

THE LONELINESS OF THE  
HOSPITALIZED PATIENT

by

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September, 1975

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## Abstract

This study is an enquiry into the loneliness of the hospitalized patient. The literature review is extensive and provides a conceptual framework for the development of loneliness. Loneliness is defined in relation to the need for relatedness and described in terms of its behavioural and cognitive dimensions.

The tool used in the study is a two-part questionnaire developed by the investigator from the literature. The first part identifies variables specific to the hospitalized patient. The second part lists statements of behavioural indicators of loneliness. The purpose of the analysis is to determine the degree of association between the variables of the first part and the behavioural indicators of the second part. The questionnaire was distributed and collected by the investigator. There are limitations in the use of the questionnaire method of data collection for this study. The literature indicates that a high degree of loneliness associated change is accompanied by a low degree of freedom to communicate. However, the data analysis did not uphold this association in all instances.

The pretest and test population samples are patients resident in three specific hospitals on the day selected for the study. Two of these hospitals were general acute treatment hospitals, each with a separate but associated Extended Care Unit, and one specialized rehabilitation hospital. The latter supplemented an otherwise deficient clinical service population within the two acute treatment centres. Four hundred and forty-three patients was the population tested.

Analysis of the data indicates that specific variables within the hospital are significantly associated with the behavioural indicators of loneliness. One of the hospital variables studied was clinical service. The variations within each clinical service, identified some primary areas of concern. Medicine and Extended Care respondents perceived loneliness associated changes in themselves but did not perceive the freedom to communicate these perceptions. While similar in their response to loneliness behaviours, respondents from Psychiatry expressed a strong sense of relatedness with the nurse and a definite freedom to communicate with her. Surgery and Maternity respondents indicated no particular areas of concern. Rehabilitation respondents, while low in loneliness expression, provided a conflicting pattern to their perceived freedom to communicate and relatedness with the nurse. Rehabilitation respondents were very positive in their sense of freedom to communicate with the nurse, yet very negative in their sense of relatedness to her.

The variable of number of visitors received per week significantly affected patient response. To a lesser, though still significant degree, patient response is influenced by the length of hospitalization and the number of visitors received per visit. The pattern of response for each of the variables is a function of the other.

Research implications and recommendations for further study are indicated. This study provides initial information and a focus for further research.

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THE LONELINESS OF THE  
HOSPITALIZED PATIENT

## Chapter One

### INTRODUCTION

I have often wondered what made me aware of the feeling of loneliness that day. It was a day similar to many other days I had spent as a nurse on a psychiatric ward. I was listening to a gentleman patient explain to me in his very reasonable, well-argued way, the genesis of his alcoholism. I had heard what he was saying before. It was a repetition of items I had heard from other patients, even from himself, the day prior. However, on this occasion as I was listening to this man, I became aware of emotions I had never noticed before. I felt myself withdrawing in a reaction of fear.

Later, as time and occasions passed, the fear lessened and acceptance grew. I look back on that day now as my first recognition of loneliness. It was not an immediate recognition. It was merely the first step in a long journey of enquiry. I tried to identify the specifics of that experience and of the many others which followed. I shared thoughts with others and found that the more I shared, the more I became aware that loneliness is hidden beneath many of the behaviours which give rise to clinical diagnoses.

While loneliness is an interesting philosophical hobby, it proved to be a difficult topic to fit into a format for research. Much is written on loneliness as a subjective experience, little is written on loneliness as an experience for objective analysis. However, there is one conviction which encouraged me to try. It is that loneliness lies

within the realm of nursing judgment and nursing action. If detected and accepted, loneliness can be dealt with.

## INTRODUCTION TO LONELINESS

Loneliness is most clearly related to the capacity for love.<sup>1</sup>  
It is a sense of being isolated, excluded, denied--a pervading sense of contrast between what is and what might have been.<sup>2</sup>

Not that I am alone but that I am desolate.  
Not that I am without you but that I am abandoned by you.  
Not that I do not love you  
but the love I remember was once ours is no longer.<sup>3</sup>

There is something about being human that condemns us to loneliness.<sup>4</sup>

We live in a society in which loneliness is a common problem for all.<sup>5</sup> Formerly, we were controlled by social class, the family the indissolubility of marital bonds and filial respect imposed by

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<sup>1</sup> Eloise Clark, "Aspects of Loneliness," Developing Behavioral Concepts in Nursing, eds. L. Zerod and H. Belcher (Southern Regional Education Board, 1968), p. 33; see also, William Duensbury, The Theme of Loneliness in Modern American Drama (Gainesville: University of Florida Press, 1960), p. 212; see also, Claire Francel, "Loneliness," Some Clinical Approaches to Psychiatric Nursing, eds. S. Burd and S. Marshall (Toronto: MacMillan Co., 1963), p. 178.

<sup>2</sup> Opinion expressed by Abraham Kaplan in an address, "Loneliness," at the University of British Columbia, May 25, 1972.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Claude Bowman, "Loneliness and Social Change," American Journal of Psychiatry, 112 (1955), 194; see also, Elisabeth Mannin, Loneliness (London: Hutchison Co., 1966), p. 9; see also, Margaret Wood, Paths of Loneliness (New York: Columbia University Press, 1953), p. 78.

tradition.<sup>6</sup> Today's society, however, is not a community, but a collectivity. The neighbourhood has given way to the zip code.<sup>7</sup> We live in a society in which loneliness is a common problem for all.

Several reasons are postulated for the increase in contemporary loneliness: the rapid urban growth and the enormity of bureaucracy; the decline in the cohesiveness of family life; the increase in the number of divorces; and the decline of the active religious life.<sup>8</sup>

Loneliness is the most exclusive form of human suffering.<sup>9</sup> It makes the courageous timid, the confident unsure.<sup>10</sup> Gregariousness has nothing to do with it; solitude does not spell it; companionship does not protect against it.<sup>11</sup> Loneliness is so productive of psychic pain that suicide is a preferred solution.<sup>12</sup> More unbearable than anxiety, its experience baffles clear recall.<sup>13</sup> Yet despite its intensity and

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<sup>6</sup> Peter Tournier, Escape From Loneliness (Philadelphia: Westminster Press, 1948), p. 20.

<sup>7</sup> Kaplan.

<sup>8</sup> Bowman; see also, Peter Slater, The Pursuit of Loneliness (Boston: Beacon Press, 1970), p. 5.

<sup>9</sup> Duensbury.

<sup>10</sup> Editorial, Nursing Outlook, 16, No. 1 (January 1968), 21.

<sup>11</sup> Wood, p. 9.

<sup>12</sup> Freida Fromm-Reichmann, "One Loneliness," Psychoanalysis and Psychotherapy, ed. D. N. Bullard (Chicago: University of Chicago Press, 1959), p. 324.

<sup>13</sup> Harry Stack Sullivan, The Interpersonal Theory of Psychiatry (New York: W. W. Norton Co., 1963), p. 161.

universality, loneliness belongs to the least satisfactorily conceptualized psychological phenomena.<sup>14</sup>

#### PURPOSE OF THE STUDY

Fromm-Reichman believed the specific problem in dealing with loneliness is for the therapist to recognize his/her own existing loneliness.<sup>15</sup> Nurses as therapists are less than fearless in their acceptance of loneliness. Pretending or ignoring are two patterns used by nurses to escape the responsibility of response to the patients' manifestations of loneliness.<sup>16</sup> If the nurse refuses to let the patient really express his feelings or implies that the patient has no right to these feelings, the result is withdrawal by the patient.<sup>17</sup> Kübler-Ross stresses the need for perceptive, understanding people in dealing with the loneliness of the dying patient.<sup>18</sup> Often, because of our own feelings of fear we allow the patient to die a very lonely death.

The significance of this study for nursing is two-fold. The first point of significance is in its attempt to provide resource information for nurses so that each nurse can discover for herself the expressions of

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<sup>14</sup> Fromm-Reichmann, p. 325.

<sup>15</sup> Ibid., p. 329.

<sup>16</sup> France1, p. 180.

<sup>17</sup> Clark, p. 35.

<sup>18</sup> Elisabeth Kübler-Ross, On Death and Dying (New York: MacMillan Co., 1969), p. 228.



loneliness. In her efforts to assist the patient, it is essential that the nurse not deny her own feelings.<sup>19</sup> If she denies her own loneliness, the nurse may be unable to accept the patient's expression of these feelings, or she may ignore obvious clues to loneliness in the patient's behaviour. The nurse may seek to avoid any feelings expressed by the patient which might arouse similar feelings within herself.<sup>20</sup>

As a clinical problem, loneliness requires nursing intervention. The second point of significance for this study is to give some notion of the occurrence of loneliness within the hospital setting and of the patient's perception of loneliness. The question of whether the patient perceives elements of his loneliness and whether he perceives the freedom to communicate to the nurse will influence the planning of nursing intervention. Along with this, the significance of the hospital induced variables on the expression of loneliness provides direction for the determination of the nursing priorities.

The purpose of the study is to determine the significance of selected variables in the response of patients to loneliness-associated statements.

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<sup>19</sup> Clark, p. 35.

<sup>20</sup> Ibid.

## Chapter Two

### REVIEW OF THE LITERATURE

Thinkers in philosophy, religion, sociology and psychology have concerned themselves with the concept of loneliness throughout the ages. Authors in the arts portray loneliness often as a central theme in drama and poetry. The literature available is extensive and its review reveals a variety of perceptions about loneliness. The research for this paper focuses primarily on two major concerns. The first is to develop a conceptual framework for loneliness to be used in this study; the second is to investigate the association between loneliness and hospitalization.

### LONELINESS A CONCEPTUAL FRAMEWORK

#### Loneliness and the Need for Relatedness

Some claim it is an instinctual need for man to be dependent on others.<sup>1</sup> Loneliness is the frustration of this instinctual need to be dependent.<sup>2</sup> Sullivan and Suttie refer to the need for interpersonal relatedness as being one of man's basic needs.<sup>3</sup> This social need of

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<sup>1</sup> Paul Halmos, Solitude and Privacy (London: Routledge and Kegan Paul Ltd., 1952), p. 1; see also, William Trotter, Instincts of the Herd in Peace and War (Houston: T. Fisher Unwin Ltd., 1921), p. 113.

<sup>2</sup> Halmos, *ibid.*

<sup>3</sup> Harry Stack Sullivan, The Interpersonal Theory of Psychiatry (New York: W. W. Norton Co., 1953), p. 161; see also, Ivan Suttie, The Origins of Love and Hate (New York: Matrix House Ltd., 1952), p. 20.

man is an adaptation to the sociocultural environment. Mother love is primal not so much as it is the first formed but it is the first outer-directed emotional relationship.<sup>4</sup>

Loneliness is most acute during pre-adolescence, although earlier developmental stages lay important groundwork.<sup>5</sup> As early as infancy, the need for contact along with the many other dependencies is characteristic of the infant's primary need for tenderness. During childhood and later, this primary need is characterized by the need for peer acceptance. Dissatisfaction or maladaptation or frustration of this need at any stage is fertile ground for loneliness.<sup>6</sup> Loneliness is associated with the dissatisfaction, maladaptation, frustration of the need for interpersonal relatedness.<sup>7</sup> Loneliness is described as the lack of understanding within a relationship or the feeling that no one ever really cared.<sup>8</sup> Loneliness is the feeling that once someone did care but that no one cares anymore.<sup>9</sup>

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<sup>4</sup> Suttie, p. 20.

<sup>5</sup> Freida Fromm-Reichmann, "On Loneliness," Psychoanalysis, Psychotherapy, ed. D. M. Bullard (Chicago: University of Chicago Press, 1959), p. 328.

<sup>6</sup> Sullivan, pp. 160-62.

<sup>7</sup> Fromm-Reichmann, p. 326; see also, Hildegard Peplau, "Loneliness," American Journal of Nursing, 55, No. 12 (December 1955), 1477.

<sup>8</sup> Eloise Clark, "Aspects of Loneliness: Toward a Framework of Nursing Intervention," Developing Behavioral Concepts in Nursing, eds. L. Zerod and H. Belcher (Georgia: Southern Regional Education Board, 1969), p. 29.

<sup>9</sup> Irene Burnside, "Loneliness in Old Age," Mental Hygiene, 55, No. 3 (July 1971), 392.

It is a very new strange feeling--of touching many people superficially and no one is touching me. . . . a kind of physical loneliness that I never experienced before I never understood before that mad wish of some people just to have humans--any humans--near them.<sup>10</sup>

Fromm-Reichmann was for years fascinated with the problem of loneliness. In her last unfinished chapter she describes loneliness as a state of mind in which

. . . the fact that there were people in one's past life is . . . forgotten and the hope [of] interpersonal relationships in one's future life is out of the realm of expectation or imagination.<sup>11</sup>

Loneliness is the experience of being denied an identity.<sup>12</sup>

The most fundamental of needs is to be recognized as the person we are.

I am neither a client, a customer, a constituent, or a citizen.  
I am the particular person I am.<sup>13</sup>

The individual experiences loneliness when he is denied his identity as a unique person by others. Thoreau claims that this lack of identity from others is the basis for his loneliness in the city.<sup>14</sup> At Walden, where he is totally alone, there is no other person there to negate his being.

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<sup>10</sup> Anne Morrow Lindberg, Bring Me a Unicorn (New York: Harcourt House, 1973), p. 49.

<sup>11</sup> Fromm-Reichmann, p. 327.

<sup>12</sup> Opinion expressed by Abraham Kaplan in an address, "Loneliness," at the University of British Columbia, May 25, 1972.

<sup>13</sup> Ibid.

<sup>14</sup> Henry David Thoreau, "Solitude," Walden and Other Writings (New York: Random House Inc., 1937), p. 142.

Loneliness is said to exist when an individual is unable to meet his basic need for relatedness. The degree to which this need is satisfied bears a relationship to the degree to which loneliness is experienced.

Loneliness can occur at any age, given the interrupted satisfaction of the need for relatedness. It can be said that the stage of development at which this interruption occurs has bearing on the degree of loneliness experienced.<sup>15</sup>

Loneliness can be either temporary or lasting.<sup>16</sup> It can be primary or secondary, contingent or essential.<sup>17</sup> The differentiation referred to is the degree of interpersonal deprivation and the severity of the behavioral maneuvers mobilized in defense against loneliness. For example, one patient in childhood retreated from loneliness by sitting in a darkened room, in adulthood by delusional thinking.<sup>18</sup> This loneliness is an example of the lasting or essential loneliness. This loneliness renders people who suffer it emotionally paralyzed and helpless.<sup>19</sup> Temporary or contingent loneliness is that which is transient or correctable.<sup>20</sup> For example, the loneliness associated with travel,

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<sup>15</sup> Clark, p. 38; see also, Fromm-Reichmann, p. 326.

<sup>16</sup> Fromm-Reichmann, p. 326.

<sup>17</sup> Henry D. von Witzleben, "On Loneliness," Psychiatry, 21 (1958), 37; see also, Kaplan.

<sup>18</sup> Fromm-Reichmann, p. 330.

<sup>19</sup> Ibid., p. 329.

<sup>20</sup> Kaplan.

death, illness are correctable either in time or when the situation corrects itself.<sup>21</sup>

### Loneliness: Behavioral Manifestations and Cognitive Dimensions

The cognitive dimension of loneliness is described as the experience of non-being, or the loss of reality.<sup>22</sup> Projective thinking, suicidal ideation, alcoholic apathy are defenses used in withdrawal from severe loneliness. Escape through unreality is the schizophrenic's main defense against loneliness.<sup>23</sup> Overly subjective and unreal thinking is observed in those attempting to cope with loneliness.<sup>24</sup> Some patients try to ward off the evolving pathology of loneliness by substituting non-personalized transactions with knowledge and things.<sup>25</sup> For some, suicide is a preferred alternative in the struggle with loneliness.<sup>26</sup> Others escape through alcohol or drugs.<sup>27</sup>

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<sup>21</sup> Kaplan.

<sup>22</sup> Clark, p. 38; see also, Fromm-Reichmann, p. 330; see also, Peplau, p. 1476; see also, Edith Wiegert, "Loneliness and Trust," Psychiatry, 2 (1960), 124.

<sup>23</sup> Antonio Ferriera, "Loneliness and Psychopathology," The American Journal of Psychoanalysis, 22, No. 2 (1962), p. 205.

<sup>24</sup> Peplau, p. 1480.

<sup>25</sup> Ibid.

<sup>26</sup> Anne Bancroft, "Now She's a Disposition Problem," Perspectives in Psychiatric Care, 9, No. 3 (1971), p. 102; see also, Claire France, "Loneliness," Some Clinical Approaches to Psychiatric Nursing, eds. S. Burrard, S. Marshall (Toronto: MacMillan Co., 1963), p. 178; see also, National Council of Social Service, Loneliness (England: Latimer Co. Ltd., 1964), p. 10.

<sup>27</sup> Clark, p. 33; see also, Peplau, p. 1476.

Loneliness invades all three time dimensions.<sup>28</sup> At times, it exhibits itself in the fusion of past experience and present events.<sup>29</sup> The anxiety of loneliness reduces clear recall of its experience.<sup>30</sup> The person is unable to remember how he felt or what he did when he was lonely.<sup>31</sup> Because feelings like these are difficult to communicate, the lonely person is even more isolated from others.

The question of whether loneliness can be directly communicated is not easily answered. Some people in severe loneliness are unable to talk about it.<sup>32</sup> They keep their loneliness hidden from others, many times, even from themselves. However, one of the great difficulties in dealing with loneliness is for the therapist to recognize traces of his own existing loneliness.<sup>33</sup> The question may not be one of the lonely person's ability to communicate but rather the therapist's ability to create a climate in which the person feels free to communicate this loneliness.

The lonely person will respond if the therapist assumes the initiative to open the discussion about loneliness.<sup>34</sup> The therapist can convey acceptance by his mere presence without any therapeutic

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<sup>28</sup> Helena Lopta, "Loneliness, Forms and Components," Social Problems, 17 (1969), 248.

<sup>29</sup> Peplau, p. 1477.

<sup>30</sup> Sullivan, p. 261.

<sup>31</sup> Fromm-Reichmann, p. 328.

<sup>32</sup> Ibid.

<sup>33</sup> Ibid., p. 335.

<sup>34</sup> Ibid.

pressure. The therapist can offer his presence to the lonely patient first in a spirit of expecting nothing but to be tolerated, then, to be accepted simply as some person who is there.<sup>35</sup> The lonely person is basically embarrassed to express feelings and emotions to another person.<sup>36</sup> People must have trust in each other before a relationship is established.<sup>37</sup> Patients when ready to talk, open up and share their loneliness.<sup>38</sup> The therapist must provide a relationship in which there is an openness to involvement, a climate for self-disclosure.<sup>39</sup>

The literature proposes that the nurse should strive to establish a relationship of trust in which the patient feels free to communicate feelings. Unfortunately efforts to establish such a climate for communication are not often made.<sup>40</sup> Were the nurse able to provide such a climate, she would function in a preventative as well as therapeutic capacity. She could prevent loneliness from reaching a painful degree and she could relieve feelings of loneliness that reach such a degree.<sup>41</sup>

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<sup>35</sup> Fromm-Reichmann, p. 335.

<sup>36</sup> Rosalee Bradley, "Measuring Loneliness" (unpublished Doctor's dissertation, University of Washington, 1969), p. 4.

<sup>37</sup> Weigert, p. 124.

<sup>38</sup> Elisabeth Kübler-Ross, On Death and Dying (New York: MacMillan Co., 1969), p. 45.

<sup>39</sup> Clark, p. 40.

<sup>40</sup> Eloise Brown, "Meeting the Patient's Psychosocial Needs in the General Hospital," Social Interaction and Patient Care, eds. J. Skipper and R. Leonard (Montreal: J. B. Lippencott Co., 1965), p. 10; see also Francel, p. 180; see also, Kübler-Ross, pp. 154, 261.

<sup>41</sup> Clark, p. 40.



Sullivan believes that the lonely person moves outward toward others. Although anxious and afraid, he directs himself toward establishing a relationship with another.<sup>42</sup> Several other authors hold an opposing view. They believe that the lonely person withdraws from others. Withdrawal into fantasy, suicide, or addiction are chosen alternatives for the lonely.<sup>43</sup> It may be postulated that a continuum exists within these divergent opinions. Initially the lonely person actively seeks the companionship of others but resorts to destructive withdrawal should his need for relatedness remain unfulfilled.

Figure 1, which follows, is presented in an attempt to summarize the concepts of loneliness presented thus far in this chapter. Loneliness is said to exist when an individual is unable to satisfy his need for relatedness. Loneliness can occur at any age, given the interruption, frustration or dissatisfaction of this basic need.

Loneliness can be of two types, essential or temporary. This depends on the degree to which the need for relatedness is unsatisfied. Essential refers to deep-rooted loneliness manifesting itself in psychotic withdrawal, addiction or suicide. Temporary loneliness is of a more transient nature, correctable either in time or when the situation corrects itself.

The lonely person, though anxious and afraid seeks the companionship of others. Often their seeking behavior causes further rejection leaving them even more lonely than before.

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<sup>42</sup> Sullivan, p. 262.

<sup>43</sup> Bancroft, p. 102; Clark, p. 33; Ferriera, p. 205; Francel, p. 178; Fromm-Reichmann, p. 330; Peplau, p. 1476.

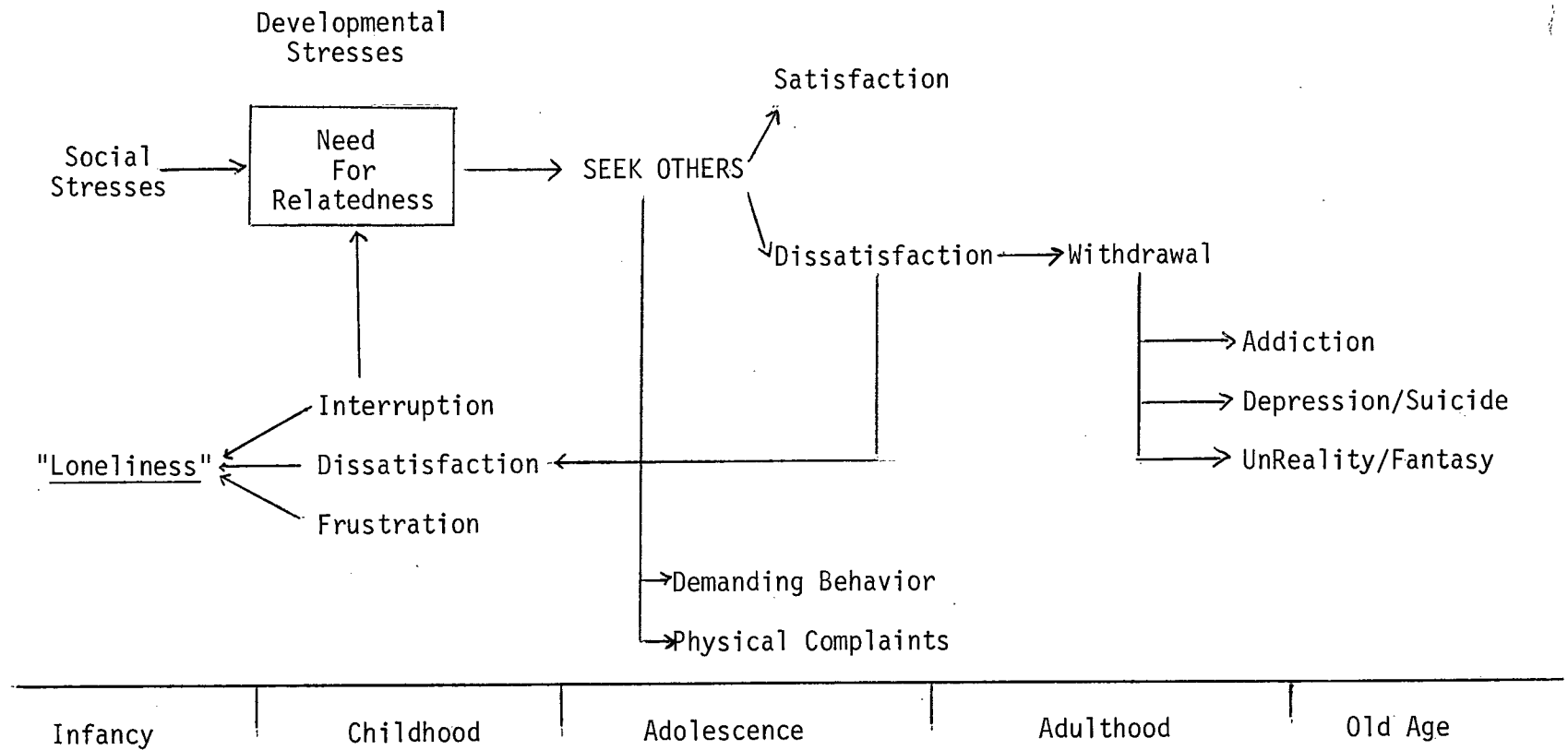


Figure 1  
Conceptual Framework for the Development  
of Loneliness as Used in this Study

## LONELINESS vs. DEPRESSION, ALIENATION

Aloneness, isolation, lonesomeness, self-imposed isolation, compulsory solitude and real loneliness are all thrown into the one terminological basket of 'loneliness.' Very little is known about the various experiences which are descriptively and dynamically different from loneliness.<sup>44</sup> With this in mind then, an attempt is made to superficially differentiate loneliness from two of these like states, depression and alienation. The rationale for this is that within the literature, alienation, depression and loneliness are frequently used interchangeably.

Loneliness vs. Depression

Zilboorg wrote of loneliness in terms of the process of depression.<sup>45</sup> Pathological loneliness is the loss of the narcissistic image and normal loneliness is a transient state within the process of mourning. The psychodynamics of loneliness are similar, if not identical with the psychodynamics of depression.<sup>46</sup> A low correlation is observed between Bradley's scale for loneliness and the M.M.P.I. scale for depression.<sup>47</sup>

Freeman's study shows that people seeking general practitioners' help, often did so because of pain or sadness, sorrow or loneliness.<sup>48</sup>

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<sup>44</sup> Fromm-Reichmann, p. 325.

<sup>45</sup> Gregory Zilboorg, "Loneliness," Atlantic Monthly, 61 (1938), 53.

<sup>46</sup> Ibid.

<sup>47</sup> Bradley, p. 18.

<sup>48</sup> Lucy Freeman, Cry for Love (New York: MacMillan Co., 1969), p. 36.

There is a link between loneliness, shame and depression.<sup>49</sup> Shame caused by guilt results in an evaluation of self as less good than others. As a result the person experiencing shame and depression withdraws into loneliness.<sup>50</sup> Buhler cites two patient examples of unexpressed loneliness.<sup>51</sup> One woman manifests a classical character disorder; the other develops nausea, pains and depression. Both are lonely.<sup>52</sup>

Loneliness is ranked as the first of nine common causes of depression and suicide among the elderly.<sup>53</sup> In a study of suicide in London, the highest rate of suicide is found with those who live a lonely life.<sup>54</sup>

The theoretical differentiation between loneliness and depression is ill-defined and the clinical picture is unclear.

It is observed, however, that in depression and loneliness there is a similar difficulty in meeting the need for relatedness. The difference between these two states is in their attempts to establish relatedness. The direction of the depressed person is inward, toward the self, away from others. The direction of the lonely person is outward, in an attempt to reestablish his relatedness to others.

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<sup>49</sup> M. Barry, "Depression, Shame and Loneliness," American Journal of Psychotherapy, 16, No. 4 (1962), 589.

<sup>50</sup> Ibid.

<sup>51</sup> Charlotte Buhler, "Loneliness in Maturity," Journal of Humanistic Psychology, 9, No. 2 (1969), 168.

<sup>52</sup> Ibid.

<sup>53</sup> Bancroft, p. 102.

<sup>54</sup> National Council of Social Science, p. 10.

### Loneliness vs. Alienation

Among the first to concern themselves with alienation were Nietzsche and Kirkegaard.<sup>55</sup> Kirkegaard's 'sickness unto death' is despair at the loss of self, a self which he believes can only be maintained through a relationship with God.<sup>56</sup> Nietzsche declares that the individual not subject himself to any deistic purpose, rather let him seek the growth of self and happiness throughout life.<sup>57</sup> Marx is concerned primarily with the limitations in which the working class suffer. He identifies a gap which exists between the worker, his work and its product. Marx attacks the powerless condition of the lower classes and the lack of personal commitment allowed them in their work.<sup>58</sup>

Sociologists call this separateness alienation. Hendin calls it 'anomie' and Reisman suggests the term 'outerdirected'.<sup>59</sup> Moustakas points out that although alienation is closely associated with loneliness, not all lonely people are alienated.<sup>60</sup> May claims that

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<sup>55</sup> Fredrick Nietzsche, Beyond Good and Evil (Edinburgh: The David Press, 1914); see also, Soren Kirkegaard, Thoughts on Crucial Situations in Human Life (Minneapolis: Augsburg Press, 1944).

<sup>56</sup> Kirkegaard, p. 248.

<sup>57</sup> Karl Marx, "Alienated Labor," Man Alone, eds. E. Josephson and N. Josephson (New York: Dell Publishing Co., 1971), pp. 93-99.

<sup>58</sup> Ibid.

<sup>59</sup> H. Hendin, "Suicide in Denmark," Who Am I? (New York: Dell Publishing Co., 1969), p. 285; see also, David Reisman, The Lonely Crowd (New York: Yale University Press, 1950), p. 14.

<sup>60</sup> Clark Moustakas, Loneliness (Michigan: Prentice-Hall Inc., 1961), p. 34.

loneliness is due to the emphasis society places on social acceptability.<sup>61</sup> The individual can temporarily lose his loneliness through social acceptance. The price is high however. He gives up his existence as an individual for that of the group. As an example of this May cites the German people during World War II who gave up their identity of self in exchange for the identity of state.<sup>62</sup> Fromm's concept of the 'marketing orientation' encompasses this same notion of social acceptance.<sup>63</sup> Personal qualities are not valuable in themselves, rather only to the extent that they are valuable to others. This leaves man alienated not only from his fellow man but alienated from himself and his own feelings.<sup>64</sup>

Ours is an age not of commitment but of alienation.<sup>65</sup> Schaectal writes that when this lack of identity or alienation becomes conscious it is experienced as being not fully a person.<sup>66</sup> The alienated feel powerless, estranged, and isolated.<sup>67</sup> Further, their behavior indicates a normlessness and meaninglessness in their lives.

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<sup>61</sup> R. May, Man's Search for Meaning (New York: W. W. Norton Co., 1953), p. 34.

<sup>62</sup> Ibid.

<sup>63</sup> Eric Fromm, Man for Himself (New York: Holt, Rinehart, and Winston, 1947), p. 80.

<sup>64</sup> Ibid.

<sup>65</sup> Kenneth Kenniston, The Uncommitted (New York: Dell Publishing Co., 1965), p. 4.

<sup>66</sup> K. Schaectal, "On Alienated Concepts of Identity," Who Am I? (New York: Dell Publishing Co., 1969), p. 13.

<sup>67</sup> Melvin Seeman, "The Meaning of Alienation," American Sociological Review, 24 (December, 1959), 783-91.

The alienated and the lonely both share the perception that a margin of difference exists between themselves and the society of others.

The difference between loneliness and alienation is found in the sense of unrelatedness. Loneliness is associated with the relatedness of the individual to others. Alienation is associated with the relatedness of the individual to society, in its institutions, mores, or expectations.

In summary the depressed and the lonely persons both exhibit difficulty in meeting the need for relatedness. The difference is observed in their attempt to meet this need. The efforts of the depressed person are inward, toward the self, whereas the efforts of the lonely person are outward, towards a relationship with others.

The alienated and the lonely persons both exhibit a difference between themselves and the society of others. In alienation, the difference is between oneself and society's institutions, mores, or expectations; in loneliness, the difference is between oneself and the sense of relatedness with others.

#### LONELINESS AND HOSPITALIZATION

Moustakas was introduced to loneliness when he experienced his daughter's hospitalization for heart surgery.<sup>68</sup> His pioneering text relates other examples of the loneliness which sick people endure during the course of accepting treatment. Not yet acquainted with other

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<sup>68</sup> Moustakas, p. 17.

patients, the newly admitted patient is particularly alone.<sup>69</sup> The admission procedure would be more aptly called "trimming" or "programming" in which the newly admitted patient is shaped and coded into the administrative machinery.<sup>70</sup>

The experience of unrelatedness is raised within the literature in connection with three particular patient groups. One group, as mentioned above, is the newly admitted patient. Another group is the patient whose illness requires extended hospitalized care. The chronically ill and the elderly are both affected by the disengagement process.<sup>71</sup> Disengagement is an adjustive response to the withdrawal or detachment of meaningful relationships.<sup>72</sup> It is a response to prolonged separation from home or loved ones which motivates the disengaged into activities which minimize interpersonal responsibility.<sup>73</sup> First the visitors come regularly, then they stop coming at all. The few available friends and family lose interest, and soon the visiting hours blend into the general monotony of the day.<sup>74</sup>

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<sup>69</sup> Brown, p. 8.

<sup>70</sup> Erving Goffman, Asylums (Garden City, N.Y.: Doubleday Anchor, 1961), p. 44.

<sup>71</sup> Rhoda L. Levine, "Disengagement in the Elderly," Nursing Outlook, 17, No. 10 (November 1969), 28-30.

<sup>72</sup> F. B. Arje, "Disengagement," Nursing Clinics of North America, 1 (June, 1966), 235.

<sup>73</sup> Ibid.

<sup>74</sup> Statement made by a resident of one of the Extended Care Units used for this study, February 1972.



The third patient group for whom relatedness is of particular concern are those admitted to the psychiatric clinical service. Often a patient finds his loneliness increased rather than relieved upon admission.<sup>75</sup> Many maladaptive patterns encountered on a psychiatric unit mask a basic loneliness. Severe anxiety, suicide, addiction, psychoses, neuroses, and character disorders can represent attempts to deal with a fundamental loneliness.<sup>76</sup> Difficulties in interpersonal relationships are concomitant with difficulties of adjustment to life. One of the more important themes within psychiatric care focuses on the establishment and maintenance of interpersonal relationships. One-to-one rapport, group encounter, or people communication through craft, role-play, meetings, focus the experiential use of interpersonal skills to regain interpersonal relatedness.

For the sensitive observer, the lonely person non-verbally communicates his loneliness in significant behavioral expressions. Time-oriented complaints are often observed. The patient complains about the endlessness of each day, days which are endured but without any effort to change. Some patients speak as though past events and present experiences are identical or fused together.<sup>77</sup> Vacillation or hesitation in making plans or the lack of any interest in any goal are

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<sup>75</sup> Francel, p. 180.

<sup>76</sup> Barry, p. 589; see also, Ferria, p. 205; see also, Fromm-Reichmann, p. 326; see also, Peplau, p. 1476; see also, N. Ross, "Death at an Early Age," Canada's Mental Health, XVIII, No. 6 (1970), 16; see also, Jack Rubins, "On the Psychopathology of Loneliness," American Journal of Psychoanalysis, 24, No. 2 (1964), 157; see also, von Witzleben, p. 38.

<sup>77</sup> Peplau, p. 1477.

observed.<sup>78</sup> The patient may over-plan or demonstrate a familiarity with things rather than people, or he may show a tendency to dislike everyone or to view people as anonymous beings.<sup>79</sup>

The lonely person moves toward establishing a relationship with others.<sup>80</sup> In their efforts to make contact with others, lonely people often show an inclination to worship other people, to invest in someone else his so-far-unmet needs and wishes. Role-reversal is seen as an attempt to establish contact with another; in addition, it ascribes to the lonely person feelings of worth and strength.<sup>81</sup> Other efforts to establish contact with the nurse include complaints about pain, noise, stuffiness, concern over strength or frequent requests for attention. Minor illnesses seem to occur in an effort to bring contact and protection. Vomiting and belching occur if the patient perceives rejection from the nurse.<sup>82</sup>

Loneliness is described as a change in behavior: grabbing of food to avoid thinking or the demand for immediate attention from the nursing staff.<sup>83</sup> Obesity, physical complaints, alcohol and drug consumption are seen as attempts to deal with a fundamental loneliness.<sup>84</sup>

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<sup>78</sup> Fromm-Reichmann, p. 330; Peplau, p. 1477.

<sup>79</sup> Peplau, *ibid.*

<sup>80</sup> Sullivan, p. 262.

<sup>81</sup> Peplau, p. 1478.

<sup>82</sup> *Ibid.*, p. 1479.

<sup>83</sup> Alice Goldman, "Learning Abortion Care," Nursing Outlook, 19, No. 5 (May 1971), 351.

<sup>84</sup> Buhler, p. 32; Clark, p. 53; Fromm-Reichmann, p. 330.

There are numerous incidents of the loneliness of the terminally ill patient: the surgical patient who knows that his surgery is only a temporary measure; the medical patient who comes to the hospital for his last admission. Their loneliness would be endurable if only

. . . someone would actually pull up a chair and sit down . . . actually listens and does not hurry by . . . someone who breaks the monotony of the loneliness . . . the agonizing waiting. . . .<sup>85</sup>

It can be said then that loneliness and hospitalization are not mutually exclusive. Hospitalization interrupts the satisfying relationships through which a person endeavors to meet his need for relatedness. The patient attempts to establish contact and meet his need for relatedness in significant patterns of behavior. Three patient groups are identified as particularly sensitive to a sense of unrelatedness within the hospital: the newly admitted, the psychiatric patient and the patient whose hospitalization is extensive. Kübler-Ross identifies a fourth group, the terminally ill patients. She, as their advocate, admonishes us for not providing in full, the quiet listening time of which they are in such desperate need.

#### SUMMARY

The purpose of this chapter is to outline the conceptual framework for loneliness and to provide some background to the loneliness of the hospitalized patient.

Loneliness is said to exist when an individual is unable to

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<sup>85</sup> Kübler-Ross, p. 259.

satisfy his need for relatedness with others. The need for relatedness is basic to man and thus the threat of loneliness is present at all stages of life. The behavioral manifestations and cognitive dimensions are described and the differences between depression and alienation are identified.

Loneliness is most often described in terms of its behavioral manifestations which frequently bring the lonely person into contact with the nurse in the clinical setting. Within the clinical setting of the hospital, the dimensions of loneliness were further studied.

Exploration of the literature relative to loneliness raises several questions:

Does the patient perceive loneliness associated changes in his behavior?

Does the patient feel free to communicate his feeling to the nurse?

Does the patient perceive a sense of relatedness with the nurse?

In the hospital, several variables effect the experience of loneliness. Identified from the literature these are: the patient care category, or the clinical service, the length of time the patient is in the hospital, and the contact the patient has with significant others. Before guidelines for nursing intervention are attempted, some direction to these questions needs to be established.

## Chapter Three

### RESEARCH DESIGN

The study's purpose and hypothesis, limitations and assumptions are outlined, along with the definition of terms used in the study. The descriptive method of research is used for this study, the data gathered by means of a self-administered questionnaire. The questionnaire used is one developed by the researcher in an attempt to systematically answer the questions raised from the literature reviewed.

### THE PURPOSE OF THE STUDY

The purpose of the study is to determine the significance of selected variables in the response of patients to loneliness-associated statements.

### DEFINITION OF TERMS

The hospitalized patients are all patients resident in three specific hospitals on the day selected for the study.

The loneliness-associated statements are derived from the literature and they seek to identify the patients' perception of his/her behavioral changes, freedom to communicate and sense of relatedness to the nurse. These loneliness-associated statements will be referred to as behavioral response categories and refer to:

- a) perceived behavioral changes;

- b) perceived freedom to communicate; and
- c) perceived relatedness to the nurse.

The selected variables are:

- a) the patient care category;
- b) the sex of the patient;
- c) the length of hospitalization; and
- d) the frequency of visitors received.

Questionnaire refers to a two part questionnaire developed by the investigator for use in this study. It represents the combination of the above two definitions. The first part of the questionnaire seeks patient information to the selected variables. The second part of the questionnaire seeks a positive or negative reply to statements within the three behavioral response categories. (See Appendix D.)

Significant is considered the .05 level of significance.

Patient care category refers to the clinical services within the general hospital. These are the services of Extended Care, Maternity, Medicine, Psychiatry, Surgery, Rehabilitation.

Extended Care refers to that level of care for persons of all ages who do not require acute hospital care and treatment nor an intensive or comprehensive program of mental and physical rehabilitation.<sup>1</sup>

Rehabilitation refers to that level of care for patients with a disability not requiring acute treatment but who could benefit from

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<sup>1</sup> British Columbia Department of Health, The British Columbia Classification of Types of Health Care (September, 1973), p. 11.

a planned intensive and comprehensive program of mental and physical rehabilitation.<sup>2</sup>

Loneliness refers to a state which exists when an individual is unable to satisfy his need for relatedness with others.

Relatedness refers to a feeling of emotional bonding an individual perceives between himself and another person.

### ASSUMPTIONS

This study is based on the following assumptions:

1. loneliness is a state experienced to some degree by hospitalized patients;
2. a lonely patient responds to the questionnaire in a different pattern than a non-lonely patient;
3. the assurance to protect the patient's anonymity predisposes the patient to be candid in his response; and
4. the patients requested to participate in the study have a level of understanding or cognitive ability to comprehend the questionnaire.

### LIMITATIONS

This study is subject to the following limitations:

1. the hospitals selected for the study service a demographically varied population. No attempt is made to relate any demographic variable to loneliness;

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<sup>2</sup> The British Columbia Classification of Types of Health Care, p. 9.

2. the time for the data collection is selected for the investigator's convenience and may have introduced some unforeseen variable not accounted for in the study;
3. the questionnaire developed from relevant literature by the investigator is constrained by subjective biases;
4. the questionnaire as a paper and pencil method of data collection is intended primarily for wide distribution. It is limited in that it seeks to achieve a surface level of information only;
5. several authors state that the lonely person is not aware of his loneliness. This study is limited by the questionnaire method of data collection in that it is based on the patient's ability to respond to loneliness-associated statements; and
6. the investigator as a stranger to the patient, distributes the questionnaire and may introduce some unforeseen variable not accounted for in the study.

#### HYPOTHESES

This study seeks to prove the following hypotheses:

1. there is no significant difference in the response of male and female patients;
2. there is no significant difference in the response of patients when length of hospitalization is compared;
3. there is no significant difference in the response of patients when clinical service is compared;



4. there is no significant difference in the response of patients when number of visits per week is compared; and
5. there is no significant difference in the response of patients when number of visitors per visit is compared.

## THE QUESTIONNAIRE

### The Development and Construction of the Questionnaire

At the outset, the design of this study involved the use of Bradley's tool to measure loneliness.<sup>3</sup> Further examination of the tool, however, presented some methodological questions which interfered with its utilization.<sup>4</sup> Since no other tool to measure loneliness could be located from the literature, it then became the task to develop one for use in this study. To establish the validity and reliability of the tool is not considered within the scope of this study. The main purpose of the tool is its attempt to establish the degree of association between the selected variables and the loneliness associated statements.

The literature reviewed regarding the loneliness of the hospitalized patient relates a disproportionate degree of loneliness with certain variables. The length of hospitalization is one variable thought to be significant to the development of loneliness. Especially susceptible is the newly admitted patient because of the unfamiliar

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<sup>3</sup> Rosalee Bradley, "Measuring Loneliness" (unpublished Doctor's dissertation, University of Washington, 1969).

<sup>4</sup> The investigator acknowledges the assistance of Dr. Donald Anderson, Professor and Director, Division of Health Sciences Research Development, University of British Columbia.

environment and somewhat impersonal admission procedure and the extended care patient because of the reduced contact, over time, with significant others. To be determined within the questionnaire then, is the length of hospitalization the patient reports when he answers the questionnaire. The time categories selected were between "less than one week" through to "three months or more." Selection of the latter category is on the basis that the majority of extended care patients are hospitalized for a minimum of three months.<sup>5</sup>

The visits or contact with significant others is thought to be crucial to the development of loneliness. For the patient whose care is extended, the contact with significant others is often reduced and thus their tendency to experience loneliness is particularly acute. In order to determine contact with significant others, two questions are asked: the number of visits the patient received within a week and the approximate number of people who came each time. Analysis of the data from these two questions will provide some indication as to the degree of contact the patient maintained with others. The degree of their relationship with the patient was not determined.

The patients using the clinical services of Psychiatry and Extended Care are most frequently cited as prone to manifest loneliness feelings. Comparison of the patients in these two services with the patients in the other clinical services within the hospital will give some credence to this observation. On the questionnaire, the clinical

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<sup>5</sup> Statement made by the Head Nurses of each Extended Care Unit used in this study.

services are listed in alphabetical order. The respondent is asked to identify his particular service. An additional category of "Don't know" is included for those respondents uncertain of their answer. The appropriate service will be identified by the investigator upon the patient's completion of the questionnaire.

Nowhere in the literature does it state whether males or females show a greater tendency to express loneliness feelings. To see whether such a tendency exists, a response to identify one's gender is requested initially in the questionnaire.

The first part of the questionnaire then, is developed to elicit responses to the variables of:

- a) the sex of the patient;
- b) the length of hospitalization;
- c) the clinical service;
- d) the number of visits received per week; and
- e) the number of visitors per visit.

The second part of the questionnaire is an attempt to corroborate empirical data with patient response. The patient is asked to respond to a series of twenty-two loneliness-associated statements derived directly from the literature. The statements are altered only to the extent that they fit the questionnaire format.

The literature reviewed indicates several behavioral changes which manifest an underlying loneliness. Whether the patient is aware that these behaviors are manifestations of loneliness is unknown;

however, the patient is reportedly able to acknowledge the behavioral change, if not the loneliness it represents. Most authors are of the opinion that the lonely person cannot communicate his loneliness directly because he does not feel a sense of relatedness in which to make this communication. Were the nurse able to create a climate of relatedness between herself and the patient, this communication of loneliness might take place.

This second part of the questionnaire then, is divided into three categories of:

- a) perceived behavioral change;
- b) perceived freedom to communicate; and
- c) perceived sense of relatedness to the nurse.

Perceived behavioral change (statements 1 to 10 inclusive) refers to an alteration in either the behavioral or emotional responses expressed by the patient since hospitalization. The specific causative factors are not determined.

Perceived freedom to communicate (statements 11 to 17 inclusive) refers to the patient's feeling of being able to share feelings or emotions with the nurse. The specific causative factors were not identified.

Perceived sense of relatedness to the nurse (statements 18 to 22 inclusive) refers to the patient's perception of being known or accepted by the nurse. These questions attempt to determine the expressed feelings by the patient of recognition, approval or understanding as demonstrated by the nurse.

The patient is requested to select whether he/she agrees or disagrees with the statements in the above three categories. Alternate responses are not offered as this design appears to be the best to elicit the desired information for analysis.

In summary, the questionnaire can thus be described as divided into two sections. The first is designed to test the variables identified as significant to the development of loneliness within the hospital. These variables are:

- a) the sex of the patient;
- b) the length of hospitalization;
- c) the clinical service;
- d) the number of visits received per week; and
- e) the number of visitors received per visit.

The second section requests [yes] or [no] responses to twenty-two loneliness associated statements. The statements are divided into the behavioral categories of:

- a) perceived behavioral change;
- b) perceived freedom to communicate; and
- c) perceived relatedness to the nurse.

#### The Pretest of the Questionnaire

A pretest questionnaire of fifty-four items was drawn up from a pool of 110 statements derived from the literature. This questionnaire was tested in one of the three hospitals included in the study.

The time period between the pretest and the later test administration was two months.

The patient population selected for the pretest were those resident in a short-stay surgical ward, a ward considered to have a complete change of its patient population within this two month period. The population sample for the pretest was thirty-eight, including twenty-three female and fifteen male patients.

The purpose of the pretest was to examine the construction of the questionnaire in terms of readability and comprehension, to gather patient comment and to familiarize the investigator with the use of the questionnaire. The results of the pretest strongly indicated that a questionnaire of fifty-four items was too lengthy. It is not reasonable to expect an unwell person to complete such a questionnaire with any degree of accuracy. The questionnaire was then revised.<sup>6</sup> Elimination of those statements which ostensibly test for the same response, reduced the questionnaire to twenty-two items.

This twenty-two itemed questionnaire was pretested in one of the hospitals included in this study. This pretest was conducted with twenty patients, including eleven female and nine male patients. No changes in the questionnaire were indicated. The pretest group was excluded from the population studied.

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<sup>6</sup> The investigator acknowledges the assistance of Mrs. Janet Gormick, Assistant Professor, School of Nursing, University of British Columbia.

### The Administration of the Questionnaire

The questionnaire was distributed and collected by the investigator. The day selected for administration of the questionnaire was at the convenience of the investigator and the nursing administrator for each hospital. Attention was paid to ward schedules and patient care requirements. The time period for the total investigation was five consecutive days.

Privacy to answer the questionnaire was provided to the extent that the situation permitted. The investigator asked each patient to participate in the study. The investigator stated that their participation was voluntary, their answers would remain anonymous, and that the purpose of the study was to help nurses to better understand patients. The investigator requested that if the patient did participate, would he please read and sign the consent form for this study. This was collected separately so that the questionnaire would not be associated with any individual's name. Any inquiries that arose from the questionnaire were answered when the investigator returned to collect the completed questionnaires. (See Appendixes A, B, and C.)

### THE POPULATION SAMPLE

The hospitals selected for this study were two general acute treatment hospitals, each with a separate but associated extended care unit and one specialized rehabilitation hospital. These hospitals were selected because their clinical services included all those to be studied and their combined patient population provided sufficient

numbers for data collection. The rehabilitation hospital supplemented an otherwise deficient clinical service population within the other two general hospitals.

The population sample consisted of all patients resident in these three hospitals on the day selected for the study. The pediatric wards were excluded from the population sample because of the difficulty in obtaining parental consent. The emergency and day care patients were also excluded from the population sample. The routine of their treatment measures would have rendered the answering of the questionnaires very inconvenient.

Table 1 represents the types of hospitals sampled and their patient population. The patient population quoted is for the day selected for the study and is exclusive of pediatric, day care or emergency ward patients.

Four hundred patients was the projected population sample, a number considered to be statistically significant for this descriptive method of research.<sup>7</sup> Patients who required help with simple reading or mechanical skills to answer the questionnaire were assisted by the investigator. Patients who were receiving treatment or who were physically or mentally incapable of answering the questionnaire were not asked to participate. The Head Nurse or her deputy on each ward assisted in this selection.

Table 2 illustrates the number and relative percentage by reason of those patients excluded from the study. The largest percentage of

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<sup>7</sup> Dr. Donald O. Anderson.



Table 1

The Type of Hospitals Used in this Study,  
 their Patient Populations on the Day  
 of the Investigation Exclusive of  
 Pediatric and Day Care Patients

Type of Hospital	Patient Population
A rehabilitative hospital	48
A general acute treatment hospital	509*
A general acute treatment hospital	305
Total	852

\* The pretest-population (20 patients) is excluded.

Table 2  
The Number and Percent by Reason of  
Non-Participants in the Study

Reason for Exclusion from the Study	Number	Percent
Receiving Treatment		
- on ward admission	8	2.0
- on ward pre-operative	9	2.2
- on ward general	8	2.0
- off ward delivery room	9	2.2
- off ward diagnostic	19	4.3
- off ward operating room	54	13.2
- off ward recovery room	35	8.6
Cognitively Unresponsive		
- aphasic	4	1.0
- pain/discomfort	13	3.2
- senility	110	26.9
- unconscious	76	18.6
Difficulty in Feeding Newborn	4	1.0
Difficulty in Language Comprehension	19	4.7
Unwilling to Participate		
- preparing for discharge	18	4.0
- receiving visitors	14	3.5
- refused, no reason stated	9	2.2
Total	409	100.0

non-participants were excluded for reasons of cognitive disability. A comparison of non-participants by clinical service was not made at the time of the study. However, it is the investigator's opinion that the major proportion of those cognitively unresponsive patients were from the clinical services of Extended Care and the specialities within Medicine and Surgery, specifically cardiology, neurology, and neurosurgery. This lack of cognitive response is not entirely foreign to the patients cared for in these particular services. It is to be noted that in the category of non-participants, those receiving treatment or feeding a newborn were visited twice to ascertain their availability before exclusion from the study.

#### SUMMARY

The specifics of the research design, its purpose, assumptions, limitations, and hypotheses were listed and the terms defined. The tool used in the study is a two-part questionnaire developed by the investigator from the literature. The first part identifies variables specific to the loneliness of the hospitalized patient. The second part lists statements of behavioral indicators of loneliness. The main purpose of the study is to determine the degree of association between the variables of the first part and the behavioral indicators of the second part. The method of pretest and distribution of the questionnaire is described. The population sample is described and the non-participating population sample is listed and identified.

## Chapter Four

### ANALYSIS OF THE DATA

Three separate sections of analysis are made on the data collected. The first section is the analysis of the population sample in terms of the selected variables. The second section determines the degree of association between the three categories of behavioral response. The third section tests the hypotheses of the study.

#### ANALYSIS IN RELATION TO THE POPULATION SAMPLE

##### The Characteristics of the Population Sample

Of the total 443 respondents, more than half were female. Table 3 represents the sample size and indicates the distribution for female and male respondents.

Table 3

Frequency of Respondents According  
to the Sex of the Respondents

Patient	Number of Respondents	Percentage
Male	141	31.8
Female	302	68.2
Total	443	100.0

Further inquiry into this disproportionate number of females reveals

that certain clinical services are more prone to treat females as demonstrated in Table 4.

Table 4  
Frequency of Male/Female Respondents  
According to Clinical Service

Clinical Service	Number of Respondents Male	Percent of Respondents	Number of Respondents Female	Percent of Respondents
Extended Care	15	3.4	72	16.3
Maternity	-	-	48	10.8
Medicine	42	9.5	42	9.5
Psychiatry	18	4.1	49	11.1
Surgery	49	11.1	50	11.3
Rehabilitation	17	3.8	41	9.3
Total	141	31.9	302	68.3

Medicine and Surgery clinical services are evenly divided between the sexes. In Psychiatry, Rehabilitation and Extended Care clinical services, the number of females is dominant. The high percentage of female respondents in Extended Care may be attributed to the longer life expectancy for females and the older age group which predominates in this service.

Table 5 represents the frequency distribution for length of hospitalization. As demonstrated in this table, the length of hospitalization holds the greatest frequency for respondents at opposite ends of the scale. More than half the respondents either reported 'less than one week' or 'more than three months' of hospitalization.

Table 5  
Frequency of Respondents According  
to Length of Hospitalization

Length of Hospitalization	Number of Respondents	Percentage
Less than 1 Week	148	33.4
1 Week - Less than 2 Weeks	78	17.6
2 Weeks - Less than 3 Weeks	34	7.7
3 Weeks - Less than 1 Month	20	4.4
1 Month - Less than 2 Months	38	8.5
2 Months - Less than 3 Months	27	6.1
3 Months or More	98	22.3
Total	443	100.0

This observation is supported by the data in Table 6 which provides the frequency distribution by clinical service.

Table 6  
Frequency of Respondents According  
to Clinical Service

Clinical Service	Number of Respondents	Percentage
Extended Care	87	19.6
Maternity	48	10.8
Medicine	84	18.9
Psychiatry	67	15.1
Surgery	99	22.3
Rehabilitation	58	13.3
Total	443	100.0

The high percentage of surgical patients, 22.3 percent, might account for those patients who responded to the 'less than one week' category. Similarly, since 19.6 percent of the respondents are from Extended Care, the 'three months or more' hospitalization would seemingly stem from their responses.

Tables 7 and 8 provide information collected on the frequency of visitors per visit.

Table 7  
Frequency of Respondents According  
to the Number of Visits/Week

Number of Visits/Week	Number of Respondents	Percentage
Daily	303	68.3
Twice a Week	85	19.1
Once a Week	31	6.9
Almost Never	24	5.7
Total	443	100.0

Table 8  
Frequency of Respondents According  
to the Number of Visitors/Visit

Number of Visitors/Visit	Number of Respondents	Percentage
One	178	40.1
2 - 3	243	54.8
4 or More	15	3.3
None	7	1.8
Total	443	100.0

These tables indicate that the majority of patients are well visited. This is both in terms of the number of visits received and the number of visitors per visit. Daily visits of two or three visitors per time are reported most frequently.

In summary, the analysis relative to the population sample is that the population sample is 68.2 percent female. Comparison of the male/female distribution by clinical service indicates a disproportionate number of females in Extended Care, Psychiatry, Rehabilitation, Maternity. The frequency distribution for length of hospitalization is loaded in two categories, 33.4 percent in the 'less than one week' and 22.3 percent for 'three months or more.' The distribution for clinical service by total population ranges from Surgery, 22.3 percent to Rehabilitation, 13.3 percent. The majority of respondents, 68.0 percent, reported daily visits, and 54.8 percent received two to three visitors per visit.

The population sample can be described as disproportionately female, with Surgery, 22.3 percent, the largest single respondent group. The major proportion of respondents were hospitalized for either less than one week or more than three months. The major proportion of respondents were well visited, reporting most frequently two to three visitors daily.

#### ANALYSIS IN RELATION TO THE BEHAVIORAL RESPONSE CATEGORIES

The degree of association among the three behavioral response categories (that is, perceived behavioral change, perceived freedom to



communicate and perceived relatedness to the nurse) is determined by the chi-square method of analysis. This analysis is to determine if there is any association among these three categories, specifically, whether these three categories elicit separate and distinct behavioral responses.

Table 9 illustrates the chi-square analysis for the behavioral response categories and the degree of freedom for these categories.

Table 9  
Association Between Categories of the Questionnaire  
Degrees of Freedom and Chi-Square Values Listed  
per Association

Questionnaire Numbers	Patient Perceived . . .	$d_f$	$\chi^2$ Value	P
1-10/11-17	Behavioral Change/ Freedom to Communicate	12	33.12	0.00098
1-10/18-22	Behavioral Change/ Relatedness to Nurse	9	41.86	0.00000
11-17/18-22	Freedom to Communicate/ Relatedness to Nurse	12	110.72	0.00000

The association between all three categories is highly significant. However, the association between the freedom to communicate and relatedness with the nurse is so highly significant that these categories appear to test for the same behavioral response.

Some conclusions can be drawn from the association of behavioral change with the other two categories. A high response to those changes in behavior reported to indicate loneliness, is associated with a low degree of freedom to communicate and perceived relatedness. The

implication is that those respondents who reported a high degree of loneliness associated behavioral changes did not feel free to communicate these feelings nor did they perceive a high degree of relatedness in which to make this communication.

The analysis of the association between the behavioral response categories reveals two interesting observations.

A high degree of perceived behavioral change is associated with a low degree of perceived freedom to communicate and perceived relatedness to the nurse. That is, the more loneliness-associated changes a patient perceives in himself, the less likely he feels free to communicate these to the nurse.

The second observation is the high degree of association between perceived freedom to communicate and perceived relatedness to the nurse. These two categories test for the same behavioral response. Freedom to communicate and perceived relatedness are one and the same perception.

Since both these categories test for the same response, a .05 level of significance for either of the two categories is considered significant for the hypothesis.

#### ANALYSIS IN RELATION TO THE HYPOTHESES OF THE STUDY

The hypotheses are tested by means of the chi-square method of analysis. Since there are no previous studies to use as a guide, the frequencies are based on the marginal totals and groupings assigned by the investigator.<sup>1</sup> These groupings provide a span from high to low

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<sup>1</sup> The investigator acknowledges the assistance of Dr. Donald Anderson, Professor and Director, Division of Health Services Research Development, University of British Columbia.

frequency distribution for each of the behavioral response categories.

The responses with small frequencies were grouped together to provide this distribution. The groupings arrived at for perceived change were:

- 0            positive responses;
- 1 to 2      positive responses;
- 3 to 4      positive responses; and
- 5 to 7      positive responses.

The groupings arrived at for perceived freedom to communicate were:

- 0 to 2      positive responses;
- 3            positive responses;
- 4            positive responses;
- 5            positive responses; and
- 6 to 7      positive responses.

The groupings arrived at for perceived relatedness were:

- 0 to 1      positive responses;
- 2            positive responses;
- 3            positive responses; and
- 4 to 5      positive responses.

### Analysis of the Data in Relation to Hypothesis 1

Hypothesis 1: There is no significant difference in the response of male and female patients.

Support for Hypothesis 1 is achieved. There is no significant difference between male and female respondents in any of the behavioral categories. Tables 10, 11 and 12 verify this conclusion.

Table 10  
Comparison of Responses indicating Perceived  
Behavioral Change and Sex of Patient

Sex of Respondent	Low Degree of Change		High Degree of Change							
	1	2	3	4						
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
Male	30.50	43	32.62	46	19.15	27	17.73	25		
Female	25.17	76	28.15	85	24.83	75	21.85	66		
Total	26.86	119	29.57	131	23.02	102	20.54	91	100.00	443

$$\chi^2 = 3.81$$

$$d_f = 3$$

$$P = 0.28201$$

Table 11  
Comparison of Responses Indicating Perceived Freedom  
to Communicate and Sex of the Patient

Sex of Patient	Low Degree of Freedom				High Degree of Freedom							
	1		2		3		4		5			
	Percent Freq.		Percent Freq.		Percent Freq.		Percent Freq.		Percent Freq.			
Male	17.73	25	21.99	31	20.57	29	22.70	32	17.02	24		
Female	24.83	75	17.55	53	17.55	53	16.23	49	23.84	72		
Total	22.57	100	18.96	84	18.51	82	18.28	81	21.67	96	100.00	443

$$\chi^2 = 7.88$$

$$d_f = 4$$

$$P = 0.09483$$

Table 12  
Comparison of Responses Indicating Perceived Relatedness  
to the Nurse and Sex of the Patient

Sex of Patient	Low Degree of Relatedness				High Degree of Relatedness					
	1		2		3		4			
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
Male	20.57	29	23.40	33	33.33	47	22.70	32		
Female	16.23	49	24.17	73	28.48	86	31.13	94		
Total	71.61	78	23.93	106	30.02	133	28.44	126	100.00	443

$$\chi^2 = 4.21$$

$$d_f = 3$$

$$P = 0.23838$$

### Analysis of the Data in Relation to Hypothesis 2

Hypothesis 2: There is no significant difference in the response of patients when length of hospitalization is compared.

Support for this hypothesis is achieved. There is no significant difference in the response of patients when length of hospitalization is compared.

The category of perceived behavioral change achieves a 34.34 ( $P = 0.00063$ ) level of significance. The categories of perceived freedom to communicate and perceived relatedness do not achieve significance.

The association between length of hospitalization and behavioral change is illustrated in Figure 2.

Clearly, patients hospitalized for '3 months or more' perceived themselves as the most changed of any group. Those in the hospital for 'less than one week' perceived the least changes. Almost consistently, the number of changes perceived increased as the length of hospitalization increased.



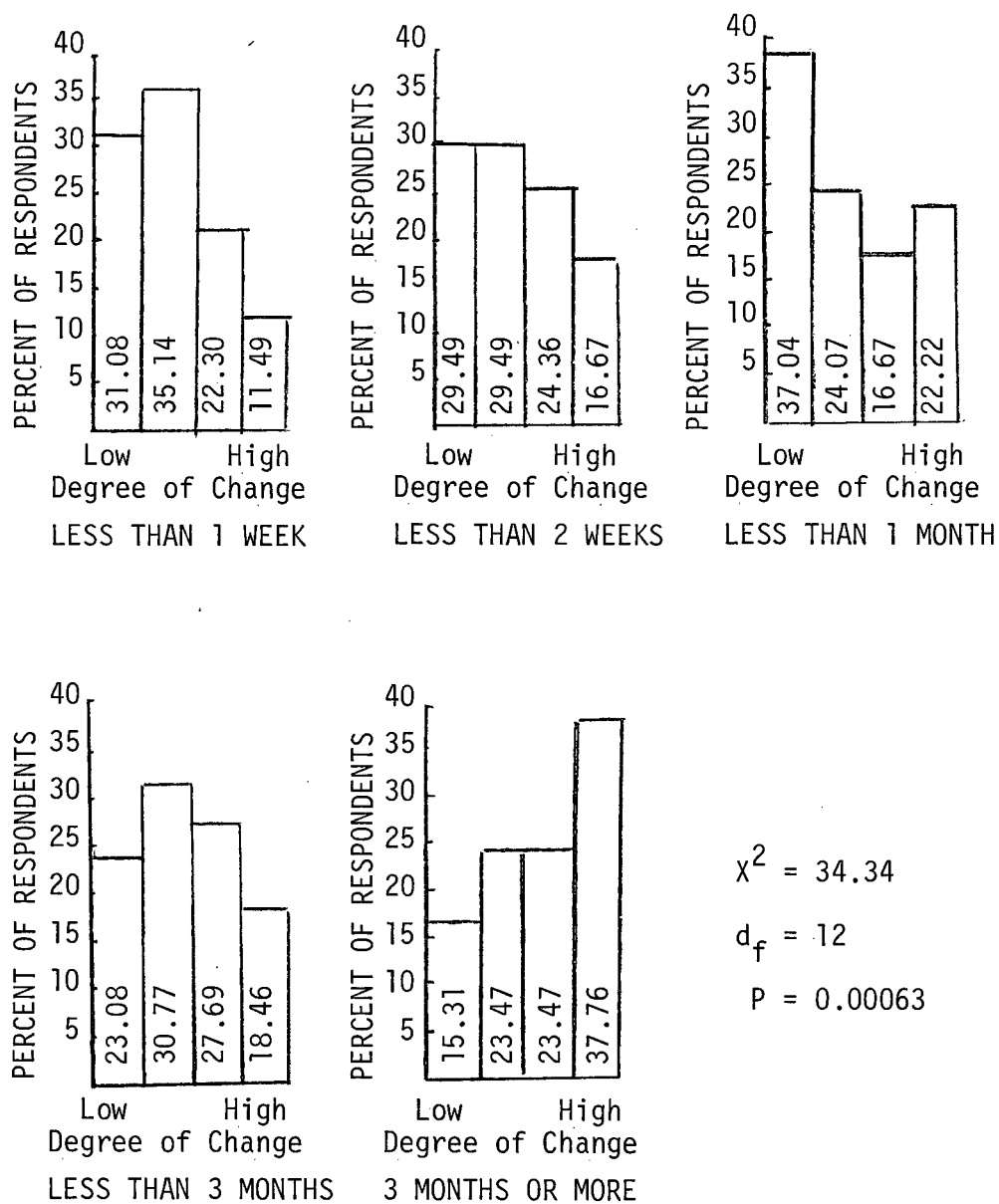


Figure 2

Comparison of Responses Indicating Perceived Behavioral Change and Length of Hospitalization

Tables 13 and 14 indicate the frequency distributions for perceived freedom to communicate and perceived relatedness with length of hospitalization. The association between both these variables and length of hospitalization is not significant.

Summarizing the data in relation to Hypothesis 2 shows support for this hypothesis is achieved. There is no significant difference in patient response when length of hospitalization is compared. However, in the category of perceived behavioral changes, a significant trend is noted. The longer the hospitalization, the more changes are perceived. Almost consistently, the number of changes perceived increased as the length of hospitalization increased.

Table 13  
Comparison of Responses Indicating Perceived Freedom  
to Communicate and Length of Hospitalization

Length of Stay	Low Degree of Freedom						High Degree of Freedom					
	1		2		3		4		5			
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
Less than 1 week	22.30	33	19.59	29	12.16	18	23.65	35	22.30	33		
Less than 2 weeks	15.38	12	20.51	16	19.23	15	23.08	18	21.79	17		
Less than 1 month	31.48	17	20.37	11	16.67	9	12.96	7	18.52	10		
Less than 3 months	23.08	15	15.38	10	27.69	18	15.38	10	18.46	12		
3 Months or more	23.47	23	18.37	18	22.45	22	11.22	11	24.49	24		
Total	22.57	100	18.96	84	18.51	82	18.28	81	21.67	96	100.00	443

$$\chi^2 = 19.56$$

$$d_f = 16$$

$$P = 0.24024$$

Table 14  
Comparison of Responses Indicating Perceived  
Relatedness and Length of Hospitalization

Length of Stay	Low Degree of Freedom				High Degree of Freedom					
	1		2		3		4			
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
Less than 1 week	14.54	23	21.62	32	27.03	40	35.81	53		
Less than 2 weeks	17.95	14	21.79	17	37.18	29	23.08	18		
Less than 1 month	12.96	7	22.22	12	42.59	23	22.22	12		
Less than 3 months	20.00	13	21.54	14	27.69	18	30.77	20		
3 Months or more	21.43	21	31.63	31	23.47	23	23.47	23		
Total	117.61	78	23.93	106	30.02	133	28.44	126	100.00	443

$$\chi^2 = 16.44$$

$$d_f = 12$$

$$p = 0.16303$$

### Analysis of the Data in Relation to Hypothesis 3

Hypothesis 3: There is no significant difference in the response of patients when clinical service is compared.

This hypothesis is rejected on the basis of the data analysis. All behavioral response categories are significant for each of the clinical services compared.

Figure 3 demonstrates the association between perceived behavioral change and clinical service.

Extended Care and Psychiatry groups both reported a high degree of perceived change. This positive association toward more change perceived is a direct contrast to the negative association demonstrated by all other clinical services. Psychiatry is the only clinical service to show so few responses within the category of 'no change perceived.' There exists within Psychiatry and Extended Care a common element which predisposes their respondents to perceive more changes in themselves.

Maternity, Medicine, Surgery, and Rehabilitation respondents all demonstrated a trend toward perceiving few changes in themselves. Maternity respondents perceived themselves as the least changed of these four clinical services. No Maternity respondents answered in the last category of 'five or more changes perceived.' Surgery respondents reported only 'one or two changes' most often. The trend for Medicine and Rehabilitation respondents was to perceive few changes in themselves, yet not as few as their Maternity and Surgery counterparts.

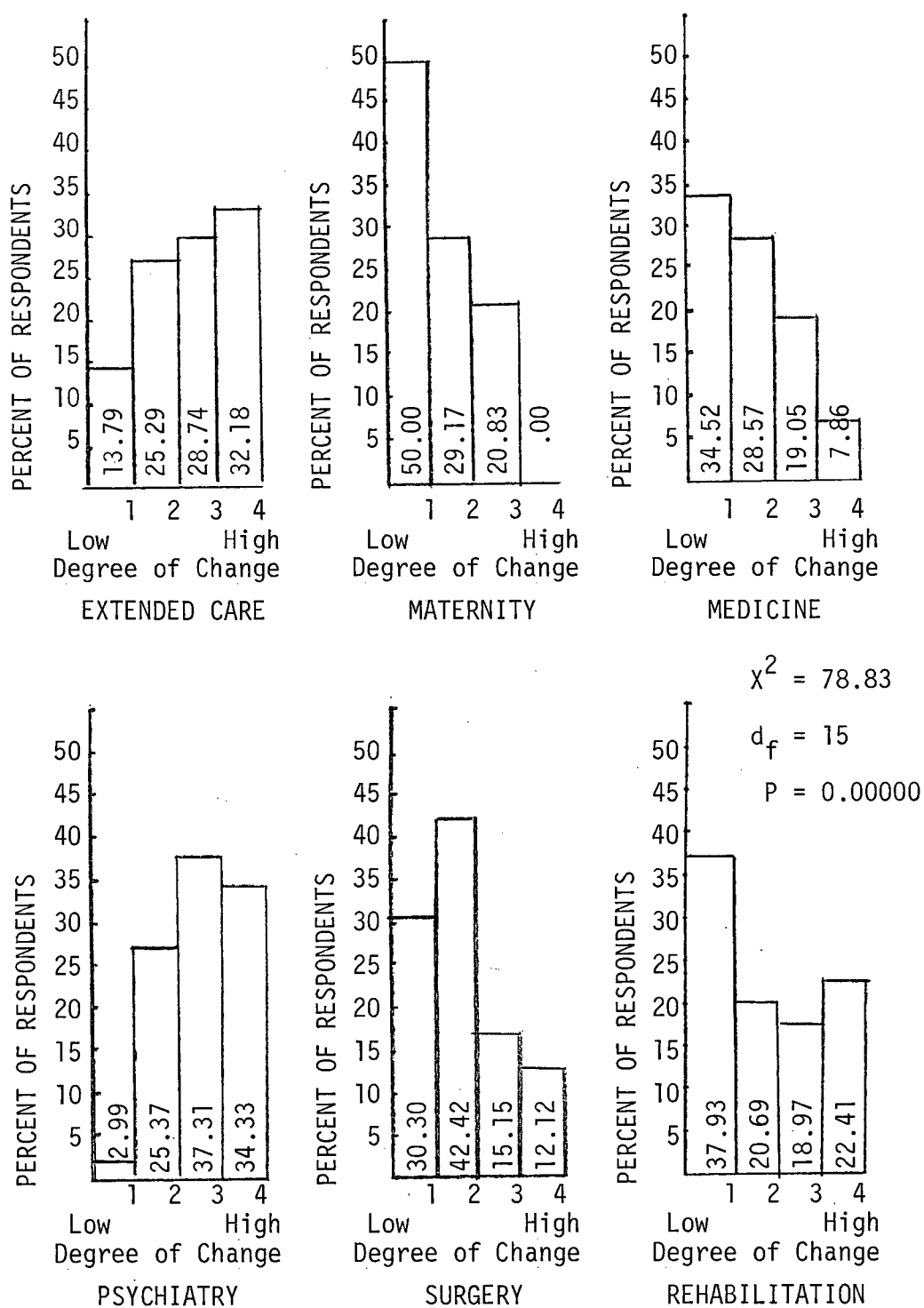


Figure 3

Comparison of Responses Indicating Perceived Behavioral Change and Clinical Service

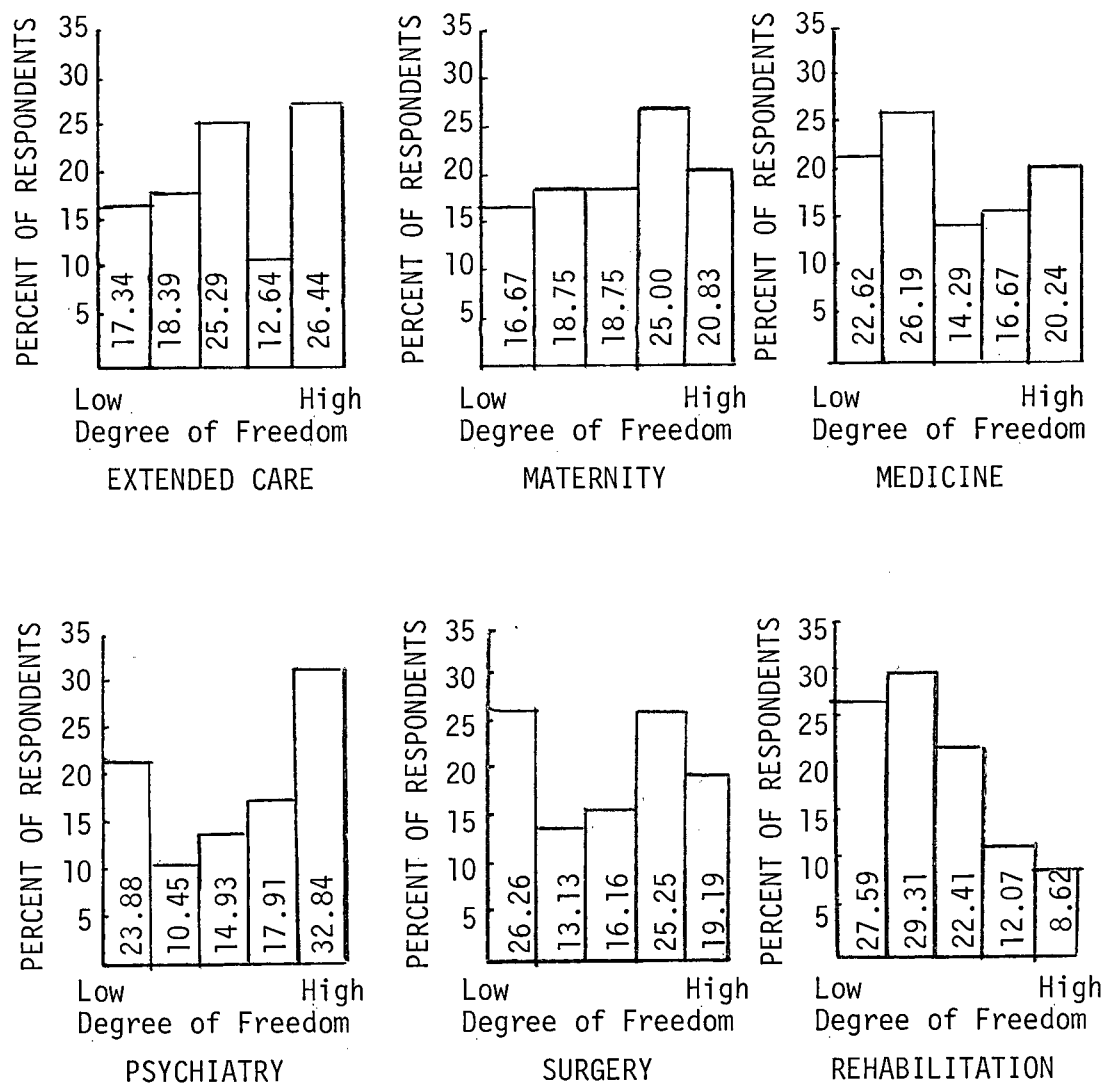
In the previous analysis of the data regarding the length of hospitalization, it is noted that increased change in behavior coincided with increased length of hospitalization. Maternity and Surgery patients are usually hospitalized for shorter periods of time than are Medicine or Rehabilitation patients. This then, might account for the more obvious downward trend toward fewer changes perceived within the Maternity and Surgery respondent groups. Hospitalized for shorter periods, Maternity and Surgery respondents would then perceive themselves as less changed than would the Medicine or Rehabilitation respondents.

In relation to perceived behavioral change then, Psychiatry and Extended Care patients perceived many changes in themselves; Medicine and Rehabilitation patients perceived a few changes; and Maternity and Surgery patients perceived the least changes of any respondent group.

Figure 4 demonstrates the association between perceived freedom to communicate and clinical service.

Rehabilitation respondents very definitely did not perceive the freedom to communicate. A high degree of difference exists between those who reported a low degree and those who reported a high degree of freedom to communicate. The contrast is especially apparent when the other clinical services are compared.

Extended Care, Surgery and Medicine respondents appear almost evenly divided between a low degree and a high degree of freedom to communicate. This minimal difference leads one to believe that freedom



$$\chi^2 = 33.66$$

$$d_f = 20$$

$$P = 0.02851$$

Figure 4

Comparison of Responses Indicating Perceived  
Freedom to Communicate and Clinical Service



to communicate is of no particular significance for either of these three groups.

The most significant association within the category of freedom to communicate is found within Psychiatry. A large proportion of the respondents from Psychiatry perceived a high degree of freedom to communicate. A similar positive association is also found within the Maternity respondent group, but not to the degree that is perceived by the Psychiatry respondents.

In relation to freedom to communicate then, Maternity and Psychiatry respondents perceived a high degree of freedom; Extended Care, Medicine and Surgery respondents were indifferent; and Rehabilitation respondents perceived little freedom in which to communicate.

Figure 5 illustrates the association between perceived relatedness to the nurse with the clinical service.

Maternity and Psychiatry respondent groups both exhibited a high degree of relatedness to the nurse. Sixty-four percent of Psychiatry respondents reported within the third and fourth highest category for relatedness. The most obvious expression of relatedness, however, comes from the Maternity respondents, 60 percent of whom answer to the highest category of relatedness.

There is an even distribution across all categories of response for Extended Care respondents. This distribution pattern seems to indicate an indifference to the question of relatedness by the Extended Care patients.

The three clinical services of Medicine, Surgery, and

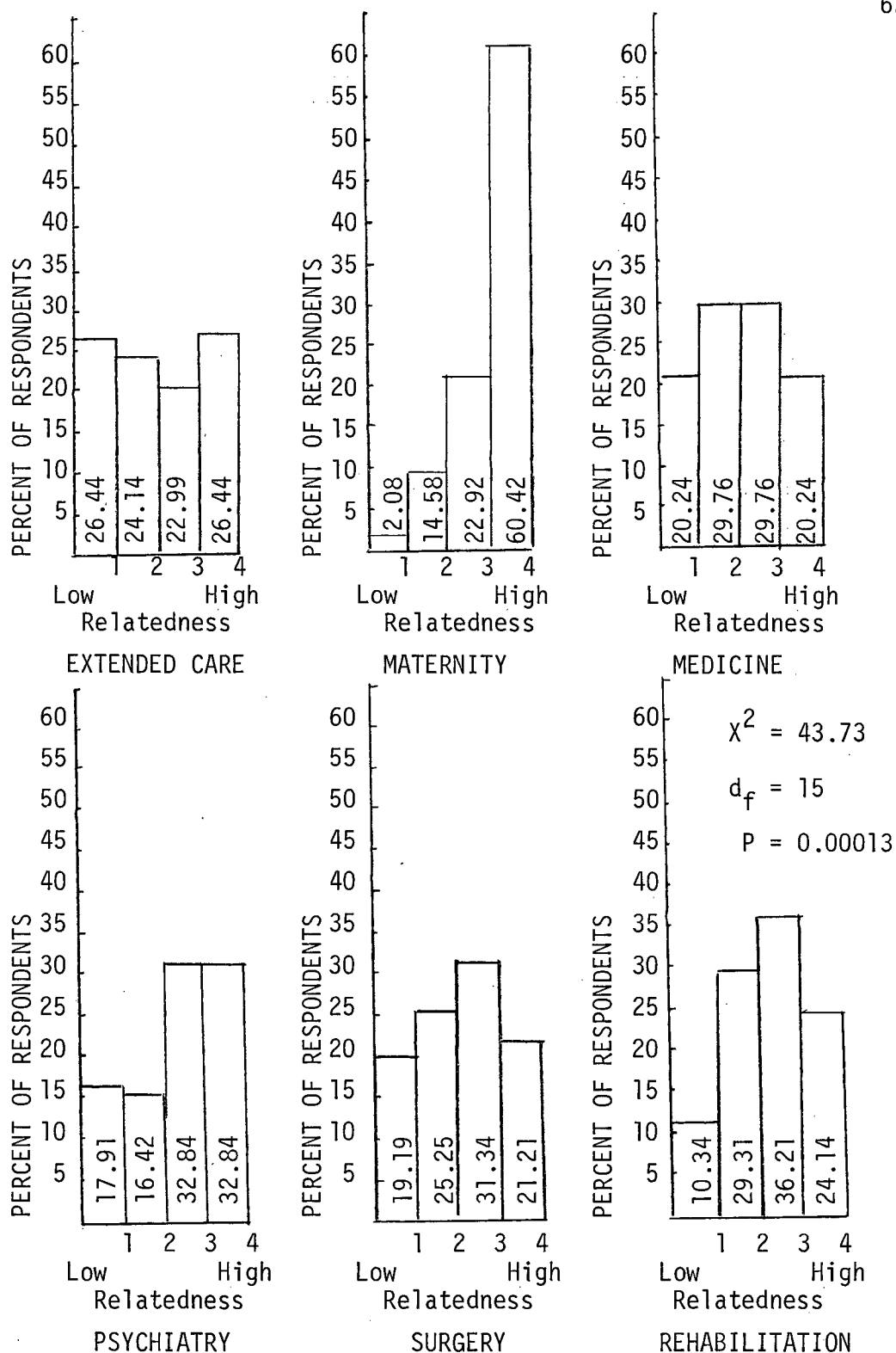


Figure 5

Comparison of Responses Indicating Perceived  
Relatedness and Clinical Service

Rehabilitation exhibit an average distribution pattern in response to the category of relatedness. The highest degree of relatedness within these three clinical services was reported by the Rehabilitation respondents.

In the section of analysis dealing with the association between the behavioral response categories (pages 44 to 46), perceived freedom to communicate and perceived relatedness were found to test for the same response. For the variable of clinical service, however, these response patterns vary. Comparison reveals some interesting contrasts as well as similarities.

The most remarkable contrast between freedom to communicate and perceived relatedness is found within the Rehabilitation respondent group. Rehabilitation patients reported the lowest of all the clinical services in the category of freedom to communicate. Curiously enough, while these respondents reacted negatively to the category of freedom to communicate they reacted positively to the category of relatedness. One speculation regarding this divergent pattern may relate to the rehabilitation treatment goals. Emphasis of the relearning tasks may predispose the patient to de-emphasize free communication in order to get on with the task at hand. However, these relearning tasks require the close involvement between patient and nurse, which predisposes the patient to perceive a sense of relatedness to the nurse.

Differences in the direction of response for Medicine and Surgery clinical services tends to be slight and unremarkable. Medicine respondents were slightly more negative in their reaction to

freedom to communicate yet average in their response to relatedness. Surgery respondents while indifferent to the category of freedom to communicate, demonstrated a slightly more positive response in their perception of relatedness.

Similarities are seen in the response patterns of patients within Extended Care, Maternity and Psychiatry. Extended Care respondents showed an indifference to both categories of response. Neither the freedom to communicate nor the sense of relatedness was of any particular significance to the respondents from Extended Care. Psychiatry respondents consistently responded in a positive direction in both categories. They reported a high degree of freedom to communicate as well as a high degree of relatedness to the nurse.

Maternity respondents also showed a positive direction in their responses to both categories. However, their positive response to relatedness was remarkable. While a 4 percent difference exists between high and low on the freedom to communicate scale, there is a 58 percent difference between high and low on the relatedness scale. Maternity respondents very definitely perceived a sense of relatedness with the nurse even though they were not as definite in their perception of their freedom to communicate with her.

Summarizing the data in relation to Hypothesis 3 shows this hypothesis is rejected. There was a significant difference in the response of patients when clinical service was compared.

Extended Care respondents reported many behavioral changes in themselves but were indifferent to the categories of perceived freedom

to communicate and perceived relatedness. Psychiatry respondents also perceived many behavioral changes, yet, they reported a positive reaction to perceived freedom to communicate and perceived relatedness.

Implications for these two clinical services is important. Patients in both perceive many loneliness associated changes in themselves but Psychiatry respondents feel free to communicate and Extended Care patients do not.

Maternity respondents replied to very few of the loneliness associated changes in behavior. Their response was positive to the categories of freedom to communicate and perceived relatedness. The positive trend for relatedness, however, far exceeds that for freedom to communicate. This seems to indicate that Maternity respondents very definitely perceived a sense of relatedness with the nurse even though they were not as definite in their perception of the freedom to communicate with her.

The data analysis for Surgery respondents indicates that few loneliness-associated behavioral changes were perceived. Freedom to communicate was of no particular significance although a positive sense of relatedness to the nurse was reported.

Medicine respondents related more loneliness-associated behavioral changes than did Surgery respondents. Medicine respondents perception of relatedness was average, but their perception of freedom to communicate was negative. The implication is important. Medicine respondents often perceive loneliness-associated changes in themselves but like Extended Care respondents, they do not perceive the freedom to

communicate these changes. Patients in both these clinical services perceived loneliness-associated change in their behavior but from the data, it seems unlikely that these changes would be communicated.

Rehabilitation respondents perceived few loneliness-associated changes in themselves. Their response to freedom to communicate was the most negative of any clinical service, yet they were positive in their response to relatedness. These respondents it appears, perceived a sense of relatedness to the nurse yet did not or would not allow themselves the freedom to communicate with her.

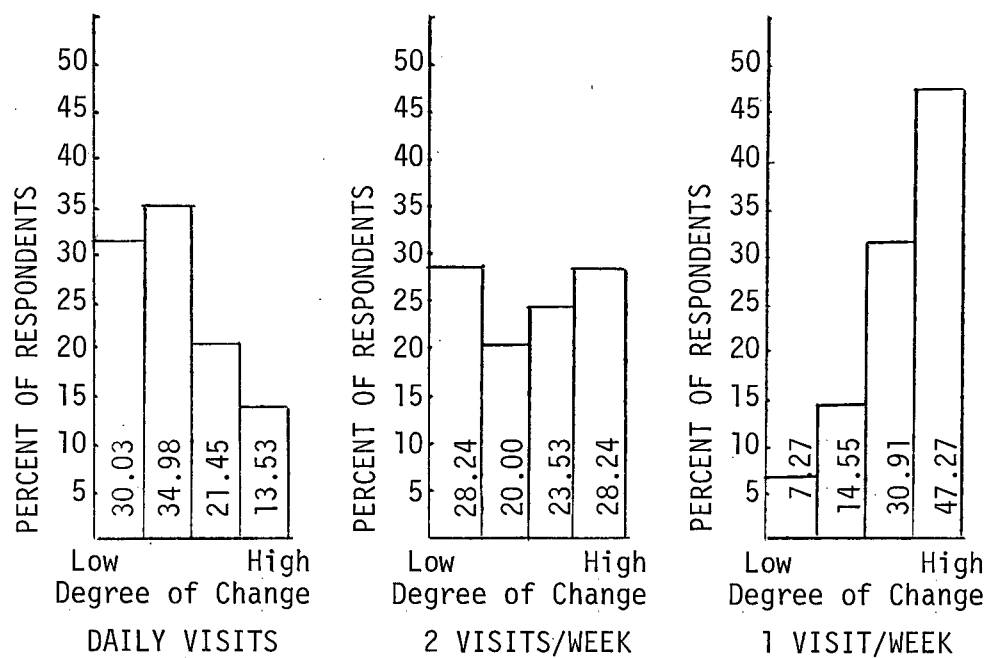
#### Analysis of the Data in Relation to Hypothesis 4

Hypothesis 4: There is no significant difference in the response of patients when number of visits received is compared.

This hypothesis is rejected on the basis of the data analysis. There is a significant difference for perceived behavioral change and perceived relatedness when number of visits is compared. However, there is no significant difference when perceived freedom to communicate is compared. As stated earlier (page 46), the hypothesis is significant when a level of significance is achieved for two of the three categories of behavioral response.

Figure 6 demonstrates the association between perceived behavioral change and number of visits received.

Respondents who received visits daily perceived very few changes in themselves. Respondents who received visitors twice a week were indifferent in their response while those who received visits only once a week reported a high degree of change perceived. Very clearly the respondents who received visitors once a week reported a high degree of change perceived.



$$\chi^2 = 49.54$$

$$d_f = 6$$

$$P = 0.00000$$

Figure 6

Comparison of Responses Indicating Perceived Behavioral Change and Number of Visits Received



Table 15 represents the association between perceived freedom to communicate and number of visits received. The data does not achieve significance. The number of visits received bears no significant association to the respondents perception of his freedom to communicate.

Figure 7 demonstrates the association between perceived relatedness and the number of visits received.

Clearly there is a significant association between perceived relatedness and number of visits received. There is a positive association between perceived relatedness and daily visits. Those who received daily visits reported a high degree of relatedness. Conversely, those who received visits twice or once a week reported a low degree of relatedness.

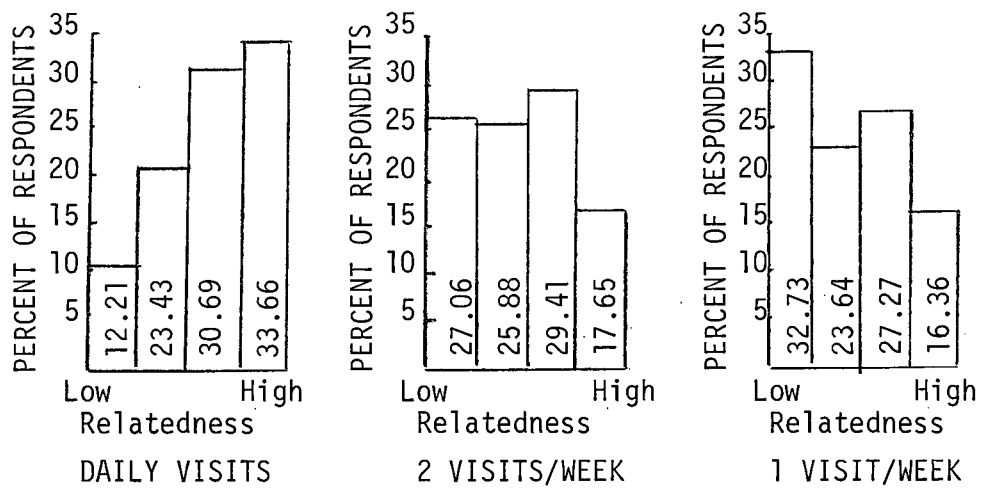
Table 15  
Comparison of Responses Indicating Perceived Freedom  
to Communicate and Number of Visits Received

No. of Visits	Low Degree of Freedom						High Degree of Freedom					
	1		2		3		4		5			
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
Daily	20.13	61	18.48	56	18.15	55	18.81	57	24.42	74		
2/Week	25.88	22	20.00	17	20.00	17	18.82	16	15.29	13		
1/Week	30.91	17	20.00	11	18.18	10	14.55	8	16.36	9		
Total	22.57	100	18.96	84	18.51	82	18.28	81	21.67	96	100.00	443

$$\chi^2 = 7.00$$

$$d_f = 8$$

$$P = 0.53765$$



$$\chi^2 = 26.04$$

$$d_f = 6$$

$$P = 0.00025$$

Figure 7

Comparison of Responses Indicating Perceived  
Relatedness and Number of Visits Received

Summarizing the data in relation to Hypothesis 4 shows this hypothesis is rejected. There is a significant difference in the response of patients when number of visits received is compared.

Those respondents who received visits daily reported very few loneliness-associated changes in themselves and indicated a high degree of relatedness to the nurse. Respondents who received visits twice a week were indifferent in their perception of loneliness-associated changes and negative in their perception of relatedness. Respondents whose visits were only once a week perceived many of the loneliness-associated changes but did not perceive a sense of relatedness to the nurse.

Clearly the area of concern is those respondents who receive less than daily visits. It seems that their reduced relatedness with significant others reduces their relatedness with the nurse and predisposes them to perceive many loneliness-associated changes in their behavior.

### Analysis of the Data in Relation to Hypothesis 5

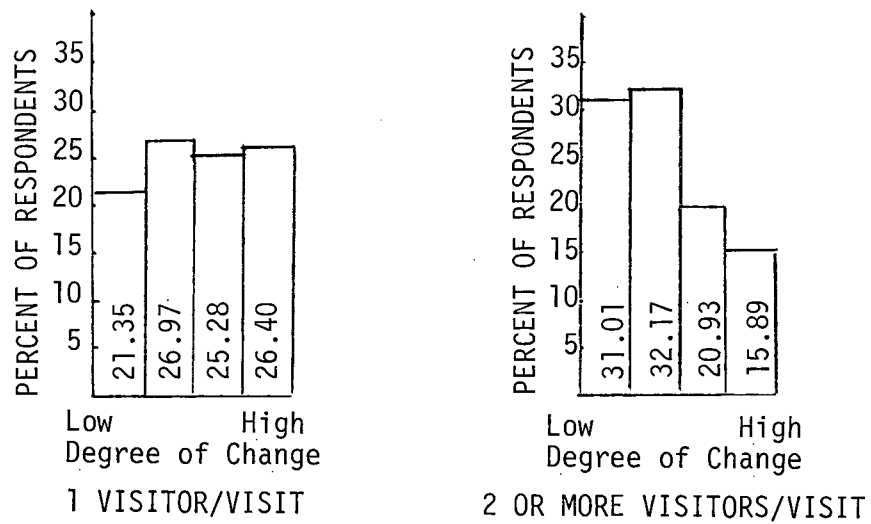
Hypothesis 5: There is no significant difference in the response of patients when number of visitors per visit is compared.

Support for this hypothesis is achieved. There is no significant difference in the response of patients when number of visitors per visit is compared.

The category of perceived behavioral change achieves a level of significance. The categories of perceived freedom to communicate and perceived relatedness do not.

Figure 8 demonstrates the association between perceived behavioral change and the number of visitors per visit received.

Comparison of previous analysis for number of visits reveals that a more notable difference exists between respondents who received visits daily and those who received visits weekly. The more obvious degree of difference indicates that visits received is more significant than number of visitors per visit.



$$\chi^2 = 11.23$$

$$d_f = 3$$

$$P = 0.01064$$

Figure 8

Comparison of Responses Indicating Perceived Behavioral Changes and Number of Visitors per Visit

Tables 16 and 17 indicate the frequency distribution for perceived freedom to communicate and perceived relatedness with number of visitors per visit. The association between both these variables and number of visitors is not significant in either category.

Summarizing the data in relation to Hypothesis 5 shows support for this hypothesis is achieved. There is no significant difference in the response of patients when number of visitors per week is compared.

Respondents who reported one visitor per visit perceived more loneliness-associated changes in themselves than did those whose visitors were more numerous. The difference, however, is not as apparent as when number of visits is compared as in Hypothesis 4.

Table 16

Comparison of Responses Indicating Perceived Freedom to Communicate  
and Number of Visitors Received per Visit

No. of Visitors	Low Degree of Freedom				High Degree of Freedom							
	1		2		3		4		5			
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
One	34.16	43	21.19	39	17.98	32	15.73	28	20.22	36		
Two or More	20.93	54	17.05	44	18.22	47	20.54	53	23.26	60		
Total	22.25	97	19.04	83	18.12	79	18.58	81	22.02	96	100.00	443

$$\chi^2 = 3.55$$

$$d_f = 4$$

$$P = 0.47200$$



Table 17  
Comparison of Responses Indicating Perceived Relatedness and  
and Number of Visitors Received per Visit

No. of Visitors	Low Degree of Relatedness				High Degree of Relatedness					
	1		2		3		4			
	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.		
One	23.03	41	24.16	43	27.53	49	25.28	45		
Two or More	13.95	36	23.64	61	31.40	81	31.01	80		
Total	17.66	77	23.85	104	29.82	130	28.67	125	100.00	443

$$\chi^2 = 6.66$$

$$d_f = 3$$

$$P = 0.08210$$

## SUMMARY

The analysis of the data is divided into three sections. The first section is the analysis of the population sample in terms of the selected variables. The population is found to be disproportionately female, with Surgery 22.3 percent, the largest respondent group. The major proportion of respondents were hospitalized for either 'less than one week' or 'more than three months.' The major proportion of patients received two to three visitors daily.

The second section is the chi-square analysis for the degree of association among the three categories of behavioral response. A high degree of perceived behavioral change is associated with a low degree of perceived freedom to communicate and a low degree of perceived relatedness to the nurse. The association between perceived freedom to communicate and perceived relatedness to the nurse indicates that these categories test for the same response. A significance level in either one of these categories is considered significant for the hypothesis.

The third section of analysis tests the hypotheses of the study. The behavioral response categories are tested against each of the variables by chi-square analysis.

Hypothesis 1 is upheld. There was no significant difference in the response of patients when sex of the patient is compared.

Hypothesis 2 is upheld. There was no significant difference in the response of patients when length of hospitalization is compared. However, the data shows significance for the category of perceived behavioral change. The association is negative. The longer the

hospitalization, the more changes are reported. The converse is also true.

Hypothesis 3 is rejected. There is a significant difference in the response of patients when clinical service is compared. Extended Care respondents reported a high degree of behavioral change, an indifference to freedom to communicate, and, a lack of relatedness to the nurse.

Maternity respondents reported very few behavioral changes, a high degree of freedom to communicate, and, a high degree of relatedness to the nurse.

Medicine respondents reported a few behavioral changes, a low degree of freedom to communicate, and, an average response to relatedness.

Psychiatry respondents reported many behavioral changes, a high degree of freedom to communicate, and, a high degree of relatedness to the nurse.

Surgery respondents reported few behavioral changes, an indifference to freedom to communicate, and, an average response to relatedness.

Rehabilitation respondents reported few behavioral changes, a low degree of freedom to communicate, and, a positive response to relatedness.

Hypothesis 4 is rejected. There is a significant difference in the response of patients when number of visits is compared. Significance is achieved in two of the three behavioral response categories:

perceived behavioral change and perceived relatedness. The association for perceived behavioral change is negative. The more frequent the visits, the fewer changes are reported. The converse is also true. The association for perceived relatedness is positive. The more frequent the visits, the more relatedness perceived. The converse is also true.

Hypothesis 5 is upheld. There is no significant difference in the response of patient when number of visitors per visit is compared. However, the data is significant for the category of perceived behavioral change. The association was negative. The more visitors per visit, the fewer behavioral changes perceived. The converse was also true.

## Chapter Five

### SUMMARY, CONCLUSION, RESEARCH IMPLICATIONS AND SUGGESTED RECOMMENDATIONS

#### SUMMARY

The purpose of the study was to determine the significance of selected variables on the response of patients to loneliness-associated statements. The variables and statements are derived from the literature relative to the topic of the loneliness of the hospitalized patient.

A greater degree of loneliness is associated with certain in situ variables. The variables identified were: the length of the patient's hospitalization, the type of clinical service and the contact the patient maintained with significant others. In order to determine the contact of significant others, two questions were asked: the number of visits the patient receives per week and the number of visitors he receives per visit. There is no indication in the literature as to whether the sex of the patient is significant in the development of loneliness. To determine whether such a significance exists, the variable of sex was added to the questionnaire.

The questionnaire, thus, is divided into two sections. The first is designed to elicit information relative to the variables of the study. The variables as mentioned are:

sex of the patient;

length of hospitalization;  
clinical service;  
number of visits received per week; and  
number of visitors received per visit.

The second section requests either [yes] or [no] response to twenty-two loneliness-associated statements. From an original group of 110 statements derived from the literature, fifty-four were selected for pretest, twenty-two for the final test. The twenty-two statements are divided into three behavioral response categories:

perceived behavioral change;  
perceived freedom to communicate; and  
perceived relatedness to the nurse.

The questionnaire was pretested on twenty patients, eleven male, nine female, resident in one of the hospitals used in the study. The pretest population of twenty was excluded from the patient sample required for data collection.

The hospitals selected for this study were two general acute treatment hospitals, each with a separate but associated extended care unit and one specialized rehabilitation hospital. These hospitals were selected because their clinical services included all those to be studied and their combined patient population provided sufficient numbers for data collection. The rehabilitation hospital supplemented an otherwise deficient clinical service population within the two general hospitals. The population sample was considered to be all patients

resident in these three hospitals on the day selected for the study. The pediatric wards were excluded from the population sample because of the difficulty in obtaining parental consent. The emergency and day care patients were also excluded from the population sample because, for the most part, their treatment measures excluded their participation in the study. Four hundred and forty-three patients was the population tested. This number is considered statistically significant for the descriptive method of research used in the study. Patients who required simple reading or mechanical skills to answer the questionnaire were assisted by the investigator. Patients who were receiving treatment or who were physically or mentally incapable of answering the questionnaire were not asked to participate. The Head Nurse or her deputy assisted in this selection.

The questionnaire was distributed and collected by the investigator. Privacy to answer the questionnaire was provided as much as the situation permitted. The investigator asked each patient to participate in the study. The investigator clearly stated that their participation was voluntary, their answers were anonymous, and that the purpose of the study was to help nurses better understand patients. Any inquiries which arose from the questionnaire were answered when the investigator returned to collect the completed questionnaire.

The data is analyzed in three separate sections. First is the analysis of the population sample in terms of the selected variables. The second analysis is by the chi-square method which is used to determine the degree of association between the three behavioral response

categories. The third section tests the hypotheses of the study.

These hypotheses are as follows:

1. there is no significant difference in the response of patients when sex of the patient is compared;
2. there is no significant difference in the response of patients when length of hospitalization is compared;
3. there is no significant difference in the response of patients when clinical service is compared;
4. there is no significant difference in the response of patients when number of visits received is compared; and
5. there is no significant difference in the response of patients when number of visitors per visit is compared.

### CONCLUSIONS

The first section of analysis deals with the population sample in terms of the selected variables. The population sample was 68.2 percent female respondents. Comparison of the male/female distribution by clinical service indicates a disproportionate number of females in Extended Care, Psychiatry, Rehabilitation and, of course, Maternity. The frequency distribution for length of hospitalization is loaded in two categories, 33.4 percent in 'less than one week' and 22.3 percent for 'three months or more.' The distribution for clinical service by total population ranges from Surgery, 22.3 percent, to Rehabilitation, 13.3 percent. The majority of respondents, 68.0 percent reported daily visits, 54.8 percent received two to three visitors per visit.



The population sample can be described as disproportionately female, with Surgery, 22.3 percent, the largest respondent group. The major proportion of respondents were hospitalized for either less than one week or more than three months. The major proportion of respondents were well visited, reporting two to three visitors daily most frequently.

The second section of analysis deals with the association between the three behavioral response categories. The degree of association is determined by chi-square analysis. The degree of association between all three behavioral response categories is significant. A high degree of perceived behavioral change is associated with a low degree of freedom to communicate and relatedness to the nurse. The implication is that those respondents who reported a high degree of loneliness-associated behavioral changes did not feel free to communicate those feelings nor did they perceive a high degree of relatedness in which to make this communication. The association between freedom to communicate and perceived relatedness indicates that these categories test for the same behavioral response. Significance achieved in either of these two categories is considered significant for the hypotheses of the study.

The third section of analysis determines the significance of the hypotheses of the study.

Hypothesis 1 is upheld. There is no significant difference in the response of patients when sex of the patient is compared.

Hypothesis 2 is upheld. There is no significant difference in

the response of patients when length of hospitalization is compared. However, the data is significant for the category of perceived behavioral change. The longer the hospitalization, the more changes were reported. Almost consistently the number of changes perceived increased as the length of hospitalization increased.

Hypothesis 3 is rejected. There is a significant difference in the response of patients when clinical service is compared.

Extended Care respondents reported many behavioral changes in themselves but were indifferent to the categories of perceived freedom to communicate and perceived relatedness. The implication is important. Extended Care respondents perceived many loneliness-associated changes in themselves but did not feel either the need or the freedom to communicate these perceptions to the nurse.

Maternity respondents replied to very few of the loneliness-associated changes in behavior. Their response was positive to the categories of freedom to communicate and perceived relatedness. The positive trend for relatedness, however, far exceeded that for freedom to communicate. This seems to indicate that Maternity patients very definitely perceive a sense of relatedness with the nurse even though they are not as definite in their freedom to communicate with her.

Surgery respondents indicated that few behavioral changes were perceived. Freedom to communicate is of no particular significance, although a positive sense of relatedness to the nurse was reported.

Medicine respondents related more loneliness-associated behavioral changes than did the Surgery respondents. Medicine

respondent's perception of relatedness was average, but their perception of freedom to communicate was negative. The implication is important. Medicine patients perceive a few loneliness-associated changes in themselves but like Extended Care patients do not perceive the freedom to communicate these changes. Respondents from both these clinical services perceived loneliness-associated changes in their behavior but from the data it seems unlikely that these changes would be communicated

Psychiatry respondents perceived many loneliness-associated changes in their behavior. Unlike Extended Care and Medicine respondents, however, Psychiatry respondents perceived a high degree of freedom to communicate and relatedness to the nurse. This observation is not inconsistent with the ward milieu which encourages open communication and self-disclosure.

Rehabilitation respondents perceived few loneliness-associated changes in themselves. Their response to freedom to communicate was the most negative of any clinical service. This is an interesting observation in view of their more positive response to relatedness. These respondents, it appears, perceived a sense of relatedness to the nurse yet did not or would not allow themselves the freedom to communicate with her. One possible explanation for this divergent pattern may relate to the rehabilitation treatment goals. Emphasis on the relearning tasks may predispose the patient to de-emphasize free communication in order to get on with the task at hand. However, these relearning tasks require close involvement between patient and nurse,

which predisposes the patient to perceive a sense of relatedness to the nurse.

Hypothesis 4 was rejected. There is a significant difference in the response of patients when number of visits is compared. Significance is achieved in two of the three behavioral response categories: perceived behavioral change and perceived relatedness. Respondents who received visits daily reported very few loneliness-associated changes in themselves and a high degree of relatedness to the nurse. Respondents who received visits only once a week perceived many of the loneliness-associated changes but did not perceive a sense of relatedness to the nurse. The implication is that reduced relatedness with significant others reduces the relatedness to the nurse and predisposes patients to perceive many loneliness-associated changes in their behavior.

Hypothesis 5 was upheld. There is no significant difference in the response of patients when number of visitors per visit is compared. However, the data is significant for the category of perceived behavioral change. Respondents who reported one visitor per visit perceived more loneliness-associated changes than did those whose visitors were more numerous. The pattern of difference between a high degree and a low degree of perceived change for number of visitors is not as significant as when number of visits is compared. Loneliness-associated changes in behavior are significantly more affected by the number of visits received per week rather than the number of visitors per visit.

In summary, the variable of sex of the patient bears no significance on the response of patients. The variables of length of hospitalization and the number of visitors received per visit significantly affects the response to the category of behavioral changes. Only two variables, that of clinical service and that of number of visits received per week significantly affect the response of patients to loneliness-associated statements.

### RESEARCH IMPLICATIONS

Frequently during the follow up visits regarding the study, the nursing staff made comments about patients whom they considered lonely. These comments and remarks were made and gathered in a random manner and are presented here as close to their original context as possible. Frequently, remarks were made with regard to the visitors the patient received. Most often there was a distinct absence of visitors, or visits, when made, were described as duty-bound or perfunctory. The nurses made their remarks in response to the patients' disappointment, disappointment which one nurse described as 'pathetic sadness.'

Overtalkativeness in certain patients was seen as a camouflage for loneliness. The pressure of conversation attempted to keep close the presence of another person.

Frequent comment was made about the aura of apartness which the lonely person conveyed. The patient had not so much withdrawn into himself but withdrawn from others. It was the sense of desperation

within this withdrawal which was disturbing to the nurse. The nurse was often unable or afraid to respond to this plea from the patient.

Sometimes the nurse openly expressed frustration in her attempts to deal with what she identified as loneliness behavior. The nurse's efforts to reach out to the patient seemed unanswered, the selection of approaches seemed inadequate, and the resulting behavior, was often one of mutual withdrawal.

The context similarity of the observations made by the nurses and the frequency of their mention is noteworthy and indicates a need for further study. Study of the behavioral manifestations of loneliness and the nursing measures designed to deal with loneliness are suggested. Often nurses deal with their observation of patients in an automatic, intuitive manner without formalizing their goals and plans. It is the opinion of the investigator that nurses already have a great deal to contribute to the study of loneliness if such a study is initiated.

Study of loneliness in any setting requires in-depth techniques for data collection. The questionnaire method is not such a technique. The questionnaire is designed essentially for wide distribution and is severely limited in the level of information it seeks to achieve. Its selection for use in this study is primarily to validate empirical data with patient response and to indicate areas for further study. Several areas for further study are indicated by the questionnaire.

The variables of clinical service and number of visitors

received per week significantly affects patient response. To a lesser, though still significant degree, patient response is influenced by the length of hospitalization and the number of visitors received per visit. The pattern of response for each of these variables appears independent, however, it could be argued that each of the variables are a function of the other. Factor analysis of each of the variables would indicate the variable most responsible for the response noted.

To validate empirical data with patient response was one of the purposes of this study. The twenty-two statements were derived from the literature pertinent to the loneliness of the hospitalized patient. Factor analysis of each of the twenty-two statements would indicate which statements were most influential in determining the noted outcome.

Analysis of the association between the three categories of behavioral responses indicated that two of the three categories (perceived freedom to communicate and perceived relatedness to the nurse) tested for the same behavioral response. Yet, on further analysis for the hypotheses of the study, the response patterns for these two categories were dissimilar, often opposing. Despite the close association statistically between these two categories there appeared to be dissimilar elements to which the patients responded. Again, factor analysis of each of the statements within these categories would indicate which statements influenced the noted outcome.

The literature indicates that a high degree of loneliness-associated change is accompanied by a low degree of freedom to

communicate. This association was not universally upheld in the data analysis. Factors not identified in this study may have accounted for this discrepancy. Identification of these factors may indicate areas for further nursing consideration.

#### SUGGESTED RECOMMENDATIONS

The suggested recommendations are as follows:

1. factor analysis of each of the significant variables to indicate the variable most responsible for the noted response;
2. factor analysis of each of the loneliness-associated statements to indicate which statement influenced the noted outcome;
3. study of the identified variables and statement in terms of prevention/intervention of the pathology of loneliness;
4. further study of the loneliness manifestations as identified by ward personnel; and
5. investigation of the reaction to and approaches of intervention initiated by ward personnel.



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## APPENDIXES

## APPENDIX A

### VERBAL REQUEST TO PARTICIPATE IN THE STUDY

"Hello. I am Diane Brennan, a Nursing Student at U.B.C. I am doing my Masters thesis now and this questionnaire is part of my research."

"Would you mind reading it over and answering it if you wish to, if you don't, that's O.K. too."

"Your answers will not have your name on it, so no one will know what answers you put down."

"If you do decide to answer the questionnaire, would you please read over and sign the consent form too."

"Do you have any question."

"I'll be back later to collect the envelopes, forms."

APPENDIX B

WRITTEN PATIENT CONSENT FORM

PATIENT IN HOSPITALCONSENT FORM

- A. I have been informed that my participation in this study is voluntary, and that I do not have to answer this questionnaire if I don't want to.
- B. I have been informed that my answers to this questionnaire will remain anonymous and that no one will know what I answered to these questions.

Patient's Signature . . . . .

Date . . . . .

APPENDIX C

WRITTEN INSTRUCTIONS FOR PARTICIPANTS



This questionnaire you are being asked to fill out is to help nurses better understand some of the feelings of patients in hospital.

I would like very much for you to participate in this study but *honesty* in answering all the questions is needed. Also it is necessary that you answer all the questions so that the study will be valid. There are no right or wrong answers. It is your feelings that are important.

The form I would like you to fill out is inside the brown envelope along with a pencil for you to use. Inside the envelope you will also find a small white one. If you would like a copy of the results of this study would you please write your name and mailing address on this white envelope and I will be happy to send the results to you when everything is completed.

I will be back in about one hour to collect your answers. I'll collect brown envelopes and white envelopes separately so your answer will remain entirely anonymous.

Thank you very much for your cooperation.

Sincerely,

A. Diane Brennan.

APPENDIX D

THE QUESTIONNAIRE

Part I of Patient in Hospital

Please answer all of the following questions by placing a check-mark [✓] beside the appropriate answer.

1. Are you        male        [ ]

                 or female        [ ]

2. Approximately how long have you been in hospital for the present admission?

                 less than 1 week        [ ]

                 1 week - less than 2 weeks        [ ]

                 2 weeks - less than 3 weeks        [ ]

                 3 weeks - less than 1 month        [ ]

                 1 month - less than 2 months        [ ]

                 2 months - less than 3 months        [ ]

                 3 months or more        [ ]

3. What would the ward you are on be classified as?

                 Extended care        [ ]

                 Maternity        [ ]

                 Medical        [ ]

                 Psychiatric        [ ]

                 Surgical        [ ]

                 Rehabilitation        [ ]

                 Don't know        [ ]

4. About how often do you have visitors?

                 daily        [ ]

                 twice a week        [ ]

once a week ☐

almost never ☐

5. Approximately how many visitors do you have each time?

one ☐

2 - 3 ☐

4 or more ☐

none ☐

### Part II of Patient in Hospital

Please answer *all* of the following statements by placing a check-mark [✓] in either the agree ☐ or disagree ☐ space beside each statement.

Agree      Disagree

1. I find myself day dreaming a lot now since I  
came to hospital . . . . . ☐ ☐
2. Sleeplessness worries me more since I'm here  
in hospital . . . . . ☐ ☐
3. The time used to go by so quickly, now it  
seems each day is endless . . . . . ☐ ☐
4. Since I've been here I find myself quite often  
wishing I was someone else . . . . . ☐ ☐
5. Since I came into hospital I don't seem to care  
to plan things like I used to . . . . . ☐ ☐
6. People now irritate me more than before I came  
into hospital . . . . . ☐ ☐

	Agree	Disagree
7. I'm not as interested in other people as I was before coming here . . . . .	[ ]	[ ]
8. Since I came to hospital I don't seem like the same person any more . . . . .	[ ]	[ ]
9. At times I feel extremely hopeless about being here in hospital . . . . .	[ ]	[ ]
10. I would prefer that no one knew I was here in hospital . . . . .	[ ]	[ ]
11. I would trust the nurses to confide a personal problem to them . . . . .	[ ]	[ ]
12. I have total confidence in the nurses who look after me here . . . . .	[ ]	[ ]
13. I would tell one of the nurses if I felt lonely here . . . . .	[ ]	[ ]
14. I think nurses are not allowed to tell patients the whole truth about their illness . . . . .	[ ]	[ ]
15. I talk to the nurses but I really don't tell them anything about me . . . . .	[ ]	[ ]
16. I choose not to let people know how I really feel inside . . . . .	[ ]	[ ]
17. I try not to admit it when I feel I want to be comforted by someone . . . . .	[ ]	[ ]
18. I think nurses prefer patients who don't complain very much . . . . .	[ ]	[ ]

Agree    Disagree

19. I think nurses have only time to listen to  
physical worries, not emotional ones . . . . . [ ] [ ]
20. Sometimes the nurses pretend not to notice  
when I'm feeling badly . . . . . [ ] [ ]
21. I believe that the nurses make every effort  
to make the patients feel worthwhile . . . . . [ ] [ ]
22. There is one nurse who seems concerned  
about me . . . . . [ ] [ ]