

RECOGNITION OF LONELINESS AS A BASIS FOR PSYCHOTHERAPY

by

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ABSTRACT

This study on the recognition of loneliness as a basis for psychotherapy developed a conceptual model for loneliness intervention. Specific loneliness behaviours and suggested loneliness interventions to be implemented during psychotherapy were identified in the conceptual model for loneliness intervention. The review of the literature supported the need for research on conceptualizing loneliness to facilitate psychotherapy with lonely clients.

A quasi-experimental design was employed in the study. The Schmidt-Sermat Loneliness Scale was utilized to identify clients who tested high in loneliness. In Part I of the study, the control group, thirteen mental health clients who tested high in loneliness were involved in psychotherapy with one of four therapists. Upon completion of six psychotherapy sessions, the clients were again tested for loneliness. An Inservice Education on loneliness and an explanation of the implementing of the conceptual model for loneliness intervention during psychotherapy, as developed by the investigator, was given. Specific loneliness behaviours and possible loneliness interventions were inherent in the model. A new group of eleven clients who tested high in loneliness were identified to the same four therapists who participated in Part I of the study. These clients formed the comparison group for Part II of the study. Loneliness consultation was provided on a weekly basis by the investigator to facilitate therapist implementation of the conceptual model for loneliness intervention. Clients were again

tested for loneliness after six therapy sessions. At the end of Part I and Part II, therapists rated their perception of progress in psychotherapy and satisfaction in attempting loneliness intervention. Open end-interviews on the implementation of the conceptual model for loneliness intervention was also conducted.

Analysis of the findings of the study resulted in Hypotheses I, II, and III being upheld. Psychotherapy was more effective in reducing loneliness when the conceptual model for loneliness intervention was implemented. Therapists who utilized loneliness intervention with clients who tested high in loneliness found the psychotherapy sessions more satisfying. Therapist perception of client progress in psychotherapy increased when the conceptual model for loneliness intervention was implemented. The findings of the study were strongly significant and indicated the usefulness of a conceptual model for loneliness intervention.

The primary recommendation of the study was that loneliness psychotherapy be conducted with mental health clients who are lonely. The presentation of loneliness as a basis for psychotherapy requires that the concept of loneliness be theoretically and conceptually defined. Basically, the study recommended that there be further exploration of the concept of loneliness in the field of mental health. For further research, it was suggested that this research be conducted in a hospital setting on a psychiatric ward where on-going therapy is conducted on a daily basis. This would allow for the facilities at the hospital to be readily integrated with the loneliness interventions which would involve

therapists to directly observe and participate in the loneliness interventions, in a role-model situation, if appropriate.

Individuals have always experienced loneliness, many have suffered from this feeling. It is the inherent goal of health professionals to promote mental health. By setting a sound base for loneliness in psychotherapy, mental health care may be improved. This can also be achieved by therapists, educators, and researchers furthering the knowledge and conceptualization of loneliness to form a strong theoretical base for this concept.

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Chapter 1

INTRODUCTION

Loneliness is common to all individuals in that at some time everyone experiences a form of loneliness. The field of mental health has not acknowledged loneliness as being a basis for behaviours which disrupt the integrity of an individual and therefore warranting specific treatment in psychotherapy. A reason may be that loneliness is not labeled as an illness or does not have a disease entity such as "depression" and "psychoses."

This research will attempt to implement a conceptual model for loneliness intervention in psychotherapy. It is expected that by identifying specific loneliness behaviour and then undertaking specific loneliness intervention, psychotherapy will be more effective. This will be indicated by a reduction of loneliness in individuals incurring loneliness. Also, therapists who are involved with psychotherapy will experience more satisfaction in conducting psychotherapy by implementing a conceptual model for loneliness intervention and will perceive more progress in therapy. A quote by Ira Tanner gives reason to the undertaking of a research study based on the need to acknowledge loneliness rather than related symptomology or diagnosis.

"After a plumber spent about two minutes in repairing the furnace in a house in suburbia, he told the homeowner the bill would be \$30. The irate breadwinner proceeded to launch into a verbal tirade that covered the broad range of "awfuls" - from inflation to the plumber's dishonesty. "You just looked at my furnace and hit it once with your

*hammer!" he stormed. "That's right," replied the plumber with cool confidence. "I charged you \$5 for the visit and \$25 for knowing where to hit." He collected."*¹

There is a fairly extensive body of theoretical knowledge on loneliness and sociology but the research studies on loneliness have been few. It appears that loneliness has been incorporated mainly into the research on aging, death and dying. This was also acknowledged by Gloria Francis² in her research study on loneliness.

Loneliness appears to be common to all individuals in every life situation possible throughout the various cultures. Many groups of individuals in society experience loneliness specific to them, such as the divorced and widowed. Francis³ found in her research study on exploring loneliness, both subjectively and objectively, that loneliness is not concomitant with age (51 years of age and above) but tends to be strongly concomitant with being younger (50 years of age and under). This was interpreted in the study to mean that the younger group had a greater investment in materialistic objects, hence, when separated from them they were lonelier. They had more living friends, relatives, and acquaintances, and were generally more materialistically orientated. Loneliness can be due to an individual's life-style or life situations which may or may not be within the control of the individual. As a result, loneliness may be an uncomfortable, painful, or devastating

¹Ira Tanner, Loneliness: The Fear of Love (New York: Harper and Row Publishers, 1973), p. xi.

²Gloria M. Francis, "Loneliness: Measuring the Abstract," International Journal of Nursing Studies 13 (1976):153.

³Ibid., p. 153.

experience.

According to Hildegard Peplau⁴ it is more important to deal directly with a client's loneliness than with the defenses that the client has formed against experiencing the pain of loneliness. She further postulates that a therapist's recognition and understanding of how loneliness has evolved for the client, facilitates the establishment of a more effective therapeutic relationship. The care of the lonely client requires the therapist to understand the generic development of the loneliness for that individual and the various ways loneliness manifests itself during the psychotherapeutic session. This research study will attempt to proceed beyond this and identify loneliness behaviours and interventions with the development of a conceptual model for loneliness psychotherapy.

Purposes

The first purpose of the study is to stimulate an awareness in therapists of the concept of loneliness, of their own personal loneliness, and the loneliness encountered by their clients.

The second purpose is to recognize the importance of conceptualizing loneliness as a basis for loneliness psychotherapy.

The third purpose is to promote effective psychotherapy by acknowledging loneliness as the basis of an individual's illness or difficulty rather than symptoms or diagnosis.

⁴Hildegard Peplau, "Loneliness," American Journal of Nursing 55 (December 1955):1477.

The final purpose is to use the concept of loneliness as a basis for communication with individuals since loneliness is common to everyone. As a therapeutic medium, loneliness needs to be investigated in the mental health setting and in society.

The Problem

Will therapists, utilizing a conceptual model for loneliness intervention with clients who test high in loneliness, attain a greater reduction of loneliness in clients than without the use of the model?

Hypotheses

H I: If a therapist utilizes a conceptual model for loneliness intervention, psychotherapy will be more effective in reducing loneliness in clients.

H II: If a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapy sessions will be more satisfying for the therapist.

H III: If a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapist will perceive more client progress in therapy sessions.

Definition of Terms

1. LONELINESS - is not feeling humanly involved with others as indicated by the desire to observe life rather than participate in it, to lack personal meaning in relationships with others.⁵
2. OPERATIONAL DEFINITION FOR LONELINESS - the Schmidt-Sermat Loneliness Scale (Appendix A) identifies an individual's level of loneliness, which is a score between "0" and "60", "low" and "high" levels of loneliness, respectively. For the purpose of this study, a score of "20" or above will indicate loneliness warranting psychotherapeutic loneliness intervention.
3. ANXIETY - unpleasurable affect consisting of psychophysiological changes in response to an intrapsychic conflict. The danger or threat in anxiety is stressful. Physiological changes consist of increased heart rate, altered breathing, trembling, sweating, and vascular changes such as paleness. Psychological changes consist of an uncomfortable feeling of impending danger accompanied by overwhelming awareness of being powerless, inability to perceive the unreality of the threat, prolonged feeling of tension, and exhaustive readiness for the expected danger.⁶
4. LONELINESS ANXIETY - is a defense that attempts to eliminate or alleviate loneliness as indicated by the individual no longer having an intimate sense of relatedness with the food eaten, clothes worn. There is

⁵Edward E. Ford and Robert L. Zorn. Why Be Lonely? (Illinois: Argus Communications, 1975), p. 22.

⁶A. Freedman, H. Kaplan, and B. Sadock, Modern Synopsis of Comprehensive Textbook of Psychiatry (Baltimore: The Williams and Wilkins Co., 1972), p. 753.

no longer a direct participation in the creation and production of the vital need of the person's family and community. There is a fundamental break between what one is and what one pretends to be. Alienation between the individual and others occurs, as well as between the individual and the environment.⁷

5. CONCEPTUAL MODEL - a conceptual representation of reality which provides the outline for theory and direction for practice, research, and teaching.⁸

6. LONELINESS MODEL - a conceptual representation of reality which provides the outline for loneliness theory and direction for loneliness psychotherapy, for teaching therapists to identify loneliness behaviours and implement loneliness intervention. It is the basis of this research study.

7. BEHAVIOUR - actions or reactions under specified circumstances.⁹

8. LONELINESS BEHAVIOUR - actions or reactions when incurring loneliness.

9. COPING BEHAVIOUR - a response which indicates, directly or by inference, the way in which an individual is attempting to satisfy a basic human need.¹⁰

⁷Clark E. Moustakas, Loneliness (New Jersey: Prentice-Hall Inc., 1961), p. 24.

⁸J. P. Reihl and C. Roy, Conceptual Models for Nursing Practice (New York: Appleton-Century Crofts, 1974), p. 6.

⁹Callista Roy, Introduction to Nursing: An Adaptation Model (New Jersey: Prentice-Hall Inc., 1976), p. 21.

¹⁰The University of British Columbia Model for Nursing August 1975.

10. COPING MECHANISMS - unconscious and conscious ways of dealing with stress without changing one's goals.¹¹
11. DEFENSE MECHANISM - unconscious process, protective in nature. It is used to relieve the anxiety and conflict arising from one's impulses and drives.¹²
12. INTERVENTION - therapeutic action(s).
13. LONELINESS INTERVENTION - action(s) taken to reduce loneliness. These specific actions are prescribed approaches for loneliness intervention as loneliness has been developed in the loneliness model.
14. THERAPIST - an individual providing mental health care.
15. CLIENT - an individual, whether healthy or ill, receiving mental health care in the community.
16. PATIENT - an individual, whether healthy or ill, receiving health care in an institutional setting.
17. PSYCHOTHERAPY - a form of treatment for mental illness and behavioural disturbances in which a trained person establishes professional contact with the client. Through definite therapeutic communication, both verbal and nonverbal, the therapist attempts to alleviate the emotional disturbance, reverse or change maladaptive patterns of behaviour, and encourage personality growth and development.¹³

¹¹Freedman, Kaplan, and Sadock, Modern Synopsis of Comprehensive Textbook of Psychiatry, p. 760.

¹²Ibid., p. 762.

¹³Ibid., p. 788.

18. THERAPEUTIC RELATIONSHIP - a conscious relationship between therapist and client in which the therapist aims to treat, bring about an improvement or provide alleviation of a distressing condition or state. Both therapist and client agree that they need to work together by means of insight and control to help the client with conflicts.¹⁴

19. THERAPY SESSION - a designated appointment, where therapist and client are involved in a one-to-one relationship, and where the therapist conducts psychotherapy. A therapy session is usually scheduled on a weekly basis for approximately an hour in length. Therapist and client attempt to resolve an area of concern for the client, which is based on the client's diagnosis, reason for attending therapy at the mental health clinic, and life-situation of the individual.

Assumptions

It is assumed that all individuals have experienced some form of loneliness.

Individuals incurring loneliness will manifest loneliness behaviour, especially in interaction with others.

Clients will be able to respond to the Schmidt-Sermat Loneliness Scale in which "true" or "false" answers are required. This loneliness scale will identify those individuals who are experiencing loneliness.

Clients will be involved in psychotherapy with a therapist. A therapeutic relationship will be established between client and therapist.

¹⁴Freedman, Kaplan, and Sadock, Modern Synopsis of Comprehensive Textbook of Psychiatry, p. 797.

Loneliness in clients will give rise to identifiable loneliness behaviours which will be present during on-going psychotherapy.

Limitations

Limitations in the study due to threats to internal validity inherent in the design were evident. There were several plausible rival explanations for a decrease in loneliness as opposed to those postulated in the hypotheses. It was known that a client could attain a higher level of mental health functioning while involved in a therapeutic relationship regardless of the competency of the therapist or the input from the therapist. Due to uncontrolled external life situations over time, the person may have improved or decompensated.

Repeated use of the loneliness scale may have caused the instrument to decrease in its power to measure loneliness although the instrument measures emotional state and life situation rather than information over time. Assuming that the scale was reliable and valid, a change in an answer to a statement on the scale indicated that the person's life situation had changed.

Therapists may have utilized loneliness interventions during the therapy sessions other than those suggested in the conceptual model for loneliness intervention in psychotherapy. These interventions were enumerated and considered as extraneous variables in that they may have caused a reduction in loneliness. Therefore, these interventions have somewhat confounded the inference that loneliness interventions are purely responsible for the decrease in loneliness.

Limitations representing threats to external validity were that clients who sought mental health care at a clinic were a selected sample because they lived within a specific catchment area. The catchment area applicable to this study involved several districts with major representative characteristics being upper socio-economic groups and elderly people. A large proportion of the clientele were psychotic and it was difficult to engage in on-going psychotherapy. Also, the philosophy of the clinic was to assist clients to become community orientated and adjust to community life, therefore, therapists were discouraging dependency from clients. Often these clients scored high in loneliness but were not seen on a regular basis, and therefore were not part of the research. This was difficult to deal with during the control part of the study since the therapists were not aware of the methodology and purpose of the study.

Methodology

This study on loneliness as experienced by mental health clients employed a quasi-experimental design to investigate certain loneliness phenomena. The same four therapists participated in Part I (control) and Part II (experimental) of the study. Following Part I, an inservice education on loneliness and a conceptual model for loneliness intervention was provided for therapists to facilitate and guide psychotherapy during Part II of the study. An experimental group of four new clients for each therapist were tested for loneliness and loneliness reduction. (Part II). Comparisons were made between the loneliness interventions and degree of success in reducing loneliness in clients

between the control and experimental groups.

Part I: (Control Group) A standardized loneliness scale was given to clients and those who tested high in loneliness were identified to their therapist. The therapist engaged in a therapeutic relationship with the client for six therapy sessions of approximately one hour in length and a week or less apart. Therapists were asked to chart on two questions at each therapy session. These questions were: "What was discussed?" and "What suggestions were made in relation to what was discussed?"

(Appendix B). The investigator monitored the control group and progress of therapy because no loneliness consultation was provided during Part I of the study. At the end of the six therapy sessions, clients were re-tested for loneliness. Therapists evaluated client progress during therapy (Appendix C) and their own satisfaction with therapy sessions. (Appendix D).

Part II: (Comparison Group) A standardized loneliness scale was given to a new caseload of clients and those who tested high in loneliness were identified to their therapists. A loneliness inservice education of approximately three hours in length was provided for the therapists. (Appendix E). This inservice developed a basis for loneliness psychotherapy by dealing with loneliness and a conceptual model for loneliness intervention. The therapists then engaged in therapeutic relationships with clients identified as testing high in loneliness. Six therapy sessions of approximately one hour in length and a week or less apart were conducted. After each interview, the therapist listed the behaviour(s) of the client that were dealt with in the therapy sessions

and the intervention modes utilized. Also, the charting was directed to these two questions, "What was discussed?" and "What suggestions were made in relation to what was discussed?" After all six therapy sessions were completed the clients were re-tested for loneliness. Therapists evaluated client progress during therapy and their personal satisfaction with the therapy sessions. The investigator functioned as a loneliness consultant regarding the implementing of a conceptual model for loneliness intervention in psychotherapy and its specified use. Weekly one-to-one interviews of approximately one hour in length were conducted for the purpose of providing direct guidance for therapists on identifying loneliness behaviour(s) and loneliness intervention(s) applicable to each of the clients. At this time the overall degree of reduction in loneliness comparing the control and experimental group was observed. A second analysis of the therapist evaluation of client progress during therapy and therapist satisfaction with therapy sessions was compared from the control and experimental groups in the study.

Sample Selection

Therapists and their clients were selected from a Community Mental Health Team in the Greater Vancouver area. (Appendix F). Therapists were verbally approached to participate in a research study on "loneliness." They then proceeded to approach the clients. (Appendix G). The therapists, who represented various professional backgrounds (Masters of Sociology, Masters of Science in Nursing, Bachelors of Social Work with a Public Health Certificate, and a Registered Nurse were involved in

psychotherapy with clients. (Appendix H). The clients at the clinic were tested for loneliness until four clients for each therapist were identified as testing high in loneliness. These clients were involved in Part I of the study. This process for selecting clients was repeated for Part II of the study. (Appendix I).

Data Gathering Instrument

The standardized loneliness scale utilized to test loneliness in clients was the Schmidt-Sermat Loneliness Scale. The original scale contained sixty items which was lengthy for the initial identification of clients testing high in loneliness, therefore, the scale was reduced (by proportional random sampling) to sixteen statements. (Appendix J). The short form of the scale was pilot tested for validity and reliability. A class of approximately 120 nursing students were randomly assigned into group A taking the long form of the scale and group B taking the short form of the scale. Both groups were re-tested in two weeks. The agreement between the long and short form of the scales correlated at 0.9, significant at a p level of .01. The reliability on the test re-test was 0.8, significant at a p level of .01.

For Part I and Part II, after each therapy session, therapists charted the behaviours acknowledged during the therapy as well as the interventions utilized to deal with these behaviours (Appendix K). This was then compared to the acknowledged behaviours indicating loneliness and possible loneliness interventions compiled by this investigator. In Part I the therapists were unaware of the loneliness behaviours and

interventions. In Part II the therapists identified loneliness behaviour(s) and specific loneliness intervention(s).

At the end of the six therapy sessions in Part I, therapists rated their satisfaction in conducting psychotherapy with clients identified as testing high in loneliness. Therapist perception of client progress following the six psychotherapy sessions was also rated. In Part II, at the end of the six therapy sessions, therapists rated their satisfaction in implementing a conceptual model for loneliness intervention with clients identified as testing high in loneliness. Therapist perception of client progress following the six psychotherapy sessions where they implemented a conceptual model for loneliness intervention was also rated.

A structured interview upon completion of the research was conducted by the investigator with the therapists. (Appendix L). The purpose of this interview was to assess the various reactions to utilizing a conceptual model for loneliness intervention.

Analysis

H I: The reduction of loneliness after psychotherapy utilizing a conceptual model for loneliness intervention was challenged by a one-tailed t-test at the .05 level of significance, on the mean pre-test post-test reduction in each of the two groups.

H II: Analysis of therapist satisfaction from the psychotherapy sessions and satisfaction from utilization of a "conceptual model for loneliness intervention" during psychotherapy sessions, was challenged by

a paired t-test at the .05 level of significance, by comparing the mean from therapist satisfaction scores from the psychotherapy sessions to the psychotherapy sessions where a conceptual model for loneliness intervention was implemented.

H III: Analysis of therapist perception of progress from the psychotherapy sessions and perception of progress from utilization of a conceptual model for loneliness intervention during psychotherapy sessions, was challenged by a paired t-test at the .05 level of significance, by comparing the mean of therapist perception of progress scores from the psychotherapy sessions to the psychotherapy sessions where a conceptual model for loneliness intervention was implemented.

Summary

It was the intent of this research study to investigate the implementation of a conceptual model for loneliness intervention in psychotherapy with an individual who was experiencing loneliness. Loneliness was viewed from a theoretical perspective as a basis for identification of loneliness behaviours and loneliness interventions.

Review of Remaining Chapters

Chapter One has introduced the problem of loneliness with mental health clients and loneliness intervention to reduce client loneliness. The problem and purpose of the research study as well as the hypotheses, definition of terms, assumptions and limitations have been stated. The methodology of the research study was explained and proposed analysis

suggested.

Chapter Two will present a review of the literature based upon theoretical knowledge and a limited body of research on loneliness.

Chapter Three follows with an expansion of the methodology of the research study.

Chapter Four will contain the analysis of the data collected from the research study.

Finally, Chapter Five provides the summary, conclusions, and recommendations from the study.

Chapter 2

REVIEW OF THE LITERATURE

Loneliness has been one of the least conceptualized psychological phenomena.¹⁵ Isolation, alienation, lonesomeness, and aloneness have been used synonymously with loneliness, thus confusing its meaning. Various types of loneliness have been identified, such as general loneliness, the loneliness of solitude, interest loneliness, and essential loneliness, but the "feeling" loneliness has been defined by few. Loneliness is a feeling which utilizes a person's energy and resources. Much strength and endurance is necessary.¹⁶ The experience of loneliness appears to be frightening and painful, thus the person attempts to avoid it in whatever way possible. The lonely person is sometimes characterized as being shy, withdrawn, self-pitying, and intentionally reclusive.¹⁷ This may remove the individual even more from others, thus increasing feelings of loneliness.

¹⁵Frieda Fromm-Reichmann, "Loneliness," Psychiatry 22 (February 1959):1.

¹⁶J. B. Hoskisson, Loneliness - An Explanation - A Cure (London: Thorsons Publishers Ltd., 1963), p. 28.

¹⁷Moustakas, Loneliness, p. 24.

Loneliness can cause a person to become powerless in life situations.¹⁸ In order to cope with these situations, the person may develop defense mechanisms to facilitate coping with this feeling of powerlessness. Unless an attempt is made to deal with the loneliness being encountered and direct life in another way, the futility and emptiness of loneliness may be experienced over and over again. Thus the identification of loneliness and loneliness behaviours becomes a basis for loneliness interventions which can be implemented in psychotherapy.

It is the purpose of this review to examine the various dimensions of loneliness in clients and describe them as a basis for successful psychotherapy. Loneliness and loneliness anxiety are defined and the types of loneliness identified. This provides the means for depicting the lonely character and understanding the behavioural components of loneliness. The character of the lonely client is developed and those individuals who are at risk with loneliness identified. This gives rise and credibility to the need for psychotherapy to focus on loneliness behaviours and possible interventions by implementing a conceptual model for loneliness intervention. Other areas considered are assessing an individual's level of loneliness by a specific instrument and the dynamics in teaching and learning loneliness intervention. The review supports the recognition of loneliness in clients as a basis for psychotherapy.

As it has been alluded to previously, the research studies on

¹⁸Jurgen Reush, Therapeutic Communication (New York: W. W. Norton Co., Inc., 1961), p. 110.

loneliness have been few. A reason for this may be due to loneliness being a relatively new area of interest. Robert Sisenwein¹⁹ in his research study on loneliness stated that despite the attention given to loneliness by theorists, the literature is almost devoid of empirical research in this area. Thus it appears that clinical research study on loneliness is of the utmost importance for future development of this concept.

Loneliness

Henry von Witzleben²⁰ states that there is no clear, universal definition of loneliness, therefore many unique meanings for loneliness have been derived, almost to the point of confusion. Robert Weiss²¹ defines loneliness as a condition that knows no boundaries and is severely distressing. Another definition for loneliness according to Peplau²² is an unnoticed inability to do anything while alone. Klaus Berblinger²³ states that loneliness is a compound of unhappy personal experiences, such as: losing one's points of references;

¹⁹Robert J. Sisenwein, "Loneliness and the Individual as Viewed by Himself and Others" (Ph.D dissertation, Columbia University, 1964), p. 10.

²⁰Henry von Witzleben, "On Loneliness," *Psychiatry* 2 (1958):38.

²¹Robert Weiss, Loneliness - The Experience of Emotional and Social Isolation (Massachusetts: The MIT Press, 1973), p. 10.

²²Peplau, p. 1476.

²³Klaus Berblinger, "A Psychiatrist Looks at Loneliness," Psychosomatics 9 (March-April 1968):96.

suffering individual and collective discontinuity; living through a crisis of identity; or emotionally dying to the point of alienation from oneself.

Ford and Zorn²⁴ define loneliness as not feeling humanly involved with others as indicated by the desire to observe life rather than participate in it, to lack relatedness to others, and to lack personal meaning in relationships with others. For the purpose of this research, this definition will be utilized.

Rosalee Bradley²⁵ in her research study on loneliness identified four categories of loneliness that have emerged from the literature:

- "(1) discrepancies between the behavioural role an individual portrays and his inner experiences,
- (2) feelings of lack of purpose and meaning in life,
- (3) feelings of lack of highly personalized relationships in one's life,
- (4) a personal need of an absence of physical closeness and contact with others."

Due to the various definitions of loneliness, it becomes necessary to select an appropriate meaning to fit the circumstances at hand. Identifying the types of loneliness is useful because it applies to the various specific situations of loneliness.

²⁴Ford and Zorn, Why Be Lonely?, p. 22.

²⁵Rosalee Bradley, "Measuring Loneliness" (Ph.D. dissertation, Washington State University, 1969), p. 21.

Types of Loneliness

The literature explicitly identifies various types of loneliness such as primary and secondary loneliness, general loneliness, and the loneliness of social isolation. Some types of loneliness function in a positive way to assist the individual in personal growth and self-awareness, whereas, other types of loneliness can be very disruptive to self-integrity.

Hoskisson²⁶ has identified many types of loneliness.

General loneliness is an unspecified loneliness comprised of a general desire for society and companionship. It may indicate the lack of relationship with others or not being a satisfactory or satisfied member of any group or family. This person suffers from not having a family or occupation to fill time. If loneliness becomes too painful or intolerable, the person may attempt to alleviate the loneliness through sickness, insanity, or suicide. The sufferer from general loneliness can be helped in psychotherapy.

Another type of loneliness defined by Hoskisson²⁷ is called interest loneliness, the desire for relationship or companionship. Sometimes this type of loneliness is seen in a person with talent and ability who is socially well-adjusted with their specific interest. An example of interest loneliness may be the "Einsteins" who gather to discuss the work they have undertaken independently in the past years.

²⁶Hoskisson, Loneliness - An Explanation - A Cure, p. 28.

²⁷Ibid., p. 28.

Another example is the adolescent paraplegic, who experiences particular personal problems because of this difficulty, and can be understood by someone else with similar problems. It is a relief to consort with others similarly handicapped.

Hoskisson²⁸ defined the loneliness for a particular environment or situation as nostalgic loneliness. There may be a longing to return home, to attain reassurance because one craves the familiar. Home may mean a dwelling, a job, a person, a routine, or a life situation. The existential philosopher postulates that if the whole universe could be one's home and if one could be at home in oneself, this type of loneliness would not exist.

The need for a faith, a hope, a goal, or "a man without a cause" was defined by Hoskisson²⁹ as faithless loneliness. The person may feel that there is no purpose to life unless one is living for a cause. There appears to be a need to find work which produces practical results and satisfying emotional needs. Three types of individuals suffer from faithless loneliness, the apathetic person who hasn't the energy to care, the superior person who cynically discounts and discredits the "fruits of life", and the suggestible person who assumes someone else's goal in a life situation.

Hoskisson³⁰ identifies two types of specific loneliness. Real

²⁸Hoskisson, Loneliness - An Explanation - A Cure, p. 30.

²⁹Ibid., p. 31.

³⁰Ibid., p. 31.

specific loneliness is the desire for the unattainable in one's life. If a relationship was terminated, not of the person's choosing, then a sense of failure and futility because of the loss may be experienced. The person must then come to the realization that life has something else to offer. Fantasy specific loneliness is the desire for the ideal or imagined. This refers to somebody created in the person's own mind. When the person rejects the real for the fanciful, then the situation progresses toward unreality.

The sense that one is not fulfilled has been defined by Hoskisson³¹ as incompletion loneliness. The individual may be well adjusted socially but may not know what is necessary to obtain fulfillment in achieving a sense of completion in life desires.

Fromm-Reichmann³² defines a physical loneliness which is the need, or at least the wish to have, at times, physical contact with another. People who give massages or osteopathic treatment often assist their clients emotionally by relieving physical loneliness.

Von Witzleben³³ distinguished between two types of loneliness, that is primary loneliness and secondary loneliness. Primary loneliness is the loneliness of one's "self" which is common to every individual. It is the feeling of being alone and helpless in the world. The person may utilize innumerable defense mechanisms to keep from conscious

³¹Hoskisson, Loneliness - An Explanation - A Cure, p. 36.

³²Fromm-Reichmann, p. 6.

³³von Witzleben, p. 38.

recognition of loneliness. Secondary loneliness is caused by the loss of an object. It is expressed in grief due to the loss of the object.

Whether the object lost or real exists only in the fantasy of the neurotic or psychotic mind, the effect of loneliness is the same.

Francis³⁴ in her research study on the loneliness experienced by hospitalized patients found that secondary loneliness varies in a direct manner with the amount of mental or emotional investment patients have in the persons and things from whom they are separated. This can be explained in that the more one has from which to be separated, the more one has to miss, and the lonelier he will be. This is the essence of cathectic investment.

The various types of loneliness provide a basis for further examination of the reasons why loneliness can be devastating for an individual, especially when it has progressed to loneliness anxiety. These various specific situations of loneliness give substance to the lonely character types that depict the dimensions of loneliness found in clients. Early personality traits, the lonely character types, as well as lonely life situations all support the evolution of loneliness anxiety.

Loneliness Anxiety

The concept of loneliness anxiety, developed and researched by Fromm-Reichmann, and later by Moustakas, is vital to this research. It provides the basis and purpose for identifying loneliness behaviour and conducting successful psychotherapy with those who suffer from loneliness

³⁴Francis, p. 156.

anxiety. Bradley³⁵ in her research study on loneliness postulates that loneliness is very basic and that it may often underlie concepts of depression and anxiety.

Moustakas³⁶ considers loneliness in two ways, the first being existential loneliness which is inevitably a part of human experience and valuable for self-understanding. His second perspective of loneliness is that of self-alienation and rejection which is not a loneliness but a disruption to the integrity of the individual and produces a vague and disturbing anxiety. The person withdraws from self and from society. This then causes the development of mental defenses to attempt to alleviate the anxiety.

Various theories on anxiety have evolved which support the theory of loneliness anxiety. Freud³⁷ viewed anxiety from the standpoint that both real and neurotic anxiety occurred in response to a danger to the organism. In real anxiety, the threat arises from a known danger outside the person; neurotic anxiety is precipitated by an unknown danger, often generated from internal problems within the person's psyche. Freud distinguished between two kinds of anxiety provoking situations. The first is the anxiety that occurs as a result of excessive instinctual stimulation that the individual cannot cope with, therefore this overruns the protective barriers of the ego, and a panic state

³⁵Bradley, p. 22.

³⁶Moustakas, Loneliness, p. 24.

³⁷Sigmund Freud, An Outline of Psychoanalysis (W. W. Norton Co., New York, 1949).

leading to trauma results. This usually occurs in infancy or childhood when the ego is immature or during a psychotic turmoil due to a panic state when the ego is overwhelmed. The second anxiety provoking situation which occurs after the defense system has matured is the anxiety that arises in anticipation of danger rather than as its result. The anxiety may arise because the person has learned to recognize, at a preconscious or unconscious level, aspects of a situation that were once traumatic. The individual may employ avoidance mechanisms to escape from a real or imagined danger from without. On the other hand, the individual may utilize ego defenses from within to guard against or reduce the quantity of instinctual excitation. In lonely circumstances, real or imaginary, have the ability to promote.

Sullivan's³⁸ Interpersonal Theory views anxiety as a perceptual response aroused by the emerging power of formerly repressed, unacceptable thoughts, feelings, drives, wishes, and actions. Sullivan considered these forbidden inner experiences to be interpersonal ones, whereas Freud viewed them as repressed instinctual or innate drives. According to Sullivan's theory, anxiety is experienced as an anticipated disapproval or loss of love from the significant people of an individual's early life relationships from whom the anxious person learned to discriminate between acceptable behaviours. Sullivan further postulates that, in order to escape from loneliness, the person may resort to anxiety-arousing experiences.

³⁸Harry Stack Sullivan, The Interpersonal Theory of Psychiatry (New York: Norton Co., 1953), p. 290.

Karen Horney³⁹ relates anxiety and hostility. During certain interactions, hostility is anticipated by others and sensed by the anxious person himself. Anxiety is connected with anticipated fear of disapproval and punishment, withdrawal of love, disruption of interpersonal relationships, and isolation. Hostility becomes a defense that the anxious person demonstrates to ward off the fears mentioned.

Fromm-Reichmann⁴⁰ relates all of these explanations of anxiety to support her theory that anxiety has a close psychological affinity to loneliness. She believes that the emotional states referred to as anxiety by theorists are actually states of loneliness or fear of loneliness. The fear of loneliness has become an actual problem today because man has lost in many ways, the experience of neighbour relationships and community life.

Fromm-Reichmann⁴¹ feels that illness may result from inadequate fulfillment of the need for human intimacy, possibly beginning in the formative years. When an adult, there is a failure to relate to others on a genuine, loving basis. She further postulates that loneliness endured for long periods of time may cause the person to manifest psychotic behaviour. Loneliness can, however, be concomitant with an

³⁹Karen Horney, Our Inner Conflicts (New York: W. W. Norton Co., 1945).

⁴⁰Fromm-Reichmann, pp.1-7.

⁴¹Ibid., p.4.

extreme psychotic disturbance. Due to interpersonal detachment incurred by some psychotic individuals, they may be more sensitive and observant of people in their environment. Occasionally, the hyperalertness of the individual suffering from loneliness produces an oversensitivity to life situations. This hyperalertness may initiate the tendency to misinterpret or exaggerate the hostile-affectionate intentions of others, thus deepening the experience of loneliness.

Moustakas⁴² views loneliness anxiety as a common condition. For the purpose of defining loneliness anxiety in this research study, this definition by Moustakas was utilized. Loneliness anxiety is indicated by the individual no longer having an intimate sense of relatedness to the food eaten, the clothes worn. There is no longer direct participation in the creation and production of the vital needs of the person's family and community. Loneliness anxiety results from a fundamental break between what one is and what one pretends to be. This alienation is occurring between the individual and others as well as between the individual and the environment. The feeling of alienation from others may eventually result in a type of chronic illness caused by persistent loneliness anxiety.

Weiss⁴³ postulates that the person suffering from loneliness anxiety is deeply suspicious and the smallest criticism hurts. Due to the constant feeling of failure, the person attempts to raise their level

⁴²Moustakas, Loneliness, p. 24.

⁴³Weiss, The Experience of Social and Emotional Isolation, p.21.

of achievement to win praise and approval. The devices and strategies the person uses often results in further alienation from others and increased attempts to hide inner feelings of anxiety. Loneliness anxiety results from the pain of loneliness and the need for relatedness and security.

The Lonely Client

As evidenced by writers and poets, such as Lynn Caine⁴⁴ and Rod McKuen⁴⁵ loneliness may be a chosen state to enhance their creativity. Usually loneliness is not a chosen state. Peplau⁴⁶ suggests that often the lonely person is not aware of the reason why he does what he does when incurring loneliness. According to Weiss⁴⁷ it therefore becomes easy to view the lonely person as out of step, as unwilling to make necessary attempts to communicate with others, and lacking in qualities to satisfy human relationships. David Reisman⁴⁸ asserted that the presence of others and the acceptance of the individual by his own group does not necessarily relieve him from

⁴⁴Lynn Caine, Widow (New York: William Morrow and Co., Inc., 1974).

⁴⁵Rod McKuen, Alone (New York: Pocket Books Inc., 1975).

⁴⁶Peplau, p. 1476.

⁴⁷Weiss, Loneliness - The Experience of Social and Emotional Isolation, p. 74.

⁴⁸David Reisman, The Lonely Crowd (New Haven: Yale University Press, 1950).

loneliness. Sisenwein⁴⁹ in his research study on loneliness in the individual, as viewed by himself and others, found that lonely people see themselves as less popular, whether they are or not. Another finding was that loneliness appears more related to how a person views himself and experiences the responses of others. Francis⁵⁰ in her research with hospitalized patients, studied the loneliness caused by temporary separation from the people and objects that individuals were attached to. She found that women were more likely to be lonely than men, and that loneliness was concomitant with being younger.

Seabrook⁵¹ describes various case histories of individuals relating the loneliness they have experienced. Because loneliness is a vague term, there are no criteria to assess the prevalence or intensity of loneliness that people admit to. It therefore becomes necessary to have each individual define loneliness as they experience it. In his book, Seabrook related the case history of a thirty year old spastic, who is female and married. This person states, "Loneliness when you're alone is reasonable, something to be overcome, but loneliness when you are with someone is a great less tolerable." This acknowledges that the individual experiences various degrees of loneliness, but it does not enable another person to assess the loneliness, as Seabrook previously postulated. The loneliness encountered by a person is usually

⁴⁹Sisenwein, p. 35.

⁵⁰Francis, p. 156.

⁵¹Jeremy Seabrook, Loneliness (New York: Universe Books, 1973), p. 144.

a part of personal life experiences, and therefore it can be difficult for the individual to relate these lonely situations.

Loneliness is often used as a synonym for lack of fulfillment, unhappiness, or failure in many areas of life experiences. It is a subject surrounded by prohibitions and embarrassments so that those who are affected by it are caught up in a spiral of self-reinforcing isolation. Many who suffer from loneliness feel that it is the result of personal unworthiness, that loneliness is something to be ashamed of, and in order to talk about it, they may require circumstances or individuals to blame.⁵² It is therefore the intent of this research that loneliness must be discussed as an entity in and of itself within the therapeutic relationship, and that therapists have a responsibility to initiate this type of communication.

Loneliness may create feelings of unexplained dread, of desperation, or of extreme restlessness. These feelings can be so intense and unbearable that automatic actions are precipitated. The problem eventually becomes how to handle the bad feelings which come from loneliness and unsuccessful attempts to be humanly involved with others. Ford and Zorn⁵³ explain how loneliness and bad feelings are cyclic, in the following way. Loneliness causes bad feelings which tend to overwhelm the psyche, making it hard to know what to do to alleviate or cope with the bad feelings. In order to deal with or overcome these feelings, one has to find relief, possibly by

⁵²Seabrook, Loneliness, p. 24.

⁵³Ford and Zorn, Why Be Lonely? p. 23-27.

decreasing the loneliness. If not, the bad feelings tend to make the person feel worse, which may lead to increasing the loneliness for that individual. Ford and Zorn further postulate that the bad feelings from loneliness tend to drain the internal physical and emotional strength necessary to handle the loneliness or the bad feelings.

Tanner⁵⁴ postulates in her theory of relating Transactional Analysis to loneliness, that loneliness has its beginning in childhood, sometime between the age of one and three. It is a root condition of life and it is during these early years that we first begin to experience doubt as to our self-worth. Townsend⁵⁵ states that a five year span of sustained loss of an essential tie, such as leaving home, regardless of the other ties, will determine if unresolvable loneliness is to occur. Weiss⁵⁶ identifies two social situations which are a risk for loneliness. The first is the situation of the unmarried, in which there is no committed intimate relationship with a close other to fend off emotional isolation. The second high risk situation is the individual who has no link to the community, because of recency of arrival, personal unacceptability, or for other reasons.

Various groups of people in society are at risk with loneliness. One group of these people are those who have a great deal of free time

⁵⁴Tanner, Loneliness: The Fear of Love, p. xv.

⁵⁵P. Townsend, Family Life of Old People (London: Routledge and Kegan Paul, Ltd., 1957).

⁵⁶Weiss, Loneliness - The Experience of Emotional and Social Isolation. pp. 71-85.

but have not learned to use it, and therefore suffer from boredom. Some people do not know how to make and maintain good friendships. For others, the family group no longer comprises the extended family but focuses on the nuclear family, thus possibly decreasing support systems. Francis⁵⁷ in her research study on the loneliness experienced by hospitalized patients, found that temporary separation from people and objects produced groups at risk from loneliness. These groups included minority cultures, younger age groups, and persons who had accumulated material goods in a fast-flowing lifestyle. The study identified loneliness risk groups but did not suggest therapy or intervention modes applicable to them.

Tanner⁵⁸ identifies various groups of people who incur loneliness. Students who are for the first time away from home for a long period may suffer from loneliness. Re-discovering their identity in an adult world may be difficult. Women who remain single through no choice of their own may have to overcome not being able to have children or a mate to care about. The divorced and widowed are often more lonely than those who never married. This deeper loneliness could be due, not only to the loss of a close companion, but, if married young the person may never have learned to live alone or face up to the loneliness experienced in earlier life. For some, retirement marks the onset of loneliness because it appears to be the end of a useful working life.⁵⁹

⁵⁷Francis, p. 10.

⁵⁸Tanner, Loneliness: The Fear of Love, p. 75.

⁵⁹Ibid., p. 83.

Psychotherapy with the Lonely Client

According to Fromm-Reichmann⁶⁰ the secretiveness and lack of communication about loneliness in the general population seems to increase the threat for the lonely person. Due to this lack of mention, they come to believe that others have not experienced similar feelings. It therefore seems apparent that therapists should acknowledge and identify a client's loneliness in psychotherapy.

Moustakas⁶¹ suggests that every real experience of loneliness involves a confrontation for the individual and forces the person to use new energies and resources to cope with life. By experiencing loneliness and gaining insight from this, a person can achieve a higher level of intrapersonal unity. The therapist can assist a client to attain this level through loneliness intervention as opposed to not acknowledging the loneliness and having the client continue to face loneliness situations in life. Moustakas⁶² further believes that the lonely individual continues to oppress loneliness and therefore responds with whatever surface or approved behaviour previous actions were based upon.

Von Witzleben⁶³ postulates that the therapist in psychotherapeutic and analytical work is so preoccupied with the dynamics underlying a symptom which may lead to neglecting to view the total personality of the individual. He further believes that the psychotherapist does not always

⁶⁰Fromm-Reichmann, p. 6.

⁶¹Moustakas, Loneliness and Love, p. 20.

⁶²Ibid., p. 31.

⁶³von Witzleben, p. 37.

pay enough attention to primary loneliness because insight into personal loneliness for the psychotherapist is limited. In other words, the therapist may be reluctant to admit or face a personal loneliness.

This in turn makes it difficult for the therapist to identify and work with the loneliness in clients. The old biblical statement, "First remove the beam from thine own eye that ye may see clearly to remove the mote from thy neighbour's eye"⁶⁴ is in essence, similar in meaning.

Francis⁶⁵ in her research study on the loneliness experienced by hospitalized patients, due to the temporary separation from people and objects, states as a finding, "If one says he is lonely, he is lonely." She compares this to the abstract concept of pain, as no one can adequately evaluate another's pain, no one can evaluate another's loneliness. The therapist must accept the suffering individual's appraisal of loneliness at face value. This can be more easily done if the therapist has accepted personal loneliness, as this acceptance can then be transferred to the client during therapy session. She further postulates that loneliness prevention would mean less hospitalization and that loneliness possibly acts as a deterrent to medical prognosis. Another finding of interest was that those patients who were reasonably certain as to when they would be discharged from hospital were significantly more lonely than those who had no idea when they might go home. She therefore concludes that patient knowledge of relative discharge date is somehow a crucial variable in the generation of loneliness.

⁶⁴A well-known biblical proverb.

⁶⁵Francis, p. 157.

Francis' findings indicate the researchable understanding of loneliness is most limited. The undocumented dimensions of loneliness are many and expansion of the few findings available is most necessary.

Audrey Brennan⁶⁶ in her research study on investigating the response of hospitalized patients to loneliness, found that extended care respondents perceived many loneliness-associated changes in themselves but did not feel either the need or freedom to communicate these perceptions to the nurse. Maternity respondents replied to very few of the loneliness-associated changes in behaviour. Psychiatry respondents perceived many loneliness-associated changes in their behaviour and perceived a high degree of freedom to communicate with the nurse and a sense of relatedness to the nurse.

Seabrook⁶⁷ postulates that it may be impossible to prevent old age, bereavement, or the decay of relationships, but their effect upon the individual can be mitigated if an effort is made. The case history of a fifty year old married female who had been hospitalized in a psychiatric setting, related the types of therapy that she received during her hospitalization,

*"I spent several months in hospital. Fortunately I was in a psychiatric ward in a general hospital, which I think is a good idea. It goes a long way to remove the stigma of mental illness. I had psychotherapy, electrotherapy, drugs - I was sent home only two days after the electrotherapy. Then another kind of loneliness began. Of all the treatment I had, I think the most helpful was being able to talk about things."*⁶⁸

⁶⁶Audrey Brennan, "The Loneliness of the Hospitalized Patient" (Master's Thesis, University of British Columbia, 1975), pp.81-92.

⁶⁷Seabrook, Loneliness, p. 9.

⁶⁸Ibid., p. 87.

This statement suggests that psychotherapy was the most effective treatment and that "another kind of loneliness began" upon returning home. It appears that the patient may have been saying that she was suffering from loneliness and therefore she needed contact with another or psychotherapy to cure her illness.

As Roy Bonistell⁶⁹ stated on his television program, "Man Alive", "loneliness is the disease of our time, reaching epidemic proportions." There is a need for loneliness psychotherapy to assist an individual to alleviate or cope with the feelings of loneliness. A conceptual model for loneliness intervention has been developed in this study to assist therapists to identify loneliness behaviours in clients and then implement loneliness interventions. To undertake this task requires therapists to learn to identify loneliness behaviours and implement appropriate loneliness interventions.

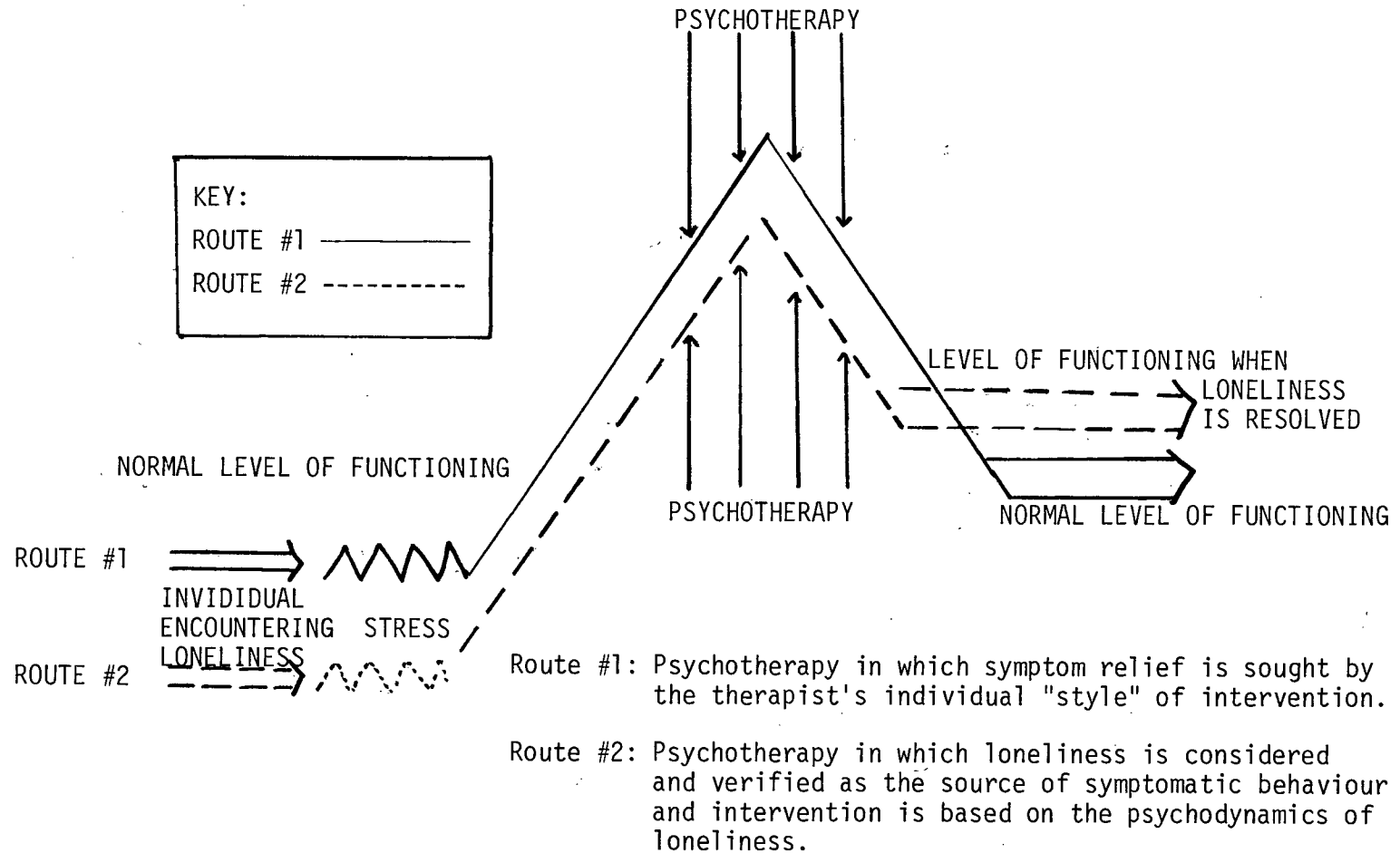
A Conceptual Model for Loneliness Intervention as Developed By The Investigator

As depicted in Figure 1, a therapist may take one of two routes when engaging in psychotherapy with clients identified as testing high in loneliness. If Route #1 is taken, the therapist will assist the client to deal with the stresses that the person is encountering as well as the symptoms related to the person's mental functioning. If Route #2 is taken, the therapist will identify specific loneliness behaviour(s) of the client and assist the person to alleviate or cope with the loneliness being encountered by implementing appropriate loneliness intervention.

⁶⁹CHEK, "Man Alive," November 8, 1976, "Alone, Not Just Me," Roy Bonistell.

A Conceptual Model For Loneliness Intervention

Figure 1



Identification of Loneliness Behaviours and Loneliness Interventions as
Developed by the Investigator

Implementation of the "Conceptual Model for Loneliness Intervention" necessitates the identification of specific loneliness behaviour. This then gives direction for possible loneliness interventions for use in psychotherapy sessions with clients identified as testing high in loneliness.

LONELINESS BEHAVIOUR	LONELINESS INTERVENTION
<p>SOMATIC COMPLAINS</p> <p>Somatic difficulties based upon the body's expression of loneliness:</p> <ul style="list-style-type: none"> - Insomnia and intense interest in sleeping are observed at the same time. - Hypersensitivity to noise or to stuffiness in a closed room may lead to the client opening and closing windows innumerable times in a day. - Vomiting and belching. - May complain of pain in the head, arm, and/or stomach. - Loss of Weight. 	<p>Observe client's sleeping patterns. Relief from loneliness can be attained from sleep but dreams concerning the loneliness may be experienced, thus keeping the client awake. If experiencing bad dreams, then sedation may not be the answer to the insomnia.</p> <p>The client may feel rejection. Establish a therapeutic relationship specifying the limits of the relationship and adhering to the limits because the client will test and re-test them. Sincerity, integrity, and honesty of the therapist are important.</p>

LONELINESS BEHAVIOUR	LONELINESS INTERVENTION
<p>ABBERRANT BEHAVIOUR TO MASK LONELINESS</p> <p>Because loneliness can be an unbearable experience, the client may engage in alternative behaviours, to mask loneliness, such as:</p> <ul style="list-style-type: none"> - drug abuse - excessive drinking - gambling - prostitution 	<ul style="list-style-type: none"> - Deal directly with the loneliness rather than with the alternate behaviours or the defenses against the pain of loneliness. - Understand how the loneliness has evolved for the client. - Allow the client to develop insight into personal loneliness. - Acknowledge and validate with the client the possible causes of loneliness.
<p>HIGHLY STYLIZED, PRECISE AFFECT</p> <p>Overplanning: emphasis on personal dressing for social appearances, almost as if the client was arranging a carefully guarded and rarely displayed picture of himself.</p>	<p>Establish a therapeutic relationship where the client can work on getting in touch with other individuals, feeling related to them, and working collaboratively with them.</p>

LONELINESS BEHAVIOUR	LONELINESS INTERVENTION
<p>TIME-ORIENTED COMPLAINTS</p> <p>The client makes complaints relating to:</p> <ul style="list-style-type: none"> - the endlessness of each day - the feeling of "putting in time." 	<ul style="list-style-type: none"> - Assist the client to have a variety of opportunities to describe, interpret, and validate what is happening in a current situation. - Have the client complete a <u>"Daily Living Schedule"</u> (Refer to Figure 2) to develop client awareness of how time is being utilized during a day. - Have client then complete <u>"Alternatives to Daily Living Schedule"</u> (Refer to Figure 3) to develop client awareness of how time could be utilized during a day.

DAILY LIVING SCHEDULE
The Way I Spend My Time

7:00	Get up, have breakfast
8:00	Leave for work
8:30	Arrive at work
10:00	Coffee break
12:00	Lunch
12:30	Back to work
4:30	Leave work
5:30	Dinner alone
7:00	Do laundry and various chores around the apartment
8:00	Watch television
11:00	Watch the late news
11:30	Go to bed

* Do for weekdays

* Do for weekends, or days off from work if different
than week days.

Figure 2

⁷⁰Ford and Zorn, Why Be Lonely? p. 80.

ALTERNATIVES TO DAILY LIVING

TIME	THE WAY I SPEND MY TIME	ALTERNATIVES TO THE WAY I SPEND MY TIME
7:00	Get up, have breakfast	Get up, have breakfast
8:00	Leave for work	Leave for work in a car pool
8:30	Arrive at work	Arrive at work
10:00	Coffee break	Coffee break with a person at work
12:00	Lunch break	Lunch break with a different person at work
4:30	Leave work	Leave work, drive home in car pool
5:30	Dinner alone	Dinner with a friend or neighbour
7:00	Do laundry and various chores around the apartment	Do laundry and various chores around the apartment
8:00	Watch television	Watch television, invite someone to watch television with you
9:30		Phone a friend
10:00		Write a letter to a friend, penpal
11:00	Watch late news	Watch late news
11:30	Go to bed	Go to bed

Figure 3

⁷¹Ford and Zorn, Why Be Lonely? p.80.

LONELINESS BEHAVIOUR	LONELINESS INTERVENTION
<p data-bbox="103 259 506 292">LACK OF DIRECTION IN LIFE</p> <p data-bbox="103 323 666 644">The client experiences planlessness to life, as if life was viewed and lived as one continual accident, based upon an expectation that something is going to happen. Sometimes the person responds to minor details that actually do occur, but does nothing to prevent or produce them.</p> <p data-bbox="103 675 634 866">Many problems confront the person all at once, everything looks impossible, frustrations grow, and this further increases the client's difficulty in making wise choices.</p>	<p data-bbox="700 323 1246 679">Make a "<u>Do Plan</u>": which consists of client goals as established by the client in conjunction with the therapist. Goals should be in positive terms because it makes them easier to remember as well as creates positive feelings in the client when attained. The goals should involve actions of short duration. (Refer to Figure 4).</p> <p data-bbox="700 689 1147 727">Six elements to a "<u>Do Plan</u>":</p> <ol data-bbox="700 758 1231 1529" style="list-style-type: none"> <li data-bbox="700 758 1231 855">1. SMALL: it is manageable, both in terms of time and what the client is going to do. <li data-bbox="700 886 1231 984">2. SPECIFIC: It is definite and detailed, something the client can visualize doing. <li data-bbox="700 1015 1231 1141">3. POSITIVE: It is not what the client is not going to do, but what the client is going to do. <li data-bbox="700 1172 1231 1270">4. REASONABLE: It makes sense, the client sees value in doing it. <li data-bbox="700 1301 1231 1398">5. REPETITIVE: It is something the client can do fairly often. <li data-bbox="700 1429 1231 1529">6. INDEPENDENT: It is not dependent on what someone else does with the client.

DO PLAN

DO PLAN	JANUARY							
	1	2	3	4	5	6	7	8
Smile and say hello to at least one person sitting in the waiting room of the clinic		✓						
Have lunch with someone at work every day	✓	✓	✓		✓			✓
Volunteer to help Saturday and Thursday night at the church bingo						✓		
Call one friend on the phone each day	✓	✓	✓	✓		✓		✓
Ask a friend or neighbour over to dinner once a week or more				✓			✓	

Figure 4

⁷²Ford and Zorn, Why Be Lonely? p. 45.

LONELINESS BEHAVIOUR	LONELINESS INTERVENTION
<p>REPORTING ACTS OF DISENGAGEMENT</p> <ul style="list-style-type: none"> - Inability to observe oneself in action, functions as a spectator, watching, waiting, and hoping. - Protects self by not recognizing own behaviour. - Rejection, no longer an object of love due to a husband, parent, friend or child dying or is otherwise withdrawn from interaction with the client. - A homesickness for a style of life or some set of activities formerly carried out with others. Possible disengagement from a prior lifestyle may be due to a status drop as a result of not sharing in a previous lifestyle. 	<p>Be aware of client's defense mechanisms so that they are not reinforced in therapy session.</p> <p>Assist client to change "role" by focussing on a newly revitalized social role. This can be facilitated by a <u>"DO PLAN"</u></p> <p>Assist the client to integrate into social networks which provide support for accepting reality.</p>

LONELINESS BEHAVIOUR	LONELINESS INTERVENTION
<p>REPORTING INABILITY TO MEET OTHERS</p> <ul style="list-style-type: none"> - Absence of anyone to care for or be the recipient of love. - Inability to make friends due to lack of skills necessary to build new patterns of relations when old ones become broken, strained, or not easily available. - Lack of self-confidence, see no choice for a happier tomorrow. The faith and ability to create a new future is gone. 	<p>Build sufficient internal strength and confidence in the client so that eventually the client can handle problems without assistance. The client may make a list on "<u>BUILDING NEW LIFE SITUATIONS</u>" by constructing a "<u>DO PLAN</u>" which slowly evolves into new life experiences for the client.</p>
<p>IDOLIZATION OF OTHERS</p> <p>The effort to establish contact or proximity with people may lead to the client idolizing certain individuals.</p>	<ul style="list-style-type: none"> - In an effort to establish contact, undertake "role reversal" to assist client to practice this communication. - Allow client to know the therapeutic interest that therapist has about client's activities.
<p>REPORTING INABILITY TO COMMUNICATE</p> <p>Difficulty communicating to people. Frightened secretiveness and lack of communication increases the threat to talk about loneliness.</p>	<p>Suggest four guidelines for conversation:</p> <ol style="list-style-type: none"> 1. be nonjudgemental when listening to another person, 2. listen with interest, 3. don't rush the conversation, give the person a chance to make a point, 4. let the other person know what you think.

The preceding identification of specific loneliness behaviour and possible loneliness interventions provide the basis and guidelines for loneliness psychotherapy. The internalization of the conceptual model for loneliness intervention occurred by means of the therapists on the research team engaging in weekly therapy sessions with lonely clients as well as weekly consultations with the investigator. Guidance and further understanding in the operationalization of the model was provided during the consultation.

Teaching and Learning a Conceptual Model for Loneliness Intervention

To conduct effective psychotherapy with clients identified as testing high in loneliness, it was necessary for therapists to internalize the conceptual model for loneliness intervention. Barbara Redman⁷³ states that teaching is an interactive process between teacher and one or more learners. She further states that the role of the learner is to participate in or initiate activities that lead toward the desired behaviour change. Therefore, an inservice education on loneliness for the therapists who were engaged in psychotherapy with clients identified as testing high in loneliness was prepared.

Jean Schweer⁷⁴ states that a creative teaching-learning milieu provides the freedom of discovery so vital to learning those things

⁷³Barbara Redman, The Process of Patient Teaching in Nursing (Saint Louis: The C. V. Mosby Company, 1972), pp.14-18.

⁷⁴Jean Schweer, Creative Teaching in Clinical Nursing (Saint Louis: The C. V. Mosby Company, 1972), p.143.

essential to the fulfillment of professional responsibilities in a rapidly changing society. The inservice education on loneliness given in this study employed a variety of teaching methods, including group discussions, guest speakers who had expertise in loneliness, active loneliness exercises, and personal loneliness mood media such as poems and songs. This teaching-learning process for therapists precluded implementing the conceptual model for loneliness intervention. The group teaching was followed by individual therapist consultation on a weekly basis to enhance the understanding and implementation of the model.

Measurements for Loneliness

A measurement for loneliness was vital to this research study, since, the reduction of loneliness in clients was a major determinant in indicating the effectiveness of the "Conceptual Model for Loneliness Intervention" in psychotherapy. An instrument which would measure the reduction of loneliness in clients was necessary.

Sisenwein⁷⁵ developed a loneliness scale to measure "loneliness in the individual" as viewed by himself and others. The scale was formed by his questioning twenty psychologists who submitted statements that described how they felt when they experienced loneliness. Also, statements on loneliness were taken from the literature. This scale was tested on 225 freshman cadets from the United States Merchant Marine Army. The questionnaire identified the loneliness scores of each cadet

⁷⁵Sisenwein, p. 59-74.

which was then compared to the loneliness rating of the cadet by his roommate and by a significant other who never lived with the cadet. The questionnaire yielded reliability coefficients of 0.83 and 0.85 and a validity coefficient of 0.72.

Bradley⁷⁶ in her research study developed a loneliness scale based on participant's evaluation of loneliness statements on a Likert scale. The Loneliness Scale (LS) was derived from an original list of 134 statements on feelings or experiences of loneliness and belongingness. Of the 134 statements forming the scale, 35 were deducted from sentence completion and peak experience responses by subjects in a preliminary study while most of the remaining statements were constructed or selected by Bradley based on her definition of loneliness. This list of statements was then administered to 94 male junior college students and the results were used for item selection and reliability. On the basis of their ability to discriminate, $p < .0005$ on one-tailed t-test between the 10 highest and 10 lowest scores made by the junior college students, 38 final items were selected for the loneliness scale (LS).

With the scores on the LS from the scores of the previous 94 male college students who participated in the preliminary study, she utilized the split-half method to obtain a measure of reliability. The items for the two halves were selected to equate the sum of the mean differences (56.0 and 56.9 for the two halves) and the sum of the standard error for the difference between the means (113.4 and 109.56 for the two halves).

⁷⁶Bradley, p. 15-22.

The result was a correlation coefficient of 0.90 ($p < .001$), and value of 0.95 as an estimate of full-scale reliability for the 38 LS items, was yielded by the Spearman-Brown prophecy formula. This split-half correlation indicates the LS items are internally consistent. Bradley's Loneliness Scale (LS) was not appropriate for this current study as the subjects would not have been able to differentiate the degrees of loneliness asked for in a Likert scale. The reason for this is that many of the subjects were psychotic and decision-making was very difficult as well as being potentially anxiety producing for them.

In a follow-up study, Belcher⁷⁷ tested 117 graduate students with the Loneliness Scale (LS) developed by Bradley, and retested again in 14 days. This yielded a rho of 0.89 ($p < .001$). In additional exploratory work, Belcher used the Pearson r to correlate the LS scores of 16 students who were again tested and retested after eight weeks. He obtained a correlation coefficient of 0.83 ($p < .001$).

Belcher then took Bradley's Loneliness Scale (LS) of 38 statements and added to it a Self-Rating Scale (SRS) and four incomplete sentences. The SRS and four incomplete sentences were drawn from Bradley's original Loneliness Scale containing 134 statements.

Belcher validated the BELS on four groups of undergraduate students from the Illinois Institute of Technology. Group 1 ($N=371$) and group 2 ($N=31$) were recruited from lower division psychology and sociology classes and given the BELS. Neither group contained subjects who had or were

⁷⁷Jay Belcher, "The Measurement of Loneliness: A Validation Study of the Belcher Extended Loneliness Scale (BELS)" (Ph.D. dissertation, Illinois Institute of Technology, 1973), p. 163-215.

currently receiving services from the university counselling center. Group 2 was voluntarily retested eleven weeks later. Group 3 (N=22) and group 4 (N=18) were subjects who had requested therapy at the university counselling center. They were tested with the BELS and then assigned a therapist for individual therapy. Group 4 subjects voluntarily terminated their therapy before eight weeks had elapsed. Group 3 subjects were still in therapy after eight weeks had elapsed and were voluntarily retested by their therapist between nine and eleven weeks.

A factor analysis was performed on group 1 data, and eight factors were subsequently obtained, Pathological Loneliness, Alienation, Loneliness Anxiety, Existential Loneliness, Estrangement, Anomie, Loneliness Depression and Separateness.

Using the factors and a total score for the BELS scale, the four groups were compared on the basis of their first administration (pre) scores. No significant differences were found between group 1 and group 2. Group 3 had consistently significantly ($p < .05$) higher pre scores than group 1 and group 2. Group 4 was consistently higher than group 1 and 2.

Group 2 and 3 pre scores were compared with those from the retest (post). While no significant differences between pre and post scores were found for group 2, a trend toward group 3 post scores resulted in significantly ($p < .05$) lower post scores. Pre and post scores for each group were correlated, and it was found that all the resulting correlation coefficients were positive and highly significant ($p < .001$).

The findings indicated that loneliness can be used to differentiate

between non-therapy and self-selected therapy subjects. The decrease in loneliness scores after nine weeks of therapy supports the widespread assumption that individual therapy reduces loneliness. This scale was not applicable to this current study since the scale indicated the type of loneliness which an individual may be suffering from. In this study the investigator was concerned about the causes of loneliness rather than the types of loneliness which may affect an individual.

Francis⁷⁸ developed a reliable graphic rating scale, "Schedules for the Measurement of Loneliness and Cathectic Investment" to identify secondary loneliness among a group at potential risk from loneliness. She studied persons separated from loved ones and objects. The scale was tested on non-intensive care, hospitalized, adult medical patients in two general, short-term urban medical center hospitals. Data were collected on 133 patients in each hospital through focussed interviews by Francis and a graduate student. A test-retest reliability coefficient for the cathectic investment items was $r = 1.000$. The coefficient for the loneliness items was $r = .980$. Francis⁷⁹ states that these extremely high coefficients are possibly functions of a number of things other than the possibility that the scale is reliable. Only 15 percent of the beds were still occupied by the same patients at retest time. Also, the personal nature of the items tend to lend themselves to the same responses independent of the individual being

⁷⁸Francis, p. 156-160.

⁷⁹Ibid., p. 6.

separated by hospitalization. Since the clientele in this current study were not hospitalized and Francis' scale was developed for hospitalized patients, neither was it applicable.

Vello Sermat⁸⁰ and Nancy Schmidt developed the Schmidt-Sermat Loneliness Scale, which was used for the purpose of this study by the investigator. Past research has shown that it correlated $+0.70$ and $+0.73$ with Sisenwein's Loneliness Questionnaire. (Appendix M) The scale started with 320 items, half worded positively on loneliness, half worded negatively on loneliness.

The original scale was taken by individuals at the Ontario Science Centre in Toronto, a public science museum. The questionnaire was completed by 275 subjects of approximately equal numbers of males and females aged 25 and over. The items which correlated more highly with the following four concepts: depression, anxiety, self-esteem, and social desirability; than with the total loneliness score of the preliminary scale were eliminated.⁸¹ The best 60 items obtained formed the "Schmidt-Sermat-Loneliness Scale."

The loneliness scale classified types of interaction into five factors:

I. Presence vs. Absence of the Relationship. This first, general category includes items intended to assess whether or not a particular relationship need is being fulfilled at all. It includes items

⁸⁰Vello Sermat, Professor, to Patricia Petryshen, York University, Faculty of Arts, Department of Psychology, Downsview, Ontario, personal letter, November 14, 1976.

⁸¹Ibid., the four concepts correlated highly with the Jackson Scales.

pertaining to a total lack of a particular relationship and items concerning an absence of relationship due to situational factors.

II. Approach vs. Avoidance of the Relationship. This category is composed of items pertaining to the types of approach or avoidance behaviours in which the individual engages with reference to a particular relationship. The category is conceptualized as including items lying along a continuum from initiating behaviours, through passive behaviours, to avoidance behaviours. Included in this category are items regarding the individual's perceptions of the approach or avoidance behaviours towards himself or significant others in the relationship.

III. Co-operation vs. Antagonism in the Relationship. This category covers items describing the provision of helping behaviours to others and the requesting of helping behaviours from others; items involving the individual in working together with others towards the achievement of common goals; items reflecting the individual's perceived support from others; and finally, items involving feelings of rapport in the relationship.

IV. Evaluation in the Relationship. This category includes items concerning the individual's evaluation of himself in the relationship, the individual's evaluation of others involved in the relationship, and the individual's perception of others' evaluation of himself in the relationship.

V. Communication in the Relationship. This category is composed of items dealing with the individual's perceived understanding of others, his

perceptions of others' understanding of himself, and his perceived ability to express his own feelings and thoughts towards others in the relationship.

The types of relationships were included under four major classifications:

- A. Romantic-Sexual
- B. Friends, non-sexual, non-romantic
- C. Family
- D. Larger groups, community

These classifications contained statements which correlated both positively and negatively with loneliness. The scale assessed the four basic life situations mentioned which are representative of individuals suffering from loneliness. It contained short, explicit, statements which required only a true or false response. Therefore, the Schmidt-Sermat Loneliness Scale was appropriate to administer to the clientele at the clinic who participated in this study. The tool was developed for the general population and correlated favourably with the Sisenwein scale. Its items deal with real life situations which determine loneliness rather than with subjective emotional responses which determine feelings which may be unrelated to the real life situation. The Schmidt-Sermat Loneliness Scale was well developed and adequately tested for reliability and validity, therefore, it was appropriate for utilization in this study.

Summary

It is important for therapists to acknowledge a client's loneliness by identifying loneliness behaviour(s) and utilizing specific loneliness interventions with clients testing high in loneliness. As a result

psychotherapy deals directly with the client's loneliness rather than with the defenses that the client has formed against the pain of loneliness.⁸² A therapist's recognition and understanding of how loneliness has evolved for the client facilitates the establishment of a more effective therapeutic relationship. The care of the lonely client requires the therapist to understand the generic development of the loneliness for that individual and the various ways loneliness manifests itself during psychotherapy.⁸³ The inherent need for loneliness to be dealt with directly in psychotherapy with a lonely client is the essence of this study.

The purpose of this chapter was to provide a basis for treatment of the lonely client. Research studies on loneliness have been few although the conceptualization of loneliness has been explicit in its many forms. The variety of loneliness scales presented indicates the broadness of the term loneliness and the need to direct loneliness into a specific frame of reference. Loneliness can become a coherent, well-deserved phenomena in the field of mental health if it is acknowledged and worked with in a practical way. This study is an attempt to clarify the concept, apply the existent theory, and formulate conclusions through scientific investigation of the process of loneliness psychotherapy.

⁸²Peplau, p. 1477.

⁸³Ibid., p. 1480.

Chapter 3

THE STUDY

This study on loneliness employed a quasi-experimental design. A control and experimental group of mental health clients were both engaged in six psychotherapy sessions. Psychotherapy in the control group was conducted according to the therapist's usual individual style. In the experimental group, psychotherapy was conducted by implementing a conceptual model for loneliness intervention. Comparisons between the control and experimental groups were then made by evaluating loneliness reduction in clients before and after psychotherapy. The progress of clients in psychotherapy as perceived by therapists, and the satisfaction for therapists in conducting loneliness psychotherapy were also rated. Previous to undertaking this study, the investigator developed a conceptual model for loneliness intervention which identified loneliness behaviours and possible loneliness interventions specific to each behaviour.

The Problem

Will therapists utilizing a conceptual model for loneliness intervention with clients who test high in loneliness, attain a greater reduction of loneliness in clients than without the use of the model?

Hypotheses

H I: If a therapist utilizes a conceptual model for loneliness intervention, psychotherapy will be more effective in reducing loneliness in clients.

Dependent Variable: loneliness behaviours

Independent Variable: loneliness intervention

H II: If a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapy sessions will be more satisfying for the therapist.

Dependent Variable: therapist satisfaction

Independent Variable: loneliness intervention

H III: If a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapist will perceive more client progress in therapy sessions.

Dependent Variable: perceived client progress in terms of resolution of loneliness behaviours

Independent Variable: loneliness intervention

Sample Selection

Therapists and clients who participated in the study were selected from a Community Mental Health Care Team which functions under the auspices of

the Greater Vancouver Mental Health Service. The team was approached by their Research Coordinator for their consent to participate in a research study on loneliness. Four therapists volunteered to form the research team for the study, two males and two females. The therapists represented various professional backgrounds, Masters of Sociology, Bachelor of Social Work with a Certificate in Public Health, Masters of Science in Nursing, and a Registered Nurse. Each therapist had been employed by the team for over two years, therefore, they had an extensive caseload of clients. This presented difficulties in attaining the client sample since therapists were not conducting psychotherapy with their clients on the regular weekly basis as described in the research design.

The clients involved in the study were approached by their therapists to participate in a research project on interpersonal relationships. The therapists then proceeded to have their clients sign the "Consent Form" for participation in a "Survey on Interpersonal Relationships," otherwise known as the "Schmidt-Sermat Loneliness Scale." During the first four weeks, each therapist identified a maximum of four clients and a minimum of two clients who tested high in loneliness. These clients were then involved in Part I of the study. This process for selecting clients was repeated for Part II of the study.

The clientele of this Community Mental Health Care Team was mostly schizophrenic, although there were also some depressed clients. The client sample was difficult to attain for various reasons, such as, some schizophrenic patients became psychotic and were then hospitalized. Many of the clients were paranoid and therefore would not complete the survey. Clients suffering from hallucinations and possibly delusions were unable to

concentrate on answering questions since their attention span and concentration ability was extremely poor. Therapists stated that some clients were following an established treatment plan and because of this they were unwilling to disrupt this consistency as it may have proved detrimental for the client. For the purpose of this study, clients had to be seen on a regular weekly basis. Client ability to read and concentrate on the scale was necessary. Extremely psychotic individuals were not involved in the study since their contact with the reality of their life was difficult for them to express in the form of a written questionnaire even though only "true" and "false" answers were required. At times even this discrimination was too difficult for them. Due to the above reasons, it was difficult for therapists to attain their four clients for Part I and four clients for Part II of the study.

The Setting

The Greater Vancouver Mental Health Service is composed of eleven Community Mental Health Care Teams. The teams are located within the catchment area that it serves. One team was selected for the purpose of this study. Clients who received mental health care from the team were a selected sample because they lived within the boundaries of the area that the team served. This area involved several distinct city districts with the major representative groups ranging from upper socio-economic families and elderly people to lower socio-economic groups and young people who were residing in boarding homes.

The team was situated in an apartment-type building which contained numerous interviewing rooms. Clients came to the team for one-to-one

psychotherapy or for family therapy. At times, therapists made home visits for such reasons as the inability of a client to travel to the centre for a therapy session or in a time of crisis.

Methodology

This study on loneliness involved four therapists and their selected clients who were identified as testing high in loneliness. One group of clients participated in Part I of the study. A new group of clients participated in Part II of the study. An inservice education on loneliness was provided for the therapists prior to Part II of the study.

Part I: (Control Group). A standardized loneliness scale was given to clients by their therapists. Those clients who tested high in loneliness were identified. Therapists then engaged in psychotherapy with their identified clients for six sessions of approximately one hour in length and a week or less apart. After each therapy session, therapists charted on two questions: "What was discussed?" and "What suggestions were made in relation to what was discussed?" The investigator monitored the control group and progress in therapy because no loneliness consultation was provided in Part I of the study. At the end of the six therapy sessions, clients were re-tested for loneliness. Therapists evaluated client progress during therapy and their own satisfaction with therapy sessions.

Inservice Education on Loneliness: Prior to the therapists conducting Part II of the study, an inservice education on loneliness was provided for the therapists. The inservice explained the concepts of loneliness and

loneliness anxiety. A conceptual model for loneliness intervention which identified loneliness behaviours and possible loneliness interventions was introduced to the therapists.

Part II: (Comparison Group) A standardized loneliness scale was given to clients by their therapists. Those clients who tested high in loneliness were identified. Therapists then engaged in psychotherapy with their clients for six sessions of approximately one hour in length and a week or less apart. During psychotherapy, therapists implemented a conceptual model for loneliness intervention by identifying the loneliness behaviours of each client and utilizing the specific loneliness interventions stated in the conceptual model. Weekly loneliness consultation was provided by the investigator to facilitate the use and understanding of the model and to support the internalization and operationalization of loneliness interventions by therapists in psychotherapy. After each therapy session, therapists charted on two questions: "What was discussed?" and "What suggestions were made in relation to what was discussed?" The investigator monitored the comparison group and progress in therapy by means of consultation. At the end of six therapy sessions, clients were re-tested for loneliness. Therapists evaluated client progress during therapy and their own satisfaction with therapy sessions.

A structured end-interview was conducted with each therapist for approximately an hour in length. Open-ended questions on the implementation of a conceptual model for loneliness intervention were asked. Since the therapists had the opportunity to internalize and operationalize the

identification of loneliness behaviours and implementing of specific loneliness intervention, their responses to this experience was of importance. Questions were directed towards the use, difficulty, advantages, disadvantages, and reactions to implementing a conceptual model for loneliness intervention.

Data Gathering Instruments

Schmidt-Sermat Loneliness Scale

The standardized loneliness scale utilized to test loneliness in clients was the "Schmidt-Sermat Loneliness Scale." The original scale contained sixty items which was lengthy for the initial identification of clients testing high in loneliness, therefore, the scale was reduced to a short form which contained sixteen statements. The short form of the scale was pilot tested for validity and reliability. A class of 120 third year nursing students were randomly assigned into group A taking the long form of the scale and group B taking the short form of the scale. Both groups were re-tested in two weeks. The agreement between the long and short form of the scales correlated at 0.9, significant at a p level of .01. The reliability on the test re-test was 0.8, significant at a p level of .01.

Clients were identified as testing high in loneliness with the short form of the scale, which was 16 statements from the "Schmidt-Sermat Loneliness Scale." The remaining 44 statements of the scale were then given to the client during the next therapy session to accommodate the operational definition of loneliness. A score of "60" indicated the highest level of loneliness, "0" indicated the lowest level of loneliness.

For the purpose of this study, a score of "20" or above indicated an individual testing high in loneliness. Clients meeting this requirement were involved in the study.

Progress Rating by Therapists

The progress in psychotherapy with a client identified as testing high in loneliness was rated by therapists on a Likert type scale. The rating scale was from "1" to "6" where "1" indicated the least amount of progress and "6" indicated the most amount of progress.

Satisfaction Rating by Therapists

The satisfaction in attempting loneliness intervention with a client testing high in loneliness was rated by therapists on a Likert type scale. The rating scale was from "1" to "5" where "1" indicated very low satisfaction and "5" indicated very high satisfaction.

Analysis of Hypotheses

H I: The reduction of loneliness after psychotherapy utilizing a conceptual model for loneliness intervention was challenged by a one-tailed t-test at the .05 level of significance, on the mean pre-test post-test loneliness reduction in both the control and comparison groups.

H II: Comparison of the means from therapist satisfaction from Part I psychotherapy sessions and satisfaction from Part II psychotherapy sessions, in which the conceptual model for loneliness intervention was implemented,

was challenged by a paired t-test at the .05 level of significance.

H III: Comparison of the means from therapist perception of progress from the Part I psychotherapy sessions and progress from Part II psychotherapy sessions, in which the conceptual model for loneliness intervention was implemented, was challenged by a paired t-test at the .05 level of significance.

Summary

Upon completion of therapist implementation of the conceptual model for loneliness intervention, analysis of Hypotheses I, II, and III was undertaken. The reduction of loneliness for clients who were involved in the loneliness psychotherapy was investigated. Therapist satisfaction in undertaking loneliness psychotherapy was investigated. Therapist perception of client progress when utilizing the model was also investigated. The results of the study will be reported in Chapter 4.

Chapter 4

ANALYSIS OF DATA

The purpose of the study focussed on the identification of loneliness behaviours and suggested loneliness interventions with the development of a conceptual model for loneliness intervention in psychotherapy. A four-fold purpose for the study was stated previously in Chapter 1.

The purpose of the study was first, to stimulate an awareness in therapists of the concept of loneliness, of their own personal loneliness, and the loneliness encountered by their clients.

The second purpose was to recognize the importance of conceptualizing loneliness as a basis for loneliness psychotherapy.

The third purpose was to promote effective psychotherapy by acknowledging loneliness as the basis of an individual's illness or difficulty rather than symptoms or diagnosis.

The final purpose was to use the concept of loneliness as a basis for communication with individuals since loneliness is common to everyone. As a therapeutic medium, loneliness warranted investigation in the mental health setting and in society.

The problem, will therapists utilizing a conceptual model for loneliness intervention with clients who test high in loneliness attain greater reduction of loneliness than without the use of this model was investigated. A quasi-experimental design was utilized to determine the

effect of implementing a conceptual model for loneliness intervention during psychotherapy. Therapist perception of client progress and therapist satisfaction when implementing a conceptual model for loneliness intervention was explored.

Analysis in Relation to the Population Sample

Four therapists, two females and two males, engaged in psychotherapy with clients identified as testing high in loneliness. Thirteen mental health clients, nine females and four males, participated in the control group, Part I of the study. Eleven clients, seven females and four males, participated in the comparison group, Part II of the study. (Refer to Table 1).

The control and comparison groups were similar when compared. Many of the clients were under 45 years of age and single. The place of birth for most of the clients was Canada, those who had not been born in Canada had resided in Vancouver for at least two years. Clients varied from religious to non-religious in both groups. The educational preparation also varied from those who held university degrees to those who did not complete grade school. Both groups were similar in this respect. Most of the clients were unemployed, usually for lengthy periods of time. Half of the clients for both groups were involved in some form of a hobby. The living situation was interesting in that clients who lived with another person did so because they were given a placement in a psychiatric boarding home by a mental health worker. The other clients lived alone, usually in apartments. Family contact was infrequent, otherwise there was no contact at all. This situation was similar with the significant others

Comparison of Demographic Data for Control and Comparison Groups

DEMOGRAPHIC DATA		CONTROL GROUP N=13	COMPARISON GROUP N=11
SEX	Female Male	9 4	7 4
AGE	17 - 24 25 - 34 35 - 44 45 - 54 55 - 64 65 and above	3 5 2 1 1 1	2 6 1 1 1 0
MARITAL STATUS	Single Married Widowed Divorced	10 0 2 1	8 1 0 2
PLACE OF BIRTH	Canada Outside Canada	8 5	10 1
RESIDENCY IN VANCOUVER	More than two years Less than two years	11 2	11 0
RELIGION	Very religious Religious No Religion	1 8 4	0 5 6
EDUCATION	University Highschool Grade school	5 3 5	4 2 5
EMPLOYMENT	Employed Unemployed Retired	1 10 2	1 10 0

Table 1

Comparison of Demographic Data for Control and Comparison Groups
(Continued)

DEMOGRAPHIC DATA		CONTROL GROUP N=13	COMPARISON GROUP N=11
HOBBIES	At least one None	7 6	6 5
LIVING SITUATION	Lives with at least one other Lives alone	4 (3 live in a psychiatric boarding home) 9	6 (4 live in a psychiatric boarding home) 5
FAMILY CONTACT	Frequent contact Infrequent contact No contact	1 7 5	1 5 5
SIGNIFICANT OTHERS	Stable friendships Unstable friendships No friendships	2 3 8	3 2 6
REFERRAL SOURCE FOR CLIENT TO BE SEEN BY THE COMMUNITY TEAM	Hospital Mental health worker Self Relative	8 2 2 1	8 1 2 1
DIAGNOSIS	Schizophrenic Depressed Neurotic	10 3 0	8 2 1
PREVIOUS PSYCHIATRIC HISTORY	Many hospitalizations One hospitalization No hospitalization	4 5 4	6 3 2

Table 1 (continued)

for the clients. Usually the clients were referred to the Community Mental Health Care Team by a hospital, although there were two self-referrals for both the control and comparison groups. The diagnosis of the clients was concomitant with the client mandate for the team, which was mainly schizophrenic clients with a few depressed and one neurotic also participating in the study. The previous psychiatric history of the clients ranged from many hospitalizations to no hospitalization. This means that some of the clients had been involved in a variety of psychiatric treatment, such as, electroconvulsive therapy, group therapy, whereas other clients had not experienced psychotherapy previously.

Analysis of Data in Relation to Hypothesis I

H I: If a therapist utilizes a conceptual model for loneliness intervention, psychotherapy will be more effective in reducing loneliness in clients.

Analysis: The reduction of loneliness after psychotherapy utilizing a conceptual model for loneliness intervention was challenged by a one-tailed t-test at the .05 level of significance, on the mean pre-test post-test loneliness reduction in both the control and comparison groups.

Results: Pre-test and post-test client loneliness scores for the control and comparison groups (Refer to Table 2) indicates that clients increased or decreased in loneliness. (Refer to Table 3) A positive reduction score indicates that the client has decreased in loneliness. A negative reduction score indicates that the client increased in loneliness.

Client Loneliness Scores
Pre-test and Post-test Scores for Control and Comparison Groups

CONTROL GROUP N=13		COMPARISON GROUP N=11	
PRE-TEST	POST-TEST	PRE-TEST	POST-TEST
24	22	39	26
37	45	45	46
28	26	40	25
32	34	25	8
30	25	23	25
31	32	24	11
30	28	30	21
38	44	45	39
32	33	40	31
20	14	32	22
22	27	35	30
21	26		
26	23		

Table 2

The Reduction in Client Loneliness Scores from the
Pre-test and Post-test Scores for Control and Comparison Groups

CONTROL GROUP N=13	COMPARISON GROUP N=11
+2	+13
-8	-1
+2	+15
-2	+17
+5	-2
-1	+13
+2	+9
-6	+6
-1	+9
+6	+10
-5	+5
-5	
+3	

A positive reduction score indicates that the client has decreased in loneliness.

A negative reduction score indicates that the client has increased in loneliness.

Table 3

Analysis of the loneliness scores, by the Equal Variance Formula, resulted in a t-value of -3.619, significant at a p level of 0.0014, with 23 degrees of freedom. This t-value indicates that Hypothesis I was upheld and was strongly significant. Therapists utilizing a conceptual model for loneliness psychotherapy was more effective in reducing loneliness.

Reporting from the Progress Notes Charted by Therapists

In Part I and Part II of the study, therapists completed progress notes after each therapy session. The two questions which guided the charting were, "What was discussed?" and "What suggestions were made in relation to what was discussed?" The investigator monitored the charting for the identification of loneliness behaviours and implementation of loneliness interventions by therapists. (Refer to Table 4) For the control group psychotherapy sessions one and two, there was no evidence of loneliness behaviour identification. For two clients during psychotherapy sessions three to six, one loneliness behaviour was identified and a loneliness intervention was implemented. For the clients in the comparison group, two loneliness behaviours were identified and two loneliness interventions were implemented throughout the six psychotherapy sessions. The comparison group was consistent in implementing the conceptual model for loneliness intervention, by identifying suggested loneliness behaviours and implementing specific loneliness interventions.

Frequency of Charting by Therapists on
Loneliness Behaviours and Loneliness Interventions
for Control and Comparison Groups

(1) FREQUENCY (f) OF LONELINESS BEHAVIOURS (L.B.) PER CLIENT.	PSYCHOTHERAPY SESSION					
	1	2	3	4	5	6
(2) FREQUENCY (f) OF LONELINESS INTERVENTIONS (L.I.) PER CLIENT.						
(1) CONTROL GROUP: f OF L.B./CLIENT TOTAL N=13 CLIENTS	0/13 (13)	0/13 (13)	0/11 2/2 (13)	0/11 2/2 (13)	0/11 2/2 (13)	0/11 2/2 (13)
(2) CONTROL GROUP: f OF L.I./CLIENT TOTAL N=13 CLIENTS	0/13 (13)	0/13 (13)	0/11 2/2 (13)	0/11 2/2 (13)	0/11 2/2 (13)	0/11 2/2 (13)
(1) COMPARISON GROUP: f OF L.B./CLIENT TOTAL N=11 CLIENTS	22/11 (11)	22/11 (11)	22/11 (11)	22/11 (11)	22/11 (11)	22/11 (11)
(2) COMPARISON GROUP: f OF L.I./CLIENT TOTAL N=11 CLIENTS	22/11 (11)	22/11 (11)	22/11 (11)	22/11 (11)	22/11 (11)	22/11 (11)

Table 4

Analysis of Data in Relation to Hypothesis II

H II: If a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapy sessions will be more satisfying for the therapist.

Analysis: Comparison of the means of therapist satisfaction from the Part I psychotherapy sessions and satisfaction from Part II psychotherapy sessions, in which the conceptual model for loneliness intervention was implemented, was challenged by a paired t-test at the .05 level of significance.

Results: The comparison of the means of therapist satisfaction from the Part I psychotherapy sessions and satisfaction from Part II psychotherapy sessions, in which the conceptual model for loneliness intervention was implemented (Refer to Table 5) indicates an increase of therapist satisfaction. (Refer to Table 6) Analysis of the means from the satisfaction rating scores, by the Paired Comparisons t-Test, resulted in a t-value of -4.84 significant at a p level of 0.0171 with 3 degrees of freedom. This t-value indicates that Hypothesis II was upheld and was strongly significant. Therapists who utilized loneliness intervention, with clients who test high in loneliness, found the therapy sessions more satisfying.

Analysis of Data in Relation to Hypothesis III

H III: If a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapist will perceive more client progress

Therapist Satisfaction Rating Scores in Attempting Loneliness
Intervention for Control and Comparison Groups

	THERAPIST NUMBER	THERAPIST SATISFACTION RATING IN ATTEMPTING LONELINESS INTERVENTION/CLIENT				
		1 VERY LOW	2 LOW	3 AVERAGE	4 HIGH	5 VERY HIGH
CONTROL GROUP N=13	1	1/1	2/1	3/1		
	2	1/1	2/2		4/1	
	3	1/2	2/1		4/1	
	4	1/1	2/1			
COMPARISON GROUP N=11	1			3/1		5/1
	2			3/1	4/2	5/1
	3	1/1				5/1
	4			3/1	4/2	

The same therapists participated in the control and comparison groups. New clients were identified for the comparison group.

Table 5

Average Therapist Satisfaction Rating Score in Attempting Loneliness
Intervention for Control and Comparison Groups

	THERAPIST NUMBER	THERAPIST SATISFACTION RATING IN ATTEMPTING LONELINESS INTERVENTION		
		SATISFACTION RATING SCORES TOTAL	NUMBER OF CLIENTS RATED	SATISFACTION RATING AVERAGE
CONTROL GROUP N=13	1	6	3	2
	2	9	3	3
	3	9	3	3
	4	3	2	1.5
COMPARISON GROUP N=11	1	8	2	4
	2	16	4	4
	3	8	2	4
	4	11	3	3.7

The same therapists participated in the control and comparison groups. New clients were identified for the comparison group.

Table 6

in therapy sessions.

Analysis: Comparison of the means for therapist perception of progress from the Part I psychotherapy sessions and progress from Part II psychotherapy sessions, in which the conceptual model for loneliness intervention was implemented, was challenged by a paired t-test at the .05 level of significance.

Results: The comparison of the means for therapist perception of progress from the Part I psychotherapy sessions and progress from Part II psychotherapy sessions, in which the conceptual model for loneliness intervention was implemented (Refer to Table 7) indicates an increase in therapist perception of progress, (Refer to Table 8) by the Paired Comparisons t-Test, resulted in a t-value of -6.53, significant at a p level of 0.007, with 3 degrees of freedom. This T-value indicates that Hypothesis III was upheld and was strongly significant. Therapist perception of progress increased when the conceptual model for loneliness intervention was implemented.

Reporting on the Structured End-Interview

Upon completion of the study, the four therapists responded to six open-ended structured questions on the implementation of the conceptual model for loneliness intervention. Therapist reactions, the advantages, disadvantages, usefulness, and the implementation of the model during psychotherapy was challenged by therapists in the end-interview.

Question 1: What is your reaction to implementing the conceptual model for loneliness intervention?

Therapist Progress Rating Scores in Attempting Loneliness
Intervention for Control and Comparison Groups

	THERAPIST NUMBER	THERAPIST PROGRESS RATING IN ATTEMPTING LONELINESS INTERVENTION/CLIENT					
		1 LEAST AMOUNT	2 MUCH LESS	3 LESS	4 MORE	5 MUCH MORE	6 MOST AMOUNT
CONTROL GROUP N=13	1		2/1	3/1	4/1		
	2		2/2		4/1	5/1	
	3		2/1	3/3			
	4			3/1		5/1	
COMPARISON GROUP N=11	1	1/1				5/1	6/1
	2				4/1	5/2	
	3				4/1	5/2	
	4				4/1		6/1

The same therapists participated in the control and comparison groups. New clients were identified for the comparison group.

Table 7

Average Therapist Progress Rating Scores in Attempting Loneliness
Intervention for Control and Comparison Groups

	THERAPIST NUMBER	THERAPIST PROGRESS RATING SCORES IN ATTEMPTING LONELINESS INTERVENTION		
		PROGRESS RATING SCORES TOTAL	NUMBER OF CLIENTS RATED	PROGRESS RATING AVERAGE
CONTROL GROUP N=13	1	6	3	2
	2	13	4	3.3
	3	11	4	2.7
	4	8	2	4
COMPARISON GROUP N=11	1	12	3	4
	2	14	3	4.7
	3	14	3	4.7
	4	10	2	5

The same therapists participated in the control and comparison groups. New clients were identified for the comparison group.

Table 8

Responses:

Therapist 1: "I have mixed feelings about implementing the conceptual model for loneliness intervention."

Therapist 2: "The conceptual model for loneliness intervention was an interesting approach. The loneliness behaviours and interventions have helped me to be more aware and to look for loneliness behaviours in my other clients. It has been a learning experience for me."

Therapist 3: "I found the conceptual model for loneliness intervention helpful when I was doing psychotherapy."

Therapist 4: "My reaction to implementing the conceptual model was that it was a variation of what I have been doing. The model reintegrates people on a hierarchy basis where you first establish their level of functioning. Then realistic goals, in terms of social reintegration, are set with the client. To be able to meet these goals, therapists must try to identify the kinds of behaviours you indicated in your conceptual model for loneliness intervention. The loneliness intervention in the model is not very different from the way that I work as a therapist, although I do conceptualize loneliness differently than you do in your model."

Question 2: What do you view the advantages to implementing the conceptual model for loneliness intervention?

Responses:

Therapist 1: "I think that the model is great for all of us, and especially for psychotherapy with moderately ill people, neurotics, mild depressives, and people who have a potentiality for depression. Often, it is up to the client to decide whether they want to carry out the plan of their therapy, and that decision is based upon good insight, good judgement, and a certain level of intellect, which I feel is required by your model."

Therapist 2: "The model provided me with a designated means to try and use specific approaches for loneliness intervention. I am used to implementing the therapeutic approaches that come out of my head. I had to try and use your set model, and that was kind of an interesting way to do it. It also was kind of a lazy way in that I knew what I was supposed to do, as far as the research was concerned. Another major advantage was that the loneliness behaviours were specific and therefore it was easy to measure whether the intervention was appropriate for the behaviour change to occur."

Therapist 3: "I think that the advantage to implementing your model was that it was helpful to clients in that it was concrete. I could assess my therapy session by referring back to the established loneliness behaviours and interventions. As a result, I could measure what I set out to do with a client."

Therapist 4: "In focussing on loneliness, one is in essence focussing on inadequacies in socialization. Building hierarchies, whereby you can help the client to educate themselves and one can educate the client in more functional methods of interacting, is the advantage to your model. In terms of social psychiatry, that is the only real workable aspect. In dealing with severe mental disorders, one must couple the one successful treatment modality, which is chemotherapy, with something that one can work on, and one thing that can be always worked on is socialization skills. Loneliness in my opinion is focussing on the inadequacy of these socialization skills."

Question 3: What do you view the disadvantages to implementing the conceptual model for loneliness intervention?

Responses:

Therapist 1: "I think that the disadvantage to the model was that some clients did not like the behavioural approach during psychotherapy. It therefore was important as to how I introduced the loneliness interventions during psychotherapy."

Therapist 2: "I think that the disadvantage of the model was that it was difficult for me to identify what loneliness behaviours were appropriate to each client. It therefore became difficult for me to designate which of the loneliness behaviours I was really working on. I am still not convinced that identification of a loneliness behaviour and then implementing loneliness intervention is going to work for everyone."

Therapist 3: "I did not view any disadvantages to implementing the conceptual model. I needed more direction when conducting loneliness intervention with a psychotic client than with one that was neurotic."

Therapist 4: "Loneliness can be a symptom of a mental or emotional disorder which is driving the person into isolation rather than it being the cause of the mental disorder. The cause of the disorder may be loneliness, but it may not be. If you believe that loneliness is causing specific behaviour, you may deal with it by your loneliness intervention rather than with other modalities of treatment. This may be a disadvantage although you have devised a behavioural and psychotherapeutic model, which looks at behaviours irrespective of the etiology of the mental disorder. Your model treats those behaviours as discreet entities in a problem-solving approach, which I do firmly agree with."

Question 4: Do you find the conceptual model for loneliness intervention useful?

Responses:

Therapist 1: "I found the model useful when working with neurotic and depressed clients."

Therapist 2: "The model was useful. It identified loneliness behaviours and provided a plan for intervention when dealing with those behaviours."

Therapist 3: "It was a useful model because it was concrete and helpful to clients. Also, it allowed me to assess what I set out to do with my clients."

Therapist 4: "I found the loneliness interventions useful. Choosing phenomenal events in the everyday life of the client and isolating these events, finding out which are least threatening to the client, and then being able to gauge the interventions, was very useful."

Question 5: Do you find the conceptual model for loneliness intervention difficult to implement?

Responses:

Therapist 1: "I did not think that it was a difficult model to implement, provided that as it was introduced in therapy, proper assessment of the client's needs was made. Also, it was necessary to keep the model in proper perspective."

Therapist 2: "The model was not difficult to implement, except for identifying the loneliness behaviours."

Therapist 3: "I did not find it difficult to implement the model. I found it difficult to conceptualize what I was doing and then fitting it within the framework of the model."

Therapist 4: "I did not find the model difficult to implement because I looked at it from a behavioural perspective."

Question 6: What suggestions would you make for loneliness intervention?

Responses:

- Therapist 1: "I think that within this setting where our team's mandate was severely mentally ill clients, it was difficult to use your conceptual model, but, I think if we were to implement this model for a while longer, it would be useful. I think that your model could be used to teach loneliness coping skills to severely ill people. Loneliness is such an abstract concept."
- Therapist 2: "I would suggest that the model be used in a more controlled setting, in fact, I think that it would be fantastic for a Token Therapy hospital ward in a therapeutic milieu. In the community, it is hard to observe clients carrying out their plans, whereas on a ward you could."
- Therapist 3: "I would like to see your model more disease oriented. I do think that the model works especially well with schizophrenics. As for a neurotic, I think that the loneliness interventions would need to be a little different, although I guess it depends on how you use the intervention."
- Therapist 4: "Over and above the loneliness interventions stated in the model, I think that everyday community mental health programs, such as encouraging a person into the system of a drop-in center, out-patient units of hospitals, are important loneliness interventions. In a supportive fashion, you encourage the person through therapy that you have suggested into a program where socialization will be more intense."

Summary

Psychotherapy in which therapists implemented a conceptual model for loneliness intervention resulted in a greater reduction in loneliness for these clients. Therapists found psychotherapy sessions more satisfying and perceived more client progress from therapy when loneliness behaviours were identified and specific loneliness interventions were implemented.

Chapter 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

In the field of mental health, loneliness has been one of the least conceptualized psychological phenomena. There existed a need to acknowledge loneliness as a basis for behaviours which disrupt the integrity of an individual. This loneliness warranted specific treatment in psychotherapy. The implementation of a conceptual model for loneliness intervention facilitated psychotherapy with lonely clients because loneliness behaviours were identified and specific interventions were suggested.

Loneliness is a feeling common to all individuals in every life situation possible through various cultures. Many types of individuals in society experience loneliness specific to them, such as the university student who leaves home for the first time. Each individual's experience of loneliness is unique to him or her. A therapist's recognition and understanding of how loneliness evolves for a client, facilitates the establishment of a therapeutic relationship. The care of the lonely client requires the therapist to understand the generic development of the loneliness for that individual and the various ways loneliness manifests itself during the psychotherapeutic relationship.

Loneliness in this study was defined as not feeling humanly involved with others as indicated by the desire to observe life rather than

participate in it, to lack relatedness to others, and to lack personal meaning in relationships with others.⁸⁴ Individuals may have suffered from various types of loneliness, such as general loneliness, nostalgic loneliness, primary and secondary loneliness. Loneliness anxiety was defined as a common condition indicated by the individual no longer having an intimate sense of relatedness to the food eaten, the clothes worn, nor direct participation in the creation and production of the vital needs of the person's family and community. Loneliness anxiety results from a fundamental break between what one is and what one pretends to be with alienation occurring between the individual and others as well as between the individual and the environment. The feeling of alienation from others eventually results in a type of chronic illness caused by persistent loneliness anxiety.⁸⁵

It was necessary for therapists to deal with a client's loneliness and loneliness anxiety in psychotherapy. Secretiveness and lack of communication about loneliness increased the threat for the lonely person to reveal their loneliness since they believed that others had not experienced similar feelings. It therefore was imperative that therapists identified and acknowledged a client's loneliness in psychotherapy. Therapists assisted clients to attain a higher level of personal unity by having the clients develop insight and ways of

⁸⁴Ford and Zorn, Why Be Lonely? p. 22.

⁸⁵Moustakas, Loneliness, p. 24.

alleviating or coping with the loneliness they were encountering rather than not acknowledging the loneliness and having the clients continue to face loneliness situations in their life without support.

To assist a therapist in dealing with the loneliness within a client, insight into his own personal loneliness was necessary. An Inservice Education on loneliness was therefore provided for the therapists to facilitate their conceptualization and understanding of loneliness. The therapists then proceeded to identify loneliness behaviours and intervene with specific loneliness interventions rather than with the symptoms or diagnosis defining the client's illness. The means to identify loneliness behaviours and specific interventions to be used during psychotherapy were provided by a conceptual model for loneliness intervention. Consultation was necessary as this new approach to loneliness psychotherapy was unfamiliar for the therapists.

Hypothesis I, if a therapist utilizes a conceptual model for loneliness intervention, psychotherapy will be more effective in reducing loneliness in clients, was upheld. Analysis of the means of the loneliness scores by the Equal Variance Formula, resulted in a t-value of -3.619, significant at a p level of 0.0014, with 23 degrees of freedom, was strongly significant. Psychotherapy was more effective in reducing loneliness when the conceptual model for loneliness intervention was implemented.

Hypothesis II, if a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapy sessions will be more satisfying for the therapist, was upheld. Analysis of the means from the

satisfaction rating scores, by the Paired Comparisons t-test, resulted in a t-value of -4.84, significant at a p level of 0.017, with 3 degrees of freedom, was strongly significant. Therapists who utilized loneliness intervention with clients who test high in loneliness found the therapy sessions more satisfying.

Hypothesis III, if a therapist utilizes loneliness intervention with clients who test high in loneliness, the therapist will perceive more client progress in therapy sessions, was upheld. Analysis of the means from the progress rating scores, by the Paired Comparisons t-test, resulted in a t-value of -6.53, significant at a p level of 0.007 with 3 degrees of freedom, was strongly significant. Therapist perception of progress increased when the conceptual model for loneliness intervention was implemented.

Recommendations

The primary recommendation of this study is that loneliness psychotherapy be conducted with mental health clients who are lonely. The loneliness, rather than the disease etiology, should be acknowledged by therapists to promote effective psychotherapy.

The presentation of loneliness as a basis for psychotherapy requires that the concept of loneliness be theoretically and conceptually defined. Since loneliness is one of the least conceptualized psychological concepts, clarity of the concept for therapists is necessary.

Prior to implementing the conceptual model for loneliness intervention, it is recommended that an introduction to the

behavioural-approach in psychotherapy be given. Since the conceptual model for loneliness intervention has a behavioural basis, therapists should have an understanding of the behavioural-approach.

Loneliness consultation is necessary upon introduction of the conceptual model for loneliness intervention as well as when therapists identify loneliness behaviours in clients and implement specific loneliness interventions in psychotherapy. Encouragement and support must be given to therapists when they are implementing the model as loneliness psychotherapy is usually unfamiliar to them. Explanations on the phenomena of loneliness will assist therapists to clarify thinking.

For effective use of the model, therapist validation with the client of the loneliness and loneliness behaviour that the client exhibits is strongly recommended. This facilitates loneliness intervention, as then, both the client and therapist can set up a contract to work on the loneliness together. A client's insight on loneliness will enhance loneliness psychotherapy.

It is recommended that the conceptual model be utilized in the following way. First, the specific loneliness behaviours are identified and then individualized for each client. An understanding as to how the loneliness has evolved for each client must be arrived at by the therapist. Second, loneliness interventions specific to each loneliness behaviour should be identified. These interventions are concrete actions, therefore, once the appropriate loneliness behaviours are identified, intervention can be implemented with much more ease. It is suggested that

therapists receive adequate consultation when identifying behaviours, as this provides the basis and gives direction to the loneliness psychotherapy sessions.

There are various views to the development of loneliness. It is suggested that all perspectives be acceptable, since the result, loneliness, is the same and warrants intervention. It is not of importance whether the person became psychotic and then lonely or whether the person was lonely and then became psychotic. This circular feud which again arises, "What comes first, the chicken or the egg?" has always been evidenced in psychiatry, especially since there are a variety of schools of thought.

Should this study be again undertaken, I would recommend that it be conducted in a hospital setting on a psychiatric ward. In this situation, on-going therapy is conducted on a consistent day-to-day basis. Also, the facilities at the hospital could be readily integrated with the loneliness intervention which would involve therapists to directly observe and participate in the loneliness intervention, in a role-model situation, if appropriate.

The conceptual model for loneliness intervention was based on the behavioural-approach. Many therapists do not conduct psychotherapy utilizing behavioural techniques. It is therefore recommended that the loneliness interventions be expanded to include behavioural actions as well as actions based upon other psychotherapeutic approaches. This would then enhance therapist individualization in implementing loneliness psychotherapy.

It is also recommended that the concept of loneliness be taught to

students in educational settings. Concepts, such as loss of body image, depersonalization, and sensory deprivation are all related to loneliness. This approach by educators could also mean that loneliness would be incorporated in textbooks and would become a better established and more acceptable concept.

Basically, I recommend that there be further exploration of the concept of loneliness in the field of mental health. Individuals have always experienced loneliness, many have suffered from this feeling. It is our inherent goal as health professionals to promote mental health. By setting a sound base for loneliness in psychotherapy, mental health care may be improved. This can be also achieved by therapists, educators, and researchers furthering the knowledge and conceptualization of loneliness to form a strong theoretical base for this concept.

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APPENDICES

APPENDIX A
SCHMIDT-SERMAT LONELINESS SCALE

Code sheet for SURVEY OF INTERPERSONAL RELATIONSHIPS which is a LONELINESS SCALE developed by Nancy Schmidt and Vello Sermat.

TYPES OF INTERACTION

The types of interaction were classified into five factors:

I. Presence vs. Absence of the Relationship: This first, general category includes items intended to assess whether or not a particular relationship need is being fulfilled at all. It includes items pertaining to a total lack of a particular relationship and items concerning an absence of relationship due to situational factors.

II. Approach vs. Avoidance of the Relationship: This category is composed of items pertaining to the types of approach or avoidance behaviours in which the individual engages with reference to a particular relationship. The category is conceptualized as including items lying along a continuum from initiating behaviours, through passive behaviours, to avoidance behaviours. Included in this category are items regarding the individual's perceptions of the approach or avoidance behaviours toward himself or significant others in the relationship.

III. Co-operation vs. Antagonism in the Relationship: This category covers items describing the provision of helping behaviours to others and the requesting of helping behaviours from others; items involving the individual in working together with others toward the achievement of common goals; items reflecting the individual's perceived support from others; and finally, items involving feelings of rapport in the relationship.

IV. Evaluation in the Relationship: This category includes items concerning the individual's evaluation of himself in the relationship, the individual's evaluation of others involved in the relationship, and the individual's perception of others' evaluation of himself in the relationship.

V. Communication in the Relationship: This category is composed of items dealing with the individual's perceived understanding of others, his perceptions of others' understanding of himself, and his perceived ability to express his own feelings and thoughts toward others in the relationship.

Type of Relationship

The types of relationship were:

- A. Romantic-Sexual
- B. Friends, non-sexual, non-romantic
- C. Family
- D. Larger groups, community

Each of the types of relationship formed a:

- (1) positive correlation with loneliness
- (2) negative correlation with loneliness

STATEMENT NUMBER AND FACTOR FOR THE SURVEY OF INTERPERSONAL RELATIONSHIPS
(SCHMIDT-SERMAT LONELINESS SCALE)

TYPE OF RELAT- IONSHIP	CORRE- LATION	STATEMENT NUMBER AND FACTOR											
A	POSITIVE	5 (I)	15 (V)	28 (III)	35 (IV)	41 (V)	58 (III)						
	NEGATIVE	9 (III)	18 (IV)	21 (I)	31 (III)	45 (I)	52 (III)						
B	POSITIVE	3 (II)	13 (II)	16 (I)	19 (III)	26 (V)	30 (I)	33 (III)	43 (V)	46 (III)	51 (I)	53 (II)	55 (IV)
	NEGATIVE	4 (V)	7 (I)	11 (III)	22 (V)	24 (II)	37 (I)	39 (III)	48 (I)	60 (III)			
C	POSITIVE	6 (III)	10 (II)	20 (V)	25 (III)	32 (V)	34 (IV)	40 (V)	44 (IV)	54 (I)	57 (II)		
	NEGATIVE	1 (V)	14 (V)	23 (III)	29 (III)	36 (I)	42 (I)	47 (IV)	50 (III)	59 (IV)			
D	POSITIVE	2 (I)	8 (III)	12 (V)	27 (IV)	38 (IV)	49 (III)						
	NEGATIVE	17 (III)	56 (V)										

SURVEY OF INTERPERSONAL RELATIONSHIPS
(SCHMIDT-SERMAT LONELINESS SCALE)

- 1) I find it easy to express feelings of affection toward family members.
- 2) Most everyone around me is a stranger.
- 3) I usually wait for a friend to call me up and invite me out before making plans to go anywhere.
- 4) Most of my friends understand my motives and reasoning.
- 5) My current romantic and/or sexual relationship is really only for convenience.
- 6) I don't get along very well with my family.
- 7) I have at least one good friend of the same sex.
- 8) I can't depend on getting moral or financial support from any group or organization in a time of trouble.
- 9) I am presently involved in a romantic/marital relationship where a genuine effort at cooperation is made by both partners.
- 10) I often become shy and retiring in the company of my relatives.
- 11) Some of my friends will stand by me in almost any difficulty.
- 12) People in my community aren't really interested in what I think or feel.
- 13) My trying to have friends and to be liked seldom succeeds the way I would like it to.
- 14) I spend time talking individually with each member of my family.
- 15) I find it most difficult to tell anyone that I love him or her.
- 16) I don't have many friends in the city where I live.
- 17) I work well with others in a group.
- 18) I am an important part of the emotional and physical well-being of my lover/spouse.
- 19) I don't feel that I can turn to my friends living around me for help when I need it.
- 20) I don't think that anyone in my family really understands me.
- 21) I have a lover/spouse who fulfills many of my emotional needs.

- 22) My friends are generally interested in what I am doing, although not to the point of being nosy.
- 23) Members of my family enjoy meeting my friends.
- 24) I allow myself to become close to my friends.
- 25) My relatives are generally too busy with their concerns to worry about my problems.
- 26) Few of my friends understand me the way I want to be understood.
- 27) No one in the community where I live really cares much about me.
- 28) Presently I am finding it difficult to get along with my lover/spouse.
- 29) Members of my family give me the kind of support that I need.
- 30) A lot of my friendships ultimately turn out to be pretty disappointing.
- 31) My romantic/marital partner gives me much support and encouragement.
- 32) I am not very open with members of my family.
- 33) I often feel resentful about certain actions of my friends.
- 34) I am embarrassed about the way my family behaves.
- 35) People who say they are in love with me are usually only trying to rationalize using me for their own purposes.
- 36) I have a good relationship with most members of my immediate family.
- 37) In my friendships, I am generally able to express both positive and negative feelings.
- 38) I don't get much satisfaction from the groups I attend.
- 39) I get plenty of help and support from my friends.
- 40) I seem to have little to say to members of my family.
- 41) I don't have any one special love relationship in which I feel really understood.
- 42) I really feel that I belong to a family.
- 43) I have few friends with whom I can talk openly.
- 44) My family is quite critical of me.
- 45) I have an active love life.

- 46) I have few friends that I can really depend on to fulfill their end of mutual commitments.
- 47) Generally I feel that members of my family acknowledge my strengths and positive qualities.
- 48) I have at least one real friend.
- 49) I don't have any neighbours who would help me out in a time of need.
- 50) Members of my family are relaxed and easy-going with each other.
- 51) I have moved around so much that I find it difficult to maintain lasting friendships.
- 52) I tend to get along well with partners in romantic relationships.
- 53) I find it difficult to invite a friend to do something with me.
- 54) I have little contact with members of my family.
- 55) My friends don't seem to stay interested in me for very long.
- 56) There are people in my community who understand my views and beliefs.
- 57) As much as possible, I avoid members of my family.
- 58) I seldom get the emotional security I need for a good romantic/sexual relationship.
- 59) My family usually values my opinion when a family decision is to be made.
- 60) Most of my friends are genuinely concerned about my welfare.

APPENDIX B
CLIENT PROGRESS NOTES AS CHARTED BY THERAPISTS

PROGRESS NOTES

THERAPIST CODE NUMBER: _____

CLIENT CODE NUMBER: _____

DATE: _____

LENGTH OF SESSION: _____

CHARTING: (I) WHAT WAS DISCUSSED?

(II) WHAT SUGGESTIONS WERE MADE TO THE CLIENT IN RELATION TO WHAT WAS DISCUSSED?

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

APPENDIX C

PROGRESS RATING BY THERAPISTS

PROGRESS RATING BY THERAPISTS

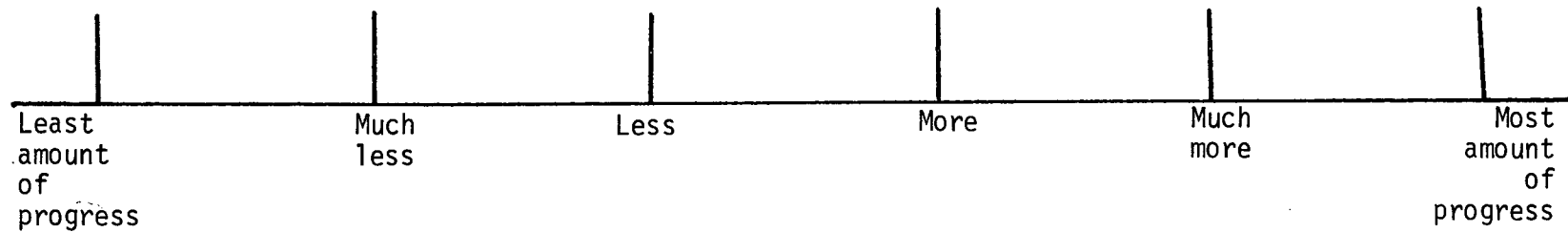
Control _____

Therapist's Code Number _____

Experimental _____

Client's Code Number _____

Rate your progress in psychotherapy with a client identified as testing high in loneliness. The rating scale is from "1" to "6" where "1" indicates the least amount of progress and where "6" indicates the most amount of progress.



APPENDIX D
SATISFACTION RATING BY THERAPIST

SATISFACTION RATING BY THERAPISTS

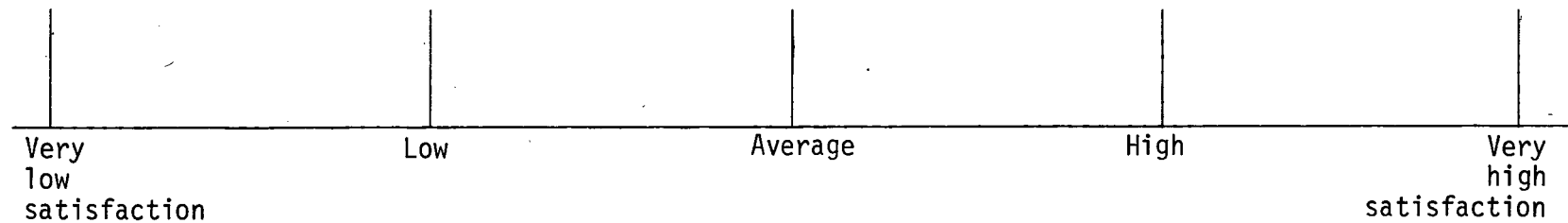
Control _____

Therapist's Code Number _____

Experimental _____

Client's Code Number _____

Rate your satisfaction in attempting loneliness intervention with a client identified as testing high in loneliness. The rating scale is from "1" to "5" where "1" indicates very low satisfaction and "5" indicates very high satisfaction.



APPENDIX E

LONELINESS INSERVICE EDUCATION:

Objectives, Content, and Teaching Action

INSERVICE ON LONELINESS

Learners' Readiness

Mental health therapists who were employed at a Community Mental Health Care Team for the Greater Vancouver area participated in an "Inservice on Loneliness." The therapists were of various professional backgrounds (Psychiatry, Sociology, Nursing, Social Work) and had experience in the field of mental health. The four therapists involved in the research study participated in the "Inservice on Loneliness" as this was the basis for PART II of the research study. They expressed that they were not familiar with the concept of loneliness.

The "Inservice on Loneliness" was conducted on two days for two hours each day. A Loneliness Manual (developed by the investigator) supplemented the Inservice. The four therapists who were involved in the research study each received a reference manual which explained loneliness, loneliness anxiety, loneliness behaviours, and loneliness interventions. Previous to the "Inservice on Loneliness," therapists completed the Schmidt-Sermat Loneliness Scale and therefore they were aware of their own loneliness score. They also were aware of clients who tested high in loneliness, and could discuss these clients at the Inservice.

OBJECTIVES

UPON HAVING PARTICIPATED IN AN "INSERVICE ON LONELINESS," A THERAPIST WILL BE ABLE TO:

1. SUPPORT THE PHENOMENA OF LONELINESS AS HAVING RELEVANCE TO MENTAL HEALTH:

- 1.1 define loneliness based upon personal experience or observation.
- 1.2 understand the phenomena of loneliness as explained by experts in the field of loneliness, such as Frieda Fromm-Reichmann and Clark E. Moustakas.
- 1.3 identify at least three types of loneliness.
- 1.4 explain at least three types of loneliness.
- 1.5 give an example of a situation where an individual may encounter a specific type of loneliness.
- 1.6 define primary and secondary loneliness.
- 1.7 distinguish between primary and secondary loneliness in life situations.
- 1.8 integrate knowledge on feelings with the feeling of loneliness.
- 1.9 formulate a new perspective towards the phenomena of loneliness in mental health.
- 1.10 generate an interest in the need for the acknowledgement of the phenomena of loneliness in mental health.

2. JUDGE IF A CLIENT IS INCURRING LONELINESS:

- 2.1 identify the characteristics of an individual incurring loneliness.
- 2.2 identify at least three groups of individuals in society who are high risks for loneliness.
- 2.3 understand the feelings being incurred by an individual experiencing loneliness.
- 2.4 understand the five reasons why bad feelings occur due to loneliness.
- 2.5 recognize the characteristics of loneliness in clients previously identified as testing high in loneliness by the Schmidt-Sermat Loneliness Scale.
- 2.6 integrate knowledge of clients' life situations with clients' loneliness.

3. JUDGE THE LONELINESS ANXIETY OF A CLIENT AS A BASIS FOR PSYCHOTHERAPY:

- 3.1 define loneliness anxiety based upon personal experience or observation.
- 3.2 understand the phenomena of loneliness anxiety as explained by experts in the field of loneliness, such as Frieda Fromm-Reichmann and Clark E. Moustakas.
- 3.3 relate current knowledge of anxiety to loneliness anxiety.
- 3.4 recognize the loneliness anxiety behaviour being exhibited by a client.
- 3.5 relate a client's loneliness to the loneliness anxiety possibly being experienced by the client.
- 3.6 plan loneliness intervention in psychotherapy based on a client's loneliness anxiety.

3.7 propose a plan for loneliness intervention to decrease a client's loneliness anxiety.

4. JUDGE THE LONELINESS BEHAVIOUR OF A CLIENT:

4.1 identify specific loneliness behaviour.

4.2 describe the loneliness behaviour.

4.3 recognize the loneliness behaviour of a client who had previously been identified as testing high in loneliness by the Schmidt-Sermat Loneliness Scale.

4.4 formulate an overview of the general behaviour of clients incurring loneliness and loneliness anxiety.

4.5 relate loneliness behaviour to loneliness anxiety for a client testing high in loneliness.

5. JUDGE THE NEEDS OF THE CLIENT INCURRING LONELINESS:

5.1 recognize the loneliness of a client based upon the life-style of the client.

5.2 recognize the problem(s) or difficulties being encountered by the lonely client.

5.3 evaluate the pain of loneliness which a client may incur.

5.4 integrate knowledge of loneliness with realistic suggestions to assist a client to decrease loneliness and/or loneliness anxiety.

6. JUDGE APPROPRIATE LONELINESS INTERVENTION IN PSYCHOTHERAPY WITH THE CLIENT WHO IS INCURRING LONELINESS AND/OR LONELINESS ANXIETY:

- 6.1 know specific loneliness intervention for specific loneliness behaviour.
- 6.2 recognize the need to alleviate or assist the client to cope with loneliness and/or loneliness anxiety.
- 6.3 recognize the need to implement appropriate loneliness intervention for the most likely therapeutic benefit for the client.
- 6.4 propose appropriate loneliness intervention based on loneliness behaviour demonstrated by the client.

7. CONDUCT PSYCHOTHERAPY WITH A CLIENT WHO IS INCURRING LONELINESS AND/OR LONELINESS ANXIETY:

- 7.1 identify a client who is incurring loneliness and/or loneliness anxiety.
- 7.2 recognize the need for loneliness intervention in psychotherapy.
- 7.3 understand various conceptualizations of the psychodynamics of loneliness developed by various experts in the field of loneliness as well as by this writer.
- 7.4 conceptualize the phenomena of loneliness based upon various conceptualizations of loneliness.
- 7.5 implement loneliness intervention to assist the client to cope with or alleviate loneliness and/or loneliness anxiety.
- 7.6 apply a conceptualization of the psychodynamics of loneliness when initiating loneliness intervention.

8. DEMONSTRATE CONFIDENCE IN IMPLEMENTING LONELINESS INTERVENTION DURING PSYCHOTHERAPY WITH A CLIENT IDENTIFIED AS TESTING HIGH IN LONELINESS BY THE SCHMIDT-SERMAT LONELINESS SCALE.

8.1 accept responsibility for maintaining a psychotherapeutic relationship with a client testing high in loneliness.

8.2 conduct loneliness intervention in psychotherapy with a client testing high in loneliness.

TEACHING CONTENT AND TEACHING ACTION FOR
INSERVICE ON LONELINESS

CONTENT	TEACHING ACTION
	<p>GENERAL APPROACH:</p> <ol style="list-style-type: none"> 1. Facilitate discussion on: <ul style="list-style-type: none"> - loneliness - loneliness anxiety - loneliness intervention in relation to specific loneliness behaviour 2. Encourage active participation in "loneliness exercises."
<p>Exercise 1: (See page 127) An experience of "situational loneliness." The means to experience a type of loneliness and what one can do to alleviate or cope with loneliness anxiety.</p> <p>The process of coping with various levels of loneliness.</p>	<p>Provide directions for Exercise 1. Conduct the exercise.</p> <p>What feelings did you experience in:</p> <ol style="list-style-type: none"> (i) the first minute? (ii) the second minute? (iii) the third minute? (iv) the fourth minute? <p>(list feelings that were experienced during the exercise). Can you describe the process of loneliness that you incurred in Exercise #1? How was the loneliness alleviated?</p>
<p>Define loneliness.</p>	<p>Can you define loneliness drawing upon your personal experience with loneliness or observations that you have made?</p>

CONTENT	TEACHING ACTION
<p>Explain the phenomena of loneliness as described by Fromm-Reichmann, Moustakas, and other experts on loneliness.</p>	<p>Are there questions? Do you agree or disagree with the views expressed by: - Fromm-Reichmann? - Moustakas?</p>
<p>Types of loneliness.</p> <p>Define primary and secondary loneliness. Given an example of loneliness in a life situation. Relate this to primary and secondary loneliness.</p>	<p>The exercise on "situational loneliness" was a type of loneliness. Can you suggest other types of loneliness?</p> <p>Can you distinguish between primary and secondary loneliness in a life situation?</p>
<p>Exercise 2: (See page 128) Draw a "Life-Line" on loneliness in your life.</p>	<p>Give directions on how to draw a life-line on loneliness. A life-line on loneliness for myself will be on a bristle board for reference.</p>
<p>Exercise 3: (See page 131) A means to facilitate further discussion by listening to a song which is recorded.</p>	
<p>Characteristics of the lonely.</p> <p>Groups of individuals in society who are high risks for loneliness.</p>	<p>What characteristics of loneliness were evident in the female portrayed as being lonely in the song?</p> <p>What types of individuals in society have you observed as being lonely?</p>

CONTENT	TEACHING ACTION
<p>Feelings incurred by the individual experiencing loneliness.</p> <p>Five reasons why an individual experiences bad feelings with loneliness?</p> <p>Life situations as an influence on loneliness.</p>	<p>What types of feelings does a lonely individual experience?</p> <p>The five reasons will be listed on a bristle board (see page 129)</p> <p>What types of life situations were the clients who tested high in loneliness involved in?</p>
<p>Define loneliness anxiety.</p> <p>Explain the phenomena of loneliness anxiety according to experts on loneliness anxiety such as Fromm-Reichmann and Moustakas.</p>	<p>Define loneliness anxiety based upon your personal experiences with loneliness or upon your experience with clients.</p> <p>Can you draw upon your knowledge of anxiety and relate it to loneliness anxiety?</p>
<p>Introduction to a: "Conceptual Model for Loneliness Intervention." (designed by this investigator) Understanding this framework as it would be implemented in psychotherapy with a client testing high in loneliness will be explained.</p>	<p>A bristle board with the conceptual model will be utilized.</p>
	<p>Is there a need to decrease a client's loneliness anxiety?</p> <p>What possible suggestions would you give to decrease the anxiety? Draw upon experiences with clients who were experiencing loneliness anxiety.</p>

CONTENT	TEACHING ACTION
<p>Identify specific loneliness behaviour.</p> <p>Describe specific loneliness behaviours.</p> <p>Relate loneliness behaviour to life-situations.</p> <p>The need to alleviate or assist a client to cope with loneliness and/or loneliness anxiety.</p>	<p>What behaviours would indicate loneliness and/or loneliness anxiety?</p> <p>Can you describe loneliness behaviour?</p> <p>Why would you see a need to alleviate or assist a client to cope with loneliness and/or loneliness anxiety?</p>
<p>Exercise 4: (See page 130)</p> <p>"Twenty activities one does": a means to acknowledge what one does and to develop insight into how one feels.</p>	<p>Bristle board to describe the assessment of the activities.</p>
<p>The need to utilize appropriate loneliness intervention for the most likely therapeutic effect in psychotherapy.</p> <p>Appropriate loneliness interventions for each loneliness behaviour.</p>	<p>Have therapists complete a:</p> <ul style="list-style-type: none"> - "Do-Plan" - "Daily Living Schedule" - "Alternatives to a Daily Living Schedule"
<p>The need to build on the positive strengths of a client.</p>	<p>Provide therapists with a personal reference manual which describes:</p> <ul style="list-style-type: none"> - loneliness - loneliness anxiety - loneliness behaviour - loneliness interventions <p>(as developed by this investigator)</p>

CONTENT	TEACHING ACTION
<p>Summary: Short overview on:</p> <ul style="list-style-type: none"> - loneliness - loneliness anxiety - loneliness behaviour - loneliness intervention 	<p>Answer questions</p>
<p>Closing Quote:</p> <p>Ira Tanner, <u>Loneliness: The Fear of Love</u>, (New York: Harper and Row Publishers, 1973), p. xi. (See page 1).</p>	<p>Read quote to therapists.</p>

Exercise 1
(Directions)

Awareness of "SITUATIONAL LONELINESS" (A four minute exercise)

Directions:

- walk aimlessly around a room
- do not verbally communicate to anyone
- follow instructions being given during the exercise

(i) for the first minute:

- do not look at anyone in the room, you may look at objects in the room.
- keep walking

(ii) for the second minute:

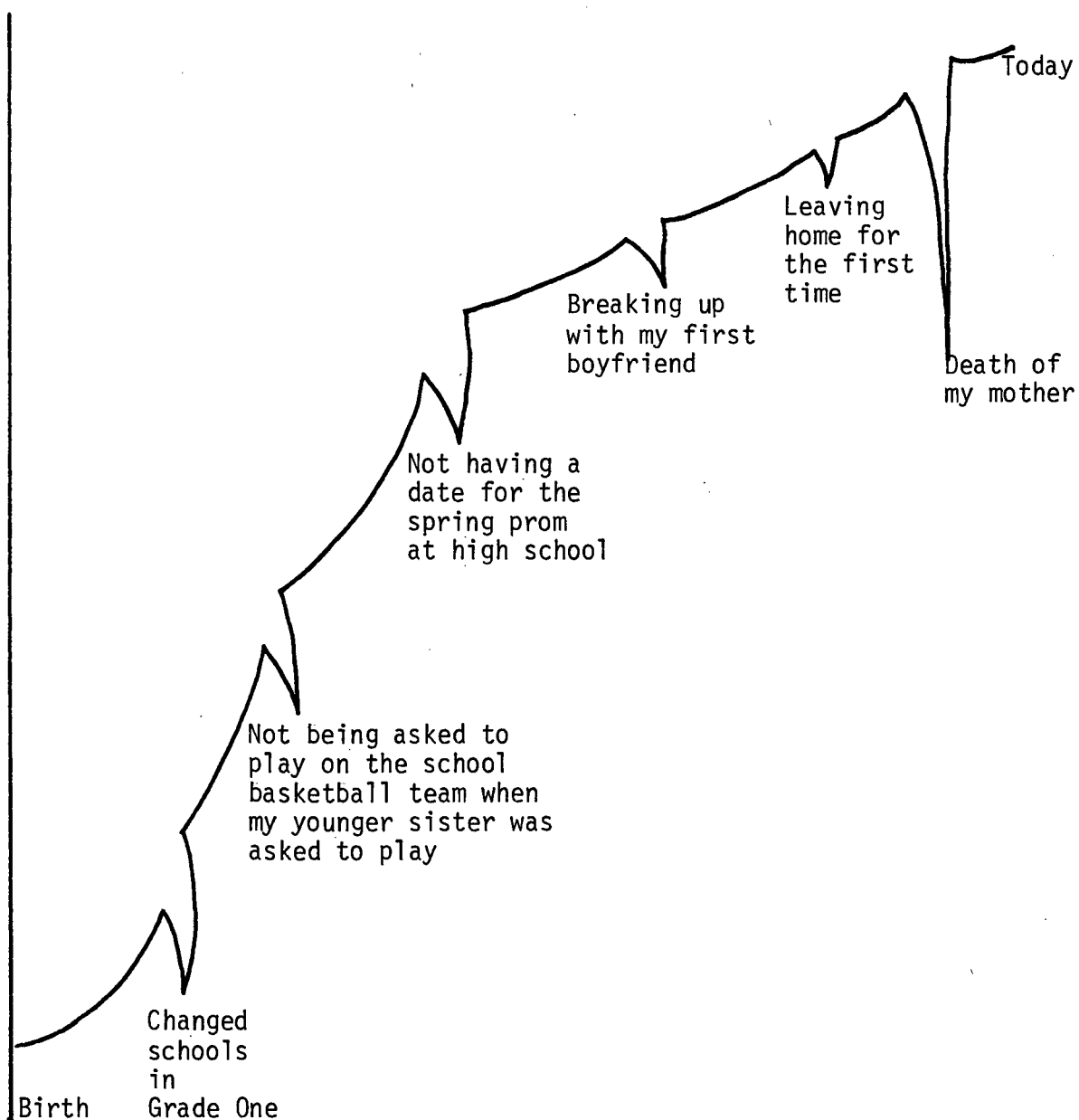
- look at the people in the room, no verbal communication.
- keep walking

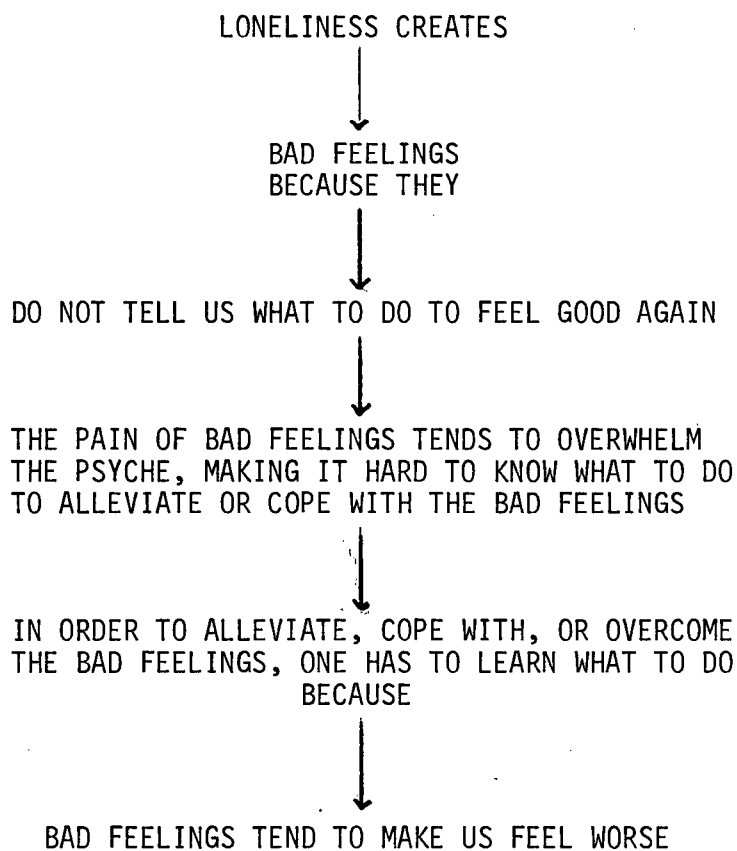
(iii) for the third minute:

- look the people directly in the eye and say only "hi."
- keep walking

(iv) for the fourth minute:

- look the people in the eye and say hi by name, shake hands with the person, and talk freely.
- keep walking

Exercise 2Life-Line
(Personal Awareness of Loneliness)

THE BAD FEELINGS CREATED BY LONELINESS

⁸⁶ Edward Ford and Robert Zorn, Why Be Lonely? p.23-37.

Exercise 4

List twenty activities you like to do:

1. Swim
2. Kiss
3. Go to the theatre
4. Eat apples
5. Water-ski
6. Snow-ski
7. Read novels
8. Talk to my mother
9. Go shopping with my sister
10. Discuss politics with my father
- .
- .
- .
20. Ride my bicycle.

Rate the twenty activities according to:

R = Risk involved

W = If you did it last week

A = If you do it alone

O = If you do it with others

B = If you would like to do it better

AS LONELY AS YOU

Song by: Murray McLauchlan

*I think of your room,
I think of you there,
I think of you dragging
Your body upstairs,
With your bed and your chair
And your stale perfume,
I never knew anybody
As lonely as you.*

*Your lovers leave,
Before it's daylight,
They want it for fun,
You want it for life,
And you get so angry
If they tell you the truth,
I never knew anybody
As lonely as you.*

*In my mind, your face disappears,
But I still see your eyes,
They look like they've heard too many lies,
They never seem to look straight into mine,
They have nothing left to lose by wasting time.*

*I can't stand to see,
I can't look when you cry,
I can't help you no how,
I'm too selfish to try,
I wish there was something
Somebody could do,
I've never known anybody
As lonely as you.
I've never known anybody
As lonely as you.*

APPENDIX F
THERAPIST AND CLIENT SELECTION CODING

THERAPISTS AND CLIENTS CODE SHEET

THERAPIST NUMBER	THERAPIST'S CODE NUMBER	CLIENT'S CODE NUMBER	
		CONTROL	EXPERIMENTAL
1	10	11	15
		12	16
		13	17
		14	18
2	20	21	25
		22	26
		23	27
		24	28
3	30	31	35
		32	36
		33	37
		34	38
4	40	41	45
		42	46
		43	47
		44	48

APPENDIX G
CONSENT FORM FOR PARTICIPATION IN RESEARCH

CONSENT FORM FOR PARTICIPATION IN A
SURVEY OF INTERPERSONAL RELATIONSHIPS

I consent to participate in this "Survey of Interpersonal Relationships." I agree to complete a questionnaire which will take approximately five to fifteen minutes. At a later date I may be asked to complete another questionnaire.

I understand that I do not have to participate in this survey and that at any time I may withdraw. My identity in this survey will be kept anonymous.

Date _____

Signature _____

Witness _____

APPENDIX H
THERAPIST IDENTIFICATION SHEET

IDENTIFICATION: THERAPISTS

137

THERAPIST'S CODE NUMBER: _____ SEX: _____

ADDRESS: _____

AGE: _____ MARITAL STATUS: _____

PLACE OF BIRTH: _____ RELIGION: _____

LENGTH OF TIME LIVING IN VANCOUVER: _____

LANGUAGE(S): SPOKEN _____ WRITTEN _____

EDUCATION: _____

LENGTH OF EMPLOYMENT AT THE CLINIC: _____

PAST EMPLOYMENT: _____

FAMILY OR SIGNIFICANT OTHERS: _____

LIVING SITUATION: _____

PAST HOSPITAL ADMISSION(S): _____

HOBBIES, SPORTS, OR AREAS OF INTEREST: _____

APPENDIX I
CLIENT IDENTIFICATION SHEET

IDENTIFICATION: CLIENT

139

CLIENT'S CODE NUMBER: _____ SEX: _____

ADDRESS: _____

AGE: _____ MARITAL STATUS: _____

PLACE OF BIRTH: _____ RELIGION: _____

LENGTH OF TIME LIVING IN VANCOUVER: _____

LANGUAGE(S): SPOKEN _____ WRITTEN _____

EDUCATION: _____

DATE OF REFERRAL TO THE CLINIC: _____

REFERRAL SOURCE: _____

REASON FOR REFERRAL: _____

PRESENT DIAGNOSIS: _____

PREVIOUS HOSPITAL ADMISSIONS: _____

PREVIOUS PSYCHIATRIC HISTORY: _____

FAMILY AND SIGNIFICANT OTHERS: _____

EMPLOYMENT SITUATION: _____

FINANCIAL SITUATION: _____

LIVING SITUATION: _____

HOBBIES, SKILLS, SPORTS, AREAS OF INTEREST: _____

APPENDIX J

SHORT FORM OF SCHMIDT-SERMAT LONELINESS SCALE

SURVEY STATEMENTS WHICH COMPRISE THE SHORT FORM OF
SURVEY OF INTERPERSONAL RELATIONSHIPS

141

RELATIONSHIP TYPE	CORRELATION WITH LONELINESS	TWO STATEMENTS SELECTED FROM LONELINESS SCALE BY RANDOM SAMPLING	
		NUMBER 1	NUMBER 2
A	POSITIVE	15 (V)	41 (V)
	NEGATIVE	9 (III)	21 (I)
B	POSITIVE	46 (III)	53 (II)
	NEGATIVE	24 (II)	60 (III)
C	POSITIVE	32 (V)	44 (IV)
	NEGATIVE	29 (III)	47 (IV)
D	POSITIVE	8 (III)	12 (V)
	NEGATIVE	17 (III)	56 (V)

SURVEY OF INTERPERSONAL RELATIONSHIPS

142

(SHORT FORM)

- 1) I can't depend on getting moral or financial support from any group or organization in a time of trouble.
- 2) I am presently involved in a romantic/marital relationship where a genuine effort at cooperation is made by both partners.
- 3) People in my community aren't really interested in what I think or feel.
- 4) I find it most difficult to tell anyone that I love him or her.
- 5) I work well with others in a group.
- 6) I have a lover/spouse who fulfills many of my emotional needs.
- 7) I allow myself to become close to my friends.
- 8) Members of my family give me the kind of support that I need.
- 9) I am not very open with members of my family.
- 10) I don't have any one special love relationship in which I feel really understood.
- 11) My family is quite critical of me.
- 12) I have few friends that I can really depend on to fulfill their end of mutual commitments.
- 14) I find it difficult to invite a friend to do something with me.
- 15) There are people in my community who understand my views and beliefs.
- 16) Most of my friends are genuinely concerned about my welfare.

APPENDIX K
DATA SHEET ON LONELINESS TEST SCORES FOR CLIENTS
DATA SHEET FOR THERAPIST'S IDENTIFICATION OF
LONELINESS BEHAVIOUR(S) AND INTERVENTIONS

Frequency of Charting by Therapists on
Loneliness Behaviours and Loneliness Interventions
for Control and Comparison Groups

	PSYCHOTHERAPY SESSION					
	1	2	3	4	5	6
(1) FREQUENCY (f) OF LONELINESS BEHAVIOURS (L.B.) PER CLIENT						
(2) FREQUENCY (f) OF LONELINESS INTERVENTIONS (L.I.) PER CLIENT						
(1) CONTROL GROUP: f OF L.B./CLIENT						
TOTAL CLIENTS						
(2) CONTROL GROUP: f OF L.I./CLIENT						
TOTAL CLIENTS						
(1) COMPARISON GROUP: f OF L.B./CLIENT						
TOTAL CLIENTS						
(2) COMPARISON GROUP: f of L.I./CLIENT						
TOTAL CLIENTS						

APPENDIX L
STRUCTURED END INTERVIEW WITH THERAPISTS

Structured End-Interview With Therapists

1. What is your reaction to implementing the conceptual model for loneliness intervention?
2. What do you view the advantages to implementing the conceptual model for loneliness intervention?
3. What do you view the disadvantages to implementing the conceptual model for loneliness intervention?
4. Do you find the conceptual model for loneliness intervention useful?
5. Do you find the conceptual model for loneliness intervention difficult to implement?
6. What suggestions would you make for loneliness intervention?

APPENDIX M
CORRESPONDENCE WITH DR. VELLO SERMAT

A Survey of Interpersonal Experiences [Form IVa, 1974]

Please return to: Prof. V. Sermat
Department of Psychology
Office York University
phone: Downsview, Ont. M3J 1P3
Canada

Your name (omit, if you prefer anonymity): _____

Age _____ ☐ male ☐ female

Education: Some high school: _____
Completed high school: _____
Some college: _____ Years: _____
College degree (B.A.): _____
Some graduate school: _____
Graduate degree: M.A. _____ PhD _____
Other (explain): _____

Your country of birth: _____ Town: _____

How long have you lived in your present home country? _____ Years. (name the country) (province, state)

Father's country of birth: _____ Mother's: _____

Primary language spoken between your parents: _____ Second: _____

Primary language spoken in your present home: _____ Another language? _____ spoken

In what other languages do you read books? _____ Newspapers? _____
often: _____
sometimes: _____
seldom: _____

Below, put a (✓) mark in the appropriate slot after each language in which you have even a limited ability, and write them in empty rows below. Check on (1) speaking, (2) reading, and (3) writing.

	Do you speak it?				Can you read in it?				Can you write in it?			
	fluently	moderately well	a little	none, or almost none	fluently	moderately well	a little	none, or almost none	fluently	moderately well	a little	none, or almost none
English												
French												

➔ **Part I:** Below are descriptions of various life situations and experiences. We would like to have you answer two questions about each of them: (1) Have you experienced it in your personal life (if so, put a check mark in the square before the item, like this: ☒), and (2) To what extent did you feel lonely at the time, or immediately after such an event? By "loneliness" we mean a feeling or mood, which in your opinion corresponds to it -- not whether you simply were "alone" (i.e., nobody else was around). We know that there can be various feelings aroused by such events: anger, bitterness, fear, insecurity, sadness, excitement, apathy etc. We are interested in the extent to which you felt lonely, and under which circumstances -- whether or not loneliness occurred separately, or together with other feelings.

If you have had the experience we are describing ☒, but felt no loneliness at the time or as a result of it having occurred, then enter the number "1" (= not at all) in the second slot (above the line, in front of the item). If you felt intensely lonely, even if it lasted for only a brief period, enter "9" or "10" (= felt very lonely) on the line 9. If you experienced loneliness only sometimes, but not always when such situations occurred, or the loneliness feeling wasn't particularly intense, choose an intermediate number from the intensity scale shown below (for ex., between "3" and "7", depending on your subjective feelings at the time of the experience). If you are not sure which number is correct, go by your first impulse, which is more likely to be accurate than a prolonged analysis.

If you have never experienced the situation described, leave the box ☐ empty, but then try to imagine how you would feel (in terms of loneliness) if you would encounter this situation one day. Choose the number from the scale that corresponds to your imagined feeling of loneliness for the item. We are interested in finding out whether people who have actually not had the experience, imagine being lonely in it to about the same degree as people who have gone through it. Please do not try to guess how others might respond; we want to know how you felt, or how you imagine you would feel, personally!

Scale:	1	2	3	4	5	6	7	8	9	10
	felt no	seldom, or		to a medium degree		rather strongly		felt very		
	loneliness	to limited extent						lonely		

- ☐ (1) being completely (in a physical, spatial sense) away or separated from other people
- ☐ (2) being faced with a difficult decision, which no-one else could make for you, and for which no-one else could share the responsibility or consequences with you
- ☐ (3) feeling that no-one could possibly fully understand the experiences you have had

- ☐ (4) preparing to leave a place and people you were fond of, and had become accustomed to
- ☐ (5) thinking of places where you had lived, which were associated with deep emotional experiences; places where you feel you had "grown roots"
- ☐ (6) feeling that it was impossible, or useless to talk to anyone about your most important and deepest feelings, concerns, thoughts etc., because you expected that other would not understand, or would not be interested and sympathetic, or might even react negatively
- ☐ (7) feeling ignored or rejected by people whom you did not know very well
- ☐ (8) feeling that you did not "belong" where you were; that people around you were "strangers" who had no interest in you as a person
- ☐ (9) feeling that there was no place in the whole world which you could call your "home"
- ☐ (10) feeling that you had not lived up to your own expectations; that you had left yourself down
- ☐ (11) while thinking about some other people who had started out in comparable circumstances with you, but seemed to have done much better, or been more successful
- ☐ (12) when people who were important to you, seemed to have a low opinion of you, or expressed unfavorable or unpleasant opinions or judgments about you
- ☐ (13) when you felt that your behavior in the company of others was awkward and unsure
- ☐ (14) when a close friend (someone you were not romantically involved with) left for a distant place
- ☐ (15) feeling lonely in the company of a person with whom you were supposed to have a close, intimate relationship (for ex. your spouse, lover, boyfriend or girlfriend)
- ☐ (16) when your relationship with girlfriend, boyfriend or marital partner broke up (opposite sex only)
- ☐ (17) To what extent have you IN THE PAST FEW MONTHS felt a basic lack of interest in everything and everybody, so that even those people you knew you didn't bother to look up, and you seemed to lack any goal in life, anything that would have provided
- ☐ (18) while being in an unfamiliar place (away from home and old friends), real satisfaction? all by yourself, you saw someone you were very attracted to and would have liked to get to know, but you did not dare to show your interest, or did not know how to go about it.
- ☐ (19) generally at those times when you lacked a romantic relationship with opposite sex
- ☐ (20) at a time when you wanted to talk to a good old friend and realized that they were all living far away, outside an easily reachable distance

- ☐ (21) while wanting to belong to some society, group or cause and to participate actively with others in working for something more important than just your own personal well-being or the immediate family circle (for ex., a desire to dedicate yourself to a cultural, national, religious or other cause)
- ☐ (22) To what extent do you feel that YOU ARE NOW INVOLVED in such a larger cause or community?
- ☐ (23) Feeling lonely when someone close to you died (parent, child, spouse or friend).

Part II: Generally speaking, would you describe yourself as a person who experiences loneliness

1 2 3 4 5 6 7 8 9 10
 never rarely occasionally an average amount quite a bit very much
 (not at all)

(please circle one number above)

Part III: Using the same number scale (from "1" to "10"), indicate how important it is for you...

- (24) to date or to marry someone who is of the same ethnic (or religious) background as you
- (25) to learn more about the history, culture, literature and country of your ancestors
- (26) to visit (or perhaps even to live in) the country where your ancestors came from
- (27) to find people who share the same ethnic or religious interests with you, and to share your thoughts with them
- (28) to what extent have you found it irritating, boring or depressing to listen to the views of your parents or their friends on ethnic, political or religious issues, because they seem to be either unwilling or unable to understand and to accept your viewpoints?
- (29) how often are you together with others of about your own age, with whom you share common views and goals in important matters, concerning ethnic, religious or political problems?
- (30) To what extent do you identify yourself with a specific ethnic group? Which? _____

You are presently living: With your parents: _____
 With friend(s) or roommate(s): _____ Other (explain briefly): _____
 Married, and living with your spouse: _____
 Not married, but living with someone of the opposite sex: _____
 Alone by yourself _____

Are there any comments or additions you would like to suggest for this questionnaire? (use other side)

Generally speaking, I would describe myself as a person who experiences loneliness

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
never	rarely	occasionally	an average amount	quite a bit	very much	always			

(PLEASE CIRCLE ONE NUMBER ABOVE)