

Loneliness and boredom in residential care: Voices of older adults

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ABSTRACT

OBJECTIVE: Older adults may experience loneliness and boredom in residential care. The purpose of this study is to extend understanding of the experiences of older adults in residential care and identify factors that residents themselves believe contribute to loneliness and boredom. In addition, I aim to identify the strategies used to cope with these experiences and provide recommendations to enhance the quality of life in residential care.

METHODS: A phenomenological qualitative study was conducted through participant observation, in-depth interviews with 24 residents and key informant interviews with 10 staff members.

RESULTS: The findings emphasise the pervasiveness of loneliness and boredom in residential care despite facilities' efforts to provide activities and support. Staff and family support helped to alleviate loneliness and boredom and participants employed individual coping strategies.

DISCUSSION: Health professionals and social workers should recognise loneliness and boredom as issues and prioritise residents' individual needs and preferences to minimise the risk of loneliness and boredom.

KEYWORDS: Boredom; loneliness; older adults; phenomenology; residential care

Loneliness and boredom are an increasingly common problem in residential care (Adams et al., 2004; Jansson et al., 2020; Neves et al., 2019; Pinguart & Sorensen, 2001; Steele & Linsley, 2015) and have various adverse health outcomes such as disability, cognitive impairment and increased rates of mortality (Wright-St Clair et al., 2017; Gale et al., 2018). The transition to residential care can be traumatic and stressful and many older adults do not always receive consistent support from social services in meeting their emotional and social needs during this time (McKenna & Staniforth, 2017).

The risk factors for loneliness and boredom in residential care include unfamiliar environment, rigid routines and a standardised caring system. A homely environment and identity-promoting care are important in establishing a meaningful existence at the end of life (Osterlind et al., 2016). The home is attached to identity, feelings of comfort, familiarity and security among older adults (Bland, 2007; Jaye et al., 2015; Robertson & Fitzgerald, 2015; Wiles et al., 2009). Brownie et al. (2014) and Prieto-Flores et al. (2011) reported that the transition from home to residential care led to increased loneliness in older adults

due to a loss of identity, independence and autonomy. It is also reasonable to suppose that the risk of loneliness is higher among older adults in residential care than those in the community due to multiple losses and disrupted meaningful engagement with friends, family and the community (Smith, 2012; Victor, 2012).

Rushed care, rigid routines, a lack of leisure opportunities, social engagement, and meaningful relationships, staff shortages and abuse tend to increase depressive symptoms and poor well-being (Bland, 2007; Brownie & Horstmansh, 2011; Harper Ice, 2002). Some studies have highlighted the importance of having social workers working alongside physicians, nurse practitioners, and registered nurses in care management (Donelan et al., 2019; McKenna & Staniforth, 2017). A flexible and comprehensive, person-centred caring culture and additional support is important to help older adults retain their identity, autonomy and independence (Paddock et al., 2019).

There has been very little research into loneliness and boredom in residential care. Previous Aotearoa New Zealand studies on loneliness have tended to be quantitative and have focused on older adults living in the community (Davies-Kelly, 2014; Jamieson, 2018; La Grow et al., 2012). This article instead draws on PhD research in which loneliness emerged as a major theme from the participants' descriptions of their experiences of leisure life in residential care facilities. The main objective of the research was to add to the knowledge on loneliness among older adults living in residential care and explore the impact of leisure experiences on their well-being. A qualitative approach was used to determine if, and why, older adults in residential care feel lonely and bored and how they cope with those feelings.

Literature review

Loneliness is defined as a subjective, unpleasant and distressing feeling associated

with the lack of companionship or inability to establish satisfying relationships (Brownie & Horstmansh, 2011; Davies-Kelly, 2014; de Jong Gierveld, 1998). It has been argued that loneliness and social isolation are different concepts (Brownie & Horstmansh, 2011; Jamieson, 2018). Older adults can feel lonely without being socially isolated. Being part of a large social network does not necessarily protect an individual from loneliness. Previous studies instead suggest that older adults seek close and reliable relationships to satisfy their emotional needs (Adams et al., 2004; Brownie & Horstmansh, 2011).

Boredom refers to absence of meaning and purpose in a person's life or not being involved in activities or lack of interest. Babalet (1999, p. 631) defines boredom as "a restless and irritable feeling about an absence of interest or an anxiety about the absence of meaning in a person's activity and circumstance." Older adults who are dependent on others for their activity, but prefer not to be a burden, or who confine themselves to their rooms because of an unfamiliar environment tend to end up doing nothing. The feeling of having nothing to do, in turn, fosters a sense of boredom and loneliness (Harper Ice, 2002). Boredom is associated with a lack of meaningful relationships, roles and having a sense of control (Steele & Linsley, 2015).

Studies of residential care facilities have highlighted the prevalence of passivity or sedentary behaviour. Many residents sit alone in their rooms doing nothing or are left in front of the television all day (Brownie & Horstmanshof, 2011; Gine-Garriga et al., 2019; Leung et al., 2021; Li et al., 2020; New Zealand Labour Party, 2010; Wilcock & Townsend, 2009). Similarly, some studies have highlighted the prevalence of enforced idleness, with few opportunities and encouragement at the facilities for residents to participate in leisure activities (Cahill & Diaz-Ponce, 2011; Fiveash, 1998; Problem of idleness in old people's homes, 1929; Sarantakos, 1989; Smith et al., 2018). As a result of this passivity, sedentary behaviour,

and enforced idleness in residential care, there is an increased risk of loneliness and boredom.

Research shows that loneliness among older adults is increasing not only in Aotearoa New Zealand, but also globally, and requires significant attention (Wright-St Clair et al., 2017; Jamieson et al., 2017; Ministry of Social Development, 2016; Ong et al., 2016; Vozikaki et al., 2018; Yang & Victor, 2011). According to a Ministry of Social Development (2016) report, loneliness is more prevalent among Aotearoa New Zealand adults aged 75 years and above than those aged 65–70 years.

A number of researchers have identified the deleterious effects of loneliness. For instance, it has been noted that older adults who are lonely and socially isolated are more susceptible to depressive symptoms, cognitive decline, dementia and frailty (Cattan et al., 2005; Wright-St Clair et al., 2017). In their study of community-dwelling older adults in Ireland, Conroy et al. (2010) reported that older adults with cognitive decline are more prone to loneliness and boredom due to a monotonous environment and an absence of cognitive stimulation and socialisation. Some studies have also noted that loneliness in later life increases the risk of serious physical health issues including heart disease, high blood pressure, Alzheimer's disease and the risk of mortality as well as the likelihood of admission into residential care (Adams et al., 2004; Beal, 2006; Gale et al., 2018; Ong et al., 2016; Pinquart & Sorensen, 2001; Schoenmakers et al., 2012). In other words, loneliness has a significant impact on the quality of life of older adults.

Methodology

This study was conducted using a qualitative approach within a phenomenological framework. Phenomenology has become a widely used qualitative method in several disciplines including nursing, health, and gerontology (Neubauer et al., 2019; Tuohy,

2013). A phenomenological framework was employed to understand the “life world” or “lived experience” of individuals in a social context as well as the process for making meaning of those experiences from the perspective of the study participants (van Manen, 1990). This approach is well-suited to exploring the lived experiences of loneliness and boredom in residential care as it allows participants to talk freely in their natural setting, which is important in understanding problems or issues from their perspective. Ethical approval for this study was obtained from the University of Otago Ethics Committee (Health).

Sampling and recruitment

This study applied two levels of sampling for the recruitment of participants. First, residential care facilities were selected from the lower South Island using stratified random sampling. The stratified random sampling method was chosen to examine the lived experiences of older adults in the facility's ambiance and care provision. Each facility was categorised into one of three groups according to the number of beds: large (80–125 beds), medium (50–79 beds) or small (25–49 beds). Random sampling was used to select two facilities from each stratum for a total of six facilities.

The data-gathering stage of the study began with the researcher observing residents in their facility settings and becoming familiar with their routines and the interactions they had with staff, friends and family members. Comprehensive field notes were taken during this period, as recommended by Creswell (2013). Doing so provided a rich context for data analysis and enabled the construction of rich, thick descriptions of the interviews and the context in which they were conducted.

Four participants from each of the six residential care facilities were selected to participate in semi-structured interviews. The interviews lasted between 30–120

minutes. Consent was obtained from each participant one day prior to the interview.

Of the 24 participants interviewed, 16 were female. Twenty participants identified as New Zealand European, three as Scottish and one identified as Māori. Their ages ranged from 71–94 years, with an average age of 85 years. Most participants were in their 80s and 90s. Pseudonyms are used to ensure the anonymity of the participants.

The final stage of data-gathering involved key informant interviews with staff members responsible for organising leisure activities for the residents. Ten staff members in total were selected from the facilities: four from the large facilities, four from the medium facilities and two from the small facilities. Only one staff member was selected from each of the small facilities because there were no other activities staff at those facilities. All key informants were female and their ages varied between 26 and 62 years. Their length of employment in the facilities varied between 4 and 34 years. Six key informants held diversional therapy qualifications and three held no formal qualifications.

Data collection

The study employed triangulation in the collection of data. Triangulation of data collection deepens the content of the data and increases the credibility of the findings (Creswell, 2003; Denzin & Lincoln, 1994, 1998; Fielding & Fielding, 1986). Data were collected through participant observations, in-depth interviews with residents, and key informant interviews with staff.

As mentioned earlier, semi-structured interviews were conducted with 24 residents and 10 key informants. The average length of interview with the residents was one hour. The inclusion criteria for participants were that they needed to be aged 65 years and above, reside in a residential care facility, be able to communicate well in English and be able to give consent. Participants who were

unable to answer the interview questions were excluded from the study.

Data analysis

To analyse the data, I used Braun's and Clarke's (2006) six steps of thematic analysis as it is a widely used method in phenomenological analysis due to its flexibility, transparency, insightfulness and clarity in finding meaning in participants' accounts. I adopted a number of approaches, including coding by hand and using the qualitative software NVivo. This process helped me to identify different patterns and themes within the data and categorise the common themes. In the first and second steps, I produced the initial codes and reviewed the lines, sentences and paragraphs from the interview transcripts and field notes, including the participant observation notes. In the third step, after completing the initial coding and collation, I matched each code to broad themes. Codes were categorised and re-categorised to generate several broad themes and sub-themes from codes generated from the transcripts of participant and key informant interviews, field notes and participant observations. In the fourth step, I began developing coherence between each theme and the codes under it. I generated new themes where the codes did not cohere with each other to develop meaning. In the fifth step, I developed an accurate thematic map. I started to relabel the major themes by going back to the codes and sub-themes I had initially created. In order to improve credibility, my PhD supervisors reviewed the entire data set with coding, sub-categories, categories and themes. Based on their feedback and an analysis of all the data, a final set of themes was developed. In the sixth step, I began reporting and writing up the analysis.

The field notes not only added to the rich descriptions of the participants during data analysis, but also allowed me to critically evaluate my performance, biases and

feelings as an interviewer (as recommended by Watt (2007)). The observational data and accompanying field notes were referred to repeatedly during all steps of the analysis and guided the final reflections, analyses and discussion. The reflexive journal and advice from my mentors and colleagues on how to deal with dilemmas and emotions occurred during the research process.

Results

Loneliness and boredom emerged as important themes from participants' narratives of their lived experiences in relation to their adjustment to living in residential care and their participation in leisure activities. Five themes were identified from the participants' narratives: loneliness and boredom; activities; support from family and visits from friends; support from staff and co-residents in the facility; and coping strategies.

Loneliness and boredom

When asked about feelings of loneliness and boredom, the responses from the participants varied from "all the time" to "not at all". Those participants who reported that they felt lonely or bored were also asked how

often they had those feelings and why. The results are shown in Table 1.

Eighteen participants reported that they felt lonely in the facility. Of these, 16 said they felt lonely sometimes. Ten participants reported that this was because they were not able to see their family very often. Two participants felt lonely because they missed their houses and their wives. Two participants felt lonely because they missed life outside the facility. Two participants felt lonely due to their health conditions. Two felt lonely all the time because of fewer leisure opportunities. Six participants stated that they did not feel lonely at present, but that they had felt lonely in the first few months at the facility.

Six participants reported that they never felt lonely because they kept themselves busy with different activities and socialised often with family and friends. Compared to the others, those participants were also more capable and mobile. For some participants, participating in activities was an opportunity to avoid monotony, whereas for others, the activities provided at the facility were not sufficient to reduce feelings of loneliness and boredom.

Table 1. Feelings of Loneliness and Boredom

	Participants	Reasons
Loneliness	18	
All the time	2	Fewer leisure opportunities
Sometimes	16	Unable to see family very often Missing their houses and wives Missing their outside life Health condition
Do not feel lonely	6	Keeping themselves busy with the activities
Total	24	
Boredom	20	
All the time	9	Offered activities catered towards female residents
Very often	2	Lack of contact with the family
Sometimes	5	Lack of social life
At weekends	4	No activities at weekends
Do not get bored	4	Keeping themselves active and occupied
Total	24	

A total of 20 participants reported that they felt bored. Among them, five reported that they felt bored sometimes. Two participants reported that they felt bored very often because of a lack of contact with family and friends and a lack of activities which interested them. Four participants mentioned that they felt bored because there were no scheduled activities in the weekends. All nine male participants said they felt bored due to a lack of activities which interested them. They also felt that most of the activities offered by the facility catered to female interests.

Activities

The participants' narratives highlighted the issue of enforced idleness in residential care due to fewer leisure opportunities as well as the increased risk of loneliness and boredom resulting from this. Some participants felt that the offered activities did not match their abilities and interests. However, despite the (perceived) loss of activities available, some participants managed to participate in self-led activities, whereas others participated in the activities offered by the facility regardless of whether they matched their abilities or interests.

The most common self-led activities pursued by the participants were walking, reading, listening to music or news, watching television, completing crosswords or other puzzles, talking on the telephone, and spending time with volunteers, friends and family members. A few participants also knitted and gardened.

The common facility-led activities were attending concerts and chapel, playing housie and bowls, completing crosswords/puzzles, and occasional van outings. Four participants helped staff with tasks such as raising funds, folding towels, picking and arranging flowers for the dining tables and folding papers for envelopes. Activities that provided opportunities to learn new skills and contribute to others were also meaningful to the residents. These provided

them with feelings of achievement and contribution despite having chronic diseases and being dependent on aged care. Seven participants reported that they felt happy that they were still able to contribute to the community.

Nine participants reported that the activities in the facility were boring and did not interest them. Ten said they did not participate in the ongoing activities as they were happy on their own. Two participants had ambivalent opinions about their current leisure activities as they said they did enjoy them when they took part, but they were not activities they were particularly interested in:

I am not really interested in you know but I do it [housie] because it's time-consuming things and that's why I do it. I quite enjoy it when I am doing it, but it's not my thing. (Lawrence, 88 years)

The facility staff reported that the activities benefitted residents in lifting their mood as they felt lonely, depressed and anxious when they remained idle. However, they also reported that, despite those benefits, the majority of the residents preferred to be on their own, rather than participate in the activities offered by the facility. Furthermore, some staff members stated that they felt the residents needed individual care and attention rather than activities, as they were in the facility to gain rest and enjoyment in their later life.

All participants noted a lack of activities that interested them. As a result of this, the majority of them said, "I don't bother to participate." A number of participants perceived that the institutions did not put enough effort into understanding what the residents really wanted when providing activities: "I don't think they organise lots here, they do sometimes but not very often"; "there is nothing that I can engage in". One participant reported that his mood became very low when he was left in his room with no activities (requiring him to take medication):

There is not a lot that really gets my mind active working properly you know. We do have television in the room but everybody gets bored watching television all the time... [crying]. Sorry but when I am left in the room doing nothing, I feel lonely all the time. (Edward, 75 years)

The male participants also shared the experience of not being interested in the activities offered by the facility because they felt many of these were aimed towards female residents. One participant criticised the staff for not taking into account his suggestion of having a walking group.

Comments and stories such as these provide evidence that more attention needs to be paid to the kinds of leisure activities offered by facilities to combat feelings of loneliness and boredom.

Support from family and friends

All the participants felt restricted by the facility in maintaining and building their social networks as they did not have many opportunities to go out, they could not drive and they could no longer join the community. They did not see their friends and family very often due to geographical distance and busyness. Fewer family visits and lack of access to a telephone in their room to contact family increased the risk of loneliness and boredom among participants.

My family used to come and see me when I was at home. . . I haven't got a phone to ring them so I have to go and ask for a phone. I have to ask someone, nurse, to ring my family. . . I had [a phone] at home with big numbers on it so I can see and pick up the phone on my own you see. (Helen, 94 years)

Many participants reported that living in residential care decreased the number of visits from family and friends. This often led to loneliness and sadness, especially for those participants with no visitors at all. In many cases, visits from friends were not

common because they were deceased or had been placed in other residential care facilities and could no longer visit.

Some participants reported that they were not interested in forming new relationships with co-residents because of the prospect of their death. This was apparently because they had experienced the loss of their partners, siblings, children and friends over their long lifetimes and did not want to experience that same grief.

As suggested earlier, most of the participants were unable to maintain or develop connections with the outside community. They felt isolated as they were no longer able to join and contribute to the community groups they had been involved with previously. Only five participants reported that they were still in contact with the community they had lived in prior to coming to the residential care facility. This was possible because the community members were supportive and still visited them or took them to events.

Support from staff and co-residents

All the participants said that most of their day-to-day interactions were with facility staff rather than co-residents. However, due to the staff's workload, it was difficult to have conversations with them. The key informants acknowledged that they were unable to provide individualised attention to each resident despite this being important for them:

I think the one-on-one contact is important for them because a lot of them don't have it. They don't have some of them coming in so I think more you know is being with someone for a time just talking to them. Care staff they don't have time because they [are] doing cares. (Activity Staff, 3)

Twenty-three participants stated that they went together to their meals, but nobody talked to each other. In some cases, they

said they were not being approached, while others found it hard to talk to their co-residents as they felt their interests and status did not match. For example, one of the participants said she felt a difference in status because her co-residents were not as educated as she was. Some participants (22) stated that taking part in meaningful conversations and building relationships was very difficult due to many of their co-residents being very unwell. The residents who did not have dementia distanced themselves from those who did, and this increased the likeliness of isolation and loneliness among residents.

You can't talk to because they can't talk to you umm . . . They are mostly stroke victims and dementia victims and they can't talk, some of them can't talk at all, some of them they can, but disjointed and that's what I find, there's no one that I can talk to apart from nurses. I can talk to them, but nobody else really. (Lawrence, 88 years)

Six participants had been able to form friendships with co-residents; however, this was not common. As suggested earlier, the main reasons the participants gave for not being interested in making friends were frailty, social status and the frequent deaths of co-residents. Less impaired residents described withdrawing from relationships with other residents in order to maintain their privacy and status. Many participants felt that the other residents were more cognitively impaired than themselves and were no longer able to communicate with them. Dave (76 years) explained that he felt lonely because he was "not having contact with people that [he] would like to."

Coping strategies

Participants reported that they felt lonely and bored all the time during their initial months at the facility, but many of them agreed that developing strategies of acceptance was important to thrive in residential care.

Some participants had developed strategies to cope with the loneliness and boredom. Despite feelings of exclusion, the majority of the participants tried to maintain and reproduce their sense of connection to others through other sources. Some participants switched their active activities for passive ones such as listening to the radio, reading books, watching television, and talking on the telephone. One participant said she liked listening to the news so she could stay in touch with the outside world. For some participants, the telephone played an important role in avoiding loneliness and boredom as they could contact their family when they felt lonely and it gave them an opportunity to maintain their social relationships:

I discovered the phone was very handy. I could do all sort of things on telephone that I could do just as well in person but I couldn't and at least a telephone gets me a chance to keep in touch with people. (Catherine, 90 years)

Participants also coped with feelings of loneliness and boredom through a positive attitude. Some participants with no family and friends preferred to be alone and justified this preference by referring to themselves as lifetime loners. One participant called herself a loner as she had lived on her own before entering residential care and preferred to continue to be on her own:

I'm quite happy with what I am doing. As I say, leave me alone, I am quite happy here. Some says you shouldn't sit here whole day on your own and I said I listen to the radio. (Sarah, 94 years)

The social isolation in the facility seemed to be more difficult for the male residents than the female residents. Christine (87 years) shared that it would be hard for her husband as he was a social kind of person, but she was managing well as she had grown up as an only child and she was happy as long as she had a book to read.

Discussion

The findings of this study provide further indicative evidence that older adults in residential care in Aotearoa New Zealand are lonely and bored despite policies of person-centred care. The role of medical professionals, social workers and support workers is significant in identifying older adults who are feeling lonely and bored. The feeling of loneliness is often unidentified or overlooked or misinterpreted (Smith, 2012). Older adults have no opportunity to prepare for the transition (Osterlind et al., 2016). The rushed and urgent transition from hospital to residential care and multiple losses and routinised/standardised care have a negative impact on identity, autonomy, self-determination and empowerment, and well-being. The findings also suggest that the initial days in residential care were the most challenging and that advance planning and additional support are needed to minimise the trauma of the transition. The increasing frailty of older adults in residential care and their decreasing ability to participate in some activities places an added importance on understanding diverse needs, as one set of strategies does not meet the requirements of all.

It is clear from this study that participation in meaningful activities is important, not only in combatting loneliness and boredom, but also in enabling residents to maintain autonomy, self-determination and empowerment even when their physical and cognitive impairments affect their ability to participate in some activities. One-to-one conversations and activities that provided a feeling of contribution or connection such as helping staff with daily chores or outings with family, friends and staff seemed to help the participants maintain and develop autonomy, self-determination and empowerment. Conversely, failure to satisfy their need for meaningful engagement and social connection increased participants' feelings of loneliness and boredom.

The findings of this study are similar to those of Paque et al. (2018), in that

loneliness in institutionalised life seemed to be linked to fewer leisure opportunities matching participants' interests and a lack of meaningful relationships with staff and co-residents. Roos and Manan's (2012) suggestion that offering group activities helps to build interpersonal relationships is not supported by this study. Many of the participants were not interested in joining group activities with other residents, but instead preferred to be on their own.

This study instead highlights the importance of frequent visits from family and friends, opportunities for outings and engaging in chores similar to those they would engage in at home for providing meaning and purpose to participants' lives. This is consistent with the findings of Koopman-Boyden et al. (2014), in that activity gives a sense of purpose and importance to older adults and enables them to live meaningful lives. Similarly, Adams et al. (2011) argued that individualised activity is important in fostering well-being because individual characteristics such as personality or gender impact on the choice, meaning and quality of activity. The findings from this study provided further evidence of a "one size fits all" strategy in residential care. Activities that are very meaningful to someone might be boring to others.

Loneliness and boredom have a negative impact on the quality of life of older adults in residential care. Opportunities for interpersonal communication and both formal and informal support are important for successful intervention (Davies-Kelly, 2014). More research is required to understand individuals' experiences of loneliness and boredom to meet the diverse cultural and individual needs of older adults in residential care in Aotearoa New Zealand. Overall, the findings of this study suggest that older adults in residential care are at risk of loneliness and boredom and understanding their experiences is pivotal in addressing these issues.

Limitations

There are limits on the generalisability of the findings from this study because the research was conducted in a small Aotearoa New Zealand city. However, the findings add to the understanding of the experiences of loneliness and boredom among older adults in residential care. In addition, participants from certain ethnic groups, such as Māori and Asian older adults, were underrepresented in this sample. Future research should address these sampling issues to increase the generalisability of the findings on loneliness and boredom. Furthermore, it would be important to consider residents with dementia. This study excluded the residents who were unable to answer the interview questions. A study focusing on residents with dementia only with multiple interviews and observations would be important.

Conclusion

This research contributes to a richer understanding of loneliness and boredom among older adults in residential care. The findings revealed that the transition from home to a residential care facility, fewer leisure opportunities, physical health and lack of meaningful relationships exacerbate the risk of loneliness and boredom. Person-centred activities, meaningful social contact, and the role of health professionals and social workers are important in meeting the diverse needs of residents. Further qualitative research with a focus on loneliness and boredom is necessary to extend the findings regarding the relationship between transition, enforced idleness, loneliness and boredom in residential care.

Implication for practice

- Collaboration between social workers, health professionals, nursing staff and activities staff is essential to identify and minimise the risk of loneliness and boredom.
- Social workers need to identify concerns, limitations and problems that affect residents' participation in activities. Collaboration between social workers, care workers and activities coordinators is important in offering diverse and meaningful activities.
- Social workers can play a key role in identifying and de-escalating psychosocial issues through information, counselling, and providing support to both older adults and their families in easing the transition process.
- One-to-one intervention is necessary to maximise residents' participation in activities.
- Residents' activity plans and activity engagement need to be continuously evaluated and updated as often as necessary.
- Further research is needed on the role of social workers in minimising the risk of loneliness and boredom.

Submitted: 21.7.21

Accepted: 10.02.22

Published: 13 May 2022

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