Exploring the effects of loneliness and isolation on health and well-being among individuals in different life situations: The role of the Sense of Coherence in shaping outcomes

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Abstract

Background: Loneliness and isolation are two distinctly different phenomena, however, when one is present, the other is often present. The two phenomena are more prevalent in older age, and bountiful research has covered the impact of health and well-being on different age groups, but what differences and similarities can we find among individuals in different life situations through their experiences with loneliness and isolation, and how do they cope?

Objective: This study aims to explore the connection between loneliness and isolation to health and well-being through the experiences of individuals in different life situations in Vestland, Norway.

Method: This study applied a qualitative methodology combined with a phenomenological study. The research leans on a salutogenic approach. Semi-structured interviews were performed with five individuals, with a focus on their perspectives and experiences. Four participants experienced loneliness and isolation. One participant who did not experience loneliness or isolation was included for comparative reasons. All collected data was analysed through a Thematic Network Analysis.

Findings: The study found links between reduced health and well-being, and loneliness and isolation. It suggests that loneliness and isolation are chronic stressors that can permeate an individual's life, coupled with a low Sense of Coherence, the coping process can become a daunting challenge. The absence of resources such as family support, social network, active participation and decision making, posed themselves as General Resistance Deficits (GRDs), and were cause for greater stress and tension among the participants who experienced loneliness and isolation. The lack of generalized resistance resources (GRRs) make coping with chronic stressors such as loneliness and isolation, and life events, more difficult.

Conclusion: Findings in this study indicates that experiences with loneliness and isolation are highly subjective and the outcome is affected by the individuals existing Sense of Coherence. A low Sense of Coherence can make coping with loneliness and isolation more difficult and negatively impacts mental health, activity levels, confidence, and well-being. Lower levels of SoC, coupled with resistance deficits in health, family support, social networks, impacts the ability to cope and respond to chronic stressors, challenges, and life events individuals are faced with, further reducing health and well-being. Findings from this study indicated that older immigrants and individuals who suffer from debilitating health issues face more barriers when coping with loneliness and isolation.

Keywords: Loneliness, Isolation, Vestland-Norway, Chronic Stressors, Health, Well-being, Sense of Coherence, Salutogenesis.

List of abbreviations

GRR-RD	Generalized Resistance Resources-Resistance Deficits
GRR	General Resistance Resource
GRD	General Resistance Deficit
HRC	Hordaland Red Cross
NSD	Norwegian Centre for Research Data
RC-CC	Red Cross Connection Centre
RC-CSS	Red Cross Community and Social Support Scheme
SDG	Sustainable Development Goal
SoC	Sense of Coherence
SRR	Specific Resistance Resource
TNA	Thematic Network Analysis

1.0 Introduction

Feelings of loneliness and isolation are two separate phenomena or experiences if you will, however, when an individual experiences one, the other is often present as well. A lack of social contact and support can lead to loneliness (Nicolaisen & Thorsen, 2014). When one experiences loneliness, it ties into social and emotional isolation (Hauge & Kirkevold, 2010; Nicolaisen & Thorsen, 2014), and lonely people often withdraw from social networks and family, increasing their isolation. Loneliness and isolation can prove to be painful experiences and present themselves as pressing health issues, exacerbating other factors and conditions that can lead to poorer health (Graneheim & Lundman, 2010).

In the older population, loneliness and isolation are experiences that pose as health challenges that can cause depression and a sense of disconnection from society. Loneliness and isolation is linked to deteriorating mental and physical health and can negatively affect well-being and perceived quality of life (Nicolaisen & Thorsen, 2014; Musich et al, 2015). Halvorsen (2008, p. 258) explains how loneliness is a subjective emotion, and a "negative feeling of lacking social relations or a lack in quality in your relations to other humans", it is also important to note that 'loneliness' does not equate to 'being alone' (Hauge & Kirkevold, 2010), and using the terms interchangeably creates some confusion. 'Loneliness' and 'isolation' are further conceptualized by Macdonald et al., (2018, p. 1140). 'Social loneliness' is the absence of an "acceptable social network" and a sense of belonging, also understood as social isolation. And 'emotional loneliness' refers to the "absence of an attachment figure in one's life". Sources of loneliness and isolation are many and varied. Research suggests that poor or reduced health, unemployment, disability, insufficient social networks, poverty, migration, lack of intimate contact, and old age, to highlight some, can be attributed as causes, or increase the risks of experiencing loneliness and isolation (Halvorsen, 2008; Bessaha et al., 2020; Nicolaisen & Thorsen, 2014; Thorsen & Clausen, 2009; Macdonald et al., 2018; Chen & Feeley, 2013). This study aims to focus on experiences of substantial (chronic) loneliness, a long-lasting subjective interpretation of lacking social networks and quality in interactions (Macdonald, et al., 2018), experiencing social isolation. To avoid confusion, throughout this paper, substantial social and emotional loneliness, and social isolation, are referred to as 'loneliness' and 'isolation'.

It is important to acknowledge that loneliness is a subjective experience, that is understood and experienced differently between every individual (Hauge & Kirkevold, 2010). To further complicate matters, good health and well-being are also subjective matters. What an individual determines as good health or well-being is depends on their understanding of these concepts. This study aims to explore how loneliness and isolation are perceived to affect health and well-being, to achieve this it is important to conceptualize well-being. Well-being can be conceptualised through three dimensions that are interdependent of one another. One, material well-being (assets, welfare, standards of living). Two, relational well-being (social relations, access to public goods, capabilities, attitudes to life and personal relationships). Lastly, subjective well-being (perception on material, social and human positions, cultural values, ideologies, and beliefs) (White, 2010). These dimensions presented here pose themselves as determinants that affect one's subjective well-being and material well-being, which will vary between individuals and the importance these individuals place on the different aspects within the three dimensions.

The connection between age and increased loneliness or isolation seems inconclusive, however, loneliness is found to be more prevalent in the older generations. In Norway, 8.4 percent of men, and 8.1 percent of women aged 60-80, report high levels of isolation and experience loneliness (Hansen & Slagsvold, 2015), and is most prevalent in the age group 70-79 and above 80, and not far behind, we find the age group 18-29 (Barstad, 2021). It is interesting to note that loneliness decreases in young adults while they are establishing, and adults in their established phase. Loneliness is more prevalent in the younger age groups, then decreases, before it increases in older age groups (Peplau & Perlman, 1982). The higher prevalence of loneliness and isolation in the higher age groups poses a challenge for Norwegian public policy going forward. The Norwegian demographic is experiencing changes, moving toward an ageing population as a result from declined fertility rates and increased life expectancy. As a percentage of the total population, the cohort of Norwegians aged 67 and above reached 13 percent in 2010 and is expected to reach 22 percent in 2060 (Andreassen, 2010). Together with a demographic change, an increase in elderly living alone can be expected, possibly increasing the prevalence of loneliness and isolation in Norway. In a global context, Norway is a rich, developed, western country with a strong welfare system and a history of strong institutions and organisations, while the prevalence of loneliness and isolation relatively low, but still existing. A salutogenic approach to these subjects might

provide insight towards reducing inequalities, creating good health and well-being, and utilizing strong institutions to combat loneliness and isolation in Norway.

1.1 Problem statement

Feelings of loneliness and isolation are subjective experiences which are interpreted differently between every individual. The effects of loneliness and isolation are detailed and thoroughly documented through research. It affects physical and mental health, well-being, and quality of life in all ages, and increases the risks of various diseases. To my knowledge, there is a lack of research situated in Norway that compares subjective interpretation on the effects of loneliness and isolation on health and well-being, as well as coping mechanisms found in individuals in different life situations. This study aims to explore the differences and similarities in how loneliness and isolation is subjectively understood and coped with and the challenges they face, among individuals who are experiencing loneliness in relation to migration, debilitating health issues/disability, and old age, through a salutogenic approach.

1.2 Research Objectives

This research study's main objective is to explore how loneliness and isolation is perceived to affect health and well-being for individuals in different life situations. To achieve this, I propose four secondary objectives of exploration. One, to understand the subjective interpretations of loneliness and isolation among individuals in different life situations (old age, immigration, health issues, not lonely). Two, to explore stressors and related to loneliness and isolation. Three, explore resources that can prevent or reduce experiences of loneliness and isolation. Four, the subjective interpretation of good health and subjective well-being. See all sub-objectives presented in bullet points below:

- Explore the subjective interpretations of loneliness and isolation among individuals in different life situations.
- Explore stressors among the individuals related to loneliness and isolation.
- Explore resources that aid in reducing or preventing loneliness and isolation
- Explore subjective interpretations of good health and well-being

2.0 Literature Review

The search for literature was done through systematic searches covering articles, reports and research addressing loneliness and isolation tied to health and well-being in different life

situations. I have used ‘Google Scholar’ and ‘Oria’ and their databases to search for relevant literature. The search for literature was done through keywords such as ‘loneliness and health’, ‘loneliness and old age’, ‘loneliness + isolation + health’, ‘loneliness + immigration’, ‘health + loneliness’, ‘understanding + loneliness’, ‘resilience + loneliness’. Literature was search for in both English and Norwegian. Some search words used have been translated to English for this paper. There was an attempt to focus on research done in a Norwegian setting due to the purpose and setting of this paper.

Loneliness and isolation are hard to define concepts, and not always synonymous with each other, neither is loneliness a disease (Halvorsen, 2008), it does however impact health and as expressed earlier, can increase the risk of other ailments one would not necessarily suffer in absence of loneliness (Halvorsen, 2008; Nicolaisen & Thorsen 2014). Nicolaisen & Thorsen (2014) explains how loneliness is also associated with - but not equivalent to - social isolation. However, loneliness is often followed by unwanted social isolation (Hauge & Kirkevold, 2010) and the two subjective experiences are often inter-connected (Hauge & Kirkevold, 2010; VanderWeele, Hawkley & Cacioppo, 2012; Halvorsen, 2008). Halvorsen (2008) defines three concepts of loneliness, 1. Social loneliness (lack of close contacts), 2. Inter-personal Loneliness (loneliness even when surrounded by others), and 3. Cultural Loneliness (trapped between two or more cultures without finding a place in either). Loneliness can be understood as a state of emotional distress, accompanying perceived deficiencies in the quantity and/or quality of one’s social relationships (Peplau & Perlman, 1982; Chen & Feeley, 2013; Halvorsen, 2008; Nicolaisen & Thorsen, 2014). Loneliness is also not synonymous with being alone or apart from others. Some individuals can be alone, and thrive or enjoy being alone, without feeling lonely. Loneliness is a more ‘multidimensional phenomenon’, and a lived experience that causes tension and stress for those who experience it (Graneheim & Lundman, 2010). In this paper, loneliness and isolation will not be defined and conceptualized further, that is beyond the scope of this researcher and paper. The lived experiences and interpretations of loneliness and isolation lived by the participants in this study will be in the centre focus. Throughout the process of searching for, and reviewing, literature in line with these subjects and this papers objectives, there perceives to be a lack of research that focuses on comparative experiences of loneliness and isolation between population groups with a salutogenic approach, especially among adults aged 35-60.

Health related issues connected to experiences of loneliness and isolation are many. Loneliness in elderly population is linked to higher risk of dementia, increased risk of heart disease and stroke, which in addition increases the risk of premature death (Hauge & Kirkevold, 2010; Nicolaisen & Thorsen, 2014; Halvorsen 2008.). It also shows that older age is associated with increased loneliness and depression due to "reduced health, cognitive function, social network and socioeconomic resources" (Hansen & Slagsvold, 2019; Fiske, Wetherell & Gatz, 2009). People who suffer from loneliness and depression in an earlier age, tend to be stable as they are aging (Hansen & Slagsvold, 2019), but loneliness drastically increases in the age group over 80 (Hansen & Slagsvold, 2019; Dykstra, 2009). Individuals suffering from disabilities were found to have increased risk of loneliness and social isolation. Those who were disabled, and experienced loneliness and social isolation, often experienced barriers in daily action, environmental barriers, and access to activities outside the home, which contributed to increased feelings of loneliness and isolation (Macdonald et al., 2018). Poverty through disability, combined with socio-economic status were found to be universal risk factors, paired with physical impairment, mental distress and a lack of participation ability, increased the likelihood of experiencing loneliness and isolation (Macdonald et al., 2018; VanderWeele, Hawkley & Cacioppo, 2012; Bessaha, 2020).

Immigrants in Norway are more pre exposed to feelings of loneliness due to language barriers, discrimination, lower income, reduced health, and problems related with family contact (Barstad, 2021), and that refugees sometimes experienced loss of decision making in daily matters (Herslund & Paulgaard, 2021). Among immigrants and refugees, lack of social support, feelings of shame, lack of quality in social relations and interactions, and feelings of isolation, can contribute to higher risk of experiencing loneliness and isolation (Nortvedt et al., 2016; ten Kate, Bilecen & Steverink, 2019).

There is an abundance of research on how loneliness affects health in the oldest age group, however, the research on middle aged adults (40-60) in Norway is slightly lacking. A report on public health in Hordaland (Norway), between 1997-2000 shows that there is a connection between subjective health problems and a lack of social relations between all age groups and genders (Aanes, Mittelmark & Hetland, 2010). Symptoms of anxiety, depression, sleeping disorders and somatic ailments are often reported among all age groups and genders who experiences lack of, or troublesome social relations (Aanes, Mittelmark & Hetland 2010; Nicolaisen & Thorsen, 2014). Nicolaisen & Thorsen (2014) report that the relationship

between age and loneliness seems inconclusive, however, studies show that loneliness is more prevalent among older adults (Nicolaisen & Thorsen, 2014; Dykstra, 2009; Dykstra, van Tilburg & de Jong Gierveld, 2005). People who experience impaired health, either physically or psychologically, that reduces their ability to participate in social events, daily social life, have reduced movement or subjectively isolates the impaired, generally report higher levels of loneliness (Normann, 2010; Aanes, Mittelmark & Hetland, 2010; VanderWeele, Hawkley & Cacioppo, 2012; Bessaha et al., 2020). Loneliness and/or isolation, are also heavily linked to reduced feelings of subjective well-being and quality of life among those who experience it (Halvorsen, 2008; Thorsen, 2005; Barstad, 2021; VanderWeele, Hawkley & Cacioppo; Gerino et al., 2017; Nicolaisen & Thorsen, 2014).

The prevalence of loneliness in the Norwegian society has been relatively stable since the 1980s (Barstad, 2021), in 2020, 37 percent of Norwegians reported to be 'somewhat' or 'very' bothered by loneliness (Barstad, 2021). In 2002, 1.5 percent of the Norwegian population between 16-79 reported chronic loneliness coupled with a lack of close contacts and classified as socially isolated with no weekly contact (Halvorsen, 2008; Barstad, 2004; Thorsen, 2005). There are issues related to measuring and reporting the prevalence of loneliness within a population due to different factors. People report less loneliness through interviews than when filling out a questionnaire (Barstad, 2021), loneliness is a subjective experience and requires self-reporting of a tabu subject which creates some uncertainty to the statistical numbers, especially through interviews (Halvorsen, 2008; de Leeuw et al., 1996; VanderWeele et al., 2012). Prevalence of loneliness is generally lower in rich western countries with generous welfare schemes (Hansen & Slagsvold, 2019) and is generally lower in Norway compared to other European countries (Hansen & Slagsvold, 2015). Elderly Norwegians aged above 70 generally report higher levels of loneliness compared to younger age groups, (Thorsen & Clausen, 2009; Barstad, 2004; Nicolaisen & Thorsen, 2014; Barstad, 2021), where Norwegian women report higher levels of loneliness.

3.0 Theoretical Framework

This study intended to explore loneliness and social isolation, as well as its interconnectedness with health and well-being. The study focuses on how different individuals deal with the challenge and stress of loneliness and isolation, where some might manage better than others, and how individuals meet and understand challenges such as

loneliness and isolation. In light of this, a salutogenic approach was chosen as a theoretical framework to guide this research. Antonovsky's theory of Salutogenesis focuses on the origins of health, and what makes people healthy, rather than disease and causes of ill health. In Salutogenetic theory, life experiences help shape one's resources to cope with stressors and how to manage tension successfully (Mittelmark & Bauer, 2017). Salutogenesis as a framework allows for focus on personal characteristics, resources, resilience, and environment as tools for maintaining good health and well-being. With research on different age groups, individuals in different life situations, with different backgrounds and varying experiences, Salutogenesis offered a promising theoretical framework to study the stressors, coping mechanisms and personal characteristics that can help a person move towards better health, and improve well-being, while facing challenges such as loneliness and isolation. Quehenberger & Krajic (2017, p. 327) note that "Salutogenesis is particularly relevant to understand the stress that many older people encounter due to an unpredictable future based on diminishing socioeconomic resources, shrinking social networks and deteriorating health and capacities".

The main components of salutogenic theory consist of Generalized Resistance Resources (GRRs), Specific Resistance Resources (SRRs), and the Sense of Coherence (SoC) together with its three dimensions, comprehensibility, manageability, and meaningfulness. A person's SoC is reflected through their view of life and capacity to respond to stressful situations (Koelen, Eriksson & Cattan, 2017), where the SoC is built on, and strengthened, through GRRs and SRRs, where GRRs contribute to the formation of a strong SoC (Slootjes et al., 2017). Vinje, Langeland & Bull (2017, p. 29) define GRRs as "any characteristic of the person, the group, or the environment that can facilitate effective tension management"; such as, education, gender, religion, social class, or cultural stability (Slootjes, et al., 2017). SRRs are to be used when facing specific stressors and are specifically created to be applied in specific encounters with such stressors (Mittelmark, Bull, Daniel & Urke, 2017), such resources can be; suicide prevention lines, unemployment benefits, or national associations for different diseases. According to Antonovsky (1996, p. 15), GRRs "foster repeated life experiences, that helps one to see the world as making sense, cognitively, instrumentally, and emotionally". GRRs are built over time through repeated stimuli in life-situations or life experiences, and through such stimuli, a person generates resources that are available and can "enable individuals to have meaningful and coherent life experiences" (Slootjes et al., 2017).

Antonovsky (1987, p. 28) introduced the concept of "major psychosocial generalized resistance resources-resistance deficits" (GRR-RDs) in his book "Unraveling the Mystery of Health". An individual could be ranked on a SoC continuum, for those that are higher in the scale, GRR-RDs would be GRRs, but for those low on the SoC scale, GRR-RDs would be GRDs (generalized resistance deficits) (Idan, Eriksson & Al-Yagon, 2016, p. 57). When an individual is lacking in consistent life experiences and has low participation in decision making, they could be said to have generalized resistance deficits, lacking resistance resources needed for effective tension management. In "Unraveling the Mystery of Health", Antonovsky (1987, p. 29) argues that "chronic resources or chronic stressors, built into the life situation of the person, are generalized and long-lasting. They are primary determinants of one's SOC level", and that GRRs and GRDs determine an individual's ability to manage stress and tension. 'Life events' as Antonovsky coined them (death of a family member, divorced, losing a job) and an individual's ability to cope with such events is tied to the individuals SoC, where someone ranking high in SoC would cope and manage stress and tension well compared to a person ranking low on SoC (Antonovsky, 1987, p. 29). Stressors through a salutogenic orientation can be viewed as salutogenic (health promoting), neutral (irrelevant) or pathogenic (cause of disease/ill health) (Langeland et al., 2022; Antonovsky, 1996).

According to Antonovsky, the SoC is a "generalized orientation towards the world" (Antonovsky, 1996, p. 15), where an individual perceives the world as comprehensible, manageable, and meaningful. To view the world as comprehensible, one would see arising issues as predictable, structured, and explicable. The manageability dimension is related to an individual's confidence that they have resources available to deal with the issues that arise and have a solid capacity to judge reality. The meaningfulness dimension relates to an individual's motivation, and that they wish to cope with the issues that arise (Antonovsky, 1996; Slootjes et al., 2017). The development of a person's SoC can be said to be affected by three types or patterns of life experiences, that are tied to the three dimensions of the SoC. Consistency (comprehensibility), under-overload balance (manageability), and participation in decision-making that is socially valued (meaningfulness), (Antonovsky, 1996; Slootjes et al., 2017). Comprehensibility is fostered through consistent life experiences and stimuli that are believed to be understood and are experienced in a stable environment. Strong comprehensibility allows a person to see the information they are provided with as ordered, consistent, predictable, and that it is making sense (Antonovsky, 1987). Consistent exposure

to stimuli and responses to these stimuli, in a stable environment, “results in stimuli becoming more familiar”, contributing to greater comprehensibility (Slootjes et al., 2017, p. 572). Manageability is largely shaped by a good “load balance”, or “under-overload” if you will (Slootjes et al., 2017; Antonovsky, 1987). Through a good load balance, individuals can meet the demands or requirements they face throughout life, they see it as challenging and engaging and can handle the amount of demands they are faced with. Underload happens when a person experience too little requirements or demands and become demotivated or uninterested. Overload is experienced when an individual is faced with too many demands and requirements, experience failure and insecurity, and face more demands that the individual can cope with (Slootjes, et al., 2017). By facing consistent demands and requirements through a good load balance manageability is fostered, the perception of available resources increase, together with the ability to apply the resources that are needed. The last dimension of the SoC, meaningfulness, is according to Antonovsky built through “participating in socially valued decision making” (Antonovsky, 1996, p. 15). An individual build meaningfulness through participating in the process of shaping one’s life and the daily experience, decision making control in daily life (Antonovsky, 1987), and that they are motivated and willing to do so (Slootjes et al., 2017). Other research also suggests that self-transcendence, achieving goals, and a sense of belonging can also contribute to building meaningfulness (Slootjes et al, 2017). Antonovsky (1996), regarded the SoC to be developed through the lifespan, and would be stable after 30 years of age. Newer research indicates that a person’s SoC is relatively stable, and improves during a lifetime of learning, even after 30 years of age, and that the SoC can fluctuate and be temporarily strengthened or weakened by major life events (Langeland et al., 2022).

4.0 Methodology

This section will be used to present the applied methodological approach to achieve the research objective and sub-objectives presented in the previous section. Here the research design and approach will be presented, together with an overview of the research process including study site and participant recruitment. This section will also include some reflections on changes in the recruitment process of participants that were done throughout the research period. An overview will be provided on the methods of data collection, including management and methods of analysis for the collected data. Lastly, ethical considerations and trustworthiness of the research will be discussed.

4.1 Research Design

A qualitative research approach was applied to this study as it lends itself well to achieve the research objectives and sub-objectives through systematic collection, organization, and interpretation of textual material derived from talk or observation (Malterud, 2001). Seeing as the study set out to explore separate experiences with loneliness and isolation through the lens of individuals in different life situations, a qualitative research approach was chosen as the most fitting, as it draws on philosophical ideas in phenomenology, symbolic interactionism, hermeneutics, and other traditions to support the attention on 'quality' rather than 'quantity' (Yilmaz, 2013). For greater context, room was given to explore the subjective interpretation of these experiences, i.e., "the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context" (Malterud, 2001, p. 483).

By the nature of the research objectives and sub-objectives, a phenomenological design was chosen as most fitting, as it "describes the meaning for several individuals of their lived experiences of a concept or phenomenon" (Creswell & Poth, 2018, p. 57). The phenomena in question would then be 'loneliness' and 'social isolation'. Through applying a phenomenological design, it allowed for a 'deep dive' into the lived experiences with loneliness and isolation of the participants in the study. The focus was then on their individual experiences and interpretations of the phenomena in question, which in turn allowed for a search of common themes and commonalities in how each participant experienced the phenomena through individual interviews (Creswell & Poth, 2018). To give greater context, a phenomenological design combined with semi-structured interviews, allowed for deeper "probing" on select themes such as health, well-being, family, and social network as examples, this will be further showcased in the section on methods for data collection.

4.2 Study Site

The interviews for this study were conducted in Bergen, (Norway) and some surrounding municipalities on the west coast of Norway. Initially, all recruited participants were planned to be located in one specific district (Laksevåg) in Bergen through a recruitment partnership with Hordaland Red Cross and the Red Cross Connection Centre located in Laksevåg. The area for recruitment was eventually increased to include participants from other surrounding municipalities around Bergen. The reason for this was partially as a result of a shortage and difficulties with recruiting participants, as well as change in research objectives and participant inclusion. By the end of the recruitment phase, participants had been recruited

from Bergen, Fjell and Alver municipality, and included participants from both urban and rural areas.

4.3 Participants.

Initially, this study planned to include elderly native Norwegians, aged 67 and above, who had lived in a single household for more than 5 years in Laksevåg. In a phenomenological study, it is seen as appropriate to include 5-25 participants who have all experienced the phenomenon (Creswell, 2007, p. 61). I aimed to include 6-10 participants, due to this being a 30 ECTS master's study.

The recruitment was to be conducted through cooperation between myself as researcher and Hordaland Red Cross, specifically the Red Cross Connection Centre (RC-CC). The RC-CC is a pilot project aiming to reduce loneliness and increase social activity for local residents in Laksevåg, aged 18+. In this period, I was simultaneously conducting my internship period in this pilot project while recruiting participants. The RC-CC would act as a gatekeeper in the recruitment process, asking their own participants if they would like to participate in my research project, perhaps unusual, I would also act as a gatekeeper in this study through my employment at the Red Cross. Gatekeepers here are referred to as "individuals, groups, and organizations that act as intermediaries between researchers and participants (Clark, 2011, p. 484). All participants were informed that not participating in the research project would have no consequences for their participation in the Connection Centre's activities, and that participation in the research project was entirely voluntary. The recruitment process was included through mapping interviews carried out by an employee at the RC-CC. Due to a one-month delay in the opening of the RC-CC, the recruitment process was also delayed by quite some time. In addition, the Connection Centre experienced a slow recruitment phase and lack of participants in their own activities, which resulted in very few participants who fit the criteria for this research project. This led to further deliberation and changes to research objectives and sub-objectives, and as a result, changes to inclusion and exclusion criteria to include a wider variety of participants. In addition, the Red Cross Companionship and Social Support Scheme (RC-CSS) was included as a gatekeeper to increase the number of potential participants. In the later stages of the recruitment, due to a lack of participants, the inclusion criteria were:

- Older than 40 years old and experience loneliness and social isolation

- Experience loneliness and/or isolation in either old age, as immigrant, or due to health issues.
- A person within the other criteria who does not experience loneliness and/or isolation.

Not all inclusion criteria for participants were met in the recruitment. In total I had six participants ranging in age group adult to old age (40-100), in total two men and four women. During the recruitment phase, there was an effort to recruit two persons from each set category, "loneliness and isolation due to health concerns", "participants with foreign background and experiences with loneliness and isolation", "Loneliness and isolation at an older age", and lastly, "persons who did not experience loneliness or isolation". Table 1 below gives and overview and explanation of the six participants in the study.

Table 1: Overview of participants in research study

Category:	Pseudonym	Age group	Other
Loneliness (health)	Anna	Adult	Single mother, disability, loneliness/isolated
Foreign background (Iran)	Mohammed	Older adult	Married, lives with wife
Loneliness (age)	Alf Rita	Old age	Unmarried, living alone. (both)
"Not lonely"	Olga	Very old age	Living alone, 30 years.
Total: 5			

All participants in the study have been given pseudonyms to ensure anonymity. As an extra safeguard to the participants anonymity, their area of residence will not be included, seeing as all participants are connected to the RC-CC and/or the RC-CSS. The pseudonyms are based

on gender. In addition, I have chosen to place the participants into age groups, rather than give their age. The reason for this is to better ensure anonymity.

4.3.1 Limitations to recruitment

Due to a delayed and slow recruitment process, the timeframe of recruiting participants and performing data collection proved to be a challenge. The recruitment phase lasted from December 2021, up until the end of March 2022. There were also challenges connected to the number of participants available in the recruitment pool, three participants were recruited through the RC-CC, and two participants from different local Red Cross RC-CSS branches.

Due to these facts, concerns on anonymity arose, the small number of participants would result in easy identification of the participants for persons working for the Red Cross. To subvert this issue, participants were selected from different channels, though all within the Red Cross. The participants who I further contacted for interviews after the Red Cross had established contact with them, were not disseminated to any gatekeepers or other people within the Red Cross, this was a step to ensure anonymity. No gatekeepers other than me would have information on which participants had been further contacted and who had completed an interview. All Red Cross employees and volunteers also sign a non-disclosure agreement, adding to ensure confidentiality in this project. In addition to a small number of participants recruited, a total number of 6, one participant withdrew from the research project, and expressed that she did not want her interview to be used. This reduced the number of participants to a total of 5. This withdrawal happened at the end of April 2022.

In addition, all participants had filled out documents in combination with their “mapping-interviews” at the RC-CC Due to my involvement and work there, these documents were handled by me after mapping-interviews, to see which participants who had agreed to take part in this research study, and for other work-related reasons. This, together with prior conversations through drop-in, phone conversations and scheduled meetings, I had established a relationship with all participants included in this study and had some form of knowledge of their situation.

4.4 Data Collection

The data collection for this research project was conducted through semi-structured in-depth interviews with each individual participant included in the study. Interviews and focus group

discussions are common qualitative research methods (Skovdal & Cornish, 2015, p. 21), and in-depth interviews are often used in phenomenological studies (Creswell, 2007, p. 61). The research objective and sub-objectives in this study required insight on the participants lived experiences of loneliness and isolation, as well as the participants subjective understanding of these phenomena. In light of this, semi-structured in-depth interviews were chosen as the method for data collection, due to its ability to "explore the experiences of participants and the meanings they attribute to them" (Tong, Sainsbury & Craig, 2007, p. 351).

The intention of the semi-structured guide behind the in-depth interviews, was to attempt to create semi-natural flowing conversation with the participants and extract valuable information through open-ended questions. The interview guide consisted of two main sections, where the first section consisted of five main questions, and the second section consisted of three main questions. The open-ended questions gave way for closer "probing" on pre-set "themes" that were deemed important and related to the research objectives when creating the interview guide. Such "probes" could be 'family', 'social relations', 'health', 'well-being', 'resources' or 'stressors'. (See appendix 9.1 + 9.2 for full interview guide).

All interviews were conducted in Norwegian and, bar one, were recorded with the use of a voice recorder. Due to covid-19, not all interviews were conducted in-person. Three interviews were conducted in-person, where two were recorded with the use of a voice recorder. Two interviews were conducted through the digital communication software 'Zoom' and recorded with a voice recorder. One interview was conducted over telephone and recorded through a voice recorder. The use of voice recorder was decided after privacy and data storage concerns were raised by the Norwegian Centre for Research Data (NSD), who recommended the use of a voice recorder, rather than personal devices such as phone or computer. Due to this, some words in the recordings of the interviews are unintelligible. One interview was conducted in-person, using notes on a personal computer, due to the participants wish to not be recorded.

I need to acknowledge that themes such as loneliness and isolation are burdening and difficult experiences for the participants. For this reason, boundaries and limitations for the interview and questions they wished to answer, were set by the participants during the interviews.

4.4.1 Data Management

Interviews with all participants were as stated conducted in Norwegian and recorded on a digital voice recorder. The participants gave oral approval to be recorded during the interview, all except one participant who requested notetaking. Transcription of the interviews were done manually by me through Word and were all transcribed in Norwegian without translating. The translation of the interviews were kept to a bare minimum to not lose important information, through translations often some meaning is lost. Translation to Norwegian was done only on quotes presented in this thesis to best keep its original meaning. All personal details, such as names, names of relatives and locations that could identify the participants, were excluded in the transcripts. Transcripts of the interviews were first saved on a password-protected personal computer, before being stored in UiB SAFE-systems. All recordings are saved on the digital voice recorder, stored in a safe and lockable location. All transcripts and recordings will be deleted after the research projects evaluation.

4.4.2 Data Analysis

The analysis process for the generated research data was done through a Thematic Network Analysis (TNA) developed by Attride-Stirling (2001). Braun & Clarke (2008, p. 79) explains that that TNA is a "method for identifying, analysing, and reporting patterns (themes) within data". In a TNA, identified themes are generated into codes, which are further distributed into basic themes, then into organizing themes, before finally reaching more abstract levels in one or several global themes. Since all transcribed interviews were kept in Norwegian, and only quotes presented in these finding were translated, all coding through the TNA was done in Norwegian to best match the dataset.

The initial analysis process was done through familiarizing myself with the dataset by reading through transcripts and listening to interviews. During this process, recurring themes were identified and written on post-it notes, before being placed into "placeholder" basic themes. Recurring and common themes were identified during this phase, and due to a small number of participants, themes applying for only one participant was also included to allow for comparison in the findings and discussion phase. After the initial phase of identifying themes, these were organized and given specific codes using the computer software Nvivo. Nvivo lent itself as a very good resource for organizing data, transcripts and creating a framework for the TNA. Data from transcripts were then organized into the generated codes in Nvivo. From these codes, new basic themes were identified, which were further distributed between three

organizing themes in line with the research objectives, no global theme was created in the TNA. For a full overview of the thematic table, see appendix 9.3).

4.5 Trustworthiness

Generating trustworthiness in qualitative research is incredibly important and can be challenging in many cases due to the nature of qualitative research. Findings and data in qualitative research and in a phenomenological study are generated through subjective thoughts and opinions of the participants. Four steps are to be included and rigorously followed up on to generate trustworthiness. For this study to ensure trustworthiness in its findings, the concepts of credibility, transferability, dependability, and confirmability have been considered. Credibility of the study here refers to that the "participants in the study finds the results of the study true or credible" (Yilmaz, 2013), credibility also assesses the internal validity of the findings. Credibility in this study was ensured through a rather unconventional triangulation of methods, with conversations and mapping-interviews coupled with in-depth interviews. As explained in section 5.3.1, I had established contact and a form of relationship with the participants before the interviews through my work at the Red Cross Connection Centre. Through these conversations, participants had already explained their situation and been informed of my study, and some form of trust was formed between myself and the participants. All participants included in this study expressed wished to "tell their story" through participation. To ensure credibility further, an emphasis was put on thick descriptions and true representation of the participants. All participants were given the option to read through the transcripts of their own interview.

Dependability refers to the justification, selection and application of research strategy and methods (Yilmaz, 2013). The research design of this study was done with assistance from two supervisors at the University of Bergen, to assure that the theory and methods applied were suitable for this research and research objectives. The choice of methods have been justified throughout this paper through reflections on the choice of method, its strengths and the limitations faced. The use of conversations, mapping-interviews, and in-depth interviews with an interview guide have been detailed and justified. Seeing as methods, study area, selection of participants and setting are described in detail, the means to achieve transferability have been met (Yilmaz, 2013), the sample size of this study is very small and cannot generate generalizable findings, however, it creates insight. Transferability is further ensured through linking insights and findings to previous literature, and can add to, or support

existing literature. Confirmability was generated through securing that all findings are reflective of the participants responses and are analysed through a thematic network analysis model. Yilmaz (2013), explains that a study enjoys confirmability "when its findings are based on the analysis of the collected data examined via an auditing process".

Throughout this research, I have reflected on my role as researcher, my biases, my subjective understanding of loneliness, and my relationship with the participants. First and foremost, for my participants, I was a trusted contact person employed by the Red Cross to aid them in reducing loneliness and isolation through the Connection Centre program. Through conversations, participants confided in me prior to interviews and developed trust in me as a professional who wished to aid them. This did affect my interviews and allowed for deeper and more in-depth interviews. In this process, I also reflected on the power structure between myself and the participants. Therefore, all participants were asked by a gatekeeper in a sense, to participate in the interviews for this study, and not specifically by me. There was a heavy focus on separating participation in the Red Cross Connection Centre and participating in the interviews for this research. The interviews used for this study, would not be connected to activities and further interactions at the Red Cross. Due to my relationship with the participants, I have done my utmost to ensure that all findings are reflected in the views and experiences of the participants. However, it is also important to acknowledge my own subjective understanding and biases when discussing loneliness. This has been rigorously reflected on throughout the research process, to best represent only the experiences, views and understandings as expressed by the participants.

5.0 ETHICAL CONSIDERATIONS

Research always faces ethical considerations and must be, to all possible extent, considered before the research is conducted, while some must be taken continuously through the process and researchers must be aware of the implications their research can have.

5.1 Ethical Clearance.

This study achieved ethical clearance from the Norwegian Centre of Research Data (NSD). This study is approved for extended data storage and sharing of anonymized data to cooperating organizations (Norwegian Red Cross). Data relevant to the RC-CC will be used

in evaluation and reports in the pilot project the researcher has participated in. (See appendix 9.6 + 9.7).

5.2 Participant rights

There are five main ethical considerations to be considered, harm, consent, deception, privacy, and confidentiality (Punch, 2014, p. 43). In my research I will be working with individuals in a vulnerable situation, and there are important ethical considerations to reflect on. I must assure that the participants can fully give consent to interviews, and that they are not cognitively impaired. The participants in this study were ensured that their active participation at the Red Cross Connection Centre was not affected whether or not they decided to take part in interviews for this research. All participants were throughout the interviews reminded that they did not have to answer questions they were uncomfortable with. Privacy and anonymity concerns were raised throughout this research process due to the participants involvement in the RC-CC and other Red Cross activities. Information about which individuals who participated in interviews was not disseminated further to other Red Cross employees but contact information to the manager of the Connection Centre was provided to all participants in the study. Participants were given pseudonyms, and all locations and identifying characteristics have been redacted. However, complete anonymity is impossible to achieve due to being active in the RC-CC, as was informed to the participants. All information confided in me through conversations prior to the interviews have not been included in this study, only findings from the interviews are represented here.

5.3 Informed Consent

In this study, informed consent was provided to the participants, and required to be signed to assure that the participants fully understand the reasoning behind the research, the background for use of interviews, to clear misunderstanding and to not mislead any participants (Punch, 2014, p. 43). Through the informed consent form all participants were explained the; purpose of this study, what the data they provide me with will be used for, as well as how confidentiality will be ensured before each interview, each participant was provided with a consent form with contact information that they could sign. To ensure confidentiality all participants and affiliated organizations, as well as interviews along with transcripts, were anonymized. (For detailed informed consent, see appendix 9.4 + 9.5)

6.0 Findings

The findings in this paper reflect the experiences and perception on loneliness among a small selection of participants located in and around Bergen, Norway. The findings section will focus on perceived internal and external resources used to alleviate loneliness and how to cope through resources perceived to be available to the individual. The findings will also illustrate how loneliness comes about and affects people in contrasting life situations. This section is divided into three main parts in accordance with the three organizing themes generated through the Thematic Network Analysis (TNA) conducted on 5 separate interviews. Each organizing theme consists of 2-3 basic themes. The organizing themes were; 1: Resistance deficits in relations and support, 2: External resources and actors, 3: Personal resources, internal processing and response.

6.1 Resistance deficits in family, social and support systems

During the interviews I wished to explore more closely how family, social networks and friendships were viewed among the participants of the study. I wanted to generate a closer understanding how in some cases, these aspects of human life act as safe support systems and great resources, and in other cases, act as a cause of tension and stress. In this findings section, I will periodically compare experiences from the four participants who experience loneliness and/or isolation, to the single participant who states that she is not experiencing loneliness or isolation.

6.1.1 Family Stressors

In healthy family relationships, close relatives are often viewed and utilised as good support systems that brings a sense of comfort when dealing with negative emotions or face situations that cause tension or stress. I wanted to explore further if and how family relations can act as stressors, and if so, is this constant or periodically? One male participant explains his relationship with his sister who lives close by, "*But then again, we don't have chemistry at all and I – its more annoying and frustrating to talk to her*" (Alf). Further the participants explain that he perceives his sister to be purposefully keeping him "in the dark" on what is happening with family and friends, "*it's natural that she conveys some information to me that is just sitting here, but no… she is just amplifying the problem",* and "*it's just to stab the knife in me, you know"* (Alf). The participant added that he withdraws from contact with his sister for his own health. Another participant highlighted as follows:

"*Everyone wants – humans want to have a sense of belonging and when you take that away – we are pack animals. If you have that pack animal emotion and become lonely, that is when negative thoughts arise. The same happens in prison, you take that sense of belonging away from someone. I am not in prison; I am free to do what I want but the sense of belonging is missing"* (Mohammed).

The same participant interestingly noted that "*you can still feel alone even if you have a family"* (Mohammed) and goes on to explain, "*physically I am not alone, but mentally I can be alone. Uhm – it's hard to explain, she sits upstairs but … yeah"*. In the same vein, one female participant who is single mother mentioned increased feelings of loneliness as her son got older, "*as my situation is now, I feel like I am becoming more and more lonely, because before – my son had a lot more need of me, now he is in a detachment phase"* (Anna). Lastly one participant pointed out that she avoids contact with family and that "*it has become too problematic, sadly"* (Rita).

During the interview rounds, it quickly became evident that family dynamics vary greatly among the participants of the study. Considering this, I wanted to explore further, if possible, how the participants viewed family as a resource and if size of the family mattered. Being very sensitive topics and seeing as most participants had experienced loss of loved ones and/or, trauma from family incidents, I did not want to push them and cause unnecessary stress during the interviews. However, some interesting subjects came up. The participant who mentioned a stressful relationship with his sister (Alf), put heavy emphasis on his good relationship with his niece who he has frequent contact with:

"*I have very good contact with my sister's daughter, my niece. We can sit, her and I can talk for hours, it has happened we have talked for 5 five hours, that has happened multiple times. We have such good chemistry – and that is so important"* (Alf).

As previously stated, I did not wish to push the participants on topics such as loss of loved ones to cause unnecessary stress, if such topics arose in the interview, I wanted it to be organic, without questions for further elaboration. One participant noted that she had lost both parents, and the thought of losing her closest aunt, who she viewed as a great resource and depended greatly on was terrifying, *"I am terrified of losing her, she was really sick this fall and, and yeah. I think "What then?"* Anna). One male participant noted that his cohabitant for 17 years had become senile some years ago, "*it clear that it becomes extra stressful, because we had it really nice. It was the highlight of my life"*, further he notes "*everything I had with*

her, and now all ties are cut, and you are flung back into that 'loneliness chair' that you… hate to be in" (Alf). The participant who did not feel lonely, expressed she had lost her brother to cancer some 30 years ago, when asked on how she experienced that period, she responded, "*I was just happy to be able to be with him. I was there at the hospital 9 times, and travelled to the city with him" (*Olga), later in the interview, the same participant elaborated on how she felt after her brother passed,

> "*I thought about it when my brother died, I'll be alone, I had not been alone a single day before in my life. We have always been together; he has lived at home and everything. And I thought, if I don't feel lonely, it's strange now thinking back on it, it's like I got used to it, that I was alone"* (Olga).

6.1.2 Lack of social networks and sense of belonging

During the interviews, it became clear that a lack of social network, a sense of not belonging and feelings of isolation were some of the biggest stressors and causes of tension within the participant group. Such stressors seem to greatly increase feelings of loneliness, one participant responded, *"Yes, no loneliness that means that you feel like you are on the outside, you are not participating in society"* (Mohammed), this sense of a lack of belonging, and feelings of exclusion were in particular shared among two of the participants. One reported that health challenges had forced her to quit working, "*now I am spending a lot of time in the hospital as a patient. I would rather be on the other side and be able to provide help to someone if you understand – that is something that really tears on my confidence"* (Anna), the participant also shared that she had been diagnosed with mental illness, and that the loss of her ability to work and participate in society as a contributing worker was a major trigger to her depression. One participant elaborated on one of her toughest experiences of 'not belonging' and a lack of social network on the 17th of May one year,

> "*I saw that, I don't know them well, but they are acquaintances and neighbours. They had a get together in the hamlet. I was sitting alone on the terrace and my son was playing games, nobody asked if we wanted to join"* (Anna).

She continued "*I remember, I was really sad that time. I didn't want to cry in front om my son. I just miss being asked or invited to join a barbeque or a gathering"* (Anna). This participant also shared feelings of not being accepted and included, and stated she had experienced alienation on several occasions, and especially when moving into a new

neighbourhood, “*Maybe I am too open, because when I told them I have ME, and my son has ADHD, it was like the adults backed away from us”* (Anna).

The participant with an immigrant background reported the most struggles with a sense of not belonging and a lack of network. When asked about his experiences with loneliness and isolation, he responded “*That is my everyday life. I experience it daily, at work, at home – it's nothing new. I have been isolated and lonely since 1987, 13. April when I came to Norway”* (Mohammed). I wanted to explore his experiences further, with a focus on work and creating social networks. The participant explained that he experienced challenges with creating friendship in and outside work because he did not share the same upbringing and common ‘memories’ as the others.

> “*Football, Manchester United, childhood, the cabin they went to as kids, the skiing holidays. They have experienced, what do I call it – a trip to a cabin that they have – something in common. They have a common point of reference that I don't share”* (Mohammed).

The participant further elaborated on some experiences in Norway, and his attempts at finding social networks. He experienced that racist attitudes, remarks and social prejudices followed him, “*There is a lot of loneliness here in Norway and people are insecure about themselves and others, and they are scared to open up to others”.* He goes on to explain:

> “*My son had a friend from an extremely religious family. The father in that household told me that both his sons had friends with foreign background, but he himself couldn't. He had tried but he didn't understand how his sons could do it”* (Mohammed)

Further the participant recalls experiences from earlier years, and how he did not feel accepted or welcomed, “*people would not sit next to me on the bus, and people would move away. I thought it would become better once I understood the culture and language, but it only became worse”* (Mohammed). Interestingly the participants highlights that he did not feel lonely and isolated when he had escaped from Iran into a different country, *“I was on the run and applied for asylum, but I was not isolated. I had friends, I had good friends. Society accepted me as a human”* (Mohammed). What is also worthy to note is the tremendous amount of effort the participant had spent to try and find a social network. He elaborated

further that he had attempted everything he could think of, religious groups, political parties, volunteering in humanitarian organisations,

> "*No, I was a stranger. It is something cultural, society has been taught, I can't do… I can't change anything. But my son, he doesn't experience this. My daughter does not experience this. I have talked to them about it, but they don't relate to this"* (Mohammed).

6.1.3 Lack of close relations

To generate further understanding, I sought to explore how a lack of close relations outside the family could act as a stressor and cause tension among the participants. Throughout the interviews, one sentiment in particular was shared among several participants, the lack of a close friend to share experiences and everyday life with, "*A friend, someone I can call a friend, go out and take a pint. A person I can go outside with, to the city, a café, restaurant, or travel with"* (Mohammed), several participants shared that this is something that is sorely missing,

> "*Someone that comes to visit me. It's about having a good time together, take me for a coffee, play chess, a glass of wine or something. That would have been nice"* (Anna), "*more friends, more acquaintances, I have moved away from all of them"* (Rita).

The importance of having a close friend, or a close relation outside the family was stated by one participant in particular, "*You can live longer, be healthier longer, just because you have a friend – a friend that can inspire you – mutual inspiration"* (Alf).

Throughout the interviews I had planned to explore social relations and networks online more in detail, due to the lack of participants, only one had any experience with this. He explained how he had attempted to replace 'real' friends with friends online through games, "*And those games, that was not real friendship… it was an attempt to – to have some friends – to replace real friends with them*" (Mohammed).

6.2 External resources and actors

Throughout the interviews, participants were asked to identify external resources, or tools if you will, that they tend to use to alleviate or reduce feelings of loneliness. Such tools could range from television or radio, family relations and social networks, to support communities

and external actors. Societal conditions were also included as external factors that impact loneliness, either introspectively and how loneliness is understood, as well as how it is discussed and viewed. During the TNA, an effort was made to conceptualize 'external resources and actors' to create a clearer image of what this includes. Through some many renditions, this became the best description "external tools, actors or persons that can impact or alleviate loneliness through active use or through indirect effect".

6.2.1 External resources and tools

When asked about resources and tools, most participants elaborated on how they used a combination of radio, tv, computers and phones to alleviate loneliness. These tools were sometimes described as 'distractions', and in other cases as useful tools that were actively used, as we can see from one participant, "*Often I put on the radio so that like, like there are people around… as a way to just dampen these feelings*". When asked about their use of computers, one responded "*the computer is my best friend, aside from my family, I use it for internet and pc-games*" (Mohammed), this participant was the only one who reported regular use of online games, where which he had met friends, as reported previously. The participant described how he had made close friendships with others online,

> "*They became such close friends that we could share each other's Facebook usernames and passwords, these were Facebook based games. There was one person in England, we shared our most private things, about marriage and we were very close. But that all disappeared when they stopped playing*" (Mohammed).

When this participant was asked if he missed these friends through online games, he responded, "*No, I really don't miss it. It was my attempt to replace real friendships with it. Since I came to Norway, I haven't had a single friend*". Another participant shared that her son got her into chess online, "*so I am a bit online and play chess, if I'm having a good day that helps a little bit, it increases my mood, and maybe I will play some candy crush*" (Anna).

When asked about their use of television, there was an interesting difference in how one participant who identified as lonely viewed the television as a resource, compared how the person who did not feel lonely or isolated, viewed it solely as a medium for entertainment. The 'not lonely' participant explained,

> "*Oh yes the TV, in the evenings after 8pm I sit here and watch tv. And its so interesting to hear – there are so many fun programs. I watch this channel called 'Visjon Norge' which have so many nice programs I listen to*" (Olga).

Another participant answered "*in the winter there is a lot of sport on the TV, and that helps a lot, it dampens it* (loneliness), (Alf). The participant goes on to explain,

> "*No, it's like this, you get – you concentrate on what you are watching. If there is* something *interesting then, then it chases the heavy thoughts away. The tv, it's so important anyway, there was this one time the tv broke. I didn't know what to – in the evenings I was so restless, I didn't know what to do*". (Alf).

When asked about their use of telephone as a resource, only the participant who identified as 'not lonely' spoke about the telephone as a great resource to her. Her use of telephone was also linked greatly to positive family and social networks and a tool in her daily life, as will be discussed later in this section. The participant explained, "*I need to have – someone to call to, or I watch television, or they call me, one person that I am related to, she often calls me, and asks me how I am doing"* (Olga). This was further emphasized later when asked about family being a strong resource for her, "*Yes it's very important, very important. To have someone to talk to, on the phone and that"* (Olga). Another participant emphasized how important the telephone can be and that he enjoyed it, however, he did not use it often enough, "*It can go a week or more, where I don't talk to another person, and in fact, when you haven't used your voice in a while, it's like you have to warm it up, it sounds like your throat hurts"* (Alf). The same participant expressed an unwanted lack of social interaction, *"just to have someone to talk on the phone with, that would help me greatly,* (Alf), he further explains, *"just to have a conversation over the phone with someone, that, that's what would save me. When I get to talk to someone, that, it's such a good time."* (Alf).

As discussed previously, bad family relations and a lack of social networks could act as stressors. On the other hand, I wanted to explore how positive family relations and social networks were identified and if they could act as resistance resources to reduce loneliness. Among the participants who identified as lonely, I noticed a lack of descriptive examples of how family and friends were resources to them, they rather explained these relationships as useful hypothetically. This is exemplified through one participants response, "*To work and do things together is extremely meaningful, you are having fun and enjoy being together.* (Alf).

On questions about the importance of contact with family and frequency of contact, one participant noted that, *"if I didn't have a Norwegian family, and Norwegian children it would be much more difficult for me"* (Mohammed) implying that his family does provide some comfort when facing loneliness, however, it is not enough. One participant explains that she has very little family, with irregular contact, "*I mostly have contact with one that we call 'nana', she is my aunt. She has taken a role as a 'reserve grandmother' for my son. We try to keep in touch once a month"* (Anna). Further on, the participant explains, *"So, in realty a have very, very little, its only her I have any contact with"* (Anna), as detailed previously, the participant expresses worry about losing the one family resource she perceives to have. One participant explained a lack of a good friend,

> "*I have my best friend in Denmark, if he had been here, we would be together all the time. He is in the same situation that I am in here, just in Denmark. I have learned not to have a friend, I haven't had a friend since 1987, I am still here.* (Mohammed).

When asked about social interactions and family as a resource, the participant who identified as 'not lonely', was more descriptive, *"Often they visit me, some people come and visit me several times a week"*. When she was younger, and after her brother passed away, the participant was more active in the local community and explained,

> *"Oh yes, I participated a lot, I remember they came and asked if I wanted to join the 'bazaar' and these kinds of things. I participated in local meetings, and they were so nice. People would come pick me up and drive me home"*

(Olga). When asked about social interaction with family and friends, the participant responded, "*Yes, it's very good, it's very nice. It is the best you can have for loneliness."* (Olga). This participant very often included family relations and social interactions to her use of telephone and was emphasized as very important to her, due to her lack of mobility in old age.

6.2.2 Societal conditions and actors

When creating the interview guide for this research, not much focus had been put on social conditions and actors and how it related to loneliness. It was not before during the interview rounds these topics were given more thought, as they were raised organically by the participants themselves. Here participants raised points about the role of actors such as the Red Cross or other organisations, increased understanding of loneliness, as well as societal

changes that could reduce loneliness. One participant also expressed concerns on how economic struggle can increase isolation,

> "*it has become an expensive society to live in. It costs a lot to go to a café or go to the movies and then people become – no you know now I have to save money for the electricity bill for example".* (Anna).

Regarding the Red Cross as a potential actor toward reducing loneliness, one participant was very clear,

> "*You have for example the Red Cross you know, you get a lot of inquiries and perhaps other organizations you know, about loneliness. This is where I think there is an opportunity … to be able to deal with this and connect people"* (Alf). The participant goes on to explain,
>
> *"They can ask those who call in, do you miss a friend? Or something like that, then they can connect people who are sitting in the living room and want someone to talk to, they are sitting alone, nobody to talk to, I am thinking about my situation here you know"* (Alf).
>
> "*It is extremely important to make something like this work, that someone 'goes for it', we have to do something here. Just to connect people who are lonely, and who don't dare or can do something about it or connect with others on their own. This is so important, it would be a tremendous help for the whole society. I cannot express how important this is.* (Alf).

Some participants expressed wishes for increased understanding of loneliness in society and for more inclusion, "*I hope more light is shed on the fact that we should be able to see each other in our struggles. So that we can be more humane, in neighbourhoods and everywhere* (Anna). This participant highlighted the importance of being able to accept others and their health struggles, "*No I wished people weren't so afraid to hear that someone has ME, someone has cancer, someone has ADHD. People back away when they hear this, they don't want anything to do with it.* (Anna). I was interested in exploring if participants had felt stigmatized by their feelings of loneliness, here none of the participants expressed any such experiences in particular, but one participant noted,

"*It's incredibly important to be able to talk about it. In one way or the other it just becomes worse and worse. There are a lot of people who would achieve a very different daily life by just connecting with someone, having someone to talk to.* (Alf).

The participant with a foreign background had the most to say about societal issues and challenges related to loneliness, he expressed that, *"For my generation, there are many people in society with a foreign background such as myself, who are very isolated"* (Mohammed). I wanted to explore his experience further and asked him to elaborate on how he perceived this issue

"*Humans are – affected by their history, the media, affected by what they have been taught, a kind of xenophobia, everything that is different is dangerous. But for the new generation, my son's generation, it's different"*

(Mohammed). When asked to elaborate, the participant responded,

"Now there are some actors that teach people that – it's normal for other to have a different colour. People a starting to learn that, learn that it's normal that this person has a beard, it doesn't mean that it's dangerous.

This study bears its mark of a very small group of participants, in particular immigrants which makes it impossible to compare experiences. For me then, it made sense to question this participant more in detail about his extremely valuable experiences and insight, to highlight, if possible, some of the challenges with social exclusion, isolation, and loneliness that native Norwegians do not have to face. When asked about if representation in media plays a role in isolation, the participant explained, "*there are a lot of people who need – people need to feel like they are a part of the society they live in"*, he explained this more in detail with an example of tv commercials,

"*until just a couple of years ago, on tv – the commercials were always filled with blonde people, they had this filter. But look now, coloured people, African backgrounds and whatnot*", "*humans have different colours, you have to see who the person is, what they know and can do, looks can be different"* (Mohammed).

When asked if he thinks that the language barrier is cause to much of the isolation immigrants experience, he responds "*I don't think language in necessarily the barrier, because I know the language, and I am isolated",* and *"it is more related to values, culture, background, how you view life and do our jobs"* (Mohammed). I was interested in the participants own feelings

about visual representation and his own experiences, he responded, "*I have developed a – to not need to see people like me, people can have any kind of appearance. I don't need to find someone that is like me. I need to find a fellow human"* (Mohammed).

6.3 Personal resources, internal processing and response

Perhaps unsurprisingly, some of the most important focal points throughout the interview rounds was on the participants personal resources, abilities, interpretations of own health and situation, and their personal experiences. These are all broad subjects in need of interpretation to be put into fitting "categories". During the TNA, these subjects were split into two basic themes under the organizing theme, 1: Personal resources and abilities and 2: Understanding of one's own situation.

6.3.1 Personal resources and abilities

Throughout the interviews there was much room given to the aspect of health and well-being in combination with loneliness. Participants were asked on how they perceived loneliness to affect health and well-being in their own experiences, if good health could reduce loneliness and the participants interpretations of "good health and well-being". One participant noted that she had never felt alone or experienced loneliness, this prompted me to ask what she thought was the reason for this, she responded, "*No, I don't know. I am – it's being healthy, that is a major thing. It's very good to be able to be healthy. If I had been sick, I had probably felt otherwise*" (Olga). The participant was then asked what she meant by "being healthy", *"I have been so lucky – I have good vision and hearing"* (Olga). When asked what she thought was the most important reason to reduce loneliness and isolation, the participant responded, *"It's to be healthy – to be healthy. I feel so sorry for those who are ill, it's so painful"* (Olga). The same participant was then asked to elaborate on why good health was a positive for her,

> *"To me – I feel so great when I am in my own home. I would rather be in my own home rather than in a nursing home. This way I can go to bed when I want, get up when I want and eat when I want"* (Olga).

A participant diagnosed with ME, was asked how she felt her health issues affected her, *"mostly I am stuck inside, and it isn't -uhm often that I have energy to go outside, and what should I leave the house for? Go to a café alone?* (Anna). She continued,

> "*It affects, of course it affects my mental health, simply because with my disease you don't get invited to things – never say never but it's really rare you are invited. I miss more and more to be able to be healthy. To simply get back to being able to work*" (Anna).

When asked what constitutes good health when facing loneliness, one participant responded, *"it's simply having something - something to do, that you have a task to perform and fill the day with. I hear other say that too"* (Alf). The participant continued, *"I think most of it is not knowing how to make time pass. When you don't have something to do for long periods of time, then the dark thoughts come"* (Alf). When asked if having a purpose was important to him, he responded, "*Yes, you need something meaningful to do, that is the medicine for this. There is no doubt"* (Alf).

Heavily related to health and having purpose, is the ability to activate oneself in daily life, maintaining or finding new activities, either alone or with someone. The meaning of activity was left open for interpretation to the participants and was not brought up as a specific term, but rather followed up where it was fitting throughout the interviews. On a question about what loneliness meant to him, one participant explained that he very much missed someone to work with and share day to day life, *"To work and do things together that is extremely meaningful. The work is so much easier and it's fun to do it together, you are having fun together"* (Alf), the participant provided more context further on, "*the most important thing is to share everyday life, in the way that, you have someone to discuss with, watch tv, go to the store or go for a drive. These things for me are so motivating"* (Alf). The participant was then asked why he though having some activities or work to do was important,

> *"I have a large area here with some forests, and I work there a lot and cut down trees for firewood, and that helps tremendously. Instead of just sitting around and stare, that is so destructive. As long as you have health to work, it, it dampens that sense of despair and loneliness"* (Alf).

The participant follows up with, *"I have said this many times, if I had lived in an apartment in the city, I would have been dead long ago. To me that is meaningless"* (Alf). The sentiments of having the ability to activate oneself with smaller or easy tasks, while living at home in old age was shared between the eldest participants in this study, "*it's the fact that I thrive at home, and I can go outside when I want to, I can travel to the hairdresser, order a taxi and go to the doctor"* (Olga). The participant shared parts of a conversation she had with an older

friend some time ago about being able to do simple tasks and the importance of living at home rather than in a nursing home, "*she was in a walker, and she told me she just had made pancakes. And then she says, no, I want to be at home as long as I can, as long as I can take care of myself"* (Olga). The participant was then asked if she was able to activate herself and how she remembered the period after her brother had passed,

> "*I was knitting a lot, big sweaters. I always had some kind of hobby when I was home, I was never unemployed. There was always something to do, that I had to do. And I enjoyed it"*, she continued, *"I was always on my feet - and had something to do, I cooked dinner and took a nap"*.

One participant shared the importance of her son, *"What keeps me going and these are perhaps strong words, what keep me alive is my dear son, that's…that's it"* (Anna).

During the interviews, I wanted to explore further how the participants explored or found new social networks, and their abilities to maintain already existing networks or friendships. The oldest participant did not express any need for, or wish to create new social networks or friendships, and gave the impression that she was content with how life was. One participant had previously explained her lack of social connections and network in her neighbourhood (see section 5.2.1) and expressed a wish for more social contact and a friend (section 5.1.3). The participant recalled when she received a surprise visit from her friend, "*three weeks ago or something like that, for the first time in many years - I love being surprised, I had a surprise visit from my best friend and her sister"* (Anna). When asked about her frequency of contact with friends, the participants explain how she is not very good at maintaining contact, "*We have to see each other you know. And I am not very good at this either, to call that friend you perhaps haven't seen in three years"* (Anna), the participants expressed lack of contact with family was detailed previously (section 5.2.1).

One participant shared how he had up until recently used personal ads in newspapers and magazines to find a friend or partner after his cohabitant for 17 years became senile, "*a couple of years ago, I – what you call it, personal ad in newspapers and magazines. There I have replied to and put inn ads myself"* (Alf). The participant shared that was how he met his previous cohabitant, "*it was back then when they had Saturday advertisements, through which I met her. And it was a perfect match from the get-go"* (Alf). Another participant shared his struggles with creating friendships throughout his life,

> *"I have tried to become friends with people, I have colleagues I would like to have as a friend. But there is so much loneliness here in Norway, people don't feel secure about themselves and others and fear opening up to anyone"* (Mohammed).

The participant explained further, *"I have tried everything, even the Red Cross. It was not successful. I am still alone, I am still a stranger"*, *"everyone acts as if I am from Mars"* (Mohammed). The participant also detailed his experiences at university,

> *"I was the black sheep among the white sheep. At university, sports environments, these that are international, nation independent, all are supposed to work together, but on the institute I was alone. They worked together. I was alone, I was the only foreigner to put it like that"* (Mohammed).

6.3.2 Understanding of one's own situation

It was important to generate more understanding of how the participants experienced their feelings of loneliness, the emotions they faced and how they would internally react or cope with what they were going through. It was also an opportunity to explore how the individual participants understood loneliness as a concept, and how they would define their own experiences. Every participant who experienced feelings of loneliness naturally had heavy emotions and thoughts related to it accompany them for years. It is again important for me to prefix that throughout the interviews, I did not wish to press the participants too much to avoid unnecessary stress. They were asked which sort of emotions they connected with loneliness, and how they would describe it, some of these will be presented here, *"You sit there alone, heavy thoughts automatically arrive in a way you know, you just don't have anyone"* (Alf). The participant tried to explain it more in detail, *"It's exhausting, you don't have any motivation, you don't have any measure to – in any way. Worst case scenario you might snap"* (Alf).

Another participant explained her thoughts on how she imagined other felt in the face of loneliness in this way, "*loneliness can be… life-threatening for those who don't have the strength to hold on. I think there are – quite many who have ended their lives because of loneliness"* (Anna). This participant described herself as 'involuntary lonely', and was asked to elaborate what she meant, "*It's – emptiness, sadness, hopelessness. Why me? The emotions*

come and I can't do anything about it. They are terribly painful thoughts to be honest" (Anna). One participant could tell of his use of medication when dealing with loneliness, "*early on, we are talking 1987, 89,90, I – uhm, used sleeping pills*" (Mohammed).

The participant who expressed no experience with loneliness was asked if she had given any previous thought as to why some might struggle with loneliness, and how it would affect someone.

> *"There are those who need to have someone around them. Something I have never been affected by. But some, like my sister, always needed someone around her. She would call me at night, no I can't explain it – it's difficult"* (Olga).

The participant with a foreign background explained how he had experience negative

> *"For a period, I started to react with, how do I put it? Negative emotions towards Norwegians, and I started to analyse it and think about what is happening? What is the matter here? This way it became easier for to analyse and understand the reaction to accept it. I cannot change anyone".*

In a follow up question, the participant was asked if the thought that his experiences with racisms had substantiated his feelings of loneliness,

> *"With or without racism I would have felt lonely anyway. The racism sort of becomes a, an explanation for the loneliness. If I was surrounded by normal people and was lonely, it would have been much tougher. The racism somewhat becomes comforting in the sense that you are dealing with an idiot, and you cannot expect that person to be your friend"* (Mohammed).

When asked on how the participant experienced loneliness and how it affected him, he explained, *"I have learned to live with it. It is nothing special, my life – of course it affects my quality of life, there is no doubt about it. But I have learned to live with it. I thrive in my own company"* (Mohammed). I was curious to explore more in depth what the participant meant by 'learned to live with it', *"what helps me a lot is that I – I am concerned about finding reasons as to why something is happening. Everything has it's reason, everything that happens around us has a reason".* (Mohammed), he continued, *"But I have learned to protect myself through analysing what is happening and that help a lot".* During a discussion on coping methods and the participants own tools for coping, he explained that it had become a part of his day-to-day life,

"It has become my normal state of living. There is a saying from Azerbaijan 'you can make hell in paradise, and paradise in hell' and I have learned to make my own paradise in hell. I don't have any problems because I don't have a choice" (Mohammed).

One participant spent a great time expressing the importance of finding 'purpose' and having something meaningful in daily life,

"*You sit there alone and its clear that it takes its toll on the physical and especially psychological. So, the days, they become more – there is no substance there – you feel like you don't have anything to live for, you don't have any contact with anyone"* (Alf).

When asked how he experienced this personally he responded, *"You just exist from day to day, there is nothing there to motivate you or bring you joy",* (Alf). The participant was further asked how if, and how, he managed to keep these feelings at bay, *"I have to keep myself active. I'm lucky that I have things to do on the house, maintenance, the garage, cars"* (Alf).

7.0 Discussion

The main objective of this study is to explore how loneliness and isolation are perceived to affect health and well-being in different life situations such as old age, immigration, and ill health through a salutogenic approach. This study leans on the learned and lived experiences of loneliness and isolation expressed by the participants, and their interpretations of these experiences will be emphasized. I propose three main parts to this discussion section. One, a deliberation on SoC in accordance with the findings. Two, a discussion on global development and health promotion in a Norwegian setting and how it relates to loneliness. Three, a discussion on findings in accordance with the objectives.

The first section, a discussion on the SoC and its three dimensions, manageability, meaningfulness, and comprehensibility (see section 3.0), is important to gain some understanding on how the participants perceive their own resources when dealing with loneliness and isolation. The second section will attempt to bring some justification for a Norwegian setting on loneliness and isolation in a global development program. This section will include a short discussion on Sustainable Development Goal (SDG) 10 (Reduced Inequalities), SDG 16 (Peace, Justice and strong Institutions), and SDG 3 (Good Health and

Well-being) in relation to loneliness and isolation in a Norwegian setting. The final section will include a more in-depth discussion on the findings according to the theoretical framework proposed in section 3.0, the section will include a discussion on the findings related to each of the four sub-objectives (see section 1.2) proposed in this thesis. Seeing as the findings section is divided into three organizing themes created through the TNA (see section 6.0), the discussion on each sub-objectives will to some degree draw from each organizing theme in a cross-section. Lastly, the discussion section will also include a smaller section on limitations to the findings and discussion in this thesis. Due to the nature of this thesis, I will highlight only the most important and significant findings.

7.1 Sense of Coherence

As previously stated, I want to highlight the importance of the three main dimensions of the SoC and discuss differences in manageability, meaningfulness, and comprehensibility between the participants in relation to loneliness and isolation. This is to attempt to paint a picture in how individuals in different life situations comprehend, manage, and find meaning when dealing with the same experiences, loneliness, and isolation.

7.1.2 Manageability

In SoC, the meaning of manageability revolves around how a person is able to use the resources at their disposal, and that these resources as adequate in dealing with the stress they face (Koelen, Eriksson & Cattan, 2017). To have a high sense of manageability is to have a solid capacity to judge reality, and to not feel victimized by events that might occur to you or feel that life is unfair. Here I will present some findings that exemplify high vs low manageability and the differences between participants in this study. One participant (Anna) mentions how she has become more and more lonely as her son grew older and less dependent on her, gradually losing her most important resource: relying on the company of her son as a relief of loneliness. In comparison, when one participant (Olga) lost her brother, she mentioned that she reflected on how she didn’t feel lonely in that period, but rather that she got used to being alone. It was also important for her that she actively participated in her local community in this period and expressed gratitude for being able to do so, indicating a stronger SoC (Antonovsky, 1987, p. 29). Here I also want to highlight that this participant (Olga) used the term ‘being alone’ as opposed to ‘lonely’ which have very different meanings (see section 2.0).

In relation to the use of television as a resource, one participant (Olga) replied how she always watched tv around 8'oclock, and how much she enjoyed these programs. For her, the television acted as a useful source of entertainment, but not essential to her subjective well-being. On the other hand, one participant (Alf) replied how he used the television to concentrate on what he was watching and explained that 'it chases the heavy thoughts away', and that it 'dampens' his emotions. For this participant (Alf), the use of television as a resource can be said to be more as a tool to experience relief and manage heavy and difficult emotions of loneliness surrounding him on a daily basis, by being able to concentrate on the program he is watching. For this participant, the television was a GRR, which can help manage tension (Vinje, Langeland & Bull, 2017), and was here used to temporarily reduce experienced loneliness in short periods of time, but it did not provide long-term relief from loneliness, or better health and well-being.

7.1.3 Comprehensibility

In terms of comprehensibility in the SoC framework of thought, strong comprehensibility is related to perceive the world around you and the stimuli and events you might experience as comprehensible, predictable, and explicable (see section 3.0). A person with high comprehensibility will be able to make sense of the events and stimuli they are confronted with, and how to respond to these events. It also relies on viewing the world as predictable and comprehensible, and when met with a surprise, still viewing this as orderable. A person with low comprehensibility, would view the world as chaotic and random, where events might be explained as inexplicable, and do not know how to respond in these events. A strong sense of comprehensibility is essential to make sense of the events one might experience.

When experiencing the loss of her brother, one participant (Olga) noted how she was 'just happy to be with him' in this period when her brother suffered from cancer, where she accompanied him many times to the hospital. That this was something unfortunate to happen, however, she found something positive in a stressful situation. This was also related to how she got used to being alone. In contrast, one participant (Anna) expressed fear of losing her most relied on family member, thinking 'what then'. Expressing fear of the thought of losing a precious family member is of course natural, but the approach to making sense of such a loss and seeing it as predictable is essential to good comprehensibility and determines one's ability to manage such an event. Further exemplified by one participant (Alf) on his previous cohabitant who became senile. In this period, the participant explained it as being thrown

back into a ‘loneliness chair’, and how all ties became cut when her condition deteriorated. Albeit unpredictable events, but the ability to make sense of, and comprehend such events, is essential to a high SoC (Slootjes et al., 2017, p. 572; Antonovsky, 1996).

Essential to high comprehensibility is being able to cope when events might occur, and that these events are experiences that can be met and dealt with. Low comprehensibility would then be to see these events as something that will happen to me regardless, which are often seen as unfortunate events. This difference in comprehensibility between two participants and how loneliness was perceived to affect them, was most evidential in two cases. One participant (Mohammed) mentioned how that he had learned to live with loneliness, that it was nothing special and how he would now thrive in his own company. In contrast, one participant (Anna) expressed emotions of unfairness and a sense of hopelessness, and thought ‘why me’? Why did she have to experience such emptiness and loneliness? Viewing loneliness as an unfortunate event that was unmanageable and out of her control. This difference in comprehensibility and viewing loneliness or isolation as something one can meet and deal with through effort, and viewing it is a challenge, is essential to achieve better health and reduce the stress caused by loneliness or isolation, turning tension from pathogenic to salutary (Antonovsky, 1996).

The concept of high comprehensibility was perhaps best exemplified by one participant (Mohammed), through internal process on how loneliness came about, and why he experienced it. He expressed that he was concerned about finding reasons as to why something was happening, that everything around us had a reason. The participant also showcased high comprehensibility when noting that he could not change societal issues by himself. The racism, alienation, and isolation he had experienced through many years were seen as societal issues, something taught through culture, things that he could not change. However, he saw that his children did not relate to these issues and did not experience them. Noting that he saw positive changes to something out of his own control, making sense of what was happening around him.

7.1.4 Meaningfulness

The aspect of meaningfulness means to take up challenges or events one is faced with in life and invest effort and energy into these events. A person who scores high on meaningfulness often report areas in life that are important to them, these events, or challenges one is faced it

must make sense cognitively and emotionally and are seen as challenges worthy of investment (Slootjes et al., 2017, Antonovsky, 1987). A person with low SoC, and who express events and challenges as burdensome or unwelcomed and does not show to particularly care about anything in life, can be said to score low on meaningfulness. I have spent a great time on the connection between meaningfulness and GRRs (section 3.0 for an explanation on GRRs/GRDs). When one invests time, energy, and effort into areas of one's life that are seen as worthy, or useful, and without these investments yielding results, these areas or events have the potential to become a generalized resistance deficit, rather than a resource. When facing loneliness or isolation, often something is reported to be missing, a friend, partner, a sense of belonging, a social network. If much effort is put into achieving or rather put, find this part that is missing, and the person perceives this as unachievable after much effort, it has the potential to become a great stressor. It is that single all-important issue that much be achieved to find comfort or relief.

This was exemplified by one participant (Alf), in his search for a 'partner' or a 'friend' in the sense of having someone to share daily life with. This participant emphasized the importance of having someone to share daily life with, work with, perform simple tasks, shop with, this was something that could generate mutual inspiration. His view of 'having a task to perform' was something seen as the best medicine for loneliness, and this was best done together with a significant other. The participant had spent a great time and effort through his years to find this person. When losing his cohabitant in his older age, there was an effort to find such a relationship again but was seen as more difficult and sought help from organizations such as the Red Cross to achieve this. When this aspect of his life was seen as incomplete, his sense of loneliness became worse, due to a lack of quality in his social relationships (Peplau & Perlman, 1982; Chen & Feeley, 2013).

Another participant (Mohammed) showed his effort to find friends and social networks through every avenue he could think of, work, organizations, political spheres and so forth. His lack of a close friend together with lacking a sense of belonging became a GRD. He expressed a need to 'find a fellow human being'. Another participant (Anna) expressed that previously, meaningfulness for her was to help others in her work, and when this become impossible due to ME, it was something that became a stressor and trigger for her depression, the inability to 'provide help to someone' and to become 'the one who needed help'. She explained how the only thing she felt that was left, and the only thing that gave meaning and

kept her alive, was her dear son. The participant (Olga) who did not express any feelings of loneliness, found much of her meaning in the ability to live at home, take care of herself and be healthy. Her perception of good health would alter as she become older, appreciating vision, hearing and being able to perform simple tasks. Her old age lowered her mobility, rather than grieving gradual loss of mobility, she appreciated what was left.

All participants in this study expressed areas of life they viewed as meaningful, something worth investing in and put effort into. However, those who expressed the highest levels of loneliness (Anna), (Alf), saw that those areas that gave meaning was disappearing, and were becoming unachievable. These areas can be said to turn into GRDs and gave the participants more grief than meaning. In particular for Anna, the ability and choice to participate at work and in social setting was taken away from her due to health issues.

I want to preface that none of the participants were measured on their level on the SoC continuum through their comprehensibility, manageability, and meaningfulness and the sense of coherence scale. However, the findings do suggest that "Olga" who did not experience loneliness has a high SoC. Mohammed shows great comprehensibility and manageability of loneliness and isolation but reported lower levels of meaningfulness throughout the interview. Alf is on the lower end of the SoC continuum, who showed medium levels of comprehensibility and low on manageability, and implied that meaningfulness was the most important determinant for his health and well-being. Being unable to fulfil his sense of meaningfulness was cause of great pathogenic tension, as he lacked the one thing that would provide him with meaning. Anna is the participant who can be interpreted to be lowest on the SoC continuum between the participants. Reporting low levels of comprehension, manageability, and meaningfulness.

7.2 "Global" Development

Due to the setting of this thesis in a global development master's programme, I see the need for somewhat of a justification on this research being set in Norway. This research would have greatly benefited from more participants with foreign backgrounds, younger persons experiencing isolation and loneliness derived from health issues, and isolation due to socio-economic differences. Due to issues with recruitment, this was not achievable. (see section 4.3 and 4.3.1). Norway stands as a country with strong institutions and a welfare system designed to take care of those who cannot provide for themselves, as well as providing aid to

individuals and families in need, including challenges such as loneliness and isolation (Hansen & Slagsvold, 2019). Sadly, some individuals will slip through the cracks, or not achieve the requirements to receive aid, and some issues are not covered by welfare programmes. Improvements to national institutions and increased focus on reducing inequalities between demographic groups is sorely needed to negate and prevent loneliness and isolation. This part of the discussion will cover a short section on SDG 10, 3 and 16, health promotion interventions, a section on the need for increased focus on loneliness and isolation prevention for immigrants, those who suffer from health issues and socio-economic challenges.

7.2.1 Sustainable Development Goals, Health Promotion, and Interventions

A focus on reducing socio-economic differences, better health promoting policy, policy for increased levels of access to social participation, improved migration and integration policy (SDG 10, 16) is necessary to decrease and combat loneliness and especially isolation for immigrants and individuals with foreign backgrounds, those with health challenges that reduces mobility, activity levels, function and participation, and individuals experiencing isolation caused by economic issues (Macdonald et al, 2018; WHO, 1986; WHO, 2022, Norwegian Red Cross, 2018; Qualter et al., 2021). Individuals who experience unwanted loneliness and isolation can strongly benefit from strong institutions and organisations (SDG 16) designed to create safe support systems and facilitate interventions that have the ability to function as resources to those who require it (WHO, 2022; Norwegian Red Cross, 2018) Examples of this are health organisations such as LHL (national association for heart and lung disease) or the Pensioners Associations or the Red Cross. Such organizations possess the ability to act as support groups, resource banks and activists for the target groups interests. Unwanted loneliness and isolation is a source of stress and tension, and has shown to negatively impact mental health and well-being (SDG 3), (Nicolaisen & Thorsen, 2014; Musich et al, 2015; Graneheim & Lundman, 2010; Halvorsen, 2008; Thorsen, 2005; Barstad, 2021; VanderWeele, Hawkley & Cacioppo; Gerino et al., 2017). Experiences of unwanted loneliness and isolation has also been linked to increase substance and alcohol abuse (Page & Cole, 1991; Blai Jr, 2010). Greater accessibility to, promotion of and visibility of such organisation and institutions are essential and need to possess the capabilities to reach out to those who can benefit from support. Going by Nilsson's (2016) seven-point scale of SDG interactions, strong institutions (goal 16), and reduced inequalities (goal 10) have a reinforcing relationship, and in turn positively interacts with good health and well-being (goal

3). Improvement in one area to tackle unwanted loneliness and isolation has a supportive effect on the other goals.

Antonovsky provided a discussion on the salutogenic model as a guide to health promotion, with the focus on the whole person and their road to the “ease” end of the health continuum, where stress and tension can potentially be health promoting (Antonovsky, 1996; Langeland et al., 2022). The Ottawa Charter for Health Promotion (1986) provides a starting point for health promotions development and could guide interventions aimed at reducing loneliness and isolation going forward. To approach more effective and better suited interventions towards loneliness and isolation in Norway, said interventions could take inspiration from a health promoting and salutogenic orientation that focuses on strengthening the SoC. Norwegian institutions, humanitarian groups and intervention programs should aim to advocate, enable, and mediate for greater health through a health promotion orientation, to increase the equity of health services, promoting agency and decision making over personal health, and promote movement towards health with the whole person in mind.
In a systematic review of loneliness interventions and non-elderly adults Bessaha et al. (2020), found that support through group and individual interventions can decrease loneliness among individuals with mental illness, disabilities, chronic diseases, immigrants, and refugees. Interventions such as online support, individual peer monitoring and group psychosocial support had shown positive results in in reducing loneliness in some intervention reviews, however, the results were varied and there were no indicators regarding the interventions relation to health promotion or a salutogenic orientation. Langeland et al. (2022, p. 202) point out a lack of consensus on what defines a salutogenic intervention in their scoping review on interventions studies with “the SoC as a primary or secondary outcome”, making it difficult to identify salutogenic interventions aimed at loneliness and isolation. Salutogenic interventions showed potential in short term and temporary strengthening of the SoC, where follow-up interventions over longer periods could help to reinforce or strengthen the SoC further (Langeland et al., 2022). Salutogenic interventions could help introduce coping mechanisms and the activation of GRRs (Langeland et al., 2022). For individuals experiencing unwanted loneliness and/or isolation, the activation of GRRs, new coping mechanisms and strengthening of their SoC could potentially help them move toward the healthy or “ease” end of the “dis-ease”/ health continuum. Sufficient GRRs, healthy coping mechanisms and a strong SoC can turn stressors such as loneliness and isolation into salutary tension, promoting greater health.

7.2.2 Immigration, Health and Economy

As mentioned in the previous section, this research would greatly benefit from an increased number of participants, especially immigrants and those who experience loneliness and isolation due to health and economic struggles. An increased focus on these issues through a salutogenic approach could generate valuable knowledge for further policy improvements and as guides for humanitarian organisations such as the Red Cross. Alas, this is beyond the scope of this research, at least in the sense of generating generalizable findings through the research. However, some valuable information about the challenges of loneliness and isolation related to immigration, health and economy was learned through two participants. One participant (Mohammed) could tell of his own experiences with isolation, racism, and discrimination. He noted how he saw many people in society in his generation with a foreign background that were very isolated, and that this was related to differences in culture, values, background, and a view of life, and not so much a language barrier (see section 6.2.2), supported by some of the findings from Barstad (2021). The participant (Mohammed) did not attribute language barrier as important to loneliness and isolation, explaining how he had learned the Norwegian language but was still isolated. These are issues that require a greater focus on better integration policy and policy that enables increased social participation and decision-making among immigrants. As previously stated, this participant (Mohammed) noted that his children did not relate to his experiences, this brings up the potential importance of institutions such as kindergarten and schools for successful integration, reducing feelings of isolation and alienation among children of immigrants and refugees.

Findings of higher levels of loneliness among individuals who experience impaired health, loss of mobility, disability, and reduced social participation has been supported by research (Normann, 2010; VanderWeele, Hawkley & Cacioppo, 2012; Macdonald, et al., 2018). One participant (Anna) showcased how both health struggles and poor economic ability had led to more loneliness and isolation in her case. Being unable to participate in society through work and seeing herself as someone who requires help, rather than being the resource person she viewed herself as, took its toll on her mental health. She also found herself alienated because of her and her son's health condition, not feeling welcomed in the community or neighbourhood (see section 6.1.3 & 6.3.1).

Loneliness and isolation have shown to become more prevalent and crippling in a higher age, especially among those over 80 (Hansen & Slagsvold, 2019; Dykstra, 2009). Long term exposure to loneliness and isolation, and many years of not coming to terms with one's own situation, while starting out with a low SoC, can have a substantial negative impact on the health and well-being of an individual. This calls for greater social support and more inclusive public policy for the groups mentioned here. Further research on long term exposure to loneliness and isolation among younger adults into older adulthood in Norway, together with preventative measures would be a welcomed addition. I wish to return to the Red Cross Connection Centre as a potential health promoting initiative and a SRR from the humanitarian sector as a measure to combat loneliness in Bergen (see section 4.3). This project aims to reduce and negate feelings of loneliness and isolation through enabling the participants to take greater control over their own health, and potentially improve their own well-being. The participants are directly involved and in control of their own progress together with volunteers and coordinators at the Red Cross. The aim is to increase their levels of activity and social contact in areas and arenas that interest them. This initiative focuses on enabling, advocacy and the participants active involvement, rather than passive recipients for aid.

7.3 Loneliness, SoC and Salutogenesis

In this section I will discuss findings in accordance with the objectives. This section will draw on some points previously presented on comprehensibility, manageability, and meaningfulness. It was important to discuss these elements first to compare differences between participants on these areas.

7.3.1 Perception on loneliness and isolation: 'Chronic Stressors'

It was difficult for the participants to express in detail their own interpretations of what loneliness and/or isolation meant to them. During the interviews, loneliness was the phenomenon they focused on the most and how they interpreted it, findings on 'isolation' are somewhat lacking. Lacking a sense of belonging and being unable to participate adequately in society was something that was brought up several times (see section 6.1.1 & 6.1.2). One participant also interestingly mentioned that you could feel lonely or alone even when you have a family, termed as inter-personal loneliness (Halvorsen, 2008). Another sentiment was the lack of having purpose and struggles with finding meaning, motivation and measures to deal with the experiences of loneliness (see section 6.3.2).

In line with the findings here and in section 7.1, would argue that loneliness and isolation can become chronic stressors that have the potential to permeate a person's life over longer periods of time, and chronic stressors have shown to be one of the primary determinants of a person's SoC (see section 3.0). It gives cause to believe that long exposure to unwanted loneliness and/or isolation can temporarily weaken the SoC. This factor, especially when coupled with resistance deficits, will see that the coping process of other major or minor life events might become more difficult, posing as pathogenic tension, further reducing health and well-being (see section 3.0). If loneliness becomes a chronic stressor that causes pathogenic tension in a person's life, it might be seen as deterministic to other events that happen. As one participant showed (Anna), she dreaded the loss of her aunt, because this would mean she would be even more alone and increase her experienced loneliness. If one experience loneliness as a chronic stressor, one's ability to cope and deal with issues such as finding purpose or meaning in daily life, lacking a sense of belonging or losing a partner and other life events becomes much more difficult. The participant who was seen to be lowest on the SoC continuum (see section 7.1.4), also expressed high levels of helplessness, lack of motivation to participate, low levels of decision making for her condition, perceived low ability for social interaction and difficulties finding social networks due to loneliness and isolation. Through the findings, one participant (Mohammed) had a more reflected and analytical view of loneliness and viewed it as something he had to deal and come to terms with (see section 7.1.2) Loneliness was still seen as something that negatively impacted him, it posed as a chronic stressor over many decades, but his own efforts of participation, efforts of social interaction and self-reflection had improved his condition and outlook on life. The different perception on loneliness between the participants varied. Those with higher levels of SoC left the impression that this was something that was possible to deal with. The person with the lowest SoC had the most negative interpretation and perception on loneliness, drawing on emotions such as helplessness and unfairness.

7.3.2 Stressors and resources in the face of loneliness and isolation

The two sub-objectives on stressors and resources (see section 1.2) were planned to be discussed separately. However, the two seem to blend into one another on several occasions in the findings. I have previously covered GRRs and GRDs, and there are tendencies that show how a lack of resource, e.g., family support or social network, health or participation can become a stressor if it is absent, and that stressor becomes a source of pathogenic tension and distress.

Supportive family and social networks proved to be a great resource for the participant who identified as not lonely (Olga). Regular contact with family and friends was described as "the best you can have for loneliness" (section 6.2.1). Through the interview, this participant did not imply that her contact with friends and family was used as a tool or resource to keep loneliness at bay, but it was seen at joyous and purposeful, a tool to maintain contact and being involved with her social network. Other participants were more descriptive in their use of family or social networks as useful tools for reducing their feelings of loneliness or isolation. One participant (Mohammed) made friends online in an attempt to "replace real friends" (section 6.1.3). Alf regularly called his niece for social contact, and on multiple occasions mentioned that conversations over the phone was one of his favourite pastimes but experienced a lack of it, and how having just one special 'friend' or 'partner' to contact would "save him" (section 6.2.1). All participants who reported that they experienced loneliness, claimed that one friend to be in regular contact with, share daily life with and share social activities with, was the one thing they sorely missed. Social networks and activities were reported as a great resource for one participant (Olga) when she lost her brother to cancer. She found her surrounding community and already existing social network to be supportive and inclusive. Participants such as Mohammed, explained how he felt alienated and isolated as an immigrant, and reported tremendous efforts into creating or joining social networks or organizations to no avail. He never felt accepted and felt the lack of social inclusion and participation (see section 6.1.4) Anna reported feelings of isolation and exclusion in her neighbourhood due to her and her sons health conditions, they were not accepting of them and were not invited to gatherings. This event can be attributed to a lack of manageability, instead of waiting to be invited, an effort must be made to involve oneself into to the social conditions and events in the neighbourhood and be actively involved.

Family and social networks as resources as shown here can be helpful when dealing with loneliness and isolation and have the ability to act as a resource. However, as discussed previously, a perceived lack of such resources become GRDs. Deficits in family and social network resources can make an individual feel more alone and more isolated. When family and social networks are presented as very important to negate or prevent loneliness, having a deficit of this can turn the resources into a stressor that is a cause of tension. An individual who might experience loneliness could benefit greatly from sharing this experience with a confidant, close friend, or family member, but when this is not possible, one might feel even more alone. To further exemplify how a GRR can turn into a GRD, is with the example of

health. One participant (Olga) said that the most important thing for her was to be healthy, and that she was grateful for this. She interpreted good health as the best resource for not feeling lonely or isolated (see section 6.3.1). For Anna, her ME diagnosis and struggles with health issues was seen as one of her greatest causes of tension. Her inability to continue to work and feelings of isolation due to reduced levels of activity led to greater feelings of loneliness, and in her case, recurring depression (see section 6.1.2). If you classify good health as a resource, then a deficit in good health can be a great cause of stress leading to pathogenic tension if one is unable to effectively manage.

Good health and well-being can be tied into the concept of finding meaning and purpose in life as exemplified especially through one participant (Alf). He interpreted meaningfulness, finding purpose, and having daily tasks as one of the most important resources to alleviate or reduce loneliness (see section 6.3.1). Having the ability and resources to activate oneself through daily tasks was also shown as important by the participant who was not lonely (Olga). For her, being able to live at home, perform daily tasks such as making food was essential to her well-being. For one participant (Anna), the absence of good health was to her a great stressor, her ME diagnosis was perceived to prevent her from participating in different aspects of life such as work, social interaction, and made simple tasks difficult (see section 6.3.1). The remaining aspect in her life that presented her purpose was to take care of her son. Finding purpose and meaning in life can then be said to be important to reduce or prevent loneliness, however, this demands effort, and is a challenge that one is forced to be met. Individuals seek meaning in different aspects of life, and to create this one must meet the challenges of creating purpose and meaning through effort, as exemplified in section 7.1.4. In light of this, it can be sensible to argue that a deficit in meaning and purpose would then be a GRD.

There was an effort to look more closely into **external actors, resources and organisations** as useful resources when experiencing loneliness and isolation. One participant (Alf) had the impression that there was great potential in organisation such as the Red Cross as actors in reducing loneliness and isolation in the Norwegian population. One participant (Mohammed) noted how he had tried the Red Cross, but this was to no help for him, in other interviews this was not given must attention. There are tendencies that allude to organisations such as the Red Cross can be useful actors for some, acting as SRRs (see section 3.0), but there was not enough data generated in the interviews to talk about this in length. External resources such as

television, radio, internet, and computer were often mentioned as resistance resources that could temporarily reduce feelings of isolation or isolation (see section 7.1.2) For the individuals who experienced loneliness, such resources only generated temporary comfort through being means of distraction from the real world. The participant who was not lonely (Olga) just saw the television as a source of entertainment.

I have proposed in this section that **loneliness and isolation are chronic stressors**. Chronic stressors are one of the primary determinants of a person's SoC, and exposure to loneliness and isolation can in worst case temporarily lower an individual's SoC. However, it is more likely, as shown through the participants in this study, that starting out with a low SoC when experiencing loneliness and isolation, makes these phenomena more difficult to cope with. Low levels of comprehensibility, manageability, and meaningfulness through inconstant life experiences, a poor over-under load balance and a lack of participation in meaningful decision-making, coupled with resistance deficits, can lead to loneliness and isolation becoming chronic stressors, causing pathogenic tension. A low SoC also makes other major or minor life events more difficult to process and cope with, which in turn can lead to increased feelings of loneliness and isolation as shown by the findings in this study.

The deficit of these resources measured here acted as stressors and led to increased pathogenic tension for the participants. Their lower levels of SoC made it more difficult to respond to deficits in family relations and support, social networks, feelings of not belonging and lack of participation. The participants in this study who can be said to be managing the best when facing loneliness and/or isolation, were the ones who were able to, and had the capacity to, respond to life events stressors and challenges they were met with in satisfying ways through the resources they perceived as available to them. Their ability to respond were greatly determined by their levels of comprehensibility, manageability, and meaningfulness. With a high SoC, tension such as loneliness and isolation can be salutary, leading to health promotion. However, it is difficult to establish what comes first. Did these deficits in resources and low SoC result in feelings of loneliness and isolation, or can these phenomena lead to lower levels of SoC over time, which in turn can lower their ability to responds to life events, challenges in life and unforeseen events that then increased their feelings of loneliness and/or isolation? I can see a need for more research on long term exposure to loneliness and isolation and its effects into old age, together with its effect on the SoC. The research that is

lacking the most, is related to which measures, interventions, public policy, and responses to loneliness that have a tangible effect in reducing loneliness and/or isolation.

7.4 Limitations and strengths of the study

This research study suffered from changes in participant inclusion criteria due to a lack of participants through the corridors of recruitment that were available. This study was first intended to explore the experiences of individuals aged over 67, and the changes to recruitment inclusion caused changes to the research objectives late in the process. Withdrawal by one participant reduced the data available in this study. One participant did not want to be recorded, notetaking made the data collection difficult. The participant was reluctant to give any detailed information to the questions posed, and very little data from that interview could be used. This study relies on subjective interpretation on concepts such as good health, well-being, loneliness, and isolation. An increased scope on various resources among the individuals would give increased understanding on how the participants coped with their experiences. A larger inclusion of resistance resources among the participants would have given a better overview of which resources can present themselves as helpful when experiencing loneliness and isolation

In many cases it was difficult for the participants to conceptualize these subjects on the spot and had issues expressing their thoughts. Throughout the interviews, the concept of well-being was particularly difficult for the participants to conceptualize and had a difficult time expressing how they interpreted good well-being and good well-being could be achieved. If possible, a focus group discussion before individual interviews could have been beneficial to give clarity to such concepts and for the participants to form their own interpretations on it, the concept of well-being should have been greater room throughout the process. My relationship to the participants, being involved in the Red Cross Connection Centre could affect the answer and information given by participants, this is covered more in-depth in section 4.5. The findings in this study are not generalisable due to the low number of participants. However, much of the findings are reflected in previous literature and research and are good indicators on the objectives posed in this study. The findings in this study shed light on the experiences and similarities between individuals in different life situations who are all experiencing the same phenomena. The setting on this research allows for follow-up evaluation on the Red Cross Connection Centre as a direct measurement to eliminate or negate feelings of loneliness and/or isolation for the participants involved.

8.0 Conclusion

This study set out to explore how loneliness and isolation is perceived to affect health and well-being among individuals in different life situations and their perspectives of the phenomena in question. The study has put emphasis on the interpretations and experiences of the participants and used Salutogenic theory to guide the research.

In light of key findings in this study, subjective interpretations of loneliness and isolation vary greatly. For individuals with a high SoC, loneliness and isolation is seen as something one can overcome and needs to be met with effort. The tension from loneliness and isolation can become salutary with a high SoC and sufficient GRRs, leading to health promotion or better health, or neutral stress. Individuals in this study who indicated lower levels of SoC were more inclined to have a more pessimistic perspective on their situation and were more inclined to view loneliness and isolation as insuperable. Loneliness and isolation were seen as painful experiences that negatively impacted mental health, confidence, activity levels, decision making and subjective well-being.

Findings from this study indicated that older immigrants and individuals who suffer from debilitating health issues met more barriers in their efforts to combat and reduce their feelings of loneliness and isolation. For one of the participants (Mohammed), a foreign background was root to increased feelings of isolation and a lack of belonging, due to alienation, racism, discrimination, differences in culture and values. Increased isolation, a sense of being alone with one's struggles and lack of social networks made the response to loneliness and isolation difficult. Debilitating health issues for one participant (Anna), led to increased isolation, loss of agency and participation, decision-making and reduced social network. She experienced barriers to social participation, work participation and breakdown of social networks.

The resources focused on in this study, good health, family support, social networks, participation and external resources and actors were all seen as GRRs for the participant who did not experience loneliness and/or isolation. For other participants, many of these GRRs presented themselves as GRDs, and would rather act as stressors and a cause of stress, rather than resources. I have proposed previously that **loneliness and isolation are chronic stressors**. Chronic stressors are one of the primary determinants of a person's SoC, and exposure to loneliness and isolation can in worst case temporarily lower an individual's SoC. However, it is more likely, as shown through the participants in this study, that starting out

with a low SoC when experiencing loneliness and isolation, makes these phenomena more difficult to cope with, but does not permanently impact the SoC. Low levels of comprehensibility, manageability, and meaningfulness through inconstant life experiences, a poor over-under load balance and a lack of participation in meaningful decision-making, coupled with resistance deficits, can lead to loneliness and isolation becoming chronic stressors, causing pathogenic tension.

A low SoC and resistance deficits in health, family and social networks makes other major and minor life events more difficult to process and cope with, which in turn can lead to increased feelings of loneliness and isolation. Findings in this study suggest that how one experiences loneliness and isolation is determined by one's existing SoC and the ability to apply the correct resources in the coping process. Absence of resources and a low SoC makes it difficult to move towards health, and tension created by loneliness and isolation becomes pathogenic rather than salutary. Loneliness and isolation are interconnected with one's life course, meaning it that life events such as health issues, disability, loss of family, partner, or social networks, can lead to experiences of loneliness and isolation. In turn, loneliness and isolation can lead to reduced health and well-being, and quality of life. One's orientation to life, the strength of one's SoC and perceived available GRRs can determine the outcome of experiences with loneliness and isolation. Long term health promotion interventions with a salutogenic orientation, focusing on reinforcing or strengthening an individual SoC, with the whole person in mind, could be beneficial to individuals experiencing loneliness and isolation. More research on this is needed.

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9.0 Appendices

9.1 Interview Guide

Interview Guide

Introduksjon:

- Introduksjon av meg selv
- Introduksjon av studien

Informert Samtykke

- Forklaring av studien
- Forklaring for hva dataen vil bli brukt til
- Be om samtykke til å gjennomføre intervju
- Be om samtykke for å ta opp intervju
- Informere om retten til å trekke seg fra intervjuet
- Informere om konfidensialitet og anonymitet

Intervju spørsmål:

SEKSJON EN:

- **Kan du fortelle meg litt mer om deg selv og ditt liv?**
  - Fokuspunkt: familie, sosiale relasjoner, hobbier, interesser, daglig liv.

- **Når jeg nevner ordene *Ensomhet* og *Sosial Isolasjon*, hva tenker du da?**
  - Fokuspunkt: Personlig refleksjon om ensomhet, Personlig refleksjon om sosial isolasjon. – HELSE. Livskvalitet – stressfaktorer – hva betyr disse ordene for dem?

- **Hva tror du er viktige faktorer som fører til at enkelte kjenner på følelser om ensomhet og sosial isolasjon i din aldersgruppe?**

- **Hva tror du kan være viktige elementer som kan forhindre eller redusere ensomhet og sosial isolasjon i din aldersgruppe?**

- **Vil du si at du kan relatere til disse følelsene? Opplever du noen av dette selv?**

SEKSJON TO

DELTAGER RELATERER IKKE TIL/OPPLEVER IKKE AT DE FØLSER EG ENSOM

- **Hva tror du er bakgrunnen for at du ikke føler det slik?**

- Fokuspunkt: familie, sosiale relasjoner/interaksjoner, samfunnet, HELSE – LIVSKVALITET, resurser – hvilke resurser anvender de?

- **Hvordan tror du følelser slik som ensomhet og sosial isolasjon påvirker mennesker?**

DELTAGER KAN RELATERE TIL/OPPLEVER FØLELSER AV ENSOMHET OG SOSIAL ISOLASJON

- **Kan du fortelle meg mer om hvordan du opplever disse følelsene? Ensomhet og sosial isolasjon**

- Probes: Family, social relations/interactions, community. HEALTH – WELL-BEING – stressors – how do they manage? Fokuspunkt: familie, sosiale relasjoner/interaksjoner, samfunnet. HELSE – LIVSKVALITET – stressfaktorer – hvordan takler de disse følelsene?

- **Hva tror du bidrar til dine følelser av ensomhet og sosial isolasjon?**

SEKSJON TRE

- **Plass for ytterlige kommentarer**

- **Utrykke takknemlighet for deltagelse**

9.2 Interview Guide, Translated to English

Interview Guide

Introduction:

- Introduction of myself
- Introduction of the study

Informed Consent

- Explanation and purpose the of study
- Explain what the data will be used for
- Ask for consent to interview
- Ask for consent to record interview
- Inform on the right to withdraw
- Information on confidentiality and anonymity

Interview Questions:

SECTION ONE

- **Could you tell me a bit about yourself and your life?**
  - Probes: Family, social relations, hobbies, interest, daily life.

- **What do you think of when I say the words, *Loneliness* and *Social Isolation*?**
  - Probes: Personal reflection on loneliness. Personal reflections on Social isolation. – Health. Well-being - Stressors - What do these words mean to them?

- **What do you think are important causes that lead to loneliness and social isolation in your age group?**

- **On the other side of this, what do you think can help PREVENT loneliness and social isolation in your age group?**

- **Can you relate to any of these feelings? Do you experience it yourself?**

SECTION TWO

PARTICIPANT DOES NOT RELATE TO/EXPERIENCE FEELINGS OF LONELINESS.

- **Why do you think that is?**
- Probes: Family, social relations/interactions, community, HEALTH – WELL-BEING, - resources – what resources do they apply?

- **How do you perceive loneliness and social isolation to affect someone?**

PARTICIPANT DOES RELATE TO/EXPERIENCE FEELINGS OF LONELINESS.

- **Could you tell me more about your experience with these feelings?**
- Probes: Family contact, social relations/interactions, community. HEALTH – WELL-BEING – stressors – how do they manage?

- **What contributes to your feelings of loneliness?**

SECTION THREE

- **Space for additional comments**

Thanking for participation

9.3 Network Analysis Table

Codes	Basic	Org
• Lack of family network and support • Poor family relations • Loss of family/partner • "lonely even though I have a family"	Family	Social relations and support
• «Someone to share the days with" • Lack of close relations outside the family • "I'm lacking a friend" • "Find a fellow human being"	Close relations	
• Loss of work from various causes • Lack of belonging in the workplace • Lack of belonging in society • "To be forgotten"	Social network and belonging	
• Games and internet to reduce loneliness • Use of radio to reduce silence • Use of television to reduce loneliness/distract	External resources and methods for managing	The role of external resources and actors
• Wish for increased understanding in society • Red Cross and external actor to facilitate contact between those who are lonely • Lack of internet and digital ability increases isolation in the older age groups • Isolation caused by economic struggles • Wish for societal change that reduce loneliness	Societal conditions and external actors - isolation:	
• Reduced perception of personal resources • To find or explore social networks alone • Comfortable with being alone • Self-activation • Isolation caused by uncertainty • Challenges with maintaining friendships or relations • Personal ability to maintain contact with family and friends	Personal resources and abilities	Personal resources, internal processing and response
• Heavy emotions when facing loneliness • "Involuntarily lonely" • Negative emotions towards other caused by trauma • «need to have someone around» • Learn to live with loneliness • «Emptiness and sadness» • Find explanations for your situation • To create meaning – «purpose in life»	Understanding of one's own situation	

9.4 Information and Consent Form

Forespørsel om deltagelse i forskningsprosjekt

Exploring the effects of loneliness and isolation on health and well-being among individuals in different life situations: The role of the Sense of Coherence

Formålet med forskningsprosjektet

Formålet med dette forskningsprosjektet er å utforske om hvordan ensomhet og isolasjon påvirker helsen og livskvaliteten til mennesker i ulike livssituasjoner. Studien vil utforske subjektive tanker om hva ensomhet og isolasjon er, samt hva som skaper god helse og livskvalitet. Dette for å utforske likheter og ulikheter i hvilke ressurser og virkemidler mennesker i ulike livssituasjoner anvender og finner nyttige i møte med følelser som ensomhet og isolasjon.

Hva betyr det å delta i dette forskningsprosjektet?

Om du velge å delta i denne studien, vil du bli bedt om å delta i ett intervju.
Dette intervjuet vil være mellom 30 minutter til en time. Formålet med dette intervjuet er å utforske dine egne tanker angående ensomhet og sosial isolasjon. Det vil også bli stilt spørsmål angående dine egne opplevelser med ensomhet i høy alder. Intervjuet vil bli tatt opp.

Håndtering av data

All innsamlet data vil kun bli brukt i forbindelse med denne studien. Dataen vil kun bli delt med personer som er direkte tilknyttet studien (forsker og studiekoordinator). Opptak av intervjuene vil bli slettet etter transkripsjon. All personlig informasjon om deg vil bli anonymisert og behandlet konfidensielt gjennom hele forskningsprosjektet. All data vil bli lagret på UiB sitt SAFE system.

Frivillig deltagelse

Deltagelse i denne studien er frivillig, og du kan velge å trekke ditt samtykke til hvilken som helst tid uten å meddele bakgrunnen for dette. Trekk av samtykke til deltagelse i intervjuet har ingen konsekvenser.

Kontaktinformasjon

Om du har noen spørsmål tilknyttet forskningsprosjektet eller din deltagelse, vennligst ta kontakt med en av disse personene:

Forsker: Øystein Sundfjord
Email: Oystein.Sundfjord@student.uib.no
Phone: 948 95 764

Studentkoordinator: Marguerite Daniel
Email: Marguerite.Daniel@uib.no
Phone: 974 32 721

Denne studien har blitt meldt til NSD for godkjenning

Samtykke for deltagelse i forskningsprosjektet

Jeg erklærer herved at jeg har mottatt og forstått informasjonen tildelt om dette forskningsprosjektet. Jeg forstår at mine rettigheter som deltager er følgende:

- Deltagelse er frivillig, og jeg kan trekke meg fra intervjuet uten konsekvenser når som helst
- Personlig informasjon vil bli anonymisert
- All data vil bli behandlet konfidensielt

Jeg ønsker å delta i dette forskningsprosjektet:

Sted, Dato   Signatur

9.5 Information and Consent form translated to English

Request for participation in research project

Exploring the effects of loneliness and isolation on health and well-being among individuals in different life situations: The role of the Sense of Coherence

Purpose of this research project

The overall purpose of this study will be to explore how loneliness and isolation affect the health and well-being among individuals in different life situations. This study aims to explore subjective thoughts on what loneliness and isolation is, as well as how good health and well-being can be achieved. This is to explore differences and similarities in which resources individuals in different life situations apply and find useful when facing loneliness and isolation.

What does participation in the research project imply?

If you take part in the research project you will be asked to participate in an interview.

The interview will last between 30 minutes and 1 hour maximum. The purpose of this interview is to explore your understanding towards loneliness and social isolation. You will also be asked about your personal experiences in dealing with loneliness and social isolation. Interviews will be audio recorded.

Data management

All collected data will be used for this study only and will not be shared with anyone who is not directly involved in this study (this being the researcher and study coordinator). Audio recordings of our interview will be deleted after transcription. All personal information about you will be anonymized and held confidential through the research project, the data will be store on the UiB SAFE system.

Voluntary Participation

Participating in this research project is entirely voluntary, and you can choose to withdraw your consent at any given time without stating a reason, this will impose no consequences.

Contact information

In case you have any questions regarding the research project or your participation, please contact the persons listed below:

Researcher: Øystein Sundfjord
Email: Oystein.Sundfjord@student.uib.no
Phone: 948 95 764

Study Coordinator: Marguerite Daniel
Email: Marguerite.Daniel@uib.no
Phone: 974 32 721

This study has been notified to the Data Protection Official for Research, NSD (Norwegian Centre for Research Data).

Consent for Participating in the Research Project

I hereby declare that I have received and understood information about the research project. I understand my rights as a participant which are:

- Participation is voluntary, and the opportunity for withdrawing is given at any time without consequence
- Personal information will be anonymized
- All data will be treated confidentially

I am willing to participate in this research project.

Place, Date Signature

9.6 Ethical Clearance from NSD

Meldeskjema / Loneliness and Social Isolation Among Individuals in Different Life Sit... / Vurdering

Vurdering

Dato
20.09.2021

Type
Standard

Referansenummer
281132

Prosjekttittel
Loneliness and Social Isolation Among Individuals in Different Life Situations

Behandlingsansvarlig institusjon
Universitetet i Bergen / Det psykologiske fakultet / Hemil-senteret

Prosjektansvarlig
Marguerite Daniel

Student
Øystein Rosnes Sundfjord

Prosjektperiode
15.06.2021 - 30.06.2022

Meldeskjema

Kommentar
Det er vår vurdering at behandlingen vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet 20.09.2021 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige personopplysninger og særlige kategorier av personopplysninger om helseforhold frem til 30.06.2022.

LOVLIG GRUNNLAG
Utvalget består av eldre mennesker ved alder 67 eller over. Vi forstår det slik at det kun inkluderes eldre personer som er i stand til å avgi et gyldig samtykke.

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 a.

For særlige kategorier av personopplysninger vil lovlig grunnlag for behandlingen være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen:

- om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet.

DE REGISTRERTES RETTIGHETER
NSD vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

9.7 Updated Ethical Clearance from NSD

Meldeskjema / Loneliness and Social Isolation Among Individuals in Different Life Si... / Vurdering

Vurdering

Dato
13.06.2022

Type
Standard

Referansenummer
281132

Prosjekttittel
Loneliness and Social Isolation Among Individuals in Different Life Situations

Behandlingsansvarlig institusjon
Universitetet i Bergen / Det psykologiske fakultet / Hemil-senteret

Prosjektansvarlig
Marguerite Daniel

Prosjektperiode
15.06.2021 - 30.06.2024

Kommentar
Vi viser til endring registrert i meldeskjemaet. Vi kan ikke se at det er gjort noen oppdateringer i meldeskjemaet eller vedlegg som har innvirkning på vår vurdering av hvordan personopplysninger behandles i prosjektet.

OPPFØLGING AV PROSJEKTET
Vi vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Kontaktperson: Henriette N. Munthe-Kaas

Lykke til videre med prosjektet!