in the cardiovascular system due to the aging process. Older adults will experience a decline in the function of the cardiovascular system organs which causes vasoconstriction of blood vessels, thereby increasing blood pressure. Hypertension in older adults is caused by changes due to old age and related risk factors (Miller, 2012). uncontrollable risk factors are: age, gender, genetics, ethnicity (Ernawati *et al.*, 2022; Jana and Chattopadhyay, 2022; Kothavale, Puri and Sangani, 2022; Ntiyani, Letamo and Keetile, 2022; Ren *et al.*, 2022), while controllable risk factors are: lifestyle, including obesity, sodium intake, physical activity, smoking, alcohol intake (Gorni and Finco, 2020; Hardiany, Kirana and Prafiantini, 2021; Yamaguchi,

Tuliao and Matsuo, 2021; Kothavale, Puri and Sangani, 2022; Wahyuni, Romadhoni and Ramadhani, 2022), and stress (Miller, 2012; Williams, 2016; Kurniawati, Adi and Widyastuti, 2020; Hardiany, Kirana and Prafiantini, 2021). Changes due to old age and risk factors owned by older adults increase the prevalence of hypertension. Thus, the increase in the number of older adults will be accompanied by an increase in the number of hypertension sufferers.

The prevalence of hypertension increases with age. Nearly two-thirds of older adults experience two or more conditions of chronic health problems and only 0.9 - 2.2% of the older adults do not have chronic disease; the main chronic problem is hypertension (Piotrowicz *et al.*, 2021). The 2020 National Social Economical Survey data in Indonesia show that 9.80% of older adults live alone. Older adult women living alone number almost three times more than men (Wandera et al., 2017; Badan Pusat Statistik, 2020; Adana et al., 2022). Poor older adults increase the risk of living alone 2.84 times compared to rich older adults. Those with high school and higher education levels have 2.38 times the risk of living alone compared to people with low education. The risk of living alone increases 1.90 times if the house they live in is not their own (Adana *et al.*, 2022).

Factors related to older adults living alone include age, area of residence, marital status, poverty status, main source of household income, poor health, and disability. The prevalence of living alone is higher among older parents (70+), living in central areas, and those who are divorced or separated. In addition, living alone is also high among older people who are disabled, financially dependent, and reporting poor health in the past 30 days (Wandera et al., 2017; Shams Ghahfarokhi, 2022). A qualitative study conducted on 10 older adults living alone and experiencing loneliness in Finland fond that there were four themes identified behind emotional loneliness: (1) loss or lack of a partner, (2) lack of meaningful friendships, (3) the complexity of being a person of old age, and (4) disturbing childhood experiences (Tiilikainen and SeppäNen, 2017).

Research conducted in Indonesia in 2022 found that, out of 1233 participants, 16.4% of older adults were living alone. Half of older women living alone reported being lonely and one-fifth of older women living alone reported depressive symptoms (Widhowati *et al.*, 2020). Stress, depression, and loneliness experienced by older adults living alone will affect blood pressure and put them at risk of experiencing various health problems.

Various health risks associated with older adults living alone have been identified. Physical-related risks include increase in hypertension, arthritis, risk of cardiovascular death, coronary heart disease, stroke, risk of dementia, poor sleeping patterns, poor diet, accelerated signs of cognitive decline, and reduced ability to perform activities of daily living (Somes, 2021 ; Carrasco et al., 2022; Huang et al., 2023); psychological related risk including stress, depression, loneliness, and suicidal ideation (Klinenberg, 2016; Widhowati et al., 2020; Somes, 2021; Carrasco et al., 2022); social related risk including loss of interaction ability or isolation (Somes, 2021; Carrasco et al., 2022; Imamura et al., 2024). Many studies have been conducted on the prevalence, related factors, and health risks arising from social isolation and loneliness in older adults living alone but studies on the experiences of hypertensive older adults living alone which include health changes and coping mechanisms used in Indonesia are unclear.

Older people may have illnesses, disabilities, or dysfunctionality that makes them dependent on daily care. Older people living alone may require home care and specialized services such as community outings, meal delivery, financial support, housework support, and so on, as well as healthcare services for mental and physical support. Optimizing social services and healthcare for older adults living alone can help them maintain their independence and promote their physical and mental health. The important goal of welfare policies for older people is to provide appropriate services that allow older adults to stay in their homes and communities instead of entering institutional care (Yi *et al.*, 2021). There have not been any qualitative studies identifying health service needs in hypertensive older adults living alone in Indonesia. High attention is needed from all elements of society in this regard because hypertensive older adults living alone need support from their surroundings considering their lives are more vulnerable. This study aimed to explore lived experience in hypertensive older adults living alone as evidence-based in the development of health services for hypertensive older adults living alone.

Materials and Methods

Research Design

Based on Husserl's perspective, a qualitative descriptive study was conducted utilizing the phenomenological approach. Phenomenological research is a research approach that investigates the everyday experiences of human beings (Larsen and Adu, 2021; Liquori et al., 2024). With this design, diverse themes and subthemes were obtained, and categories

generated about the experiences of hypertensive older adults living alone.

Participants and Setting

This study was conducted in a community setting from April until July 2022 in Kendari City. The sample size was determined by data saturation at which point new themes were no longer emerging. Participants were selected through a purposive sampling technique. This type of sampling calls for the researcher to set a specific criterion that should be followed for participants to take part in the study. Criterion sampling differs from one study to the other and the implementation is according to the study's set research question and available population. It helps to ensure that a quality sample is located without biases to increase the reliability and trustworthiness of the findings (Nyimbili and Nyimbili, 2024). The participants were 15 hypertensive older adults with the criteria: diagnosed with hypertension by doctor, living alone, aged > 60 years, not experiencing cognitive function disorders, and understanding Indonesian. Participant selection commenced by identifying each participant, explaining the research aims, and asking their willingness to participate. The investigators simultaneously recruited the participants while analyzing the data, conducting interviews until data saturation was achieved, indicating that no new concepts of information emerged from the interviews.

Research instruments

The older adults' experiences were explored through a combination of in-depth and semi-structured interview techniques. The interview guidelines were developed based on a thorough literature review. Our research team, comprising experienced professionals, collaboratively developed the interview guidelines. The data collection instruments included demographic data questionnaires, field notes, interview guides, and audio tape recorders. The demographic questionnaires were used to obtain the participant's age, gender, educational level, ethnic group, and length of time the older adults had lived alone. The following topics were asked during each interview in the Indonesian language: 1) What are the problems experienced by hypertensive older adults living alone; 2) How do they cope with their problems; 3) What they thought and felt would support them. Several probing follow-up questions were used to gain more in-depth information from the participants. Field notes were used to capture nonverbal responses and a written record of observed facial expressions and gestures from participants. Audio tape recorders were used to capture deliberations during the interview and later typed up verbatim in the form of a transcript.

Ethical consideration

The research ethics committee of the Faculty of Nursing at Universitas Indonesia approved this study and granted ethical permission number KET-164/UN2.F12.D1.2.1/PPM.00.02/ 2023. The rights of participants were ensured by obtaining both written and verbal consent before data collection. Privacy was safeguarded by pseudonyms. Confidentiality was ascertained by reassuring the study participants that facts and information shared would be unreachable by any other persons except those involved in the study. Anonymity was ensured by using pseudonyms instead of the participant's real identities.

Data collection

The researchers screened potential participants by taking data from the person in charge of the older adults program at the Talia Health Center. Furthermore, the researcher visited the homes of the older adults living alone and explained the aims and objectives of the research. Researchers first conducted a Mini Mental State Examination (MMSE) to determine the cognitive function of older adults. If the older adults did not experience cognitive dysfunction and were willing to become respondents, the researcher submitted informed consent to be signed by the older adult participants. The next researcher contracted the time and place for collecting interview data. Time for the interview was 30 to 50 minutes. The language used was Indonesian. To enhance the data's reliability, participants were invited to review interview transcripts and analyses and make corrections, adding to the credibility of the findings. The triangulation method, incorporating field notes and observations, enriched the research findings by cross-verifying information from multiple sources. The data collection process concluded when data saturation was reached, i.e., when new major themes were no longer emerging.

Data analysis

Fifteen interview transcripts were analyzed using inductive thematic analysis—namely, the interview results were analyzed using Colaizzi's original seven-step method (Praveena and Sasikumar, 2021). The analytical process unfolded as follows: First, the phenomenon was described verbatim based on the participants' opinions or statements in the transcript. Second, the researchers read the entire description of the phenomenon, reread the transcript, and quoted the statement. Third, the

researchers described the meaning in the form of keywords. Fourth, the researchers organized the keywords into a collection of meanings arranged into categories, subthemes, and themes. Fifth, the researchers wrote a comprehensive report on the results. Strict adherence to the original seven-step method was maintained throughout this analytical process, ensuring a thorough exploration of the experiences of older adults living alone with hypertension. The duration of the audit process was one month.

Trustworthiness

The trustworthiness of data is the validity and reliability of qualitative research including credibility, dependability, confirmability, and transferability. Credibility was ensured by returning interview transcripts to participants for verification. All participants in this study agreed with the results of the transcript submitted by the researcher by placing a checklist (√) on each of their answers and not adding to the results of the existing transcript. Dependability involved an external reviewer with a supervisor, also known as an audit inquiry. In this study, the researcher submitted all the results of the interview transcripts and field notes to the supervisor in the form of a soft file which was sent via email so that the supervisor could review the research results that had been obtained. Confirmability was by attaching the final research report and the article was constructed so that readers follow the researcher's flow of thought. This was done by the researcher by showing all transcripts along with field notes, theme categorization tables, and theme analysis tables to external reviewers and attaching them to the final research report and articles so that the reader follows the researcher's flow of thought. Transferability was by describing the themes that have been identified in a similar sample that is not involved in the study to determine using the external check method on other older adults by submitting printouts of the themes that have been identified and asking the trial participants to give a checklist (√) if they agreed with the themes that appeared.

Results

Participants' characteristics

This study explores 15 older adults' characteristics as research participants. Table 1 provides an overview of the participants' characteristics consisting of 10 women and five men with participants' ages ranging from 61 to 80 years. The average participant's education level was not attending school. The participants came from different ethnic groups, namely Bugis, Muna, Buton, Tolaki, and Javanese. The length of time the older adults lived alone varied, from a range of 1 year to 13 years. The participants' characteristics can be seen in Table 1.

Based on inductive thematic analysis method, three themes were identified: 1) health changes in the older adults living alone consisting of physical, emotional, social, and spiritual changes; 2) coping mechanisms consisting of emotion-focused coping, biobehavioral-focused coping, social-focused coping, and spiritual-focused coping; and 3) healthcare needs consisting of health information needs, health checks regularly, group activities, and spiritual activities.

Health changes in hypertensive older adults living alone

Four themes were identified from 15 interview transcripts, namely physical changes, emotional changes, social changes, and spiritual changes. The

Table 1. Study participants' characteristics

Code	Gender	Age (Years)	Education	Ethnic	Time living alone (years)
P1	F	69	Not attending school	Bugis	13
P2	F	70	Not attending school	Bugis	1
P3	F	66	Elementary school	Muna	10
P4	F	80	Not attending school	Bugis	6
P5	F	67	Elementary school	Jawa	3
P6	M	65	Senior high school	Tolaki	2
P7	F	62	Junior high school	Tolaki	4
P8	M	71	Not attending school	Buton	3
P9	F	69	Elementary school	Tolaki	2
P10	F	75	Not attending school	Muna	1
P11	M	66	Elementary school	Muna	5
P12	F	63	Elementary school	Muna	8
P13	M	70	Not attending school	Tolaki	3
P14	M	68	Not attending school	Buton	7
P15	F	60	Senior high school	Muna	4

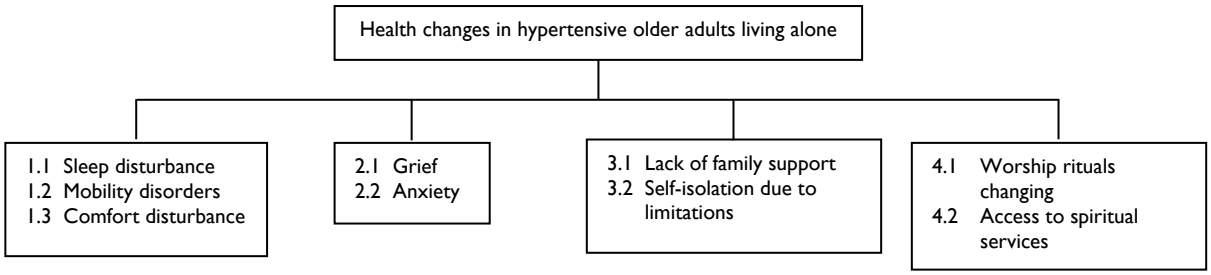

Figure 1. The four themes and nine subthemes related to health changes in hypertensive older adults living alone

theme of physical changes consists of subthemes of sleep disturbances, mobility disorders, and comfort disturbances. The emotional change theme consists of the subthemes of grief and anxiety. The theme of social changes consists of the subthemes of lack of family support and self-isolation due to limitations. The theme of spiritual change consists of the subthemes of worship rituals changing and access to spiritual services. The four themes and nine subthemes related to health changes in hypertensive older adults living alone can be seen in Figure 1. The selection of statements based on themes and subthemes can be seen in Table 2.

Coping of hypertensive older adults living alone

Four themes were identified from 15 interview transcripts, namely emotion-focused coping, biobehavior-focused coping, social-focused coping, and spiritual-focused coping. The emotion-focused coping theme consists of the subthemes of expressing feelings, harboring feelings, ignoring, and positive thinking. The biobehavior-focused coping theme consists of subthemes self-soothing activities, diversion activities, and communicating with others. The social-focused coping theme consists of subthemes of neighbor interaction, peer interaction, and visiting family homes. The spiritually focused coping theme consists of subthemes of praying and performing worship rituals. The four themes and twelve subthemes related to coping of hypertensive older adults living alone can be seen in Figure 2. The election of statements based on themes and subthemes can be seen in Table 3.

The healthcare needs for hypertensive older adults living alone

Four themes were identified from 15 interview transcripts, namely health information, health check regularly, group activities, and spiritual activities. The theme of health information needs consists of the subthemes of information from health workers and sharing with others. The theme of the need for health checks regularly consists of the subthemes of healthcare facilities and home visits. The theme of needs for group activities consists of the subthemes of exercise and group activities. The theme of spiritual activities consists of the subthemes of spiritual guidance and worship ritual guidance. The four themes and eight subthemes related to the health services needs of hypertensive older adults living alone can be seen in Figure 3. The selection of statements based on themes and subthemes can be seen in Table 4.

Discussions

Health changes in hypertensive older adults living alone

Physical changes in hypertensive older adults living alone identified in this study are sleep disturbances, mobility disorders, and disturbances of safety and comfort. Aging is associated with several changes in sleep patterns. Older adults have an increased

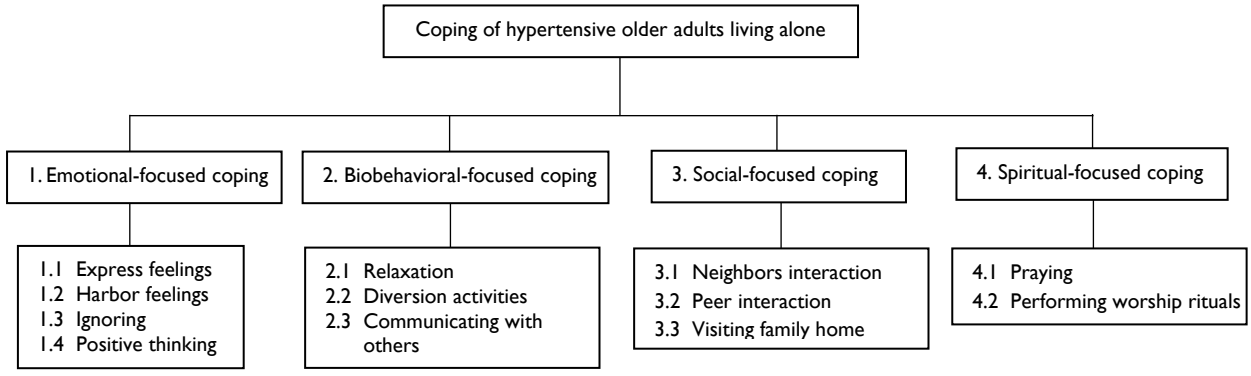

Figure 2. The four themes and twelve subthemes related to coping with hypertensive older adults living alone

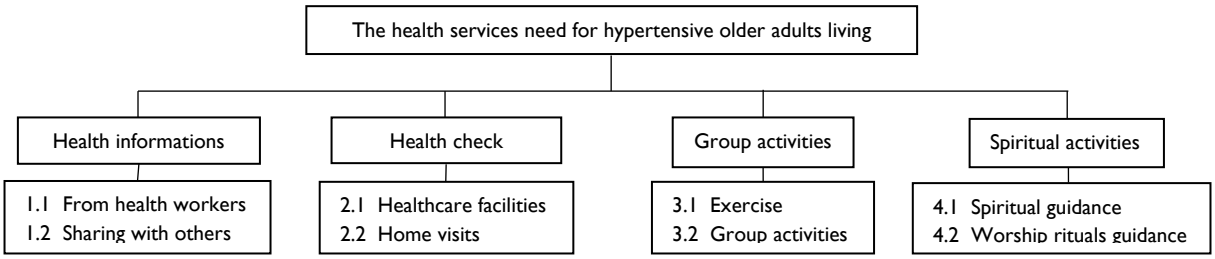

Figure 3. The four themes and eight subthemes related to the health services needs of hypertensive older adults living alone

prevalence of primary sleep disorders including insomnia, sleep-disordered breathing, restless legs syndrome, REM sleep behavior disorder, and circadian rhythm disturbances (Tatineny *et al.*, 2020). In the older adult's group, sleep problems were found in 7% of cases in the 60-year age group and 22% of cases in the 70-year age group. In addition, there are 30% of cases in the age group of 70 years who woke up a lot at night. Sleep disturbance can be caused by extrinsic factors, such as a noisy environment, cold environment, and medication side effects (Tatineny *et al.*, 2020), and intrinsic factors, namely organic factors, such as pain, itching, calf cramps, toothache, moving limb syndrome (akathisia), and psychogenic factors such as depression, anxiety, stress, irritability, and anger which causes anxiety (Widuri, 2010; Tatineny et al., 2020; Song et al., 2022; Zhang et al., 2023). Raised blood pressure was associated with obstructive sleep apnea (OSA), oxygen desaturation index (ODI), short sleep duration, and long sleep duration (Han *et al.*, 2020). Unhealthy sleep behaviors were found during daytime and bedtime, particularly among those who were retired/unemployed or living alone (Song *et al.*, 2022). The results of the study showed that hypertensive older adults living alone experience sleep disturbances due to physical problems, including muscle pain and cramps, as well as environmental problems, including noisy or cold environments. Psychological factors also contribute to sleep disturbance in older adults living alone such as stress, depression, and loneliness (Tatineny et al., 2020; Zhang et al., 2023). It is important to identify the physical, psychological, and environmental factors that cause sleep disorders in older adults living alone so that sleep disorder management can be more effective. Methods for coping with sleep problems, non-sleep behaviors in bed, or beliefs about sleep may differ between older adults. For example, some older adults may think that sleep problems are a part of aging and thus may not seek treatment for their sleep issues. Some behaviors before going to bed or in bed may be culturally unique and indicate a required modification to traditional sleep disorder management. Understanding beliefs and attitudes about sleep and sleep disorders is an important first step in tailoring sleep disorder management to meet the needs of racial and ethnic older adults with sleep problems (Song *et al.*, 2022).

Another physical change in hypertensive older adults living alone was impaired mobility including frailty or weakness and risk of fall. Lower extremity function had a high value for predicting the frail status of older adults with hypertension (Zhang et al., 2022). The study found that increasing age, living alone, low levels of exercise, polypharmacy, malnutrition, and lower vitamin D levels were associated with aging individuals being more likely to experience frailty (Wang, Hu and Wu, 2022). It is necessary to develop physical activities as weakness improvement interventions to improve the quality of life of older adults living alone (Kim and Cho, 2022). Physical activity needs to be done to increase the strength of the lower extremity muscles so it can prevent weakness and falls for older adults living alone. Another study showed that weakness fully mediates the relationship between major depression and falls in older people living alone. Thus, older people living alone and suffering from major depression need special attention from nurses in the community, and treatment for oxidative stress resulting from diminished antioxidant levels is important because it is a key vulnerability for the pathogenesis of frailty, exacerbating illnesses related to human aging (Kameda *et al.*, 2020). Thus physical activity, stress management, and prevention of depression and loneliness are important to prevent weakness and risk of falls in older adults living alone.

Another finding in this study about physical change in hypertensive older adults living alone was safety and comfort disturbances often complained about by older adults including cramps in the extremities and risk of falling. Chronic pain and cramps often occur in older adults, it is estimated that 80% of the older adults experience at least one chronic condition associated with pain. The cause may be known to be persistent or progressive such as increased blood pressure, rheumatoid arthritis, cancer, or unknown or difficult to find. Pain and cramps can cause decreased activity,

Table 2. Selection of participant statements based on the theme of health changes in hypertensive older adults living alone

Themes, Subthemes, and Category	Quotes
Theme 1. Physical changes	
Subtheme 1. Sleep disturbances	
1. Sleep disturbance due to physical problems	"At night my legs seem to die... cramps... cramps... I tie them up so I can sleep." (P2)
2. Sleep disturbance due to environmental conditions	"I have 24 grandchildren, 4 great-grandchildren. When they all come, it's so crowded... The tension increases, and I can't sleep because everyone's screaming… playing... Going in and out…I used to get angry. I told them to go home... it was very noisy." (P2)
Subtheme 2. Mobility disorders	
1. Weakness	"I can't walk long distances... just inside the house or around the house... that's why I've never been to an older adults center." (P2)
2. Fear of traveling alone	"Now I'm afraid to go to the city alone... even though I used to walk alone to all around the City to sell oil when I was young." (P4)
Subtheme 3. Comfort disturbances	
1. Risk of falling	"If I get dizzy... my blood pressure rises... I'm afraid to fall."(P2)
2. Cramps in the legs	"My leg (stroking leg)... usually cramps... I don't feel good." (P4)
Theme 2. Emotional changes	
Subtheme 1. Grief	
1. Denial	"Until now I still prepare food where he usually eats… I feel like he's still there." (P2) "I have lots of kids but now I'm living alone."(P2)
2. Anger	"I'm not feeling well… Usually there is a husband... if we are sick, who do we complain to… if there is a shortage, who will we talk to." (P5)
3. Bargaining	"Live alone sometimes makes me happy… calm… not noisy… but sad it's feeling lonely...but if it's crowded you get dizzy too… I want my children and grandchildren to come but don't make a fuss."(P2)
4. Depression	"I feel sad. I have many children… now I live alone… what if we get sick at night... die immediately... until now I'm still sad... I still remember." (P1,P2,P10) "It's feeling hurts... but. I keep it to myself. I can't get angry... They have husbands and wives. I don't expect it.. if they have a conflict because of me I will be the target... so I keep it."(P1,P3)
5. Acceptance	"I skip this... I usually move to sleep... hear every sound of the mosque going to prayer, and realize that it's already night again... I skip it... calm down." (P7) "If I am alone... Enjoy sleeping... nothing will disturb me." (P1) "There is no feeling of sadness or loneliness. I don't know that either. I don't have any bad feelings... thank goodness. it's okay." (P6) "There's nothing... not afraid... nothing at all… that's what people say... Ugh, grandma lives alone not afraid? … I lock my house... there is God... we pray to God... I sleep normally... praying God bless us." (P3)
Subtheme 2. Anxiety	
1. Anxiety about disease recurrence	"If I get sick at night... I'll die right away...stay alone." (P2, P3)
2. Anxiety about meeting daily needs	"I thought about how to eat...if I can't cook, I bite the bread...since I've been sick I haven't cooked anymore." (P1)
3. Anxiety about facing death	"We are old... while young people can die suddenly... moreover, we are sick... we are old... I think... if I get sick at night... I will die right away... cause stay alone." (P2) "That's a pity... in my heart... I feel sorry for myself…fortunately, I have two nephews... if not... nobody cares… so sad... I'm lucky that I have them." (P5) "I only thinking of my death... I know that I have the disease and I kept crying... I'll just be ready to die… I'll order my children to take care of their child… don't hit them…I'm going to die."
Theme 3. Social changes	
Subtheme 1. Lack of family support	
1. Differences in children's characters	"I don't know... there are good children... there are also children who talk a lot when I speak to... that's why sometimes I cry again and don't talk to my children." (P1)
2. Busy child	"Children don't necessarily come to visit me...they have work too." (P2, P4)
Subtheme 2. Self-isolation due to limitations	
1. Disease limitations	"Before I got sick, I used to take part in mobile older adults' exercise activities with the midwife... I've been to the Mayor's office, Governor's office...but now I can't join because of my illness." (P1)
2. Weakness	"I never went to a health center because of my weakness…I couldn't walk." (P2)
3. Limit interactions	"I rarely talk to my neighbors... I don't want to start the conversation first... I listen to it... I can't get on with it... there's no point in telling a story if it's not important." (P5)
4. Feel neglected	"There's a neighbor who can see us on the street but he doesn't care... what I want is he could ask me... where am I going? It can make me feel glad." (P1)
Theme 4. Spiritual changes	
Subtheme 1. Changes in worship rituals	
1. Changes due to disease	"Usually, I am called to pray together at the mosque or their house... I said I couldn't... although they said I can do it by sitting on the chair or the floor... but I won't do it if my pain comes again." (P1)
2. Lack of knowledge	They usually call me to join... but I said no... I don't know how to recite the Koran." (P3)
Subtheme 2. Access to spiritual services	
1. Distance to health facilities	"I keep my prayers… 5 times a day... because my house is near to the mosque." (P3)
2. The exclamation or invitation or alarm of worship	"I skip the time... I go to pray when I hear the sound of the call to prayer in the mosque-.. time has passed and oh... it's already midnight again." (P4)

social isolation, sleep disturbances, and depression, which can affect the quality of life of older adults (Stanley and Beare, 2007). Older age, lower education level, polypharmacy, malnutrition, living alone, living in

Table 3. Selection of participant statements based on the theme of coping with hypertensive older adults living alone

Themes, Subthemes, and Category	Quotes
Theme 1. Emotional focus coping	
Subtheme 1. Express feelings	
1. Crying	"I'm so sad… I'm crying alone… I thinking of living alone." (P1,P2,P3)
2. Talk to other	"I have children… if they come to visit me... I talk to them." (P2, P8,P9)
Subtheme 2. Harbor feelings	
1. Save feelings	"It hurts... but I keep it to myself… if the pain comes, I don't wake up my son...he will get angry... they have husbands and wives... if they fight because of me, I am the target so I save it.." (P1)
2. No hopes	"What do I want... I don't have a husband so just be patient... I don't have expectations of my children." (P1)
Subtheme 3. Ignoring	
1. Ignore	"I usually feel my legs are cramped... but I don't bother it." (P4)
Subtheme 4. Positive thinking	
1. Positive thinking	"My older adult neighbor told me… what would I do if I died... I have nothing.. my children are not there either.. but for me, if I die I have many children... there are my grandchildren." (P3)
Theme 2. Behavioral focus coping	
Subtheme 1. Relaxation	
1. Relaxation	"If there are sad thoughts... I sit down first... I keep calm." (P1,P2) "If I feel sad... I'll lie down first... make myself calm and relax." (P3)
Subtheme 2. Doing diversion activities	
2. Doing home activities	"I stay at home... doing something like cooking… clean the house." (P4)
3. Productive activity	"I make something for sales... it's called Tenteng… beans give brown sugar." (P2) "I sell filtered sago... I buy sago... I filter it... I pack it up... I sell it at home… people who buy come to my house."(P2) "I have a small shop in my house… if anyone wants to buy something I go to serve them." (P3, P5)
4. Walking	"If I have sad thoughts... I sit and if it can't go away, I went out walking on the street so that it's gone." (P1)
Subtheme 3. Communicating with others	
5. Calling children	"If I'm sick at home... I call all my children... I said I'm going to die...so everyone can come to my house." (P3)
Theme 3. Social-focused coping	
Subtheme 1. Interaction with neighbors	
1. Interaction with neighbors	"I usually go there… (while pointing at the neighbor's house)... when I'm tired, I'll go and tell stories again… but if the grandchildren are in trouble again... I'm going home." (P4)
Subtheme 2. Interaction with peers	
1. Stories from fellow older adults	"There is an older adult neighbor… when I sit on the terrace there he comes here to tell stories." (P2) "Going out to meet an older adult friend too... talk to each other." (P1, P6, P7)
Subtheme 3. Visits to family home	
1. Visits to family home	"My house is surrounded by children's houses... I usually go to their house or those who come to my house." (P2) "So far, only my grandchildren and nephews have been invited to tell stories." (P1) "I went out to my niece's house." (P1, P5)
Theme 4. Spiritual-focused coping	
Subtheme 1. Praying	
1. Praying	"I pray to God, I pray for my child to be healthy, if I die who wants to see me." (P1)
Subtheme 2. Performing worship rituals	
1. Sholat	"There is a God, we pray... Sholat... God will take care of us." (P4)

an urban area, smoking, and alcohol consumption increase the risk of falls in the aging population. Additionally, comorbidities such as cardiac disease, hypertension, diabetes, stroke, frailty, previous history of falls, depression, Parkinson's disease, and pain increase the risk of falls (Xu, Ou and Li, 2022). For those reasons, older adults living alone are more vulnerable to physical, mental, and social impacts on health, which highlights the need for societal attention and support to help them maintain multilateral aspects of health and function as well as their independence (Wang, Hu and Wu, 2022).

The studies on emotional changes in hypertensive older adults living alone show that hypertensive older adults living alone experience the grieving process. Kübler-Ross's fundamental premise was that the stages of grief or a dying individual go through five stages: denial, anger, bargaining, depression, and acceptance (Wright and Hogan, 2008; Avis et al., 2021). The length of time older adults lived alone in this study varied from a range of 1 year to 13 years. The highest intensity of grieving is felt in years 1-2, and the stage of receiving is experienced after the fifth year (Meuser and Marwit, 2001). The grieving process has an important role in the ability to adapt to stressors (Noyes *et al.*, 2010). Factors associated with an increased risk of complicated grieving included living alone, not having a partner, dying while intubated, problematic communication, and not having the opportunity to say goodbye (Sanderson *et al.*, 2022). Community nurses need to be able to identify dysfunctional grieving in older adults living alone so that appropriate interventions can be identified so that the

Table 4. Selection of participant statements based on the theme of healthcare needs of hypertensive older adults living alone

Themes, Subthemes, and Category	
Theme 1. Health information	
Subtheme 1. Health education	
1. Health education from health workers	"If an officer comes I ask them... if I don't know… I hope they teach me… so I know what to do." (P2)
Subtheme 2. Sharing among older adults	
1. Sharing among the older adults	"If there was the older adults came home from the health center, I am asking them what was conveyed." (P2)
Theme 2. Health check regularly	
Subtheme 1. The examinations in healthcare facilities	
1. Information about the time	"If there are any more activities I will go again... I am waiting for the information."(P5)
2. Availability of facilities	"If I'm sick, I go to the health center (Pustu) and get checked... there are always officers."(P4)
Subtheme 2. Home visit	
1. Home visit	"I want to be examined... someone is coming to check me at home... I can't go there." (P4)
Theme 3. Group activities	
Subtheme 1. Older adults exercise	
1. Older adults exercise	"If it's older adults exercise and some officers invite... I'll join." (P1)
Subtheme 2. Group activities	
1. Older adults group activities	"If there is an older adults group activity, I want to join." (P1, P2, P3, P4, P5)
Theme 4. Spiritual activities	
Subtheme 1. Spiritual guidance	
1. Guidance in dealing with death	"We are old... while young people can die suddenly... moreover, we are sick... so we want someone to teach us." (P2)
Subtheme 2. Guidance of worship rituals	
1. Prayer Guidance	"People say you can pray by sitting but I don't know how... I don't do it... I want someone to teach me."(P2)
2. Guidance on Reading the Scriptures or Koran	"They often take me to recite the Koran... but I don't go because I can't... because I didn't learn about it before." (P4)

older adults can carry out their grieving process functionally and properly.

Hypertensive older adults living alone also experience anxiety related to disease recurrence, meeting their daily needs, and facing death. Older adults living alone with poorer sleep quality and more pronounced anxiety were positively associated with higher levels of depressive symptoms. Older adults living alone should be encouraged to engage in social activities that may improve sleep quality, relieve anxiety, and improve feelings of loneliness caused by living alone. Meanwhile, older adults living alone should receive attention and support to alleviate their depressive symptoms (Huang *et al.*, 2023). Community nurses must provide preparation for older adults living alone when facing disease recurrence and death. Preparing for death is very important to anticipate death and grieve. The results of previous research show that discussing death, preparing for death, planning long-term plans, and reducing stress can improve adaptation in dealing with loss (Garrido and Prigerson, 2014). Reducing stress and anxiety are the needs detected in older women (Espinoza *et al.*, 2019).

Social changes in the older adults living alone identified in this study are the lack of interaction with family and self-isolation due to limitations. Older people living alone are at higher risk for isolation because of physical frailty as well as deaths in their family and friendship networks (Klinenberg, 2016). Psychological distress has a considerable impact on the social functioning of older adults (Matud and García, 2019). Isolation or limitation of social relations is also created by environmental situations, loss of partner, the busyness of the closest family members such as children, and lack of public concern. People need to maintain the need for interpersonal intimacy and contact with others until they die. Research shows that the road to successful aging is to stay active. Several studies report that after the death of a spouse contact with others is limited, resulting in moments of intense loneliness (Jeon, Hong and Jang, 2022). Increased social participation is associated with lower rates of weakness and feelings of loneliness. It was suggested that loneliness and weakness should be measured and addressed simultaneously among adults living in the community (Ge, Yap and Heng, 2022). Healthcare providers should focus on enhancing social interactions and support for older adults living alone because of their effects on health (Imamura *et al.*, 2024).

The spiritual changes in older adults living alone are changes in worship rituals and access to spiritual services. Spirituality is described as a transcendence relationship between humans and the Most High, described as a source of strength and hope, giving meaning to life. Spirituality is different from religion or religiosity. Spirituality deals with one's internal beliefs and personal experience with God whereas religion or religiosity is a way of expressing aspects of one's

personal beliefs. Religion or religiosity is more related to worship practices, community practices, and external behavior. The need for religiosity can be fulfilled by religious actions such as praying or confession, reading holy books, or improving human relations. Older men living alone missed their departed spouse or longed for a companion, and they experienced loneliness and anxiety; comparing objective measures of their health status with others in the same age group increased their subjective well-being, and transcendence was one of the most significant factors enhancing spiritual health (Hirakawa *et al.*, 2019). The self-transcendence enhancement program is effective in improving the level of self-transcendence in older adults living alone and helping them to attain spiritual and psychological well-being (Kim and Ahn, 2021). The types of nursing interventions vary according to the unique spiritual needs determined by basic assessment and ongoing assessment. Interventions that can be given include worship rituals guidance like praying, spending time with the older adults to listen to their feelings, listening to religious music or chanting scriptures, watching the sunset by the lake, walking along the river, or giving a touch. Conversations about spiritual matters, the spiritual benefits of illness and adversity, and preparation for death are some of the topics that older people enjoy that have a therapeutic effect (Stanley and Beare, 2007). For nearly all patients it is recommended integrating the kind of personal spiritual conversation into primary care (Mächler *et al.*, 2022).

Coping of hypertensive older adults living alone

The coping mechanisms of the older adults living alone identified in this study are emotion-focused coping mechanisms, biobehavior-focused coping mechanisms, social-focused coping mechanisms, and spiritual-focused coping mechanisms. The emotion-focused coping mechanisms identified are expressing feelings, harboring feelings, ignoring them, and thinking positively. Several participants expressed feelings and thought positively about their condition. Gratitude for small pleasures, acceptance of situations, and optimism for the future are generally owned by older adults. Comparing the positive aspects with others who are less fortunate will give positive thoughts. Making meaning and positive reappraisal are important strategies that enable them to strengthen their relationships (Fiocco, Gryspeerdt and Franco, 2021). Another emotion-focused coping mechanism of the older adults living alone was ignoring and harboring feelings by seeking to change one's expectations about relationships. Individuals in higher age groups look more to emotional regulation strategies (i.e., lowering expectations) than means of improving relationships (Willis and Vickery, 2022). It is important to identify how hypertensive older adults living alone adapted to the problems so as to find out whether the coping mechanisms used are adaptive or maladaptive so that appropriate interventions can be developed by changing maladaptive coping mechanisms to adaptive ones, including positive reframing and assertiveness.

The biobehavior-focused coping mechanisms identified in this study are relaxation, diversion activities, and communication with children. Behavioral strategies such as maintaining a daily schedule are important coping strategies for older adults. Participants also talked about the importance of staying busy and doing activities such as cleaning the house, making cakes to sell, taking walks, and communicating with children as behavioral strategies that distract older adults from feeling sad, lonely, and depressed due to living alone. Doing sports and staying physically active is another common behavioral method for coping with grief and maintaining health in older adults with chronic disease (Bahtiar, Sahar and Wiarsih, 2022). Getting outside on walks was considered an important strategy for staying healthy, especially for those living in smaller spaces (Fiocco, Gryspeerdt and Franco, 2021). This study also identified that all participants carried out diversion activities to adapt to the changes caused by living alone. Diversion activity is self-control that can prevent panic and detrimental actions in threatening situations; self-control is a response that is very helpful in finding self-strength (Kozier and Erb, 2014).

The social-focused coping mechanisms identified in this study are interactions with neighbors, stories from fellow older adults, and visits to family homes. The support received from family and community, including emotional and tangible support, was highly valued by the participants. The majority of them were grateful for a good relationship with their family and environment. Participants who did not have children reflected support from other families such as nephews and the surrounding environment. Several participants emphasized the importance of connecting with fellow older adults as a way of not feeling alone and disseminating health information obtained from healthcare workers and facilities. Many seniors share a deep sense of community with their neighbors, reflecting on time spent socializing with the neighborhood, helping one another, sharing resources, and engaging in social activities in their community. Older adults living alone require a greater quantity and

need of social support than is regularly available (Fiocco, Gryspeerdt and Franco, 2021).

Spiritually-focused coping mechanisms identified in this study are praying and performing worship rituals. Religion or religiosity is more related to worship practices, community practices, and external behavior. The need for religiosity can be fulfilled by religious actions such as praying or confession, reading holy books, or improving human relations (Stanley and Beare, 2007). The prayer and *dhikr* activities carried out by the participants caused the older adults to feel calm and able to adapt to the conditions of being old. This type of coping does not solve the problem but can make older adults feel better (Kozier and Erb, 2014). Older adults living alone were enjoying their autonomous status and freedom, despite widespread negative views of them. Spiritual care is a core element of end-of-life care for older people. The spiritual health of older adults living alone was enhanced through gratitude to everyone with whom they had crossed paths in their life, and confirming their health measurements were comparative or better than those of others in the same age group (Hirakawa *et al.*, 2019).

The health services need for hypertensive older adults living alone.

The health service needs of the older adults living alone identified in this study are health information, regular health checks, group activities, and spiritual activities. Participants expect information related to the management of older adults with various health problems they experience. This is consistent with research that states that educational programs can increase knowledge and skills, reduce psychological stress, increase social networks, and help people feel more confident (Klimova *et al.*, 2019). Besides that, discussing and exchanging ideas and stories is one of the efforts in taking a social approach. Allowing gathering with fellow older adults means creating socialization for them. Communication with fellow older adults is important to improve social relations, and provide awareness of a sense of shared fate and having shared rights and obligations (Widuri, 2010).

Older adults with chronic diseases need health checks regularly as do older adults who experience physical and cognitive weaknesses and limitations so that they experience impaired mobility and thus require home visits. The hope of having home visits to be able to carry out health checks, and provide education and assistance to older adults living alone at home is supported by research which states that when home visits are carried out by nurses it can make clients feel comfortable and experience reduced stress, clients also get information related to health so that cause positive changes and improve their quality of life (Vullings et al., 2020). Becoming empowered and recognized as a person was experienced as the major benefit of the support and advice given during the preventive home visit. The support and advice generated conditions for the person to become empowered by contributing to a feeling of control and preparedness for the future. Furthermore, the support and advice contributed to the feeling of becoming recognized as a person, as an outcome of the supportive dialogue and the assessments of their health, behavior, and surrounding environment (Nivestam *et al.*, 2021).

Group activities for the older adults living alone identified in this study are physical exercise and peer group activities. Physical exercises such as gymnastics for older adults can be effective against weakness, gait parameters, cognitive function, and quality of life for older adults in nursing homes. The design of physical exercise for older adults is aimed at providing them with proper exercises, improving their physical function, and improving or delaying weakness, which is principally important for developing countries in East Asia where rehabilitation resources are generally scarce (Liu *et al.*, 2022). The group process describes a process that is always changing, developing, and adapting to changing circumstances. It takes communication, team motivation, and team diversity to resolve conflicts during the group process, and groups usually show the same interests needs, and goals. Peer support groups are one of the social support systems that can be formed for older adults in the community (Achjar, 2011). Research shows that participants express hope that there is a peer group to increase knowledge. This condition is found by research that states that peer-group-based education can increase and improve support (van Wezel et al., 2021).

Spiritual activities for the older adults living alone identified in this study are spiritual guidance in dealing with death and guidance on religious rituals including prayer guidance when sick and guidance on reading the holy book. In facing death, every older adult has a different reaction, depending on their personality and how they face life. Therefore, nurses must carefully examine the strengths and weaknesses of older adults. If the weakness is in an aspect of spirituality, the nurse is obliged to look for efforts so that the older adult client's suffering can be alleviated. Nurses can provide opportunities for the older adults to carry out their worship or directly provide spiritual guidance by

recommending carrying out their worship, such as reading the holy book or helping teach the older adults to fulfill their religious obligations. Generally, at the time of death, one's religion or belief is an important factor. Thus the presence of a spiritual teacher is necessary to comfort older adults in the face of death (Widuri, 2010). Implementation of religious intervention resulted in improved subjective vitality and a diminished sense of loneliness among older adults (Borji and Tarjoman, 2020). The study showed more frequent therapeutics of nurse-provided spiritual care included: presence, assessment of spiritual or religious beliefs and practices, and listening for either spiritual themes in patient stories or spiritual concerns. The least common therapeutics provided included: offering to read a spiritually nurturing passage; arranging for the patient's clergy or a chaplain to visit; and documenting spiritual care. Other rather infrequent therapeutics with means around included: asking how to support their spiritual or religious practices, telling patients about spiritual resources, encouraging patients to talk about spiritual challenges, and discussing spiritual care for a patient with colleagues (Taylor *et al.*, 2023). Community nurses need to provide spiritual care needs of hypertensive older adults living alone, including guidance on worship rituals according to their respective religions and facilitating access to spiritual guidance needs in the community.

Conclusion

This phenomenological study explored lived experiences including health changes, coping mechanisms, and healthcare needs of hypertensive older adults living alone consisting of physical, emotional, social, and spiritual aspects. Hypertensive older adults living alone need support from their surroundings considering that their lives are at greater risk. Implications of the findings for practice were that community health nurses can create effective holistic care programs including physical, psychological, social, and spiritual for hypertensive older adults living alone, leveraging the role of community volunteers as support groups to enhance hypertensive prevention and promotion efforts among older adults. In addition, hypertensive older adults living alone also need support from their families even though they do not live in the same house and support from the social environment such as older adults group activities. Group activities need to be developed to prevent and overcome physical, psychological, social, and spiritual problems holistically to increase social involvement so that they can prevent and treat physical complaints, stress, depression, and loneliness, and could prevent the severity or complications of hypertension.

Recommendations in this study include developing a holistic hypertensive care program consisting of physical, psychological, social, and spiritual activities. It is necessary to develop family support even though they do not live in the same house, social support in the form of group activities with various activities to prevent and overcome physical, psychological, social, and spiritual problems in hypertensive older adults living alone. Further research needs to develop an adaptive coping strategies model for hypertensive older adults living alone, factors influencing the adaptation process of the older adults living alone, explore the effectiveness of holistic hypertension care on blood pressure, stress, coping, and quality of life of hypertensive older adults by comparing older adults living alone with older adults living with family, and qualitative research using ethnographic methods to determine the adaptation process of the older adults living alone according to culture.

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