THE EXPERIENCES OF PATIENTS WHO ELOPE
FROM PSYCHIATRIC UNITS:
A QUALITATIVE STUDY

By

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Abstract

This study was designed to investigate how psychiatric patients explain their elopements from hospital. A limited amount is known about elopement and the available literature is written from the perspective of the caretaker.

The study was qualitative in design. Indepth interviews were conducted with five patients when they returned to the hospital following their elopements. The data from these interviews were analyzed using content analysis and from this analysis, conceptual themes were constructed. The concept of alienation was utilized by the researcher to explain the accounts of the patients. The patients in the study experienced a loss of control over their entry into hospital, over their treatment and programme, and over events directly linked to their elopements. The programmes and treatments were frequently viewed as meaningless or not making sense. Elopement was viewed as a positive event by each of the patients because it provided an opportunity for some control and some freedom.

The interdependence between the patients' subjective experiences and the objective organization of the hospital was examined. It was explained that due to their placement in the hierarchy of the hospital, patients often feel powerless to affect what is occurring. Moreover, the patients in this study felt they were not informed about the rationales for the decisions that were made about them. It was argued
that while nurses believe they are addressing the concerns of patients, this did not occur for the people in this study.

Implications for nursing practice, education and research concluded this study.
# Table of Contents

Abstract ........................................... ii
Table of Contents ................................ iv
Acknowledgements ................................ vii

Chapter One: Introduction to the Problem and Purposes ................................ 1
  Conceptual Framework ................................ 5
  Statement of the Problem ................................ 8
  Purposes of the Study ................................ 9
  Theoretical and Methodological Perspective of the Study ................................ 9
  Assumptions of the Study ................................ 11
  Limitations of the Study ................................ 11
  Summary ............................................. 12

Chapter Two: Methodology ................................ 13
  Selection of Participants ............................. 13
    Criteria for selection ................................ 13
    Selection procedure ................................ 14
    Description of the participants .................... 14
  Data Collection ..................................... 15
    Construction of the accounts ....................... 16
  Data Analysis ....................................... 17
  Ethical Considerations ............................... 18
  Summary ............................................. 19

Chapter Three: The Process of the Analysis of the Data .............................. 20
  Introduction to the Theme ............................ 20
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Chapter One

Introduction to the Problem and Purposes

People make inferences about the minds of others by observing their behaviour (Curtin, 1979). In psychiatric/mental health practice, one often hears the statement, "All behaviour has meaning." This same declaration is seen in the literature (Kyes & Hofling, 1980; Robinson, 1972). Unfortunately, the understanding of human behaviour remains in a primitive state (Clare, 1976). One behaviour which occasionally occurs on a psychiatric unit is the elopement of a patient. Elopement is the departure of a patient, without staff sanction, from the physical boundaries of the hospital in which the patient is currently hospitalized. When this behaviour occurs, much time and energy are typically invested in returning the patient who has eloped. The nurse caring for the patient, the nurse in charge of the unit, the nursing supervisor, the primary therapist, the police, and the relatives of the patient who eloped are typically involved at some level. Time and energy are also invested in the writing of an incident report and in the writing on the chart. Despite the number of people involved and despite the documentation, one element seems to be missing: the patient's perception of the events related to the elopement.
The behaviour of elopement pertains to the practice of nurses. Nurses are the professionals most frequently involved in the daily life of the patient (Schrock, 1980) and psychiatric nurses are often involved in the return or attempted return of the patient who elopes. As with other members of the health care team, the role of the psychiatric nurse is to support patients in the healthy aspects of their behaviour and to provide the setting in which they can learn more effective behaviours to replace the ones which are mal-adaptive (Robinson, 1972). Peplau (1980) reinforces this stance by stating nurses should "promote health conducive behavior, and...aid the release and development of the client's potential" (p. 131). Thus, whether elopement is viewed as a positive or a negative behaviour, the nurse has a mandate to be involved. Other reasons also exist as to why nurses should know about this behaviour. Nurses often feel a sense of guilt or personal failure when a patient elopes. A frequently asked question is, "Why didn't I know this was going to happen?" Another concern relates to the legal liability of the nurse if something does happen to the patient. Litigation against health professionals is becoming more common.

Whether elopement is a positive or a negative behaviour is open to debate. Two opposing points of view will be briefly outlined to indicate how the behaviour has implications for the profession of nursing.

Patients who have eloped may or may not be committed.
If they are committed, they can be detained in the hospital without giving their permission. The patients are considered a danger either to themselves or to others. If they are not committed, they have chosen to leave a setting which they technically have the right to do. The contravention of the wish to leave may be seen as an infringement on the "protection of liberty and of personal rights of patients admitted to psychiatric units" (Mellor, 1977, p. 21). There is currently a great value placed on the right to be an individual, to express oneself as one sees fit. How much then, and in what manner, should people influence one another? (Curtin, 1979). Nurses cannot just intervene for the purpose of interfering (Matheney & Topalis, 1974). They must have logical and rational grounds to justify the aims of their actions as well as the methods used to reach their goals (Mellor, 1977). As well, in this age of the growing expense of health care, nurses are accountable "for the best use of their time, and the economical use of resources" (Peplau, 1980, p. 132). Does the behaviour of elopement automatically warrant the extensive resources that are currently mobilized?

The more common and more traditional approach to elopement views the behaviour as a potential threat to the patient. Certain psychiatric problems are characterized by impaired judgement and defective perception (Kyes & Hofling, 1980). Nurses are drawn into a protective role when caring for a variety of patients (Darcy, 1978). If a patient is known to be highly suicidal, staff are concerned about the patient
who has disappeared. As Darcy states:

The psychiatric nurse has developed skills which may be seen as custodial....When restrictions are called for, the nurse must be prepared to refute the accusation that she is custodial or over-protective simply because she is protecting patients or staff from harm. (p. 31)

There is little written information on the patient who elopes. In a Registered Nurses' Association of British Columbia document, elopement is listed as a possibility under the behavioural concept of depression. The nurse is instructed to assess the patient's potential for "self-mutilating and suicidal acts" -- the behaviour under discussion is given as an example (Bastable, Gordon, Miller, & Tregunna, 1977, p. 29). Another book associates elopement with the patient who uses projection or the patient who abuses alcohol and becomes "rebellious" (Matheney & Topalis, 1974, pp. 253, 358).

Though rebellion can be viewed as either positive or negative behaviour depending on one's conceptual framework (Peplau, 1978), when elopement is mentioned it tends to be categorized as a negative event. The author of a "problem behavior report sheet" lists elopement as a "high defiance" problem behaviour which "deviates from the staff desired, standing patterns of behavior" (Bailey, 1979, pp. 488-494). Another behaviour inventory which states it measures "the severity of psychopathological disturbance in the ward behaviors of adult psychiatric patients" also lists elopement (Burdock & Hardesty, 1979, p. 221). One behavioural check-
list classifies elopement in the same category as sexual acting out, assaultive or threatening behaviour, and destruction of property (Moran, 1979).

Of the literature reviewed, only three authors who mention elopement consider examining the reason for the behaviour. Krall (1976) simply states there must be a cause for the behaviour and this must be considered when planning the patient's treatment. Matheney and Topalis (1974) write that patients who are suspicious believe they are correct in their concerns and that hospitalization is therefore unnecessary. As a result, they leave the hospital without permission. In an anecdotal account of a patient who eloped, Vousden (1979) writes that if the patient had been warned a group of people would be visiting, the patient might not have left the unit.

In summary, despite the concern nurses have when a patient elopes from a psychiatric unit, there is only a limited amount known about the behaviour. When elopement is considered in the literature, it tends to be viewed as a negative event though there is little justification for this. How the patient perceives the behaviour is not known.

**Conceptual Framework**

Whether elopement is a positive or a negative behaviour, nurses should have an understanding of the experiences of the patient. Since nurses are accountable to patients, they should work with them to resolve issues in ways that are most
beneficial for them (Peplau, 1980). In this instance, the needs of the patient might be met through some means other than elopement.

Nursing has acknowledged the need to understand the patient as an individual who is different from other people. Curtin (1979) stresses that each person is unique and thus "filters...experiences through his or her own perceptions" (p. 106). To best help the individual, nurses must have some knowledge of the patient's perspective. A variety of authors reiterate this point (Altschul, 1977; Kyes & Hofling, 1980; Matheney & Topalis, 1974; Schrock, 1980). Wilson and Kneisl (1979) address the issue in this manner:

The notion that people act in a situation based on the unique meaning that situation has for them is all but ignored in many approaches to psychiatric nursing. Instead, human conduct is treated as the product of various factors that play on passive human beings....the meaning of experiences for the particular person is either bypassed or swallowed by the other factors that are used to account for the patient's behavior. This...neglects the role of meaning in the formation of human behavior....the psychiatric nurse must be wary of interventions that convey an invalidation of the meaning of an experience to the client in favor of the nurse's definition of the situation. A corollary is the need for nurses to develop skill in observing, interpreting and responding to the meanings within the client's frame of reference in the hope of arriving at a common ground of negotiated meanings. (p. 6)

Smith (1975), a Canadian sociologist, discusses the importance of examining the everyday world of the individual. She also emphasizes the importance of locating the individual's experience within the broader sociocultural context:

[The study of the individual] is not left dangling therefore. It becomes an essential part of the work
of understanding a total process. The micro-socio-
logical level of study of the everyday world and the
macro-sociological inquiry...are pulled into a rela-
tion of necessary interdependence....The experienced
world, the worlds in which people are actually located
and which organize their experience, are viewed as
generated in their varieties by an organization of
social and material relations because that is indeed
how they are related. (p. 375)

Kleinman (1978) has constructed a conceptual framework
of the health care system which acknowledges the importance
of the patient's perception and which also locates the
patient's experience within the broader sociocultural context.
The health care system as a cultural system involves the arti-
culation of the health, illness, and health care aspects of
societies. Kleinman's framework has provided the direction
for this study.

A state of nonhealth has three dimensions: disease,
ilness, and sickness. Sickness is a complex phenomenon
which has biological, psychological, and sociocultural
aspects (Kleinman, Eisenberg, & Good, 1978). Kleinman states
sickness can be experienced in three different structural
domains of the health care system: the professional sector
which includes scientific medicine; the folk sector which
includes non-professional healers; and the popular sector
which includes the individual, the family, and the social
network. Each structural domain has its own clinical real-
ity which includes beliefs, expectations, roles, and relation-
ships (Kleinman, 1978). For the same sickness episode, the
different domains would have different explanatory models
to describe "what is wrong with the patient and what should
be done" (Kleinman et al., 1978, p. 254). When people from different sectors interact, the incongruent explanatory models can lead to conflicting expectations. The concept of disease is commonly associated with the professional sector. Disease is viewed as a disruption in the biological or psychological processes. The concept of illness is commonly associated with the popular sector. Illness is viewed as the personal or interpersonal response to disease: "Illness...is most frequently articulated in a highly personal, non-technical, concrete idiom concerned with the life problems that result from sickness" (Kleinman, 1978, p. 88). The patient's response to sickness is affected by such influences as ethnic group, social class, or family -- this is equally true for those in the professional sector (Kleinman et al., 1978). People's subjective experiences are located within social, cultural, technical, economic, and historical settings which influence personal experience (Kleinman, 1978). As Kleinman states: "[Models]...must be able to examine both individual as well as social dimensions of health care beliefs and actions. Neither alone gives a satisfactory analysis of sickness and healing" (p. 89).

Statement of the Problem

This study is designed to gain an understanding of how patients view their own elopements. This understanding or subjective recollection encompasses reasons for the behaviour and the experiences during the elopement. These subjective
recollections are then analyzed within the broader context of the sociocultural structures which influence the experiences of the patients.

**Purposes of the Study**

The purposes of the study are:

1. to describe patients' perceptions of what led to their elopements;
2. to describe how patients view their experiences of the elopements;
3. to describe what purpose patients feel the elopements served for them; and
4. to analyze the subjective experiences of patients within the broader sociocultural context.

**Theoretical and Methodological Perspective of the Study**

Phenomenology, which is a philosophy, an approach, and a method, describes human experience as it is lived (Oiler, 1982). This approach was chosen as appropriate for meeting the purposes of this study because it emphasizes the understanding of behaviour from the patient's own perspective (Rist, 1979). As Davis (1978) states: "human actions are highly situational and human actors act in accord with their constructions of meaning for the concrete situations they face" (p. 194). The phenomenological approach thus allows for a greater depth of understanding than is usual in the more traditional methods of investigation (Rist, 1979).
Using this approach also melds with the philosophy of the nursing profession: "emphasizing a reverence for clients' experiences" and advocating "the individual as author of his own world; definer of his own reality" (Oiler, 1982, p. 178).

Data collection and data analysis differ from the approaches used in the more common quantitative investigations. In the phenomenological approach, participants are chosen because they "fit" what is being studied. One begins with the subjective perceptions of these participants. "As descriptions are compared and contrasted recurring elements are noticed. This allows identification of the ingredients of the phenomenon and the way the ingredients relate to each other" (Oiler, 1982, p. 180). It is the responsibility of the researcher to clearly interpret the data and to show how the interpretation was made by referring to the information collected. In this way, the reader can determine if the researcher's interpretation is valid (Cicourel, 1968).

The relationship between participant and researcher is viewed in a very different manner than in more orthodox forms of research. Schutz (1970) describes the concept of intersubjectivity which exists between two people who are interacting:

This world is not only mine but also my fellow men's environment; moreover these fellow men are elements of my situation, as I am of theirs. Acting upon the others and acted upon by them I know of this mutual relationship. (p. 164)

Each individual comes to a situation with a unique background or knowledge, but through a verbal interaction of questioning
and clarification one can gain an understanding of the other (Schutz, 1970). Therefore, the role of the researcher is an
integral part of phenomenological research -- the major in-
strument for the collection of data is the investigator
(Ragucci, 1972). Bias of the researcher cannot be eliminated,
but it can be recognized and incorporated into the study
(Davis, 1978).

Kleinman's (1978) conceptual framework is complemented
by the phenomenological approach to research. Each is con-
cerned with the understanding of the perspective of the indi-
vidual. The phenomenological approach provides the vehicle
for exploring the clinical reality of those in the popular
sector of the health care system. Using Kleinman's concep-
tual framework, the researcher is then able to relate these
data to the surrounding sociocultural context.

Assumptions of the Study

This study is based on three assumptions: elopement
has meaning for the person who engages in it; this meaning
can be relayed to others so they can better evaluate care;
and the patient who elopes will speak truthfully about the
experience.

Limitations of the Study

There are two main limitations in this study. The
primary limitation is the likelihood that subjects may not
have always been fully open in the interviews as some felt
uncomfortable in divulging requested data. At times, participants refused to answer or continually evaded certain questions. In addition, due to time constraints, the richness of the data may not have been as fully explored as might have been possible.

Summary

This chapter has described the problem under study and has presented a survey of the literature on the psychiatric patient who elopes from hospital. It has shown that a limited amount is known about this behaviour and that the writings which do exist are formulated from the perspective of the caretakers rather than the patient. The need for the nurse to explore the patient's understanding of elopement and the need to place this understanding into the larger sociocultural context were shown.
Chapter Two
Methodology

This chapter describes the methodological perspective for this study. Four major areas will be discussed: the selection of the participants for the study, data collection, data analysis, and the ethical considerations involving the participants.

Selection of Participants

Criteria for selection. Five criteria were utilized in selecting participants for this study:

1. The patients returned to the unit from which they had eloped. This return could be of the patients' choice or it could be in spite of their choice. This criterion was employed so the researcher would be able to make contact with the participants through an agency.

2. The patients gave consent for the first interview with the researcher within 72 hours of returning from their elopements. This time period was established so the participants' experiences would still be vivid and clear in their memories.

3. The patients were fluent in English. This criterion was important because the interviews needed for this type of study required indepth discussions.
4. The patients were 18 years or older. This was due to the researcher's interest in the experiences of adults.

5. The patients were competent to give informed consent for the interviews.

**Selection procedure.** This study was conducted on the psychiatric units of three general hospitals in the Vancouver area. Depending on the preference of the institution involved, two methods were used to alert the researcher when a patient had returned from an elopement: the staff on a unit contacted the researcher or the researcher routinely contacted the hospital every second day.

After consulting with a staff member to verify that the patient was capable of giving informed consent, the researcher made the initial contact with the patient who had eloped. The study was explained to the patient, and, if the patient expressed an interest in participating, he or she was shown the consent form (see Appendix A). If the consent form was signed by the patient, the first interview then began.

**Description of the participants.** There were three female and two male participants in this study. The oldest was 33 years old and the others were under the age of 25. All the participants were Caucasian. One of the patients was married, two were single, and two were involved in heterosexual relationships. Prior to hospitalization, three of the participants had lived with their families of origin, one had lived with his spouse and children, and one had lived
with a friend. Four of the five participants had been unemployed for the six months prior to hospitalization.

The diagnoses of the participants were broadly categorized as either affective or thought disorders. The length of time the patients had been in hospital ranged from three days to two months. The length of the actual elopements ranged from a few hours to three days.

Three of the participants were considered voluntary admissions in that they had signed consent forms for hospitalization. Two of the participants were on committal papers. This meant two doctors and another individual who knew the patients felt they should be in hospital though they did not want to be there. Such patients are considered to be potentially harmful either to themselves or to someone else.

Approximately ten people who met the researcher's criteria were not included in the study. Most of them were hesitant to discuss their situation. Despite the researcher's reassurance of confidentiality, they expressed concern some of the staff might have access to the data. Most of the people who refused to talk with the researcher were over the age of 35. How this age demarcation "fits" with the decision regarding participation is not known, but it did appear to be a factor.

Data Collection

Data were collected in audiotaped interviews which were
conducted in the hospital. Two interviews were held with four of the participants. One patient refused a second interview stating he was "too sick." The length of the interviews ranged from 30 to 90 minutes.

The first interview was to occur within a maximum of 72 hours after patients had returned to the hospital from their elopements. Four of the initial interviews were, in fact, completed within 48 hours of the participant's return. The concerns of the participants were the foci and open ended questions were used extensively. However, the interviews were structured in the sense that the researcher covered certain broad areas which were suggested by the purposes of the study (see Appendix B).

The second interview was conducted six to eight days after the first. In the time intervening, the first tape was transcribed and analyzed. The second interview served two main purposes: to clarify any questions which arose after listening to the previous tape; and to ascertain if the participant's perception of the experience had altered in the intervening week.

Construction of the accounts. In Chapter One, it was explained that the researcher would describe how the participants viewed their own elopements. Interviews were held between each participant and the researcher to gather the data. The process by which the researcher gathered the information was the construction of the accounts. This construction was affected by both the individuals involved as
each came to the interaction with their own experiences and their own expectations. The researcher had worked and had taught in the clinical area of psychiatry -- she tried to identify her own preconceived assumptions about patients who eloped. The participants acknowledged they, too, had certain ideas about the interaction. Two of the participants referred to the researcher as "doctor" -- both felt nurses did not engage in research. One of the participants asked if there was anything "special" the researcher would like her to say -- she wanted the researcher to obtain the "right" results. All of the participants viewed the interviews as an opportunity to make a statement about their difficulties.

To ensure the participant and the researcher were congruent in their understanding of events or words, the researcher frequently sought clarification or further data from the participant. Even with this approach, it is likely that misunderstandings could have occurred.

Data Analysis

After each interview, the researcher transcribed the audiotape. The researcher then examined each transcript, noting emerging trends or themes. These were then examined in relation to the literature. Based on constant comparative analysis of the data and the investigation of the literature, the researcher adapted future interviews with participants. The major theme which was constructed from the analysis of the data was the concept which the researcher felt was the
most consistent and the most unifying for each participant.

Ethical Considerations

Ethical considerations were addressed in a variety of ways. Before contacting the patient, the researcher discussed with a staff member the competency of the patient to give an informed consent and then personally assessed this competency.

After the researcher had clarified her role, the study was explained to the patient. This same information was reiterated in the consent form. It was stated that the patient had the right to refuse to participate in the study and that such a refusal would not affect the care received. Patients were assured that the interview materials would be kept confidential except in cases of life threatening information. They were told their names would not appear on the tapes or in the thesis. It was also explained that the tapes would be erased after the thesis was written.

The patients were informed there was no expected risk if they participated in the study. It was explained that, while there may be no known benefit for them other than having the opportunity to talk about the experience, the study might be of benefit to others in the future. They were also informed they had the right to withdraw from the study at any point in time. For those who were interested, a summary of the results of the study was offered.
Summary

This chapter has described the methodology used to explore the perceptions of patients who have eloped from a psychiatric unit. The researcher's criteria and rationale for the selection of the participants were described as were the selection procedure and the participants themselves. The concurrent processes of data collection and data analysis were discussed. A discussion of ethical considerations for the study completed the chapter.
Chapter Three

The Process of Analysis of the Data

This chapter has two purposes: to briefly introduce the reader to the major theme which was constructed from the analysis of the data and to relate this theme to Kleinman's (1978) conceptual framework. This information will enable the reader to understand the interpretation of the data which is presented in the following chapter.

Introduction to the Theme

When the writer began the research, she entered the process with as few preconceived ideas as possible. After interviews with the first two participants, however, it was noted that both individuals identified a sense of a loss of control over their lives and a sense they did not "fit" in the hospital. The researcher began an investigation of the related literature at this point. As further interviews occurred and as the researcher began to focus on these perceptions of the participants, the trends persisted and strengthened. For the researcher, one concept, that of alienation, clearly provided an explanatory framework which "made sense" of the data. The following chapter will demonstrate how the theme melds with the data.
The term alienation was used by the ancient Greeks and Romans to denote the transfer of property or the sale of goods. The Romans also used the word in describing one's mental capacity (Ludz, 1981). It can thus be seen alienation is not simply a characteristic of our modern age. The term has recently been used in a variety of disciplines: theology, philosophy, history, psychiatry, psychology, sociology, anthropology, ethnography, economics, and education (F. Johnson, 1973b). Despite its history and frequent use, alienation is not a clearly defined concept. It has been, and still is, interpreted in a myriad of ways:

The proliferation of alienation concepts, terms, and synonyms which has occurred in recent years has produced a corresponding interest in finding a core theme, common denominator, or unifying multidimensional concept under which all varieties of alienation can be subsumed. The suggestion is that alienation is a "syndrome" of diverse forms which display a certain unity, and there is a common meaning which extends beyond some general notion of separation.

Whether this suggestion is plausible, or whether it is even worthwhile to pursue, is a matter for debate. (Geyer & Schweitzer, 1976, p. xxiii)

Hays (1976), who uses a psycholinguistic approach to analyze existing theories of alienation, expresses relief at only having to transcribe theories rather than decide which is the "right" one.

Overall, however, alienation is viewed as a lack of a bond between an individual and something or someone else. Although usually viewed as a negative occurrence (F. Johnson, 1973a), alienation is also sometimes viewed as being either
of positive or of neutral value. Schweitzer (1982) states that perception of alienation can benefit both the individual and society; Ludz (1981) states that alienation can aid the creative individual. Two major categories of alienation are delineated by most writers in the field: subjective and objective alienation. In subjective alienation:

Attention is focussed upon psychological states—upon people's perceptions of, feelings about and attitudes toward the situations and relationships in which they find themselves. The forms of discord encountered here might thus be termed "experiential." (Schacht, 1976, p. 136)

In objective alienation:

Attention is focussed upon social relations—upon the [lack of] integration or "mutual fit" of the behavior and activities of individuals with the conventions and expectations of groups and with the laws and institutions of the socio-politico-economic order in which they live. The forms of discord here might thus be termed "social structural." (Schacht, 1976, p. 136)

Thus, one category relates to the psychological situation while the other relates to the sociological situation. In examining the two categories of alienation, there is a certain amount of overlapping of ideas. Usually a dominance of one or the other is apparent and the researcher has separated the readings on this basis.

Relationship of Alienation to Kleinman's Conceptual Framework

As stated in Chapter One, in Kleinman's model the patient is a member of the popular domain of the health care system. As such, the individual has certain beliefs, expectations, and explanatory models. The perceptions, feelings,
and attitudes which exist in subjective alienation can be located within this sphere of Kleinman's model. Interacting with the popular domain are the professional and folk sectors of the health care system and the external factors which affect the health care system as a whole. The reality of the situation which surrounds the patient can be seen as a potential source of objective alienation.

In recent years, emphasis has been placed on the concept of subjective alienation. As a result, problems in the social structure have been ignored. Geyer and Schweitzer (1976) state that even when alienation is seen as a subjective experience, the objective circumstances surrounding the experience should be examined. This would allow the researcher to make a judgement about the sociocultural context surrounding the individual's feelings:

What is at stake here is a choice not so much between objective and subjective definitions of alienation, but between competing epistemologies and departure points explicitly associated with these distinct conceptualizations of alienation. The choice between objective and subjective concepts, with their concomitant points of departure, determines not only the way questions and answers are formulated, but also the methodologies, strategies, and remedies for change, action, and de-alienation. (Schweitzer, 1982, p. 69)

Twaddle (1982) reinforces the need for an examination of the individual's feelings and the surrounding context. He describes a movement from medical sociology to a sociology of health. In the past, emphasis has been placed on the biological, psychological, and social dimensions of an individual in poor health. Now, emphasis is being placed "on
all kinds of events, structures, etc. that limit freedom of choice and/or reduce personal effectiveness" (p. 349). While some critics have stated that a movement toward examining larger social units will lead to dehumanization, others believe that certain events can only be accurately understood by examination at a higher level than the individual (Twaddle, 1982). Twaddle (1982) makes an eloquent plea for both levels of examination:

I am very disturbed by the stance of some of my colleagues that understanding macrosystemic processes and structures is both necessary and sufficient. Equally necessary, and equally insufficient, are the microsystemic structures and processes: personalities, role, interaction, identities, group dynamics, and the like. We need to be aware of both the atomistic and the ecological fallacies. There is a critical need for maintaining a dialectical consciousness of the fact that societies are simultaneously made of structures and people. (p. 356)

Implications for This Study

Influenced by the writings of Twaddle (1982), and Geyer and Schweitzer (1976), this study addresses both subjective and objective alienation. The phenomenological approach promotes the understanding of the subjective experiences of the participants. Kleinman's conceptual framework promotes the analysis of these experiences within the broader sociocultural context.

The researcher has presented the findings of this study in the following format. Chapter Four addresses the literature on both subjective and objective alienation. The presentation and discussion of the participants' accounts are
then interwoven with an examination of the health care system.

Summary

In this chapter, the construction of the concept of alienation from the analysis of the data has been described. The two major categories of alienation have been related to Kleinman's conceptual framework and to the phenomenological approach to research.
Chapter Four
Alienation

In this chapter, some of the literature on both subjective and objective alienation is presented and examined. Because of the specific theme which emerged from the analysis of the data and because most of the information on this topic is in the field of sociology, the literature review is largely based on writings in sociology. This review lays the foundation for understanding the feelings and perceptions of the participants in this study. These experiences will be shown to be a reflection of the larger socio-cultural context in which they took place.

The presentation and discussion of the accounts of the participants are organized according to Seeman's (1959/1972) conception and the concept of objective alienation. By so doing, different aspects of alienation can be highlighted.

Literature Concerning Subjective Alienation
Before embarking on the actual review of the literature, the researcher feels obligated to enter a caveat to the reader:

This proliferation [of definitions of alienation] has certainly not resulted in a Maoist flower garden, nor has the extreme diversity brought about a great leap forward. The advantages of diversity disappear when nearly everyone conceptualizes alienation in a
slightly different way, without bothering to specify the differences and the similarities with the alienation concepts used by others. Research results are consequently difficult to compare, let alone to accumulate. These difficulties, in turn, impede effective theory building. (Geyer, 1976, p. 189)

Seeman's conceptualization of subjective alienation.
Seeman's 1959 piece, "On the Meaning of Alienation," is considered a classic work on subjective alienation. His article, which appears to be the catalyst for much of the renewed interest in this field, is still a basis for discussion (Geyer, 1976; Ludz, 1976; Schweitzer, 1982). While he later expanded the number of categories to six, Seeman (1959/1972) initially visualized five ways in which the theme of alienation was expressed. The original five categories of powerlessness, meaninglessness, normlessness, isolation, and self-estrangement dealt primarily with "the ideas of expectation and value" (p. 46). He acknowledged the need for research to determine what social conditions caused the various types of alienation just as he acknowledged that the behavioural consequences of alienation must be investigated. Seeman thus saw his work as an attempt to organize a common language for those in the field -- he did not see it as an answer to all questions about the concept.

Writings reflecting Seeman's work. Blauner's (1964/1972) work discussing modern industry was actually a hybrid of subjective and objective alienation:

Alienation is viewed as a quality of personal experience which results from specific kinds of social arrangements... Alienation is a general syndrome made
up of different objective conditions and subjective feeling-states which emerge from certain relationships between workers and the sociotechnical settings of employment. (p. 110)

What is particularly noteworthy about Blauner's work is his conceptualization of alienation: his four subcategories of subjective-objective alienation can be directly linked to Seeman's subcategories of subjective alienation.

Geyer (1976) utilized a general systems theory approach in analyzing alienation. Individuals were viewed as systems in interaction with their environments. Because only human beings have potential awareness of their state, only they as individuals can be seen as alienated. Seeman's five types of alienation were seen as various problems which could arise in the information processing by the system. Thus, powerlessness, or the expectancy held by individuals that they cannot determine the outcome they seek, was related to a difficulty in the system's output. Geyer's work differs from Seeman's in two important ways: it is at a different analytical level and it also relates the causes of alienation to the system.

Bloch (1978), who utilized Seeman's five categories of alienation, traced its causes to either social or psychological factors. While she did not develop her own theory of alienation, she cited a series of studies which related the concept to the health care field. Her work is particularly relevant because she stated how nurses can intervene in alienation and she utilized clinical examples as illus-
trations.

D. Johnson (1967), who discussed powerlessness as a variation of Seeman's conception of alienation, described it as a more or less permanent personality trait. This is in contradiction to Seeman's (1959/1972) own viewpoint. Linking the subtheme with Rotter's social learning theory, she stated that if powerlessness was high, learning was adversely affected. This would obviously influence the teaching nurses did with patients. If a nurse recognized the powerlessness of a patient who was extremely dependent, the nurse might be better able to cope with the situation. Johnson thus applied the concept directly to nursing practice though, like Bloch (1978), she did not formulate her own definition of the concept.

Roberts (1978), like D. Johnson (1967), addressed powerlessness as a variation of Seeman's conception of alienation and described two causes: a lack of knowledge or a loss of psychological, physical, or environmental control. Due to the feelings of powerlessness experienced by a patient, his or her behaviour may be altered. One of the behavioural possibilities described was "acting out" and elopement was identified as acting out by some of the authors quoted in Chapter One. Roberts' work is useful due to her suggestions on how the nurse can help the patient reduce the experience of alienation.

Conceptual frameworks for subjective alienation. Keniston (1972) has attempted to define subjective alienation
on the basis of four facets: focus, replacement, mode, and agent. Focus asks from what is the person alienated; replacement asks what replaces the old relationship; mode asks how is the alienation shown; and agent asks who or what decided on this feeling. Keniston used alienation to refer only to those situations which the individual has chosen to reject. His use of the term thus excluded such situations as a person being rejected by an institution or another individual. This is a significant departure from some of the definitions.

Manderscheid (1981) formulated a biopsychosocial model which viewed alienation as a method of coping with stress. This model is being discussed under the heading of subjective alienation as it allowed for individual variation in psychological and physiobiochemical reactions to stress:

Alienation was conceptualized as an intervening variable contingent on the dynamics of social structure and antecedent to perceptual style... and alienation was viewed as a successful form of coping with stress. (p. 178)

This model is noteworthy for four reasons: it acknowledges both subjective and objective alienation; it addresses both overt and covert responses to stress; it states that individuals need not be aware of their stress; and it views alienation as positive.

Shoham (1976) viewed subjective alienation within an ontological framework. In his personality theory, people were inevitably alienated due to the three developmental stages of birth, the formation of an ego boundary, and the
socialization process:

After these [developmental stages] the individual is on his own, ontologically lonely and trying desperately to regain the togetherness of his lost fold. In this uphill climb, the individual may choose either legitimate or illegitimate paths, either strictly acceptable or deviant avenues.

In this conceptualization, then, people are alienated and they cannot alter this fact.

Application of the concept to the therapeutic milieu.

F. Johnson (1976) employed a phenomenological approach in his psychotherapy with schizoidal patients. These severely withdrawn individuals were viewed as experiencing a self-alienation with ontological concerns at the crux of their experiences. As well as feeling a sense of being overwhelmed by all about them, they felt a purposelessness in their actions. By emphasizing the direction given by phenomenology, Johnson focussed on interactive techniques such as examining the meaning of the experience for the patient and using empathy and closeness in his treatment. Johnson thus related alienation to patients with a particular psychiatric diagnosis and he used himself as the major therapeutic tool.

Carser and Doona (1978) addressed alienation as a primarily subjective experience which can be either positive or negative for the individual. The concept was used by the authors to help their nursing students to become more aware of alienation as it affected themselves and their patients.
In a very brief vignette, Aspy (1972) described the experience of an individual who was admitted to hospital for cataract surgery. A sense of bewilderment and a loss of control were clearly outlined as a relatively healthy person was processed into the role of a patient.

**Literature Concerning Objective Alienation**

Schaff (1980) wrote that to define both subjective and objective alienation by using the same noun creates a difficulty because the two concepts are quite different. He suggested that a different term for each would help to clarify the situation. He viewed a connection between the two, though, as subjective alienation was seen as a derivative of objective alienation. To Schaff, dealing only with subjective alienation did not convey a true understanding of a situation: "Objective alienation is always primary, the process of change starts with it, which later leads to various forms of subjective alienation" (p. 66).

The writings of Marx (Finifter, 1972) are considered the classic works on objective alienation. Because his writings focussed on the work force, many of the current articles continue to reflect this influence. Due to the fact that the researcher is interested in objective alienation as it relates to patients, this aspect of the concept will not be emphasized. There are, however, two crucial points: 1) there is inequality in the distribution of valuable resources (Nowakowska, 1981); 2) because of the vertical hierarchy in
most bureaucracies, with control held by only a few individuals, people who are at the bottom of an organization are often powerless to affect what occurs (Cherns, 1981; Olsen, 1976).

"Alienation...means a social situation which is beyond the control of the actor, and hence, unresponsive to his basic human needs" (Etzioni, 1968, p. 879). Etzioni stated that a certain degree of alienation was inevitable: in meeting one need, another need might be thwarted. He also saw, however, that most forms of alienation were reducible. Alienation could usually be decreased through the redistribution of power or through the development of sociocultural patterns which would be more responsive to human needs. Etzioni's viewpoint again demonstrates the idea that some external force is negatively affecting the degree of control held by an individual.

Etzioni (1968) also addressed the way in which the structures of organizations affect people. An authentic social condition was one which appeared to be, and structurally was, responsive to human needs. Some structures were seen as being inauthentic: while they gave the appearance of being responsive to needs, the underlying structure did not permit this. An important point is being made in this work. While groups may say one thing, their actions may not be congruent with their stated philosophies. A highly alienating situation can then result.

F. Johnson (1973c) devised a table for relating the
level of social relationships or associations to the experiences of alienation. The third level of this five tiered table dealt with institutional relationships and described the association between an individual and an organization to which he or she belonged. An individual was seen as influenced by parts of an organization which the person never dealt with directly. To a certain extent, alienation was seen as inevitable in a social organization, but:

This basic and inevitable estrangement is either amplified or minimized by the degree to which the individual participates in and identifies (at a symbolical level) with the overall purposes, ethics, and norms of the larger organization. If one's status and identification within the institution are agreeable, then the experience of both social and psychological alienation would be minimized. Conversely, if one's status is felt to be insignificant, or if one is conflicted about the goals of the institution (or finds such goals meaningless), the sense of alienation would be high. (p. 375)

As in Etzioni's viewpoint, alienation is inevitable, but the degree of alienation can vary with the organization and the individual's "fit" with that organization.

In summary, objective alienation can be viewed as a "lack of fit" between an individual and some structure to which he or she belongs. This lack usually involves a valuable resource such as control, of which there is only a limited amount.

Writings relating objective alienation and the health care system. Geiger (1975) described his experience when he was hospitalized on the unit on which he was an intern:

At one moment I was a physician: elite, technically skilled, vested with authority, wielding power over
others, affectively neutral. The next moment I was a patient: dependent, anxious, sanctioned in an illness only if I was cooperative. A protected dependency and the promise of effective technical help were mine--if I accepted a considerable degree of psychological and social servitude....If I had to choose between having my illness accurately diagnosed and competently treated or having my emotional needs as a patient filled, I would choose the former every time. (pp. 13-15)

Geiger's writing is important for a number of reasons. In describing his subjective feeling state when his role changed, he openly acknowledged his former power which was stripped when he became a patient. He also indirectly indicated that the primary purpose of the health care system was to deal with the immediate problem. The psychological integrity of the patient, while a pleasant nicety, was a secondary requirement.

Geiger (1975) viewed four sources of humanizing or dehumanizing elements in health care: sources in the social order or general society; sources in our rational, scientific approach to the world; sources in the subculture of the health professions; and sources in political movements trying to affect health care. He, too, links the experience of the patient to the larger social order just as the authors describing objective alienation linked a person's experience to the larger social order.

Howard's (1975) approach was generally consistent with that of Geiger. She saw the dehumanization in health care not as an individual's problem, but as a reflection of the organization of medical work and the process of sickness.
Torrance (1981) described the growth of hospitals in Canada "from small, simple organizations to large, bureau-
ratized, technologically complex industries" (p. 254). Coburn, D'Arcy, New, and Torrance (1981) saw the Canadian 
health care system as oriented to cure, rather than the 
physical, mental, and social well being of the individual: 

There is little attempt to view health as related to the life experiences of different social classes, as deeply indicated in issues of health in the work-
place, with income inequality, or as related to broad societal goals and social policy generally....The health sector has been changing from a "cottage" in-
dustry to a complex, technologically sophisticated, 
bureaucratic industry, with a highly rationalized 
division of labour. The system is still in the midst of these processes of reorganization, rationalization, 
and bureaucratization. The hospital, the central health-care institution, more and more resembles 
other industrial, service, and welfare bureaucracies, 
as the technocrats seek to apply the cult of efficiency to the care and cure of the sick. (p. 439)

Two important elements are noted in this article: the health care system was viewed as a bureaucracy with an emphasis on efficiency and the primary goal of the health care system was again seen as the cure of the immediate problem.

Though Kaluzny, Warner, Warren, and Zelman (1982) are describing the American system, they reiterate the viewpoint of Coburn et al. (1981). As health services have to prove managerial accountability, particularly in financial matters, staff and patients may be adversely affected. They fear that health care workers may face an increased chance of "burnout" and that patients will increasingly face arbitrary and fixed rules. These authors address the potentially harm-
ful effects of bureaucracy on both patients and staff.
While the general consensus is that the health care system holds the greatest amount of power, Numerof (1982) wrote that some of this control may now be shifting to the patient, at least in the United States. People are expecting more of health care, social institutions in general are being criticized, and consumers are increasingly expressing their displeasure through such actions as lawsuits. Consumers are thus making a more concerted effort to have their needs met.

Twaddle's (1982) work has shown a strong connection between alienation and the health care system:

Alienation and autonomy are linked by the central issue of resource control. The more any group gains control over an important set of resources (e.g. the means of production), the more any other group is barred from meaningful decision making (e.g. the more that group is alienated). This refers, of course, to objective alienation. (p. 336)

Twaddle saw that in four distinct areas where physicians had a high degree of professional autonomy, patients had a correspondingly high degree of alienation. Two of the four areas are particularly relevant to this discussion and are typical of the health care system in general. The two are clinical control/alienation and organizational control/alienation.

The element of clinical control cannot be eliminated or underestimated. Professionals in the health care field have a specialized knowledge which patients do not have. In this sense, the professionals have a monopoly. While the sense of alienation due to clinical control can be reduced,
it is inevitable:

Any institutions, which serve to promote the attainment of a wide range of human values, essentially involve an inequitable distribution of powers, reserving forms of influence and control to some while denying them to others. And by seizing upon the existence of avoidable forms of powerlessness in such cases, while neglecting to consider the contexts in which they occur, the significance of the institutions of which they are features is only too easily misunderstood. (Schacht, 1978, p. 433)

The above is crucial to this study. Because the professionals in the health care field do have a specialized knowledge, they may make decisions about patients which do not make sense or have meaning for them. The safety and the care of the patient must be maintained, thus clinical control can be shared, but only to a certain degree. However, clinical decisions can and should be explained and discussed with the patients so care does have more meaning and the potential for alienation may be decreased.

Organizational control refers to the settings in which health care is provided. Most care is now provided in the formal health care setting rather than the patient's home. As such, the patient is in someone else's territory and automatically has decreased control as a result: "Procedures are set for the convenience of the staff, which often maximize inconvenience to the patients" (Twaddle, 1979, p. 168). It is in this realm where more adjustments might be made to accommodate patients.

Summary of the literature on objective alienation.

Objective alienation is due to conditions in the sociocul-
tural setting. It appears in many organizations due to the vertical hierarchy which allows a small number of people to have a disproportionate amount of control. A certain amount of alienation is inevitable, however.

The primary goal of the hospital is still the management of the immediate problem of the patient. To provide effective care, the members of the health care team retain clinical control. Because the hospital has become a large bureaucracy with an emphasis on efficiency, recognition of the needs of the patient has assumed a low priority. In areas such as organizational control which could be shared the patient has little input.

Presentation and Discussion of the Accounts of the Participants

This section of the chapter describes how the participants in the study viewed their own elopements. While the focus was initially on the behaviour being investigated, other information related to their hospitalization and to their personal lives emerged. These data have been woven into the accounts and the discussion of the accounts because they help to clarify the purposes of this study: to describe the patients' perceptions of what led to their elopements; to describe how patients view their experiences of the elopements; to describe what purpose patients feel the elopements served for them; and to analyze the subjective experiences of patients within the broader sociocultural context. The purposes are related to Seeman's five cate-
giorizations of subjective alienation. These categories have been utilized to "make sense" of the experience of elopement. The researcher chose Seeman's work as a framework for the discussion of the participants' accounts for three specific reasons: it is considered a classic work and is thus familiar to a great number of people; it made no pretences to the absolute answer on the topic; and it can be readily utilized and understood.

As one illustration of how the subjective experiences of the participants can be linked to the objective surrounding conditions, Goffman's writing will be used.

In his classic work, Asylums, Goffman (1961) defined a total institution as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). He saw that "The handling of many human needs by the bureaucratic organization of whole blocks of people... is the key fact of total institutions" (p. 6). Many of the features of a total institution, as defined by Goffman, were described by the participants in this study:

<table>
<thead>
<tr>
<th>Features of a total institution</th>
<th>Comments of the participants</th>
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<tr>
<td>Staff and patients see each other in stereotypes, with staff typically seen as superior, and with patients typically seen as inferior.</td>
<td>&quot;Who is helpful here? The cleaners at least talk to you. That's better than most people here.&quot;</td>
</tr>
<tr>
<td>Decisions are usually made about the patients without their input.</td>
<td>&quot;They changed my room. I was happy where I was, but I had to go.&quot;</td>
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</table>
**Features of a total institution**

Patients are placed in the position of having to ask for everyday things.

Patients see themselves as unable to exert autonomy.

A privilege system of rules encourages conformity.

To be released from the institution, one must be "good."

A special language is often associated with the institution.

"Messing up," or doing something which is forbidden, can be a means of purposefully prolonging a stay in the institution.

A therapeutic stance often exists that for the patients to become better, they must adopt a new way of behaving.

**Comments of the participants**

"Um, no, I asked permission to leave to go shopping."

"I just listen to what I'm told and that's it."

"[Since my elopement], they won't change my phase, they won't even consider it."

"It pays not to complain."

"I've asked for a change in my phase."

"I took off from here because I had my privileges and everything and they were going to release me."

"It seems to me they wanted me to change my whole life. They gave me a whole page of problems."

Obviously, many of the facets of Goffman's description of a total institution are related to the participants' experiences in the hospital. There is a strong linkage of the subjective feelings to the objective structure of the health care system. Other writers have also described this phenomenon as will be indicated in the discussions which follow.

**Powerlessness.** Seeman (1959/1972) described powerlessness as probably being the most common form of alienation. Defined as "the expectancy or probability held by an individual that his own behaviour cannot determine the occurrence of the outcomes, or reinforcements, he seeks" (p. 46),
powerlessness does not reflect the value of the control for the person. Seeman saw powerlessness in terms of man's relationship to the larger social order. In this study, it has been interpreted in relationship to any events surrounding the person.

Powerlessness was the most frequently occurring variation of alienation in this study. Instances were readily apparent with each of the participants and these instances will be described in three clusters: situations surrounding the patient's admission to the hospital; situations directly linked to the elopement; and situations surrounding the treatment and management of the patient.

Four of the participants saw someone other than themselves as being instrumental in their admission to hospital. Doctors, welfare workers, and significant others were all cited at least twice as contributing to the hospitalization of the patients. Only one person had freely chosen to enter hospital, and she had the opposite problem: "It took me two years to get the help I need." Of the four participants who were reluctant, three acknowledged they were having problems, but they also felt these problems did not warrant admission. One participant denied he was having any problem, and he obviously thought he should not have been hospitalized. The four patients felt they had in some way been coerced into hospitalization by either the threat of withdrawn financial support or the threat of withdrawn living quarters:

P(participant): Well, I knew, I knew I'd have to come here until I, the government sort of forces me to
come here because I can't go anywhere else. I can't get welfare, wh-, when welfare wants me to be in the hospital, right? So how am I going to do financially, I'm n-, I'm not well enough to go to work right now. I have no place to say, stuff like that.

Reseacher: Sounds like you were feeling some pressure then, you saw it as being --

P: --about the only place I could go.

Thus, four of the participants felt they did not even have control over their admission to hospital. Decisions by others and perceived threats placed them in a situation in which they did not want to be.

Both interactions with staff and events which occurred in the hospital were linked with situations which caused feelings of powerlessness in the participants. With two of the participants, a specific incident which could be interpreted as relating to the patient's feelings of powerlessness sparked their elopements. In two other cases, feelings of powerlessness related to the care or treatment being received led to the sanctioned leaving of the hospital.

One patient left the hospital after his request for discharge had been denied by the doctor. Since the committal papers had been signed by his wife, he felt she should be able to discontinue them and thus free him:

P: She [his wife] didn't want...she didn't want... to help out...

R: And when she didn't want to help out, how did that make you feel?

P: Pretty bad.

R: Pretty bad.
P: Angry!

R: Okay, so you got angry that she wouldn't stand up for you --

P: She knows that I'm committed, right? She knows that I can't just walk out. She could just tear up the papers like I wanted her to. She signed me in, and I said she could just sign me out!

In this instance, the patient was very aware of his involuntary status as he was admitted "on papers." Having been refused discharge by his doctor his "last hope" was to enlist the aid of his wife. With her refusal to help him, he ran off the unit. He was powerless to take charge of his own life and he had been powerless in his attempts to sway her.

Another dramatic incident surrounds the case of a young woman who eloped after another patient tried to physically harm her:

R: What happened that made you decide to leave hospital?

P: When I got into her room she grabbed me by the throat with one hand and squeezed hard. I got really scared and hit her and ran back to my room ....The nurses came and asked what was wrong. I told them and they didn't believe me. They said that's not true, she's not violent. I got really upset and thought why am I here if nobody believes me.

Thus, the patient was suddenly confronted with a situation over which she had no control. When she sought the support of the staff, they compounded her feelings of powerlessness by not taking her concerns seriously. As a result, the patient's perception of the nursing staff was negatively affected:
P: I was really angry when I took off. I had a headache that just throbbed. If they'd tried to stop me, I'd have taken off again as soon as I had the chance.

R: Who were you angry at when you left?

P: The nurses and [patient who tried to harm her], but mainly the nurses. She has a problem, that's why she's here, but supposedly the staff has it together.

Two other patients, while not having such dramatic events which sparked their departure, described feelings of powerlessness over their treatment which directly contributed to their elopement. One patient, who had a parent who was continually being admitted to hospital for psychiatric care, was very preoccupied with the medications she was receiving. She wondered about the side-effects, the possibility of addiction, how long she would be taking the drugs, and the effect of the medications on her life when she was discharged. She strongly felt drug treatment was inappropriate for her, and that what she really required was counselling as she wasn't "sick enough" to warrant hospitalization:

R: Okay. Had you told this to people here, had you told this to the doctor that you're working with, or the nurses that you're working with?

P: Umm, yeah, but they don't, they just don't, they think I'm a hapychondriac (sic).

Even when the patient attempted to negotiate treatment with the staff, she felt she had no impact. She left the interaction with the sense she did not have control over what was being done to treat her.

Another patient left hospital because of her perceived
inability to influence her length of stay in the institution. She knew if she was discharged, she would return home:

P: I took off from here because I had my privileges and everything and they were going to release me to the outside world and I wasn't ready for it.

R: So they were gonna let you go and you didn't want to go.

P: Yeah. It was too early. No place to go but home, and look at it. It's full of headaches, pain, and sorrow. But if you're in a home-like boarding home, it'll be nice.

R: What headaches and sorrow?

P: My dad is mean—he beat me up last week. Bad news bears, right? He started slugging me which is why I was black and blue when you saw me. My dad's an alcoholic and my mum's a pill freak.

The patient, who was powerless to deal with the situation at home and powerless to extend her stay in the hospital, ran away.

In the four instances cited, a sense of powerlessness over the events in the hospital led to the elopement of the patient. In each case, though other concerns were also present, none were as paramount as the events already discussed. An inability to negotiate with staff was described in each situation, though this inability was not necessarily the precipitating factor. In each instance, the patient stated she tried to explain the concern to at least one staff member.

R: Had you asked them before you took off about staying here?

P: Yuh.

R: What did they say?

P: No way, Jose.
A series of incidents which could be interpreted as involving powerlessness were related to the treatment and the management of the participants while in the hospital. Some of the incidents were perceived by the patients as being more crucial than others and these critical occurrences tended to be those involving other people. It was annoying to have a noisy environment; it was boring to have a lack of activities; and it was frustrating to have one's clothes lost in another hospital, but it created feelings of powerlessness when one could not obtain the reinforcement one sought from others.

Patients felt the wards were run in such a way that, while they were told they had input into decision-making, their actual control was very limited. Two participants described this as being more frustrating than being told they had no power: "If they're honest, I can live with that. It's when they pretend, you know." The patient then described how she was told her medications wouldn't be altered unless she was informed -- and then her dosage of haloperidol was increased. Comments reflecting powerlessness in their everyday lives on the ward were frequent: "If I get too upset, they just give me a shot;" "I'm tired of the little baby staff -- they don't listen;" "What can you do? Sweet nothing. They've got you;" "They want a break, so they stick me in my room;" "Doctors got the authority and nurses don't. The nurses get pissed off and frustrated and take it out on us. We're the bottom line;" and "The student nurses
are...here now. They're always writing stuff down, right in front of me. Where does that stuff go?"

This sense of routine lack of control is well illustrated in the following example. A patient described how she requested a change in her privilege level after she eloped. She followed the protocol as outlined, but her request was not brought up at the appropriate meeting. When the staff was questioned, an explanation was given, "but they should have told me beforehand, not just ignored my request."

The patients frequently disagreed with the nature of their treatments, especially when medications were involved. The amount and types of medications were frequently listed as issues where the patients had unsuccessfully tried to gain control.

Just as the patients perceived a lack of control over their treatment, they also perceived a lack of control over the information which related to them. One patient stated he disagreed with his diagnosis, but he knew he could not change it; another participant stated that "things" put on a report could influence his length of stay in hospital, but that he himself did not have input into the report.

In two different situations, staff members made errors which resulted in the patients having to deal with the consequences. In one incident, a patient's sleeping medication was discontinued for three or four nights. She doggedly pursued the issue, and indeed there had been an error. Her frustration lay in the fact she had to contact three staff
members before someone rectified the situation: "All they had to do was check my chart properly."

In another situation, the patient who had been physically abused by her father had requested no visitors:

P: I told, strictly told the nurses that I did not want to see my family. He [Dad] came up with because I told the nurses I did not want any contact with the family. I was really upset about that. I feel it was their responsibility. They had it in their charts that I have no visitors. So I don't think it was fair at all. I thought, "Shit, is he going to hit me, or what?"

In both instances, staff did not fulfill the safeguarding role which the patients expected.

Two of the five participants were returned to the hospital on committal papers. Of the three others, only one person, the individual who had voluntarily entered the hospital, felt positive about her decision to return: "I wanted to get help if they'd have me back." The other two participants returned because they had nowhere else to go. This interaction concluded the second interview with one of these two:

R: Ok, have you thought about leaving here in the past week?

P: Yeah.

R: Uh - huh. And did you actually leave?

P: No.

R: What stopped you from going?

P: Nothing.

R: Nothing? You must have stopped yourself in some way. Why did you decide not to go?

P: Uh, because I had no place to go and I still have no place to go until the end of the month.
One has the sense the participant has completed a circle: he was powerless over his coming into hospital and he was powerless over his leaving.

So far in this discussion of powerlessness, one incident of this variation of alienation has followed another. The theme of powerlessness has been shown throughout the hospital experience. How does this theme blend with the actual elopements of the patients? This will be the focus of the conclusion of the discussion.

The participants in this study perceived themselves as powerless to affect what was happening in their environment. If the sociocultural setting of the patients is examined, this perception existed because it was true to a certain extent. The hospital is a hierarchy and in a hierarchy people have different levels of control. The patient is at the bottom of the hospital's hierarchy, and thus has limited input into the system. The participants in this study, then, were simply aware of their situation. "We're [the patients] the bottom line." Thus, as Twaddle (1979) has argued, if some people have greater access to a desired resource such as control, those who have less of the resource may struggle to obtain a greater portion. The elopements of the participants were the vehicles to regain some control in their lives. All of the participants stated they felt constrained or "hemmed in" before they left. Each of the five participants stated the elopement was a positive event and, given similar circumstances, they would react in the same way again.
One of the participants preplanned her leaving by obtaining a pass: "I wanted to lie, lie, purposely lie, because I wanted to leave hospital." Though she realized her elopement might affect her privileges, she wanted to leave to have some time alone and decide if hospitalization was "right" for her:

R: How was your mood when you were out? How were you feeling?

P: Um, pretty happy. Just felt, you know, it felt like, felt really good to be responsible, when I did go shopping. I felt really responsible.

An interesting twist occurred with the patient who was afraid to be discharged home. She knew that if she eloped, she would likely be kept longer in hospital. She had eloped from other hospitals in the past. She, too, described the simple pleasures of being out of hospital:

R: What stands out most in your mind about the time you were out of here?

P: The freedom.

R: Tell me more about that.

P: The freedom to do what I want to do. Freedom to feed the chickens. Make bacon and toast. Eat real food.

The experiences were consistently described as providing freedom for the participants: "I could breathe fresh air again;" "I was responsible for myself;" "It felt good—I got rid of all the cobwebs;" and "Do you know how great it was not having someone tell you when you could have a cigarette?"

Two of the participants described ways in which they
increased their power in more than the sense of freedom during their elopements. One patient telephoned the unit twice while she was out on her elopement. Each time she stated she was returning and each time she delayed. Another patient told the researcher that while he was on his elopement he had disarmed some nuclear warheads, but no one had thanked him.

As a result of their elopements, two of the patients, one of whom was on committal papers, had their privileges decreased. One of these patients was the person who wished to stay in hospital longer and the other patient stated the brief freedom more than compensated for the "punishment." Three patients stated their privileges were not reduced, but two of them described alterations in medications as a result. One of these three felt he indirectly gained privileges because the staff was more willing to listen to him when he returned.

In summary, then, feelings of powerlessness were experienced by all the participants in this study. Incidents involving these feelings were frequent. One way in which the participants handled these emotions was to leave the physical setting to gain a sense of control over their lives again.

Meaninglessness and isolation. Seeman (1959/1972) described meaninglessness as "the individual's sense of understanding the events in which he is engaged" (p. 50). When this form of alienation is strong, the person isn't sure what he or she ought to believe. As will be seen in this
section of the chapter, instances of meaninglessness usually involved the patient's understanding of his or her programme or treatment. These same circumstances often reflected Seeman's (1959/1972) definition of isolation in which the person "assign[s] low reward value to goals or beliefs that are typically highly valued in the given society" (p. 52), assuming the given society is the hospital setting. Because in many instances there is an overlapping or intertwining, these two categorizations of alienation will be dealt with simultaneously.

The discussion of meaninglessness/isolation will centre on three foci: the patient's perception of whether or not he or she should be in the hospital; the formal treatment of the patient; and the programme in which the patient is engaged.

At some point, all of the participants queried whether or not hospitalization was correct for them. As stated earlier, four of the participants felt they should not have been admitted to hospital. The patients obviously perceived what was occurring in their lives differently than the people who had aided their admission. It is assumed the patients' perceptions also differed from those of the caretakers in the hospital who had admitted and treated them:

P: Just the thought of being here....I don't like it.

R: Okay. You don't like being in the hospital because?

P: Yeah.

R: Because? Because why?
P: Just, I just don't think I should be here.
R: Mmm. Why did you come into hospital?
P: Doctor sent me. I don't know why.
R: You're not sure of the reason then.
P: No.
R: So you don't feel you should be here, and you don't know why you're here.
P: Yeah.
R: What does it mean for you to be in hospital?
P: I just don't like it.

Another participant explained her presence in hospital this way:

R: Do you feel you need to be in hospital?
P: No....Oh, yeah, 'cause I'm crazy. Does that sound good? How should we put it for the tape? I'm , criminally insane. Thank you. Does that sound good?
R: (Laughing) I'm asking you do you feel you need to be here?
P: That's a joke. I can't find a room out there. I can't find meals, so I may as well stay here until I can find my meals.

Because they viewed the need for hospitalization differently, the participants were automatically in disagreement with others (the staff) in their environment. If each starts from the cornerstone that they are correct and they perceive the same situation quite differently, a chasm must be breached if understanding is to be achieved.

The participants frequently queried if their treatment was the "right one" for them. Three of the participants
asked the researcher her opinion about their treatment. Because they had reservations about their treatment, they typically assigned it a low value and made suggestions as to how it could be improved:

P: I'm so concerned maybe I need some, a bit of help, you know. Like, I need counselling, but I don't need medication, and psychiatric wards that'll worsen my head, I think....I'm worried more about medication and how I'm going to feel once I get out of hospital, if it's going to do me any good.

Another patient, who felt all his medications but one should be discontinued, was convinced he had been misdiagnosed: "That means all of this is a lot of crap. Then--mind you, hospital is a lot of crap."

Much of the difficulty seems to arise from the fact that decisions were made about the patients, but the patients perceived things differently. This is well illustrated with a woman whose treatment included a low stimulus environment:

P: But now like, they got me mad.

R: Um, who's they?

P: The nurses. "Come out every hour for a cigarette." I don't need that. I don't need that shit. Who do they think they are to tell me what to do?

Staff was generally perceived as not being very helpful.

P: They're just kids. I'm 20, but I've lived on the streets. They haven't lived out there. They have nice homes, nice parents, nice family. I have rotten home, rotten family, rotten friends.

R: So you feel?

P: They don't understand.
The role of the staff was not very clear to the patients either:

P: Um, I don't really understand the staff here, how they work, if they're nurses or secretaries or what. They're helpful on a one to one basis but in groups they look in on us and write down notes. We don't get feedback from them really, and I feel they should give us a little more insight. They've been to school....The doctors here are just like friends, they just ask a lot of questions. I don't see them very long. They're a lot better than nurses.

It can be seen that if people do not have an understanding of each other, it is difficult to make their needs known. An important thrust is being illustrated. What has meaning for the staff does not necessarily have meaning for the patient. As stated in Kleinman's (1978) model, those in the professional sector have their own beliefs, roles, and expectations which differ from the beliefs, roles, and expectations of those in the popular sector. Thus, while the staff saw the patient's low stimulus programme as needed to reduce her manic behaviour, she perceived it as an infantilizing punishment. While the patients saw the rules as restricting their freedom, the staff saw the rules as a means of safeguarding the patients or as a means of ensuring the patients acted in a responsible way.

The participants' lack of understanding about the role of the nurse can also be linked to their perception of the nurse. As has been shown and will continue to be shown, many of the patients' statements expressed anger or frustration with the nurses. Comments about the doctors tended to
be neutral or positive. The following is a typical statement by one of the participants: "I do not like the nurses. There are some nurses that are really uptight....The doctors, they know what's wrong with you."

Until the researcher examined the sociocultural setting in which the subjective experiences of the patients were located, it was difficult to understand this perception of the nurses. When examining the transcripts, one of the participant's comments led to the analysis being utilized: "Doctors got the authority and nurses don't." The researcher then began an investigation of the literature on power:

The more legitimate one is perceived to be, the greater the likelihood of compliance with one's attempts to influence, and the less resentment of going along. Power goes to those who are seen as having a right to it. Conversely, the less legitimate forms of influence breed resistance and resentment....The more a person has access to controlling rewards and punishments, the greater his/her power. Thus a person who can give the formal rewards or use the formal punishments of an organization...will have the most power.... Whatever it is that people value or fear, those who control it will have power to influence behavior.... The more power attributed to a person, the more he/she is the recipient of...deference by others seeking power. (Cohen, Fink, Gadon, & Willitts, 1976, pp. 196-197)

On the basis of the verbalizations of the participants in this study and on the basis of the literature on power, one can hypothesize that physicians are imbued with legitimate authority by patients. Doctors certainly control "rewards" and "punishments" for the patients: they determine a patient's admission; they determine a patient's medications; they decide if a patient requires committal papers; and they decide on a patient's discharge.
Conversely, nurses are not perceived as having legitimate power if the reactions of the participants in this study are a reliable indicator. Most of the patients stated they didn't really know what the role of the nurse was. This may explain the resistance and resentment of the participants towards the nurses which Cohen et al. (1976) describe when those having a less legitimate form of influence try to exert power.

Just as the patients did not understand the role of the staff, they did not understand the purpose of their programme or the therapeutic milieu. Frequently, patients expressed their own opinion of what would be most helpful:

R: So you were feeling okay and you couldn't see any point in being here anymore.

P: I was still feeling a little bit, you know, strange, but it wasn't nothing serious. You know, I could lay around home and rest a lot easier and rest a lot nicer there. That's all I need is a rest, you know.

This same patient later expressed how the programme "interfered" with his own goal:

P: They [staff] ask you to go out to exercise, and meetings and all that kind of stuff. I'm not really interested. My main concern is to get better.

Another patient was more openly critical of the programme:

P: You have to do certain things at certain times. You've got to paint like a baby. You've got to clean up all the time. Aw, it's a joke.

R: Why do you think they ask those things?

P: For something to do. That's all. It's not therapy. I can do that anywhere.

One of the patients relayed her perception of the meaningless-
ness of the rules regarding her physical movement. This restraint of movement was a major issue under the discussion of powerlessness.

P: I wanted to get outside so I could feel free, and my mind could be at ease. They wouldn't let me go. No nurse would take me outside. They told me to stick my hands outside the window. Isn't that stupid? I'm a person that likes to go outside--I walk, and jog, and run. It's hard to change.

In general, it was difficult for the patients to understand that the hospital is a bureaucracy with a need for efficiency: "If I don't get to dinner between 5 and 5:30, that's it. I don't eat."

How does the theme of meaninglessness/isolation relate to the elopements? If individuals are having difficulty justifying the events in which they are engaged and if they see these activities as having little value, they will likely seek a situation which does have meaning and worth for them. During their elopements, the participants described the events in which they were engaged: going for walks, going home, seeing friends, and shopping. When one of the patients was asked what stood out most in her mind about being away from the hospital, she replied, "playing bingo." These concrete, "normal" events had meaning and value for the people involved.

Normlessness. In Seeman's (1959/1972) definition of normlessness "there is a high expectancy that socially unapproved behaviors are required to achieve given goals" (p. 50). Elopements themselves are considered inappropriate
behaviours and it can thus easily be seen that the participants in this study "fit" this definition. What will be stressed in this section of the paper is the pattern of normlessness which exists in the lives of the participants.

While there are various ways of looking at the reasons coping behaviours are established (Eaton, Peterson, & Davis, 1976), it is generally agreed a coping behaviour is used to help a person meet a need. The behaviour thus serves a purpose for the person who engages in it, though the purpose may not be evident to other people. A repertoire of coping behaviours is developed to deal with life. If a particular behaviour has been useful to the person in the past, "this pattern is likely to be one of the behaviors called forth from the person's memory bank and put into operation" (Grace, Layton, & Camilleri, 1977, p. 69). Though the behaviour is not fixed and it can be modified or eliminated, if opportunities are not provided for the behaviour to be changed it usually persists (Millon & Millon, 1974).

The behaviour of elopement was the commonality which caused each participant to be in this study. As some of the participants themselves stated, elopement is a form of "running away" or "escaping." As the interviews progressed, it became evident that "running away" was a pattern or style of behaviour for the participants:

P: You see, I've run away from a lot of places when I was younger, and there's been a lot of different people's places, and just that I've run away for, all my life, so it's pretty hard.
All the participants related past "escapes." Each of the participants identified at least one place which they had left and four of the participants identified at least three places which they had left. These included: psychiatric hospitals; schools; home; court; foster homes; and juvenile detention centres. For the participants, "running away" was a means of dealing with the situation at hand:

P: I was having problems, my parents were having problems, I was having problems at school.... That's what made me start running away first, my parents, and just life in general.

Another participant explained it this way:

P: Why did I leave? Same reason. Just don't feel right. Just that you hate it so much you can't even think....I just hated it. Just the thought of being there.

Overall, two reasons were given as to why people "ran away." The inability to handle the situation in any other way was cited as one reason:

P: You've got the same trouble, problems, and you haven't really been dealing with it. I just throw them off, run away, I didn't really want to deal with my problems.

R: So it seems that when you have problems, that --

P: --too stressful for me, then I just feel like running away.

Another participant stated:

P: I took off on the law one time, too.

R: You took off...?

P: On the law. I was supposed to appear in court for undue care and attention, and I took off for a year....I was scared to stay.

The second reason given as to why people "ran away"
was the need for freedom, the need to escape from constraints which the participants perceived:

R: How come you used to do that [run away from home]?

P: I just wanted freedom, that's all....They [parents] were work, work, work, all work, and that's all there was--that and school....I got nothing against work, but it was a little ridiculous.... My father had me on the tractor by the time I was about six.

A second participant also listed the same need:

R: Why did you leave at that time [from a previous elopement]?

P: Just bored, boredom. I wanted to get out, I, I like to walk a lot, like ten miles sometimes, and I, I like, really like to walk a lot to keep me in shape, and my mind mentally, it helps it, helps it.

R: Okay--

P: Just, freedom purpose, I think, more than anything.

Each of the participants in this study had used "running away" as a means of coping with difficult situations. Indeed, each participant learned this behaviour early in life, often during adolescence. Not only had the behaviour been in their respective repertoires, but it had successfully met a need at least some of the time by either allowing them to leave the situation for a time or allowing the freedom they required. The behaviour of "running away" had therefore served a useful purpose for these individuals in the past.

Alcohol and/or drug misuse was also a pattern for four of the participants. One of the patients stated she became intoxicated while on her elopement. The reasons given for
the substance misuse varied: one individual stated it was the thing to do at the time; one stated it was a means of avoiding her problems; and another stated he felt better as a result. Whatever the reason, the misuse reinforces the pattern of normlessness for the participants in the study.

**Self-estrangement.** As Seeman (1959/1972) stated, "To be self-alienated in the final analysis, means to be something less than one might ideally be if the circumstances in society were otherwise" (p. 53).

Self-estrangement was the variation of alienation which occurred least often. This theme was particularly important for one person though, as it was the main reason he eloped. His terse interaction with the researcher requires no further comment:

R: No. So, it was mainly the way the staff acted toward you that you eloped.

P: Yeah.

R: Anyone in particular?

P: No.

R: No. Okay. Did that happen just once in a while, or all the time, or just once?

P: All the time.

R: All the time.

P: Yeah.

R: Do you find that's still happening?

P: Yeah.

R: You do....How does that make you feel when they, they ignore you?
P: Not too good. Quite bad.
R: Yeah. Bad.
P: It just doesn't feel right.
R: Yeah.
P: Sort of a real weird feeling.
R: Mmhmm. Can you explain a bit more about that weird feeling?
P: Just doesn't seem like you're here.

Subjective Alienation Within an Objective Context

The intertwining of subjective and objective alienation has been illustrated in the presentation and discussion of the participants' accounts. Goffman (1961) eloquently summarized this intertwining:

On the outside, the individual can hold objects of self-feeling—such as his body, his immediate actions, his thoughts, and some of his possessions—clear of contact with alien and contaminating things. But in total institutions, these territories of the self are violated; the boundary between his being and the environment is invaded. (p. 23)

Summary

This chapter has been concerned with the concept of alienation. The review of the literature on both subjective and objective alienation analyzed a cross-section of readings which displayed how differently and how widely the concept is defined. The accounts of the participants were presented and discussed concurrently using Seeman's conception of alienation as a framework. The major thrust of the
feelings of the participants was a sense of loss of control over what was happening to and around them. They tended to see little meaning or little value in their experiences in the hospital. A past pattern of not conforming to social norms was also shown. A sense of separateness was a thread throughout this chapter and this sense was shown to be related to the organization of the health care system in which the participants' experiences took place. The vertical hierarchy in a hospital and the patient's position in this hierarchy were shown to be crucial. The patient's actual control was viewed as limited and, while this might be required in clinical matters, other areas of control might be amenable to redistribution.
Chapter Five

Summary, Conclusions, and Implications for Nursing

Summary and Conclusions

This study was designed to gain an understanding of how psychiatric patients view their own elopements from hospital. The limited amount of information available about elopement is from the perspective of the health care worker. A better understanding of the behaviour is important for nurses because much time and effort are utilized when a patient elopes. Moreover, there is concern for the safety of the patient. Because events do not occur in isolation, the experiences of the patients were also examined in relation to the sociocultural context in which they occurred.

To gain an understanding of those who left the hospital without the permission of the staff, an approach was used which emphasizes the importance of identifying what is meaningful for the subjects from their point of view. This approach complemented three of the purposes of this study: what led to the elopement; how the actual elopement was perceived; and what purpose the elopement served. The fourth purpose of this study, analyzing the perceptions of the subjects within the sociocultural context, was congruent with Kleinman's (1978) conceptual framework which was used
in this study. In Kleinman's framework, the perceptions of patients are addressed as well as the forces which influence those perceptions.

Interviews were conducted with five subjects once they had returned to the hospital. Through the interviews, the patient and the researcher constructed an account of the experience. Through an interactive process, the researcher came to an understanding of the subject's perspective. From the construction of the accounts and the ensuing review of the literature, an interpretation of the experiences of the participants was made.

Alienation was the unifying concept identified by the researcher to explain or make sense of the accounts of the patients. This concept can be viewed as having both subjective and objective components. To present the broadest possible viewpoint and to be congruent with Kleinman's conceptual framework, both aspects of alienation were utilized.

Subjective alienation was identifiable in the case of each subject. The patients experienced a loss of control in a variety of ways: over their entry into hospital; over their treatment and their programme; and over events directly linked to their elopements. They felt that events were occurring, but they had no input into these. Four of the subjects stated they had not sought hospitalization, but were admitted because of external events or controls. The programme and the treatments were frequently viewed as meaningless or not making sense. The patients were asked
to engage in activities which they perceived as being incor-
rect for them and their needs. Thus, the patients assigned
a low value to their treatment, to their programme, and to
their hospitalization. In each instance, the subject identi-
ified a "last straw" which caused his or her unsanctioned
leaving. In some cases, this was a crisis situation such
as when a subject was physically assaulted by another patient.
A continual building up of a particular concern also led to
elopement such as when a patient felt the staff did not
listen to his concerns.

The elopement was viewed as positive by each subject,
though some patients did experience a reduction in privileges
or an increase in medications as a result of it. All stated
that through their elopements they were able to regain some
control and some freedom. This perception of elopement as
a positive event contradicts the perceptions of health care
workers as reported in the literature.

A pattern of running away behaviour was typical for the
subjects. This coping pattern had helped them in the past
when they were experiencing a stress. Other nonconforming
patterns such as drug and alcohol misuse were also noted
amongst them.

When Kleinman's framework was utilized to place the
subjective experiences of the participants in their socio-
cultural context, the organization of the hospital as a
bureaucracy was examined. It was suggested that, due to
their placement in the hierarchy, patients are often power-
less to affect what is occurring. To a certain extent, this feeling is inevitable; health care workers have an expert knowledge which patients do not have. As such, staff may often take control and do things which don't "make sense" to the patients. As an example, one patient who was "high" felt she was being punished by being kept in a low stimulus environment. The subjects frequently felt they were not informed about the rationales for the decisions which were made about them. It was suggested that there were areas other than clinical matters where patients might have more control. For example, one patient commented she had to change her room on five minutes notice and she had no choice in her new roommate.

One very strong conclusion which emerged from this study was that the subjects tended to perceive nurses negatively while they tended to perceive doctors neutrally or positively. It was hypothesized the patients do not see the nurses as having legitimate power and thus resented the nurses' attempts to influence them.

**Implications for Nursing Practice**

The findings of this study suggest several directions for nursing practice. They are not new or unique but a reiteration of ideas which have been taught in nursing programmes and which have been addressed in the literature for years.

Nurses need to listen to the concerns of the patient
from the patient's perspective. Even when similar words are used, the meanings attached to those words can vary greatly. To reach a mutual understanding, nurses will have to explain their perception of the situation. A process of negotiation can then occur.

Nurses need to assess the understanding of the patient before they begin teaching if the teaching is to have meaning for the patient. Teaching about a treatment should be done in advance of the event so the patient knows, if not understands, why the action is being taken.

While the aims of a programme may be evident to the staff, this is not necessarily so for the patients. They will require explanations on admission and as different aspects of the programme are expanded or deleted. The reasons for the rules in a programme also require discussion.

Nurses should investigate previous patterns of coping which patients have utilized when they have felt constrained or powerless. A relevant nursing assessment may help the nurse to anticipate certain behaviours.

The nurse should restore as much control as possible to the patient. Allowing the expression of feelings and encouraging verbal participation can help in this area even when the actual decisions the patient can make are minimal. While it may be difficult for the staff, acknowledging the need for rebellious behaviour can help the self-concept of the patient. Allowing a sense of control over the environment may be one concrete way of increasing the patient's per-
ception of control.

It is imperative that the nurse explain why certain events cannot be modified to suit the patient. Again, it is important to do this in advance so the patient does not receive a false perception of a situation. This relates to consistency. If one thing is said and another done, patients may perceive their concerns are not being treated seriously.

There is a direct implication for nursing administration in this study. In the profession, the uniqueness of the individual is verbally acknowledged. However, there is no one answer suitable for all patients and yet we permit little flexibility in policies and approaches.

As a profession, nursing needs to examine its priorities. If we truly believe in a role as a patient advocate and if we truly believe in interacting with the patient as a bio-psycho-social being, we need to be congruent in our actions.

Nurses should be involved in increasing the competence of health consumers so they can make informed decisions. If consumers band together, collective action can be promoted to influence the organization of health care.

As a profession, nursing should be involved in decisions regarding organization of the health care system and other structures which affect patients. To have the greatest influence, nurses must have input at the decision-making level.
Implications for Nursing Education

Nursing curricula need to prepare students to examine different views of clinical reality. Students, as a part of being socialized into a new role, must realize that the perspective of the patient may be different from that of the health care professional. To elicit the perspective of the patient and to promote effective communication, skill is required in the use of sophisticated interpersonal techniques. Placing students in the role of the patient might help them to be more sensitive towards the needs of "the other side."

Instilling an awareness of how behaviour can affect others is crucial. Health professionals are frequently unaware of the impact on patients of casual replies or unexplained actions.

Students should have the knowledge and the skills to present their role to patients and to fellow health care workers. This obviously requires a sense of professional identity. If nurses do accept the responsibility of being the patient's advocate, students need to learn ways to operationalize this role.

Curricula must foster an understanding of the health care system and the factors which influence the system if students are to understand how they can make an impact at the decision-making level. The political skills to affect the system also need to be provided.

It is particularly important to note that, while we as
nurses believe we address these issues in both education and practice, implementation may not be as effective or consistent as we might wish.

**Implications for Nursing Research**

Subsequent studies on the elopement of psychiatric patients would produce a broader knowledge of this subject. If a similar methodology were used, other concepts or themes might be identified. Additional interactions with the subjects could heighten the richness of the data. In retrospect, it would have been useful to interview the patients once they had left the hospital to assess their perceptions when they were "free." An obvious extension of this study would be to examine the perceptions of patients who elope from non-psychiatric units of a hospital.

As a direct result of this study, some questions have been raised which would benefit from further investigation. Would patients who were older perceive their situation differently? Is there a consistent relationship between elopement and a previous coping pattern of running away? How do the staff perceive the behaviour of a patient who elopes? Would patients who had initially wanted to be in hospital and subsequently eloped perceive their situation differently? If elopement is perceived as one behavioural manifestation of alienation, are there other manifestations that can be identified? How can patients be allowed more control at the same time that safe and effective care is provided?
An unexpected finding of this study was the fact that the role of the staff was unclear to the subjects. It would be useful to know how patients perceive staff just as it would be useful to know what expectations patients have of health care professionals. This information would be useful to establish a basis for negotiation with patients.

Research on how the hierarchy of the hospital could be more responsive to patients' needs as well as an examination of the effects of the flattening of this hierarchy is indicated. This information could be used as a basis for changing the parts of the system which could be improved or strengthening those features which are beneficial for patient care.

In conclusion, then, this thesis will have made obvious the fact that continued research into this field is necessary. The reasons for the patients' elopements have been viewed from their perspective and it is clear that the patients perceive justifiable rationales for this behaviour. Through further examination of these reasons, health care workers will expand their understanding of the elopements of psychiatric patients. This continued research will help practitioners cope with an area of serious concern both for them and for the patients who have eloped.
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Appendix A

Information and Consent Form
Information and Consent Form

My name is Kathy McIndoe. I am a registered nurse who is currently working on a Master's Degree in nursing at the University of British Columbia. I am interested in learning about people who have left the hospital without the permission of the staff. My interest in this developed when I was working and I could find out little information about this matter.

I would like to meet with you twice to discuss your recent leaving of the hospital. While you may not benefit from my study, other than having the opportunity to discuss the matter, it is hoped that other people in the future will benefit. If you give your consent, I would like to tape record the conversations. The tapes will be erased after my thesis has been finished. Your name will not appear on the tapes or in the thesis. Your privacy will be ensured.

You may refuse to answer any questions. Your participation or non-participation will not affect your care or treatment in any way. If you do enter the study, you may withdraw at any time.

If you have any questions, please feel free to ask them.

I understand the nature of the study and give my consent to participate.

Date:

Patient's signature:

Researcher's signature:
Appendix B

Interview Guide
Sample of Interview Questions

1. What things made you decide to leave the hospital without the permission of the staff?

2. What was it like for you while you weren't here? (How did it feel?)

3. Do you feel it was a positive or a negative event for you, or both? In what ways was it _______?

4. What stands out most in your mind about the experience?

5. What purposes did the elopement serve for you? Has it affected your hospitalization in any way?